claimants who will not be called back or who have been laid off indefinitely because of the company's uncertain future plans may be expected to accept other suitable permanent work. If the work is suitable and if the refusal is based on objections to the job itself, claimants may reasonably be disqualified for having refused suitable work. However, if the refusal is based on unwillingness to take any work while awaiting recall, they may reasonably be held unavailable for work.

The application of a policy that makes it possible to pay benefits to claimants with definite prospects of a recall within a reasonable time will increase the employer's assurance that his experienced employees can afford to wait until he again has work for them. Its application depends, however, not only on a reconsideration of policy by some State appeal bodies but also on the extent to which employers furnish information concerning the probable duration of a lay-off, both to their employees and to the State employment security agency. Without this information, employees cannot decide intelligently whether to accept temporary or permanent work elsewhere and the State employment security agencies are working in the dark. On the one hand, they may deny benefits to claimants who will be recalled in the early future; on the other, they may pay benefits to claimants on the basis of uninformed statements of claimants and foremen, even though management does not expect to rehire these claimants.

To the extent that employers wish to increase the likelihood that their laid-off workers will return when needed, they can facilitate the work of their State employment security agency in holding these claimants eligible for benefits by advising both their employees and the agency of the anticipated length of a lay-off and of individual claimants' prospects for recall.

The Hospital Survey and Construction Act

By V. M. Hoge*

THE SIGNING of the Hospital Survey and Construction Act by the President on August 13 launched the Nation on the most comprehensive hospital and public health construction program ever undertaken. Congress has authorized the appropriation during the next 5 years of $375 million in Federal funds for the building of hospitals and health centers. Since the act provides that the Federal share is to constitute one-third of the cost, and non-Federal funds the other two-thirds, the total expenditure for this Nation-wide hospital program would approximate $1,125 million.

The Hospital Survey and Construction Act is more or less unique in social legislation. Rarely has a legislative act had the unanimous support of so many interested groups, both professional and consumer. At the hearings on the bill, spokesmen for medical, hospital, labor, farm, and civic groups backed the proposal. Particular credit goes to the professional groups, including the national hospital associations and the American Public Health Association, which spearheaded the planning for the program that the act now authorizes.

The act itself is testimony to the fact that the current conception of public health includes responsibility for the treatment and care of the individual. Before adequate health and medical care can be attained, well-equipped hospitals and health centers must be located throughout the country in proportion to need. More important still, they must be planned State by State and community by community with a view to meeting the total facility needs of each.

How great these needs are, Surgeon General Thomas Parran of the U. S. Public Health Service pointed out in his testimony at the hearings. He emphasized that, whereas some States have a higher ratio of hospital beds to population than others, many of these beds are substandard, and that in no State is every community adequately served. Of the more than 3,000 counties in the Nation, approximately 40 percent, serving some 15 million people, have no registered hospitals. While many of these counties which lack facilities are too small to support a full-fledged hospital, they could all profit from some type of health facility. As it is now, the best and most abundant hospital facilities are concentrated in the wealthiest States and metropolitan areas, while rural and poor areas have the least adequate hospital and related services.

Preliminary estimates indicate that general hospital beds should be increased by about 36 percent to bring them up to the ratio of 4½ beds per 1,000 population; beds for tuberculosis patients by about 68 percent to bring all States to the ratio of 2½ beds per death from tuberculosis; and beds for mental and nervous diseases by 43 percent to reach 5 per 1,000 population. Chronic disease hospitals and health centers need to be increased several fold, the former on the basis of 2 beds per 1,000 population and the latter on the basis of 1 per 20,000–30,000 population.

Before the war, the total estimated cost of providing these needed beds and facilities was approximately $4,000 million. Against these needs is the $1,125 million which will be available when all the Federal funds have been met by non-Federal funds. Even on the basis of prewar costs, as Dr. Parran recently pointed out, this expenditure would meet only about 37 percent of the costs of new facilities and 29 percent of new and replacement facilities combined. With the present cost of building approximately 50 percent higher than it was when the act was first considered, it is obvious that these appropriations, substantial as they are, can serve only fractionally the purpose of the act, namely, to provide hospital facilities for all the people.

Nevertheless, all groups concerned with a broad national health program consider the act a long step forward. Since its administration is the responsibility of the Surgeon General, it is significant to note his views on the future role of hospitals. He visualizes the hospital of the future as having a broader and more important function than in the past. It should

*Chief, Division of Hospital Facilities, U. S. Public Health Service.

be an instrument for total community health, an institution prepared to promote health and prevent disease as well as to treat the sick.

