Why U.S. health care must return to the Hill-Burton standard

by Donald MacNay, M.D., Marcia Merry, and the EIR Economics Staff

In August 1946, a new federal health care law went into effect, which became known as the "Hill-Burton Program." It was a nationwide hospital-building program, designed to provide the necessary number of staffed hospital beds per 1,000 people throughout the land—regardless of race, color, creed, gender, or ability to pay. It was an unprecedented move in the history of the United States: Prior to 1946, hospitals had evolved willy-nilly, under differing local circumstances, and with wide disparities in the quality of facilities. The only systematic hospital system which had been in effect, was that provided for seamen by the surgeon general and the Public Health Service.

The Hill-Burton standards changed all that. Its approach, which ought to be carefully studied today, typified the post-war, do-the-job infrastructure-building approach, and it was highly successful. It is the authors' view that if the same or a similar approach were applied today, it could lead the way out of the crisis of spiralling health care costs, combined with drastic degradation in the quality of care available.

Unfortunately, for many otherwise decent citizens, the issue of the overall health of the population only becomes a matter of concern during times of war, plague, or other catastrophes. The rest of the time, most tend to sink to the level of a local approach, and debates center around accounting questions such as costs. But today's problems are insoluble with such an approach. Going back to look at the context in which Hill-Burton was enacted is therefore a useful means of getting back into the right frame of mind to actually crack the problem.

Start with the population

At the end of World War II, the U.S. population numbered about 148 million, and the wartime mobilization posed demographic features with obvious significance for health care planning. Thousands of wounded veterans had to have continuous treatment. There was also a malnutrition problem, which had been revealed by the number of youth who had been turned down by the Armed Services as unfit for duty.

The war mobilization accentuated certain regional variations in age and sex population profiles. For example, there were new concentrations of women of child-bearing years in such wartime boom towns as Los Angeles, where the "Rosie-the-Riveter" phenomenon was born. The national birth rate, which had fallen during the 1930s Depression years, shot up immediately after the war's end. Between 1946 and 1949, close to 15 million children were born, in contrast to the four years prior to World War II, when only 10 million were born.

The differing regional and age bracket profiles called for differing numbers and types of equipment, facilities, and medics, in order to provide the health care required. For example, concentrations of obstetrical services were required in Los Angeles. At the same time, tuberculosis was still taking its toll, and poliomyelitis (from a waterborne virus) was claiming more victims.

What seemed obvious to policymakers at the time, was the need to wage a peacetime war against disease, and to provide care wherever it was needed. The wartime production and logistics mobilization itself had in fact contributed much to the arsenal of potential peacetime health care advances: new pharmaceuticals, logistics systems, and medical techniques. Streptomycin was developed in 1944; blood plasma was successfully developed for use in 1940; mobile medical care systems were perfected during that time.

Why not universal care?

In his 1944 State of the Union address, President Franklin Delano Roosevelt spoke of an "economic bill of rights," including "the right to adequate medical care and the opportunity to achieve and enjoy good health." In 1945, in his Jan. 6 State of the Union address, the President again spoke of the right to "good medical care," but he made no specific proposals from then until his death in April. Then, on Nov. 19 of that year, President Harry Truman sent to Congress a message on health care legislation, proposing that a universal care system be worked out in connection with the Social Security system. But Sen. Robert A. Taft (R-Ohio) led a charge to denounce even the idea of universal care as "left-wing" and "socialistic." The upshot of the conflict in Washington was that some federal funds were granted to states in order to provide care for those unable to afford it; some of that money went to private insurance companies.

Sidestepping all the name-calling and position-taking, senators Lister Hill (D-Ala.) and Harold Burton (R-Ohio)

went ahead and introduced their straightforward "Hospital Survey and Construction Act." The act became law on Aug. 13, 1946, and had the effect of advancing the facilities and mobilization to bring health care improvements to all.

The act specified how states were to inventory and add to their existing hospitals to "afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people." It spelled out that "such a hospital or addition to a hospital will be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed, or color." The text admittedly also contains the "Jim Crow" separate-but-equal policy typical of the pre-Civil Rights Act period (see *Documentation*), and had the effect of inhibiting the full potential of Hill-Burton. But even so, the bill's effect was unprecedented.

