NURSING HOMES AND RELATED LONG-TERM CARE SERVICES

HEARINGS

BEFORE THE

JOINT SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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NOTE.—Three hearings on nursing homes were held as follows:
Part 1—Washington, D.C., May 5, 1964.
Part 2—Washington, D.C., May 6, 1964.
Part 3—Washington, D.C., May 7, 1964.

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NURSING HOMES AND RELATED LONG-TERM CARE SERVICES

TUESDAY, MAY 5, 1964

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

The subcommittee met, pursuant to call, at 10:15 a.m., Hon. Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss, Neuberger, Long, Yarborough, and Fong.

Also present: Frank C. Frantz and Jay B. Constantine, professional staff members and John Guy Miller, minority staff director.

Senator MOSS. The joint subcommittee will come to order. We expect there will be additional Senators able to come from time to time during these hearings. Since we are a special subcommittee we are able to sit while the Senate is in session, but it means we have some obstacles to contend with such as quorum calls and other demands on Senators' time.

It is a pleasure to welcome all of you to the first day of our current series of hearings on nursing home problems.

This is the Joint Subcommittee on Long-Term Care of the Special Committee on Aging. It consists of our Subcommittee on Housing and our Subcommittee on Health of the Elderly. The interests of these two subcommittees converge as we consider the needs of those who must combine their living arrangements with some continuing health care. It is my privilege to lead this joint inquiry.

The joint subcommittee held hearings in December in which we gathered information on the various Federal activities dealing with nursing homes and related facilities. These Federal programs have each been devised to meet some particular need. In some cases they are simply applications to nursing homes of larger programs with objectives unrelated to the health field.

Much that is good has been accomplished under these programs; there is no question about that. But these earlier hearings made clear that from the point of view of the nursing home field, our programs are a patchwork. The Federal Government lacks a coherent policy toward the long-term care field and toward its role in assisting this field to develop.

The task of the joint subcommittee, then is to begin the long and difficult process of rethinking our Federal policies in this field.

Achievements in medical science, and developments in the methods of bringing these achievements to the people who need them, offer great potential for better services to the chronically infirm aged. It is a national responsibility to assist in realizing this potential.

But as I review our present efforts at the national level, I think that our people in the helping and healing professions have long since passed us by. I suggest that in our Federal programs we may be guilty of irrelevance.

This morning, and for the next 3 days, we will be hearing from witnesses amply qualified to help us begin this task of rethinking the national role in developing the best patterns of long-term care services for our citizens, and to become more responsive, within the framework of that role, to the needs of communities where this care is given.

We are pleased, indeed, to have several distinguished witnesses today. Our first witness will be Miss Ollie A. Randall, who is vice president of the National Council on the Aging. We will be glad to hear from Miss Randall now.

Be seated at the table, please.

STATEMENT OF MISS OLLIE A. RANDALL, VICE PRESIDENT, NATIONAL COUNCIL ON THE AGING

Miss Randall. First I want to thank you for the opportunity of participating in these hearings on a topic of such vital importance to the elderly of the Nation and one which is, and has been, of major concern since its very inception in 1950 to the National Council on the Aging, which I represent here today as one of its officers.

However, my own personal interest and involvement in the operation and improvement of long-term care facilities outdates that of the council by about a quarter of a century. So in my personal comments I might do something quite different.

It is worthy to note that one of the first tasks undertaken by the then national committee, now the national council, was the preparation of a three-volume report on "Suggested Standards of Institutional Care for the Elderly." This task which was financed by the Schimper Foundation in New York was undertaken as a much-needed voluntary national service by the council, at the request of the Social Security Administration.

It was thought at that time (and I gather it still is thought at this time) undesirable, if not inappropriate, for the Federal agency to establish such standards.

This was regarded as the primary function of the States, all of which were however required to include licensure (based on State standards) of such long-term care facilities in their State plans by 1953 in order to qualify for reimbursement of funds expended for care in medical and health facilities as authorized by the amendments to the Social Security Act effective in 1953.

It was also recognized that many local communities have their own codes or standards, some of which obtain, though they may exceed in their requirements those adopted by the States, so that Federal intrusion through standard setting in these situations appeared to be an even more questionable procedure.

These volumes on suggested standards although originally published in 1953 are still in constant demand in view of the increasing interest by a number of national, State, and local organizations, official and philanthropic, for adaptation to their specific memberships and institutional programs.

They are about to be brought up to date on factual data. On the other hand, they are far from out of date (indeed in 1964 they are still "ahead of time") in the goals suggested for quality of care, for they are yet to be fully realized in the majority of institutions or any type of long-term care facility under any auspice.

It is our own hope, and even belief that the spotlight thrown by all our combined efforts on the need for improvement in physical structures and providing more suitable accommodations will help toward achieving a higher quality of care which must be our chief objective at all times.

I have read with considerable care and great interest the reports of your previous hearings which you have just mentioned. Hence it seems a futile exercise to repeat for today's records the many pertinent statistics you already have or to comment extensively on points so ably presented and discussed by the members of your well-informed committee and by those reporting to you.

There are however, several points on which, as I move about the country, participating in institutes on this topic, in research projects, and listening as well as experiencing the strong resistance to both official and voluntary efforts to raise standards, the comments or opinions of a "voluntary" observer may have some value for you.

First, I would like to comment there is real need for much better understanding of what is meant by long-term care facilities. These include, of course, hospitals, (general and special), homes for the aged (the traditional and long-established facility), nursing homes (sometimes called convalescent homes), residential and personal care homes, hospitals for the mentally ill, and last but not least, quantitatively, the person's own home which serves the greatest number of persons as a long-term care facility.

The latter is often overlooked when the feasibility or need of insitutionalized long-term care is being determined and an evaluation of the adequacy and demonstrated actual availability of the community services which make good care in the home possible or appropriate constitutes an important but often neglected component in this determination.

Often the development of these and their use might have prevented or could prevent, institutionalization. It is to find definitive answers to some of the vague information on the medical economics of giving the right kind of care in the home as compared with that given in long-term care facilities, as well as to discover whether this kind of care can be given in the home with effective organization of visiting and outpatient care that the study of "Health Care of the Aged," financed by the Ford Foundation, is being conducted in Rochester, N.Y.

Now in its third year, it is the only study of its kind with this objective to be made in depth, so that there should be from it a contribution not only to sound information on costs and methods, but to better knowledge as to quality of care and how we may measure it.

I would like to discuss homes for the aged as long-term care facilities. It has occurred to me as I work as a consultant to the Hill-Burton program in New York State on nursing homes, on the preparation of practical State and municipal codes for both proprietary and nonprofit facilities, that the greatest need in the field is for the

clarification or interpretation to members of official agencies with responsibility for the use of available funds and to the general public as to just what is a "home for the aged" (usually a nonprofit agency) today and what it is likely to be tomorrow. "Home for the aged," I would like to comment, is a generic term used loosely to describe a number of types of long-term care, such as:

1. The home which still follows the traditional pattern, changed very little and familiar to many people as a pattern of accepting so-called well-aged persons and which, without any overt emphasis based on nursing care guarantees to give lifelong care to its residents.

2. The home for the aged, with its average age of the resident census in the mideighties and that of applicants or newly accepted residents about 80 or 81—which has drifted— willy-nilly, into being a "nursing home" for a high percentage of its residents, infirm, frail, chronically ill or invalid, without having at an earlier date consciously planned for this development, but which has faced up to the responsibility for good care for those for whom they have guaranteed life care.

3. The home for the aged which has accepted the new role of providing up-to-date health care, according to modern medical and nursing standards, in buildings well designed and equipped for this service for both those already in residence and for new admissions.

Those appearing for the American Association of Homes for the Aged before this committee later this week will report on the surprisingly high number of nursing care beds (some 200,000), available or being planned by the homes which are members of the association.

Yet in my own experience we still find persons in official agencies raising serious questions as to whether design and equipment in these can be approved when new construction or rehabilitation is underway just because the institution bears the name "home for the aged." And I might add that it would expedite local and State programs enormously if all Federal agencies could or would interpret the definition for any type of facility in the same way—not only here in Washington, but in their regional offices also. This will be of extreme importance in any future legislative statutes or in the rules and regulations for administering them.

I would like to talk for a moment about the function of the facility. In thinking of long-term care and including "homes for the aged" as significant in the contribution to this care, it may be pertinent to point out the basic difference in purpose between these and the "nursing home" under proprietary or nonprofit auspices.

Older people go to a "home for the aged" primarily as a "place to live" with the guarantee of health care only one factor which commends it as a place of residence. Here they hope to go on living to the extent of their ability and so far as opportunities for this are provided by the home.

Older people go, or more often are placed or admitted, to nursing homes to be "kept alive" through treatment of a specific disease or illness or for a chronic ailment which cannot be cared for adequately elsewhere. The term "nursing home" has become more and more a "misnomer," for the new, presumably efficient facilities so described are actually hospitals without some of the equipment and personnel which qualifies a medical facility for accreditation as a general hospital.

In a home for the aged the person may become a patient—but first and foremost he is a person. In a nursing home an individual is a patient first—and someone with personal and social needs only secondarily. In the nursing home he may often fail to become this.

The newly constructed nursing homes, despite their lounges and "recreational" areas, are not places in which any of us would choose to live, were choice ours, except for temporary care. Besides, the high cost of care in these precludes extended care of long duration for most people.

We therefore find the anomalous and socially undesirable, though deemed economically desirable, situation of public welfare payments, being used to keep the less suitable homes in operation in which many persons on public assistance or limited social security benefits pay for their care (or it may be paid for them) in unlicensed or substandard homes which are licensed because of the lack of better accommodations and this is the only place in which they can afford to be.

Therefore, both care is less adequate than is desirable and this maintenace of low standards is supported by tax funds by the group that has every stake in the world in raising them. The level of reimbursement payments and State standards of assistance are of course controlling factors here also, and vary from State to State.

To those of us concerned with improving the level of care for the elderly, in long-term care facilities the discriminatory practices of the Federal loan programs in favor of the proprietary interests are a source not only of puzzlement but of great dissatisfaction. The programs of the Housing and Home Finance Agency and the Small Business Administration, which provide much more favorable loan possibilities to this group than to any nonprofit groups seem to encourage the development of this type of facility under a type of auspice which fails to provide facts as to the true costs of operation and of the level of care provided.

The operation of official and nonprofit facilities are subject to public scrutiny and control, and would seem therefore to merit at least as favorable support in upgrading their facilities as the private entrepreneur who may be a businessman, a doctor, or merely someone interested in a potentially profitable enterprise without any real concern in its purpose, and who has resources to which to turn other than the Government.

Perhaps this committee can throw some light on this situation which has never been satisfactorily explained or justified so far as I know. Probably the basic question to be answered is whether the Government agencies are more interested in protecting their financial interests than in providing protection for those of the elderly who require long-term care at a cost which does not include high profits for those providing it. This Federal policy which favors proprietary interests has resulted in the following action this year in New York State. There, the need for long-term care facilities or new nursing home beds is identified as being 15,000 beds in New York City alone in the next decade—with an almost equivalent need in the rest of the State.

Senator McNeil Mitchell sponsored and steered to passage in the 1964 legislature a bill which will allow a substantial part of future Mitchell-Lama projects now used for housing to be used for nursing home facilities.

As he expresses it, this will be a boon to voluntary agencies in their efforts to cope with the nursing home problem. In addition an amendment to the constitution of New York State was passed by the State legislature and will go before the electorate in referendum in 1965, which will allow the full use of Mitchell-Lama funds for nursing home purposes.

Some of the requirements which call for more intensive review may be commented on—

In some of the proposals for insurance coverage for the care of the elderly the actual "distinct part of the building" which I put in quotes, in which care is given has been designated as a requirement for eligibility for such.

This is in direct conflict with modern concepts of care, which, with preventative and restorative therapy a major component for both the physical and psychological well-being of the patient, mean that today such care is preferably provided to the patient in his own room rather than having that patient moved to an infirmary or a given floor where no better care can be given than he can receive "where he wants to be."

The place care is given is to me incidental, or should be. The true basis for payments should be the type of care or service required by the patient and actually given that patient. Nowhere have I seen in proposals for Government coverage that basis explored as it has been in hospitalization coverage by Blue Cross, Blue Shield, or commercial insurance programs.

My personal fear—this is not the council's, but mine—is that this will have a serious effect on architectural designs for these facilities in which there is real effort at present to achieve flexibility of use of space and accommodations.

In your previous hearing I found certain statements as to the involvement of the medical profession in nursing home administration which, in my experience, are far too optimistic. In a study conducted in New York State with the cooperation of the county medical societies, a high proportion of physicians visited nursing homes in their counties for the first time even though they had been referring patients to them.

Despite the code provision that there should be a "medical advisory board" for every home, this usually is in my words, a "paper board." Even, as is increasingly true for many, when a physician has found the ownership of a nursing home a profitable venture, the involvement of medical personnel is seldom as great or as frequent as it should be. I have also been somewhat shocked to learn how little concern some physicians who have real interest in the practice of medicine with older people have as to the actual events in the overall administration of a nursing home which may have even greater effect upon the patient's improvement or lack of it than his own treatment.

The difficulty of persuading busy physicians—or perhaps physicians disinterested in chronic illness or chronically ill elderly patients—to visit in nursing homes is demonstrated very dramatically by the records of the infrequency of such visits even when emergencies arise.

The in-and-out transfer of patients between nursing homes and hospitals in emergency situations in New York City, and I presume elsewhere, is eloquent testimony of this. But I would like to say a

word about the question of affiliation or agreements which I think have been mentioned as eligibility requirements for coverage by insurance.

These agreements arrived at between long-term care facilities and hospitals will, I am sure be discussed fully by others appearing at these hearings. However, I want to go on record to point out the great necessity for much more study and demonstration of this type of arrangement before it is made a requirement for administration of such a facility to be eligible for funds from governmental sources for construction or for reimbursement for patient care.

In the first place, "affiliation" between a proprietary nursing home and a hospital is still very rare—for few hospitals enter into negotiations for such an arrangement, although I think this will be coming in the future.

Also an "affiliation," in my experience in New York Hill-Burton explorations, reveals that it is even where formally signed and endorsed by the two parties, a piece of paper which has little meaning for either party beyond the fact that it is "on record."

The recently published guide to principles of agreements issued by the American Hospital Association should be a genuine contribution to better understanding of what should constitute such agreements and how they may be arrived at, so that they are useful arrangements in assuring continuity of care for patients requiring long-term care.

Then it also seems timely to suggest the common administration of hospitals and nursing homes as a device which will assure improved care. This does not always prove to be true. Certain advantages accrue to the long-term care facility through the availability of some services which can be provided more economically.

On the other hand, certain disadvantages have been noted where hospitals have the controlling administration of long-term care units whether in separate buildings or in wards in the hospital building as is current practice in some of our New York municipal hospitals.

Service to the long-term care patient is regarded as less demanding and less important than those of the hospitals proper. So where emergencies arise in the latter, the services in the former are apt to suffer. Personnel is usually not of as high a caliber as in the hospital, hence, service itself does not measure up to the best standards.

With shortages of qualified personnel of all categories in hospitals and long-term care facilities this perhaps is understandable. However, if patients are people with demonstrated need and demonstrated ability in many instances for a return to self-care with proper restorative and intensive care, no matter what their chronological age, the plan for common administration needs to be promoted with extreme caution and very careful research as to whether this really favors them by promising the best care for the long-term patient.

As one of the elements in long-term care which should be a criterion for judging "quality of care"—something which still, I must say, eludes practical measurement—should be the "restorative" or "rehabilitative" approach and provisions in long-term care.

This has been demonstrated—first in Illinois as I know you have already been advised—as a possibility without high costs to the home or the patient and with reduced costs ultimately to the community.

It has also been proved to be good "business" even though it may mean higher turnover in patient census to the nursing home.

What it means to the patient in his own capacity for living can be materially measured in lowered costs for care, but it defies measurement in the meaning life can have for an individual who has been given the means of being a more self-sufficient person.

It is also my hope that this committee will keep within its scope of interest the review of the recent development in public housing of "group living facilities." Most of us with long experience in the administration of housing for the elderly and of long-term care facilities view this plan with some apprehension—even with some alarm. The proposal is for housing, with nonhousekeeping accommodations but with a common dining room for persons "not able to manage themselves" in independent housing arrangements.

This to us outlines an institution with the necessity for very specially qualified staff which may be provided through arrangements with the Welafre Administration—but which can very quickly and easily, as a low-cost arrangement for a low-income group, become nothing more than our currently troublesome "personal care homes."

This is indeed a social welfare institutional program first—and a housing one second, so that many of us with our experience with public housing authorities through the years and up to the present time, regard this plan as fraught with heavy problems that call for a high degree of competence and supervision.

Such a responsibility has not previously been accepted by most public housing authorities where even casual social service to say nothing of intensive service, has been thought not to be a function of the landlord-tenant relationship.

One of the most urgent emergency problems for the long-term care facility has been mentioned in your hearings, but since it is one of major interest to the council as well as myself, I should like to mention it briefly.

This has to do with the provisions for the elderly who cannot, without help, manage themselves or their affairs—and who are being discharged from mental hospitals or are not being admitted for care, thereby relieving the hospitals but transferring the problem of appropriate care to nursing homes and the community.

Here fiscal arrangements have a real impact on choice of place of care—since hospitals for the mentally ill are State institutions and care is financed wholly from State funds.

Usually in other facilities care must be paid for from local and State funds, the latter of which include any available Federal reimbursements. Therefore, transfers from the local facility to the State facility have formerly been very much simpler to arrange than that from the hospital back to the local facility—this accounting to some extent for the high percentage of elderly patients not requiring hospital care who are still found in the State facility.

Homes for the aged and nursing homes are seldom equipped for giving the needed care—although New York State has regulations which under certain prescribed conditions permit the retention or reception of patients who previously would have been sent to or have been kept in hospitals for the mentally ill.

The regulation states that "When a patient is suffering from such a degree of mental disease that there is either danger to himself or others, or behavior so socially unacceptable or disturbing as to interfere with adequate care or comfort of other patients, arrangements shall be made for his transfer to an appropriate [1] facility under the provisions of the State mental hygiene law, after due consultation with responsible persons or agencies, physicians and other persons concerned" (reg. 476.5 (f)[1]).

The "halfway house"—demonstrated to be so useful in Great Britain—is a proposal that seems to have merit. There has also been proposed a "part way house" and how this differs from the "halfway house" I am not sure. But the principle of care geared to the needs of these elderly people is inherent in them both.

There have been demonstrations of the potential of many of them to profit by treatment to the point of returning to a greater ability for self-direction in some of our more progressive hospitals for the mentally ill and homes for the aged—such as Kings County Hospital in New York City and in Canada where open wards in hospitals for the mentally ill have encouraged institutions to experiment in concentrated care of such patients.

But for the record it is my hope that persons with competence and positive experience will be involved in your hearings on this area of care so that we may profit from their considered testimony in our next steps. The National Council on the Aging is about to embark on a demonstration project in protective services for the elderly in several communities with a grant from the National Institute of Mental Health.

This is encouraging for it is still very difficult to arouse interest or concern in mental health programs for the prevention or treatment of mental confusion or mental illness in elderly people.

Now, my last two comments will be very brief. The first is that I believe the all-out effort of everyone concerned with the administration of long-term care should be addressed to finding ways and means of determining the quality of care, type of care needed, but as I have previously indicated, actually provided.

The price paid for this care in proprietary institutions bears little relation to quality, and this is a matter which appears to have great relevance to public welfare agencies which are paying for at least 60 percent of the patients in these institutions.

While Federal studies have been undertaken to determine what care is given and how it is given for those of us whose business it has been to find care and to find money to pay for it, real figures of cost have been very elusive, either through intent not to reveal them or through genuine lack of knowledge of what they are. The movement to improve accounting methods, sponsored by both nonprofit groups and the Government as well as the profitmaking groups, will help us to expand insurance coverage of care in long-term care facilities such as homes for the aged on a group basis experimentation which is already underway.

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[1] Today that appropriate facility may be a specialized nursing home or a home for the aged which undertakes the care of persons whose behavior rather than actual mental illness calls for the need for specialized care.

The other point which I merely want to record is that there should be administrative improvement in all our Government agencies, Federal, State, and local, to reduce the tremendously high and costly expenditure of time as well as money in processing applications and plans for financing and constructing facilities.

The rigidity in application of detailed rules on small items of relative unimportance which delays by weeks and months any final closure or approval of large loans has, for nonprofit groups, and I also believe for proprietary groups as well, been enormously frustrating and difficult.

There seems to be little recognition on the part of the official representatives of the competence and experience of some architects and some operative groups which understand fully the functional requirements of the facility they hope to build and operate.

This experience is not localized. It is general across the country. I run into it anywhere I go. It indicates that any devices which can achieve great improvement of communication between Washington offices and regional headquarters as well as a greater concentration on teamwork between public agencies and nonprofit and proprietary groups will be more effective in producing the facilities that are so badly needed in many communities today.

Much of what I have had to say to you this morning is repetitious of what has been presented to your committee earlier. Its only value may rest in its endorsement of previous statements and in the observations and experience of a long-time worker in programs for older people, to whom their well-being in all situations, but especially in long-term care programs is of primary concern as it is to the National Council on the Aging.

Thank you very much.

Senator Moss. Thank you, Miss Randall. That is a very fine statement and we appreciate your coming here to contribute today. There may be a few questions that we would like to ask.

One that occurs to me; you spoke of official agencies limiting the facilities for nursing care in homes for the aged. Do you have in mind the FHA section 231 program for housing for the elderly?

Miss Randall. Yes, sir; that is one of the programs. And you may or may not be aware, that it was only 2 weeks ago the Housing and Home Finance Agency called together a number of the nonprofit groups, including church, philanthropic groups, and others, because they were concerned there had not been enough use of this program by these groups. They had not been well enough informed to know how to go about getting this, and facing, as I said, the discriminatory methods for loans, 90 percent for the proprietary group and 50 percent for the nonprofit groups. They were reluctant to enter into negotiations.

I talked with a member of that staff just yesterday and it was reported that this particular session had been productive of improved relationships and understanding. I hope it will result in some changes in some of the rules and regulations for the future use of section 231 with which I am very familiar.

Senator Moss. Thank you. In your statement also you said that you have noticed some strong resistance from some areas to raising standards.

Miss RANDALL. Yes, sir.

Senator MOSS. Just what are those areas of resistance?

Miss RANDALL. Our major concern today, sir, has been in upgrading our codes in a great many communities for the operation of both proprietary and nonprofit long-term care facilities. My most recent experience has been in New York City where I have worked on preparing the new code which I think was put into effect last year, after a long and arduous effort to remove the grandfather clause, so called, so that the homes that were in business in unsuitable buildings might really improve their facilities to a point where they would be safe and better managed.

The result of this has been that one of the homes has brought suit against the commissioner of hospitals who is responsible for licensure in New York City and has questioned the constitutional right to establish these codes. I was called down to work with the corporation counsel to try to discover why these requirements had been established and so forth. The case has not come up in court as yet, although the commissioner says "I am enforcing the code at the moment as nearly as I can," and he further said, "If they win the case we will appeal it, and if we win it they will appeal it, so it will be a little while before we really resolve this question."

But our major problem in establishing codes has been these physical accommodations in places where people are established in old buildings which are not safe. You have read about some of the fires and other catastrophes that have taken place. We are attempting to remove the possibility of using these buildings for patients who cannot manage for themselves in the case of a crisis, fire or any other kind. This is one of our greatest difficulties in the whole situation at the moment.

Senator MOSS. At one place you said that New York State required a medical advisory board for review of the home, but that this was largely a "paper board." Does this paper board exist in a lot of other States, too?

Miss RANDALL. I think it does, because we have found that where it is required it is established as a committee, and advisory group. Advisory groups, and I am a member of a lot of them, do not always have too much effect upon an operation, and the doctors, I think, in this particular area, have not been too vitally concerned with the quality of care.

Certainly we have not found that in New York State where I am a little more familiar than I am with the others, although I think I have worked with about 20 of the States on their plans for the administration of nursing homes, and this concerns not only proprietary groups.

I think some of our philanthropic groups are much more aware of using their medical staff, shall we say, even when they are volunteer members of the staff perhaps a little more religiously than some of the others.

Senator MOSS. Why do you think that where hospitals and nursing homes are under common control, the services are likely to drop to a lower level?

