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HOSPITALS AND MEDICAL FACILITIES

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH,
WELFARE, HOUSING AND YOUTH AFFAIRS

OF THE

COMMITTEE ON
THE DISTRICT OF COLUMBIA
HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

FIRST SESSION

ON

H.R. 11628

TO AUTHORIZE GRANTS AND LOAN GUARANTEES FOR
CONSTRUCTION OR MODERNIZATION OF HOSPITALS
AND OTHER MEDICAL FACILITIES IN THE DISTRICT
OF COLUMBIA

NOVEMBER 11 AND DECEMBER 1, 1971

Printed for the use of the
Committee on the District of Columbia



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HOSPITALS AND MEDICAL FACILITIES

THURSDAY, NOVEMBER 11, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH,
WELFARE, HOUSING AND YOUTH AFFAIRS OF THE COMMITTEE
ON THE DISTRICT OF COLUMBIA,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:00 a.m. in room 1310, Longworth House Office Building, Representative W. S. Stuckey, (chairman of the subcommittee) presiding.

Present: Representatives Stuckey, Cabell, Mikva, Nelsen, Broyhill, Gude, and Smith.

Also present: James T. Clark, clerk; Hayden A. Garber, counsel; Patrick E. Kelly, assistant counsel; John Hogan, minority clerk; and Leonard O. Hilder, legislative assistant.

Mr. STUCKEY. The committee will come to order.

This morning, the bill that we have before us is H.R. 11628, authorizing for the construction of hospitals and medical facilities, seventy million dollars in grants and two million dollars in loan interest subsidy for the District of Columbia.

(The bill referred to and summary of legislation follow:)

H.R. 11628, 92d Cong, 1st sess., by Mr. Stuckey (for himself, Mr. McMillan, Mr. Dellums, Mr. Diggs, Mr. O'Konski, Mr. McKinney, Mr. Mikva, Mr. Madden, Mr. Carter, Mr. Fauntroy, Mr. Roy, Mr. Gude, Mr. Nelsen, Mr. Conte, Mr. Giaimo, Mr. Staggers, Mr. Preyer of North Carolina, Mr. Broyhill of Virginia, Mr. Fraser, Mr. Rogers, Mr. Link, Mr. Springer, and Mr. Fuqua) (by request), on Nov. 8, 1971, and H.R. 11770 by Mr. Patten on Nov. 15, 1971.

A BILL to authorize grants and loan guarantees for construction or modernization of hospitals and other medical facilities in the District of Columbia

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "District of Columbia Medical Facilities Construction Act of 1972".

CONSTRUCTION AND MODERNIZATION GRANTS

SEC. 2. (a) The Secretary of Health, Education, and Welfare (hereinafter in this Act referred to as the "Secretary") may make grants to nonprofit private entities to assist in meeting the cost of projects for the modernization of nonprofit private hospitals in the District of Columbia and in meeting the cost of

projects for the construction or modernization of long-term care facilities (including extended care facilities), diagnostic or treatment centers, outpatient facilities, rehabilitation facilities, facilities for the mentally retarded, and community mental health centers in the District of Columbia.

(b) To carry out this section there are authorized to be appropriated such sums as may be necessary for the fiscal year ending June 30, 1972, and for each of the next three fiscal years; except that the total amount appropriated under this subsection may not exceed \$70,000,000.

LOAN GUARANTEES AND INTEREST SUBSIDIES FOR CONSTRUCTION AND
MODERNIZATION PROJECTS

SEC. 3. (a) To assist nonprofit private entities to carry out approved projects in the District of Columbia for the modernization or construction of nonprofit private hospitals or other facilities referred to in section 2 of this Act, the Secretary, during the period July 1, 1972, through June 30, 1976, may in accordance with the provisions of this Act guarantee to any non-Federal lender which makes a loan to any such entity for such a project payment when due of the principal of any interest on such loan if such entity is eligible (as determined under regulations of the Secretary) for a grant under section 2 of such project.

(b) In the case of any loan guaranteed under subsection (a), the Secretary shall pay to the holder of the loan guaranteed (and for and on behalf of the entity which received such loan) amounts sufficient to reduce by not to exceed 3 per centum per annum the net effective interest rate otherwise payable on such loan.

(c) (1) The United States shall be entitled to recover from the applicant for a loan guarantee under this section the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

(2) Guarantees of loans under this section shall be subject to such terms and conditions as the Secretary determines to be necessary to assure that the purposes of this section will be achieved; and, to the extent permitted by paragraph (3), any terms and conditions applicable to a loan guarantee under this section may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

(3) Any loan guarantee made by the Secretary pursuant to this section shall be incontestable in the hands of an applicant on whose behalf such guarantee is made, and as to any person who makes or contracts to make a loan to such applicant in reliance thereon, except for fraud or misrepresentation on the part of such applicant or such other person.

(d) There is established in the Treasury a loan guarantee and interest subsidy fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, (1) to enable him to discharge his responsibilities under guarantees issued by him under this section, and (2) for interest subsidy payments authorized by this section. For each fiscal year there are authorized to be appropriated \$2,000,000 for interest subsidy payments and such sums as may be necessary to discharge his responsibilities under loan guarantees. If at any time the sums in the fund are insufficient to enable the Secretary to discharge his responsibilities under guarantees issued by him under this section or to make interest subsidy payments authorized by this section, he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury, but only in such amounts as may be specified from time to time in appropriation Acts. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued hereunder and for that purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act

are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this subsection. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this subsection shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund.

(e) The Secretary, with the consent of the Secretary of Housing and Urban Development, may obtain from the Department of Housing and Urban Development such assistance with respect to the administration of this section as will promote efficiency and economy thereof.

APPROVAL OF APPLICATIONS

Sec. 4. (a) An application for a grant or loan guarantee with respect to any project may be approved by the Secretary under this Act only if an application for a grant with respect to such project has been filed under a Medical Facilities Act (which for purposes of this Act means title VI of the Public Health Service Act or, where appropriate, title II or part C of title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) and—

(1) has been approved under the Medical Facilities Act and the application filed under this Act is for additional funds in connection therewith, or

(2) has been denied under the Medical Facilities Act because insufficient funds are available from the allotments of the District of Columbia under the Medical Facilities Act to permit approval of the application.

In determining whether to approve an application for a grant under a Medical Facilities Act for any project in the District of Columbia, the availability of additional funds for such project under this Act shall be taken into consideration. Approval of such application may be made contingent upon the approval of an application or applications with respect to such project under this Act and upon such additional funds being made so available.

(b) The Secretary shall establish criteria for determining the order in which to approve, under this Act, applications for grants and loan guarantees with respect to projects. Such criteria with respect to construction or modernization projects for the same type of facility shall be consistent with the criteria developed by the State agency or the District of Columbia pursuant to the State plan approved under the applicable Medical Facilities Act.

(c) In the case of any project with respect to which an application for a grant or loan guarantee is filed under this Act and with respect to which an application for a grant has been denied under a Medical Facilities Act, such application under this Act may be approved only if there is compliance with the same terms and conditions (including determination, in accordance with the applicable State plan, that the project is needed) as are applicable to applications for grants under the Medical Facilities Act, other than the availability of sufficient funds in the appropriate allotment of the District of Columbia.

(d) An application for a grant or loan guarantee under this Act with respect to any project may not be approved unless an opportunity to review the application has been afforded to a body found by the Secretary to be a responsible metropolitan areawide planning body, and any recommendations of such body that were timely made have been considered by the appropriate State agency or the District of Columbia and have been submitted to the Secretary in connection with the application.

PAYMENTS OF GRANTS

Sec. 5. (a) Payments under grants made under this Act with respect to any project shall be made in the manner provided under the applicable Medical Facilities Act for payment of the Federal share of the cost of projects for which applications are approved under such Act; except that payments under grants made under this Act shall also be subject to such reasonable conditions as the Secretary deems appropriate to safeguard the Federal interest.

(b) The total of the payments of grants made under this Act with respect to any project, together with any payments made with respect thereto under a Medical Facilities Act, may not exceed—

(1) in the case of a construction project for a long-term care facility (including extended care facilities), a diagnostic or treatment center, an outpatient facility, or a rehabilitation facility, 66⅔ per centum of the cost of such project; and

(2) in the case of any other project (including a modernization project), 50 per centum of the cost of such project.

RECOVERY OF PAYMENTS

SEC. 6. Payments of grants under this Act shall be subject to recovery or recapture under the same conditions and to the same extent as is provided under the applicable Medical Facilities Act with respect to payments made thereunder.

MEANING OF TERMS

SEC. 7. The terms used in this Act shall have the same meaning as when such terms are used in the applicable Medical Facilities Act.

PROJECTS APPROVED UNDER PUBLIC LAW 90-457—EXHIBIT, PUBLIC LAW 90-457, PROJECT FUNDING REPORT

Hospitals	Grant	Loan	Totals
Cafritz Memorial.....	\$500,000		\$500,000
Columbia Hospital for Women.....	500,000		500,000
Providence.....	500,000		500,000
Sibley Memorial.....	500,000		500,000
George Washington.....	4,064,000	\$4,976,842	9,040,842
Georgetown.....	6,189,000	11,080,000	17,269,000
Rogers Memorial.....	6,510,000	6,510,000	13,020,000
Washington Hospital Center.....	7,889,421	4,608,579	12,498,000
Children's.....	13,399,579	13,399,579	26,799,158
Total.....	40,052,000	40,575,000	80,627,000

Source: Hospital Council of the National Capital Area, Inc.

SUMMARY OF PROPOSED PROJECTS UNDER H.R. 11628—BRIEF EMPHASIS BY PROJECT

	Federal grant	Hospital loan	Program total
Cafritz Memorial Hospital: To provide for a new ambulatory and family care center as well as to provide for the expansion of necessary diagnostic and ancillary supportive services.....	\$10,000,000	\$9,000,000	\$19,000,000
Children's National Medical Center: To provide for completion of programmed construction under Public Law 90-457 inclusive of specialty pediatric facilities for mental health.....	12,400,000	12,400,000	24,800,000
Columbia Hospital for Women: To provide for the total replacement of the existing hospital and to permit reasonable options for expansion.....	4,000,000	4,500,000	8,500,000
George Washington University Medical Center: To provide for expansion of radiological facilities, modernization of elevators and the addition of a major ambulatory care center.....	7,600,000	4,800,000	12,400,000
Georgetown University Medical Center: To provide for modernization and space revisions within the existing hospital and to provide additional space for outpatient services.....	9,500,000	6,500,000	16,000,000
Providence Hospital: To provide essential expansion and modernization includes air conditioning, elevators, extended care beds, and an ambulatory care facility.....	12,200,000	8,800,000	21,000,000
Rogers Memorial Hospital: To provide for the completion of programmed construction delayed because of financial limitations under Public Law 90-457 inclusive of a multistory ambulatory care and referral center and the addition of extended care beds.....	6,300,000	6,300,000	12,600,000
Sibley Memorial Hospital: To provide for the modernization of ancillary and service areas of the existing hospital and to provide for the more effective utilization of the training school building.....	3,500,000	3,500,000	7,000,000
Washington Hospital Center: To provide for a neighborhood health center, expansion of nuclear medicine department, outpatient and emergency departments, and to provide for the expansion and relocation of the ancillary service departments.....	3,000,000	2,700,000	5,700,000
Hadley Memorial Hospital: Situated in the Anacostia area urgently needs funds to provide modernization and expansion of its outpatient facilities in order to have sufficient space for carrying out the services it is now rendering.....	1,500,000	1,500,000	3,000,000
Total.....	70,000,000	60,000,000	130,000,000

DISTRICT OF COLUMBIA HOSPITAL GRANTS

Public Law 648 of August 7, 1946 (60 Stat. 890) and amended by Public Law 82-221 of October 25, 1951, (65 Stat. 657) and Public Law 85-73, June 29, 1957 (71 Stat. 243) provides for more adequate hospital facilities in the District of Columbia by acquiring land, constructing buildings and making grants to private agencies. The District of Columbia, under the amended act, is required to repay fifty percent of the net cost, at the annual rate, without interest, of three percent of the net cost of such percentages. Of the \$40,818,552 which has been authorized to be appropriated for this purpose, \$23,398,099 has been expended for a hospital center located on the Soldiers Home grounds which was occupied in the Spring of 1958, and \$17,420,453 for grants to seven private agencies. The District's share of this liability is estimated to be as follows:

	Total cost	District of Columbia share		Repayments through fiscal year 1971			Balance due	
		Grant	Percent	Amount	Number	Amount	Number of payments	Amount
Children's Hospital No. 1.....	\$3,502,318	\$441,913	50	\$220,956	14	\$92,805	{18 at \$6,629 1 at \$8,829	\$128,151
Children's Hospital No. 2.....	873,542	234,000	50	117,000	11	38,500	{21 at \$3,500 1 at \$5,000	78,500
Providence Hospital.....	8,285,467	4,097,040	50	2,048,520	11	676,520	{210 at \$6,512 1 at \$4,480	1,372,000
Casualty Hospital.....	3,526,971	1,300,000	50	650,000	11	214,500	{21 at \$19,500 1 at \$26,000	435,500
Columbia Hospital.....	3,686,000	1,428,500	{30 percent of \$570,000 50 percent of \$858,136	600,250	9	162,000	{24 at \$18,000 1 at \$6,250	438,250
Georgetown Hospital.....	7,200,000	2,170,000	{30 percent of \$450,000 50 percent of \$1,720,000	995,000	10	298,000	{22 at \$29,800 1 at \$41,400	697,000
Sibley Hospital.....	8,755,791	4,374,000	50	2,187,000	10	657,090	{22 at \$65,610 1 at \$86,490	1,529,910
Cafritz Memorial Hospital (South-east).....	9,000,000	3,375,000	30	1,012,500	4	121,500	{29 at \$30,375 1 at \$10,125	891,000
Washington Hospital Center.....	23,398,099	23,398,099	50	10,419,249	10	3,439,718	{22 at \$312,694 1 at \$100,263	6,979,531
Total.....	67,628,188	40,818,552		18,250,475		5,700,633		12,549,842

Source: District of Columbia government, Executive Office, Budget and Program Analysis, Nov. 11, 1971.

Mr. STUCKEY. We are very honored and pleased this morning to have as our first witness to give his testimony, our beloved former Speaker, the Honorable John W. McCormack of Massachusetts. Mr. Speaker, we are delighted and honored to have you with us this morning.

**STATEMENT OF THE HONORABLE JOHN W. McCORMACK, FORMER
SPEAKER OF THE HOUSE OF REPRESENTATIVES**

Speaker McCORMACK. Thank you very much, Mr. Chairman, I am very happy to be here, I am back in familiar territory and atmosphere. I feel completely at home.

As you know, I had forty-two years in the House and my colleagues were very generous to me and very kind to me, which I shall always treasure and value very much.

I am particularly pleased to appear before your Committee, Mr. Chairman and members of the subcommittee in support of H.R. 11628, relating to hospitals in the District of Columbia.

I have been very much interested in hospitals throughout the entire country for my entire life, non-legislative and legislative, during the years I was a member of the Massachusetts Legislature, seven years, both branches, and as a member of the Constitutional Convention prior to that.

I was always very deeply interested, not excluding other activities but very interested in the hospital work.

I was commenting here to some of the participants, having a little chat, and I made a little comment that we have the dedication for cancer research now, but in 1926, when I was a member of the Massachusetts State Senate, my hair was black then, I introduced a bill which became law establishing the first public cancer hospital of the United States. It is still in existence and doing very effective work, about thirty or forty miles outside of Boston.

So it is a pleasure for me to be here in support of this Bill because it is something that concerns the depths of my feelings and of my heart, because I see in hospitals human beings going in and out with their sickness and their hopes, depending upon the doctors, the nurses and even those who clean the rooms. That is the sort of picture that runs through my mind and always has.

Now, in discussing continued support of the construction of needed medical facilities, we should consider the Congressional actions that resulted in significant achievements in the District of Columbia.

In all of these actions I have been a staunch advocate in the interest of providing the backlog of needed medical facilities.

In 1931 the Hospital Medical Center or the Hospital Center Act was amended to authorize grants up to fifty percent of the cost of construction or renovating hospital facilities in the District. I remember the Hospital Center Act as I played a leading part in the passage and in connection with this particular amendment, I introduced the Bill amending the Hospital Center Act, related, as I remember, to Sibley Memorial Hospital, Providence Hospital, Children's Hospital. One other private hospital at Georgetown, as I remember.

That authorized grants up to fifty percent of the cost of construction or renovating hospital facilities in the District. The District of Columbia is required to repay fifty percent of the Federal cost of con-

struction. This was lowered to thirty percent in 1938 with respect to grants made after that time.

Under the 1951 and subsequent amendments, grants of seventeen million four hundred and twenty thousand four hundred and fifty-three dollars have been made for projects having an estimated cost of approximately forty-four million dollars. The act expired in 1962.

In 1962 Public Law 87-460 was enacted authorizing grants up to two million five hundred thousand dollars for fifty percent of the cost of constructing an addition to George Washington University Hospital.

Just incidentally, I introduced that bill, the addition to the George Washington University Hospital.

Funds for that purpose were appropriated by the Congress in fiscal year 1964 and the project is now complete.

In addition to the Hospital Center Act and Public Law 87-460, both of which applied solely to the District, federal financial assistance had been given for the construction of hospitals and other medical facilities in Washington through two generally applicable federal programs. The Wartime Defense Housing and the Public Works Program. Commonly referred to as the Lanham Act. I remember that very well.

The program authorized by Title VI of the Public Health Service Act, commonly called the Hill-Burton Program, which I also remember very well in passage of it years ago. Under the Lanham Act two hospitals received a federal contribution of five million six hundred and fifty-five thousand dollars, under the Hill-Burton Program a total of seven million one hundred and ninety-four thousand dollars in grants was approved through fiscal year 1966 for twenty-seven projects in the District.

The present bill, H.R. 11628, is an extension of the Law 94-567. I personally supported the matter on the Floor of the House.

In 1968 we provided eighty million dollars in grants and loans toward meeting the backlog of needs. This was caused by federal legislative inequities within the Health Facilities Act as they applied to the District of Columbia.

The present bill, H.R. 11628 provides seventy-two million dollars in grants and loan interest subsidy over a period of years that it covers, I think it is four years.