The impact of the Hill-Burton Act

The Hill-Burton Act specified that for general care, there should be made available an average of 4.5 hospital beds per 1,000 people in states, with their local distribution made according to intrastate densities of settlement. In particular, for rural states, the act called for a higher average number of beds per 1,000 people, in order to accommodate people facing more difficult travel logistics. An average of 5 beds per 1,000 people was called for for those states with a density of 6-12 people per square mile; 5.5 beds per 1,000 were mandated for states with 6 or fewer people per square mile.

These bed ratio standards refer to general-care beds. In addition, the Hill-Burton Act mandated the provision of additional ratios of beds for such care as tuberculosis, mental illness, and chronic disease.

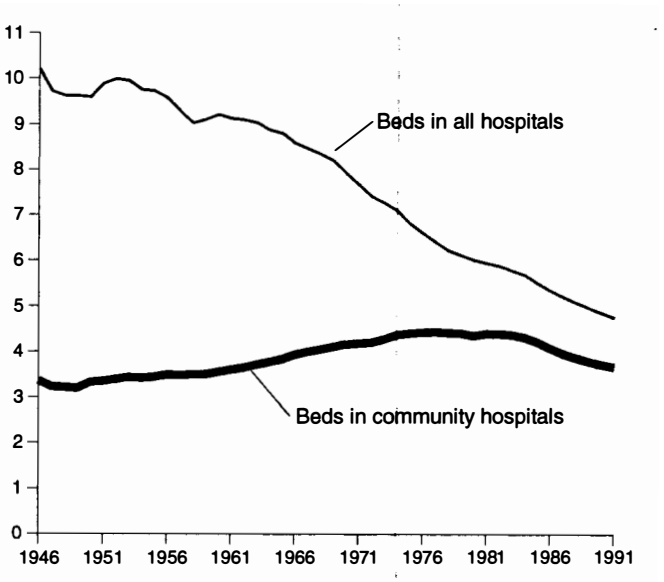
The ratios were devised on the basis of a "needs" analysis, which began by asking what kinds of care medical science could give as of mid-century, and what kind of bed use this would mean. In 1946, the physical facilities did not yet exist on the scale required by existing medical science. A building boom took place, with dramatic results in use of facilities and improvements in health.

Figure 1 shows that in 1946, the United States beds-per-1,000 ratio for community hospitals was 3.5—far below the Hill-Burton standard. In many states, the ratio was far lower. Between 1947 and 1974, through successive congressional extensions of Hill-Burton, over $4 billion in federal grants and loans for construction of general-care hospitals and expansion of facilities was distributed, which was expended along with another $10.4 billion in state and local funds. The results are clear from the graph.

As of the mid-1970s, the nationwide average for beds in community hospitals was at the average Hill-Burton standard of 4.5 beds per 1,000 people. Many rural areas had access to hospital care for the first time.

How the Hill-Burton implementation worked is described by one contemporary account, by Dr. Ralph Chester Williams, assistant surgeon general, in 1950:

FIGURE 1
Hospital bed availability, 1946-91
(beds per 100,000 people in the United States)



Sources: *U.S. Statistical Abstracts*; *Historical Statistics of the United States.*

"The National Hospital Program has now been in operation for three years. It had brought about a comprehensive plan showing the location and size of hospital facilities which are needed in each state. For the first time, a definite plan is being followed by each state in determining the location, size, and type of facility which can best meet the hospital and health center needs of the people. Hospital construction plans prepared by each state agency and approved by the U.S. Public Health Service have been extremely valuable in stimulating local communities to construct hospitals and health centers. In addition, the program has resulted in the enactment of hospital licensure laws in many states where none existed previously. The impact of the program on modern design and construction has been gratifying with respect not only to hospitals built under the program, but also to those built without Federal aid. Improved services to patients have likewise resulted from better planned and better designed hospitals.

"A total of 65,000 hospital beds and 250 public health centers are being added to the nation's health plant by 1,300 projects approved as of June 30, 1950. This represents a total expenditure of nearly $1 billion, toward which the Federal contribution will be about $345 million. Approximately 300 of these projects are already in operation, and 500 of the remainder are under construction.