Miss RANDALL. I think at this moment from my own work with hospitals as well as in nursing homes, and I do a good deal of this, that everybody is familiar with the tremendous shortage of good

nursing staff, and good programs of care. There is abroad the feeling that care of the chronically ill, the invalided, the persons who need nursing care in nursing homes or the nursing wards which New York City, for instance, has set up, really do not need the same quality of care, do not need the same quality of supervision as other patients. I have found that while the advantages accrue from the common basis of staff, you see, of providing certain kinds of overall purchasing, direction, and so forth, we do not get the same quality when this is an added burden for the hospital.

They do have a great deal to undertake right now to carry out their own charges and to add this to it. This is often a real burden.

I have, as I have indicated to you, worked for a number of years with the Hill-Burton program in New York, and I have the opportunity of working with our hospital development program and with the nursing home program, where I have found that this does raise real questions as to whether you can maintain the proper quality of care for this group.

Senator Moss. Thank you, Miss Randall. I should say for the members of the subcommittee, we do have a live quorum call going now. I do not know whether you could hear; the buzzer did not sound in here, but we will have to go and answer the quorum.

There may be additional questions of Miss Randall. If you would like to alternate this some way perhaps we could keep it going and still answer our quorum.

There may be additional questions. Do any of you have additional questions of Miss Randall now?

Senator Long. I do not at this time. I am sorry I will not be able to come back because I particularly wanted to hear Dr. Murray from Missouri, who will testify this afternoon.

Miss Randall. May I add one point; you run along, Senator Moss, if you want to. I would like to have this committee really have under its purview one of our very serious problems in States where the license for the care of unrelated persons in a boarding home is limited to four persons, unrelated to the operator, and then it is licensed at the level of four or three.

Connecticut, I believe, is the only State where licenses are required and where there is only one unrelated person taken in for board or room and care.

At this point we have too many places throughout the country, where they have taken in two persons, and there is no licensure of any care. Public welfare is paying very high rates for this care.

Senator Moss. Perhaps we had better go and answer our quorum, and we will ask you if you will answer a few more questions when we return.

We will be in temporary recess for 5 minutes.

(A brief recess was taken.)

Senator Moss. We will now resume. We have made our obedience to the Senate rules and answered the quorum and we are now back again. I think Senator Neuberger had a question or two she wanted to ask of you, Miss Randall, on the record.

Miss Randall. That is fine.

Senator Neuberger. Reviewing your testimony, you say it was thought originally, and you suppose it still is thought at this time,

undesirable, if not inappropriate for the Federal agency to establish such standards; referring to standards for institutional care.

Miss RANDALL. That is right.

Senator NEUBERGER. Do you mean that you yourself think it would be undesirable to have a minimum floor of Federal standards for nursing homes?

Miss RANDALL. I think the difficulty will be the implementation of having that established because of the great variability in all States, Senator. I think they felt at that time the undesirability lay in the fact they did not want to impose any level of standard on any given State, that they felt this was the function of the State.

Whether or not there has been any change in that opinion on the part of the Department of Health, Education, and Welfare group, I do not know.

Senator NEUBERGER. But if the home receives Federal funds, with part of the funds coming from all the taxpayers, why should not minimum Federal standards apply?

Miss RANDALL. I do not have any real feeling that it should not be done, except I think that too often the Federal group that would have the task of attempting to enforce any such standards would be so remote from the medical application of them that it would not be practical.

Our greatest problem in the whole matter of standards is actually not only establishing these, you can put them on paper very easily in codes and so forth, but I do not know of any community yet where I think they have adequate staff—I mean adequate in number or in caliber—for really working with the development and enforcement of standards.

So I just have a feeling at the moment that we have our minimum. I would say there is not a State in the country that has anything above minimum standards.

Senator NEUBERGER. Let us talk about this in relationship to welfare payments because you indicate here that the level of welfare payment is a factor.

Miss RANDALL. It is.

Senator NEUBERGER. In the quality of nursing home care?

Miss RANDALL. It is.

Senator NEUBERGER. Then would you advocate increasing, perhaps through Federal contribution, the amount of payment; and if we do increase the payments, should we not impose higher standards?

Miss RANDALL. I think they should go together and whether it is the Federal job or the State job, I do not know, because there will be local money in it as well. But my feeling here is that up to now in our public welfare payments we are frequently paying far too high rates for the kind of care that is given and that we need a very much more careful evaluation of what we are paying for. I have just come from an all-day meeting at which this was the basis of discussion, because it seemed that our public welfare workers who are responsible for these 60 percent of the patients do have, Senator, a responsibility to have some idea of the quality of care and what they are paying for.

So, whether or not this comes through with a standard that is minimum from the point of view of Federal, below which you would not want to pay, might be a possibility at this time.

Senator NEUBERGER. Now, we have Federal-State cooperation in the Hill-Burton program to which you referred.

Miss RANDALL. I know, I work with it all the time, and I do know this.

Senator NEUBERGER. Does that not set standards?

Miss RANDALL. We have standards of construction, but not standards of operation. This is a very different thing, and this is why I have indicated that perhaps our improved standards of construction may help us ultimately in having better service because people can work better in some of these that are now being built. The Federal-State agency works with the Public Health Service on setting or agreeing on those standards for construction, but there standards of operation are not set for us by this.

This we have to determine at the State and local level at present.

Senator NEUBERGER. I do not understand why we have to set them at the State and local level.

Miss RANDALL. Maybe you know more about it than I do, and I am sure you do, but at this point, I am saying this is our situation.

Senator NEUBERGER. Well, I know, but let us move on from this point.

Miss RANDALL. You know Oregon, I know a little, and I know some of the situations there. You know Missouri, you know Mississippi, and some of these States, and to set a minimum standard that would be possible there to be applied nationally would create, I think, a situation in some of our other States which might downgrade standards that are already higher than they are in those States.

Senator NEUBERGER. But you are going to set a minimum standard.

Miss RANDALL. What is that?

Senator NEUBERGER. You are only going to set a minimum.

Miss RANDALL. May I say, and I have said this over and over again in other meetings. A minimum tends to become a maximum in any set of standards that I have ever seen. People do not try to go beyond it, and your minimum which you would have to set so that it could be met, shall we say, in Mississippi, would be so much lower than we hoped to achieve in Michigan, shall we say, or New York or Illinois, that I would hate to have us bring it down.

Senator NEUBERGER. I do not think that is borne out. I know a lot of Federal aid to impacted areas in schools, for instance, and the standards for those schools vary a great deal in different States.

Miss RANDALL. We do have this experience, Senator Neuberger, for instance, in New York State where certain standard-setting authority can be delegated to a community as it is to New York City. And there we have several sets of standards, I might observe.

We have the one that is set by the city licensing authority which is vested in the hospital department. Then we have the New York City Department of Welfare which sets its own certification standards for the use by its department and it does not always use all places that are licensed because some of them are not approved for their welfare recipients.

So you see we have there several sets of standards that apply, and upstate we have two communities where their standards are higher than those of the State and those are the ones that we follow.

This same thing might happen if you could establish a Federal standard agreed upon by the States.

Senator NEUBERGER. I do not want to prolong this too long, Mr. Chairman.

Miss RANDALL. I have not answered you because I cannot, except that this was the position taken by the Federal Government at the time that we were asked to establish suggested standards only.

Senator NEUBERGER. May I move on to another point about physician ownership of nursing homes. Is this a different situation from physician operation of nursing homes?

Miss RANDALL. Yes; because we do not get too active cooperation by doctors.

Owners may be absentee owners. We have run into this in New York State which I am using as typical. I have just come from a meeting with a gentleman who owns Holiday Inns, and he owns nursing homes across the country and he has nothing to do with the operation of them.

We get this with certain groups of doctors who have undertaken to operate nursing homes. We have had some dentists who have done this in New York, and so forth, but they are not involved in the medical program of the institution which they have bought or operate.

I am just pointing out the doctor is not the only sinner in this situation of being an absentee owner. We do have, as a matter of fact, as one of our major problems today certain syndicates that are buying up chains of nursing homes. When you attempt to get at violations the operator is not the owner and then we have some difficulty in tracing through to the person who is ultimately responsible for the maintenance of standards.

So these are all the kinds of difficulties encountered with private enterprise which, however, I think has done a tremendous job in meeting the need for long-term care facilities because the philanthropic groups and communities really have not been able to organize themselves to do it. Nevertheless, I do believe it is time for us to take a look at it and see what we can do to make it possible for some of the nonprofit and philanthropic groups to "get into the act."

Senator NEUBERGER. That is all.

Senator MOSS. Senator Fong?

Senator FONG. Miss Randall, how large is this problem of the aged requiring permanent nursing care?

Miss RANDALL. Well, at the moment we have not had any increase in the so-called percentage of people who need to be institutionalized for care, and this varies from 4 to 6 percent of the total population. However, as the numbers of older people increase that means that percentage represents a very much larger number of people. For instance, 6 percent of 18 million means many more individuals who need this kind of care than did 10 years ago when the number was 11 million.

Now, the other thing that we have to take into consideration, sir, is that because of the lack of certain organized services in the community that could keep people in their own homes or out of the institution we do have in this 4 to 6 percent a number of people who are in institutions who ought not to be there. Take one mental hospital, for instance, that I visited the other day while working with the director, he said, "I have 1,500 patients here who do not need hospital care for their particular type of behavior difficulty or lack of orientation. But there is no place in this particular area or county to which to take these people. This is what I am trying to indicate.

So, we have a poor distribution of older people in need of long-term care, Senator, at the moment. We have some in institutions that ought not to be there, and we have some outside who ought to be in, but I do not think there is great variability in the percentage of persons who need this kind of care.

We were told at the conference in 1961 that the older people would be using about 2½ times as much of this institutionalized care as people who were younger.

And this is the upper age group that is tripling in size in the next 20 years so that (I think it is 20, maybe a little longer), so you see this does represent perhaps quite an increase in the number of people who will need this type of care. This again will depend on what we do about the younger group to prevent their needing institutionalization and providing community services for them.

Senator FONG. Now, you have two types of individuals who are aged. Is that correct?

Miss RANDALL. Yes.

Senator FONG. One group does not need any medical care, but just wants a place to stay?

Miss RANDALL. That is right.

Senator FONG. What percentage of the older population would you say they constitute?

Miss RANDALL. This is hard to differentiate because most of us need a place to live. The question is whether they need a specialized place to live, is that what you mean, Senator?

Senator FONG. Yes.

Miss RANDALL. I think you are asking about the people who have social needs for a specialized living.

Senator FONG. For a place to live?

Miss RANDALL. I would think this would not be more than 1 or 2 percent of our population. I do not think it would be quite that.

Senator FONG. Most of the older people prefer to live by themselves, right?

Miss RANDALL. Very much so.

Senator FONG. And most of them do provide for their own place to live?

Miss RANDALL. This is a trend, Senator Fong, that has developed as a result of our improved social security benefits, our improved assistance and our pension programs, so that people can continue to pay their rents or maintain their homes. Therefore they will stay there much longer than they could have done even 10 or 20 years ago.

Senator FONG. So would you say that if a person had sufficient income and there were sufficient payments to the elderly people, then actually we do not need homes for the aged?

Miss RANDALL. Oh, we need some.

Senator FONG. From the standpoint of just those who do not need medical care.

Miss RANDALL. I do not think you would need many.

Senator FONG. I am not speaking of the nursing home.

Miss RANDALL. There are people who are alone, who need to live with other people simply for social reasons, therefore, some of the homes do provide just this, and I would not want to deny that as a possible situation. What happens there, Senator, is this: When you

take the person to a home at 70 or 75, it is not very long before his need is going to change and he will require some kind of nursing supervision and care. As we get older we do have frailties of several kinds, so that you have to have some other place to which you can send older people in order to have continuity of living arrangements for that individual, if you do not provide it in the residence where people have been living on their own.

We have a good many people living in boarding homes, right now, and a good many in private hotels. I cannot give you the number because they are not licensed, they are not supervised, and we cannot identify that quantitatively, but we do know that it is an increasing number who are moving into that kind of situation.

Then the problem arises at the point when there is a crisis in that person's situation, and he has to move into some kind of nursing facility, so I cannot give you numberwise what it is, because we have no way of having a count on it.

Senator FONG. But typically speaking, you feel we need more aged homes.

Miss RANDALL. Yes. I think we need more, and we need better ones. We have a number I would like to see go out of existence and replaced with really good buildings and good operations.

Senator FONG. Even for those elderly who do not need medical care?

Miss RANDALL. Yes, I think we need—I do not like to call it home for the aged. What I am saying is, I think we need better living accommodations without making it a home, because the minute you use that word it implies that there must be residential supervision of that person's life and his daily living. I think what we need are better housing accommodations for the group you are talking about where they can really maintain themselves pretty well without having this kind of institutionalization which means somebody watching what they do from morning to night.

Senator FONG. We have the same problem with the older people who are elderly, but they are not so acute.

Miss RANDALL. We have the problem of good housing in the United States anyhow. We are way behind in providing it. I recently saw some new building out your way, so I know they are thinking about it there too.

Senator FONG. Coming to nursing homes, do these people go there and remain permanently or do they just go in for a short period?

Miss RANDALL. May I say we see some very hopeful signs in our nursing homes today. With our new look at restorative therapy and so forth, poeple are not necessarily going to nursing homes to stay. They and their situations can be improved, and we are looking toward removing them from the nursing homes as we are in our hospitals today.

Senator FONG. And we have been doing that, getting them away from the nursing homes.

Miss RANDALL. Yes. This program that was started in Illinois has demonstrated that a lot of rehabilitative gadgetry was not needed if good rehabilitative nursing is given. Most of the work of rehabilitation is 90 percent good nursing and good care. When we get this we can get people taking care of themselves, and if we can at the same time keep them in touch with their families, and others in the community we can move them out.

We have a new nursing home in Rochester, N.Y., that has been in business a year and a half, and they tell me 60 percent of their patients they have been able to return to the community because of good care. This is a new look and I am sure the people here representing the nursing homes will say this is something they want to see happen.

Senator FONG. What would be the average stay in a nursing home?

Miss RANDALL. It goes anywhere from a few weeks to 10 or 12 years at the moment. It depends on the nursing home. It also depends on what else there is in the community for the person to go back to. This is what I meant by saying there were a good many people in nursing homes that would not have to be there if there were other places for them to go.

Am I overdoing this, Senator Moss?

Senator FONG. I am trying to clarify the problem. There are those in nursing homes who actually do not need to be there, but there is no place else for them to be.

Miss RANDALL. There is no place else in the community for them to be, and this is a situation we would like to have taken care of. I am sure the operators and sponsors of both your county homes, your city homes, and all of these institutions would be delighted to have done if we could.

Senator FONG. What would you recommend as a place for them to go if they do not require the nursing care?

Miss RANDALL. It depends on the status of the person, Senator Fong, whether it is an individual who could really take care of himself in his own living accommodations. Then I would like to have specialized housing for that group with built-in management, you see.

If the person cannot take care of himself fully then I think we need the kind of institution that you are talking about, a place where there is some supervision but not necessarily total guidance, but better housing. This is what we need.

Senator FONG. Now, these nursing homes, are they mostly proprietary or are they mostly——

Miss RANDALL. The largest number of so-called nursing homes are proprietary, yes. The number of homes for the aged that are operating nursing facilities also is a very large group, but we do not identify them in the count of nursing homes. They are homes for the aged with nursing infirmaries and nursing facilities or nursing services and these are not currently in the count of the nursing homes. I would rather that the nursing home group who are here would give you the figures on that than myself.

Senator FONG. If they are proprietary then the patients in these homes naturally have to pay a certain sum per month.

Miss RANDALL. That is right.

Senator FONG. They either pay themselves or somebody who is related to them pays it.

Miss RANDALL. That is right, but I hope you got the point that 60 percent of them are being paid through public assistance funds or social security benefits.

In other words, the public welfare agencies are paying for at least 60 percent of the patients in proprietary nursing homes.

Senator FONG. And there is no public facility for them so they have to send them to a proprietary home.

Miss RANDALL. In very many of our counties the public facility is not adequate or it may have been contracted out to a nursing home operator so that we do not have adequate official, shall I say, agencies.

When I talked about our affiliation agreements with which we had difficulty in New York State, the situation was between a public county infirmary and a hospital. Getting these relationships made operative while realizing that the county facility was not really medically satisfactory in its care, since it did not have the proper standards there at all, was not at all simple.

Senator FONG. Now, do the governmental authorities find it difficult, once they place a person in the nursing home, a proprietary home to take them out later and place them somewhere else?

Miss RANDALL. They have just the same difficulty that the individual has of finding the proper place, so that this is one of our major problems, Senator. It really is. But also I think it could be improved, the situation could be improved. When you are a social worker and you have to place a person who is sick, and you have been fortunate enough to find him a place, you leave him there. It is so much easier than struggling to find another place and move him on.

Also remember our public welfare workers are pretty well overtaxed in the size of their caseloads and they do not follow as closely with patients in the nursing home as maybe a family does. Therefore there is not the urge to move in and move that patient—especially if it is hard to find another place.

Senator FONG. So, if we are able to provide housing needs for the aged, aside from taking care of their medical expenses and their medical care, it would alleviate the situation pretty much, would it not?

Miss RANDALL. Oh, very, very much.

Senator FONG. The same way with nursing homes.

Miss RANDALL. Yes. I would think it would improve also the care, the type of care you could get in nursing homes because you have a better relationship to the type of patient that gets the people they ought to have and not those they do not.

It can be awfully monotonous taking care of chronically ill patients when there is no observable change from day to day. Sometimes there is very little stimulation for either the nurse or doctor in this. Nevertheless, we do know that a great deal can be done with the rehabilitative approach if we can motivate the person as well as the staff to do something toward self-help.

Senator FONG. Would you say most of the aged can be rehabilitated?

Miss RANDALL. No, I would say they can be improved much more than we had ever dreamed long ago, as long as 40 years ago when I started operating a home for the aged with a larger infirmary. At that time we let people stay in bed. Now we know that is the wrong thing to do. We now can get them up and about and have a certain amount of self-care.

To say all older people could be restored to their original capacities is wrong. We can improve them and we can get them through by good care—and this has been demonstrated in nursing homes—to taking better care of themselves and to be returned to the community.

Senator FONG. Outside of a very few would you say most or many of them could be improved so they could take care of themselves?

Miss RANDALL. Yes, sir.

Senator FONG. So they do not have to crowd the nursing homes and hospitals.

Miss RANDALL. Yes, sir. I can give you one or two instances of homes for the aged where they have some 300 older people. When I asked how large their infirmary was (that is the place where people were really bedridden) there were only 10 beds, and only 3 of those people were bedridden 24 hours a day, because of very much improved nursing and medical care, so that we are getting a different approach to this kind of care.

Senator MOSS. This has been a very fine discussion. It has helped us make the record and I appreciate it, but we do have to move on.

Senator YARBOROUGH. I have one question here.

Senator MOSS. Senator Yarborough?

Senator YARBOROUGH. I noticed on page 7, Miss Randall, you have this sentence, "Probably the basic question to be answered is whether the Government agencies are more interested in protecting their financial interest than in providing protection for those of the elderly who require long-term care at a cost which does not include high profits for those providing it."

Now, my question there would be whether the problem was not that the Federal agency is more interested in protecting its financial interest but that a lot of people building these homes are more interested in profits they are going to make out of it than they are in the elderly?

Miss RANDALL. That is another whole topic, Senator.

All I meant there was that I believe we have encouraged the proprietary interests much more than we have the group that would go into this business of housing and care because of a genuine concern for people which group is often the philanthropic group, the religious or church groups. Unfortunately, some of those are thinking about this by building some of these very luxurious units on the west coast and so forth, but primarily this was what I was getting at.

Senator YARBOROUGH. I think you have raised a very good point. You say it is a basic question, and I think it is a very basic question.

Miss RANDALL. I think it is, too, very seriously.

Senator YARBOROUGH. In the interest of the other four witnesses I will not pursue it further.

Miss RANDALL. Thank you very much.

Senator MOSS. Thank you, Miss Randall. The fact that we had so many questions indicates that we were anxious to get your opinion and your experience for the committee. We do appreciate your coming.

Senator MOSS. Our next witness is Mr. William E. Beaumont, Jr., who is president of the American Nursing Home Association and past president of the Arkansas Nursing Home Association. I understand you are accompanied by Mr. Alfred S. Ercolano, who is the executive director. Is that correct?

Mr. BEAUMONT. That is correct.

Senator MOSS. Very good. We are glad to have you gentlemen, and you may proceed.

STATEMENT OF WILLIAM E. BEAUMONT, JR., PRESIDENT, AMERICAN NURSING HOME ASSOCIATION, AND PAST PRESIDENT, ARKANSAS NURSING HOME ASSOCIATION; ACCOMPANIED BY ALFRED S. ERCOLANO, EXECUTIVE DIRECTOR, AMERICAN NURSING HOME ASSOCIATION

Mr. BEAUMONT. Mr. Chairman and committee members, I am William E. Beaumont, Jr., president of the American Nursing Home Association, whose national offices are located at 1346 Connecticut Avenue NW., Washington, D.C. I also am a past president of the Arkansas Nursing Home Association and am the owner-administrator of a 47-bed nursing home in Little Rock, Ark. I have with me today, Alfred S. Ercolano, executive director of the American Nursing Home Association. The American Nursing Home Association has a membership in excess of 4,500 nursing homes in 48 of the 50 States, and affiliated State associations in 47 States. Our membership represents some 170,000 beds. Among its member homes are private, or proprietary, voluntary nonprofit and public homes.

We who must deal with the problems of caring for our aged and chronically ill on a day-to-day basis, appreciate the opportunity afforded by this committee to present to you this statement on the condition of nursing homes in the United States today.

Since its inception in 1949, the American Nursing Home Association and its predecessor organizations have provided leadership in improving nursing home facilities and standards of care in nursing homes throughout the country.

We have worked diligently with other organizations in the medical and paramedical fields in meeting the health problems of the aged. Our association is a member with the American Medical Association in the Joint Council To Improve the Health Care of the Aged. At present, I am chairman of the joint council.

As an integral part of its program of providing leadership in raising standards of care in nursing home facilities, the ANHA plays an active role as a member itself in a number of national organizations. It is a member of the National Fire Protection Association, the National Safety Council, the National Health Council, the U.S. Chamber of Commerce.

Our association is a contributing member of the National Council for the Accreditation of Nursing Homes. In conjunction with the Health Industries Association it is engaged in an expanding program of regional workshops and exhibitions designed to elevate the capabilities of nursing home administrators and other personnel and to keep them aware of the latest advances in equipment available for nursing homes.

ANHA is in the process at this very moment in establishing liaison committees with the American Nurses Association and the National League for Nursing and another liaison committee with the Health Insurance Council of America.

What are the results of these horizontal activities? Let us take, for example, the National Safety Council, ANHA in cooperation with the

council and under the direction of Miss Doris Mersdorf—who testified at your 1960 hearings, has produced a very complete new safety manual for nursing homes and related facilities.

ANHA joined with the American Pharmaceutical Association and the American Society of Hospital Pharmacists in producing a pharmaceutical manual for nursing homes.

ANHA cooperated with the U.S. Public Health Service in the production of a nurse's aid manual which is being used by local Red Cross chapters and other groups in training nurse's aids in the manpower retraining program of the Federal Government, and as an inservice training manual in nursing homes. Fifty thousand copies have been distributed.

At present, ANHA is engaged in a pilot project study with the U.S. Public Health Service on the cost of care in nursing homes. Authoritative information on nursing home care costs is sorrowfully lacking and such is important not only to public agencies who provide financial assistance for patients, but also to hospital insurance groups which are expanding their coverage to include care in nursing homes.

ANHA also has made a request for funds to conduct a preliminary study of current practices in the care of the mentally ill and mentally retarded in nursing homes. In some States literally thousands of our aged persons have been transferred from overcrowded, overinstitutionalized mental facilities to nursing homes in the past few years.

In the past the association has worked with the Public Health Service through one of its State affiliates in the development of a system of uniform expense accounting for nursing homes.

There is a revolution going on in the nursing home field. Though perhaps quiet, it, nevertheless, is dramatic.

The nursing home, as many of you were aware or have been advised during current hearings, is a relatively young member in the community of health facilities.