It encompasses the individual and collective efforts of non-profit health care institutions to meet community health needs in the most effective and economic manner. It provides for the completion of several projects currently under construction.

Throughout all of the years one of the primary thoughts my mind and influence in connection with hospitals and many other activities, but confining myself to hospitals, is the fact that millions of Americans from all over the country visit the Capitol. I think last year it was estimated that over six million persons visited the Capitol and this year there will be seven or eight million and it will be only a matter of a few years that it will be ten million persons visiting the Capitol from all over the country.

Some of those visitors get sick and that is a strain on the hospitals of the District of Columbia which no other city has throughout the country. Other cities have their problems, I am not underestimating the problems of other cities but the Capitol city of Washington has

this extra responsibility. When people get sick requiring hospitalization they have to receive it and the hospitals of the District have got to respond and always have.

So, there is that extra problem concerning the District of Columbia concerning hospitals that no other city has. No matter how large or small it might be and as I say, every city has its problems. But the District of Columbia has an addition to this normal problem confronting it, this national problem that arises between some of the persons of the millions who come to the District visiting it, tourists interested in our country, take sick, requiring hospitalization. Sponsors of projects for construction in the District of Columbia experience serious difficulty in raising the non-federal share of the cost thereof.

In local city and county jurisdictions, financial assistance to meet hospital construction funds requirements is forthcoming from the Governments, local Government, Federal Government in recent years, local Governments in addition to individual and industrial contributions.

The grant program is equivalent to the bond issues and direct contributions in other jurisdictions. Because of the uniqueness of the Nation's Capitol where upwards of seventy percent of the population is employed by the United States Government or supportive industries, no such possibility exists. Certainly it is reduced to a minimum. A dynamic and critical approach to meeting community needs as set forth within this legislation emphasizes the million of out-patient diagnostic and treatment facilities and the use of low cost extended care services. That is very important, I know from my own experience.

The legislations is outmoded, uneconomical and inefficient facilities and therefore compells cost consciousness. Incentive matching fund ratios emphasis is with sixty-six and two-thirds percent for extended care and diagnostic treatment facilities, and fifty percent for authorization and new construction. It is my sincere hope, Mr. Chairman and members of the subcommittee, that the wisdom of you gentlemen will continue this obligation of Congress to the hospitals of the District of Columbia reporting this Bill to the full committee and I hope the full committee will report it properly in the near future to the House, in which eventually I know that the bill will pass the House with ease and meet favorable response in the Senate.

In conclusion, I want to express to you my appreciation for the opportunity of appearing before you on any occasion, particularly on this particular time in support of this very humane, constructive and meritorious bill.

Mr. STUCKEY. Mr. Speaker, let me say that we appreciate your being here this morning and your very informative testimony, particularly the history behind the hospitals in the District of Columbia and the bill we have. I would like to personally thank you for the contribution that you have made, not only to the country but specifically to the hospital in the District of Columbia. I know from a personal standpoint that had it not been for your work and efforts at the Sibley Hospital, it would not be in existence, and I use that facility about once a month with five children so I feel I owe you a personal thanks.

Speaker McCORMACK. Well, have you got a minute? You know where Sibley is located on the hill out there on the District line, ap-

parently there was a facility there for delinquent girls for many years. That is the information I received. It was discontinued and many years ago it was under the jurisdiction of the Army Engineers, so when it was discontinued the Army Engineers claimed it reverted to them. General Services claimed that by the reason of the law passed, and I was on the committee of Government Operations when we reported out the General Services Bill, that it came under the jurisdiction of General Services. The information I got was that the Army Engineers wanted the land for use sometime in the year 2000.

Well, I didn't figure I would be around by that time. This is back some few years ago now, time passes so quickly. The General Services—and they were not disposed to sell any land to the Sibley Hospital, whose original intentions, as I remember, if I am correct, you will understand that I am throwing my mind back many years, that Sibley was going to be built on the American University campus. That meant years ahead to tapping the university. We could look ahead twenty-five years and see difficulties arising.

So, they came to see me. The title had to be cleared and the bill had to be passed to clear the title so it would be in General Services. Now, General Services were perfectly agreeable to selling the necessary portion of that hill out there. I think it was twelve or thirteen acres, something like that. So, I introduced the Bill. They came to me and I had the pleasure of introducing that Bill to clear the title and those things bring a lot of happiness to me, not only in memories because I don't live in memories, because I am still looking ahead.

The fact that I am here today is an illustration that while memories are a part of all of our lives, nevertheless I am not just relying on memories alone. It was rather interesting. The title was cleared and they came to me for consultation as to whom I thought—I was then Majority Leader, whom I thought was the best member of the House to introduce the Bill. Of course, when they came to me for that advice I knew they thought I was, so I said if you want me to introduce the Bill I will do it.

Well, that is the little history of how it came about.

Mr. NELSON. Mr. Speaker, just a moment. I would like to associate myself with the remarks of the Chairman in welcoming our distinguished former Speaker to the committee and expressing my thanks and appreciation for your coming here to help us with the Bill. All of us, of course, owe you a debt of gratitude to your magnificent service to the country over the years, and I can assure you how people appreciate the services you have rendered to the Nation's Capital in the development and improvement of the Health Services System here. I shudder to think what would be the condition of the Health Services here in the area without not only your interest, but your leadership in making sure we provide the services we need. There is no question in my mind this is going to give us the additional impetus we need to get this bill through.

Thank you very much.

Speaker McCORMACK. Thank you.

Mr. MIKVA. It is not at all surprising that the Speaker is here this morning for the name of John McCormack has always been identified with this legislation. From the time I was a young boy, I knew John McCormack was fighting for health legislation and it is only fitting

that his name be associated with this bill, by his being here as a witness. We are privileged to have your testimony.

Speaker McCORMACK. Thank you very much.

Mr. BROYHILL. I would also like to thank you very deeply. Although I haven't had the opportunity to use the facilities at Sibley, my children use the emergency room every time they fall out of a tree or cut something, and I am very deeply in debt to you.

Thank you.

Speaker McCORMACK. Thank you very much.

[Applause.]

Mr. STUCKEY. At this time we will hear from the Medical Society of the District of Columbia, Dr. Korengold.

STATEMENT OF MARVIN C. KORENGOLD, M.D., PRESIDENT OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

Dr. KORENGOLD. Chairman Stuckey and members of this Subcommittee, I am Dr. Marvin C. Korengold, a physician in the practice of Neurology in Washington, D.C. I appear today as President of the Medical Society of the District of Columbia. I am pleased to be here Mr. Chairman, to present the views of the Medical Society of the District of Columbia in support of the District of Columbia Medical Facilities Act of 1972.

The Medical Society of the District of Columbia, which has a membership of 2,600 physicians who practice in this metropolitan area, supports the enactment of this bill: a Bill which provides for the replacement of outmoded, uneconomical, and inefficient facilities in the city's medical care institutions.

Major health programs in the United States during the past five years have increasingly stressed three attributes of health care services and their delivery: comprehensiveness in the types of services provided: cooperation among the various providers of services: and accessibility of the services to the consumer. The Medical Society believes that this Bill incorporates these three aspects of medical care.

If enacted into law, this legislation would assure the citizens of the District of Columbia, as well as those who visit it and use our metropolitan area, well equipped modernized health facilities. In order to achieve this therefore, the funding provision, which was made possible by Public Law 90-457, should be continued for the next three years.

Good medical programs and delivery systems to provide these programs are only as good as the providers of medical services can collectively make them. This Bill has met all criteria of the area wide planning council, hospital council, and the Medical Society. This Bill does therefore incorporate good comprehensive planning concepts.

The thrust of today's medical care is based on ambulatory type services. The administration's emphasis upon the development of health maintenance organizations, regional medical programs, etcetera, is based on the concept of ambulatory medical care. This Bill places special emphasis on the revitalization of ambulatory facilities of the major hospitals of the District of Columbia. The Medical Society of the District of Columbia endorses the need for continued renovation of these outmoded facilities so that high levels of quality care can be

maintained for the citizens of Washington. The Medical Society strongly recommends enactment of H.R. 11628 as introduced.

Thank you.

Mr. STUCKEY. Thank you, doctor.

Just one brief question. If this bill were not enacted into law providing for the next four years, do you think it would be impossible to continue the services you have mentioned without the seventy million dollars in grant, and the two million dollar loan interest subsidy?

Dr. KORENGOLD. I think we are suffering now and have been suffering for the past few years because of the delay in providing the kind of facilities needed. I think any further delay will only compound the problem tremendously. It is a very difficult, trying time of problems, with physicians taking care of people, not to be able to have room to place their patients, to find hospital beds filled, to find no operating room space, to see personnel in hospitals that are so sorely needed standing waiting for outmoded elevators to slowly make their way so that they can wheel the patient down to the operating room. The multiplicity of problems that are available at this time will only be many times compounded.

Mr. STUCKEY. Do you feel the \$70 million in grant is adequate?

Dr. KORENGOLD. I don't think I am qualified to comment on the amount. I can only comment on the need.

Mr. STUCKEY. Thank you doctor.

Mr. Nelson?

Mr. NELSON. No questions.

Mr. STUCKEY. Mr. Mikva?

Mr. MIKVA. No questions.

Mr. STUCKEY. Mr. Gude?

Mr. GUDE. Dr. Korengold, you mentioned in your statement about ambulatory facilities and I was wondering if you could specify exactly the type of facilities and how this could possibly help with the bed situation or the need for more hospital space?

Dr. KORENGOLD. The whole trend in modern thinking in medical care is to reduce the duration of hospital stay because this is the area of the most cost, and to increase in and out kind of services. If we can send people to ambulatory care centers where they can come and get a multiplicity of services rendered to them and leave and head back for their homes, this will save everybody, consumers, physicians, hospital staffs.

At the present time there are many areas where minor kinds of procedure virtually require admission to a hospital. Now, in the last few years many of the facilities have produced and enlarged upon in and out kinds of facilities. This has to be greatly expanded, so that the use of a hospital bed is preserved for those who really and deeply need it and that it should always be available for them, but the bulk of the kinds of care that are rendered is not requiring hospitalization and this would facilitate, under the rules of institutions equipped to give this kind of care where you can come in and get minor surgery, extra facilities, laboratory testing, radioactive isotopes, procedures done without having to go from one building by cab to another facility half way across town. In every conceivable way it makes good sense to have this kind of facility under one roof in a given institution. A given location. This type of proposal would help enhance the development and expansion of these kinds of services in a community.

I think it is sorely needed.

Mr. GUDE. What you are saying is that the development of ambulatory facilities would reduce the number of admissions to hospitals, and, therefore, this would cut down on the cost for those who don't require 24-hour a day service.

Dr. KORENGOLD. Basically, this is true. If we can cut down on some of the people who are going into the hospitals now by development of these facilities, we will make room for many needed people who are unable to get in the hospital today.

Mr. GUDE. And you can cut down on the pressure with the expansion of hospital facilities, where patients don't need hospital facilities?

Dr. KORENGOLD. By all means, this will produce considerable relief of the pressure of the admitting services.

Mr. GUDE. Thank you very much, Mr. Chairman.

Mr. NELSEN. Mr. Chairman, we have one of our members in the Health and Environment Subcommittee who has a press conference at 11:00 o'clock dealing with a health maintenance and organization type of a bill. It seems to me some of the things you are suggesting here fits into that category, it might very well be that if the program is set up nationally, this will be something that your activity or your objective will fit in with, and it might be a good idea, Dr. Korengold, to examine some of these bills and legislation proposed in the area where you might be a recipient.

Dr. KORENGOLD. Yes.

Mr. STUCKEY. Thank you, Dr. Korengold.

At this time we will hear from the Health Facilities Planning Council.

STATEMENT OF JOHN McKINNEY, HEALTH DIRECTOR, HEALTH FACILITIES PLANNING COUNCIL, ON BEHALF OF EDWARD W. NICKLAS, M.D., CHAIRMAN OF THE BOARD

Mr. McKINNEY. I am not Dr. Nicklas; he is out of town. I am John McKinney, Health Director of the Health Facilities Planning Council for Metropolitan Washington.

The Health Facilities Planning Council for Metropolitan Washington, D.C. was established in 1962 to foster and promote an orderly and economic development of health facilities and services in the Washington Metropolitan Area. The Council is a non-profit organization with a twenty-one member Board of Directors representing an equal number of citizens from Maryland and Virginia as well as the District of Columbia.

For nine years the Council has been engaged in a program of data collection concerning utilization of area health facilities and in the projection of probable demand for additional services in the years ahead. These have been published and are available to the public.

In addition to this activity, the Council has on a number of occasions reviewed specific proposals for the construction of new facilities or the expansion of existing ones to determine their consistency with the needs of the Metropolitan Area as projected by the Council. On September 16, 1969, the Secretary of Health, Education and Welfare notified the Council that he recognized the Council as the responsible areawide planning body to perform the Metropolitan areawide review

function required under P.L. 90-457, and the D.C. Medical Facilities Construction Act of 1968. The Council has diligently endeavored to carry out this obligation since that time.

The Council recognizes the continuing need for Federal support for the development and renovation of health facilities of the District of Columbia. Because of the unique economic characteristics of the District of Columbia, we believe Federal support is essential if these institutions are to continue to serve the residents of the District of Columbia and the surrounding suburban communities in Maryland and Virginia.

Accordingly, the Health Facilities Planning Council expresses its support for an extension of this bill which would continue to provide funds for this purpose. The Council agrees to continue in its role in reviewing these projects if the Secretary so desires.

In accepting this obligation, however, the Council would like to explicitly state that this does not imply Council endorsement of any of the projects presently contemplated for funding under this act. The Council will review these and any other proposals that may be presented and give its best judgment about the relative priorities of need among those contemplated.

Mr. STUCKEY. Thank you, Mr. McKinney.

Mr. NELSEN. I have no questions, thank you.

Mr. STUCKEY. Mr. Brophy?

Mr. BROPHY. Doctor, a moment ago Mr. Nelsen referred to this Health Maintenance organization. At the present time, we are holding hearings in the Ways and Means Committee on the National Health Insurance Proposal. There is no question but what some proposal will be approved by that committee and enacted by the Congress. This will put ten or twenty million dollars more into some kind of health insurance program. This is undoubtedly going to increase the needs for hospital facilities, just as Medicaid and Medicare have done. This is one of the reasons why we created the Health Facilities Planning Council. We were required to do so in one of these prior acts.

I think it was Medicaid or Medicare that required some area planning organization be established. Have you taken into consideration or has the Health Facilities Planning Council taken into consideration, the possible additional increase in the need for additional hospital facilities as a result of this pending legislation?

Mr. MCKINNEY. We are trying to, Mr. Brophy. It is a very difficult thing to judge until a particular bill is enacted, and we get some regulations to see how it is to be administered. As you know, the Bills pending are quite diverse and it is difficult at this time to estimate with any precision what the effect is going to be. We do have this pretty much in mind.

Mr. BROPHY. There is no question that that legislation will cause an increased demand, and without this legislation your problem will be somewhat compounded, wouldn't it?

Mr. MCKINNEY. What this bill will do is provide the necessary flexibility to meet the demand that arises. In other words, if we see a sudden shift from in-patient utilization toward ambulatory facilities, if you do not have the funds to provide those facilities, you sort of belt yourself into a box. On the other hand, if the need goes the other way, you have this flexibility.

Mr. BROYHILL. One of the things that has been brought up here today is the need for some sort of legislation that would facilitate this carryover utilization of these facilities. That is going to be a problem itself. There is a tendency to be wasteful in the utilization of facilities.

So, it is a question of what we are going to have.

Mr. MCKINNEY. I think the way these things are ultimately funded is going to be a key as to what developments will be. For example, we have seen certain Federal programs that will not pay for care in certain facilities and although they are needed, payment simply doesn't develop. I think this bill will provide the flexibility you need to meet this future demand.

Mr. BROYHILL. Thank you.

Mr. STUCKEY. Thank you, Dr. McKinney.

Next we have the Hospital Council for the National Capital Area. Father Collins and Mr. Bucher.

Mr. BROYHILL. Mr. Chairman, I also had a statement that I would like to have entered in the record at this point.

Mr. STUCKEY. Without objection, it is so ordered.

STATEMENT OF HON. JOEL T. BROYHILL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. Chairman, I am pleased to be a co-sponsor of this proposed legislation, which is urgently needed in the interest of the entire Washington Metropolitan Area.

This bill, H.R. 11628, entitled the "District of Columbia Medical Facilities Construction Act of 1972", will serve in general to extend the provisions of Public Law 90-457, approved August 3, 1968, for the present fiscal year and the next three fiscal years, in order to enable nonprofit private entities to meet the cost of essential projects for the modernization of private nonprofit hospitals in the District of Columbia, and also the cost of construction or modernization of long-term care facilities, diagnostic or treatment centers, outpatient facilities, rehabilitation facilities, facilities for the mentally retarded, and community health centers here in the Nation's capital.

Public Law 90-457, referred to above, was designed to meet the needs for such facilities as they appeared to be needed three years ago. This Act provided authorization for funds, not in excess of \$40,052,000 in the aggregate, to enable the Secretary of Health, Education, and Welfare to make grants to assist in meeting the costs of these facilities, not in excess of 66 $\frac{2}{3}$ percent of such costs in certain types of projects and 50 percent of the cost in others. Also, the Secretary was authorized to make loans to assist the institutions in meeting the remaining costs of such projects . . . that is, the part of such costs not covered by the grants themselves. These loans are at 2.5 percent interest, and are repayable over a period not exceeding 50 years, starting when the projects themselves are completed.

The entire amount authorized for these grants, the total of \$40,052,000, has been allocated and approved by the Secretary of HEW, as well as \$40,575,000 in loans as authorized. This sum of \$80,627,000 is being used, or is to be used, in projects involving nine hospitals and medical centers in the District of Columbia. These are Cafritz Memorial, Columbia Hospital for Women, Providence, Sibley

Memorial, George Washington, Georgetown, Rogers Memorial, Washington Hospital Center, and Children's Hospital.

Unfortunately, however, the grants and loans under the authority of this Act are completely allocated, and the need for still further facilities in this essential field, I am advised, remains unfilled.

