REMARKS OF THE HONORABLE JOHN E. FOGARTY AT THE ANNUAL MEETING OF HOSPITAL ASSOCIATION OF RHODE ISLAND AT THE SHERATON-BILTMORE HOTEL ON OCTOBER 4, 1960.

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I am always glad to talk to hospital people, and most especially glad to talk to the hospital people of our State. In fact, I think this is a most propitious time because of the outstanding honor recently accorded to an official of the State's largest hospital. I refer, of course, to the fact that the American Hospital Association, at its annual convention in San Francisco last August, presented its 1960 Distinguished Service Award to Mr. Oliver Goodell Pratt, Director of Rhode Island Hospital. Such national recognition was well deserved, and I am glad that Mr. Pratt's meritorious achievements were recognized so befittingly by the Nation's hospital leaders.

Health, hospitals, medical research, and medical care, as you all probably know, are among my major interests. For many years, I have devoted a great deal of time, in Washington and in Rhode Island, to a program for improving the health of our Nation and, by the same token, the strength of our Nation.

In speaking to you this afternoon, I am going to give you a few of my ideas of what we ought to plan for in the decade of the 1960's, especially with regard to our hospitals and the demands which will be made upon them during the next ten years.

During my years in the Congress and especially as Chairman of the House Subcommittee on Appropriations for the Department of Health, Education and Welfare, I have dedicated my major efforts to initiating and planning adequate Federal aid to health and medical research programs. It is to insure that the Federal government assumes its pro rata share of responsibility for all of our people, and because these funds complement and supplement the medical resources which we in Rhode Island provide.

The health needs of our Nation are great and our problems are many, but much has already been accomplished. At the close of 1959, Hill-Burton projects approved since the program's beginning totalled 4,847, at an aggregate estimated cost of $4,142,167,583. The Federal share of this amount was slightly less than one-third. Bought for this money were 205,914 hospital beds in public and non-profit institutions; 1,307 health centers

for out-patient care, and several hundred nursing homes, rehabilitation centers and diagnostic treatment facilities. Where the United States had 938,000 hospital beds in 1948, it now has 1,153,472 beds for civilian use--a 37 percent increase to about 7.5 beds per thousand population.

The Hospital Survey and Construction Act has given material aid to the State of Rhode Island. As of August 30, there have been 35 projects approved and for these $6,767,300 of Federal money has been allocated. In another area, that of aid to Health Research facilities, Brown University has received $433,557 for the construction of a Psychology Research building; $503,084 for construction of a Biology Research building, and an additional $46,200 for equipment for the Biology building has been recommended for this fiscal year. The University of Rhode Island has received $14,000 for a Biology Research laboratory, and $217,035 for its College of Pharmacy has been recommended by the National Advisory Council on Health Research Facilities for the next fiscal year. To assist our hospital research, Rhode Island Hospital received $25,000 for its Cancer Research facility.

Turning back to the Hill-Burton Program, all that has been built is in accordance with State plans which indicate what kind of facilities are needed and where. These State plans point out with thundering unanimity that thousands of beds are still needed; that we have barely begun to meet the demand for the care of the chronically ill, the tuberculosis and mental patients, and that the ever-advancing deterioration of hospitals in metropolitan areas demands prompt attention.

Without Federal assistance, our hospitals could not have expanded as they have during the past years. Much of this expansion is due to the fact that nowadays the whole community, both the well and the sick, are prepaying for hospitalization--which provides a sounder financial base. Medical specialization, new medical technology, and health insurance are some of the new elements in today's picture. People want nothing less than the best in medical and hospital care, and nothing less than the best can be afforded. We are paying more for health service--but what infinitely more we are getting for our money!

The most striking answer to the question "Can we afford the higher cost of medical care?" is the fact that national individual and family incomes in our country have increased beyond the highest expectations and beyond anything the world has ever known. Average family income in 1929 was $2,340. In 1958, it was $6,220. In 1970, it is expected to be nearly $10,000.

To get an idea of the progress that has been made, let's look back just ten years to 1950. In that year, America's hospital plant was valued at about eight billion dollars. It's nearly thirteen billion today. Then, hospitals employed about 900,000 people. Today's figure is more than 1,464,000. Yet we do not consider 1950 as the "old days." It's just that we move at a very rapid pace.

I believe the time for hospitals to operate as strictly separate units has passed. What we need today is a hospital system wherein the medical skills and facilities of an entire region or area are so closely integrated and coordinated

that each strengthens the other. Elimination of duplicated effort, improved training programs and full utilization of medical manpower is one of the answers to this decade's needs. A system of hospital coordination that really functions is an absolute necessity for the 1960's.

This will bring closer the dream of having the very best medical care for all of our people. It is an old dream and a worthy one, equally shared by physicians, medical educators, hospital workers, and all men of good will. We can do it within the next decade if our doctors, deans, trustees, and administrators are able, ready and willing to join in group activities. As our population expands and as more and more specialized care is needed, we will not be able to do as well as we are doing today unless we overhaul our present system. We *must* coordinate in order to permit dynamic planning and the most economical utilization of our resources. The most effective way to accomplish this is on a regional basis--within an appropriate geographic area--while still retaining all the advantages of local enterprise and responsibility.