Their development dates back to the early part of this century although their real growth began in the decades of the forties and fifties and has been even more significant in the sixties.

Many nursing home owners and administrators were literally backed into the field. Many of them were elderly women who took in another elderly person who needed only personal care and attention. Others began by operating boardinghouses for elderly persons. As the years passed, some of their guests became ill and bedfast and before they knew it, these boardinghouse operators in effect had become nursing home owners for there was no place to send these unfortunate individuals.

As you may realize, it has not been many years since the person of average or low income faced the prospect of going "over the hill to the poor farm" or being committed to a State mental institution as a result of even mild senility as age pressed in upon him.

As inadequate as these converted oversized residences might have been as nursing homes or personal care homes, they were in most cases more desirable to the alternatives that the community had at its disposal for the care of the aged.

Since 1950, there has been a tremendous increase in the number of nursing homes and related facilities caring for our elderly. I am not going to bore you with a mountain of statistics for I am sure you will

be getting figures from more authoritative studies than I can give you at this time. I will let it suffice to say that in 1939 there were an estimated 1,200 homes with about 25,000 beds.

By 1961, there were 23,000 nonhospital facilities providing for care of the aged and chronically ill with a bed capacity of 592,800, a 32-percent increase over a 1954 survey.

Of these facilities, 11,600 were nursing or convalescent homes with 369,300 beds. The remainder were other facilities for the aged including homes for the aged, boarding homes, rest homes, and the like.

Construction of new homes, spurred on by the FHA loan guarantee program, SBA loans, and the Hill-Burton program as well as the recognition of commrecial mortgage houses that such homes were needed and would be safe investments of their shareholders' funds, has been tremendous in the last 3 years. I have seen estimates as high as $113 million a year in construction.

These new homes, in some areas replacing the older converted houses, are larger in size. The 1961 Public Health Service survey indicated that skilled nursing homes had a median size of 25 beds, a one-third increase from the 1954 median of 19. Most new homes today range in size from about 50 beds to as high as 450.

Their construction costs vary from as low as $4,000 to $5,000 a bed to as high as $15,000 per bed.

The American Nursing Home Association and its membership generally have maintained an enlightened view of the nursing home situation and the need for improvement.

In its early days the association and its member State groups fought for licensing. In 1950, for example, only five States had nursing home licensing laws. Today every State licenses nursing homes.

By the mid-1950's, leaders of the association were beginning to look to accreditation as a means of elevating standards of care and facilities on a cross-country basis. Some States established their own accrediting programs. To halt this fragmentation of effort and to bring about some uniformity, the association on its own in 1962 established a national but unilateral accrediting program.

This quickly was supplanted with the establishment of the National Council for Accreditation of Nursing Homes under the joint sponsorship and financing of ANHA and the American Medical Association. Other interested groups have been invited to participate in the program.

Let us take a brief look at some of the accomplishments and some aspects of the changing nursing home scene.

1. The emphasis upon accreditation and increased standards has brought to nursing homes an increased recognition by medical and paramedical groups that nursing homes are truly part of the community of health facilities serving the people of this country.

2. This change in attitude has been enhanced by other developments such as the creation of the American College of Nursing Home Administrators organized in 1963 with the support of ANHA and other leaders in the health care field, and the establishment last year of the American Nursing Home Educational Foundation, a nonprofit organization, incorporated under the laws of the District of Columbia to accept funds and to carry on research and education programs in the field of geriatrics with particular emphasis on nursing homes.

3. There has been a marked and significant increased activity in the educational field as the most direct means of improving nursing home care. Literally hundreds of workshops are held annually at State and local levels to better prepare nursing home personnel for the job they must accomplish in the fields of restoration and rehabilitation, dietetics and nutrition, recordkeeping and cost accounting, medical and nursing care, management and administration, ethics and social consultation work.

ANHA and its State affiliates cooperate with State and local health agencies and universities and colleges in sponsorship of workshops and seminars on the many aspects of nursing home care.

ANHA has given active support and encouragement to the George Washington University in establishment of the first graduate curriculum in nursing home administration.

ANHA and its members not only support programs but also help provide faculty for 6-week short courses at a number of colleges and universities including Northeastern University, in Boston, Columbia University, the University of Iowa, the University of Oklahoma, and Michigan State University; just to name a few.

ANHA and its members are engaged in a series of regional conferences and exhibitions in cooperation with State associations and Health Industries Association. These are tremendously successful working sessions drawing upward of 2,000 persons each.

Registration fees are kept low to encourage nursing home owners and administrators to bring other personnel from their homes to participate in the sessions. Three already have been held, a fourth is scheduled for Washington in July, a fifth in Chicago in November, and plans are being made for similar programs to be held in the Far West and the Southeast in the years ahead. Attached is a report on subjects covered at these conferences. (See exhibit 1 at p. 28.)

The Joint Council To Improve Health Care of the Aged, with the full cooperation of ANHA, has five regional nursing homes care institutes—Boston, Dallas, Denver, Cincinnati, and Portland, Oreg.—now in the advance planning stage for this summer and early fall.

I think that the magnitude of this educational program is obvious and its success in terms of participation in the past is proof of the tremendous thirst for knowledge that nursing home personnel have in their desire to constantly improve the care—physical, mental, medical, social, and psychological—that they are able to provide those entrusted to them.

4. Nursing Homes, the official journal of the American Nursing Home Association, goes to some 8,500 subscribers, the vast majority of which are nursing home personnel. The 32- to 40-page monthly journal is predominantly educational in nature and carries articles describing progress and experience in the field of care of the aging.

5. Because of the increased emphasis on restoration and rehabilitation and the changing attitude on the part of other medical professionals, nursing homes are rapidly losing their identity as "the point of no return."

Nursing homes truly are a place to live rather than a place to die. Nursing home personnel, from the maids and cutodians to the administrator, medical directors and nurses, work as a team in an effort to restore their patients to the outside community. They work not only with the patients, but with the patients' families.

More and more we are seeing social caseworkers being assigned to help in the "bringing back" of these patients. Nursing homes in the future will become sort of "half-way houses" between the acute hospital and the community itself where patients of all ages can get the necessary nursing care and rehabilitation without the necessarily high cost of actual acute hospitalization.

6. Nursing home owners and administrators like others, both professional and lay, no longer are content to let the aged lie in bed. Every effort is made to restore patients to their maximum potential even if this is only an awareness of their appearance, an ability to feed or partially clothe themselves.

There have been astounding results in rehabilitation and in the number of our aged who have been returned to their families. At the same time, nursing home personnel are well aware of the limitations of rehabilitation and they seek to restore each individual to his own maximum potential.

7. Nursing homes, through experience and the necessity of keeping care costs as low as possible while meeting patients' needs, have turned to consultants and part-time retention of professionals in the fields of nutrition, physical and recreational therapy, social work, and psychiatry.

8. The accreditation program and education programs have brought an awareness on the part of nursing home personnel to the need for maintaining adequate medical records on all of our patients. Such records not only serve the home and the patient's physician, but also go with the patient if he must be transferred to a hospital for more acute care.

9. Many nursing home owners who have had converted houses in the past now are transferring their operations to new homes because modern construction methods and modern layouts and planning techniques make it more economical to provide the care and safety the patients require. There still are many converted homes in existence, but they have been substantially improved by modern fire protection systems, et cetera, to provide for safe and better care of patients.

10. Educational programs within the nursing home profession itself are being supplemented by programs through vocational education and the Federal manpower retraining program with the result that staffing is improving at all levels in the nursing home.

Administrators are better trained, nurses are getting better preparation in geriatric work, licensed practical nurses—who are a bulwark of the personnel setup—are being trained at an ever-increasing pace. Volunteer nurse's aid programs are being expanded along with inservice team training in the nursing homes themselves.

What are the problems ahead? Nursing home leaders and the American Nursing Home Association are among the first to recognize the shortcomings in providing adeqaute nursing home care for all those who need it. There still are many substandard homes; there still are some States without adequate licensing laws and adequate inspection systems and without adequate consultant and guidance services. But the situation has sharply improved over the past few years.

1. As long as there are inadequate inspection and licensing laws and as long as the public, State agencies, and legislatures refuse to provide adeqaute payments for nursing home care of public assistance pa-

tients—and these account for more than half of the patients in nursing homes—there will continue to be substandard homes.

You go to a modest hotel or motel where services are at a minimum and you pay $6 to $12 a day minimum for your room. This includes no meals; it includes no bedside service; certainly it includes no medications, no doctor calls, no nursing services.

Yet in many instances we have States unwilling to pay even the cost of providing the very minimum of services in nursing homes. In Massachusetts where 80 percent of patients in private or proprietary nursing homes receive public assistance, welfare rates from 1959 to 1964 increased only 35 cents or 5 percent to $6.85 a day.

During the same period welfare rates to 136 hospitals increased 41.3 percent and for 12 chronic hospitals 36.6 percent. The average increase alone for hospitals was $8.47, $1.62 more than the total per day cost paid to nursing homes. At the same time a State nursing home (650 beds) had an operational cost of $12.43 a day.

In Wisconsin, care rates vary widely from county to county with minimum care rates set as low as $75 a month, that is $2.50 a day, and maximum care as high as $275.

In Iowa, the public assistance rate for custodial care is $80 to $113 per month. The range for nursing home care is $96 to $225 with an average of $150. The average does not meet operating costs. In New York, county after county pays much less for care of a patient in a nursing home than it is paying for care in the country infirmary.

Attached is a study of these payments as made by Robert P. Simmons, of the New York State association. (See exhibit 2 at p. 29.)

The fact is that today it is difficult to provide nursing care and other rehabilitation services for patients for less than $8 to $10 a day or $250 to $300 a month. Yet in most instances the States are not approaching this sum. Too few States also are relating welfare rates of payment to the specific services required by individual patients and to the ability of individual homes to provide these services.

2. Some areas are being rapidly overbuilt as far as nursing home beds are concerned. In Denver, Colo., we are told there are 800 to 1,000 vacant beds at this time, yet construction, spurred on by Federal loan guarantees and outright grants, continues.

In Iowa, 94 new homes with 4,469 beds have been constructed in the last 7 years. Seventy other homes with a capacity of 5,262 beds are in the advance planning or construction stage, and estimates are that by the end of 1965 occupancy rates now averaging 90 percent could be as low as 80 percent. In at least one State (the situation since has been corrected) Hill-Burton authorities would grant a "certificate of need" for a home built under FHA standards only to declare the beds "unacceptable" after construction because of the differing standards applied by Hill-Burton authorities as to the acceptability of beds.

3. Unrealistic construction and equipment requirements, related only indirectly to improved patient care, may well place new facilities out of the price range of low- and moderate-income families and of public assistance patients. As long as State welfare authorities have only

so many dollars to spend per patient-day they are forced to put public assistance patients where they can purchase for the money available the degree of care nearest to the care the patient requires.

In some States, authorities actually have overlooked substandard conditions because of the necessity of stretching the public assistance dollar as far as it will go. In at least one State, authorities have even put welfare patients in unlicensed nursing homes.

4. A major problem faced today is just how far a nursing home should go in providing other than nursing, personal, and restorative services. Some of the newer homes—particularly the larger ones—have gone in for expensive laboratory, rehabilitation, and examination and treatment equipment. These all add to the daily cost of care.

In some instances, authorities appear to want to make junior hospitals of nursing homes and, on the surface at least, this seems to be unreasonable, if costs of care are to be kept within the reach of low- and middle-income families who either are paying for their parents' care or who must look to public assistance to pay at least part of the cost. The result, of course, too, can mean the increased institutionalizing of an environment which to many of us should be made as homelike as possible.

5. There is a growing need for improved working relationships between doctors, hospitals, nursing home, and community health facility planners. In many cases, those commissions and committees who are making long-range plans for community health facilities have no nursing home representative among their memberships.

Just as it is a waste of the taxpayers' money for neighboring hospitals to duplicate expensive radiology equipment and the like, so it seems wasteful to us to duplicate facilities from hospital to nursing home.

In most instances, nursing homes would do well to purchase rehabilitation, even pharmaceutical services, from a hospital and to set up procedures for the easy transfer of patients from nursing home to hospital and from hospital to nursing home.

A nursing home may not be able to find, let alone afford, the exclusive service of a nutritionist or a physical therapist but it should strive to purchase such services from another facility or to join in the cooperative employment of such experts.

There are, as you can see, many, many problems to be solved but great headway is being made in their solution. The nursing home profession is a dynamic, young profession and is one undergoing dramatic change at this very moment.

About this there can be no doubt—there have been terrific advances made in the professionalization and improvement of the care of nursing home patients and in the licensing, regulating, and inspecting of nursing homes.

There is room for a great deal of improvement and the American Nursing Home Association will continue to be in the forefront of those working for such improvements and working for the basic, best interests of the patients entrusted to the care of those in the field.

EXHIBIT 1

Subject listing of nursing home programs

Subject title	Type of presentation	Number of hours	Where presented [1]
Accounting—Determining Adequate Charges: Payment and Methods of Reimbursement.	Constructive workshop	2	2MA.
Accounting—Determining Costs	do	2	2MA.
Better Community Relations	do	2	1MA.
Financial Management:			
Accounting Procedures	do	2	2EA-3MA.
Purchasing Practices	do	2	2EA-3MA.
Internal Theft	do	2	2EA-3MA.
Accreditation Clinic	do	2	2MA.
Accreditation of Nursing Homes	do	1½	1MA.
Accreditation: Legal and Ethical Responsibilities in Nursing Home Care.	do	2	1EA.
Accreditation—Medical Records	do	2	1EA.
Accreditation—Personnel—Training, Selection, Motivation.	do	2	1EA.
Professional Aspects of Accreditation	Address		1EA.
Care of the Chronically Ill and Aged—The Professional Approach.	do		1EA.
Dental Care for the Chronically Ill and Aged (American Dental Association).	Film		1EA.
Community Relations—The Necessity To Create and Maintain an Effective Public Image.	Constructive workshop	2	2MA.
Cost Analysis and Accounting	do	2	1MA.
Environmental Health Aspects of Nursing Home (U.S. Public Health Service).	Film		1EA.
Educational Program for Nursing Home Administrators.	Panel	1	1MA.
Food and Food Service Techniques	Constructive workshop	2	2MA.
Menu and Food Planning	do	1½	1MA.
Housekeeping and Sanitation	do	1½	1MA.
Legislation That Will Affect Nursing Homes	Address		1MA.
Reaching the Market:			
Relationships With Professional Referral	Constructive workshop	2	2EA-3MA.
Selling Your Home to the Public	do	2	2EA-3MA.
Medical and Paramedical Services	do	1½	1MA.
Uniform Medical Records	do	1½	1MA.
Nursing Care Procedures	Address		1EA.
Meeting Tomorrow's Nursing Home Needs Today:			
How Nursing Homes Are Attempting To Meet These Needs.	do		2MA.
What the Church Expects for Its Aging	do		2MA.
What the Government Expects for Its Aging	do		2MA.
Modern Nursing Home (American Nursing Home Association).	Film		1EA.
Patient Services:			
Admitting Procedures	Constructive workshop	2	2EA-3MA.
New Areas, Such as Visiting Nurse and Day Care Programs.	do	2	2EA-3MA.
Volunteer Activities	do	2	2EA-3MA.
Personnel Management:			
Employee Orientation and In-Service Training	do	2	2EA-3MA.
Recruitment	do	2	2EA-3MA.
Staff Supervision and Staffing Patterns	do	2	2EA-3MA.
Philosophy of the Nursing Home	do	1½	1MA.
Planning, Designing, Financing Nursing Homes	do	1½	1MA.
Role of the Nursing Home in Society in the Future:			
Achieving Better Motivation in the Nursing Home Profession.	Address		2MA.
How Government Can Work With Nursing Homes To Provide Proper Care for the Aged.	do		2MA.
How Hospitals and Nursing Homes Can Cooperate To Provide Proper Care for the Aged.	do		2MA.
Rehabilitation and Restoration—The Medical, Surgical, and Psychologically Damaged Patient.	Constructive workshop	2	2MA.
Remotivation—Developing the Remotivation Technique.	do	2	2MA.
Remotivation—Mental and Physical Remotivation of the Patient.	do	2	2MA.
Remotivation—The Role of the Patient's Family in Nursing Home Care.	do	2	2MA.

See footnote at end of table.

Subject listing of nursing home programs—Continued

Subject title	Type of presentation	Number of hours	Where presented [1]
Remotivation, Restoration, and Rehabilitation:			
Nutritional and Dental Therapy	Constructive workshop	2	1EA.
Occupational and Recreational Therapy	do	2	1EA.
Physical Therapy	do	2	1EA.
Nursing Homes for Retarded Children—Their Increasing Importance; Their Professional Problems.	do	2	2MA.
Fire Safety in the Nursing Home	do	2	2MA.
Matter of Seconds (National Safety Council)	Film		1EA.
How Suppliers Can Best Serve Nursing Homes	Constructive workshop	2	1MA.
The Functions of and Benefits To Be Derived From Membership in the American Nursing Home Association.	Address		2EA-3MA.

[1] Explanation of symbols are:
1MA=1st Mid-America Nursing Home Convention and Exhibition, Chicago, Nov. 13–15, 1962.
1EA=1st Eastern American Nursing Home Convention and Exhibition, New York City, Aug. 11–16, 1963.
2MA=2d Mid-America Nursing Home Convention and Exhibition, Chicago, Nov. 24–26, 1963.
2EA=2d Eastern American Nursing Home Convention and Exhibition, Washington, D.C., July 21–23, 1964.
3MA=3d Mid-America Nursing Home Convention and Exhibition, Chicago, Nov. 17–19, 1964.

EXHIBIT 2

Public welfare rates for private proprietary nursing homes, private proprietary homes for adults, and county infirmary rates of public welfare districts in New York State

County	Rates		
	Private proprietary nursing homes	Private proprietary homes for adults	County infirmary
Albany County	Minimum, $170 per month (6 homes); medium, $200 (1 home): maximum, $225 per month (1 home).	Maximum, $125 per month	$7.07 per day.
Allegany County	$160 per month	Minimum, $60 per month; maximum, $90 per month.	$4.66 per day.
Broome County	Minimum, $150 per month; maximum $200 per month with L.P.N. in charge, $210 per month with R.N. in charge.	Minimum, $90 per month; maximum, $150 per month.	$9.02 per day.
1. Binghamton City	Same as Broome County	$100 per month	Same as (9.02) Broome County.
2. Towns of Union, Endwell.	Minimum, $210 per month; maximum, $220 per month.	$85 per month	Do.
Cattaraugus County	$190 per month	Minimum, $76 per month; medium, $91 per month; maximum, $106 per month.	$8.26 per day.
Cayuga County	$185 per month	$115 per month	$10.23 per day.
1. Auburn City	$180 per month	Up to $130 per month	Same as (10.23) Cayuga County.
Chautauqua County	Does not patronize private proprietary nursing homes.	Does not patronize private proprietary homes for adults.	$10.10 per day.
1. Jamestown City	$214 per month	None	Patronizes private nursing homes.
Chemung County	$55 per week (1 home)	Minimum, $57.50 per month; maximum, $77.50 per month.	$7.20 per day.
Chenango County	Minimum, $125 per month (type I); medium, $150 per month (type II); maximum $175 per month (type III).	None	None.
Clinton County	$175 per month	Minimum, $65 per month; maximum, $90 per month.	$7.11 per day.
Columbia County	$184 per month	Minimum, $80 per month; maximum, $90 per month.	$7.79 per day.

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Public welfare rates for private proprietary nursing homes, private proprietary home for adults, and county infirmary rates of public welfare districts in New York State—Continued

County	Rates		
	Private proprietary nursing homes	Private proprietary homes for adults	County infirmary
Cortland County	$175 per month	Minimum. $75 per month; maximum, $130 per month.	None.
Delaware County	$156 per month	$80 per month	County infirmary (not approved), $132 per month: county home, $91 per month.
Dutchess County	$200 per month	$110 per month	$5.53 per day.
1. City of Poughkeepsie.	$175 per month	No homes for adults; boarding homes, $75 per month.	City infirmary $10.10 per day.
Erie County	$232.50 per month	$105 per month	$168 per month.
Essex County	Minimum, $115 per month; maximum, $155 per month.	Minimum, $65 per month; maximum, $85 per month.	$11.74 per day.
Franklin County	Minimum, $140 per month (2 homes): medium, $155 (1 home), $180 (1 home); maximum, $300 per month (1 home).	None	None
Fulton County	$154.70 per month	Minimum $65 per month; medium $78 per month; maximum, $100 per month.	Do.
Genesee County	$175 per month	$50 per month	$5.18 per day.
Greene County	$150 per month	Minimum, $75 per month; maximum, $90 per month.	None.
Hamilton County	None	None; private family homes; minimum, $60 per month; maximum, $75 per month.	Do.
Herkimer County	$185 per month	$100 per month	County home, $4.62 per day.
1. Little Falls	Same as Herkimer County	Same as Herkimer County	Same as Herkimer County.
Jefferson County	Minimum, $120 per month; medium, $134 per month; maximum, $160 per month.	Minimum, $61 per month; Medium, $67, $80, and $100 per month; maximum, $120 per month.	County Chronic Disease Hospital, $8.51 per day
Lewis County	$180 per month	Minimum, $90 per month; maximum, $115 per month.	None.
Livingston County	Minimum, $150 per month; maximum, $175 per month.	$90 per month	County home, $4.78 per day.
Madison County	$170 per month	$100 per month	$191 per month
Monroe County	$218.40 per month	$120 per month	$13.20 per day.
Montgomery County	$150 per month	Minimum, $40 per month; maximum, $75 per month.	None.
Nassau County	$330 per month	Minimum, $85 per month; maximum, $14 per month.	$17 per day.
New York City	$265 per month	None	$14.48 per day.
Niagara County	$180 per month	Maximum, $100 per month	$10 per day.
Oneida County	$200 per month	$100 per month	None
Onondaga County	Minimum, $175 per month (nonsprinkled); maximum, $188 per month (sprinkled).	Maximum, $86.66 per month.	$12.48 per day.
Ontario County	$165 per month	Minimum, $75 per month; maximum, $90 per month.	$8.25 per day.
Orange County	$225 per month	$70 per month	$8 per day.
1. Newburgh City	Maximum, $200 per month	None	$5.99 per day.
2. Port Jervis	Same as Orange County	Same as Orange County	Same as Orange County.

Public welfare rates for private proprietary nursing homes, private proprietary home for adults, and county infirmary rates of public welfare districts in New York State—Continued

County	Rates		
	Private proprietary nursing homes	Private proprietary homes for adults	County infirmary
Orleans County	$175 per month	None	$8.26 per day.
Oswego County	$170 per month	Minimum, $70 per month; maximum, $110 per month.	$6.46 per day.
1. Oswego City	None	None	None.
Otsego County	$150 per month	Minimum, $60 per month; maximum, $90 per month.	$8.40 per day.
Putnam County	$200 per month	$85 per month	None.
Rensselaer County	$180 per month	Minimum, $80 per month; medium, $100 per month; maximum, $120 per month.	$6.92 per day.
Rockland County	$225 per month	$120 per month	$8.47 per day.
St. Lawrence County	$210 per month	Minimum, $60 per month; maximum, $89 per month.	None.
Saratoga County	$125 per month	$65 per month	$8.08 per day.
Schenectady County	$180 per month	None	$9.50 per day.
Schoharie County	$150 per month	Minimum, $80 per month; maximum, $100 per month.	None.
Schuyler County	$167.30 per month	Minimum, $65 per month; maximum, $85 per month.	Do.
Seneca County	$180 per month	$115.40 per month	Do.
Steuben County	Minimum, $160 per month; maximum, $170 per month.	Maximum, $120 per month	$7.32 per day.
1. Hornell City	Same as Steuben County	Same as Steuben County	Same as Steuben County.
2. Cornell City	do	do	Do.
Suffolk County	$205 per month	$135 per month	Not stated.
Sullivan County	$220 per month	None	$6.97 per day.
Tioga County	Minimum, $170 per month for less than R.N.'s; maximum, $190 per month for all R.N. coverage.	Minimum, $85 per month; maximum, $100 per month.	None.
Tompkins County	$200 per month	None	County home, $94 per month.
Ulster County	No reply	do	No reply.
Warren County	$161.66 per month	$91.33 per month	$7.36 per day.
Washington County	$150 per month	None	$4.97 per day.
Wayne County	$135 per month	Minimum, $65 per month; maximum, $85 per month.	$10.83 per day.
Westchester County	Minimum, $165 per month (1 home); medium $100 per month (1 home), $215 per month (7 homes); maximum, $240 per month (39 homes).	Minimum, $175 per month; maximum $195 per month.	$7.71 per day.
Wyoming County	Maximum, $175 per month	None	None.
Yates County	$146 per month	$75 per month	Do.

