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FACT SHEET
HF#1

Health Facilities:

Amendments to the Hospital Survey and Construction Act.

BACKGROUND

Chronology

1933-36 - First Program--Public Works

Federal assistance to community hospitals was first provided during the 1930's as a part of public works programs. About $219 million was spent for hospitals during the period 1933-36, of which the Federal Government contributed about 50 percent.

1940-45 - Grants in World War II

During the war years, Federal grants for the construction of hospitals (along with other community facilities) were provided to communities having substantial increases in population due to defense activities.

Grants were not provided on a systematic matching basis, but were determined for each project on the basis of the community's needs.

From 1940 to 1945, nearly $100 million was spent by the Federal Government on 874 projects. These included hospitals, nurses' homes, and health centers. Local contributions totaled about $22 million.

1946 - Hospital Survey and Construction Act

This Act was the first systematic, Nationwide hospital construction program with Federal assistance to States and local communities. Its purpose was to make available "adequate hospital, clinic, and similar service to all their people." This legislation provided for:

Grants to the States to survey their existing facilities and to develop comprehensive programs for meeting the need for hospitals, public health centers, and related facilities.

Authorization of $3 million to be allotted to the States, on the basis of population, to pay one-third of the survey costs.

Grants to the States for the construction of public and voluntary nonprofit hospitals, public health centers, and related facilities, in accordance with a State plan for furnishing hospital services.

Authorization of $75 million annually for a 5-year period, to be allotted to the States (with a minimum of $100,000 to any State) on the basis of population and relative per capita income. Federal payments were limited to one-third of the total cost of each project; the remaining two-thirds was to come from State and local funds.

Priority for general hospitals was given to communities with the greatest need, with special emphasis on the needs of rural areas.

1949 - Amendments of 1949

These amendments made changes in the Hospital Survey and Construction Act as follows:

Permitted States to have a uniform Federal share for all projects or to select a sliding scale of Federal participation in the costs of a project. The sliding scale allowed the States to adopt a Federal share for individual projects which could range from a minimum of one-third to a maximum of two-thirds, depending upon the economic status and the community's relative need for a hospital, in relation to the need in other communities in the State.

Authorized grants for the conduct of research, experiments, and demonstrations relating to the effective development and utilization of hospital services, facilities, and resources.

Increased the annual authorization from $75 million to $150 million ($150 million appropriated only for the fiscal year 1950) and increased the minimum allotment to any State to $200,000.

Extended the program to June 30, 1955.

1953 - Extension of 1953

This amendment extended the Hospital Survey and Construction Act to June 30, 1957.

THE PROGRAM TODAY

Scope

The survey activity required by the Hospital Survey and Construction Act has been an historic step in guiding the location and priority of new facilities and the expansion of existing facilities. State hospital plans are revised annually to reflect changes in population and unmet need.

Since 1947 substantial progress has been made under the Act. Construction includes four categories of hospitals -- general, chronic, mental, and tuberculosis facilities -- as well as public health centers. It also includes, in connection with hospitals, a variety of related facilities, such as State health laboratories, nurse training facilities, out-patient departments, and nurseries for premature infants.

Accomplishments

Under the program to date, 106,000 additional hospital beds are being provided and 446 public health centers. These are included in 2,200 projects, of which 1,400, with 58,000 beds, have been completed and are in use.

By January 1, 1954, the program had an estimated total cost of $1,769 million. Of this total, Federal funds amounted to $600 million, a ratio of one Federal dollar to two dollars of non-Federal funds.

By far the largest share of this program is in general hospitals, with a total of 86,000 beds. Beds added for mental care total 11,000; in hospitals for chronic disease, 3,000; and in tuberculosis hospitals, 6,000.

In low-income States, the program is more than twice that in States with highest income. In low-income States, very little additional hospital construction is being undertaken outside this program. In high-income States, however, the program represents a minor portion of all new hospital construction.

UNMET NEEDS

Need for Hospitals and Health Centers

Today there is an estimated national shortage of 5.3 hospital beds per thousand population in all categories of hospitals combined. Conservatively estimated, this amounts to more than 500,000 beds.

This need varies among the States from 8 beds per thousand population to 3 beds per thousand. Among hospital areas within States the differences are even more pronounced.

Among the categories of hospitals, need is by far the most acute in those for the care of chronic illness. Proportionately, only 12 percent of estimated need is now available in chronic disease hospitals. In contrast, general hospitals have available 73 percent of total bed need, and mental hospitals 57 percent.

The 700 acceptable public health centers now in use constitute only one-third of the program planned to carry on the functions of local public health departments in protecting and promoting the public health.

Urgency of Need for Facilities to Care for Chronic Illness

The chronic and disabling diseases are today's major health problem. Chronic illness causes substantially more days of disability than acute illness. It is estimated that about 5.3 million people in the United States today are suffering from long-term illnesses.

The need for more beds for chronic illness is intensified by the aging character of our population. Within the last 50 years the proportion of the population over 65 has doubled, and this ratio is continuing to rise. The rate of disability among people over age 65 is 2-1/4 times as high as the disability rate for the whole population.

Proper care of chronic illness often requires a variety of facilities and professional skills. These may constitute a heavy financial drain on family and community resources.