"In general, hospitals are being built first where they are needed most, and usually these are also in areas of lowest

TABLE 1

Changes in rank order of the top ten leading causes of death in the United States

1900	1950	1990
1. Pneumonia (all forms) and influenza	1. Diseases of the heart	1. Diseases of the heart
2. Tuberculosis (all forms)	2. Cancer and other malignant tumors	2. Cancer and other malignant tumors
3. Diarrhea, enteritis, and ulceration of the intestines	3. Intracranial lesions of vascular origin	3. Cerebrovascular diseases
4. Diseases of the heart	4. Nephritis	4. Accidents (over 50% motor vehicles)
5. Senility (ill-defined and unknown)	5. Accidents, excluding motor vehicles	5. Chronic obstructive pulmonary diseases
6. Intracranial lesions of vascular origin	6. Pneumonia (all forms) and influenza	6. Pneumonia and influenza
7. Nephritis	7. Tuberculosis (all forms)	7. Diabetes mellitis
8. All accidents	8. Premature birth	8. Suicide
9. Cancer and other malignant tumors	9. Diabetes mellitus	9. Homicide and legal intervention
10. Diphtheria	10. Motor-vehicle accidents	10. AIDS and other infective and parasitic diseases

Sources: *The United States Public Health Service, 1798-1950,* by Ralph Chester Williams, M.D., Bethesda, Maryland: Commissioned Officers Association of the Public Health Service, 1951; and *Statistical Abstract of the United States, 1992.*

income. General hospital projects predominate in the program. Eighty percent of the total beds added to date are in these facilities. About one-half of the general hospital projects are new facilities, nearly all of which are located in towns of less than 10,000 population. These are typically small hospitals of 50 beds or less.

"Increasing attention is being given to other categories of hospital facilities, particularly tuberculosis, psychiatric and chronic units in general hospitals, and to public health centers. Four States (Georgia, Louisiana, Mississippi and South Carolina) now have extensive programs for health centers, and other States are beginning to develop such programs."

Winning the war against disease

The impact of the Hill-Burton approach is manifest in the mid-century progress in combatting disease. The postwar expansion of facilities, detection, and treatment, fought the final, winning rounds against the "microbes" (infectious diseases from bacteria, viruses, etc.). New efforts were also launched against chronic diseases, or diseases associated with a longer-lived population.

Table 1 shows this shift in the U.S. population's disease profile. The top killer diseases at the turn of the century were pneumonia and influenza, tuberculosis, and diarrhea and related diseases. The introduction of water purification, sewage treatment, and other sanitation practices, along with new drugs (such as penicillin, which was identified in 1928), opened the prospect of wiping out these diseases. By 1950, the infectious diseases had fallen in rank far below the chronic diseases—heart disease, cancer, stroke—as causes of death.

From 1946-50, mortality fell by 50% for maternity cases, appendicitis, and tuberculosis. The availability and use of the facilities, and provision of care of high standards of medical treatment, are the cause. The same Dr. Williams quoted above gave some specifics of the record use of the new facilities:

"In 1949, more than 16 million patients received bed-care in hospitals in the United States. This was the largest number ever recorded. It may seem strange to count the increase of hospital patients as a sign of progress in American health. But it is a good sign that the attitude of the public toward the hospital has been changed. The people are learning to turn to it as a place where they can get modern services that will restore them to health, or better still, prevent serious illness. Fifty years ago, people as a rule went to the hospital only as a last resort [before the common availability of antiseptic and anaesthesia practices, etc., that were pioneered in the last century—ed.]. A good statistical measure of the recently changed attitude is the increase of births in hospitals. In 1949, for example, more than 86% of the births occurred in hospitals; in 1935, the percentage was only 37%. . . .

"New services in health departments also contribute to individual and family health. During 1950, about 15 million people stepped before X-ray machines and had chest X-ray examinations made. As a result, more cases of tuberculosis are being discovered in the early, most curable stages. In the same year, more than 2.5 million persons visited local health departments to be examined for venereal diseases. As a result, nearly half a million were found to be infected."

As the infectious diseases were beaten back, the spirit of the Hill-Burton approach was evident in a set of survey hearings in October 1953, called "Health Inquiry," held by the Committee on Interstate and Foreign Commerce. The hearings were divided into sessions to review each of the top five major causes of death, beginning with heart disease. And the official topic was, "The Causes, Control, and Remedies of the Principal Diseases of Mankind."

What the Hill-Burton Act said

The Hill-Burton Act became law on Aug. 13, 1946, as Public Law 725. The official title is "Hospital Survey and Construction Act," and the entire document is only nine pages in length. The act was an amendment to the Public Health Service Act, from the 1930s. In brief, Hill-Burton authorized grants to the states for surveying the adequacy of their hospitals and public health centers, and for planning construction of additional facilities. The Hill-Burton law was extended in several subsequent acts of Congress. The full text of the Hill-Burton Act can be found in the public laws volume for the 79th Congress, 2nd session, Chapter 958. We have added bold sub-headings.