In view of this situation, H.R. 11628 has been introduced for the purpose of extending this humane program for a period of four additional fiscal years. The total amount appropriated during the entire four-year period, however, cannot exceed \$70 million.

The same limitation as to the percentage of costs which these grants may cover is provided in H.R. 11628 as prevailed in the Act of 1968 . . . that is, 66 $\frac{2}{3}$ percent in some types of projects and 50 percent in others.

However, H.R. 11628 does not authorize loans to the institutions to aid in the financing of the balance of the costs involved in these projects, as did Public Law 90-457. Instead, it provides a system of loan guarantees and interest subsidies, whereby the Secretary of HEW may assist the qualified entities in financing the remainder of these costs through loans from non-Federal lenders. I shall not take the time of the Subcommittee to explain the somewhat complex details of this provision of the bill, but I do wish to state that I am assured that the interests of the Federal government in this connection are thoroughly protected.

Mr. Chairman, inasmuch as we have a lengthy list of distinguished witnesses here this morning, I shall defer to them as we all are greatly interested in hearing their testimony. Suffice it to say, therefore, that I and my colleagues who also cosponsored this important legislation are convinced that a further need exists for the completion and extension of the construction and modernization of these badly needed medical facilities, and that we must proceed to assure the funding necessary for this purpose.

STATEMENT OF THE REVEREND T. BYRON COLLINS, S.J., CHAIRMAN, TRUSTEE PLANNING COMMITTEE, AND WILLIAM M. BUCHER, VICE PRESIDENT AND DIRECTOR, HOSPITAL COUNCIL OF THE NATIONAL CAPITAL PLANNING AREA, INC.

Fr. COLLINS. Thank you, Mr. Chairman.

With Mr. Bucher and myself are a panel from the hospitals of the District of Columbia. We would like to add to the record their statements and exhibits, if it would meet your pleasure.

Mr. STUCKEY. If there are no objections they will be entered into the record at this point, and I also have been advised that there are several co-sponsors of this proposed legislation who are unable to be here with us today, and they desire to file a statement in support of the bill, so without objection, their statements will be also included in the record.

Fr. COLLINS. We will be very brief, Mr. Stuckey.

The program we offer for your consideration and the members of your committee is to present the basic needs for the continuation of this legislation a very brief synoptic outline of what each of the hospitals would do and then be at the pleasure of the committee's questions.

The purpose of this legislation is to continue to authorize grants and loan interest subsidies for construction and modernization of hospitals,

and other medical facilities. The reason we ask this public law 90-457 is because the first law recognized it was to do a phased approach for the private non-profit hospitals in the District of Columbia in their meeting the needs of the metropolitan area. I would like at this time to request also the former testimony of the Secretary of HEW, the former Secretary of HEW and the District of Columbia Government and the prior Bill be introduced if this would meet your pleasure.

This particular bill has as its purpose, as I said, the continuation of a program that is underway. The basic question is in terms of why should the private hospitals of the District of Columbia come to the Federal Government for necessary assistance and the answer is very simple, if we were in Georgia, if we were in Virginia, if we were in Minnesota and any of the other states, we would be able to come to our State Legislature and ask for support, for necessary support to complement the Federal support. Here we are pleased to have you be our State Legislature, and it is under this aspect that we come to you.

Mr. STUCKEY. Thank you for the devotion, Father.

(Laughter.)

Fr. COLLINS. The second reason is that the Hill-Burton formula, the Federal formula, as it applies to the District of Columbia has a built in inequity that the Secretary of HEW has recognized. The District of Columbia is an anomaly in the sense that it is a city, a county, and a state. The formula of Hill-Burton applied to this complexity works an inequity to the hospitals of the District of Columbia, recognized by the Health, Education and Welfare Secretary. That is the second reason.

In this particular bill there is a change from the prior bill. The prior bill had a grant program and a direct federal loan program. To make this bill consistent with the national legislation, at the request of the Secretary's office, this bill has been changed so that the grant portion does remain, but in place of a direct federal loan, this bill provides an interest subsidy, placing the responsibility on each of the hospitals to raise or borrow the funds to match the federal grants, and if they borrow the funds, they would receive half in the Hill-Burton program a three percent subsidy towards the interest cost on it. That is a change at the request of the Secretary's office. The need for this is extremely critical.

In the first place under Public Law 90-457, we started three projects that were recognized by the Secretary's office as partially funded from the first Bill. These three projects are in construction, under construction. This Bill is, from our point of view, extremely urgent, because the funds necessary to complete these projects depend upon this Bill.

I think these are the basic arguments and reasons why we are here. I would ask Mr. Bucher to give a quick record on what the prior Bill did, in terms of achievement.

Mr. BUCHER. Mr. Chairman, the Public Law 90-457, in brief, has accomplished the first phase of a most critical backlog need, specifically the Roger's Memorial and Children's Hospital construction programs have been initiated. Therefore, programming to eliminate nonconforming facilities has been started.

Another priority met is the construction of a three-hundred bed extended care facility at the Washington Hospital Center. Projects then under way at the Georgetown and George Washington University Medical Centers, as a part of their clinical studies, have been com-

pleted. Funds to effect the necessary consultation and planning were provided for the Cafritz Memorial Hospital, the Columbia Hospital for Women, Providence Hospital and Sibley Memorial Hospital. The attached exhibit which I would like to have in the record entitled Project Exhibit Detail on the Columbia Medical Facilities Act of 1968, further spells out in detail the projects, their purpose and the dollar allocation to those projects.

Mr. STUCKEY. If there are no objections, they will be included.
(The document referred to follows:)

H.R. 11628

BACKGROUND INFORMATION ON BEHALF OF THE HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA, INC.

SECTION I—LEGISLATIVE SUMMARY OF PUBLIC LAW 90-457

Purpose: To authorize project grants and loans for construction and modernization of hospitals and other medical center facilities in the District of Columbia, to correct an eight year backlog of demand caused by Federal legislative inequities in the Federal Health Facilities Acts as they apply to the District of Columbia, and to provide a program to meet these needs in the most effective, economical manner.

Grant need.—1968 and subsequent annual Federal Legislation for construction of such facilities in the District of Columbia amounts to \$441,619 which is to be compared to a demonstrated researched and phased need of \$40,052,000 of grants-in-aid. Prior legislation (Washington Hospital Center Act) sets specific precedent for special assistance to the District of Columbia and such grant-in-aid programs.

Loans need—matching requirements.—The demonstrated inability of private local resources to provide the necessary matching requirements because of the lack of area industry and the transient nature of Washington area population requires the majority of the matching funds to be borrowed in order that this backlog program could start within a reasonable time.

The high interest rates made it infeasible to borrow money on private market without raising hospital charges to an unreasonably high rate.

Therefore, the matching requirement of \$40,575,000 in repayable loans was supplied by long term, low rate Federal borrowing as a method comparable to that offered by other states, counties, and cities by their bonds and loan programs and also comparable to other Federal programs in education and housing.

Special emphasis.—In setting a course of priorities to resolve problems of unacceptable facilities, a two phase format of criteria was developed to assure initiation of certain projects and the resolution of noted problem areas. The use of trend and other patient usage data denoted the need for a dynamic and critical approach to meeting the community needs with the use of low cost extended care facilities within the existing hospital and medical center complexes in addition to the replacement of outmoded, uneconomical and inefficient facilities. The special emphasis was provided as an inducement to initiate the programs and community services and included matching fund ratios of 50 per centum for modernization and 66⅔ per centum for extended care and other low cost facilities.

The second phase was held in abeyance and included the problems, priorities and criteria which is noted within the HR 11628 legislation justification.

Accomplishment.—Public Law 90-457 has accomplished the first phase of the most critical backlog need. Specifically, the Rogers Memorial and Children's Hospitals construction programs have been initiated. Therefore, programming to eliminate non conforming facilities has been started. Another priority met is the construction of a 300 bed extended care facility at the Washington Hospital Center. Projects then underway at the Georgetown and George Washington University Medical Centers as part of their clinical facilities have been completed. Funds to effect the necessary consultation and planning were provided for the Cafritz Memorial Hospital, Columbia Hospital for Women, Providence Hospital, and Sibley Memorial Hospital. The attached exhibit shows the schedule of funds for achieving this community program.

Loans.—As the special Federal aid previously given for construction of District medical facilities indicates, the Hill-Burton, mental retardation, and mental health center construction programs provide only a partial answer to the problem of financing the construction of such facilities in the District. Sponsors

of projects for such construction in the District of Columbia experienced serious difficulty in raising the non-Federal share of the cost thereof.

Nonprofit medical facility groups seeking contributions in Washington do not have available to them the important support from corporate gifts which is available in other communities. Corporate gifts often make up from 60 to 70 percent of the total private funds subscribed for constructing hospitals in cities the size of the District; and more than half of these corporate gifts come from manufacturing corporations. The District, however, has only about 14 percent of the per capita potential of metropolitan areas of comparable population for receiving contributions from manufacturing corporations.

Another reason for the difficulty experienced by project sponsors in the District in securing funds to meet the non-Federal share of the cost of constructing hospitals and other medical facilities is that, although the average income here is among the highest in the country, a large proportion of those on the upper part of the income scale are temporary residents who do not feel an obligation to support capital improvement drives to the same extent that permanent residents here or elsewhere do, or indeed, to the extent that these same temporary Washington residents feel in relation to their "home" communities. This factor has made it impossible to raise money for these facilities in the amounts which might be expected if the average income alone were used as a guide.

A unique medical facility utilization and construction problem exists in the District because of the large number of patients from other "States" who occupy general hospital beds in the District. Approximately 40 percent of the patients in District hospitals come from outside the District, primarily from the Maryland and Virginia counties in the metropolitan area. These areas are considered as part of the impact of the Federal Government concentration in this metropolitan area and is an additional reason for special aid to the D.C. hospitals and medical center.

The need for Federal aid is most acute in the case of long-term care facilities. The lack of private fund-raising potential for construction of these facilities is even more pronounced than in the case of short-term facilities—as demonstrated by the fact that the District has been unable to use much of the money available to it under the Hill-Burton program for construction of long-term care facilities due to inability to raise the required matching funds.

For the reason cited above, special Federal assistance for the modernization of hospitals and the construction or modernization of other medical facilities in the District of Columbia clearly required to make up for the loss of normal private sources of support caused by the presence of the Federal Government in the District. It was necessary to have the direct Federal loans at a low rate of interest on a long-term basis if these pressing needs were to be constructed.

Historic background.—This legislation represented an eight-year accumulation of individual and collective efforts of these health care institutions to meet the expressed and researched community needs. Area-wide regional planning concepts as well as the endorsement of these plans has been accomplished. The legislation requires that each project submitted meet the community facility plans and those of the Secretary of HEW. This process is a continuous one for each of the grant and loan requests. All projects funded have approval of the planning agencies.

Role of Federal Government as a State-county government for the District of Columbia.—In local city, county, and state jurisdictions throughout the country, financial assistance to meet matching funds is forthcoming from the government itself in addition to individual and industrial contributions. The direct Federal loan program was equivalent to the bond issues in other jurisdictions. Because of the uniqueness of the Nation's capital where upwards of 70 percent of the population is employed by the United States Government or by its supportive service industries, no such possibility existed.

HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA, INC.,
Washington, D.C., November 11, 1971.

PUBLIC LAW 90-457: PROJECT DETAIL ON DISTRICT OF COLUMBIA
MEDICAL FACILITIES ACT OF 1968

(Prepared by William M. Bucher)

There are five construction and four planning projects involved within the priority program established, as follows:

APPROPRIATION ALLOTMENT

	Grant	Direct Federal loan	Total
A. CONSTRUCTION PROJECTS			
1. Children's Hospital of the District of Columbia..... The Children's Hospital has received approval from area health advisory groups, encouragement from Government and counsel from consultants to move from its present nonconforming uneconomical building complex to the grounds of the Washington Hospital Center. Within its 1st phase, it is in process of constructing the replacement of its existing beds and support facilities. The 2d phase is to provide for the completion of space for its outpatient diagnostic, treatment, and research areas and its pediatric mental health section.	\$13,399,579	\$13,399,579	\$26,799,158
2. Georgetown University Medical Center..... As an essential part of its community responsibility to supply medical personnel fully trained and experienced as well as its responsibility to provide services for the community, the Georgetown University Medical Center embarked upon a multiphase construction program. The 4 projects involved are constructionwise nearly completed and include a diagnostic treatment facility with special emphasis for services to mentally retarded children, a new outpatient facility for dental services and modernization and expansion of the antiquated basic clinical-science service facility. These facilities, together with the central utilities system required have been completed. The equipment and instrumentation phase will be completed upon receipt of the fiscal 1972 funding.	6,189,000	11,080,000	17,269,000
3. George Washington University Medical Center..... In order to attempt to meet in a phased program the service requirements of both its in and outpatient public, as well as to attempt to meet continuously growing needs of the emergency service as an intown hospital, the George Washington University Medical Center embarked upon programs of significant size and cost in 3 areas. It enlarged its emergency room facility and expanded the necessary supportive services. A modernization and equipment updating of diagnostic and treatment areas within the hospital such as the heart station and intensive care units took place. It purchased and renovated the multistory Keystone apartment building adjacent to its medical center to offer comprehensive outpatient diagnostic and treatment services under a physician-team service program.	4,064,000	4,976,842	9,040,842
4. Rogers Memorial Hospital (formerly Casualty)..... The family physician to a large low-income center city population, as well as the emergency station for a large area, the Rogers Memorial Hospital has the responsibility to modernize and enlarge its emergency, outpatient and supportive service to the inner city. Its project received priority approval and includes such areas as physiotherapy, electroencephalography, coronary care, medical and surgical intensive care, as well as the emergency and clinic areas. A 2d high-priority project under development provides for eliminating 72 nonconforming beds, and modernization and extension of ancillary services. This 1st phase is under construction.	6,510,000	6,510,000	13,020,000
5. Washington Hospital Center..... 1 of the 10 busiest hospitals in the Nation with a board of trustee commitment to accept the community responsibility of a 300-bed extended care facility, the Washington Hospital Center will have completed its planning during the current year and arrived at a position of bids early within the fiscal 1971 year. It will also have completed the installation of an emergency generator system which will provide essential standby electrical power under this legislation. The provision of the fiscal 1972 funding budgetary authority will permit the orderly progression of planning, bidding, and construction of these high priority projects.	7,889,421	4,608,699	12,498,000
B. PLANNING PROJECTS			
1. Cafritz Memorial Hospital.....	500,000		500,000
2. Columbia Hospital for Women..... A health facility specializing in obstetrics and gynecology, the Columbia Hospital for Women must program the complete replacement of its antiquated facility.	500,000		500,000
3. Providence Hospital..... A general acute care hospital servicing the far northeast, Providence Hospital must bring its ancillary and service facilities up to date to maintain local and national accreditation standards and to provide the necessary support programs.	500,000		500,000
4. Sibley Memorial Hospital..... A general acute care hospital requiring substantial modernization of its limited basic support service areas and its professional diagnostic and treatment and business service areas in order to meet required minimal standards and to achieve a more economical and efficient plant.	500,000		500,000

Fr. COLLINS. Next I would like the permission of the Chairman to briefly state what each of these projects would do, ask the cognizant member of the Board of representative of the hospital to stand, give his name, and then I would take the next one and do the same and then at the end, if there are any questions on the specific elements of the total program, Mr. Bucher and I would respond, anything specifically would ask the representative to respond, if this would meet your pleasure.

Mr. STUCKEY. Would you like for the Panel of the District of Columbia Representative to come up and join you?

Fr. COLLINS. They are all here Mr. Chairman.

The first integrated program is Cafritz Memorial Hospital which is to provide a new ambulatory and family care center as well as to provide for the expansion of necessary diagnostic and ambulatory support services, the funds estimated at this time are listed, the review of the project has started. It has to have the area-wide planning review and approval as well as the District of Columbia Advisory Council.

The representative for Cafritz is Mr. McDonough.

Mr. McDONOUGH. I am Raymond J. McDonough, President of the Board, sir. I should like to present the following statement.

(The document referred to follows:)

THE MORRIS CAFRITZ MEMORIAL HOSPITAL POSITION STATEMENT ON EXPANSION AND MODERNIZATION PLANS IN SUPPORT OF EXTENSION AND FUNDING OF PUBLIC LAW 90-457

Since opening The Morris Cafritz Memorial Hospital in April 1966 this 418 bed acute general hospital has provided health care services to 84,461 inpatients, and to 259,807 emergency and outpatients. Federal funding under the Hospital Center Act and under Hill-Burton provided \$4,595,000 of the approximate \$11 million required to open the Hospital.

Regrettably, planning for this new hospital in the early 1960's did not foresee the current need for vastly expanded outpatient facilities. We now wish to return to Congress, in concert with other hospitals of the District of Columbia, in support of the effort to obtain needed funds to provide adequate health care facilities for patients both from the District and from surrounding States.

Long range plans for our hospital have been under development over the past two years. The health care needs of the community served by Cafritz have been carefully analyzed by our planning consultants. Their recommendation to develop an ambulatory care and clinical practice center, to expand emergency and outpatient areas, to expand our diagnostic and treatment capabilities, to provide expanded educational facilities for both medical and paramedical personnel, and to provide adequate support services for these enlarged programs has been approved by the Board of Trustees of the Hospital.

These plans respond to the Program Goals and Policies of the District of Columbia Plan for the Construction and Modernization of Hospitals, Public Health Centers and Medical Facilities—1971-1972, just published. On page 49 this document states, "one of the most important aspects of health planning at this time is the provision of adequate and properly located services for ambulatory patients."

When Cafritz Hospital opened in 1966 facilities were provided for limited outpatient services and what was felt to be adequate space for the care of emergency patients. Visits to the Emergency Department have increased from 80 per day in 1968 to over 200 per day with an expected further increase to 300 per day. The space currently available for emergency, walk-in and appointment visits is woefully inadequate. Expansion of waiting room space, processing areas and treatment areas is needed promptly.

At present representatives of our immediate community have entered suit against us charging a failure to provide adequate outpatient services. Primarily our expansion plans are to provide facilities which will allow us to care for 120,000 patient visits per year as we work closely with the D.C. Department of

Health and their plans for Neighborhood Health Centers and the bi-level Health System.