Senator Moss. Thank you, Mr. Beaumont, for a very fine statement. I was interested to note that the nursing home association was so widely organized, and it apparently has young and aggressive leadership as I can see from you two young men at the table here. I wonder if you could give me a breakdown of your membership; how many are proprietary, how many are nonprofit, and how many are public institutions?

Mr. Beaumont. About 15 percent of our membership are either public or nonprofit and the balance of them are proprietary. This roughly corresponds with the situation as it exists in the field.

Senator Moss. Is this about a cross-section then of the nursing homes that exist? Are 85 percent of our nursing homes proprietary, overall?

Mr. Beaumont. I believe it is 87 percent according to the last Public Health Service inventory.

Senator Moss. So are you pretty well a cross-section of the nursing home field?

Mr. BEAUMONT. This is correct.

Senator MOSS. What percentage of all nursing homes, then, belong to your association?

Mr. BEAUMONT. It is less than 50 percent and the basic reason for this is that many of the homes are two, four, six, and eight beds, and they are not—we say they are not joiners and they feel that a national association would have very little to offer for them.

In the State of California they have several hundred nursing homes of precisely six beds in size. This concerns some quirk of their licensing law there and we have almost none of those people, but we do represent a goodly sum of the number of beds that are licensed.

Senator MOSS. You would say then that most of the larger nursing homes belong to the association, and, generally, the ones who do not belong are the small operations?

Mr. BEAUMONT. Yes, sir, that is correct.

Senator MOSS. You spoke about the overbuilding of facilities in the Denver area where there are vacant beds in nursing homes; and yet we are told there is still need for about half a million beds. Can you suggest some way that we might get away from this improper placement? There seems to be overbuilding in one place while we are underbuilt in another.

Mr. BEAUMONT. Yes, sir, we need to identify more precisely those homes that are now in existence that are acceptable. Under the Hill-Burton plan each State is required to submit an inventory of facilities that exist there. The States are given freedom in determining what they shall list as acceptable or unacceptable, and in some cases some of the States have listed all nursing homes that were not constructed under Hill-Burton auspices as being unacceptable. We believe this to be unrealistic.

For example, a friend of mine in New Jersey built a very beautiful place there, it cost almost a million dollars and it was listed immediately as unacceptable, even though it met Federal Housing Administration standards which are very high, but it was not constructed under Hill-Burton auspices, so therefore, under that State plan it was unacceptable.

In some other areas we see that the State Hill-Burton plan agency will render a certificate of need to nursing homes to be constructed with private funds, FHA funds, or SBA funds, area redevelopment funds, any of the Federal programs, and upon its completion, even though it meets the State licensing law, they are declared unacceptable.

We think there needs to be some serious study in this area. There is another area that I would suggest. I noticed you and Miss Randall and some others—and all of us—have some problems in identifying just exactly what the need is. I agree wholeheartedly with Miss Randall, that anyone who is able to care for themselves should not be in a nursing home taking up the place for someone that does need the specific services of a nursing home.

Unfortunately many people think that whenever the magic age of 65 is reached this person automatically is in the market for a nursing home or home for the aged. I personally believe that this is far from true, the vast majority of the people that reach 65 are well able to care for themselves, they are in good condition as a rule, many of them continue to work, and unless they are senile, mentally, physically, or

in some other way incapacitated, they are not all interested in living in a housing for the elderly project. They want to live on the street where you and I live, where the grandchildren are, and they want to maintain their freedom of operation, and I think they should do this.

Senator MOSS. I am sure we agree on that. I noticed in your statement you stressed the number of people who were rehabilitated and were able to go back to their families.

Do you have any percentage figures on that? How many nursing home patients are restored, at least enough to go back and live with their families or in private dwellings.

Mr. ERCOLANO. I might be better able to provide you with that information, Senator.

Senator MOSS. All right, sir.

Mr. ERCOLANO. We do not have any actual statistics on this. However, in talking with our members and in talking with other nursing home people, we have found that they are seeing a change in the nursing home patient where 5 years ago or even 3 years ago a patient came to the nursing home and was admitted.

This person was there for all practical purposes until death do us part. However, now they are noticing that there is an increasing number of people that are coming in, staying a comparatively short time which in the nursing home would be approximately 6 months to a year, and then being discharged back home.

One of the nursing home administrators that I talked with about this said that within the past 6 months in about a 70-bed home, he had 50 discharges back either to the patient's home or to the community. So that we are seeing a tremendous change in the use of the nursing home by families and by other medical groups in providing for this long-term patient, short-term care, and sending him back to the community when they are able to.

Senator MOSS. You have not assembled any figures yet on this?

Mr. ERCOLANO. No, sir; we have not.

Mr. BEAUMONT. I can report to you on my own home if you like.

Senator MOSS. All right.

Mr. BEAUMONT. It is a 47-bed home and if I remember correctly we had 52 discharges last year, 1963, we had two deaths which are included in that, more than 80 percent of these went back into the community and the others to similar facilities, homes for the aged, boarding homes, or nursing homes.

Senator MOSS. Thank you, that is interesting to have that in the record.

Senator Yarborough?

Senator YARBOROUGH. I think this is a very interesting statement, Mr. Chairman. It furnishes a lot of very valuable information. I think this American Nursing Home Association has rendered a valuable service to the aged, to the American people generally.

I know in my own State, the State nursing home association in Texas had, well, in a profession you might call a code of ethics, a set of standards, before the State had a State law. Unless I am mistaken in memory, I think the nursing home association in Texas now has a certain code of ethics over and above the State law to protect these aged.

Of course, not all nursing home operators have to join the association, some do not. It is like in all professions they have substandard members, but if they belong to the association they are supposed to follow a code of ethics and practices that are over and beyond the requirements of the law itself.

I know that is true in my State and I assume that association is affiliated with your association?

Mr. BEAUMONT. We have a very fine affiliate in Texas, and they are very progressive.

Senator YARBOROUGH. Back when our State laws were very weak, I know what they were doing, they pioneered for the law for these associations.

Now, on page 2, Mr. Beaumont, you say in the first paragraph:

> The association is a member with the American Medical Association of the Joint Council to Improve the Health Care of the Aged.

Are there any other members of that joint council other than AMA and your association?

Mr. BEAUMONT. Not at the present time.

Senator YARBOROUGH. Of course, health goes beyond that, there are other branches of the healing arts.

Mr. BEAUMONT. Yes, sir. There are none at the present time. However, it is open and I suspect that others will join.

Senator YARBOROUGH. In the third paragraph above the bottom of that page you say you are:

> In the process at the moment of establishing liaison committees with the American Nurses Association and the National League for Nursing and another liaison committee with the Health Insurance Council of America.

What are the objectives of that particular liaison that you are attempting to form with the Health Insurance Council, the nurses, and the National League for Nursing?

Mr. BEAUMONT. It is to work out a definitive standard for nursing practices for nursing homes. You fill a broader need in nursing homes because of the long-term nature than you would in an acute hospital.

This patient is an appendectomy patient and they get that treatment, see. There is a new or different concept in a long-term facility, be it a nursing home or home for the aged, in that you must treat the entire person, this person will stay with you on the average of more than 1 year. There must be religious services, social activities, medical, nursing, psychiatric, and all of these phases must be brought together, and the theory is to agitate the person back up out of the bed to do——

Senator YARBOROUGH. In other words, you regard this visit to the nursing home of an elderly person as a two-way street. It is not some place to stay until they die, but you try to see what you can do to get them back home and make way for another aged person. With all of these services it is hoped they will be rehabilitated so far as their age will permit and go back home to what they call in some parts of the world the civilian economy.

Mr. BEAUMONT. That is right. You take a patient 75 or 80 years old, you comb their hair 7 straight days in a row, and then the eighth day they cannot comb their hair, they need assistance in it. So we are attempting to emphasize the fact that it should be assistance in combing the hair, assistance in feeding rather than do every single thing for the patient.

Senator YARBOROUGH. I congratulate you on the scientific approach that the American Nursing Home Association has taken on this problem, calling in all facets of knowledge dealing with age to alleviate some of the burden of this on the economy and on our society with humaneness to those persons; and not merely humaneness in the sense of being kind, but in the higher sense of making them better able to care for themselves and receive more enjoyment in their declining years.

Thank you, Mr. Beaumont.

Mr. BEAUMONT. I appreciate that, Senator Yarborough.

Senator MOSS. Senator Neuberger?

Senator NEUBERGER. What is your association's policy about these nursing homes that are physician owned? Are they a good thing?

Mr. BEAUMONT. We have no policy with respect to ownership. In our association we have nursing homes that are owned by county and State governments, we have nursing homes that are owned by cities. We have nursing homes that are owned by partnerships, corporations, individuals, by church groups, by voluntary agencies, community groups, and many of these, I am sorry I do not have the percentage as to how many are owned by doctors, but certainly their determination as to whether they would be given membership in our association would depend on the amount of care rendered in that specific home rather than on the basis of who owns it.

Senator NEUBERGER. Do you see any possibility of a conflict of interest involved in a doctor-owned nursing home?

Mr. BEAUMONT. No, I do not think so. There would be some—the physician as the owner certainly would know about medical practice and maybe there would be some advantages to it. But we have not studied it from the type of ownership. We have studied it on the basis of how can services best be rendered.

Senator NEUBERGER. I am particularly interested in this question of standards we discussed with the last witness. You said in your statement that in 1950 only five States had nursing home licensing laws. I would presume that has something to do with standards, or they could not be licensed.

Mr. BEAUMONT. That is correct.

Senator NEUBERGER. And you say that now every State has such laws. To what do you attribute that quick changeover?

Mr. BEAUMONT. There are several reasons. Principal among them I would suggest would be the Hill-Burton Act requiring States to be eligible for participation in this act to have the system of licensure and inspection for hospitals and for nursing homes.

Also I believe that our association has played some role of leadership in this. It is impossible to be a member of this association unless you are also a member of the State affiliate and the State cannot become affiliated unless there is a licensing program.

We have encouraged all of our affiliates to seek improvement of these licensing laws for the mutual protection of the patient in the home and community at large, including the nursing home.

Senator NEUBERGER. There is a third reason, too, is there not? It seems to me that about 1951 the Social Security Act was amended to require such State standards.

Mr. BEAUMONT. Yes, that is right.

Senator NEUBERGER. As a condition for receiving matching welfare payments.

Mr. BEAUMONT. Yes, you are correct.

Senator NEUBERGER. Maybe that had quite a bit to do with the sudden change from 1950.

Mr. BEAUMONT. I would not be surprised.

Senator NEUBERGER. I have the feeling it had a great deal to do with causing this change. In other words, it seems to me we do have a role to play in setting standards, and sometimes we find that this is necessary or useful from more than just a self-interest point of view.

The one thing you do not mention anywhere in your testimony nor do you even indicate or suggest that you have any difficulty getting nurses for nursing homes?

Mr. BEAUMONT. Well, that is a whole new subject——

Senator NEUBERGER. All right, let us not go into it.

Mr. BEAUMONT. I will grant you that it is very difficult, but it is becoming easier for nursing homes. Now, the general trend has not changed, but as nursing homes have progressed and have improved their public acceptance, shall we say, the registered nurses and licensed practical nurses more and more are moving to working in nursing homes.

Senator NEUBERGER. Were you interested in the legislation we had affecting grants for nurses training? I should think you would be interested in getting more nurses trained. Hospitals all complain about this, and it has been one of the faults I have seen in the Hill-Burton Act recently. It has gone almost too far in building facilities before there were nurses to staff it. I am right now engaged in just a personal survey of the proliferation of Hill-Burton funds before they are able to meet the standards. We are building buildings—doctors do not want to drive 15 miles down the pike to another hospital, so they want one in their own community—and yet, in one place in Oregon, there are not five nurses in an area of seven counties, to staff another facility. So, I am just amazed that you, as an association do not say something in this statement about the shortage of nurses.

Mr. BEAUMONT. We talk about the training of nurses aids. There are schools of nursing and we did not feel that we had the expertise or the finance to train registered nurses or licensed practical nurses.

We did comment in here somewhat about the vocational training for licensed practicals, I believe, and liaison with the American Nurses Association, and the national league.

Senator NEUBERGER. Tell me another thing. Do your services vary according to welfare funds?

What percentage of the payments received in these nursing homes in your association comes from welfare payments?

Mr. BEAUMONT. About 60 percent.

Senator NEUBERGER. 60 percent?

Mr. BEAUMONT. Yes.

Senator NEUBERGER. So, whatever happens in welfare payments in a locality has a great deal of effect on your association.

Mr. BEAUMONT. It would definitely affect it and my personal position is that an across-the-board increase in public assistance payments would not have the total desired effect that we would like so far as elevation of standards. I think that this must be geared to the amount

of care that the individual patient requires and the ability of the individual nursing home to deliver this care.

Senator NEUBERGER. Well, you surely would recommend that the patients in your nursing homes receive the care they need, would you not?

Mr. BEAUMONT. You are absolutely right.

Senator NEUBERGER. So, you would not vary the care according to what money they had?

Mr. BEAUMONT. Well, Senator, if the grant is $5 a day, and if this is for all types of patients, the ambulatory possibly with some mild senility, it may be adequate for that, whereas, if the patient were bedridden, required much medical attention, nursing attention, it would be inadequate.

My position is that the public assistance agency would conserve the taxpayers funds better and set up a more equitable arrangement both for the patient, the nursing home and the taxpayer, to gear the payments to the needs of the patient and to the ability of the home to deliver those services.

Mr. ERCOLANO. Senator, if I could add to this. One of the problems that we have is that in many States the welfare department relates the payment to the care that the patient requires.

In some States the welfare department will pay more money for a bed patient than they will for an ambulatory patient. Well, this puts the nursing home in a bind in a sense that the Health Department in that State is training the nursing home people on how to get people out of bed and rehabilitate them, but the welfare department will pay them more money to keep the patient in bed than it will if they are ambulatory, so the nursing home is caught in the middle on this thing.

Senator NEUBERGER. You have my sympathy. This is something we are exploring.

Mr. BEAUMONT. Mr. Chairman, I do not want to commercialize here, but Senator Neuberger has a wonderful home in her State, Mount Angel. Sister Marie Antoinette serves the administrator as our regional educational chairman for the whole Pacific coast area.

Senator NEUBERGER. I was a member of our Oregon State Legislature when we did something about this nursing home problem, and I am very proud of it.

Senator MOSS. I have one or two questions, Mr. Beaumont. What is the attitude of your organization toward nursing home affiliation with a hospital?

Mr. BEAUMONT. I do not think that the formal affiliation accomplishes too much for the benefit of a patient. There are some benefits to the nursing home. However, most of the benefits are to the hospital and if they create a ready group of people that move in there.

We are studying this and we have no definite position on it at this point. Now the Public Health Service for a couple or 3 years has advocated such an affiliation on a formal basis but I understand they are taking a new look at it now and they may be ready to back off somewhat. Even the American Hospital Association which conceived the idea in the first place has just in the last 3 or 4 months published a new position paper on it and it is considerably watered down from what it was originally.

Senator Moss. Do you have a policy on absentee ownership of nursing homes? Do you take any specific attitude on that?

Mr. Beaumont. We deal strictly with the care that is rendered in the home and absentee ownership. This is really something that will throw you sort of off the track. For example, if the Federal Government owned the home and it was in Utah, that would be just about as absent as you could get, really. And it could very well be a good home. I do not know that it is necessary for the owner of the real estate to be there every particular day, but certainly under the licensing laws and under the standards that we have espoused he would have a responsibility of maintaining adequate care for those people that are entrusted to him.

I heard Miss Randall talk at great length on this, and they have attacked this problem in the State of New York. Maybe she was not familiar with all of it. A corporation cannot own a nursing home in New York. It has to be an individual proprietorship, so you do not have the breakdown of the placement of responsibility. Now, I am not sure this would be good.

Senator Moss. Your association would be made up of members who are the operators, really, and you do not concern yourself with the next step removed: who owns the facility?

Mr. Beaumont. That is correct, yes, sir.

Senator Moss. Thank you very much, Mr. Beaumont and Mr. Ercolano, for coming here and being with us today. This is an intensely interesting and intricate subject, as has been apparent. We thought we might finish in the forenoon, but obviously we cannot. You are excused now, and we appreciate it. The committee will have to recess now until 2 o'clock when we will resume and hear the three other witnesses we have scheduled for today.

(Whereupon, at 12:20 p.m., the hearing recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 2:05 p.m., Senator Frank E. Moss, chairman of the subcommittee, presiding.)

Senator Moss. The subcommittee will come to order. We will proceed with our next witness who is Mr. Richard E. Stevens, assistant technical secretary of the National Fire Protection Association.

Mr. Stevens, we are glad to have you and we will look forward to your testimony.

STATEMENT OF RICHARD E. STEVENS, ASSISTANT TECHNICAL SECRETARY, NATIONAL FIRE PROTECTION ASSOCIATION

Mr. Stevens. Mr. Chairman, members of the subcommittee, a recent study by the National Fire Protection Association shows that 228 people died in 41 fires in nursing homes in the period 1953 through 1963.

When one compares this fatal fire record with the record of fatal fires in other types of property, it becomes clearly evident that many nursing homes are extremely unsafe places to live. Yet these are the places in which the aged and, in many cases, in infirm are being housed.

There is nothing unique about the type of fires that occur in nursing

homes nor about the contributing factors that result in the heavy loss of life as distinct from other types of property. There is, however, one significant difference which must be considered in evaluating the need and form of the protection required.

This factor is that the elderly citizens housed in these homes cannot be expected to react normally or even rationally in an emergency fire situation. These physical and psychological characteristics have been demonstrated repeatedly in nursing home fire experience.

The aged and infirm must be removed individually and bodily from their haven of refuge in case of fire and some must be restrained after removal from reentering. It must be even expected that rescuers will be fought by those they are attempting to evacuate and in many cases not one but two or more rescuers are required to extricate a single occupant.

Coupled with the fact that elderly folks are particularly susceptible to smoke poisoning, exposure, and shock, the nursing home presents an interesting challenge to fire authorities.

The National Fire Protection Association is thoroughly aware of its obligation to provide recommendations for reasonable and practical fire protection for nursing homes. The association is devoted to reduction of loss of life and property by fire and since 1912 has promulgated recommendations for life safety from fire in all types of properties, including nursing homes.

These recommendations are published in what is commonly known as the Building Exits Code, a document prepared by a voluntary NFPA committee of experts. The Building Exits Code has been quite widely adopted and is the law in several States and municipalities. It also is the basis on which the safety to life provisions of many model building codes and local ordinances are prepared. This code and a general upgrading of local ordinances and enforcement born of the tragedies which have occurred have resulted in a marked increase in the fire safety in new nursing homes constructed during the last few years.

The real problem lies with nursing homes occupied before the adoption of applicable codes and with those located in rural areas where there is no code. The former escape the benefit of sound safety standards unless strong retroactive code enforcement is sought and secured; the latter will not be supervised unless action is taken at a State level.

Applying modern code provisions retroactively is frequently fought by nursing home operators who complain that code adherence would result in prohibitive expenses that would put them out of business.

A common comment heard in such a defense is that the moneys received by nursing home operators for State-aided patients are hardly adequate to keep the homes operating and certainly do not provide any excess of funds for fire protection. We must reply that fire protection is a requirement in this type of property and that a minimum code will not place an undue hardship on anyone.

The NFPA Building Exits Code contains two sections on nursing homes; one on new buildings, and the other on existing buildings. This recognizes that meeting the requirements for new buildings may not always be possible in existing buildings and, that in existing buildings, it may be necessary to provide protection of a type not necessary in a new building.

In general, it can be said that several States need to be encouraged to adopt a code for safety of life in nursing homes to be enforced through the State fire marshal's office.

Those States which do not have a State fire marshal should establish such a position, enact legislation to provide him with the necessary legal machinery to adopt and enforce codes, and provide the necessary funds to staff his office with an adequate number of qualified personnel. Some States that have a State fire marshal have not been realistic in providing him with the funds to properly staff his office. This is extremely important for the proper enforcement of codes.

It would seem appropriate to suggest that Federal Governmental departments and agencies that supply Federal funds for the care of the aged and infirm would be justified in asking for evidence of adequate State codes to regulate life safety from fire in buildings in which the aged are housed and for which Federal moneys are being used. It would also be reasonable to suggest that evidence be provided that the State or municipal codes, if any, are properly promulgated and enforced by qualified people.

Beyond these suggestions you may be assured of the continued efforts of the National Fire Protection Association to upgrade the fire safety in nursing homes and related institutions.

Mr. Chairman, in order to exemplify some of the points made in my statement I have selected a few slides and, with your indulgence I would ask that they be shown at this time.

Senator Moss. All right. Can we cut the lights and see a little better?

FIGURE 1.—LARGO, FLA.—MARCH 29, 1953.

Mr. STEVENS. Thirty-two patients and a nurse were trapped and killed by fire in a nursing home near Largo, Fla., that occurred in the early morning hours, March 29, 1953. In addition, one of the group of rescued patients being transported by car to a hospital suffered fatal injuries when the vehicle was involved in an accident. The driver of the car was also killed.

FIGURE 2.—LARGO, FLA.—MARCH 29, 1953.

Located outside the limits of any organized community the nursing home did not have the protection of a local fire department. So far as could be determined, no fire inspector had ever made an official investigation of the home during its 20-odd years of existence.

FIGURE 3.—FITCHVILLE, OHIO—NOVEMBER 23, 1963.

During the early morning hours of November 23, 1963, fire destroyed a nursing home in Fitchville, Ohio, killing 63 of the 84 elderly patients. The fire, which started from a short circuit in overloaded improperly installed wiring, spread throughout the undivided attic

before it was discovered. Within a few minutes after discovery of the blaze, the building was filled with killing smoke and fire bursting down from the attic trapped the victims, most of whom were still in their beds. Most of the 21 persons who escaped owe their lives to passers-by who stopped to help to rescue them.

As in many nursing home fires, those who died were victims of a lack of understanding by all concerned of the life hazards from fire in homes for the aged. Since early 1961 the Ohio State Federation of Licensed Nursing Homes and others have, by means of court actions, prevented statewide regulations from being placed in effect. The home had been inspected by State authorities in March 1963, and approved for safety in compliance with existing State laws.

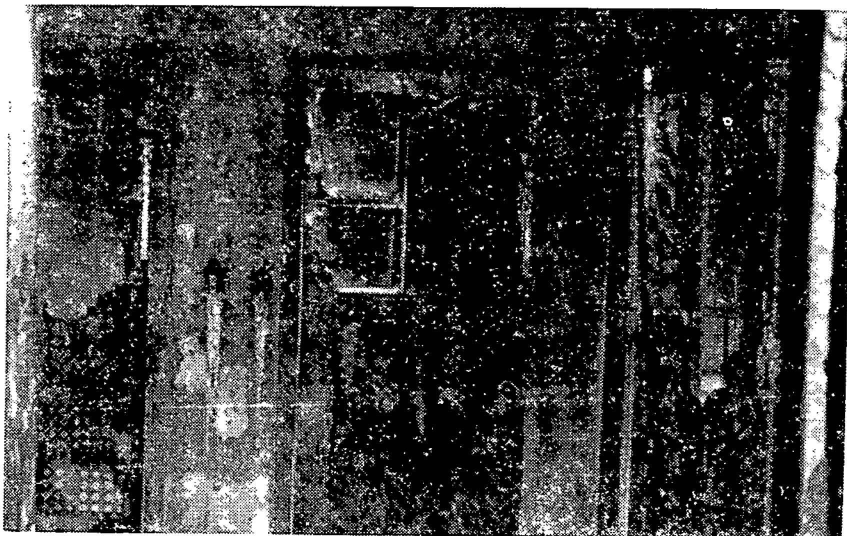

FIGURE 4.—HUDSON, MASS.—DECEMBER 20, 1962.