Purpose: physical facilities to furnish care for all the people

Sec. 601. The purpose of this title is to assist the several States—

(a) to inventory their existing hospitals (as defined in section 631 (e)), to survey the need for construction of hospitals, and to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people; and

(b) to construct public and other nonprofit hospitals in accordance with such programs."

Standards: number of beds per 1,000 people

Sec. 622. Within six months after the enactment of this title, the Surgeon General, with the approval of the Federal Hospital Council and the Administrator, shall by general regulation prescribe—

(a) The number of general hospital beds required to provide adequate hospital services to the people residing in a State, and the general method or methods by which such beds shall be distributed among base areas, intermediate areas, and rural areas: PROVIDED, That for the purposes of this title, the total of such beds for any State shall not exceed four and one-half per thousand population, except that in States having less than twelve and more than six persons per square mile the limit shall be five beds per thousand population, and in States having six persons or less per square mile the limit shall be five and one-half beds per thousand population; but if, in any area (as defined in the regulations) within the State, there are more beds than required by the standards prescribed

Lister Hill, champion of the public good

The post-World War II hospital building boom known as the Hill-Burton Program took its name from the leading sponsors of the enabling federal legislation on health care: Senators Lister Hill (D-Ala.) and Harold H. Burton (R-Ohio). These men had collaborated on other matters; but soon after the Hill-Burton Act became law in August 1946, Burton was appointed to the Supreme Court, and his legislative activities ceased. Hill served in the U.S. Senate until 1968.

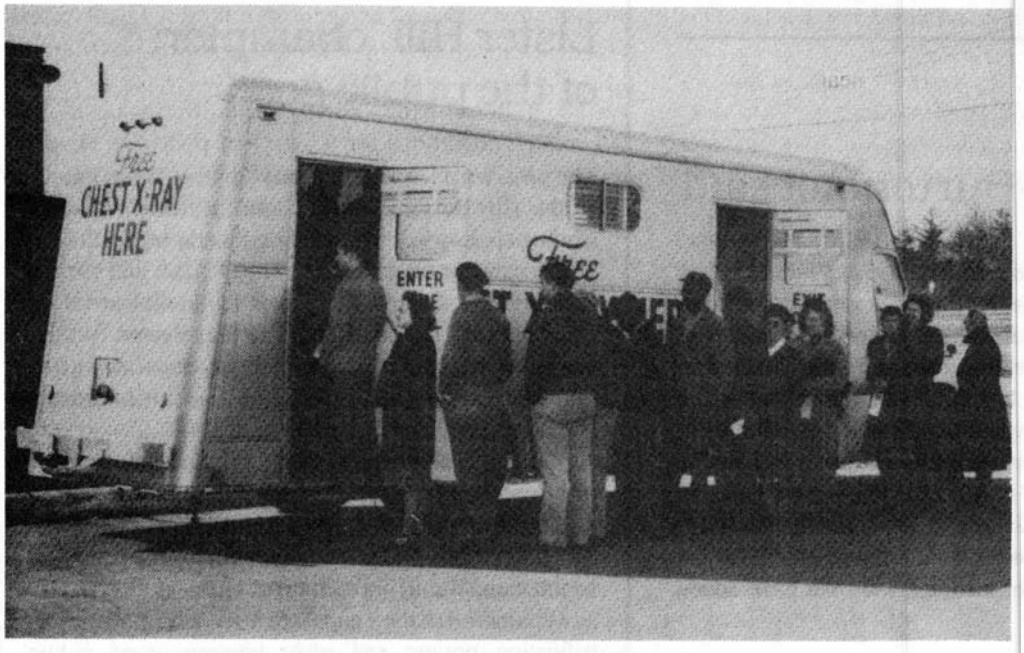
Today, a major part of the U.S. national archives of biomedicine is housed at the Lister Hill Center in Bethesda, Maryland, near Washington, D.C., in recognition of Senator Hill's initiatives for hospitals and health care. But in his own time, Hill was also known as a champion of the Tennessee Valley Authority electrification project and other common-good public works, and for his foreign policy initiatives to prevent war.

Hill was born in 1894 in Montgomery, Alabama, the first son of Dr. Luther Leonidas Hill, a surgeon whose family was active in city politics. Dr. Hill, who still practiced and held regular office hours until his 80s, had studied in England under Lord Joseph Lister—a pioneer of antisepsis. And so, Dr. Hill named his son after his mentor.

The first successful heart suture procedure in U.S. practice was performed by Dr. Hill. Lister Hill's two brothers and two brothers-in-law also became physicians in Alabama, but Lister Hill went into public policy from the start.