During the past several months Cafritz Hospital has established residency and fellowship affiliated programs with University and Walter Reed Medical Centers. Currently twelve residents and fellows are on rotation at Cafritz. Allocation of space for education and training is a new but pressing need.

Specifically then, The Morris Cafritz Memorial Hospital requests grant and loan funds to accomplish the following:

1. To remodel and expand the chassis of the present hospital to enlarge emergency and special outpatient care capabilities, to provide expanded diagnostic and treatment facilities, and to provide adequate support services.

2. To develop an ambulatory care and clinical practice center in order to become increasingly responsive to the health care needs of our community, particularly the Southeast D. C. sector.

3. To remodel existing acute care nursing units to permit more efficient patient care and to provide improved food service to patients.

4. To expand the existing effort in educating paramedical personnel including physician assistants and extend our residency training programs in the major specialties including Family Care.

We anticipate that these plans will vastly improve the availability of primary health care to the 151,000 people who live within a two mile radius of the Hospital, and at the same time will upgrade secondary health care to the entire community served by the Hospital.

November 8, 1971.

Fr. COLLINS. Next is Children's National Medical Center, who request provision for the completion of its program of construction commenced under Public Law 90-457, inclusive of Specialty Pediatric Facilities or Mental Health. This particular project is one of the most critical of our needs, since this actually is under construction and the authorizations here are necessary to accomplish its totality.

The representative is Mr. Werble.

Mr. WERBLE. I am Wallace Werble, member of the Board and former President, and I wish to present a statement on behalf of Children's National Medical Center.

(The document referred to follows:)

DISTRICT OF COLUMBIA MEDICAL FACILITIES ACT OF 1972, CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER

Children's Hospital National Medical Center strongly urges establishment of the D.C. Medical Facilities Act of 1972. The previous Public Law 90-457 enabled us to begin the urgently needed replacement of existing Children's Hospital facilities. Enactment of a new Act is vital to our completing a children's medical and health center as a national and a metropolitan area resource. Under the new Act Children's Hospital National Medical Center would request \$12.4 million in grant funds and \$12.4 million in interest-subsidized loans to complete the programmed construction for replacing the existing hospital and to include facilities for mental health and hearing and speech diagnosis and treatment.

Previous funding was sufficient for a limited but viable portion of the new facilities. Additional funding as requested would create a well-rounded center which would meet all anticipated needs for many years to come.

The major components of the project summarized are:

1. Replace existing facilities with modern resources for children who need to be in the Hospital.

2. Develop ambulatory clinical service facilities in which comprehensive and coordinated care will be provided.

3. Provide expanded facilities for clinical experience with children, receiving hospital and ambulatory care, for students of affiliated medical and nursing schools and other associated schools preparing students in such related disciplines as social work, laboratory, X-ray technicians, etc.

4. Maintain and develop the research program which is focused on the solution of clinical problems of children.

5. Continue development and delivery of services concerned with mental health of children and hearing and speech problems of children.

6. Identify and develop the clinical specialties which will assure that all children can have access to modern medical services.

(Examples currently under development are Children's Physical Medicine and Rehabilitation Service, Children's Orthopedic Service, and Children's Neurosurgical Service.)

7. Continue postgraduate and continuing education programs for physicians.

The planning has taken into account economics of operation made possible by this modernizing and this relocation to land provided by the Washington Hospital Center.

Priority approval has been received for the program and services in the following plans: the District of Columbia Plan for the Construction, Modernization of Hospitals, Public Health Centers and Medical Facilities; the Health Facilities Planning Council for Metropolitan Washington, D.C.; the Government of the District of Columbia and other public and private agencies.

At present the new facilities are under construction with completion expected in the spring of 1974. To date funds have been committed for over \$9 million of work, \$4 million of planning and construction are already in place and final design of the project is nearing completion. The funds requested by this Act are needed to complete construction of the Children's Hospital National Medical Center as programmed above.

Fr. COLLINS. The project for Columbia Hospital for Women is to provide for the replacement of its existing, and I will use the word, hospital, and permit for reasonable options for expanding, together with the specialized services it necessarily performs for the District of Columbia and the entire metropolitan area.

Mr. SCHEURER. Donald P. Scheurer, administrator, representing the President of the Hospital and file the following statement.

(The document referred to follows:)

**JUSTIFICATION FOR CONSTRUCTION GRANT AND LOAN FUNDS UNDER
DISTRICT OF COLUMBIA MEDICAL FACILITIES ACT OF 1972**

(By: D. B. Scheurer, Administrator, Columbia Hospital for women,
Washington, D.C.)

FACILITIES PROJECTION	
Grant.....	\$4,000,000
Loan.....	4,500,000
Hospital funds.....	2,152,000
Total.....	10,652,000
Justification increase in patient capacity: ¹	
Outpatient increase (facilities).....	7,092
Outpatient visits plus emergency room OP 4,492 plus ER 200.....	2,400
High risk followup clinic visits (pediatrics).....	1,482
Inpatient (patient-days):	
Increase, adults.....	1,778
Decrease, infants.....	

¹ Justification for replacement facility is not based upon increased patient services. See program explanation, pp. 3-4

**COMPLETION OF REPLACEMENT FACILITY PROJECTED FOR APRIL 1976/PATIENT STATISTICS THROUGH
DECEMBER 1975**

	Actual through 1970	Projected through 1975	Increase (decrease)
Outpatient visits.....	13,508	18,000	4,492
Emergency room visits.....	2,150	2,350	200
High risk followup clinic visits (pediatrics).....	0	2,400	2,400
Total.....	15,658	22,750	7,092
Inpatients:			
Adults.....	44,066	45,548	1,482
Infants.....	20,482	18,704	(1,778)
Total adults and infants.....	64,548	64,252	(296)

Note: Inpatient decreases are projected on the basis of an anticipated reduction in length of stay for the adult patient from 3.6 in 1970 to 3.4 in 1975 and to anticipated decline in birth rate.

ANALYSIS OF SERVICE

	Adults	Infants	Total
Inpatient days (most current annual period) (calendar year ending 1970):			
District of Columbia.....	22, 474	9, 829	32, 303
Non-District of Columbia.....	21, 592	10, 653	32, 245
Total.....	44, 066	20, 482	64, 548
Projection (inpatient days total 64,252 (calendar year ending 1975):			
District of Columbia.....	28, 140	11, 471	39, 611
Non-District of Columbia.....	17, 408	7, 233	24, 641
Total.....	45, 548	18, 704	64, 252

OUTPATIENT TOTAL PLUS EMERGENCY ROOM

	High-risk pediatrics	Outpatient	Emergency	Total
District of Columbia.....	1, 440	16, 912	1, 996	20, 348
Non-District of Columbia.....	960	1, 088	354	2, 402
Total.....	2, 400	18, 000	2, 350	22, 750

Note: Date when it is estimated facility will be in operation to achieve the above increase is April 1976.

Adult admissions through 1975 are expected to be 13,300, an estimated increase of 1,066 over 1970 admissions of 12,234. However, patient-days are expected to decrease due to reduced length of stay of the adult patient from 3.6 days in 1970 to 3.4 days by year ending 1975. This anticipated reduction in patient stay is attributable to advancements in medicine, technological improvements, and outpatient minor surgery "in and out" procedure permitting the patient to enter and leave the hospital on the same day. As a result of improved birth control, broadened abortion laws, and the uncertain economy, decline in births is expected to occur during projection period of this analysis.

BAD DEBTS AND ALLOWANCES FOR CALENDAR YEAR ENDING 1970

Total.....	\$747, 401
District of Columbia.....	689, 154
Non-District of Columbia.....	58, 247
Subdivision of above:	
Provision for uncollectible accounts.....	204, 484
Charity—Staff patients.....	163, 607
Contractual adjustments:	
Blue Cross.....	184, 296
District of Columbia Medical Assistance Division.....	88, 225
House of Mercy.....	13, 176
Health and Welfare Council.....	2, 684
Medicare.....	10, 705
Medicaid.....	76, 264
Clinic—Radiology.....	3, 519
Discounts.....	441
Total.....	747, 401

PROGRAM EXPLANATION

Columbia Hospital serves a dual role of service to D.C. residents and, due to its specialization, to the Metropolitan Area as a whole. Ninety-two percent of the patients receiving outpatient care are from the District of Columbia, mostly from the inner city, and while its inpatients come from the entire Metropolitan region, the proportion of District to non-District residents is increasing from 36% in 1966 to 51% in 1970 and is estimated to reach 60% by 1975.

The cost of free services to the medically indigent accounts for more than 20% of the total patient overall services rendered.

The development of the existing building, occupied in 1916, and expanded in 1959, has been of an episodic nature to meet changing needs as they arose, and of necessity to date, most development has been confined to internal modification and reorganization. But modification alone can no longer accommodate the continually increasing demand and need for services, and provision for the comprehensive and long-range needs of the hospital cannot be made. Today, Columbia Hospital for Women is a 153-bed acute care hospital specializing in the field of obstetrics and gynecology, with 83 bassinets, and an outpatient clinic consisting of eight examining and treatment rooms.

The Hospital has continued to maintain the highest standards of medical care with the most advanced techniques within aging structures originally designed for services and techniques appropriate to their times but now greatly changed. Much has been done over the years to renovate, improve and increase service capability, patient comfort and safety. Outpatient surgery and outpatient clinics have been expanded to meet community needs. While increasing ambulatory serv-

ices, the Hospital imposed additional burdens on already limited support areas capability. Outstanding among these latter are Central Sterile Supply, Bulk Storage, Linen Exchange, Housekeeping, and the Diagnostic Services of Radiology and Laboratory. In these areas, internal reorganization for greater utilization and operational efficiency is not feasible and even if it were would not, in itself, answer the need. The problem is that these support areas require additional space. The magnitude of this space problem is suggested by a comparison between this Hospital and studies that have been made of departmental area requirements for hospitals of similar size and function by such organizations as the U.S. Public Health Service, the American Hospital Association, the American Institute of Architects, and independent hospital consultants. These studies indicate that facilities at Columbia are from 25% to 35% below the norm for comparable institutions.

Nearly all of the Hospital's mechanical, electrical and vertical transportation services other than those modernized in the latest modifications are in need of replacement due to age or insufficient capacity to meet modern demands or standards.

Inadequate area, inefficiently related space, structural configuration, and the obsolescence of the mechanical and electrical systems combine to leave no point of departure for further modification and expansion of magnitude required to overcome the deficiencies in area and systems. Limited expansion capability would further seriously compromise the program envisioned by Columbia's intention toward greater affiliation with local medical schools for the purpose of providing an improved teaching environment in obstetrics, gynecology and pediatrics. Any alternative expansion scheme predicated upon retention of this building would have to accept functional and uneconomical compromise of present requirements, minimal options for future growth, extreme disruption of hospital services during construction, and high renovation costs due to the condition of the buildings and inefficient phasing required to keep the existing plant in operation during renovation. *Total replacement of the existing hospital is the only reasonable and justifiable alternative.*

Columbia Hospital for Women planning budget

		153-Bed Replacement @ 900 S.F./Bed	
A. Construction+Group I.....	137,700 S.F.×\$45=	\$6, 197, 000	
B. Parking	300 cars @ \$3000=	900, 000	
C. Site Development.....		300, 000	
D. Demolition		110, 000	
E. Total		7, 507, 000	
F. Contingencies (5%).....		375, 000	
G. Total		7, 882, 000	
H. Escalation (2 years @ 6%).....		946, 000	
I. Total Construction.....		8, 828, 000	
J. Professional and other Fees.....		724, 000	
K. Groups II & III Equipment.....		1, 100, 000	
L. Total Project Cost.....		10, 652, 000	

Columbia Hospital for Women, Calendar Year 1970

GHI cost per diem : ¹	
Adults:	
Non-OB	\$75. 73
OB	84. 05
Average	79. 40
Infants	35. 89
GHI charges per diem ¹	80. 92
Medicaid per diem cost:	
Adults	87. 40
Infants	40. 62
Medicaid charges per diem.....	90. 84
Audited patient day cost.....	89. 41
Total operating expenses.....	5, 193, 133
Date of Audit.....	December 31, 1970

¹ Does not include Medical Service Items.

Fr. COLLINS. George Washington University Medical Center's program is to provide for further expansion of radiological facilities, modernization of elevators and the addition to their major ambulatory care center. Their representative is Dr. Parks.

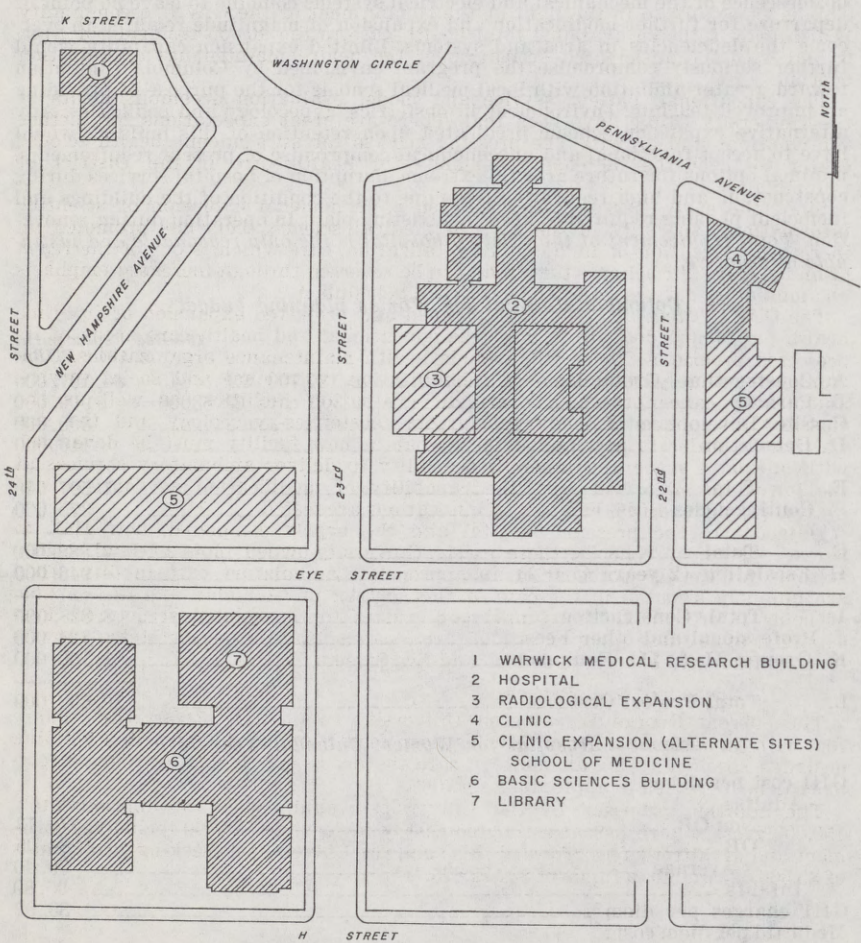
Dr. PARKS. John Parks, Dean of the Medical Center. I have a statement.

(The document referred to follows:)

APPLICATION FOR CONSTRUCTION, GRANT AND LOAN FUNDS UNDER
RE-AUTHORIZATION OF PUBLIC LAW 90-457

THE GEORGE WASHINGTON UNIVERSITY
MEDICAL CENTER SITE PLAN

NOVEMBER, 1971



PROJECT NO. 1—THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

*Program for Growth of Ambulatory Medical Care**I. Description*

From a modest beginning in 1825, the G.W.U. Medical Center has become one of the Nation's outstanding medical resources. This preeminence has been achieved through the efforts of its School of Medicine, its University Hospital, and more recently through its ambulatory facility, the G.W.U. Clinic.

Approximately 15 years ago, the G.W.U. Medical Center saw the need to evolve a different medical care delivery system. Thus, in 1967, after extensive planning, the establishment of the G.W.U. Clinic brought to fruition the concept of a full-time faculty group practice program. Since 1968, the full-time clinical faculty has been housed in the Burns Building, a renovated apartment house adjacent to the Hospital—a facility which, due to its rapid growth, is becoming inadequate for its full-time physician staff of 75 and support services and personnel. Hence, the unit must be expanded to meet tomorrow's needs and challenges. This is especially so in the light of the commitment of the G.W.U.'s community health team to make available total health care to the 40,000 residents of Area 9, and with the anticipated activation of the health maintenance organization concept.

The educational, patient service and model evaluation accomplishments of the University Clinic have been real. There are great expectations for further contributions and growth. The pressing need is for an academic health science center to meet the increasing demands for health care in the District of Columbia.

Since the early 1940's, there has been a phenomenal explosion of scientific information, especially in the area of medical science. This has promoted an increased utilization of high-cost hospitalization, care which is out of the reach of many. Our staff believes this trend can be reversed through increased emphasis on ambulatory care as set forth in attached Schedule A.

The G.W.U. Medical Center has planned and projected expansion of full-time health personnel adequate to meet the educational and health care needs of its projected programs. These will include health maintenance organizations, community psychiatry, expansion of rehabilitation, vocational and social service, ambulatory cancer therapy, overnight evaluation facilities, as well as the classical disciplines of medicine, surgery, obstetrics-gynecology and the specialties. In order to accomplish these goals a new facility must be developed, with adequate space and inherent flexibility to deliver ambulatory services at the lowest possible cost with the capability of modification as concepts are evaluated and modified, and as new innovations are tested.

Adjacent to the present Hospital and the nearly completed, new Hall of Science (Medical School), there exists University-owned plots of land, highly suitable for the development of an appropriate ambulatory care facility. They are uniquely situated in the core of the District of Columbia and are capable of being interconnected by tunnels or bridges to the related structures. Fortunately, also, these plots of ground are located near the major Metro subway terminal that will be located at 23rd and Eye Streets, N.W.

II. Space and Cost Estimate

The current George Washington University Clinic has 95,000 gross square feet with an assignable net of 54,000 square feet. It is hoped that with a building designed specifically for ambulatory care the net assignable ratio to gross footage can be increased to approximately 70%.

The addition proposed by the University would consist of approximately 150,000 gross square feet at estimated cost of at least \$8,533,500 including equipment and architect's fees. Toward this sum, the University is seeking grant funds of \$5,360,625 and loan funds of \$3,172,875.