Hudson, Mass., December 20, 1962, nine killed. Fire broke out in the three-story and basement wooden home in a hall closet at the rear of the second story and was detected by a heat detector in the hallway outside the closet. The fire-detection system was connected through an auxiliary fire alarm box to fire department headquarters. Nurses investigating the sound of the fire-detection system gong were able to remove 3 of the 19 patients in the second story down an open stairway. Firefighters and policemen assisted in the eventual evacuation of 14 others from the second story, 16 from the first story and 3 employees from the third story.

While rescues were in progress, one firefighter easily extinguished the fire with one preconnected 1½-inch hose line. Two of the second story patients died during the fire and seven others died within the next 8 days.

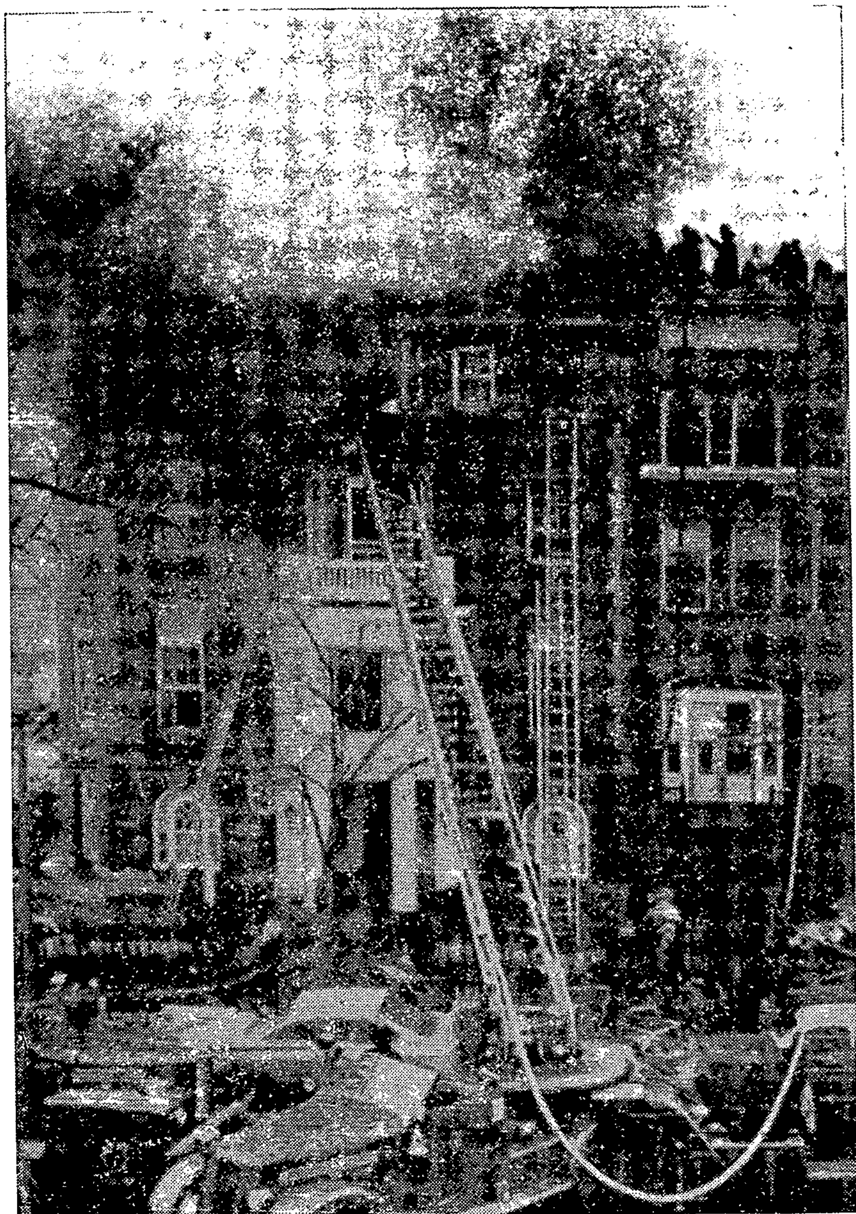

FIGURE 5.—WASHINGTON, D.C.—FEBRUARY 1, 1961.

Washington, D.C., February 1, 1961. The fire, which originated in a storage closet on the first floor of the four-story brick, wood-joisted nursing home, trapped and killed 7 patients on the fourth floor; 15 bedridden patients and 2 ambulatory patients were rescued.

When the blaze broke out of the closet, it quickly spread up a wooden rear stairway to involve the fourth floor and attic. The person who

discovered the fire delayed sending the alarm for several minutes while he tried unsuccessfully to extinguish the blaze with a portable extinguisher. The first call to the fire department was from a police detective who saw smoke pouring from the fourth floor and radioed the alarm.

FIGURE 6.—WASHINGTON, D.C.—FEBRUARY 1, 1961.

Passers-by and employees of a nearby firm rescued many of the occupants of the nursing home before the first fire companies arrived. Inspection officials had reported that the nursing home had a better record of orderliness and cleanliness than some of the others in town, but that it did not comply with present building codes, which unfortunately, were not enforced in buildings constructed before 1946 and, therefore, were not enforced in this nursing home.

FIGURE 7.—PUXICO, MO.—JULY 30, 1956.

Puxico, Mo., July 30, 1956. Ten aged patients, the nursing home operator, and a small boy lost their lives in fire which broke out during the night while everyone was asleep in the second story and attic of the 2½-story wood-frame home for the aged. The fire originated in an upholstered couch in the first story living room, burned through the combustible fiberboard wall and ceiling finish and up the open stairway, being helped along by a ventilating fan in the attic. When discovered by an outsider at 10:20 p.m., the fire had so much headway that it was impossible to save the occupants. No attendants were on duty.

Kincaid, Kans., September 17, 1954, 7 of the 10 patients in the three-story wooden building lost their lives in fire that broke out during the night in the recreation room on the first floor. Discovery was by an attendant on the second floor when he was awakened by smoke. There was still time to get the patients out by way of an emergency exit from the second story, but none of the three attendants attempted to do this. Without someone to guide them, the old people, although all able to walk, stayed in their rooms and died.

Council Bluffs, Iowa, February 13, 1957, 15 killed. This home for the aged was a 67-year-old 2½-story-and-basement wood-frame building that had formerly been a dwelling. Interior stairways were not enclosed but had a door at the head of each. It was not unusual for these doors to be blocked open.

FIGURE 8.—KINCAID, KANS.—SEPTEMBER 17, 1954.

FIGURE 9.—COUNCIL BLUFFS, IOWA—FEBRUARY 13, 1957.

At the time of the fire, the manager's three small children were in a basement apartment, 20 patients were in the second story, and one ill attendant was in the employees' quarters in the attic.

Attendants, most of whom were in the kitchen eating lunch at the time of the fire, included the manager, a 70-year-old practical nurse, seven mentally retarded persons who were on probation from a school for the feebleminded, and one other person.

Thank you, Mr. Chairman.

Senator Moss. Thank you, Mr. Stevens. Those pictures certainly underline that part of your testimony in which you point out that nurs-

ing homes are particularly susceptible to danger because of the characteristics of the people who are there and in some instances because of the lack of adequate personnel in attendance in the home.

Do you recommend anything in your code on this point of having competent people to operate the homes?

Mr. STEVENS. We did at one time but this was deleted about 2 years ago because the people on our committee that developed the code felt that this was not a prerogative of the NFPA since it is not directly a fire protection matter and the number of attendants generally are spelled out by other standards that are not fire protection standards.

Senator MOSS. I notice in one of them you said there were no attendants present. Certainly that would be one of the requirements, would you not say, that there must be attendants present all the time?

Mr. STEVENS. Very definitely.

Senator MOSS. In your efforts to get standards adopted on fire hazards have you found any organized opposition from the nursing home organizations or institutions?

Mr. STEVENS. Generally speaking the nursing home associations and operators have been extremely cooperative. There have been some cases, of which the Ohio case which I cited in the slides is one. But overall they are quite cooperative. They serve on our committees and we hope there will be more active participation by them. In general they want to do the right thing.

There is some local opposition, of course, to spending money and generally fire protection in an existing building involves the spending of money. This they find objectionable.

Senator MOSS. Many of these nursing homes are converted buildings. Are they protected generally by these grandfather clauses in the regulations?

Mr. STEVENS. This varies tremendously with the location. Many municipalities have retroactive codes and can take care of this situation, but I am afraid there is a larger percentage that do not and therefore they do not fall within the general regulations of the local codes.

Senator MOSS. How many of the States have adopted regulations recommended by your association?

Mr. STEVENS. This we have never been able to measure exactly. We do know that six States have adopted all NFPA standards, and this would include the building exits code.

We know of several others who have drawn up codes that are definitely based on the building exits code. They have excerpted and extracted from it. Many municipalities have used it directly and are using it directly.

Senator MOSS. Are the rural areas left out of the codes in some of the States?

Mr. STEVENS. They should not be.

Senator MOSS. The codes should apply uniformly.

Mr. STEVENS. That is right.

Senator MOSS. What is the reason, then, for having these gaps in some of these rural areas? Is it just lack of enforcement?

Mr. STEVENS. I am afraid that is part of the picture; and, of course, there are some States that have little or no regulation in this regard and those that do have some are very inadequately staffed. They do not have the facilities or the personnel to do the job correctly.

Senator Moss. Thank you, Mr. Stevens. We do appreciate your testimony and your recommendations. This is all part of this problem that we are trying to delineate and decide how we can deal with it more adequately.

Mr. STEVENS. Thank you.

Senator Moss. Our next witness will be Dr. Ralph T. Murray, assistant director, of the Metropolitan St. Louis Hospital Planning Commission. Dr. Murray, we are glad to have you. Senator Long said this morning he wished he could be here at the time of your testimony. I am sorry he cannot be here at this time, but we are most pleased that you have come to help us make this record.

STATEMENT OF DR. RALPH T. MURRAY, ASSISTANT DIRECTOR, METROPOLITAN ST. LOUIS HOSPITAL PLANNING COMMISSION

Dr. MURRAY. Mr. Chairman, I am certainly flattered at having this invitation. I am here today as a representative of the Metropolitan St. Louis Hospital Planning Commission, a voluntary organization engaged in areawide planning for hospitals and related health care facilities in the St. Louis area. I should like to extend to you the thanks of the executive director of the commission, Mr. Robert W. Carithers, and the members of the board of directors for this opportunity to present some of our findings and conclusions with respect to the growing problems of health care for the aged.

Prior testimony before this joint subcommittee has established all too clearly the existing shortage of long-term medical care beds across the Nation. Within the past 3 to 5 years millions of dollars have gone into the construction of elaborate nursing home facilities. A large proportion of the money used to finance these new facilities has been underwritten by various agencies of the Government. Thousands of skilled nursing home beds have come into existence through direct and participating loans and through mortgage insurance programs sponsored by agencies of the Government.

In a recent Public Health Service publication entitled "Federal Aid for Nursing Homes," it was stated that—

> * * * 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.

A recent study of long-term medical care facilities in the St. Louis metropolitan area has demonstrated that the construction of new nursing homes, many of these financed through Federal programs, may have failed to improve the quality of nursing home facilities and may have contributed to a lowering of the quality of care being rendered in the area.

Theoretically the construction of new, modern, well-designed nursing homes, offering comprehensive services to the long-term-care patient, should drive substandard facilities out of the market; yet, this is not what we observe happening in the St. Louis metropolitan area.

The factor of ability to pay for skilled nursing home care is the uncontrolled variable which forces many families to place patients in substandard facilities in lieu of placement in the new modern homes. In our study we found that the vast majority of persons most susceptible to long-term illnesses requiring prolonged institutionalization were those with the least ability to pay for the care they needed.

The families of these individuals are the ones who ultimately decide where the patients will be placed. After looking over and pricing accommodations in new nursing homes the patient is usually placed in a small proprietary facility with a terminal emphasis patient-care philosophy, but at a price substantially lower than the average monthly patient charge in the new facility.

As beds become available in new homes and remain vacant, the proprietary operators, who in most cases have high fixed costs, begin to reduce rates to meet competition. In order to retain profit margins, they must also reduce operating costs.

This can be done only by reducing service to the patient and, directly or indirectly, the quality of patient care. Such reductions are usually characterized by a reduction in the number of qualified professional and/or practical nursing personnel, a reduction in the quality and quantity of food served to patients, by reducing or cutting out entirely all rehabilitative and recreational therapeutic services and, ultimately, by offering a total program of service far below the comprehensive services which are needed in the skilled nursing home today.

What happens to the older facilities which meet minimum building standards, render only minimal care, have no planned entertainment for the ambulatory patients, yet offer long-term facilities at a reduced rate? These homes are not forced out of business. Actually, they become the ones best prepared to meet the price competition caused by overbuilding.

In the St. Louis metropolitan area it has been interesting to note that the older nursing home facilities are rapidly being acquired by practicing physicians. After minimal alterations, from which they extract the full measure of advertising and public relations benefits, they open for business.

In no sense of the word can these repainted, refurnished old buildings offer the comprehensive services being offered by the new facilities. Yet we can predict with almost certain accuracy that the old facilities will fill up before the new ones because of their decided economic advantage.

Upon close analysis we find ourselves faced with the strange paradox of lowering the quality of nursing home care and services with each new facility constructed.

Why does this happen? First of all the States cannot elevate standards of ancillary services by legislation. The items which constitute satisfaction and better rapport are items which cannot be written into regulatory statutes.

Second, we have no well-defined, established accreditation body which can publicize discrepancies in the various nursing home facilities. Third, we have an uninformed public who have little or no concept of the things to look for in selecting a nursing home facility. Finally, the segment of the population who needs skilled nursing home care most can least afford to pay for it.

A recent survey of newly constructed nursing homes in operation for 6 months or longer in the St. Louis area revealed that occupancy has tended to remain at approximately 40 percent of capacity.

The patient charges in these facilities range from $275 to $350 per month. The occupancy experience of the new homes in the St. Louis metropolitan area has not been different from the experience of homes

recently constructed in the Chicago area. Correspondence with the former director of Central Services for the Chronically Ill in Chicago, Miss Edna Nicholson, reveals that while overall occupancy of nursing home beds in the Chicago area has averaged 78 percent, the nonprofit homes are close to 100 percent occupancy.

Many of the new proprietary homes in the higher price brackets are in the 40-percent occupancy range. Approximately 3,000 proprietary beds have been constructed in Chicago in the past 2 years.

In summary, I would like to suggest several areas of exploration which may be of help in better understanding the current problems in meeting the long-term medical care needs of our population.

First, new nursing homes being constructed today attempt to provide such a broad range of services that they price themselves above what the majority of the market can pay. Perhaps we should analyze the cost of building new facilities and determine what services are essential to high quality patient care and only include those essentials.

For example, studies have demonstrated that it is not socially productive to attempt to rehabilitate aged institutionalized persons, yet all Hill-Burton and FHA-financed homes require elaborate rehabilitation and recreational areas.

Perhaps we should carefully assess our long-range objectives as to the design of long-term care facilities since there are indications that we may not be meeting the needs of the vast majority of the public.

Second, it is imperative that more money be available to procure the needed restorative and preventive care required by our aging population. One of the major and possibly the only factor retarding the use of new facilities is lack of financial resources among long-term care patients.

Additional money through current programs or through proposed new programs is necessary if the majority of the aged population is to be able to purchase the care needed.

Third and last, a definite need exists for additional applied research to determine alternative ways of providing medical care for the rapidly growing numbers of persons afflicted with long-term chronic illness.

Construction of additional brick and mortar warehousing facilities is not a satisfactory solution to meeting the physical, social, and emotional needs of our aging population.

Those of us in medical care planning see a similarity between the construction of orphanages back in the 1920's and early 1930's and our present-day nursing home patient problems.

Planning and building bigger and better orphanages was all in vogue 30 to 40 years ago. Since the concept of foster home placement was introduced in the 1940's the landscape has become blighted with empty orphanages which represent the expenditures of tremendous sums of money.

Seldom can these buildings be remodeled because the specific design does not readily lend itself to medical care facility conversion. Unless we concentrate on research to find new ways to meet the growing problem of chronic illness, we may very well find ourselves in a situation similar to the orphanage dilemma in the next 20 to 40 years.

Perhaps the future trend in long-term care rests with home care programs, foster home placements, day care centers or perhaps some

totally new health care concept. In any event we should be aware of overbuilding and begin immediately to look toward the time when medical science provides alternatives to institutionalization.

At this point, Mr. Chairman, I would like to have an abstract of the Metropolitan St. Louis Hospital Planning Commission's study on long-term care facilities and services entered into the record. I feel that the methods and materials contained in this report may be of help to the committee.

Senator Moss. That will be included in the record at this point.

(The report referred to will be found at p. 53.)

Dr. Murray. Mr. Chairman, I thank you for your kind indulgence during this presentation and I shall be happy to answer any questions that the committee might have.

Senator Moss. Thank you. We appreciate this statement, Dr. Murray.

Under the Hill-Burton Act the States are required to have a plan for building of hospital facilities and the FHA and the Small Business programs require a certificate of need from the State. Why, then do you think we are getting this maldistribution of new facilities?

Dr. Murray. Well, it has been our experience in both Missouri and Illinois that the Hill-Burton planners are grossly understaffed so far as doing comprehensive population projections and accumulating planning data on existing facilities.

For example, in the St. Louis area quite an interesting thing occurred. Back in the fall of 1962 the Secretary of the local nursing home association, Mr. Kenneth Haas, went on television accusing the State health commissioner of issuing too many certificates for new facilities and it was the feeling of the local nursing home group that this was going to overflood the market and lower the quality of care.

The State health commissioner replied to this accusation and he came up with a figure that some 3,000 additional beds were needed in the area. He contended that he obtained these figures from the State Hill-Burton group.

As a result we decided to do a very comprehensive study of long-term facilities and what did we find? We found that there was not a shortage of beds at all. That if the current beds being constructed in the area were completed, that by 1965, we would drop the level of occupancy down to approximately 60 percent which would mean that many proprietary operators would be operating in the red in the St. Louis area.

So, I think in answer to your question in many cases where you do not have sufficient data and you do not have the services of a good biostatistician, it is very easy to get in trouble in projecting bed needs.

Senator Moss. Is there something that could be required in addition to a certificate of need, or is the problem all centered in the lack of adequate staffing?

Dr. Murray. I believe that it is basically just a problem of coordinating with the local planning agencies. For example, we are purely a voluntary agency where the State agency is an official agency and since we have conducted both short- and long-term investigations into bed availabilities the State Hill-Burton agencies have used our figures almost exclusively.

We have an excellent working arrangement with both Illinois and Missouri for the specific area that we serve. I think perhaps it is

just that they do not have enough staff to be able to really study these problems in depth.

Senator Moss. There is one sentence in your statement that gives me some concern. It is in the middle of about the fifth or sixth page where you say "For example, studies have demonstrated that it is not socially productive to attempt to rehabilitate aged institutionalized persons." Is that an accurate statement? I gathered from testimony this morning that there has been a great deal done to rehabilitate aged persons.

Dr. Murray. I do not know where people get the idea that you can rehabilitate the long-term chronic patient. If you are really familiar with the long-term, chronic diseased patient he represents an aged person in excess of 80 years of age. In most of the nursing homes, I do not know where people conceive the idea that you can do much with these patients. There has been one study I will quote here by Muller, Tobis, and Kelman, that was published in the American Journal of Public Health entitled "The Rehabilitation Potential of Nursing Home Patients":

> The weight of evidence indicates that it is not socially productive to direct extensive rehabilitation efforts toward such groups in nursing homes. Such groups being persons in nursing homes with physical impairments restricting activities of daily living.

It seems almost cruel, Senator, to think in terms of forcing these people into recreational and physical therapy activities; people who are impaired in many cases with arthritis and similar debilitating diseases.

When you look over the scope of long-term diseases you find that roughly 64 percent of all chronic conditions represent some affliction to the patient which represents just a general deterioration of the status of the patient's health. In many cases this person, if the condition is not aggravated, can go on and live a fairly full, active life; but in cases where there is great emotional duress brought about by extensive physical therapy efforts, this just does not pay off. In the recent evaluation by the director of the geriatric program for the St. Louis City hospitals, it has been indicated that potentially only about 12 percent of the total patients in the St. Louis Chronic Hospital could benefit in any way from what is called maintenance type of physical therapy—in other words, enabling the person to maintain the present status of their health.

Out of that 12 percent in only six-tenths of 1 percent could he actually measure any physical improvement after a 6-month period of therapy.

Senator Moss. That is surprising. I thought maybe the difference might have been in our definition of an aged person. Your statement here is a little bit broad, just aged institutionalized persons.

Now, I do not know where aged comes in, whether it starts at 65 or 80, or where. But saying that only 12 percent profit is a little bit surprising to me.

I am going to have to leave to answer a quorum. Do I gather the chief burden of your recommendation here on substandard nursing homes would be to have an accreditation program for nursing homes? Would that be a way to reach them?

Dr. Murray. This would help in several ways. One way would be financially because in a great number of cases now commercial car-

riers of health and accident insurance will not honor claims of patients in unaccredited facilities. By unaccredited they mean nonrecognized nursing home facilities.

Since approximately 20 percent of the people in nursing homes suffer from traumatic types of illnesses such as breaking of a leg, falling, or accidental injury of some type that require 6 to 8 months institutionalization, these persons could benefit monetarily through insurance programs if there were an accrediting body that would approve a certain number of homes or could give assurance that they did meet certain requirements. I think it would be a financial incentive in many cases and also we have no way of really knowing about the quality of care being offered in most homes other than the health department's reports which are based primarily on physical evidence of physical facilities.

Senator Moss. Thank you very much, Dr. Murray. We appreciate your testimony. It is going to give us a great deal to think about as we consider these problems in the committee.

We will now stand in recess for 10 minutes.

(A brief recess was taken.)

ABSTRACT OF REPORT

Facilities and Services for Long-Term Chronic Illness and Convalescent Care in the Metropolitan St. Louis Area

A Study of Present Bed Availabilities and Future Requirements for Long-Term Care in Chronic Hospitals, Chronic Care Units of General Hospitals and Skilled Nursing Homes

(Published November 1963)

Metropolitan St. Louis Hospital Planning Commission, Inc.

FOREWORD

This abstract has been prepared for presentation at public hearings conducted by the Joint Subcommittee on Long-Term Care of the Special Committee on Aging, U.S. Senate, May 5 through May 7, 1964. The abstract concentrates primarily on data relating to skilled nursing homes because of the conclusions, after detailed study, that serious problems are developing in this area of patient care.

The efforts of the Metropolitan St. Louis Hospital Planning Commission in areawide planning for hospitals and related health care facilities during 1964, including the preparation of this abstract, are supported in part by U.S. Public Health Service Research Grant No. HM 00357–01, from the Division of Hospital and Medical Facilities.

Robert W. Carithers,
Executive Director.

A nursing home facility has been defined by the Division of Health of Missouri as follows:

"A facility which is operated in connection with a hospital, or in which nursing care and medical services are prescribed by or under the general direction of persons licensed to practice medicine or surgery within 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 community service."[1]

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[1] The State of Missouri, Division of Health, Missouri Hospital Plan, 15th revision, 1964, Jefferson City, Mo., 1964, p. 71.

Skilled nursing is defined as nursing services and procedures employed in caring for the sick which requires training, judgment, technical knowledge and skills beyond that which the untrained person possesses. It involves administering medications and carrying out procedures in accordance with the orders, instructions, and prescription of the attending physician or surgeon. Skilled nursing care normally can be provided only by professional registered nurses or trained practical nurses.

NURSING HOME BED AVAILABILITY

In the St. Louis metropolitan area there were, as of November 1963, 97 homes with a total of 5,181 beds rendering skilled nursing home care. There were an additional 51 homes with 3,452 beds which rendered domiciliary care. A tabulation of beds, average census, and percentage of occupancy for each area and the total metropolitan area is contained in table I which follows:

TABLE I.—*Utilization of skilled nursing homes and domiciliary home beds, Metropolitan St. Louis area, 1963*

Area	Skilled nursing homes				Domiciliary homes			
	Number	Beds	Census	Percent occupied	Number	Beds	Census	Percent occupied
St. Louis city	9	965	834	86.4	20	2,273	2,041	89.8
St. Louis County	45	2,241	1,768	78.9	11	700	588	84.0
St. Charles County	7	298	168	56.4				
Jefferson County	7	502	455	90.6	2	19	17	89.5
Madison County	12	412	386	93.7	9	229	195	85.2
St. Clair County	17	763	608	79.7	9	231	193	83.5
Total	97	5,181	4,219	81.4	51	3,452	3,034	87.9

While recognizing obvious limitations, but having employed valid research techniques by which to reduce those limitations, the composite tabulation of nursing home utilization as shown in table I is considered representative.