Hill studied law, did military duty in World War I, and, at the age of 22, began his public service career by being appointed president of the Montgomery Board of Education in 1917, serving until 1922. In 1923, he was elected to the House of Representatives and served for 14 consecutive years. As chairman of the House Military Affairs Committee, he championed the Tennessee Valley development project. He became what colleagues called "a consistent New Dealer."

In 1937, Hill declared his candidacy for the Senate, in opposition to a 68-year-old veteran politician, Thomas Heflin, an avowed Ku Klux Klan advocate, who some expected to win because of the Klan's resurgence. With the endorsement of President Roosevelt in his pocket, Hill defeated Heflin 88,000 to 48,000, and held his Alabama Senate seat from 1938 through 1968. Lister Hill died in 1984.



A typical mobile chest X-ray unit used under the Hill-Burton standard to reach people who did not appear at fixed detection sites.

by the Surgeon General, the excess over such standards may be eliminated in calculating this maximum allowance."

Additional beds for tuberculous, mentally ill, and others

(b) The number of beds required to provide adequate hospital services for tuberculous patients, mental patients, and chronic-disease patients in a State, and the general method or methods by which such beds shall be distributed throughout the State: PROVIDED, That for the purposes of this title the total number of beds for tuberculous patients shall not exceed two and one-half times the average annual deaths from tuberculosis in the State over the five-year period from 1940-1944, inclusive, the total number of beds for mental patients shall not exceed five per thousand population, and the total number of beds for chronic-disease patients shall not exceed two per thousand population.

(c) The number of public health centers and the general method of distribution of such centers throughout the State, which for the purposes of this title, shall not exceed one per thirty thousand population, except that in States having less than 12 persons per square mile, it shall not exceed one per twenty thousand population."

Special concerns: rural and poor areas

(d) The general manner in which the State agency shall determine the priority of projects based on the relative need of different sections of the population and of different areas lacking adequate hospital facilities, giving special consideration to hospitals serving rural communities and areas with relatively small financial resources.

(e) General standards of construction and equipment for hospitals of different classes and in different types of location."

Universal care

(f) That the State plan shall provide for adequate hospital facilities for the people residing in a State, without discrimination on account of race, creed, or color, and shall provide for adequate hospital facilities for persons unable to pay therefor. Such regulation may require that before approval of any application for a hospital or addition to a hospital is recommended by a State agency, assurance shall be received by the State from the applicant that (1) such hospital or addition to a hospital will be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed, or color, but an exception shall be made in cases where separate hosital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group; and (2) there will be made available in each such hospital or addition to a hospital a reasonable volume of hospital services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial standpoint."

Common-sense definitions

Sec. 631. For the purposes of this title—

. . . (e) the term "hospital" (except as used in section 622 (a) and (b)) includes public health centers and general, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, out-patient departments, nurses' home and training facilities, and central

service facilities operated in connection with hospitals, but does not include any hospital furnishing primarily domiciliary care;

(f) the term "public health center" means a publicly owned facility for the provision of public health services, including related facilities such as laboratories, clinics, and administrative offices operated in connection with public health centers;

(g) the term "nonprofit hospital" means any hospital owned and operated by a corporation or association, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual;

(h) the term "construction" includes construction of new buildings, expansion, remodeling, and alteration of existing buildings, and initial equipment of any such buildings; including architects' fees, but excluding the cost of off-site inmprovements and, except with respect to public health centers, the cost of the acquisition of land; and

(i) the term "cost of construction" means the amount found by the Surgeon General to be necessary for the construction of a project.

'Post-industrialism' killed Hill-Burton

Take another look at the graph on page 7 of hospital beds per 1,000 people during this century. It shows clearly that, as of the mid-1970s, there was an abandonment of the Hill-Burton-style commitment to providing care facilities and combatting disease. Although this is now obvious in myriad ways, consider just the simple beds-to-people ratios. Beginning in the late 1970s, there are downward trends both in the community (general care) beds ratio and in special-care beds (TB, mental illness, etc.)

Consider the relative number of special-care beds during the 1940s and 1950s. At that time, the high numbers of special-care beds reflected the sanitoria for tuberculosis, the special polio wards, wartime injuries follow-up, etc. The 1946 Hill-Burton Act, besides specifying standards of general-care bed availability, also specified standards for tuberculosis and other treatment. Altogether, a certain region of the country—for example, southeastern Pennsylvania—might expect to make available 4.5 general-care beds per 1,000 population, plus another 4-5 beds, depending on the prevalence of TB, the density of the population, and other factors. Health care planners strove for a dispersed network of community hospitals, with specialties concentrated in larger "regional" and "central" hospitals.