State-wide planning, Dr. Parran thinks, should be directed toward a planned network of facilities to include medical centers, district hospitals, rural hospitals, and health centers. In each metropolitan center there should be one or more medical centers, in which all types of medical service, medical research, and teaching will be carried on, preferably connected with a medical school. Auxiliary to the medical center should be several complete general or district hospitals, each serving its respective community with complete medical service, generally without basic research and undergraduate medical education, but with training programs for nurses and interns. Further toward the periphery from the base hospitals should be a series of rural hospitals, smaller than the district hospitals and rendering a more limited type of service. The fourth link in this service chain should be public health centers located in health districts of larger cities, in smaller cities and counties, and in the remote rural center which is too small to maintain even a rural hospital. In addition to providing for conventional public health work, these health centers should in many places be adapted to all local community health needs and might even include a few hospital beds for emergency use.

Table 1.—*State allotments under the Hospital Survey and Construction Act*[1]

State[2]	Survey and planning[3]	Construction[4]
Total	$3,000,000	$75,000,000
Alabama	62,422	2,888,925
Alaska	10,000	40,200
Arizona	13,482	452,175
Arkansas	39,294	1,968,300
California	185,820	1,957,875
Colorado	24,279	657,300
Connecticut	40,474	421,950
Delaware	10,000	86,625
District of Columbia	19,145	298,350
Florida	47,141	1,461,900
Georgia	68,735	2,978,775
Hawaii	10,119	237,525
Idaho	10.531	293,550
Illinois	172,752	2,771,175
Indiana	77,526	1,727,775
Iowa	61,182	1,341,675
Kansas	37,908	933,750
Kentucky	57,672	2,589,600
Louisiana	53,631	2,156,850
Maine	17,671	454,875
Maryland	46,167	870,675
Massachusetts	93,515	1,595,550
Michigan	124,372	2,172,000
Minnesota	56,876	1,655,700
Mississippi	45,548	2,403,825
Missouri	79,679	2,282,550
Montana	10,355	231,825
Nebraska	26,461	685,200
Nevada	10,000	49,575
New Hampshire	10,207	342,375
New Jersey	93,928	1,313,775
New Mexico	11,210	457,500
New York	282,492	2,945,100
North Carolina	76,287	3,432,825
North Dakota	11,889	308,475
Ohio	156,144	2 692,575
Oklahoma	44.427	1,640,550
Oregon	27,317	460,875
Pennsylvania	209,243	4,551,675
Puerto Rico	46,049	2,430,525
Rhode Island	15,989	280,275
South Carolina	41,123	1,976,775
South Dakota	12,066	359,625
Tennessee	64,812	2,673,300
Texas	145,051	4,842,075
Utah	13,541	365,100
Vermont	10,000	214,725
Virginia	64,310	2,210,175
Washington	44,722	512,100
West Virginia	39,204	1,555,650
Wisconsin	67,142	1,622,925
Wyoming	10,000	144,975

[1] Preliminary estimates, contingent on Department of Commerce certification of population data.
[2] Includes Puerto Rico.
[3] Based solely on State population.
[4] Based on a formula which takes into consideration both population and per capita income of the State.

Summary of Hospital Survey and Construction Act

As its name implies, the hospital act falls into two broad sectors: first, assistance to the States in surveying over-all State needs and in making plans for hospital and health facilities; and second, assistance for the next 5 years in the construction necessary to carry out these plans. To accomplish this two-fold aim, authorization is given for the appropriation of $3 million in Federal money to assist with the surveys, and $75 million annually for the next 5 years, starting July 1, 1946, to assist with construction.

The kinds of facilities which may be constructed under this program include hospitals, public health centers, and related facilities. By hospitals are meant general, tuberculosis, mental, chronic disease, and other types, except those furnishing primarily domiciliary care. They include, in addition to public hospitals, other nonprofit hospitals—that is, any hospital owned and operated by a corporation or association, no part of the net earnings of which inures to the benefit of any private individual. Public health centers are defined to mean a publicly owned facility for the provision of public health services, the scope of which would be a matter of State law. Related facilities, in the case of a hospital, would include laboratories, out-patient departments, nurses' homes and training facilities, and central service facilities operated in connection with the hospital. In the case of a public health center, related facilities would include laboratories, clinics, and administrative offices. As used in this act the term "construction" is broadly defined to include construction of new buildings; expansion, remodeling, and alteration of existing buildings; and initial equipment of any such new or existing facilities. Specifically excluded are the cost of off-site improvements and, except for public health centers, the cost of the acquisition of land.

Administration of this program is the responsibility of the Surgeon General of the Public Health Service in the Federal Security Agency. He will have the advice and assistance of a Federal Hospital Council, with which he is required to consult in administering the act. The Council, which already has had its initial meeting in Washington, consists of the Surgeon General, as chairman, and eight members appointed by the Federal Security Administrator. Of the eight members, four are persons outstanding in hospital and health activities and four represent the consumers of hospital services.

The Council is not merely advisory but assumes considerable administrative responsibility. It must approve the Surgeon General's general regulations governing State construction plans. Moreover, it is also the body to which an appeal may be taken by States whose construction programs are disapproved by the Surgeon General.