SCHEDULE A.—UTILIZATION OF AMBULATORY FACILITIES AT GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

Year	Emergency room visits					Clinic visits				
	Patient source				Total	Patient source				Total
	District of Columbia		Other			District of Columbia		Other		
	Number	Percent	Number	Percent		Number	Percent	Number	Percent	
1967	16,100	70	6,900	30	22,941	15,680	49	16,320	51	32,000
1970	23,106	70	9,900	30	32,871	46,550	49	48,450	51	95,000
1975 (estimated)	29,400	70	12,600	30	42,000	89,180	49	92,820	51	182,000
1980 (estimated)	31,500	70	13,500	30	45,000	122,500	49	127,500	51	250,000

NOVEMBER 1971.

PROJECT NO. 2—THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

*Expansion of Diagnostic and Treatment Radiological Facilities**I. Description*

During the early and mid-sixties, the George Washington University Hospital undertook a major expansion and remodeling program. However, due to fund limitations, several compromises had to be made. One of these was the minimal expansion of the Department of Radiology, a facility which has become grossly inadequate. The major thrust of this request is for assistance to provide a new diagnostic and treatment X-ray Department which will utilize present facilities to the maximum degree possible.

The Hospital's present admitting and diagnostic testing facilities, located on the first floor, also, are inadequate. Entrance and exit to the Hospital are not at street level and are very difficult for the infirm and wheel-chair patients. Thus, it is planned to update and relocate these facilities at the street level. Also, as a part of the admitting procedure, an area is planned where the patient's admitting diagnostic procedures may be taken in the most convenient manner for the patient without delays that add to the length of the hospital stay.

New leadership in the Department of Radiology and increased full-time faculty have led to the development of a dynamic department to provide diagnostic and treatment services not previously available. These procedures will greatly enhance the patient care and services rendered by the G.W.U. Hospital. Within the past year, major additions to the teaching faculty also have been made in Gastroenterology, Neurosurgery, Pulmonary Medicine and Urology. Each of these specialties will be a major consumer of modern radiologic modalities, and it is anticipated that the demand for Radiologists, as a key individual in patient management will continue to grow.

II. Scope of Project

The projected program is to construct a two level addition to the University Hospital in the vacant area at the present 23rd Street entrance. This will permit the development of a mass of space for an expanded centralized diagnostic and treatment facility for the Department of Radiology which will encompass the present department and incorporate into it the present radiology offices and radioisotope division which are scattered throughout the Hospital. Included in this project will be the relocation of the admitting and business functions so as to provide an efficient and economical patient flow.

The redevelopment and expansion of the Radiology Department has become necessary to:

- Accommodate the increased volume of patients as projected in attached Schedule C.
- Offer treatment and diagnostic services not previously available.
- Provide improved training programs for interns, residents and medical students.
- Provide facilities in which a training program for x-ray technicians can be developed. This will provide urgently needed paramedical personnel to the community.

e. Aid in the recruitment of talented full-time radiographic subspecialists which will enhance patient care and the training programs of other physicians and medical students.

Expansion and equipment needs are based upon the following growth factors, plus future anticipated growth:

a. Since 1967, the total number of patients examined in the diagnostic x-ray division has risen 48%.

b. Special procedures have risen 47% since 1967.

c. Nuclear Medicine procedures have increased 60% since 1968.

d. Radiotherapy patients treated have increased from approximately 10 patients a day to the present average of 50 patients per day since 1966.

The present Radiology Department consists of approximately 11,000 square feet; our plans call for doubling its size to meet present and future needs.

Currently, slightly in excess of 50% of the procedures are for ambulatory patients and for District of Columbia residents. Increases are expected in both the ambulatory percentage and in the proportion of patients from the District.

III. Cost Estimate

The total cost of this project is estimated at \$3,531,500, towards which we are seeking \$2,071,875 in grant funds and \$1,459,625 in loan funds.

SCHEDULE C.—PAST AND PROJECTED RADIOGRAPHIC PROCEDURES, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

Year	Hospital inpatients	Emergency room	Ambulatory patients	Total diagnostic procedures	Nuclear medicine (radioisotopes)	Radiation therapy ¹	Total
1967-----	² 52, 616	(?)	(?)	52, 616	1, 993	7, 460	62, 069
1970-----	36, 398	18, 963	13, 066	68, 427	3, 003	10, 290	81, 720
1974 (projected)-----	44, 390	22, 910	16, 850	84, 150	5, 000	15, 500	104, 650
1981 (projected)-----	62, 600	30, 350	22, 250	115, 100	14, 100	17, 000	146, 200

¹ Reflects patient visits in radiation therapy.

² In 1967 and prior years ambulatory and emergency room procedures were included in the "Hospital inpatient" statistics.

NOVEMBER 1971.

PROJECT NO. 3—THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

Improvement and Modernization Program

I. Description

The purpose of the program is to modernize the 5 elevators in the University Hospital which have been in service for the past 24 years. The present equipment is difficult and expensive to maintain. It is obsolete and parts are not readily available, making service difficult. The degree and frequency of outage is frequent. With the limited number of elevators available, outage can be critical.

II. Scope of the Project

During the past two decades, the demand for vertical transportation has increased by at least 50%. The existing facilities at the G.W.U. Hospital are not able to meet today's needs. A new set of elevators has been proposed for the existing shafts—high speed, self-leveling cars which will provide more rapid service for patients, visitors and staff.

This modernization program will allow the Hospital to eliminate elevator operators at an annual saving of \$83,863.

III. Cost Estimate

The total cost of this project is \$335,000, toward which \$167,000 in grant support and \$167,500 in loan funds is sought.

SUMMARY OF COST FOR PROJECTS 1, 2 AND 3

The funds requested will be in excess of \$12.4 million, and funds will be in a ratio of \$7.6 million dollars in Grant and \$4.8 million in loan.

Fr. COLLINS. Georgetown University Medical Center is to provide for modernization and space provisions within the existing hospital, and to provide additional space for out-patient services.

The representative is Dean John Rose.

Dr. ROSE. Dean Rose.

Fr. COLLINS. With Dean Rose is the Administrator of the Hospital.

Dr. CURLY. Joseph Curly.

(Their statement for Mr. McNulty follows:)

Mr. Stuckey and Members of this Committee, I am Matthew F. McNulty, Jr., Vice President for Medical Center Affairs at Georgetown University. Georgetown University is vitally interested in the District of Columbia Medical Facilities Act of 1972, which is a re-introduction of Public Law 90-457.

The original law was enacted to provide assistance resources necessary to meet the qualitative and quantitative health needs of the District of Columbia and the metropolitan area. Resources for health construction were available to other communities from state funds, but were unavailable to Washington institutions because of the unique nature of the District. The circumstances of this unique situation were defined further in the testimony in support of H.R. 6526 and S. 1228 of 1968. Those circumstances are equally applicable today. Specifically, then this initial effort enabled the community non-profit health institutions to begin to meet those programmed health needs for which funds had once been lacking.

Georgetown's response to the enactment of 90-457 in 1968 was to remodel and expand its diagnostic and clinically oriented instructional health facilities. We built facilities to enable students, interns, residents, and clinical faculty physicians and dentists to increase their diagnostic skills. We enlarged facilities to accommodate an additional 42,500 outpatient visits per year. We constructed facilities to provide for the latest, most up-to-date information on health services and medical research—information which is not merely for Georgetown's use, but is available to the entire metropolitan area.

With these new facilities, we attracted 94 new clinical faculty members and facilitated an increase in the student clinical orientation programs. The increase from 133 full-time clinical faculty members in 1965 to 227 full-time clinical faculty members in 1971 has also allowed the Georgetown Medical Center to provide more medical manpower to the District and metropolitan area, as well as to the nation.

A necessary extension of this significant initial contribution is dependent upon the provision of additional facilities wherein the clinical skills of this talented manpower can be made available for delivery of services. Without additional space, a proper balance between education, research, and service will be lost. In this instance, by "service" we mean ambulatory care and its extensions. The availability of many nationally noted physicians presently at Georgetown University will be minimized instead of maximized for citizens of the District of Columbia metropolitan area. Therefore, part of the resources (funds) requested by Georgetown University would be used for developing a facility for expanded patient care.

The other major concern of Georgetown University deals with the critical obsolescence of Georgetown University Hospital, the treatment component of Georgetown University Medical Center. When Georgetown University Hospital was constructed in 1947, it was necessarily developed from pre-World War II concepts of such facilities. It was built without the many necessary facilities a teaching hospital requires, such as conference rooms, complex diagnostic and therapeutic facilities, and extensive laboratories. It also lacked the extensive ambulatory facilities necessary to support a practicing clinical faculty and residency teaching programs in all disciplines.

These pre-World War II construction concepts pre-dated the development of present Hill-Burton construction principles or guidelines for the adequacy of facilities of teaching hospitals. Subsequent to the 1948 Hill-Burton legislation, guidelines have become more precise in stating what meets minimum adequate requirements, for everything from workrooms to nurseries to electrical safety standards. As a matter of fact, since 1965 and the increased attention of Federal public legislation, the definitions of personnel as well as patient safety requirements have become more sophisticated and demanding.

As these standards have become more precise, the District of Columbia Public Health Department has, appropriately, included them in the licensure requirements for hospitals in the District. Similarly, the Joint Commission on Accreditation of Hospitals has, after three years of intensive study, issued an extensive revision of their own guidelines in 1971 which, in addition to the District standards, must be followed. The Georgetown University Hospital has been increasingly less able to adapt our clinical activities and service functions to the guidelines.

This is in no way to suggest that the structure of the building is not basically sound. On the contrary, planning efforts at Georgetown University Hospital have carefully balanced new construction with renovation of the present facilities. By constructing the Concentrated Care Center, now underway, to include the most technologically changed services (operating room, selected laboratories, diagnostic radiology, intensive care/concentrated care units, emergency-disaster area) and then renovating and reallocating space within the present facility, Georgetown will have developed a model for demonstrating the most economical method of upgrading a medical center.

We do have on hand, or obtainable, the funds to construct a Concentrated Care Center. We do not have available or obtainable the funds to undertake urgent needs. In order to progress, Georgetown University Hospital must undertake some specific changes and modernizations in the present hospital facilities. It is these specifics of modernization in the present Hospital which we now would like to outline for you:

The development of air conditioning and air handling systems was elementary when Georgetown University Hospital was opened in 1947. The technology in this field has become much more advanced, and so have regulations and guidelines developed by Hill Burton and licensure bodies. The relationship between effective air handling and prevention of infection has become much more specific; therefore, it will be necessary for Georgetown to completely re-do its air handling and air conditioning system, which includes air handling equipment, duct work, and controls.

The use of electrical systems in life-monitoring and life-supporting equipment has increased at a geometric rate since 1947. The increased use of such electrical equipment adds to the need to have an electrical system which will protect the safety of patients through the avoidance of micro-shock. Power must be non-interruptible. For this reason, it is essential that the utility lines and electrical systems within the Hospital be updated to permit us to respond to both the use of life-monitoring and -supporting equipment and to safety requirements.

Because of the expansion of diagnostic and therapeutic techniques and the evolution of pre-packaged materials and supplies, as well as the increased use of equipment, movement of materiel and people throughout the Hospital has shown a very marked increase. Additionally, the implementation of progressive patient care in itself entails an accelerated movement of patients from intensive through self-care units. Georgetown therefore will need to install new elevators in our present facility and automate the material-handling system to the most cost-effective level. In a labor-intensive industry, any improvement in the work flow system will assist in minimizing the escalating costs of operating health facilities. It is our objective, then, to reduce our dependence on costly labor by utilizing technology which can do the same work at a decreased expense.

To summarize, then, in the 25 years since Georgetown University Hospital was opened, medical techniques for treating illness and maintaining health have increased at a geometric rate. Consequently, for a teaching hospital that stands in the forefront in the development and implementation of these new techniques, the need is great to maintain its physical facilities at such a level that it can respond to further applications of this medical technology. Georgetown's request is therefore to renovate the vital mechanical, electrical, and other supportive systems which will permit rapid response to the changes in medical technology. It is in this way that Georgetown University can fulfill its role as a teacher, researcher, and service resource to the District of Columbia and metropolitan area.

The foregoing projects have been evaluated by engineering and architectural studies, which have demonstrated that the needs are in excess of \$16 million.

Fr. COLLINS. The Providence Hospital project is to provide essential expansion and modernization including air conditioning, elevators, extended care beds and ambulatory care facilities, and their representative is Sister Rosa.

Sister ROSA DALY. My name is Sister Rosa Daly and I have a statement.

(The document referred to follows:)

PROVIDENCE HOSPITAL

WASHINGTON, D.C.

CONSTRUCTION PROGRAM

One of the oldest hospitals in the District of Columbia, Providence was established in 1861 in southeast Washington and moved to its present site in 1956. Today it is a 390 bed acute care general hospital providing comprehensive health care through a full range of major medical and surgical services, Emergency Department and Outpatients Clinics.

Striving to be very much a part of the community, Providence has voting membership in the Northeast Coordinating Council, works on various community health programs in cooperation with Georgetown University Medical School's Department of Community Medicine, the National League of Nursing Community Planning Committee, the Visiting Nurse Association and Homemaker Service. For years we have, under contract with the District of Columbia Government, provided care for the indigent patients of the city. We also work closely with and provide office space for the Vocational Rehabilitation Program of the District of Columbia and Welfare representatives. Our Social Service Department, in affiliation with Catholic University and the University of Maryland, provide complete social services for patients and their families.

More specific examples of community concern may be seen in the use of our auditorium by such community groups as the Northeast Coordinating Council and the Northeast Chapter of the American Cancer Society; and in providing annual physical examinations in our clinic for residents of the Little Sisters of the Poor and on-going care whenever needed. We also provide physical examinations for the athletic program at St. Anthony's High School. We have a physical examination and clinic program for residents of Regional Addiction Program known in the community as "RAP".

The needs of the area are great and Providence is seeking the most effective means of meeting them within its abilities.

AMBULATORY CARE FACILITIES

In brief, the proposed Ambulatory Care Facility will be housed in Labouré Hall, a six-story building formerly used as a nurses' home and will house scheduled clinics.

An enclosed corridor—not part of this project—will connect the main hospital building with this building. An additional elevator and air conditioning of the 4th, 5th and 6th floors, the only floors not now air conditioned, will be necessary.

This facility will include over fifty clinics providing a complete range of specialty clinics such as dental, prenatal, pediatrics, surgical and medical with availability of complete diagnostic x-ray and clinical laboratory services and physical medicine and rehabilitation services. In 1970, 97% of the clinic patients were from the District of Columbia with half from the Northeast sector of the city.

Our present ambulatory care facilities are now providing health care services to the community in a consistently increasing volume. The severely cramped Outpatient Department provides fundamental medical and surgical facilities to the community and together with our modern Emergency Room, constructed in 1935, handled 90,729 Outpatient visits in 1970. There has been a consistent increase in Outpatient visits—over 23,000 in the last two years. Our Home Care program is enabling the hospital to follow through on care to many community patients.

PROJECT NUMBER DCMF-13—MAIN HOSPITAL BUILDING

The Hospital fully recognizes its responsibility to provide Comprehensive Health Care to the Community it serves and is cognizant of the continuing need to combat the steadily rising costs of hospitalization. In response to such commitments, Providence Hospital has prepared a construction program which includes enlargement and modernization of ancillary and support facilities and increases the Hospital capacity from 390 to 472 beds.

This program provides for the establishment of an 8 bed surgical intensive care unit and 96 beds for long term or extended care. In reference to the latter, the regional planning agency has validated the need at Providence Hospital.

The program contemplates two major additions to the existing Hospital. One addition consists of 6 stories and a basement and the other of 3 stories and basement. Extensive remodeling work and modernization is contemplated in existing areas adjacent to the proposed new additions.

Providence Hospital will be able to provide complete progressive care services from Ambulatory through Intensive and Acute Care to Extended Care as well as Home Care. The patient will be cared for in the environment best suited to his needs and most economical to the community.

Fr. COLLINS. Rogers Memorial Hospital plans to provide for the completion of program construction delayed because of financial limitations under Public Law 90-457 inclusive of a multistory ambulatory care and referral center and the addition of extended care beds. Once again, this is one of our extremely critical projects that is under construction and part of the phased program, and presses us with urgency so that we will have the funds available to finish this program. It is represented by Mr. Gary.

Mr. Roy V. Terry, administrator, representing the president, Dr. Young.

(The document referred to follows:)

ROGERS MEMORIAL HOSPITAL,
Washington, D.C., November 8, 1971.

APPLICATION FOR CONSTRUCTION, GRANT AND LOAN FUNDS TO COMPLETE PHASE II OF THE MASTER PLAN UNDER P.L. 90-457 AND THE DISTRICT OF COLUMBIA MEDICAL FACILITIES CONSTRUCTION ACT OF 1972

Rogers Memorial Hospital, formerly known as Eastern Dispensary and Casualty Hospital, originally chartered in 1888; is a voluntary, non-profit, medical-surgical hospital, governed by a Board of Directors made up of twenty-one representatives from the metropolitan Washington area. Rogers Memorial Hospital provides medical care to all without regard to race, creed, color, national origin, or ability to pay, and is the only remaining general hospital located in and serving the downtown, inner-city Capitol Hill area. The Emergency Department is open twenty-four hours a day, seven days a week, and the hospital provides a full range of patient care for medical-surgical cases, including intensive and coronary care. In 1929 and 1958, two building programs expanded the original facilities. Block, McGibony & Associates, Inc. completed a 1968-69, comprehensive evaluation, and developed a master plan for the hospital.

The master plan developed by Block, McGibony & Associates, Inc. provides a critical analysis of Rogers Memorial Hospital's environment, primary service areas, scope and range of services, and an evaluation of physical plant and bed needs. The plan is presented in a systematic two phase approach. It calls for modernization and expansion of services to meet present and future medical care needs of the hospital's primary service area, an area which encompasses the economically disadvantaged inner-city, where health care is provided on a crisis basis.

An analysis of statistics indicates that the primary service area of Rogers Memorial Hospital is the least advantaged of any segment of the District. By comparison with the District as a whole, it reflects:

- Highest population density.
- Highest proportion of non-white population.
- Highest proportion of old, deteriorating or dilapidated housing.
- Highest occupancy per household with more than one person per room (21% against 12.4%).
- Lowest family income.