In the densely populated five boroughs of New York City, for example, the 1949 hospital plan, commissioned by Hill-Burton and the New York Committee of Post-War Public Works, used the following guidelines: for every one million people, a network of community hospitals (each with 50-300 beds), plus regional hospitals of about 650 beds each, plus central hospitals with 750-plus beds each. The higher up the pyramid, the more specialty facilities and staff were available.

By the late 1960s, the need for the TB and polio beds had all but vanished: The aggressive lung X-ray detection, quarantine, and follow-up treatment of the Hill-Burton period had all but wiped out TB, while the development and mass use of Dr. Jonas Salk's polio vaccine beginning in 1955 had created conditions for wiping out polio. A universal, nationwide vaccination program was begun, in which all individuals in target age brackets were given the vaccine. In 1963, the anti-measles vaccine was developed.

If the Hill-Burton approach to health care had been continued, the 1970s would have seen the total elimination of these infectious diseases, opening up the opportunity to concentrate even more effort into basic biomedical research and into early detection and least-cost treatment of chronic diseases. This was the stated goal of the 1953 Congressional "Health Inquiry" hearings, to find the "Causes, Control, and Remedies of the Principal Diseases of Mankind."

But the opposite took place. Economic policies of "post-industrialism" prevailed in the United States. The era of rampant speculation, junk bonds, derivatives, "Big MAC"-style austerity began. Upkeep and expansion of vital infrastructure—water, energy, physical health care facilities, public transit—went into decline. Beginning in the late 1970s, both the number of general-care beds per 1,000 people, and specialty care beds went into decline.

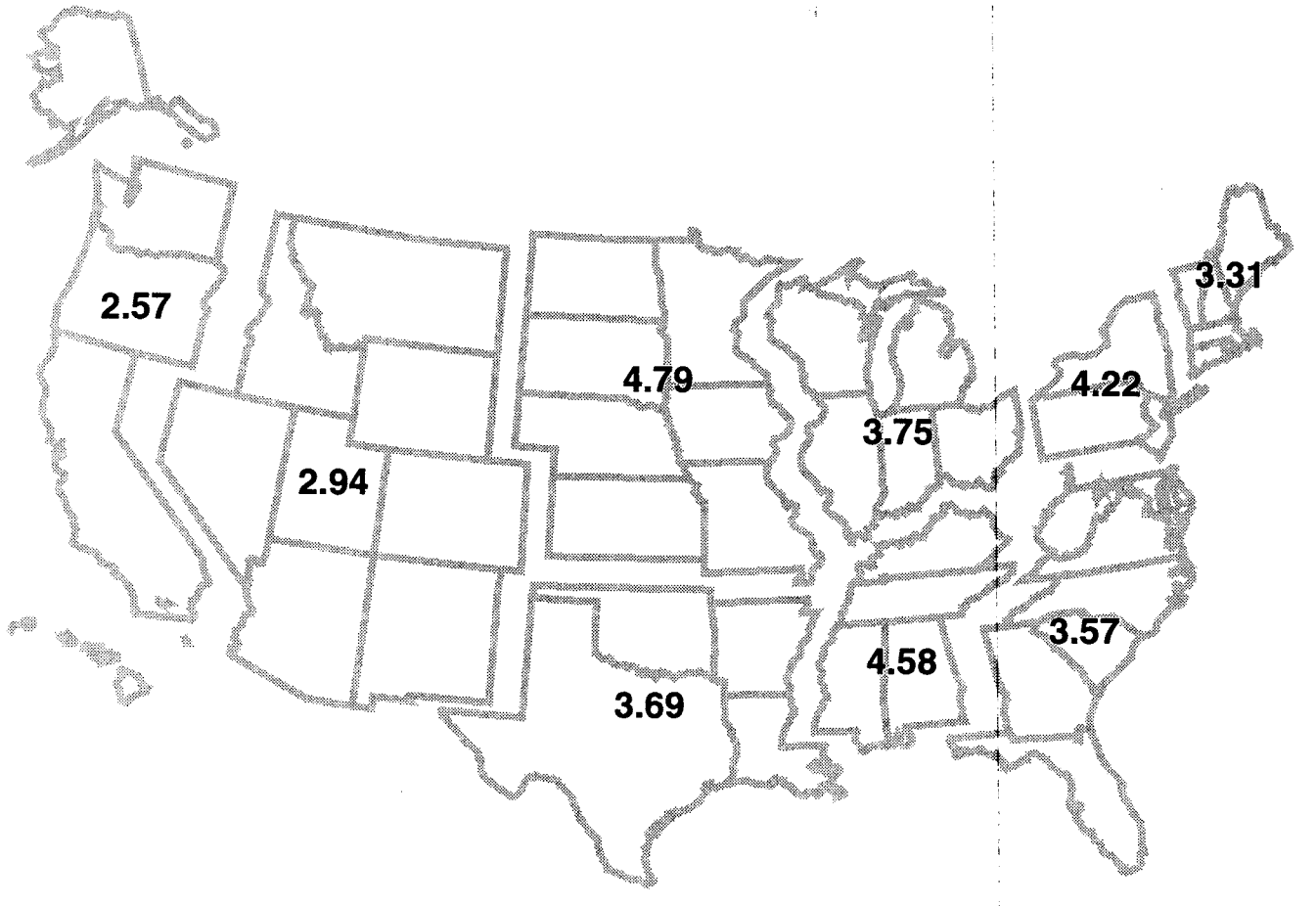
This deterioration in physical facilities was masked by continued advances in the "mechanics" of surgical procedures, so that hospital stays and bed use could be shortened, or even eliminated, through outpatient surgery. In the late 1970s, arthroscopy (joint microsurgery) using fiber optics was developed, and at the same time, laporoscopy (abdominal microsurgery) was begun, using micro instruments, and, more recently, using laser scalpel techniques.