Survey and Planning

While it is evident that the act will not fulfill its goal of providing hospital facilities for everyone, the fact that it authorizes Federal funds to assist States in making surveys of their hospital needs is considered by many hospital authorities one of its most important features. To qualify for a Federal grant for such surveying and planning, a State must designate a single State agency to conduct the work, must provide for a State advisory council made up of representatives of nongovernment groups, and must make an applica-

tion for approval to the Surgeon General indicating that these steps have been followed. The funds appropriated by Congress for surveys and planning will be allotted among the States on a population basis (table 1). Within its allotment, each State is entitled to receive 33⅓ percent of its expenditures in carrying out these functions.

Construction of Hospitals and Related Facilities

Within 6 months after the act became law, the Surgeon General with the approval of the Federal Hospital Council and the Federal Security Administrator must promulgate general regulations for carrying out its provisions. These regulations will be concerned largely with the number and general method of distribution of hospitals to be constructed. Briefly, the matters specified for regulation are as follows:

1. In the case of general hospitals, the distribution is intended to recognize base areas, intermediate areas, and rural areas. Beds are limited to 4½ per 1,000 population except in sparsely populated States, where ratios of 5 or 5½ beds to 1,000 would be permitted.

2. The maximum ratio of beds for other types of hospitals would be as follows: tuberculosis, two and one-half times the annual average deaths from this disease in the State over the 5-year period 1940–44; mental, 5 beds per 1,000 population; chronic disease, 2 beds per 1,000; and public health centers, 1 per 30,000, except in States having less than 12 persons per square mile, where 1 per 20,000 would be permitted.

3. Regulations are authorized prescribing the manner in which the State agency must decide the priority of projects on the basis of the relative need of different sections of the population and of different areas, with special consideration to be given to rural communities and low-income areas.

4. Regulations will also cover general standards of construction and equipment.

5. The regulations will require that the State plan provide for adequate hospital facilities without discrimination on account of race, creed, or color, and for adequate facilities for persons unable to pay. Such regulations may require that an applicant for an individual project must give assurance that it will serve all persons residing in the area. This requirement, however, will permit an exception where separate hospital facilities are provided for separate population groups, but only if the State plan makes equitable provision, on the basis of need, for facilities and services of like quality for each group. The regulations may also require that an applicant give assurance to the State that it will furnish a reasonable volume of hospital services to persons unable to pay, unless the hospital is financially unable to undertake such a commitment.

6. Regulations will prescribe also the general methods for administration of the State construction plan. These regulations do not in any way relate to the administration of the hospitals.

To obtain Federal funds for construction the State must submit for approval to the Surgeon General a State construction plan based on its survey of hospital needs and in accordance with the regulations prescribed. In so doing it must designate a State agency to administer and supervise this plan, and an advisory council to consult with the agency. Furthermore, the State must provide that applicants for a construction project have an opportunity for a hearing before the State agency, and must submit reports and information required by the Surgeon General. The State agency must also review its construction program from time to time and submit to the Surgeon General such modifications as it considers necessary.

The Surgeon General is required to approve any State plan which complies with these conditions. Should he disapprove a plan, the Federal Hospital Council must afford the State agency a hearing. If the Council determines that the plan complies with requirements, the Surgeon General must then approve it.

When the State plan has been approved, an application for construction from the State, public, or nonprofit agency must be submitted to the Surgeon General through the State agency. It should contain a description of the site and reasonable assurance as to its title; plans and specifications complying with Federal regulations; reasonable assurance of adequate financial support for both construction and maintenance of the hospital when completed; and assurance of the payment of prevailing wages for construction work.

When such an application has been approved, funds to meet 33⅓ percent of the cost may be allotted, provided, of course, that they are still available from the State's allotment. The State allotment is based on two factors: population and per capita income. The States with the lower per capita incomes are allowed a higher amount of funds per capita.

Federal funds may be withheld if, after notice and opportunity for hearings, the Surgeon General finds that a State agency is not complying with the provisions required, or that funds have been diverted from the purpose for which they are allotted, or that an individual applicant is not complying with approved plans and specifications for construction projects. The Surgeon General's action on withholding funds or refusing to approve an application for construction funds would be subject to appeal to the United States circuit court of appeals.

This summary of the Hospital Survey and Construction Act, brief as it is, indicates that close cooperation will be required to carry it out, cooperation not only between the Federal and State Governments but of counties, communities, and even of local hospital and welfare groups. But since few social legislative acts have received such unanimous support, such cooperation should not be lacking. Without hospitals it is impossible to bring the benefits of the health-saving sciences to the people. Without hospitals it is impossible to raise the Nation's health standards. It may even be claimed that this Nation-wide hospital plan is the keystone in the arch of the national-health program.