Nursing homes, with sufficient service demand, can maintain with relative ease an occupancy rate of 95 percent. Cursory observation of the utilization rates in table I would seem to indicate that pressure for beds is low with a resultant generally low occupancy, but this observation points up the most obvious limitation of such a composite tabulation. Many of the beds included, particularly in the skilled nursing homes, are in homes of recent construction. Occupancy in these homes had not the chance to build up by the time of this study with the result that overall utilization rates were lowered. It is nonetheless true, however, that as more and more new beds are available for service, the demand for facilities is spread among a larger and larger number. Just at what point a saturation of the market may occur is a matter of speculation.

NURSING HOME UTILIZATION RELATED TO CHARGES

A survey of nursing homes in the total metropolitan area, conducted during 1963, requested information relative to highest, lowest, and average monthly patient charges in the individual homes. The response to this request was excellent and information was obtained on 68 percent of the skilled nursing homes.

Monthly patient charges in nursing homes relate generally to the type of service being offered. The rates in skilled nursing homes are understandably higher than in the domiciliary homes, and vary within each classification in relation to the extent of services. The average monthly patient charges revealed by the survey were as follows:

Skilled nursing homes with professional nursing	$244.66
Skilled nursing homes with practical nursing	191.36
Domiciliary homes	138.14

It is of interest to note that the median or midpoint of the charges actually being paid by patients in the homes was fairly close to the average of charges for all accommodations in the homes, with the skilled professional at $256.25, the skilled practical at $192.15, and the domiciliary at $154.15.

Of the 97 skilled nursing homes in the metropolitan area, 66 (68 percent) replied in full to that section of the survey questionnaire pertaining to charges. In these 66 homes are 4,217 (81.4 percent) of the 5,181 skilled beds in the area. On the basis of the homes reporting financial information, average occupancy and size of home are compared to average monthly charges in table II.

From table II one can see that the greatest demand for beds falls within the $100 to $249 per month average charge range which represents 68.2 percent of the homes and 60.4 percent of the beds. The information contained in table II has limited value as an indicator of market demand since so few homes and beds are represented in the higher average monthly charge categories. A better index of market potential is perhaps income and sources of payment available for nursing home care.

TABLE II.—*Average size and occupancy in relation to average monthly charges, skilled nursing homes, Metropolitan St. Louis area, 1963*

Average monthly charges	Number of homes	Percent	Number of beds	Percent	Percent occupancy	Average beds per home
$400 to $499	1	1.5	25	0.6	44.0	25
$350 to $399	1	1.5	56	1.3	94.6	56
$300 to $349	4	6.1	411	9.7	83.5	103
$250 to $299	15	22.7	1,179	28.0	[1] 55.2	79
$200 to $249	18	27.3	967	22.9	90.8	54
$150 to $199	22	33.3	1,276	30.3	90.6	58
$100 to $149	5	7.6	303	7.2	86.8	61
Total	66	100.0	5,217	100.0	79.6	64

[1] Of the 15 homes in this category, 5 were new homes, open less than 12 months, with an average occupancy of 25.8 percent; the remaining 10 had an average occupancy of 75.4 percent.

ECONOMIC PROBLEMS OF CHRONIC ILLNESS AMONG THE AGED

Proportionately more of the population aged 65 years or more have low income, high medical expense, and low insurance protection. While prepayment and commercial insurance coverage for older persons has increased in recent years, there is still a dropoff in third party payment for hospital stays conversely with the increasing age of the patient. This was demonstrated most recently in a study conducted by Walter J. McNerney and others on hospital charges and sources of payment in Michigan.[2]

While needing more home care or institutional care, the majority of the aged have inflation-prone fixed incomes and less family support.

Recent studies have shown that in 1962, 50 percent of individuals aged 65 years or more had incomes of less than $1,248 for the year, and 88 percent had incomes of less than $3,000. The comparative median incomes for families and individuals over and under the age of 65 years in the entire Nation is shown in table III.

TABLE III.—*Median money income of 2-person families and persons living alone, United States, 1962*

	Under age 65	Age 65 or over
2-person families [1]	$6,052	$3,204
Persons living alone	2,895	1,248

[1] For 2-person families, median income is shown for those with head of family over or under age 65.

Source: U.S. Bureau of the Census, "Current Population Reports: Consumer Income." series P–60, No. 41, Washington, Oct. 21, 1963.

A more detailed analysis of the 1960 census data on income of persons 65 years of age or older in the St. Louis metropolitan area is shown in table IV.

[2] McNerney, W. J., et al., "Hospital and Medical Economics," Chicago, Hospital Research and Educational Trust, 1962, vol. 1, p. 398.

TABLE IV.—*Income of persons aged 65 years and over, Metropolitan St. Louis area, 1960*

Annual income (all sources)	Number of persons	Percent of population aged 65 or over
$4,000 or over	23,267	12.4
$3,000 to $3,999	9,006	4.8
$2,000 to $2,999	17,517	9.3
Up to $1,999	137,735	73.5
Total	187,525	100.0

Source: U.S. Bureau of the Census, "U.S. Census of Population, 1960—Detailed Characteristics, Missouri." Final report PC-(1)-27D. Washington, 1962.

On the basis of the 1960 census data, as shown in table IV, the general income level of older persons in the St. Louis area is slighty better than the average for the Nation as a whole, with about 82 percent with incomes of $3,000 or less compared to 88 percent in the national average.

According to the most recent Social Security Administration data, at December 1961 prices, an elderly couple needing care could expect their combined hospital and medical bills for the year to approximate $1,160. For an individual total medical costs would average about $895.[3] With 73.5 percent of the older population having incomes of less than $2,000 per year and over 50 percent with incomes of less than $1,000 per year, these average costs represent large percentages of the total money income and contribute to a condition of medical indigence for a significant portion of the elderly population.

PROJECTED POPULATION OF THE METROPOLITAN AREA

An estimate of the total population and populations of persons 65 years of age and older has been made for each county of the metropolitan area. These estimates are based upon the findings of the 1960 census.[4] (Table V.)

From the projections contained in table V one can see that there is a variance among the counties in the metropolitan area in relation to percentage of persons 65 years of age and older. It immediately becomes apparent that older persons presently live in the urban centers close to the core cities.

PROJECTION OF FUTURE SKILLED NURSING HOME BEDS NEEDS

For purposes of developing a State hospital plan under the Federal Hill-Burton and related Public Health Service regulations, a general allocation has been made of 2 chronic hospital beds per 1,000 population and 3 nursing home beds per 1,000 population. In the States of Missouri and Illinois, and in other States, planning has been approached on the basis of the aggregate of 5 beds per 1,000 population allowing a maximum of 4 nursing home beds and 1 chronic disease bed per 1,000 population. This adaptation is permissible under section 53.61 of Public Health Service Regulations.[5]

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[3] Department of Health, Education, and Welfare, Social Security Administration, Division of Program Research, "The Health Care of Aged," Washington, D.C., GPO, p. 40.

[4] U.S. Department of Commerce, Bureau of the Census, "U.S. Censuses of Population and Housing: 1960 Census Tracts. St. Louis, Missouri-Illinois Standard Metropolitan Statistical Area," final report PHC (1)-131, Washington, D.C., GPO, 1962.

[5] U.S. Department of Health, Education, and Welfare, Public Health Service, "Public Health Service Regulations—Part 53. Pertaining to Hospital and Medical Facilities Survey and Construction Legislation." U.S. Public Health Service Publication No. 930-A-1, GPO, Washington, 1961.

TABLE V.—*Projected population development, 1963–70, Metropolitan St. Louis area*

Area	1963			1965			1970		
	Total population	Population 65-plus	Percent 65-plus	Total population	Population 65-plus	Percent 65-plus	Total population	Population 65-plus	Percent 65-plus
St. Louis City	723,130	96,160	13.2	705,200	100,157	14.2	677,000	103,581	15.3
St. Louis County	794,052	51,306	6.4	854,400	51,460	6.0	987,200	63,181	6.4
St. Charles County	66,188	4,049	6.1	75,000	4,104	5.5	108,000	6,264	5.8
Jefferson County	79,892	5,340	6.7	88,900	5,412	6.1	111,200	7,117	6.4
Madison County	235,195	19,674	8.4	242,200	20,052	8.3	263,500	22,925	8.7
St. Clair County	273,483	22,725	8.3	280,800	23,426	8.3	298,900	26,568	8.9
Metropolitan area	2,171,940	199,254	9.2	2,246,500	204,611	9.1	2,445,800	229,636	9.4

The current bed-population ratios for skilled nursing home beds and chronic disease beds are shown in table VI. Ratios are presented for the total population and for the population aged 65 years or older.

With reference to table VI, the wide variation in bed-population ratios among the counties in the metropolitan area is immediately apparent. Similarly, it will be noted that the present total number of skilled nursing home beds in the metropolitan area does not approach the calculated need when based upon bed-population criteria.

In St. Charles and Jefferson Counties, the bed-population ratio would indicate overbuilding at the present time. In each of these countries, however, general hospital facilities are under heavy occupancy pressure, particularly in the medical and surgical services. When under this pressure, long-term patients are seldom permitted to occupy acute-care facilities with the result that a greater demand is created for other facilities such as the skilled nursing home. Utilization of skilled nursing homes in Jefferson County is now at the rate of 90.6-percent occupancy. The relatively low occupancy rate of 56.4 percent in St. Charles County is somewhat misleading. Two of the seven homes were completely new at the time of the Hospital Planning Commission survey, with few patients admitted at that time. The remaining five homes are currently being utilized at a 93.3-percent occupancy rate, an exceptionally good rate and indicative of the demand for service in that county. There are no chronic disease beds in special or general hospitals in either of the two counties.

FACILITIES PLANNED OR UNDER CONSTRUCTION, 1963–65

Considerable activity continues in the area of planning and construction of new or expanded chronic and convalescent facilities. These projects are in various stages of planning or activation. As a result of a special survey conducted by the Hospital Planning Commission, a complete tabulation of existing and planned chronic disease and nursing home beds is shown in table VII.

TABLE VI.—*Bed-population ratios for nursing home and chronic disease beds, Metropolitan St. Louis area, June 1963*

Area	Skilled nursing home beds			Chronic disease beds			Total all beds		
	Number of beds	Beds per 1,000		Number of beds	Beds per 1,000		Number of beds	Beds per 1,000	
		Total population	65-plus population		Total population	65-plus population		Total population	65-plus population
St. Louis City	965	1.3	10.0	1,863	2.6	38.6	2,828	3.9	29.4
St. Louis County	2,241	2.8	43.7	338	.4	6.6	2,579	3.2	50.3
St. Charles County	298	4.5	73.6				298	4.5	73.6
Jefferson County	502	6.3	94.0				502	6.3	94.0
Madison County	412	1.8	20.9	22	.1	1.1	434	1.8	22.1
St. Clair County	763	2.8	33.6				763	2.8	33.6
Total	5,181	2.4	26.0	2,223	1.0	11.2	7,404	3.4	37.2

TABLE VII.—*Chronic and nursing home beds existing, planned, or under construction, Metropolitan St. Louis area, 1963–65*

Type beds	Area						
	St. Louis City	St. Louis County	St. Charles County	Jefferson County	Madison County	St. Clair County	Total
Existing:							
Nursing home	965	2,241	298	502	412	763	5,181
Chronic disease	1,863	338			22		2,223
Planned for completion (estimate) 1963:							
Nursing home	41	428			70	55	594
Chronic disease							
1964:							
Nursing home	1,401	1,152		360	127	200	3,240
Chronic disease	764	200				45	1,009
1965:							
Nursing home	400					20	420
Chronic disease	38	50			65		153
Total	5,472	4,409	298	862	696	1,083	12,820

It must be emphasized that completion dates for new construction or expansion of existing facilities may vary considerably, but the estimated dates as shown in table VII are considered reasonable. No listing of the individual institutions or homes involved in new construction or expansion is included in this report for the principal reason that the information was obtained in confidence. Some of the plans have not as yet been approved for licensure and others are in the speculative stage prior to public announcement.

PROJECTED BED-POPULATION RATIOS, 1965

If all the additional beds now programed for completion are actually completed by 1965, the gross number of beds available in the metropolitan area will exceed the ratio of 5 beds per 1,000 population currently considered adequate as a planning criterion. Projected bed-population ratios are shown in table VIII, following this page.

Considering only skilled nursing homes, a projected bed-population ratio is contained in table IX.

From table IX one can see that the rule of thumb of 3 beds per 1,000 population is rapidly being exceeded in most counties of the metropolitan area.

BED AVAILABILITY VERSUS BED DEMAND, 1965–70

Even a cursory observation of the projected bed population ratios in 1965 would warn of overbuilding of skilled nursing home beds in sections of the metropolitan area. This observation incorporates a broad assumption, of course, that all beds now planned for construction will be undertaken and completed. The fact that new proposals for nursing home construction are made known figuratively with each new week would more than offset an expected mortality among all proposals and would lend validity to the assumption.

(1) Current utilization projected

When analyzed by other criteria, the projected availability demand relationship does not appear any more promising. In projecting potential demand for utilization rates for acute, short-term patient care services, the use of current and past utilization trends has proved successful in terms of a reasonable range of accuracy. This method assumes that known utilization in terms of patient-days per 1,000 population will continue, reflecting increased demand with increases in population. The availability and accuracy of current and past patient care statistics is the most important requisite to making a reasonable projection.

In the case of long-term-care patients, however, and particularly for those in nursing homes, accurate patient care statistics have not been uniformly available.

Using the current average daily census of 4,219 patients in nursing homes and 1,978 patients in chronic hospital facilities (including chronic care units in general hospitals), the current average census totals 6,197 patients. This means a total of 2,261,905 patient-days of care rendered in 1963 (6,197 by 365 days = 2,261,905 patient-days). The patient-days per 1,000 population are determined as follows:

TABLE VIII.—*Projected bed-population ratios reflecting all additional chronic hospital and nursing home beds planned or under construction, Metropolitan St. Louis area, 1963–65*

Area	1963			1964			1965		
	Beds existing and planned	Beds per 1,000 population		Beds existing and planned	Beds per 1,000 population		Beds existing and planned	Beds per 1,000 population	
		Total	65 plus		Total	65 plus		Total	65 plus
St. Louis City	2,869	3.967	29.835	5,034	7.048	51.259	5,472	7.759	54.634
St. Louis County	3,007	3.786	58.609	4,359	5.288	85.063	4,409	5.160	85.678
St. Charles County	298	4.502	73.598	298	4.221	73.417	298	3.973	76.612
Jefferson County	502	6.283	94.007	862	10.213	160.760	862	9.696	159.275
Madison County	504	2.142	25.617	631	2.643	31.754	696	2.873	34.709
St. Clair County	818	2.991	35.995	1,063	3.835	45.813	1,083	3.856	46.230
Total	7,998	3.682	40.139	12,247	5.543	60.645	12,820	5.706	62.655
SUMMARY BY STATE AREAS									
Missouri counties	6,676	4.013	42.561	10,553	6.231	66.424	11,041	6.406	68.521
Illinois counties	1,322	2.598	31.179	1,694	3.283	39,327	1,779	5.372	40.917
Total	7,998	3.682	40.139	12,247	5.543	60.645	12,820	5.706	62.655

TABLE IX.—*Projected bed-population ratios for skilled nursing home bed additions, Metropolitan St. Louis area, 1963–65*

Area	1963			1964			1965		
	Population	Beds		Population	Beds		Population	Beds	
		Existing and planned	Per 1,000		Existing and planned	Per 1,000		Existing and planned	Per 1,000
St. Louis City	723,130	1,006	1.391	714,162	2,407	3.370	705,200	2,807	3.980
St. Louis County	794,052	2,669	3.361	824,228	3,821	4.635	854,400	3,821	4.472
St. Charles County	66,188	298	4.502	70,594	298	4.221	75,000	298	3.973
Jefferson County	79,892	502	6.283	84,397	862	10.213	88,900	862	9.696
Madison County	235,195	482	2.049	238,697	609	2.551	242,200	609	2.514
St. Clair County	273,483	818	2.991	277,141	1,018	3.673	280,800	1,038	3.696
Total	2,171,940	5,775	2.658	2,209,219	9,015	4.080	2,246,500	9,435	4.199

SUMMARY BY MAJOR AREA

Area	1963 Population	1963 Beds Existing and planned	1963 Per 1,000	1964 Population	1964 Beds Existing and planned	1964 Per 1,000	1965 Population	1965 Beds Existing and planned	1965 Per 1,000
St. Louis City and County	1,517,182	3,675	2.422	1,538,390	6,228	4.048	1,559,600	6,628	4.249
Missouri counties including St. Louis	1,663,262	4,475	2.690	1,693,381	7,388	4.362	1,723,500	7,788	4.518
Illinois counties	508,678	1,300	2.555	515,838	1,627	3.154	523,000	1,647	3.149
Total	2,171,940	5,775	2.658	2,209,219	9,015	4.080	2,246,500	9,435	4.199

Dividing 2,261,905 patient-days by 2,171,940,000 population equals 1,041,421 patient days per 1,000 population.

Projecting potential utilization in future years on the basis of current utilization involves the use of the following formula:

Step 1

Projected population in thousands by patient-days per 1,000 population equals projected total patient days.

Step 2

Projected patient-days divided by 365 days equals projected average daily census.

Step 3

Projected average daily census divided by desirable occupancy rate (80, 85, 90 percent, etc.) equals projected total bed need.

A projection of chronic and skilled nursing home bed needs based solely upon current utilization rates is shown in table X.

TABLE X.—*Projected chronic and skilled nursing home bed needs based upon current utilization rates, Metropolitan St. Louis area*

Year	Projected population	Patient-days per 1,000 population	Projected patient-days	Projected average daily census	Projected bed needs at occupancy rates [1]		
					80 percent	85 percent	90 percent
1965 [2]	2, 246, 500	1041. 421	2, 339, 552	6, 410	8, 012	7, 541	7, 122
1970	2, 445, 800	1041. 421	2, 547, 107	6, 978	8, 723	8, 210	7, 754
1975	2, 634, 900	1041. 421	2, 744, 040	7, 518	9, 397	8, 845	8, 353

[1] Projected average daily census divided by occupancy rate at 0.80, 0.85, and 0.90 equals projected bed needs.

[2] Estimated beds available by 1965 equals 12,820.

If a determination of future needs were to be based solely upon a projection of current utilization experience, as shown in table X, it is obvious that bed availabilities would far exceed demand with a resultant 50 to 60 percent occupancy and serious financial operating problems.

(2) *Additional demand—Potential and effective*

The National Health Survey revealed that in addition to those persons institutionalized, there were, among the persons 65 years or older, an additional 24.8 per 1,000 who required constant or full-time nursing care at home.[6] This can be considered the potential additional market for skilled nursing home or chronic hospital services. These persons are not now in an institution for one or more of the following representative reasons:

Inability to pay for needed skilled nursing home services or private chronic hospital care.

Reluctance to leave the home situation.

Willingness and desire of the spouse or other relative to continue care at home for so long as possible.

Reluctance to accept public or charity service.

Lack of suitable nursing home facilities and services.

The latter reason seems unlikely to apply to the situation in the metropolitan area where few private nursing homes are under a high demand pressure.

By 1965, 24.8 persons per 1,000 in the older population would mean a total of 5,074 persons (by 1970, 5,695 persons) representing the potential additional demand for chronic care or nursing home services. This total cannot be considered as representing the effective demand, however. The effective demand must be considered as that number who will seek the service, either with the ability to afford private care or with a willingness to accept charity or public care.

[6] U.S. Department of Health, Education, and Welfare, Public Health Service, "Persons Receiving Care at Home, United States, July 1958–June 1959." Health Statistics From the U.S. National Health Survey, USPHS publication No. 583–B28, GPO, Washington, 1961.

(3) Effective demand and the skilled nursing home

Since 89 percent of the existing and almost 100 percent of the proposed skilled nursing homes are proprietary organizations operated for profit, the estimate of effective demand looms as of extreme importance to future operations and profit maintenance.

To project an estimate of demand for skilled nursing homes alone necessitates consideration of the following factors:

Only those persons not now in nursing homes but with annual incomes of $2,000 or more (26.5 percent can be considered financially able to purchase private nursing home services independently or with help from relatives.

While the average charge for skilled nursing home services is now about $220 per month, reports of minimum charges for new homes now under construction indicate a higher minimum charge of about $290. Considering the additional expenses for physicians' services, laboratory tests, and other services incidental to long-term illness, the annual cost for the long-term patient can be estimated conservatively at a minimum of $3,000 to $3,600 in skilled nursing homes.

In proprietary operations, it must be assumed that free service will be kept to an unavoidable minimum. The nonprofit operations may be expected to assume a considerable burden of charity or free service, but they represent only 15 percent of the skilled beds. Taking the nonprofit free service into account, however, and assuming that some free service will be rendered in proprietary operations, an additional allocation of 4 percent charity or free patients out of the total potential market not now in institutions can be applied to the effective market.

It should be noted that the use of the $2,000 level of annual income as a determinant of ability to pay rather than the $3,000 level represents a more liberal allocation to the so-called effective market. This is intentionally an attempt to arrive at a projection of the greatest potential utilization. This liberal allocation also takes cognizance of possible improvements in income and other factors which should help lessen the effect of catastrophic illness among the aged, such as a possible Federal Government program for health care of the aged, broadened Kerr-Mills participation among the various States, improved OASI benefits, and expanded voluntary and commercial insurance coverage.

Using the same formula for projecting patient-days of care based on current utilization, the current patient-days in skilled nursing homes (4,219 average daily census times 365 days) totals 1,539,935. Dividing this by the total population of 2,171,940 results in an average of 709 patient-days per 1,000 population. Again using the same formula for projection as illustrated in table X, a projection of probable census and occupancy rates in skilled nursing homes is shown in table XI.

TABLE XI.—*Projected utilization of skilled nursing home beds reflecting estimated effective demand, Metropolitan St. Louis area, 1965–70*

Year	Projected population	Patient-days per 1,000	Projected patient-days	Projected census by prior utilization	Additional effective market	Projected average daily census	Estimate beds available	Estimate occupancy rate (percent)
1965	2,246,500	709	1,592,769	4,364	[1] 1,549	5,912	9,435	62.7
1970	2,445,800	709	1,734,569	4,752	[2] 1,737	6,489	[3] 9,435	68.7

[1] 1,345 additional private or full-pay patients (26.5 percent times 5,074) plus 203 charity or part-pay patients (4 percent times 5,074), all aged 65 years or over.

[2] 1,509 additional private or full-pay patients (26.5 percent times 5,695) plus 228 charity or part-pay patients (4 percent times 5,695), all aged 65 years or over.

[3] Assumes no further additions.

(4) Another look at effective demand

To this point, two methods have been employed in an effort to determine the approximate utilization of nursing home and chronic hospital facilities in the immediate future. These methods have involved a projection based upon current patient days of utilization per 1,000 population and an incorporation of an assessment for the potential and effective demand among those persons now receiving full-time or constant nursing care at home. These methods for projection have been employed for chronic-nursing home facilities combined and then modified on the basis of ability to pay for the skilled nursing home facilities and services.

The methods previously employed have incorporated the broad assumption that only those persons aged 65 years or older among the population receiving full-time care at home represent the potential market for nursing homes and chronic hospital facilities. While it has been found to be true that approximately 86 percent of patients in nursing homes[7] and 77 percent of those in chronic hospital facilities[8] are in this older age group, many of those persons now receiving care at home are under 65 years of age. The national health survey revealed that, for the total population, 3.8 persons per 1,000 were receiving constant care at home. Applied to 1963 population estimates for the metropolitan area, this group would involve a total of 8,253 persons.

In an effort to explore all possibilities for increasing projected utilization, a third method has been developed. This involves a projection of census based upon the present utilization and distribution of patients among long-term care facilities. This projection is augmented by an allocation of the potential market by the same percentage by which the present institutionalized population is distributed among the various types of facilities. For example, the base for this type of projection is shown in table XII.