Such gains from surgery advances have indeed been spectacular. One orthopedic example: In 1970, a simple knee meniscectomy (removing a damaged cartilage) required open surgery and hospitalization of 5-7 days. The successful procedure then resulted in a compromised knee joint, with the onset of arthritis coming normally within 10 years. Today, the torn segment of the damaged cartilage can be selectively removed, leaving the knee to function normally thereafter. The operation (which takes longer than the primitive 1970s meniscectomy), can be done on an outpatient basis.

But such advances have been islands amid a deepening sea of cost-benefit-driven degradation of health care. By the 1980s, community hospitals had become de facto "outpatient" centers. By 1990, the number of surgical procedures of all kinds done on an outpatient basis began to *exceed* those done on an inpatient basis; in that year, 11 million were done on an outpatient basis and 10.5 million inpatient.

Another way to look at this, is that the number of outpatient visits to community hospitals outnumbered the the days of inpatient care provided. As of 1985, there were about 226 million outpatient visits to community hospitals (an average

Disparity in relative numbers of community hospital beds in the nine U.S. census divisions, 1992
(beds per 1,000 people)



Source: *American Hospital Association Statistics*, 1993-94 Edition.

of one visit per American resident per year), and about 225 million days of stay in a community hospital (one overnight per year per American). Since that time, the outpatient visits to community hospitals have been almost twice the number of days of inpatient care.

The 'excess bed' hoax

What did the post-industrial cost-benefit experts conclude from this? They demanded there be a mass shutdown of "excess" beds. The media publicized empty beds as overcapacity. In reality, the 1970s marked the time when, by government decree—following orders from self-selected banking interests demanding austerity—hospitals were driven into bankruptcy and mergers, and out of existence.

For example, during the time of the "Big MAC" (Municipal Assistance Corporation) swindle in the 1970s in New York City, budget officials in New York in 1974 decreed a penalty of withholding state reimbursement for community hospital care for indigent residents, if the hospital in question fell below a new state-decreed percentage of use (75-85%). This drove many facilities into insolvency. In addition, a large number of specialty-care beds for the mentally ill were eliminated by Big MAC-style decree in New York, and the patients were turned out into the street.

Variations of this campaign to remove "excess beds" took place all over the country, mostly in poor rural and inner-city areas. Every year since 1977 has seen a net loss of community hospitals. In 1992 alone, 39 community hospitals closed. The most common mechanism of shutdown has been cutbacks in government funds. After the Medicare and Medicaid system was enacted in the 1960s, when financial hardship set in during the 1970s and 80s, state and local governments cut back their payments to hospitals. On top of this came the various types of insurance rackets.

The stage has now been reached where, in large numbers of locales across the United States, the number of beds for

general care do not even exist on minimum requirement levels. The map of the nine census areas shows the average number of community beds per thousand population in 1992, ranging from 2.57 in the Pacific zone (as compared to 4.5 under Hill-Burton), to 4.79 in the West North Central states (5.5 under Hill-Burton).