And, in addition:

- Highest welfare case loads.
- Highest crime rate.
- Poorest schools.
- Poorest park and recreation resources.

Highest rate of illegitimacy.

Most dense arterial traffic flows through residential areas.

Lowest median age (27 as against 32).

Lowest proportion of population over age 65 (5.1% as against 9.1%).

Lowest educational attainment.

Highest unemployment rate.

Phase I has been funded with grant and loan monies under P.L. 90-457. This phase will expand and modernize the Emergency Department as well as improve those facilities currently occupied by the Radiology and Pathology Departments. Phase I will additionally expand the physical plant, bringing all beds into conformity with current Health Department standards for in-patient facilities. This phase will not increase the number of in-patient beds, nor will it enable the hospital to alter significantly its mode of delivery of health care.

The entry point into the health care system for most patients living in the area served by Rogers Memorial Hospital is through the Emergency Department. Few patients have a primary physician and therefore must depend upon the hospital's Emergency and Out-Patient Departments to meet their health care needs. The completion of Phase I of the Rogers Memorial Hospital master plan will enable the hospital to continue meeting the crisis needs of the community; however, Phase II must be completed if Rogers Memorial Hospital is to shift the emphasis of care from crisis to preventative. Provision of comprehensive health care must emphasize the preventative, as contrasted to the crisis oriented care system. Stress on the vertical care delivery system and minimization of the horizontal type of care, is the primary goal of Rogers Memorial Hospital.

Phase II of the hospital's plan provides for:

1. *Ambulatory Care and Referral Center.*—As the only inner-city voluntary, non-profit, general hospital in the Capital Hill area, Rogers Memorial Hospital plans to construct a multi-story ambulatory care and referral center to provide vertical care for the un-met inter-city demand which is increasing at the rate of 20% per year. This facility will be contiguous to the hospital and provide optimum utilization of hospital ancillary facilities and eliminate duplication of services.

Programs scheduled are as follows:

- (1) Personal and preventive care services including diagnostic and therapeutic services.
- (2) A home care program and community health education.
- (3) Specialty clinics for progressive patient care.
- (4) Neighborhood clinic support and administration areas.
- (5) A multiphasic Screening Center.
- (6) A renal dialysis area and related highly technical procedures which can be provided on a vertical basis under controlled conditions.
- (7) Educational and training facilities for medical and paramedical personnel.
- (8) A pulmonary function area.
- (9) A social service program area.
- (10) Ancillary and supporting areas for these programs.

This project is estimated to cost \$7,400,000, plus \$1,000,000 for merging ancillary and related services, for a total of \$8,400,000.

Ambulatory care services will be co-ordinated with similar programs of the National Medical Association, and others now in existence or hereafter instituted, with provision for an interchange of patients at all levels of care and both in-patients and outpatients. This program will provide a continuity of care as the patient is guided through the system and will eliminate the usual problems of availability, accessibility and fragmentation where different levels of care are available only at separate and non-related facilities. Patient records and other services will be centralized to insure quality care and reduce duplication.

It is anticipated that a prepaid capitation program will provide for a spectrum of health services including acute, long term, ambulatory and emergency care in conjunction with preventive, diagnostic, rehabilitative and therapeutic services.

General health maintenance will be available at centers maintained by other organizations as well as at this facility with only this facility providing specialty clinics. Each patient will have available to him a personal physician and a family health team which will have primary responsibility for continued health surveillance.

The hospital has been seriously hampered by lack of adequate facilities and equipment to carry out much needed teaching and training programs for medical, paramedical personnel and community oriented programs. The proposed construc-

tion program will provide such areas and equipment and will enable the hospital to effectuate affiliations with medical schools, attract interns and residents, and establish programs in paramedical training skills.

Through this construction program, it is intended to establish a program in multiphasic screening, renal dialysis, pulmonary function, and other programs which will extend the scope of the hospital's health care capabilities.

2. *Extended Care.*—Project 2 of Phase II provides for the construction of a multi-story building providing 100 extended care beds with supporting and ancillary areas and provision for rehabilitation services to include:

- | | |
|--------------------------------|-------------------------------|
| (1) Vocational therapy | (5) Psychological counselling |
| (2) Occupational therapy | (6) Social Services |
| (3) Physical therapy | (7) Social rehabilitation |
| (4) Activities of daily living | |

This project is estimated to cost \$4,200,000.

The objectives of the proposed extended care and home care programs are:
To furnish comprehensive medical, nursing, casework and related care in the home to patients whose medical needs can be satisfactorily met in this milieu . . .

To restore patients to normal family living and useful functional activity . . .

To shorten the hospital stay of selected patients . . .

To release acute patient beds for those who need them . . .

To furnish an adequate quality of care at lower cost than in the hospital by using the patient's home as the locale of treatment . . .

To train professional and technical health personnel to work as a team in an extramural setting . . .

To furnish field experience for students in the health professions . . .

Phase II facilities will thus enable Rogers Memorial to provide a broader range of inpatient and ancillary services as well as general, medical-surgical care with intensive and coronary care units. Obstetrical inpatient care will be referred to area hospitals equipped to care for these patients.

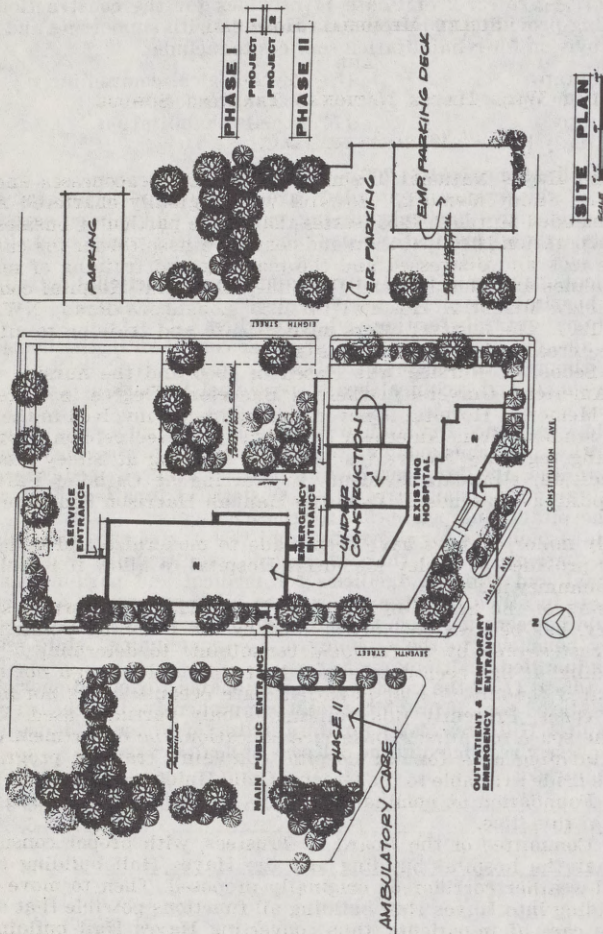
Phase II provides facilities for preventive and restorative type care which is so needed by the patients within the service area. Additionally, Phase II will provide educational and training facilities for medical and para-medical programs. Participants in allied health manpower training programs, conducted by the hospital, would be recruited from the community served by the hospital, thus proving mutually beneficial to the economy of the community, while reducing current shortages in allied health manpower.

Completion of Phase II of the master plan will enable Rogers Memorial Hospital to attain its stated goal of providing total comprehensive health care within the innercity, Capitol Hill area. Without the funding of Phase II, however, the hospital will be severely restricted in the delivery of health care.

Total funds required:

(1) Grants	-----	\$6, 300, 000
(2) Loans	-----	\$6, 300, 000
Total	-----	\$12, 600, 000

RAY V. TERRY,
Executive Director.



ROGERS MEMORIAL HOSPITAL WASHINGTON DC

BLOCK, MCGIBONY + ASSOCIATES, INC.
PLANNING AND ARCHITECTURAL CONSULTANTS
WILMOT & PORTER
ENGINEERS ARCHITECTS INTERIOR DESIGNERS

Fr. COLLINS. Sibley Memorial Hospital plans to provide for the modernization of its ancillary and service areas of existing hospital and to provide for the more effective utilization of the training school

building, and its training school program. Its representative is Mr. Rogers.

Mr. ROGERS. Cary Rogers, Executive Director. Mr. Cree Sandefur was going to be here but he had to go out of town.

(The document referred to follows:)

SIBLEY MEMORIAL HOSPITAL

AND

LUCY WEBB HAYES NATIONAL TRAINING SCHOOL

WASHINGTON, D.C.

The Lucy Webb Hayes National Training School for Deaconesses and Missionaries operating Sibley Memorial Hospital was originally chartered August 8, 1894 and as amended March 2, 1955, states that, "The particular business and object of said Corporation is to maintain and conduct a hospital for the care and treatment of the sick and distressed and the teaching and training of nurses".

In 1958 the Hahnemann Hospital and the Sibley Memorial Hospital combined and the new Sibley Memorial Hospital at 5255 Loughboro Road, NW., was opened May 30, 1961. The hospital offers medical care and training to all without regard to race, creed, color, or national origin.

The Diploma School of Nursing was closed in 1966 and the nursing school transferred to American University where a Bachelor's Degree in Nursing is provided. Sibley Memorial Hospital is nevertheless directly involved in the training of nurses as students from American University and Georgetown University Schools of Nursing regularly receive teaching and training at Sibley Memorial Hospital. In addition, Graduate Students in Nursing at Catholic University train at the hospital, as do students from the Hannah Harrison School of Practical Nurses.

Since 1961 only minor changes have been made to modernize and update the medical services provided at Sibley Memorial Hospital to allow it to fulfill its service to the community it serves.

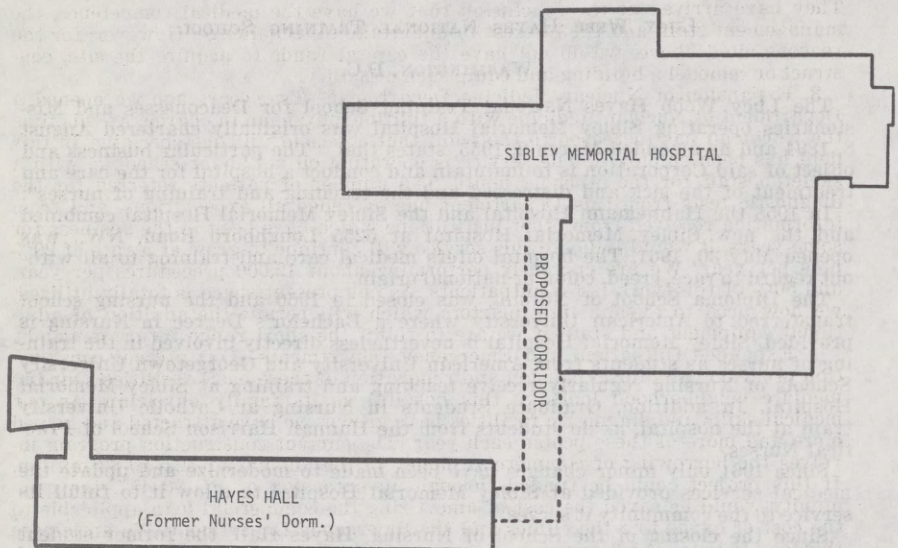
Since the closing of the School of Nursing, Hayes Hall, the former student nurses' dormitory, has been extensively studied by the Planning Committee of the Board of Trustees and by professional consultants to determine a proper use for the building. It has been determined that this building can not be economically renovated for any type of in-patient care because of its not meeting proper building codes. Presently this building is only partially used. We are using some of the space for nurses' in-service education, the department of personnel and the training area for our hospital chaplain's training program. In addition, space is made available to the Groome Child Guidance Clinic and the International Eye Foundation at nominal cost. This leaves a large portion of the building unused at this time.

The Planning Committee of the Board of Trustees, with proper consultants, has proposed that the hospital building and the Hayes Hall building be connected by an all-weather corridor as originally proposed. Then to move out of the hospital building into Hayes Hall building all functions possible that are not necessary to the care of in-patients, thus converting Hayes Hall building into an administrative—out-patient care building and relieve space in the present hospital building for modernization and up-dating of patient care areas. This would mean moving offices, medical records, locker rooms and out-patient services thereby developing areas within the hospital for development of some of the following services:

1. In and Out Surgical Service which will reduce the cost to the patients for medical care.
2. Development of a new urological operating room for a service that has greatly expanded since 1961.
3. Allow for expansion of our radiology services, particularly for out-patient examinations and in return reducing patient cost.
4. Allow for expanding our Ophthalmology out-patient clinic in conjunction with the International Eye Foundation.
5. Allow for expansion of the physiotherapy department for better treatment for our large load of over-65 patients and also enable us to properly give out-

patient therapy to these patients and in many cases, permit earlier discharge from an in-patient status.

6. Space for development of other out-patient services as our service to the Metropolitan Area, as is warranted. This renovation and modernization of other areas can be done without large sums being expended for new construction and will allow an estimated 25% increase in out-patient services, 11% increase for in-patient services, as well as supply a new service for In and Out Surgery, giving services for 1800 to 2200 cases per year at reduced cost inasmuch as they will not require hospitalization. The cost of this program is approximately \$7,000,000.



Fr. COLLINS. Washington Hospital Center will provide for a neighborhood Health Center, expansion of nuclear medicine, out-patient and emergency departments, and to provide for expansion and relocation of the ancillary services, represented by Richard Loughery, representative of Judge Samuel Sterrett, Chairman.

STATEMENT OF R. M. LOUGHERY, ADMINISTRATOR OF WASHINGTON HOSPITAL CENTER
IN REGARD TO EXTENSION OF PUBLIC LAW 90-457

As part of the total request being made on behalf of the hospitals of the District of Columbia, I should like to present the needs of the Washington Hospital Center for expanded capabilities in rendering ambulatory care and patient teaching programs.

1. Expansion of Physicians Office Building—The purpose of our facility has been to provide proximity of physicians to the hospital in order that they could better serve the needs of the immediate community and have ready access to the complete diagnostic and treatment facilities in the adjoining hospital. In addition to serving some 50 physicians of our own medical staff, we have also provided one half of one floor to the Group Health Association as a satellite clinic to provide outpatient care to a large number of their subscribers in this immediate area, as well as an OEO-funded project to provide care for some 1,000 families. Another one-half floor provides an ambulatory care center which serves the needs of the police and firemen of the city. Both Group Health Association and the Police and Fire Clinic need to double their space, and we currently have a waiting list of seven physicians who desire office space in the building. All of these requests are legitimate and indicate the growing need of physicians' offices adjacent to a major hospital with its complete diagnostic and treatment facilities. These programs have already proven to be an effective means to make better use of the physicians' time as well as a convenience to the patients. Although the hos-

pital financed the original construction of the present building, it is not possible for this to be done again as the hospital has used its own funds plus made loans for commercial money for the current twelve million dollar construction program that is in progress.

2. **Neighborhood Health Facility**—Recently our Board of Trustees has directed that we investigate the possibilities of creating a neighborhood health center in an area of the District of Columbia where there is currently a shortage of physicians for a population with demonstrated health needs which are not currently being served. A special committee composed of trustees, physicians, and management personnel is investigating how this service could be accomplished. They have arrived at the conclusion that we have the medical competence, the management staff, and the interest to undertake this challenge. However, for the reasons cited above, we do not have the capital funds to acquire the site, construct or remodel a building and equip such a facility.

3. **Expansion of Nuclear Medicine Department**—Two years ago we opened a Department of Nuclear Medicine with a fulltime physician in charge. At this time the workload has increased to the point that a second fulltime specialist in this field has been employed. The service is operating on a 12-hour schedule, with a skeleton staff for the other 12 hours. The number of patients referred for the diagnostic tests from this Department has exceeded all expectations, and from information received from other institutions which have been in the business for some years, it would indicate this service will continue to grow at a rate of 20% plus per year. We are currently performing about 12,000 procedures per year, and 50% of this work is for outpatients. As our present space is totally utilized, we now need to expand into quarters which will permit the addition of additional equipment and staff, if we are to fulfill the short range future demands.

4. **Expanded Outpatient and Emergency Departments**—Our present construction program calls for expansion and renovation of these basic facilities. Our immediate neighborhood looks to this hospital as its family physician. As our medical skills and diagnostic facilities have grown, we have attracted and helped more and more of these people each year. The current construction program involves the borrowing of commercial money in the amount of \$2.5 to \$3 million. If this project could be funded through an extension of PL 90-457, the community would be saved the cost of amortizing the commercial loan applicable to the cost of expanding the clinics and the Emergency Department. We anticipate this load to grow at 5% per year.

5. **Closed-Circuit Television**—Our educational programs for the physicians, nurses and paramedicals have grown to the point that our educational effort now represents approximately 10% of our costs. The media of closed-circuit television is being advocated by leading educators as a more economical means to teach. An additional area which we recognize as a tremendous need is in the teaching of both inpatients and outpatients. Because of the scattered location of these patients the conventional teacher-classroom modality is not economically feasible. Thus we are proposing the use of specially prepared tapes and/or film cassettes which can be used for teaching ambulatory patients in many areas—from the activities of daily living program for the heart patient, to a dietary program to a laryngectomized patient as well as prospective new mothers and many other types of patients. One of the most effective methods of helping to reduce the cost inflation of health care is to teach the consumer the principles of good health maintenance so that he won't have to use expensive hospital facilities.

6. **Relocation of Central Service Department and Added Space for the Laboratories**—A relocation for Central Service to a new structure more centrally located would release the present space for acute patient treatment (non-bed) facilities, would also be in proximity to our Extended Care Facility and would make possible an independent labor-free, thus cost saving, materials handling system.

Our Laboratory is the most active hospital laboratory in the whole Metropolitan area, and it is performing work for many of the other hospitals in the city and as far away as Culpepper, Virginia. It provides a full 24-hour, 7-day week operation. Because of the total and speedy services rendered, the growth of the Laboratory volume of work has exceeded all expectations. We have continued to add labor-saving devices in order to expedite work flow, reduce payroll costs, and save space. However, we are now in a position where we will have to start refusing requests, and this is particularly unfortunate in view of the fact that we could do some work for Children's Hospital as well as expand services to other hospitals in the area. Also the physicians in our Physicians Office Building need

the help of this department. If we build a neighborhood health center, all of the heavy lab work would be expected to be done here in the base hospital. Approximately 25% of the laboratory work is for outpatients; this seems to be the growing area of need. In 1970 we performed 130,762 outpatients lab procedures.