TABLE XII.—*Proportionate utilization of long-term facilities, Metropolitan St. Louis area, 1963*

Facility	Total census	Percent total distribution	Census, aged 65+	Percent distribution, aged 65+
Skilled nursing homes	4,219	20.907	3,622	31.827
Chronic hospitals	1,978	9.803	1,521	13.365
Mental hospitals	5,359	26.558	1,198	10.527
Tuberculosis hospitals	370	1.834	98	.863
At home	[1] 8,253	40.898	[2] 4,941	43.418
Total	20,179	100.000	11,380	100.000

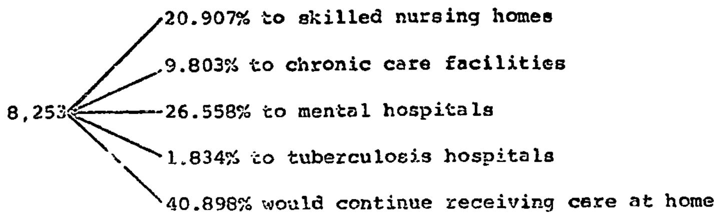
[1] 3.8 per 1,000 in total population.
[2] 24.8 per 1,000 in population aged 65 years or older.

Referring to table XII, the proportion of persons aged 65 years or older among the total census in the chronic, mental, and tuberculosis facilities was determined by a hospital planning commission survey of ages of current patients in these facilities in St. Louis and St. Louis County. It is interesting to note that the total census of patients either institutionalized or receiving care at home represents less than 1 percent of the total population. The census of older persons, however, represents approximately 5.7 percent of the population aged 65 years or older.

[7] Health and Welfare Council of Metropolitan St. Louis, "80 Nursing Homes and Homes for the Aged in St. Louis City and County, and Jefferson and St. Charles Counties, Mo." Mimeographed results of a study receiving project support from the Chronic Disease Division, Public Health Service, U.S. Department of Health, Education, and Welfare, and the Division of Health of the State of Missouri, January 1962.

[8] Littauer, D., Steinberg, F. U., and Gee, D. A., "Organizing and Operating a Chronic Disease Unit in a General Hospital: Analysis of 5 Years' Operating Experience," Hospital Monograph Series No. 13, Chicago, American Hospital Association, 1963.

If the total of those persons receiving constant care at home is considered to be the total potential market for long-term care facilities, it can be assumed that these persons would obtain care in various facilities in approximately the same proportion as the current pattern of utilization of the various types of long-term facilities. This assumption is graphically illustrated as follows:



This distribution of the potential market would represent the maximum utilization that might be expected if current utilization patterns prevail. It gives no specific consideration to the ability to pay for services, but inherently recognizes this matter as it reflects current utilization. The distribution of this potential market as applied to 1965 and 1970 populations is shown in table XIII.

TABLE XIII.—*Projection of long-term facility utilization by persons estimated to be receiving full-time care at home, Metropolitan St. Louis area, 1965–70*

Type of facility	Percent census distribution	1965	1970
Skilled nursing homes	20.907	1,785	1,943
Chronic hospitals	9.803	837	911
Mental hospitals	26.558	2,267	2,468
Tuberculosis hospitals	1.834	157	170
Care at home	40.898	3,490	3,801
Total	100.000	[1] 8,536	[1] 9,293

[1] 3.8 per 1,000 total population.

To project the maximum estimated utilization, the allocated potential market totals are added to a projected census of patients based upon current utilization. This projection is shown in table XIV.

TABLE XIV.—*Projected census in skilled nursing homes and chronic care facilities, Metropolitan St. Louis area, 1965–70*

	1965		1970	
	Nursing homes	Chronic facilities	Nursing homes	Chronic facilities
Projected census based on current utilization	4,364	2,046	4,751	2,228
Projected potential census from persons receiving care at home	1,785	837	1,943	911
Total	6,149	2,883	6,694	3,139

Considering the projected census figures in table XIV to be the maximum potential utilization which reasonably could be expected, the general level of occupancy for both types of facilities has been projected and is shown in table XV.

TABLE XV.—*Estimated bed availabilities, maximum census and occupancy rate in skilled nursing homes and chronic care facilities Metropolitan St. Louis area, 1965–70*

Type of facility	1965			1970		
	Beds available	Census	Percent occupancy	Beds available	Census	Percent occupancy
Skilled nursing homes	9,435	6,149	65.2	[1] 9,435	6,694	70.9
Chronic care facilities	3,385	2,883	85.2	3,385	3,139	92.7
Total	12,820	9,032	70.4	12,820	9,833	76.7

[1] Assumes no further additions.

SUMMARY OF BED AND UTILIZATION PROJECTIONS

With the three methods of projecting estimated demand for skilled nursing home and chronic care services, three different figures for probable census and occupancy rate have resulted. While differently constructed, the three estimates are quite similar and each would indicate a relatively lower potential nursing home utilization than would be indicated by the present rush to construction. For comparison, the three projections are combined in table XVI.

By any of the three means of projection, the outlook for effective utilization of skilled nursing home facilities, assuming the present plans for additional beds are completed, is not encouraging. It is of interest to note a comparison of the projected average daily census by method (3), table XVI, with the number of beds considered desirable under the Hill-Burton bed-population ratio. On the basis of 3 skilled nursing home beds per 1,000 population, there should be a total of 7,337 beds by 1970. The projected daily census of 6,694 would mean an occupancy of 91.1 percent, a very healthy and effective rate of utilization.

TABLE XVI.—*Comparison of estimated census and occupancy rates by three separate methods of projection, Metropolitan St. Louis area, 1965–70*

	Estimated beds available	(1) Projection based solely on current utilization		(2) Projection based on current utilization plus ability to pay age 65+		(3) Projection based on current utilization plus distribution of full potential market	
		Census	Percent of occupancy	Census	Percent of occupancy	Census	Percent of occupancy
	1965						
Skilled nursing homes	9,435	4,364	46.2	5,912	62.7	6,149	65.2
Chronic care facilities	3,385	2,046	60.4	[1]	----------	2,883	85.2
Total	12,820	6,410	50.0	----------	----------	9,032	70.5
	1970						
Skilled nursing homes	9,435	4,752	50.4	6,489	68.7	6,694	70.9
Chronic care facilities	3,385	2,226	65.8	----------	----------	3,139	92.7
Total	[2] 12,820	6,978	54.4	----------	----------	9,833	76.7

[1] Not calculated for chronic hospital facilities.
[2] Assumes no further additions.

CONCLUSIONS

1. By 1965, skilled nursing home and chronic disease bed availabilities will exceed recommended bed population ratios

The current surge in new nursing home and, to a lesser extent, chronic care facility construction and expansion of existing facilities indicates a 65-percent increase in numbers of beds available at some time during the year 1964. The overall bed population ratio for the metropolitan area will increase from 3.4 per 1,000 at present to 5.5 per 1,000 in the short period of 1 year. This ratio will increase to 5.7 per 1,000 by 1965 if all planned construction is completed.

2. New nursing home construction is primarily in higher cost accommodations

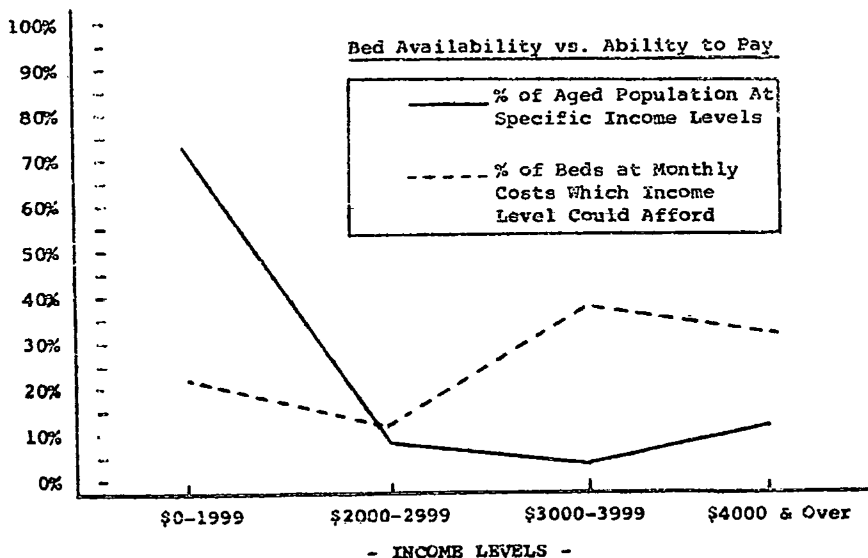
In the Hospital Planning Commission's survey of all new construction planned or underway, the minimum charges anticipated by the promoters or operators are equal to or in excess of the current median charge for skilled nursing home services. The majority are envisioned as being within the minimum range of $270 to $300 per month.

To afford these services, and the other costs incidental to long-term illness, will require an income of $3,500 to $4,000 per year or considerable financial subsidy of the patient by relatives or from other sources. While the relative proportion of beds in these higher price categories is increasing, there is no indication that the effective market of persons in corresponding income categories will increase. At the present time, only 17 percent of all persons in the metropolitan area aged 65 years or more have incomes in excess of $3,000 per year.

3. Expected gross increases in numbers of persons aged 65 years or older will bring increased demand for low cost and public chronic care and nursing home facilities

By 1970, the number of persons in the metropolitan area aged 65 years or more is expected to increase by about 30,000 from 199,254 to 229,636. The most notable increase is expected to occur in the city of St. Louis where this age group, now representing 13.2 percent of the total population, is projected to represent 15.3 percent of the population in 1970. The proportionate percentage for the entire metropolitan area is expected to increase from 9.2 to 9.4 percent.

An inverse relationship exists between planned nursing home and chronic disease facilities and the growth of numbers of persons who can afford the services. The growth in beds is in facilities requiring incomes of $3,000 to $3,600 or more to support while the growth in numbers of people can be expected to swell the ranks of persons with incomes under that figure. This relationship between bed availability and ability to pay is graphically illustrated as follows (at projected 1965 level):



4. Problems incident to overbuilding can be serious

It would seem that with the majority of nursing homes being proprietary ventures, the question of possible overbuilding would be a matter of academic economics; i.e., if the available facilities exceed demand, then marginal operations would be forced out of business. This principle is undoubtedly correct, but other effects could be produced which could have serious consequences relative to quality of patient care service.

(1) *Profit protection versus service.*—In a proprietary endeavor, successful operation hinges upon the maintenance of a reasonable profit and return on investment. In the realm of patient care, the only product is service and service to the patient determines the quality of the patient care program. If, in a proprietary operation, a reasonable profit or return is threatened by a lessening in demand or other factors, the only opportunity to further protect a profit is to reduce service. It is at this point where the motives of proprietary endeavor and patient care service come into direct conflict, and if the operation is to be maintained, it will be at the expense of the patient care program.

(2) *Availability of Hill-Burton funds.*—The growing trend toward construction of proprietary nursing homes has corresponded to a very slow development of nonprofit homes, particularly as a part of or in conjunction with general hospitals. That general hospitals have been reluctant to enter this area of patient care is borne out by the fact that only 180 beds in the entire metropolitan area are classified as being for chronic or convalescent care in general hospitals and only 8 nursing homes in the area are acknowledged by the American Hospital Association as being operated by or having an affiliation with a general hospital.[9]

The American Hospital Association and the U.S. Public Health Service strongly urge that nursing homes be developed by or in affiliation with general hospitals. The State health departments or divisions in Missouri and Illinois support this principle. This recommendation is based solely upon the service needs of the patients and the inadvisability of duplicating services in every skilled nursing home.

The strongest inducement for hospital construction of nonprofit nursing home units is the availability of matching Federal funds through the Hill-Burton program. If the bed-population ratios in any planning area exceed the recommended Hill-Burton ratio, however, these funds cannot be allocated to that area, notwithstanding the fact that the majority of the beds may be in the proprietary category. If nursing home construction continues in the metropolitan area at the present pace, no Federal funds will be available to nonprofit institutions for this purpose by 1965.

5. A program of accreditation for skilled nursing homes should be vigorously pursued and supported.

Since 1959, consideration has been given nationally by the American Hospital Association, the American Medical Association, the American Nursing Home Association, and other groups concerned with the quality of care for the aged to the development of a program of accreditation for skilled nursing homes. Early efforts indicated an inclusion of skilled nursing homes within the area of responsibility of the Joint Commission on Accreditation of Hospitals.

In April of 1963, however, a joint program for accreditation of nursing homes was announced by the American Medical Association and the American Nursing Home Association. This program represents a bilateral approach rather than the multilateral approach of the Joint Commission where many agencies and many disciplines involved in determining the quality of care are involved in setting standards. No evaluation program has at this time been prepared by the two organizations. It is to be hoped that the possibility of incorporating the accrediting program under the well-established and respected Joint Commission will be reconsidered by both the Medical Association and the Nursing Home Association.

Until a sound accreditation program is developed, the program of registration and listing by the American Hospital Association offers the only reliable criteria for evaluating nursing home organization and service. While not so broad as accreditation would be, the AHA program does establish requirements designed

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[9] Hospitals, JAHA, Guide Issue, vol. 37, No. 15, Aug. 11, 1963, Chicago: American Hospital Association, p. 315.

to serve as minimum standards for acceptable nursing home facilities and services. These requirements are listed as follows:

> The institution shall have beds for the care of patients who require continuing planned medical and nursing care and supervision, and who stay on the average in excess of 24 hours per admission.
>
> The facility shall be licensed or approved by the legally authorized agency or agencies.
>
> Each patient shall be under the care of a duly licensed doctor of medicine or doctor of osteopathy, and shall be seen by a physician as the need indicates, and there shall be evidence of general supervision of the clinical work by doctors of medicine.
>
> There shall be one or more duly licensed doctors of medicine who shall advise on medical administrative problems, review the institution's plan for patient care, and handle emergencies if the patient's personal physician is unavailable.
>
> There shall be a medical record maintained for each patient, which shall include at least, (*a*) the medical history, (*b*) report of physical examination, (*c*) diagnosis, (*d*) physician's orders, (*e*) progress notes (medical and nursing), (*f*) medications and treatments given.
>
> There shall be arrangements to provide diagnostic services, such as clinical laboratory and X-ray procedures, which shall be regularly and conveniently available.
>
> The nursing service shall be under the supervision of a registered nurse and there shall be such other nursing personnel as are necessary to provide adequate care of patients 24 hours a day.
>
> There shall be evidence that food served to patients meets their nutritional and dietary requirements, as reflected in menus that are planned in advance and kept on file for at least 1 month.
>
> The physical plant shall be safe and sanitary and the number of patients accepted shall not overtax the facility.
>
> There shall be proper storage and control of narcotics and other medications in accordance with physicians' orders.
>
> There shall be arrangements with at least one acute short-term hospital where patients whose condition requires it will be admitted with a minimum of delay.

Both the program of registration and a program of accreditation (when developed) should lead to a raising of standards of care in all nursing homes. The most obvious value will accrue in the assurance of quality care to the patients. Other benefits will accrue also—

> To facilitate development of formal relationships between general hospitals and long-term care facilities.
>
> To serve as a criterion for extension of prepayment and commercial insurance coverage for care in skilled nursing homes. Participation could be limited to accredited or registered homes.
>
> To serve as a criterion for a central referral service as envisioned by the health and welfare council for the metropolitan area.
>
> To provide a means of uniform reporting of patient care data and resultant improved analysis of total care being rendered.

The above benefits can be considered as representative. Many other benefits can be assumed, but none is more important than the assurance to the prospective patients and to the citizens of the metropolitan area that quality of care is of major concern and is measured against accepted standards.

Senator Moss. The subcommittee will come to order. We will now proceed to hear from the National Rehabilitation Commission of the American Legion. Mr. Robert Murphy, who is the assistant director of the national legislative commission; Mr. John Corcoran, the director of the rehabilitation commission; Dr. Irving Brick—is Dr. Brick here?

Mr. Murphy. No, sir.

Senator Moss. We are delighted to have you gentlemen with us and you may proceed.

STATEMENT OF JOHN J. CORCORAN, DIRECTOR, NATIONAL REHABILITATION COMMISSION OF THE AMERICAN LEGION; ACCOMPANIED BY ROBERT F. MURPHY, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION

Mr. MURPHY. Mr. Chairman, my name is Robert F. Murphy, and I am assistant director of the National Legislative Commission of the American Legion.

The American Legion certainly appreciates this opportunity to come before you and express its views on this most important subject.

For a number of years now the American Legion has had a continuing study on this subject, the overall problems of the aging, but in particular, of course, the aging war veteran.

Within our organization the responsibility of this study is confined to two of our commissions; namely, the national economic commission and the national rehabilitation commission.

Today, to present the views of our organization we have with us the director of our national rehabilitation commission, Mr. John J. Corcoran.

Senator MOSS. We are very pleased to have you, Mr. Corcoran. We will listen to your testimony.

Mr. CORCORAN. Thank you, Mr. Chairman. If it pleases the Chair, I would propose, in the interest of time, to give a summary of my prepared statement. I will try to avoid that disaster that sometimes occurs when the summary is longer than the prepared statement. I think I would be able to summarize perhaps in 8 or 10 minutes if this is agreeable.

Senator MOSS. This is agreeable. The entire statement will be placed in the record as though read in full and we will ask you to summarize it.

(The statement referred to follows:)

STATEMENT OF JOHN J. CORCORAN, DIRECTOR, NATIONAL REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and members of the subcommittee, since 1955, the American Legion has given increasing attention to the problems of the aged and aging war veteran. Our special committee on the matter, composed of members of our national economic and national rehabilitation commissions, has considered the problems from the standpoint of income, housing, employment, medical care, and hospital care.

In a recent address, President Johnson gave expression to a principle that long has been the guide for the American Legion's approach to Federal programs created for the benefit of the war veteran population. That is to say, that the costs of war veterans benefits are directly related to, and a part of, the cost of war. We hold that, by service in the Armed Forces in time of war, in the service of the Federal Government, the war veteran population has been established as a special concern of our Government. And the care of the veterans is as much a part of the cost of war as the guns, the ships, the planes, the missiles, that these war veterans used to wage our wars.

THE VETERANS' ADMINISTRATION

The American Legion has always supported the idea that there should be one Federal agency dealing with programs for the war veterans and his dependents. Our officials participated actively in the discussions that led to the establishment of the Veterans' Bureau, later to become the Veterans' Administration.

The Veterans' Administration has a competence second to none among Federal departments and agencies, in the conduct of its business. Created to deal with the affairs of World War I and earlier wars, the Veterans' Administration has successively and successfully dealt with the expansion of the veteran population arising out of World War II and the Korean conflict.

It is today an ongoing agency, nationally conceived and operating in the 50 States of the Union. Often investigated, constantly under the scrutiny of the people of our country, it is today giving a standard of operation that is not excelled.

For all these, and for many other reasons, the American Legion is of the belief that the Veterans' Administration should be given the opportunity to apply its talents and resources as the war veteran population moves into the higher age brackets.

We have been greatly concerned with the neglect shown the Veterans' Administration in the rising crescendo of attention given to the problems of the aged and aging in our citizenry. It is our belief that—if the Veterans' Administration is permitted to use its great resources—the problems of a great segment of the population among those 65 and over will reach a more nearly successful plateau of solution.

Insofar as the Congress is concerned, the American Legion observation is that veterans affairs have been considered without regard to political partisanship. We have found that where the attention of the Congress could be brought to bear upon the question of veterans affairs, fair consideration has resulted. Down through the years since World War II, there has been one agency consistently devoting its attention to the idea that the Veterans' Administration shall be downgraded, that its sphere of activities shall be reduced. Consistently, this agency, the Bureau of the Budget, opposes legislation dealing with veterans affairs when such legislation is before the Congress. Because organizations such as ours are at a great disadvantage in dealing with the Bureau of the Budget, occupying as the Bureau does an almost cloistered protection, it is difficult to present to the Congress an effective answer to this studied, consistent opposition.

As a part of this presentation, in support of the Veterans' Administration as the agency to care for the aged and aging war veteran, we are attaching, as table A, a statement showing VA expenditures since 1930 as a percentage of gross national product, national income, etc. This record, we believe, compares favorably with that of any other department or agency in the Federal Government.

THE WAR VETERAN AS A SEGMENT OF THE 65 AND OVER POPULATION

In 1960, the Veterans' Administration published its study of the aging American war veteran and the national economy. In table 3, part 5, of that study, the VA estimated the projections for the aging male population, 65 and over, showing the percentage of male veterans from 1950 to and including the year 2000. This is how that table pinpointed the rising proportion of war veterans in the aging male population:

	Total (millions)	Veteran (millions)	Percent veteran
1950	5.8	0.2	3.5
1955	6.5	.7	10.8
1960	7.1	1.8	25.4
1965	7.7	2.3	29.9
1970	8.4	2.0	23.8
1975	9.3	2.2	23.7
1980	10.3	3.0	29.1
1985	11.2	5.1	45.5
1990	12.3	7.5	61.0
1995	12.9	8.6	66.7
2000	13.1	8.3	63.4

Again, in July 1962, the Veterans' Administration published its veteran population projections. Table 1, page 3, of that study is attached as our table B, so that your committee will have before it a showing of the size of the problem in the years 1961–2040, as projected by the Veterans' Administration.

The data thus presented to you as viewed by the Veterans' Administration will indicate the size of the problem, insofar as the aging war veteran is concerned.

Perhaps a word should be included to indicate the importance of the war veteran population in our Nation. At the present time, the war veteran population with dependents is about 40 percent of the total population. In addition to its service to the Nation in the Armed Forces during times of war. It is an equally honorable group in its peacetime contribution. As has been said repeatedly, the war veteran is a true cross section of the Nation's population. He pays taxes, he supports the churches, he makes the laws, he mans the courts, he is your doctor, your banker, your economist, your industrial labor force, your minister, your teacher, your editor. He occupies a prominent place in Who's Who. In short, he is a valuable asset. His voice is at least as reasonable as that of any other segment of the total population. He merits, and is grateful for, the attention of your subcommittee today.

AREAS OF AMERICAN LEGION ACTIVITY

Following are some of the fields in which the American Legion is attempting to better the position of the aging war veteran. We believe it is proper that the Veterans' Administration deal with veterans affairs, since it is national in scope, is not plagued by matters of residency, offers a program universally equable to those eligible under the laws created by the Congress, and is constantly under scrutiny by official and nonofficial groups and agencies, as it administers its benefits programs.

Income.—For the aging war veteran and his dependents, the two chief sources of income are disability compensation for those with service-connected rating; and pensions, for those in financial need and with disabilities not attributed to service.

From the viewpoint of the American Legion, neither the service-disabled war veteran, nor the pensioner, has had an income adjustment that fits with the rising costs of living, or with rising standards of payment in an expanding economy. The Veterans' Administration has stated that in dollars of constant 1935 purchasing power, the payment for total disability under service-connected ratings (1959) was 106 percent of the 1935 schedule. In current dollars, the 1959 rate was $225.

The same authority has stated (1958) that 65 percent of the war veterans 65 and over had an income not exceeding $3,000.

With respect to the aging pensioner, the VA, using 1935 as the base, stated (1958) that in terms of constant purchasing power the pension rate had gone from $30 to $37 from 1935 to 1959. In the latter year, the rate in current dollars was $72.

While it is true that the VA programs have a record of small cost in terms of percentage of the gross national product, it is nevertheless also true that the dollar cost for even a slight increase in benefits in the war veterans income programs is sufficiently large to increase the difficulty of bettering the rates. In a war on poverty, this seems unjust in our opinion, for no dollar goes into the economy faster than that provided for the disabled war veteran and his dependents.

Medical and hospital—nursing care.—The Department of Medicine and Surgery was established in the Veterans' Administration following World War II in a successful effort to upgrade the quality of care provided for those treated in VA hospitals. Now, approximately 20 years later, and with dynamic new approaches to medicine, surgery, and care of the long-term patient, the Veterans' Administration is finding it difficult to secure sufficient funds to keep up with the latest advances practiced in the best non-VA hospitals. The American Legion

is hopeful that the difficulties in this area will be overcome, though the opposition of the Bureau of the Budget in this field is ever present.