Within the states in each census area, there is also a wide disparity of availability of community hospitals.

During this same time, facilities and logistics for other health care services have also been cut back below levels needed for minimum national health security. There now exists an acute shortage of general practitioners for primary care. Nationwide administration of standard childhood vaccinations is no longer routine, as it used to be under Hill-Burton.

The cumulative result of this began asserting itself in the early 1980s, as increasing crowds of people began to show up at hospital emergency rooms.

The results of the build-down in health infrastructure are also evident in the growing spread of AIDS, and in the resurgence of tuberculosis and other diseases. Even if facilities and treatment patterns had been up to par, mutations and new outcrops of microbes would require new R&D breakthroughs for successful health care, because continued use of the same antibiotics has reached the outer limits of effectiveness—as shown, for example, by the hantavirus outbreak in the Southwest over the past year.

The most dramatic example, however, is the appearance of drug-resistant tuberculosis, which is now hitting the United States on an epidemiologically significant scale. As of 1991, according to a survey reported in the February 1994 *Journal of the American Medical Association,* the proportion of TB cases resistant to standard treatment drugs is now at the 13% level in New York, 6.6% in New Jersey, 4.9% in Florida, 4.3% in Hawaii, and significant levels in nine other states. In the United States overall, the proportion of drug-resistant TB cases was 3.5%.

Recommendations

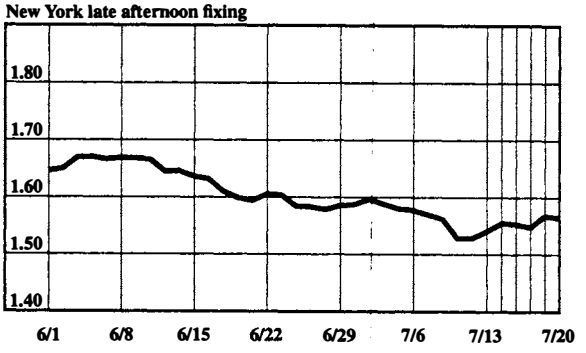
As the TB and AIDS prevalence shows, a return to the Hill-Burton method of setting standards for facilities, and then building them to those standards, is the only way to approach the task of restoring health to the nation. The graph of specialty hospital beds per 1,000 people should be made to swing upward over the remainder of the 1990s to reflect construction of special facilities for treating AIDS and TB cases. Specialists recommend that separate facilities must be built on a crash basis to handle this caseload—pending breakthroughs in treating the HIV virus—because it is medically undesirable to handle these diseases in proximity to general-care facilities.

The community general-care bed ratios should be improved overall, and region-by-region, in order to meet current standards of treatment for each age bracket, as the age pyramid profile dictates from place to place.

Currency Rates

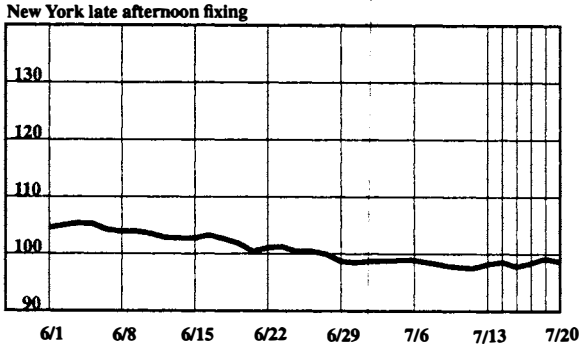
The dollar in deutschemarks

New York late afternoon fixing



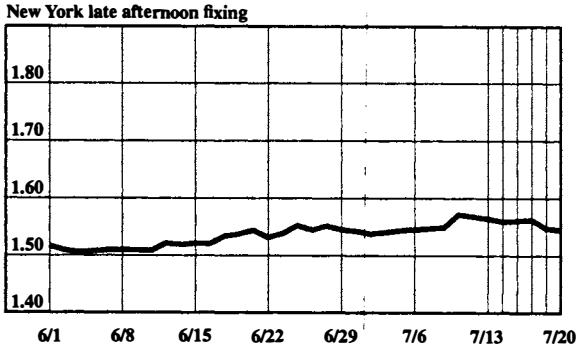
The dollar in yen

New York late afternoon fixing



The British pound in dollars

New York late afternoon fixing



The dollar in Swiss francs

New York late afternoon fixing