Some statistics of our overall hospital workload—

55% of our bed patients live in the District of Columbia;

45% of our bed patients come from outside the District of Columbia;

92% of our ambulatory care patients live in D.C.;

85% of patients coming to our Emergency Department live in D.C.;

133,000 outpatient visits during 1970. If we can expand the services described, we would anticipate a 50% increase in outpatient capabilities.

Fr. COLLINS. Hadley Memorial Hospital urgently needs funds to provide expansion of its out-patient facilities in order to have sufficient place to carry out the services they are now rendering. James P. Cookey, representing the Chairman of the Board, Cree Sandefur.

(The document referred to follows:)

REQUEST FOR MODERNIZATION: DISTRICT OF COLUMBIA MEDICAL FACILITIES CONSTRUCTION ACT

I. The History

Hadley Memorial Hospital is operated by the Seventh-day Adventist church. This 82 bed non-profit acute-care hospital is located in the Far Southeast health service Area 4. The hospital was designed in 1945 and was partially opened in 1952.

II. The Setting

This hospital, which stressed outpatient care from its very inception, is still continuing to provide diagnostic and primary care facilities to its community. This year, nearly 30,000 inpatient days will be provided and over 41,000 patients will be seen in the outpatient clinics. Throughout the years, ninety-five percent of the patients have come from the District of Columbia. They come to Hadley Memorial Hospital because it is the physician's office, because it represents an entry into the medical care system through a network of specialty clinics, because it is fully operational six days a week, because its night clinic hours encourage visitation when private doctors are usually unavailable.

Over five years ago, the physical facilities of this hospital were deemed to be inadequate for even an 82 bed hospital. It was felt that any additional patient load was impossible and that expansion was imperative. With the opening of the Morris Cafritz Memorial Hospital, it was strongly urged by planners and consultants, however, that Hadley Memorial Hospital constrain all growth for it was felt that duplication was imminent. Accordingly, the Board accepted these recommendations and deferred all long-range plans despite upward trends and demands for expansions.

This year, the Board engaged the services of Block, McGibony and Associates to once again evaluate the hospital's future, to determine a need for expansion, and to develop a long-range plan. The Board recently received the consultant's report and desires to continue to provide community health care for the people of the Anacostia area.

III. The Present Facilities

This structure, designed for the 40's, could have never anticipated the medical-technological challenges of the 70's, the impact of Medicare-Medicaid, and the concern for verticare. Consequently, all areas of the Hospital are markedly deficient in space. To care for the needs of the 41,000 patients who will be treated in the outpatient department this year, 1,900 square feet is grossly inadequate. This department has one observation room, five small clinic rooms, and one emergency room. There are no work areas, utility rooms, or support facilities for the clinic staff. Waiting areas are too small, resulting in corridor waiting. Many patients stand for long periods of time. The registration-interviewing takes place in the midst of a crowded waiting room and major corridor exit with no privacy given for the patient during the interview process; this together with the general congested corridors of the suite comprise patient privacy during the actual examination-treatment.

The clinical laboratory has assumed an increasing role in the diagnostic process and the number of procedures has experienced substantial increases

throughout the history of the Hospital. Both radiology and clinical laboratory services at Hadley are serving needs akin to those of a much larger hospital and the resultant pressures on all services are severe. This laboratory performs 40% of its tests for the outpatient. In view of the large clinic activity one would expect to find a department at least seven times larger than its existing 580 square feet. Because of the inadequate space prohibiting the increase of personnel, there are great delays for the outpatient. There is no blood drawing area, and the patient is brought to a counter into the middle of the work and testing area. Remote public toilets are used for specimen collections from the patients. Because there is no room for a clerk, all technologists must perform routine clerical duties.

Several years ago, the clinic patient flow began to rise with such intensity that the clinic hours were changed from 9 A.M.-5 P.M. operation to an 8 A.M.-11 P.M. operation. Community desires were expressed for this change and managerially this was intended to attempt to spread the work more evenly. This extension of hours met a community request but did not produce the intended efficiency since there was an increase in day visits as well as an 87% increase in evening patient.

In the Department of Radiology, there is only space for two fluoroscopic machines. Neither room is large enough for special procedures. Narrow doors restrict the entry of a bed thus eliminating the use of these machines for the bed-fast patient. A pair of small curtained patient dressing cubicles lack privacy and security for the patient. The small film storage area has a capacity for four to nine months' film based on current activity. There is a major problem in respect to waiting areas. Most of the waiting now backs into the already congested clinic corridors.

In addition to the hospital-based house physicians who provide primary care, the attending staff (most of whom are Board certified) conduct fifteen specialty clinics each week: Allergy; Ear-Nose-Throat; Family planning, Gynecology; Genito-urinary; Internal medicine; Ophthalmology; Optometry; Orthopedics; General Surgery. There are constant requests from the community for care of the alcoholic, the problems of drug addiction, dental care, pediatrics, mental health, and industrial-occupational health. Despite space limitations, there is a constant renovation program in process. In 1970, over \$100,000 was spent in renovation or new equipment. Last year, a minor surgery ward replaced existing beds to accommodate up to six patients for post-anesthesia observations to minimize the necessity for overnight hospitalization and to promote ambulatory surgery.

There has been complete internal funding for all renovation and construction. This is the first time in its history that the Hospital has had to request governmental grants.

IV. The Plan: Phase I

A. The health care mission of Hadley Memorial Hospital is to continue to provide both inpatient and primary outpatient health care of high quality to the residents of the Anacostia area. The Hospital needs to continue to assert its role as a Family Health Center available for all; a center that provides coordination of focus, personal and family physical and mental health services, preventive care, diagnostic, care, rehabilitative care, general medical and surgical care, proper referral to specialized facilities and services, and health education.

B. To do this a facility must be provided to house the new diagnostic and treatment center for ambulatory care, laboratory, radiology, rehabilitation, and pulmonary functions; community services; referral and counseling services, observation, and emergency receiving. Renovations must take into consideration materials handling, and recycling; employee facilities; dietary; medical records, operating rooms; central supply and pharmacy.

C. To achieve Phase I of the modernization, Hadley Memorial Hospital will need the minimum support of the District of Columbia Medical Facilities Construction Act in the amount of \$3 million:

	<i>Amount</i>
Construction and group I equipment (18,000 times \$60)-----	\$1, 080, 000
Heating, ventilation, air condition-----	448, 000
Remodeling in existing building (23,800 times \$25)-----	595, 000
Construction cost-----	2, 123, 000
Project cost-----	3, 000, 000

FR. COLLINS. Mr. Chairman, this again is an integrated program by the voluntary cooperation and sacrifice of the hospitals of the District of Columbia, working together with the District of Columbia Government, the Secretary's office and the area-wide Planning Agency to present to you a package approach that is extremely necessary and in some ways very vital, and this is the end of our testimony, and we are open for questions.

MR. STUCKEY. Well, Father Collins, thank you very much and I would like to say this is one of the most distinguished panels we have had before this committee. We appreciate your being here and if there are no objections, we will include the various statements of the representatives of the hospitals into the record at this point.

FR. COLLINS. I would like to ask if you would comment a little more about the inequities that exist under the Hill-Burton Act within the District of Columbia where we do not fit the formula, and therefore there is this need of the grant plus the interest subsidy?

FR. COLLINS. Yes. The Secretary of HEW, in testifying on this precise point, pointed out that the District of Columbia in terms of amounts of funds that it would receive under the Hill-Burton formula, the complexity of that is based on a series of factors of population, average income, existing beds, use of beds, a very complex formula. When you take for instance the State of Pennsylvania, and take the whole state and contract it if the State of Pennsylvania or the City of Washington the allocations and the total variables in the District of Columbia as though it were Pennsylvania, represents an inequity, and it shows up in the dollar signs, the amount of money available to the District of Columbia.

Given the number of beds that it has, the occupancy, the number of citizens that are in the metropolitan area that it serves, the funds available would provide a series of elevators which is an obvious inequity.

MR. STUCKEY. The District of Columbia does have Hill-Burton funds, isn't that correct?

FR. COLLINS. That is correct. They do receive some.

MR. STUCKEY. Could you give us some idea where these inequities would apply even though we do receive Hill-Burton funds?

FR. COLLINS. The Hill-Burton funds that the District of Columbia would receive this year for all of the projects that are listed here and modernization would be in the neighborhood of one million dollars. Now, this is under all of the categories of Hill-Burton. If the District of Columbia were spread out so that this were a state, given the same number of people, the formula would increase it by about five-fold, to about five million dollars. So, just in the Hill-Burton formula itself, there is an eighty percent reduction if this were spread as a typical state.

The second point is that we do come to the Federal Government as our State Government, because arguments and reasons are presented and necessary.

MR. STUCKEY. Do you think that the Secretary of HEW would favor legislation that we have before us?

FR. COLLINS. As I indicated, I would like formally to request that the testimony of the Secretary of HEW supporting Public Law 90-457, together with the District Government Report of it, be tendered

into the record. I believe after talking with the Secretary's representative that the fact that these phased programs of construction have been approved by the Secretary, that he would be constrained to give us support. I believe that the Secretary's office, by approval of the program as we are operating, would be necessitated to give support. I cannot speak for the Secretary's office.

Mr. STUCKEY. Mr. Nelsen?

Mr. NELSEN. I have no questions, only to compliment Father Collins and his associates for being here and of course having in mind the great efforts Father Collins has always exerted in this direction. I cannot help but say that coming to this committee, coming to our private offices, he is always welcome and we enjoy him very much, and he is a very effective salesman for better facilities for this District of Columbia. I am sure all of us see some value in this legislation.

I might point out that yesterday morning at breakfast a group was in from Minnesota representing seven counties, and their plan was not in construction of hospital facilities but in utilization. For example, to see to it that the hospital beds were available for those who really needed the hospital beds. The outpatient care facilities would be expanded. They would examine the operation of each hospital to see whether it is following a correct pattern, what are the charges made by the doctors, are they out of line or not out of line, et cetera. It is sort of a little checking agency from all of the hospitals to come to some central group which in turn would see to it that the patient gets a reasonable care and reasonable cost.

This might be an overall pattern that could very well fit in with the District of Columbia here because you have a very compact situation where all these hospitals in this area could very well work out and examine this plan. I think it is very good.

Again, Father Collins, you are the best salesman and you get those dollars so gracefully, and I congratulate you.

Mr. STUCKEY. I might also add that you are a great salesman and you have done a great job on behalf of the bill before us.

My only other comment would be if you are not registered as a lobbyist, you might do that.

Mr. BROYHILL. I think I put it that way the last time you appeared before us.

Fr. COLLINS. I don't get paid so I don't have to register.

Mr. BROYHILL. Mr. Bucher testified on this and also Father Collins. Do I understand that such projects as Children's Hospital would be incomplete, left partially under construction, if this bill is not passed?

Fr. COLLINS. That is precisely right, Mr. Broyhill. The logistic problem in terms of Children's Hospital as part of the package was that we had to start Children's Hospital. The present site and location and facility is not adequate, to put it very mildly, for a hospital. The phasing of the construction of the hospital was to do that portion of replacement of the existing facility, designing it so the service it gives to the children of the District of Columbia and the metropolitan area could be faced.

So, we are under construction at Children's. Without these funds we will not be able to finish it. I would estimate that we will have, bluntly, unfinished girders, unfinished rooms, sections of it completely

unfinished that require this bill. We had to because if we didn't start it we would still be waiting to try to start it.

Mr. BROYHILL. Father, is this because of costs going up or errors in estimating?

Fr. COLLINS. It was a combination of two things, Mr. Broyhill. The increased costs—we started in 1957 on this legislation and the estimates at that time were based on 1957.

Well, we are under construction some thirteen years later. That was a very primary reason for it. The second was that when you saw this rise in cost, the objective and the plans of Children's have remained the same. As we define them, very precisely the cost did grow in essence. So, it is for both reasons.

Mr. BROYHILL. We are going to be asked as this legislation progresses, as I hope it will, whether the total of this entire program will come to one hundred thirty million dollars. The total grants and loans under Public Law 90-457 amounted to eighty million dollars, and this Bill provides for seventy million dollars in grants and two million dollars per year in loan interest subsidies. I know the loan interest subsidies are not something you can put in bricks and mortar, but the two sources do total one-hundred-fifty-million dollars plus interest subsidies, and the total present program is one-hundred-thirty million dollars.

Now, is that the cost of new construction or what? Also, this present total program, does this include expenditures under the previous act, or is this just additional funds needed?

Fr. COLLINS. The first program was eighty million dollars.

Mr. BROYHILL. Does that include this figure?

Fr. COLLINS. No, it excludes that. This is an addition to that in the second phase of the program.

Mr. BROYHILL. Eighty million dollars is already washed out before you get to these figures?

Fr. COLLINS. That is right.

Mr. BROYHILL. So what we are considering here is a total program of one-hundred-thirty-million dollars, and this bill will provide only seventy million of that plus the interest subsidies?

Fr. COLLINS. That is right, two-million dollars provided for interest subsidy that the hospitals will have to borrow and repay. The one-hundred-thirty-million dollars will be a total cost, the Federal participation would be seventy-million dollars in grants, two-million dollars per year towards repayment of sixty-million dollars. Just as in the Hill-Burton.

Mr. BROYHILL. I understand.

Fr. COLLINS. But you raised the point that the hospitals of the District of Columbia provide a service in terms of dollars for the metropolitan area for which they do not receive funds. Off the annual reports of the last year of these hospitals, the amount of service that they rendered to patients, indigent patients and patients that were unable to pay in the metropolitan area, was in excess of twenty-two-million dollars. Now, if we were able to obtain this twenty-two-million dollars, which in the concrete circumstances of the present legislation we are unable to, and the support, this Bill asks for really seventy-million dollars over a four year span. We are giving twenty-two million dollars worth of service to the area for which we don't receive funds and

four times twenty-two would be eighty-eight million dollars over a four year span that in a sense spells another reason why we are here, that the services given that we don't receive funds cost our hospitals twenty-two million dollars a year out of operating costs.

We are asking, since it is impossible to get these, that this being another reason why we ask for the grant portions—

Mr. BROYHILL. The question will probably be asked why you are such a poor collection agency, why you let that twenty-two million dollars accumulate each year. In fact, we asked what would happen if someone wanted to walk up and pay cash for services at D.C. General Hospital. They wouldn't know how to handle it, as there hadn't been any collections in so long. So, I think the question is, why do you have that twenty-two million dollar deficit, why can't you collect from the District Government or the communities in the suburbs?

Fr. COLLINS. Let me respond in general and then specifically. In general, twenty-two million dollars, which is a cost that the hospitals give, a service that they give for which they don't receive funds, in testimony being given before the Ways and Means Committee, on the Medicare and Medicaid portions, when you get to the Federal and State Governments, it is not a total comprehensive coverage. We give a service to the indigent in all instances. At Georgetown University we give services to the people of the District of Columbia and in the metropolitan area who can't pay. Many of them would not qualify for Medicaid payments. We have to give them service and we want to. This is true in all of the hospitals. There are others where other particular kinds of insurance they are carrying, it is only partial insurance. The insurance companies will only cover a portion of the cost. If the person is unable to pay that, then once again we have to give the service.

So, to respond to the question, why don't we, it is because there is no comprehensive insurance program and we must give the service.

Mr. STUCKEY. Let me ask this, Father: what is the first procedure that a person goes through when he goes to any of the hospitals that are represented here? He fills out the forms and doesn't it show whether he has some type of insurance and whether he has Medicaid?

Fr. COLLINS. Yes, it does.

Mr. STUCKEY. What if he doesn't have this?

Fr. COLLINS. You treat him.

Mr. STUCKEY. Is that true of any hospital represented here?

Fr. COLLINS. I know most of them—the last time a man asked me that it was a Congressman, he asked me that and he said we ask you for your credit or your money and if you don't have it you are treated. He said that is true, because that is what happened to him at Georgetown. He had no identification and he had a broken arm.

Mr. STUCKEY. There again I can understand his situation.

Mr. BROYHILL. At Columbia Hospital we have other legislation pending on transferring certain property to Columbia Hospital. This would be contingent upon that happening.

Fr. COLLINS. To do the program for which the Columbia Hospital has accepted the responsibility and charge as part of our group, they need that land. For them to put a facility that should be for the District of Columbia and the metropolitan area for a Woman's Hospital, they need that land.

My response would be, after going over it, with the representatives of the Columbia Hospital, that the funds in this Bill require that they acquire that land.

Mr. BROYHILL. Unfortunately, that legislation has some opposition, Father. I am supporting it, but a number of our colleagues just haven't warmed up to it sufficiently yet. You haven't worked on that legislation, have you?

Fr. COLLINS. I think we have a solution to it, and I will see you after. [Laughter.]

Mr. BROYHILL. I apologize for taking so much time, Mr. Chairman.

The Speaker mentioned tourists who come in here; you mentioned the citizens from the metropolitan area who come in here quite a bit. I appreciate your mentioning this, but sometimes our colleagues are not so sympathetic to the people in the suburbs. I think we should try to present this as an application of responsibility of this city as the nation's capital, and not too much as a responsibility to the suburbs. Even though I represent a suburban district, I feel they should pay their own way. I think a good example of this is the fact that legislators, high government officials, come here to serve and make this their home. Not necessarily their legal residence, but their home, and they use the hospital services here. Normally, you would go to the state government or the city government for financial help. I think we discussed this before; but I am merely attempting right now to develop as effective an argument as possible for our colleagues. That is, normally you would go to the State Legislature or the City Council. If you went to the D.C. City Council on this particular problem, they would not have the authority to act; and if they did have the authority, the matter would still wind up before us anyway in the nature of a demand for additional Federal payments, would it not?

Fr. COLLINS. That is correct.

Mr. BROYHILL. We have no other place to go?

Fr. COLLINS. That is right.

Mr. BROYHILL. And that twenty-two million dollars, other than what Medicaid and Medicare might pay, I would think that through your Planning Council you could do something about the indigents in the suburbs, because the community hospitals in the suburbs have some relief for their own indigent patients. I think that is nothing more than fair. But certainly the City Council would have a responsibility to you, and if you didn't have it in this program you would have it right in this Federal payment that we are considering this afternoon.