The concept of a coordinated regional hospital system was written into the Hospital Survey and Construction Act of 1946 as a fundamental principle. It was included on the recommendation of the American Hospital Association, the United States Public Health Service, and the public advisory groups that helped shape the Program. It was recognized, even 14 years ago, that the small hospitals of rural areas should have the benefit of active affiliation with larger hospitals in order to improve their effectiveness.

This plan for hospital regions is very sound. Consider how important the teaching hospital is with regard to the recent avalanche of new medical knowledge. Until now, the university or medical college has been regarded as having the obligation for the preparation of physicians. Today they can meet only a portion of that duty. A substantial part of the clinical education of undergraduate students frequently is provided in other than university hospitals. Over three-quarters of the approved internships and over one-half of the residencies are in such hospitals.

A large part of medical education in the United States is actually under hospital supervision and guidance. This makes the hospital a vital part of the whole educational system of medicine, and a vehicle of great value in research efforts and the community application of new knowledge regarding health and disease prevention.

I am certain that this concept of a coordinated regional hospital system, making the best and most extensive use of all facilities for all the people, is a sound and progressive plan that deserves our encouragement and support. A phase of this development in our national and local health effort that must be given priority in the immediate future is the care and treatment of our senior citizens. As you know, a new field of medicine--geriatrics--is developing to take care of this rapidly growing segment of our population.

It has long been known that illness is greatest among those who can least afford it--the aged and the poor. People are not just statistics--they are precious individuals created to the image of God. They have individual health problems.

Regionalization of hospital facilities will go a long way to helping solve their problems. One great measure of medical economy would be to provide less expensive facilities for the chronically ill and the convalescents. They do not always need the amount of care provided by the general hospital, but they do need facilities, such as adequate nursing homes, between the hospital and complete cure and rehabilitation.

There is need for change on the part of the public from a negative to a positive attitude toward chronic illness and disability. This change in attitude is basic toward securing the funds, the professional personnel, the facilities, and the rehabilitation programs that older disabled people need in order to be restored to more useful lives.

During our lifetimes, tremendous strides have been made in the art and science of making sick people well again, of taking that last tragic syllable out of the word "hopeless." Let ours be the generation to see the job through to its logical conclusion. We can add materially to the productivity of our Nation by providing community health clinics that will rehabilitate an untold number of people previously regarded as hopeless.

It is certainly not beyond our ability to devise something better than today's haphazard methods of providing during our productive years for the medical costs that almost inevitably accompany old age. The health needs of our older people are not too greatly different to those of the population as a whole. They need good nutrition, adequate medical attention, acceptable housing, and chances for appropriate social, intellectual and physical activity.

But our senior citizens do have one need that becomes increasingly important the older they get. That is the need for taking care of the costs of long-term illness. For those whose retirement income is just enough to meet ordinary living costs, the expenses of long-term hospitalization and medical care constitute tragedy. The disability benefits of their working years, Blue Cross insurance and other prepaid medical plans are not generally available to all of these people at the time they need such help.

Another part of the general problem, and one that should receive much more attention, is that of providing more adequate facilities and programs for domiciliary care for our older people.

Certainly, the best place for our older people to stay is in their own homes; but when this isn't possible there should be homelike places for them in their own communities. This all fits into the regional plan I have outlined for you. It is an essential part of the community health and welfare services and should be expanded to meet this specific need. A little medical attention, some home nursing service, dietary consultation, home-maker services, and suitable recreation programs would keep many of our people happy and healthy right in their own homes at far less cost to themselves, their relatives, and their communities than keeping them in hospitals and nursing homes.

We must do these things and all of us can help. We have the basic facilities and all we have to do is build on them or amplify them. We must find ways for the older people to help themselves, thus earning part of their own support and thereby maintaining both themselves and their self-respect.

In the closing days of the recent session of Congress, which ended on September 1st, a program of medical care for the aged was approved by the Senate and House of Representatives and

enacted into law by the President of the United States. While I believe that this legislation leaves much to be desired in (1) number of people who will be benefited, (2) the manner in which the program will be financed, and (3) the invasion of personal privacy involved in the means test. Much more must be done to insure that medical care will be readily available to all our senior citizens who, through lack of funds, are unable to provide it for themselves. I will continue to vigorously sponsor and support legislation designed to accomplish that end.

Advancement in any degree towards the attainment of a sound and adequate health program is always most heartening to those of us who have spent our years in Congress waging the good fight for those we represent. I know we are doing no more than reflecting the will of the people, but each step forward affords me great personal satisfaction. Each advance--made possible through farsighted support by the Congress in which I have represented you--marks a victory for all of us.

I am confident that, continuing to reflect the will of the people, we can and will move ahead in all areas of health. The end of this decade should see our national health problem under very good control. I know that you and I want to see these things come to pass during our lifetime. That is why I have consistently worked for all things that will give us a sound program of health and welfare, rather than adopting a stand-pat and do-as-little-as possible attitude. My colleagues in the Congress, and you, the people of Rhode Island whom I represent, have supported my beliefs and my leadership in these things--and we have always approached the problems of health and research programs with a positive attitude and with one guiding philosophy: to seek the maximum potential for positive action to improve health.

I thank you. It has been a privilege to talk to you.