The great shortage of hospital beds planned for chronic care is resulting in wide use, instead, of general hospital facilities. This employs beds which are needed for acute illness and services which are more expensive than would usually be required for care of long-term illness.

Need for Special Health Facilities

Nursing homes.--Nursing homes now constitute a significant portion of our facilities for medical care. Prolonged illness, especially among elderly people, does not always require care in general or chronic disease hospitals. The cost is prohibitive, and some services are not necessary.

Nursing homes have developed rapidly since 1930 and now include between 1 and 2 beds per thousand population nationally. There are great differences in the character of service and the regional distribution of present facilities. Any accurate measure of total need for nursing homes will be unknown until extensive studies now under way are completed.

The cost of care in high quality nursing homes is less than one-half that of care in general hospitals.

There is no question of the need for additional nursing homes, as an auxiliary approach to caring, under medical direction, for patients with chronic illness.

Diagnostic or treatment centers.--Centers for the diagnosis and treatment of ambulatory patients emphasize prevention and early diagnosis of illness. These permit more effective treatment and early recovery, with great savings in cost and in protection of individual health.

A diagnostic and treatment center is a facility in which physician and technicians operate as a team, to make full use of advances in modern medical science and of the equipment available for accurate diagnosis and effective treatment. Most centers with such specialized services are now largely concentrated in metropolitan areas. The full extent of the need for such centers is not yet known.

Out-patient departments are needed on a much wider scale in major hospitals now established. In addition, independent diagnostic or treatment centers could be provided in smaller communities to serve surrounding rural areas.

Rehabilitation facilities.--Rehabilitation is the process of restoring a physically handicapped person to the point where he can either take care of himself at home or become productively employed. This process is important to the national health, in terms of both personal human values and economic gains to society.

Restoration of the patient to self-care relieves a heavy private burden on families and diminishes the patient load in hospitals and nursing homes. Return to productive employment, called vocational rehabilitation, decreases the burden of public assistance and contributes to public revenues through taxes paid on income.

The President's message on the health needs of the Nation sets a goal of 200,000 disabled persons to be rehabilitated annually by 1959 through the Federal-State vocational rehabilitation program. (See Fact Sheet GLA-VR#1) The present yearly rate is about 60,000. To meet this goal would require a substantial expansion of the comprehensive rehabilitation facilities required for the treatment of the severely disabled.

Throughout the country, only 23 facilities now offer comprehensive rehabilitation services. Partial service is available on a very limited scale in 38 other facilities. There are, in addition, 7 comprehensive rehabilitation facilities for the blind and 13 facilities offering partial services for the blind. (Both types of facilities are exclusive of physical medicine departments in hospitals.)

PROPOSALS TO BROADEN THE HOSPITAL SURVEY AND CONSTRUCTION ACT

The Hospital Survey and Construction Act would be amended to achieve the following objectives:

To increase health maintenance facilities for persons chronically ill or physically impaired. These facilities are urgently needed in view of the increasing proportion of older people in our population.

To increase facilities urgently needed for health services to ambulatory patients, particularly in the more rural areas.

To increase rehabilitation facilities for the physically handicapped.

These objectives would be achieved by providing financial assistance to the States to survey their needs for, and to assist in the construction of, the following types of medical facilities:

Hospitals for the care of the chronically ill.

Nursing and convalescent homes with medically directed patient care.

Diagnostic or treatment centers and out-patient clinics for ambulatory patients.

Rehabilitation facilities for the disabled.

Under the proposal, grants totaling $60 million for constructing and equipping facilities by public and nonprofit sponsors would be authorized in annual appropriations for the fiscal years 1955, 1956, and 1957. A limited authorization of $2 million would be added to assist the States in surveying their needs for these types of medical facilities and to plan their construction where the needs are greatest.

The $60 million annual appropriation would be allotted to the States on the basis of population and per capita income. This would include $20 million each for hospitals for care of the chronically ill and for diagnostic or treatment centers for ambulatory patients. It would include $10 million each for nursing homes with medically directed patient care and for rehabilitation facilities.

Matching funds would be required of project sponsors at the rate of $1 for each $1 of Federal funds in all States where per capita income is above the national average. In other States the Federal share would be increased on a scale related to income deficiency, to a maximum of $2 in Federal funds for $1 in sponsor funds in those States with lowest per capita incomes.

The effect of the broadened Act would be to provide more beds for care of chronic illness than the same funds can produce in general hospitals. Construction costs for chronic illness hospitals average $13,000 per bed, and nursing homes $8,000 per bed, while general hospitals cost an average of $16,000 per bed. At these costs, the broadened Act with matching funds could provide 2,770 beds in chronic disease hospitals and 2,250 beds in nursing homes, for a total of 5,020 beds, in lieu of an aggregate of 3,370 beds in general hospitals.

The cost of care in hospitals for chronic illness now averages under $7 per day, and in nursing homes from $2 to $8, while care in general hospitals exceeds $18 per day in cost.

Diagnostic and treatment centers would provide services now chiefly available for indigent patients and those of above-average means. These would also help reduce the burden on general and chronic hospital facilities.

It is estimated that the present annual capacity of the Nation's comprehensive rehabilitation facilities is about 8,000 persons. Assuming that $10 million of Federal funds is fully matched by $8 million non-Federal funds, the resulting increased capacity would be expected to serve about 12,000 additional disabled persons annually.