We believe that those who supply funds for the operation of the VA Department of Medicine and Surgery should keep in mind the fact that the high quality of VA research and care has largely wiped out tuberculosis as a menacing national disease, has led to a great increase in the number of patients able to leave mental institutions and return to their communities, and, in many other ways, has had a substantial beneficial impact upon the health of the entire Nation.

You gentlemen of this subcommittee are familiar with the fact that in August 1963, the late President Kennedy authorized the establishment of an additional number of beds to care for 2,000 aging war veterans within the VA hospital system. This was to be a nursing-care program for the long-term patients who had reached maximum hospital benefit status and were retained in hospitals because there was no place else for them to go. We are sorry to report that this program is encountering delay in getting underway, and again we understand that the Bureau of the Budget is holding the position that these beds for long-term nursing care are not additional to the previously authorized 125,000-bed capacity, but are to be included within that number of beds.

Likewise you are familiar with the program included in H.R. 8009, to provide 2,000 nursing care beds in the VA hospital system, and to provide other improvements in the various phases of the medical program to benefit the aging war veteran. With House approval in September 1963, this measure is being considered in the Subcommittee on Veterans' Affairs of the Senate Labor and Public Welfare Committee. We are hopeful that the bill will be reported favorably and that the Senate will give its approval to this proposal during the 88th Congress.

Standards for nursing home care.—Through foster homes, day care centers, restoration centers, and other institutions, the Veterans' Administration has been engaged in a program to return the veteran to his community, that is, to discharge him from VA hospitals and other facilities when he has reached the point termed "maximum hospital benefit."

While recognizing the value of such a program, the American Legion has been concerned with the quality of care to which such discharged VA patients have been transferred. The VA has relied upon the individual judgments of the VA employees concerned in effecting such discharges. There is no formal set of standards established by the VA for judging the quality of the foster homes, nursing homes, and other like institutions available to the low-income hospital-discharged veterans.

Our national rehabilitation commission authorized our rehabilitation staff to seek ways of working with the VA in establishing standards for care in long-term institutions.

As a result of joint action by the Legion and the VA in the State of Maine, where outplacement of VA patients had landed discharged VA patients in some homes of questionable quality, the VA Chief Medical Director issued an all-station letter (No. 64–11, Mar. 31, 1964) titled "Evaluation of Homes Other Than Their Own To Be Used by Veterans," and containing the following paragraph, which may be considered a beginning in establishing standards for such institutions:

"In addition to using all applicable State and local licensing laws and regulations to insure adequate levels of safety and sanitation, there should be consideration with health and safety officers in applying local standards and practices. The hospital engineering and housekeeping staffs should be consulted in developing methods of evaluation of safety and sanitation in foster homes."

Table A

Gross national product (billions)	Fiscal year	VA expenditures as a percent of—			Per capita expenditures (excluding foreign)
		Federal budget expenditures	National income	Gross national product	
$91.1	1930	18.6	0.8		
	1931	20.0	1.0		
	1932	16.9	1.5		
$55.9	1933	16.9	1.9		
$68.7	1934	7.4	1.1	0.7	$3.55
$75.2	1935	8.5	1.0	.1	3.45
$86.8	1936	6.8	.9	.6	3.78
$88.0	1937	7.5	.8	.6	3.82
$88.2	1938	8.6	.8	.6	3.94
$95.7	1939	6.3	.8	.6	4.08
$100.6	1940	6.2	.7	.6	3.95
$140.5	1941	4.2	.6	.4	4.09
$178.4	1942	1.6	.4	.3	4.30
$202.8	1943	.8	.4	.3	4.90
$218.3	1944	.8	.4	.4	7.19
$213.6	1945	2.1	1.1	1.5	22.67
$221.5	1946	7.3	2.4	3.0	47.62
$245.0	1947	19.1	3.9	2.8	47.82
$260.5	1948	19.6	3.1	2.7	47.88
$263.0	1949	16.9	3.0	2.5	43.89
$284.6	1950	16.7	2.9	2.4	41.35
$311.8	1951	12.0	2.0	1.4	31.01
$336.8	1952	7.7	1.7	1.2	27.28
$358.4	1953	5.9	1.5	1.1	26.12
$360.6	1954	6.3	1.4		
$397.5	1955	6.9	1.4	1.2	25.83
$442.8	1956	7.2	1.4	1.1	26.80
	1957	7.0	1.4	1.1	26.74
$444.5	1958	7.2	1.4	1.1	28.05
$482.7	1959	6.6	1.4	1.1	28.08
$503.4	1960	7.0	1.3	1.0	27.61
$518.7	1961	6.8	1.3	1.0	28.21
$553.9	1962	6.4	1.3	1.0	28.19
$558.0	1963	6.3	1.3	1.0	29.21
Percentage change for 1962-63 expenditures from—					
1934-35					+261
1949-50					−44
1959-60					+02

NOTE.—In 1963 the 1940 dollar had a value of 47 cents.

TABLE B-1.—*Number of veterans in civil life, by period of service: Projections for single years 1962–70; quinquennially, 1975–2040*

[In thousands]

June 30	Total [1]	Spanish-American War	World War I	World War II [2]	Korean conflict: Total [2]	Korean conflict: No service in World War II
1961	22,290	31	2,565	15,156	5,531	4,538
PROJECTED						
1962	22,153	26	2,455	15,126	5,586	4,546
1963	22,039	22	2,343	15,098	5,670	4,576
1964	21,891	18	2,226	15,061	5,733	4,586
1965	21,728	15	2,108	15,013	5,788	4,592
1966	21,545	12	1,988	14,954	5,834	4,591
1967	21,350	10	1,866	14,876	5,879	4,598
1968	21,149	8	1,744	14,767	5,926	4,630
1969	20,934	6	1,623	14,641	5,968	4,664
1970	20,701	5	1,502	14,497	6,003	4,697
1975	19,522	1	973	13,644	6,195	4,904
1980	17,841	(3)	527	12,464	6,049	4,850
1985	15,886	(3)	220	10,995	5,751	4,671
1990	13,689	----------	66	9,255	5,302	4,368
1995	11,274	----------	14	7,300	4,724	3,960
2000	8,657	----------	2	5,220	4,008	3,435
2005	6,026	----------	(3)	3,244	3,161	2,782
2010	3,690	----------	(3)	1,661	2,239	2,029
2015	1,900	----------	----------	651	1,340	1,249
2020	792	----------	----------	184	635	608
2025	249	----------	----------	38	217	211
2030	59	----------	----------	5	55	54
2035	10	----------	----------	(3)	10	10
2040	1	----------	----------	(3)	1	1

[1] Veterans who served in both World War II and the Korean conflict are counted once.
[2] Includes veterans who served in both World War II and the Korean conflict.
[3] Less than 500.

In addition to this action, our staff has been working toward establishing minimum standards that might be used in consideration of the quality of long-term care institutions to which war veterans might be assigned.

This staff study considers the accreditation program jointly sponsored by the American Medical Association and the American Nursing Home Association; the registration program of the American Hospital Association, largely limited to facilities affiliated with accredited hospitals; and programs of other organizations.

An interesting development in this field is the series of four articles published January-April 1964 by Consumer Reports. This series advances many practical questions to be used in determining nursing care standards in any given case.

CONCLUSION

At some point in any program that is developed federally, the eligible aging war veteran must be considered. Insofar as VA cash benefits programs and the programs for medical, hospital, and nursing care are concerned, we are convinced the Veterans' Administration is the proper agency for aging war veterans. We believe the records show that VA will develop and operate such programs efficiently and economically, since its competence in the field of veterans' affairs is unmatched. If the problems of the war veteran, 65 and over in age, are cared for within VA, the demand for other new agencies, or expansion of programs under other established agencies, will be impressively decreased.

Mr. Chairman, we appreciate this opportunity to express the views of the American Legion.

Mr. CORCORAN. Thank you. I want to express our gratitude to you for allowing us to squeeze in today and keep a previous travel commitment we had. I am also sorry Dr. Brick, our senior medical consultant, could not be with us this afternoon due to a conflicting engagement.

As Mr. Murphy said, the Legion has given attention over the past decade to the problem of aging. The handling of this matter, from an organizational viewpoint, has paralleled that of this subcommittee. We in the Legion formed and have had for the past 5 years a special joint committee composed of our rehabilitation and economic commissions. That special committee has attempted to consider all of the needs of the aged and has tried to determine ways in which the American Legion as an organization, and the Federal Government, through the Veterans' Administration, can meet those needs.

It perhaps is not completely appropriate to mention at this particular hearing the matter of filial responsibility, that is to say, the obligation of the child to the parent, but we of the American Legion have had this foremost in our minds as we considered this matter. It happens, of course, that sometimes the son or daughter is unwilling or unable to accept that responsibility or sometimes there is no son or daughter, so there is, of course, more to the problem than that. But I felt constrained to mention that because we feel that point rather deeply, Mr. Chairman.

The concern of this joint subcommittee on long-term care at this time, and the subject matter of this hearing, is of course, only one of the problems of the aged, although a very important one. That is to say a consideration of the need for long-term institutional care and an exploration of the means of insuring the adequacy and the quality of the institutions that provide that care.

Because I represent the legion, my remarks must necessarily be focused mainly upon the needs of veterans. I will try to outline who we believe is responsible for the care of eligible war veterans, a brief mention of the problems encountered, and a report on what the American Legion is doing to help find solutions.

The American Legion takes the position that the Veterans' Administration has the primary responsibility to provide high quality care, including nursing care, for the service disabled and for those seeking non-service-connected medical attention provided they are unable to personally defray the necessary expenses.

What are the implications of that statement of principle? Will this prove to be an excessive or unbearable burden upon the taxpayer? We think not. And in this connection we draw your attention to table 1 attached to the end of our statement in which we set forth the cost of veterans' benefits in relation to various standards since the year 1930.

Will this principle that we have just mentioned, if accepted by the Federal Government, lead to an excessive expansion of the VA medical program? Again we think not. In this connection certain statistics on the number of VA hospital beds provided at various times since 1940 are of great significance.

In the year 1940, after World War I, of course, there were 13.2 beds per 1,000 veterans. In the year 1950, after World War II, of course, there were 5.6 beds per 1,000 veterans; and in 1963, the latest figures available, after the Korean conflict, there are 5.5 beds per 1,000 veterans.

It is true that these hearings are directed toward matters involving non-VA facilities. Nonetheless, we take a real interest for several reasons.

he major reason is the large number of veterans that are constantly being transferred from VA hospitals to private institutions such as foster homes, nursing homes, and so forth, facilities not under the direct supervision and control of Veterans' Administration.

In VA there is a substantial number of veterans who have passed the acute stage of their illness and should more properly be in another type of institution. The estimated number of such patients has varied, I find, anywhere from 5,600 up to 20,000, but the figure most generally used by the Veterans' Administration is 10,000. VA has an intensive outplacement program, they call it, and tries very hard to transfer such patients to more appropriate facilities. But VA has a tremendous problem for the following reason:

A great bulk of the patients in VA hospitals are receiving attention for non-service-connected conditions. They got into the hospital only because they were unable to pay for care elsewhere. Once they get through the acute stage of their illness, they, of course, continue to be unable to be taken care of anywhere else. Therefore, the VA has great difficulty in placing them in suitable facilities.

To show the financial characteristics of these patients and the consequent dilemma faced by VA, I would like to draw attention, Mr. Chairman, to a survey conducted in very late 1961. At that time all non-service-connected nonemergency patients were surveyed. The average monthly income of these patients was $157, and one-fifth of them had no income at all. The average ready assets of these patients was $271,000 and 14,500 of the 19,000 surveyed had no ready assets at all.

All of us are aware of the problems involved in outplacing VA patients, and the fact that there exist substandard nursing homes, foster homes, and so forth. The Legion has made two main attacks on the problem. First, attempt to persuade the Government to make available adequate income to the service disabled and those nonservice-connected who are permanently and totally disabled and in financial need.

Secondly, attempt to persuade the Government to make available through VA to eligible veterans a comprehensive medical program.

Dr. Engle, the Deputy Chief Medical Director, appeared before this subcommittee on December 18, 1963, and described in detail that program.

As you know, VA operates hospitals, outpatient clinics, a restoration center, nursing care beds, and domiciliaries and attempts to provide a comprehensive medical program.

The American Legion tries to support, to oversee, and sometimes even to inspire that medical program. We do this in several ways. First, in attempting to secure through the Congress adequate appropriations. We carry on constant what we call visitations to VA hospitals through our field service and submit reports on those to the VA Chief Medical Director. We make specific recommendations on how we think this program can be improved. Again, as I mentioned earlier, we seem to parallel the thinking of this subcommittee. For years we tried to encourage rethinking in the Veterans' Administration. We tried to get the Veterans' Administration to accept the Federal responsibility for the nursing-type patient.

This was finally done on August 12, 1963, when the late President Kennedy instructed the VA to activate and operate beds for 2,000 nursing care patients. I regret to report to the subcommittee that as of this moment no beds are yet in operation. We received approximately a week ago a notice from the Deputy Administrator that by June 1, 46 beds will be put into operation in 2 localities.

The main topic of this hearing, again, is licensure and standards. Is there a place for the Federal Government in this matter? Does the Federal Government have a role to play? Does the Federal Government have a responsibility?

I suppose, Mr. Chairman, that I probably should disqualify myself somewhat in attempting to answer that question because it largely deals with matters outside the Veterans' Administration. But I would like to make this comment.

It appears to me that the Federal Government has already accepted a responsibility. I think the mere fact that the Government makes subsidies to various programs indicates an acceptance of that responsibility. If this be true it seems to me that the Government should then make sure that the money is well spent.

Also, perhaps, there would be a place here for an application of the good Samaritan rule that is familiar in the law. When the Government, when anyone, decides to accept a responsibility he must make sure that he accepts it carefully and performs it to the fullest of his ability.

At any rate, perhaps the essential and the most difficult question that is being pursued by this subcommittee is not whether the Government should accept the responsibility or whether they should play a role, but how to exercise and implement that responsibility.

We do have a very direct interest, of course, in what the Veterans' Administration does, when it refers patients in its outplacement activity, to make sure that the facilities to which these patients go, since they are non-VA, are adequate.

In this connection we have done several things, and I am now going to close, Mr. Chairman, my remarks. In this connection we have done several things. We have performed specific surveys, aided by our ladies auxiliary, in individual localities and reported the findings

to the Veterans' Administration. I regret to report, Mr. Chairman, that our surveys confirm the need that was described by the chairman in his opening remarks, confirm the fact that there is a great need for some further participation by the Federal Government.

In addition to that, we have performed staff studies on the overall problems of what standards ought to be suggested and we have worked with the VA on those standards.

Incidentally, there is under consideration, Mr. Chairman, a bill, passed by the House, now pending in the Senate, H.R. 8009. As the chairman knows, this would provide a rather comprehensive nursing program for veterans. One provision of that bill would authorize the Administrator to put certain patients in private nursing homes. That bill would require the Chief Medical Director to establish standards that those homes would have to follow.

Here again the device that would be used to justify the intervention, if that word is not inappropriate, of the Federal Government, would be simply a laying down of the condition precedent.

The VA will say to the nursing homes, if you wanted these patients, if you want the money, live up to the standards that we set.

Lastly, Mr. Chairman, the American Legion and the auxiliary have participated in a program within VA known as the patient returns to the community program. Through the use of volunteers we are attempting to insure that patients returning to the community go to adequate places, know of and use all of the community facilities available.

Mr. Chairman, this concludes my presentation. I thank you again for your consideration in receiving the views of the Legion.

Senator Moss. Thank you, Mr. Corcoran. It was a very fine statement, and the full statement is also most valuable to us. We appreciate the work that the Legion has been doing in this area and we value your observations because we consider the things you are doing to be applicable to the problems of the entire population.

When we had hearings earlier the Veterans' Administration testified that it had compiled a list of 10,000 nongovernmental facilities to which hospital discharged patients could go. Do you know if there were any standards applied as to places that it considered suitable for those patients?

Mr. Corcoran. Mr. Chairman, I think that there were not. This statement by the Deputy Chief Medical Director interested us. We thereupon inquired of the Veterans' Administration what criteria had been observed, what standard had been followed in assembling this list of 10,000. It is my opinion that the answer they gave us indicates that no standards established by the VA were followed.

Rather, in individual communities based mainly upon common knowledge or some list of licensed facilities, this resource list was built.

We of the American Legion, from experiences in Maine, from experiences in isolated places throughout the country, know that there are a substantial number of occasions on which discharged patients are sent to inadequate and improper facilities.

Senator Moss. You suggested that the Veterans' Administration might very well insist on minimum standards if it referred patients to nursing homes. It is your idea that there ought to be general Fed-

eral standards imposed for nursing homes now for adequate care to be rendered?

Mr. CORCORAN. Well, Mr. Chairman, I want to give you an opinion on that and I am going to, but before I do I must state that I wonder if I am fully qualified to express an opinion in the face of an array of experts that you have had and will have before you.

But notwithstanding I have the courage of my convictions and I see no alternative, I see no other way of improving the situation to any substantial degree and I see no other way of protecting the Federal money that is being provided to some of these institutions.

Senator MOSS. Thank you, Mr. Corcoran. Just one last question.

If the VA begins to provide these facilities, nursing care facilities, assuming that we get adequate standards for nursing homes in general, is there not a possibility that providing for veterans in VA facilities would be isolating the veterans from the general group of people to the disadvantage of the veterans?

Mr. CORCORAN. I think not. Now, of course, there already is a hospital program available to veterans now who are in financial need. You could compare that with the hospital facilities that are available throughout the country to indigent persons.

Certainly in the case that I have picked to attempt to draw an analogy, the veterans are not at a disadvantage. One reason is because the level of need is higher for veterans, that is to say they do not have to be in abject poverty in order to get VA hospitalization. In addition to that, whether it is because the VA system is run by the Federal Government or because of the oversight activity of the Congress or because of the presence of veterans organizations and other interested parties, I am convinced that the level of care provided in VA is very high.

So, unless I have missed your question, Mr. Chairman, I do not think that the veteran would be disadvantaged if two sets of facilities were set up.

Senator MOSS. Thank you, Mr. Corcoran.

I appreciate it very much. And you, too, Mr. Murphy, for testifying before us today. You have been most helpful.

This will conclude the witnesses that will be heard today, and the committee will now be in recess until tomorrow morning at 10:15.

(Whereupon, at 3:18 p.m., the subcommittee recessed, to reconvene at 10:15 a.m., Wednesday, May 6, 1964.)

(Subsequently the following information was submitted:)

ALBI MANUFACTURING CO., INC.,
Rockville, Conn., May 6, 1964.

Senator FRANK MOSS,
Chairman, Senate Subcommittee on Long-Term Care, Special Committee on Aging, Senate Office Building, Washington, D.C.

DEAR SENATOR MOSS: As a leading manufacturer of fire retardant coatings, we regret that we had not been invited to meet with your committee. However, we would like to submit the enclosed material which constitutes a technical memorandum, to be included in the record of your hearings on old-age and nursing home construction, relating to the special fire hazards of combustible interior finishes in such buildings.

In this connection we wish to offer the following suggestions regarding the recommendations of the NFPA Building Exits Code (sec. 44) which are pertinent to those buildings of substandard construction which are converted to nursing home and old-age home occupancy:

The limitation on the flame-spread ratings permitted for interior finishes are most important for the protection of bedridden or semi-invalided patients who may not be able to escape unaided from a burning building. The experience in the Hartford Hospital fire and similar fires throughout the country have proven that, even in a so-called fireproof building, serious fire hazards exist if the interior finishes are of a combustible nature.

The use of fire retardant paint is a low-cost and effective means of protection in such instances. However, the NFPA Building Exits Code does not offer sufficient assurance of permanent protection, once the application is made, since the requirement is based solely on meeting a minimum flame-spread rate. Then additional considerations should be added to this requirement:

1. Smoke development: A great deal of hazard to life is created in the development of toxic gases during a fire. This is generally recognized as "smoke."

While there is no known tolerance level which is considered "safe," there is general acceptance of a standard in this field which is based on materials which offer the lowest available levels of smoke development. Therefore, we suggest that the standards which the committee establish should include the requirement that the fire-retardant paint shall offer a smoke hazard no greater than the flame-spread rating. This smoke development rate is determined by the same testing agencies which establish the flame-spread rate. The listings published by the Underwriters' Laboratories, for example, provide easy reference.

2. We suggest further, that the paint should meet the durability and serviceability standards established by the Federal specification for fire-retardant paint (DOD TT-P-0026b) which has set requirements for washability and leaching which assure the permanence of the protection provided by the paint. Many fire-retardant paints are affected by atmospheric humidity. Over a period of time these will lose their fire-retardant characteristics. It is important to avoid such loss of protection by establishing those standards of permanence which would be acceptable under your rules.

3. Although many areas have already accepted the principles outlined above, local laws are frequently loosely established and even more loosely interpreted.

The State of New Jersey Department of Institutions and Agencies has recently established regulations which offer a very useful guide in setting up a workable and enforcible program for controlling flame-spread in such institutions. We are enclosing a copy of these regulations as part of this memorandum.

We wish to make one further point: Fire-retardant paint is neither a replacement nor a substitute for sprinkler systems or other methods of protection.

It is a very valuable additional means of protection which can be quickly provided at low cost where hazardous conditions exist.

We would be happy to meet with your committee at your request to elaborate on this memorandum and to answer any further questions you may have.

Looking forward to being of further service we are,

Very truly yours,

ALBI MANUFACTURING CO., INC.,
SEYMOUR I. KAWALLER,
Vice President.

MEMORANDUM RELATIVE TO PROPOSED CHANGES IN FIRE SAFETY LAWS DEALING WITH INTERIOR FINISHES

Building code authorities such as the NFPA, BOCA, etc., have established flame-spread standards for interior finishes in various categories of occupancies, as follows:

	Flame spread
Class A	0– 25
Class B	26– 75
Class C	76–200

In general, class A (0–25) and in some cases class B (26–75) are required in occupancies such as hospitals, schools, institutions, convalescent homes, etc.

While these codes do not break down "smoke developed" classifications as reported by the Underwriters' Laboratories, Inc., some authorities have set "smoke developed" limits not to exceed 20–25 in means of egress areas in institutional occupancies, and 50 in other occupancies.

Many authorities including the U.S. Government now specify that in addition to flame-spread and smoke developed ratings that approved or acceptable fire-retardant paints shall possess characteristics to insure continued protection for a period of time. Specifically, a fire-retardant paint must successfully withstand washability and leaching tests. Such tests assure durability of fire protection desired in the original application.

The purposes of these additional requirements are:

(1) *Washability tests.*—Obviously there is little use in applying a fire-retardant paint which will gradually disappear in continued washings, thus cutting down the degree of fire protection originally intended.

(2) *Leaching tests.*—This procedure is intended to insure that the paint will not lose any of its fire-retardant properties on being exposed to high humidity conditions or direct water application.

We are attaching a number of State and governmental specifications outlining these requirements:[1]

(*a*) State of New Jersey.

(*b*) New York State, Division of Standards and Purchases, covering schools, hospitals, and institutions.

(*c*) State of Michigan (copy available upon request).

(*d*) Fire-retardant specification Paint, Interior White and Tints, Fire Retardant, TT-P-0026b (DOD).

Approved fire-retardant paint shall mean a product meeting the minimum requirements as set forth in the attached specification and which has been approved by the State fire marshal's office.

We feel that the washability and leaching tests are particularly important in setting up standards for acceptability under the proposed code. A suggested specification incorporating these two important points is included as per the attached.

CERTIFICATION AND INSPECTION

Where fire-retardant paint is used as a means of compliance to meet the proposed code amendments, and to assist the enforcing authorities, we recommend that certification be required to insure proper control of fire-hazard violations. When supplying the fire-retardant paint intended for compliance with the requirements, the manufacturer of the fire-retardant paint or the manufacturer's authorized representative shall furnish the buyer with a certificate attesting to the purchase of the approved product, number of gallons purchased, and the date of purchase. Upon completion of the fire-retardant paint job, the owner or contractor doing the work shall complete the certificate, identifying—

(1) The name and address of the institution.
(2) Trade name of the fire-retardant paint used.
(3) Number of gallons applied.
(4) Areas painted.
(5) Approximate total square footage painted.
(6) Dates of application.

A copy of this certificate will then become part of the inspection report by the authorized enforcing agency.

We are attaching a model certificate outlining these suggestions.

[1] The exhibits referred to are held in the files of the joint subcommittee.