That is all I have. This wasn't a question, but a statement more than anything else. That is all I have, Mr. Chairman.

Mr. STUCKEY. Mr. Cabell, do you have any questions.

Mr. CABELL. No questions.

Mr. STUCKEY. Mr. Smith?

Mr. SMITH. Mr. Chairman, I wish merely to echo the remarks of my associates here in welcoming Father Collins. I am very happy to have an opportunity to start hearing Father Collins' great exercises.

Fr. COLLINS. Thank you very much, Mr. Smith. I am always inspired by going to the hospitals, for you as a private patient perhaps don't go to the same areas that I do, when I walk in the out-patient areas and

see the poor of the District and the poor of the area taken care of. I am proud to be in here fighting for them.

Mr. STUCKEY. Thank you.

Do we have any further questions? [No response.]

Thank you, Father Collins.

Fr. COLLINS. Thank you.

Mr. STUCKEY. We stand adjourned, subject to the Call of the Chair.

(Whereupon, at 11:20 a.m. the Hearing was adjourned, subject to the Call of the Chair.)

HOSPITALS AND MEDICAL FACILITIES

WEDNESDAY, DECEMBER 1, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH, WELFARE,
HOUSING AND YOUTH AFFAIRS,
COMMITTEE ON THE DISTRICT OF COLUMBIA,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:00 a.m. in room 1310, Longworth House Office Building, Hon. W. S. Stuckey, Jr. (Chairman of the subcommittee) presiding.

Present: Representatives Stuckey (presiding), Fauntroy, and Gude.

Also Present: James T. Clark, Clerk; Patrick E. Kelly, Assistant Counsel; John Hogan, Minority Clerk; and Leonard O. Hilder, Legislative Assistant.

Mr. STUCKEY. The committee will be in order.

This morning we will continue hearings on H.R. 11628, a bill to authorize grants and loan guarantees for construction or modernization of hospitals and other medical facilities in the District of Columbia.

As our first witness we have Mr. Richard Seggel, the Deputy Assistant Secretary for Health Policy Implementation, Department of Health, Education, and Welfare. Mr. Seggel.

STATEMENT OF HON. RICHARD L. SEGSEL, DEPUTY ASSISTANT SECRETARY FOR HEALTH POLICY IMPLEMENTATION; ACCOMPANIED BY DR. HARALD M. GRANING, DIRECTOR, HEALTH FACILITIES PLANNING AND CONSTRUCTION SERVICE; AND ROBERT L. SCHAEFFER, HEALTH FACILITIES PLANNING AND CONSTRUCTION SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. SEGSEL. Mr. Chairman, I have here with me to assist in this testimony, Dr. Harald Graning, Director of the Health Facilities Planning and Construction Service, and Mr. Robert Schaeffer of the same organization. They will assist me with respect to the technical aspects of this legislation.

It is a pleasure to appear before you today to discuss our position with regard to H.R. 11628, the District of Columbia Facilities Act of 1972.

As you know, this bill is proposed as an extension of P.L. 90-457 which passed in 1968. However, unlike P.L. 90-457, this bill excludes assistance to publicly-owned health facilities and limits it to private nonprofit health facilities.

Under P.L. 90-457, five private nonprofit health facilities in the District of Columbia have benefitted from the \$80 million authorized under the Act.

Beginning with FY 1972 and for three years thereafter, the proposed grant authorization under H.R. 11628 is for annual amounts

as may be necessary but not to exceed \$70 million in the aggregate. The bill also provides for loan guarantees with interest subsidy beginning with FY 1973 through FY 1977. The proposed authorization for subsidy funds, to be applied at a rate of 3 percent to the guaranteed loans, is \$2 million annually.

It will be recalled that P.L. 90-457 was enacted because of the difficulty hospitals in the District had been encountering in providing matching funds for Federal grants, due in part to the lack of large industrial organizations in the District. As you know, in other areas large industries are usually substantial contributors to hospital fund drives.

Since passage of P.L. 90-457, however, three important pieces of legislation have been enacted which we believe have substantially enhanced the ability of hospitals in the District to undertake any necessary modernization. The first of these, Section 242 of the Housing and Urban Development Act of 1970, provides that nonprofit and proprietary hospitals may obtain from the Department of Housing and Urban Development a guaranteed construction loan of up to \$50 million per hospital providing its need is justified in the Hill-Burton State Plan and the hospital has the ability to generate sufficient income to repay the indebtedness. The second piece of legislation is the 1971 Amendments to the Hill-Burton program which provide for loan guarantees with an interest subsidy at 3 percent as well as for grants. The loan allocation for the District in fiscal '72 is \$1,353,500 and, in addition to the new loan guarantee feature, the minimum grant allotment for States and the District of Columbia has since 1968 been increased from \$750,000 to \$1.2 million. Finally, since the District is contributing to the Nation's health manpower pool, the two universities—Georgetown and George Washington—will be eligible for assistance under the recently enacted and expanded Comprehensive Health Manpower Training Act.

Parenthetically, Mr. Chairman, I would add that when the President's National Health Insurance Partnership Act is in place we feel that this would provide a much more stable financial base of support for hospitals than has existed in the past.

We are of the opinion that the previously cited difficulties encountered by hospitals in the District in the field of construction financing have been substantially reduced by the funds already appropriated under P.L. 90-457 and with recent changes in general legislation, nonprofit hospitals in the District will in the future be able successfully to obtain necessary construction aid from the Federal Government.

I feel it significant for this subcommittee to note that in addition to the funds already appropriated under P.L. 90-457, support from the regular Hill-Burton allotments to the District of Columbia have amounted to \$4,058,261 from FY 1969 through 1971. With the addition of the funding level proposed under H.R. 11628, that of an additional \$70 million in grants, and an estimated \$304 million¹ in low interest subsidized loans, the nonprofit private health facilities in the District could possibly receive, by the close of FY 1976, a grand total of more than \$460 million² in capital project support, less the FY 73-76 Hill-Burton allotments. This is a disproportionately high level of support compared to the aggregate funds for FY '69-'71 allocated to other jurisdictions of comparable population to the District of Columbia.

¹ Subsequently corrected to read "\$264 million." See Appendix, p. 88.

² Subsequently corrected to read "\$420 million." See appendix, p. 88.

In summary, Mr. Chairman, we recommend against the enactment of H.R. 11628. We believe there is no longer need for special added authority to meet the District of Columbia's needs for the construction of nonprofit health facilities. These needs should be determined at the local level and met with the assistance of the general Federal programs now available.

I will be glad to answer any questions, Mr. Chairman.

Mr. STUCKEY. Thank you, Mr. Seggel. Will you supply for the record an up-to-date itemization of the grants and loans to the D.C. hospitals under the Hill-Burton and other Federal programs such as Public Law 90-457?

Mr. SEGSEL. Yes, sir.

(The information follows:)

TABLE 1.—HILL-BURTON GRANTS: ALLOCATIONS TO STATES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND RELATED HEALTH FACILITIES, FISCAL YEARS 1969-72

State	Total	Modernization	Hospitals and public health centers	Long-term care facilities	Diagnostic or treatment centers	Rehabilitation facilities
1969						
Total.....	\$267, 200, 000	\$52, 485, 000	\$119, 285, 000	\$66, 800, 000	\$19, 085, 000	\$9, 545, 000
Alabama.....	7, 005, 701	847, 499	3, 445, 191	1, 913, 684	532, 834	266, 493
Alaska.....	750, 000	200, 000	200, 000	200, 000	100, 000	50, 000
Arizona.....	2, 467, 602	397, 272	1, 158, 241	643, 363	179, 134	89, 592
Arkansas.....	3, 891, 932	362, 348	1, 974, 617	1, 096, 831	305, 395	152, 741
California.....	14, 779, 536	2, 565, 295	6, 833, 227	3, 795, 620	1, 056, 830	528, 564
Colorado.....	2, 682, 931	668, 580	1, 126, 924	625, 967	174, 290	87, 170
Connecticut.....	2, 610, 629	960, 665	923, 068	512, 733	142, 762	71, 401
Delaware.....	750, 000	200, 000	200, 000	200, 000	100, 000	50, 000
District of Columbia.....	753, 261	200, 000	203, 261	200, 000	100, 000	50, 000
Florida.....	8, 946, 150	1, 337, 417	4, 256, 686	2, 364, 442	658, 341	329, 264
Georgia.....	7, 685, 927	848, 328	3, 825, 278	2, 124, 809	591, 619	295, 893
Hawaii.....	918, 430	200, 000	365, 441	202, 989	100, 000	50, 000
Idaho.....	1, 176, 508	204, 517	528, 454	293, 537	100, 000	50, 000
Illinois.....	9, 624, 188	2, 358, 136	4, 064, 975	2, 257, 952	628, 691	314, 434
Indiana.....	6, 339, 872	1, 454, 262	2, 733, 243	1, 518, 221	422, 724	211, 422
Iowa.....	4, 141, 118	1, 052, 120	1, 728, 132	959, 917	267, 274	133, 675
Kansas.....	3, 208, 948	750, 604	1, 375, 314	763, 939	212, 707	106, 384
Kentucky.....	5, 803, 489	684, 176	2, 863, 987	1, 590, 846	442, 945	221, 535
Louisiana.....	6, 408, 161	629, 458	3, 232, 881	1, 795, 753	499, 999	250, 070
Maine.....	1, 720, 767	342, 606	771, 009	428, 269	119, 244	59, 639
Maryland.....	3, 808, 534	738, 478	1, 717, 535	954, 031	265, 635	132, 855
Massachusetts.....	6, 418, 828	2, 158, 127	2, 383, 639	1, 324, 028	368, 654	184, 380
Michigan.....	9, 776, 282	2, 351, 660	4, 153, 687	2, 307, 228	642, 411	321, 296
Minnesota.....	4, 965, 955	1, 051, 550	2, 189, 904	1, 216, 416	338, 691	169, 394
Mississippi.....	5, 215, 299	435, 045	2, 674, 301	1, 485, 481	413, 609	206, 863
Missouri.....	6, 522, 793	1, 490, 533	2, 815, 285	1, 563, 793	435, 414	217, 768
Montana.....	1, 207, 709	320, 396	485, 587	269, 726	100, 000	50, 000
Nebraska.....	2, 129, 987	487, 898	918, 662	510, 285	142, 081	71, 061
Nevada.....	750, 000	200, 000	200, 000	200, 000	100, 000	50, 000
New Hampshire.....	1, 026, 781	200, 000	435, 099	241, 682	100, 000	50, 000
New Jersey.....	6, 780, 060	2, 143, 049	2, 594, 164	1, 440, 968	401, 215	200, 664
New Mexico.....	1, 627, 754	200, 000	798, 754	443, 680	123, 535	61, 785
New York.....	16, 269, 443	4, 571, 136	6, 544, 589	3, 635, 292	1, 012, 189	506, 237
North Carolina.....	9, 590, 783	1, 515, 922	4, 517, 460	2, 509, 293	698, 673	349, 435
North Dakota.....	1, 162, 397	209, 854	515, 951	286, 592	100, 000	50, 000
Ohio.....	12, 482, 715	2, 423, 942	5, 627, 356	3, 125, 801	870, 329	435, 287
Oklahoma.....	4, 070, 651	560, 647	1, 963, 663	1, 090, 746	303, 701	151, 894
Oregon.....	2, 435, 829	438, 931	1, 117, 160	620, 544	172, 780	86, 414
Pennsylvania.....	15, 993, 888	4, 206, 612	6, 594, 362	3, 662, 939	1, 019, 887	510, 088
Rhode Island.....	1, 106, 684	203, 377	484, 277	269, 000	100, 000	50, 000
South Carolina.....	5, 389, 551	643, 138	2, 655, 369	1, 474, 965	410, 080	205, 399
South Dakota.....	1, 294, 255	246, 695	577, 036	320, 524	100, 000	50, 000
Tennessee.....	7, 775, 041	1, 404, 208	3, 564, 147	1, 979, 760	551, 232	275, 694
Texas.....	17, 041, 903	2, 600, 894	8, 078, 987	4, 487, 597	1, 249, 499	624, 926
Utah.....	1, 525, 267	224, 155	727, 904	404, 325	112, 578	56, 305
Vermont.....	872, 692	200, 000	322, 692	200, 000	100, 000	50, 000
Virginia.....	7, 077, 729	1, 227, 724	3, 272, 771	1, 817, 911	506, 168	253, 155
Washington.....	3, 563, 420	794, 751	1, 548, 925	860, 374	239, 558	119, 812
West Virginia.....	3, 640, 110	715, 213	1, 636, 326	908, 923	253, 075	126, 573
Wisconsin.....	5, 353, 621	949, 887	2, 463, 658	1, 368, 476	381, 031	190, 569
Wyoming.....	750, 000	200, 000	200, 000	200, 000	100, 000	50, 000
American Samoa.....	69, 233	3, 678	36, 675	20, 371	5, 672	2, 837
Guam.....	394, 908	100, 000	119, 908	100, 000	50, 000	25, 000
Puerto Rico.....	7, 069, 778	922, 217	3, 439, 238	1, 910, 377	531, 914	266, 032
Virgin Islands.....	375, 000	100, 000	100, 000	100, 000	50, 000	25, 000

TABLE 1.—HILL-BURTON GRANTS: ALLOCATIONS TO STATES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND RELATED HEALTH FACILITIES, FISCAL YEARS 1969-72—Continued

State	Total	Modernization	Hospitals and public health centers	Long-term care facilities	Diagnostic or treatment centers	Rehabilitation facilities
1970						
Total	172,200,000	27,100,000	54,200,000	63,600,000	18,200,000	9,100,000
Alabama	4,350,943	317,305	1,510,750	1,780,497	494,927	247,464
Alaska	750,000	200,000	200,000	200,000	100,000	50,000
Arizona	1,656,199	200,000	545,401	642,784	178,676	89,338
Arkansas	2,554,781	206,354	879,575	1,036,624	288,152	144,076
California	10,238,841	1,297,308	3,348,943	3,969,903	1,097,125	548,562
Colorado	1,755,543	317,455	538,619	634,790	176,453	88,226
Connecticut	1,497,679	383,570	417,276	491,782	136,701	68,350
Delaware	750,000	200,000	200,000	200,000	100,000	50,000
District of Columbia	750,000	200,000	200,000	200,000	100,000	50,000
Florida	5,796,957	610,853	1,942,393	2,289,210	636,334	318,167
Georgia	4,903,527	420,996	1,678,878	1,978,644	550,006	275,003
Hawaii	762,436	200,000	200,000	212,436	100,000	50,000
Idaho	883,241	200,000	244,769	288,472	100,000	50,000
Illinois	6,123,740	1,316,083	1,800,648	2,122,161	589,898	294,950
Indiana	3,988,147	737,224	1,217,594	1,434,997	398,888	199,444
Iowa	2,350,760	486,734	698,149	822,804	228,715	114,358
Kansas	2,030,019	385,022	616,114	726,121	201,841	100,921
Kentucky	3,665,450	330,824	1,248,944	1,471,945	409,158	204,579
Louisiana	4,250,683	453,614	1,422,146	1,676,073	465,900	232,950
Maine	1,078,682	200,000	329,100	387,861	107,814	53,907
Maryland	2,358,744	272,269	781,464	920,996	256,010	128,005
Massachusetts	3,966,314	1,097,837	1,074,353	1,266,181	351,962	175,981
Michigan	5,785,780	980,980	1,799,580	2,120,898	589,548	294,774
Minnesota	3,101,058	526,188	964,386	1,136,580	315,936	157,968
Mississippi	3,315,171	200,572	1,166,535	1,374,823	382,161	191,080
Missouri	4,094,288	685,654	1,276,663	1,504,613	418,239	209,119
Montana	818,782	200,000	215,181	253,601	100,000	50,000
Nebraska	1,214,719	200,000	380,051	447,909	124,506	62,253
Nevada	750,000	200,000	200,000	200,000	100,000	50,000
New Hampshire	781,445	200,000	200,000	231,445	100,000	50,000
New Jersey	4,311,839	1,013,574	1,235,325	1,455,895	404,697	202,348
New Mexico	1,160,105	200,000	359,596	423,802	117,805	58,902
New York	10,603,987	2,555,538	3,014,449	3,552,685	987,543	493,772
North Carolina	5,972,147	646,726	1,994,572	2,350,707	653,428	326,714
North Dakota	823,436	200,000	217,317	256,119	100,000	50,000
Ohio	7,684,355	929,259	2,530,039	2,981,783	828,849	414,425
Oklahoma	2,643,383	310,071	873,914	1,029,953	286,297	143,148
Oregon	1,624,095	228,785	522,596	615,907	171,204	85,603
Pennsylvania	9,807,233	2,012,177	2,919,544	3,440,834	956,452	478,226
Rhode Island	810,289	200,000	211,282	249,007	100,000	50,000
South Carolina	3,420,560	334,052	1,156,014	1,362,423	378,714	189,357
South Dakota	850,895	200,000	229,921	270,974	100,000	50,000
Tennessee	4,757,268	615,259	1,551,339	1,828,334	503,224	254,112
Texas	10,972,317	1,299,261	3,622,926	4,269,806	1,186,883	593,441
Utah	1,136,577	200,000	350,784	413,416	114,918	57,459
Vermont	750,000	200,000	200,000	200,000	100,000	50,000
Virginia	4,498,586	606,121	1,457,875	1,718,182	477,605	238,803
Washington	2,267,889	392,457	702,420	827,839	230,115	115,058
West Virginia	2,290,219	349,048	727,042	856,857	238,182	119,090
Wisconsin	3,362,670	328,842	1,061,376	1,250,886	347,711	173,855
Wyoming	750,000	200,000	200,000	200,000	100,000	50,000
American Samoa	51,175	1,978	18,426	21,716	6,036	3,019
Guam	375,000	100,000	100,000	100,000	50,000	25,000
Puerto Rico	4,577,046	450,010	1,545,731	1,821,725	505,387	253,193
Virgin Islands	375,000	100,000	100,000	100,000	50,000	25,000

TABLE 1.—HILL-BURTON GRANTS: ALLOCATIONS TO STATES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND RELATED HEALTH FACILITIES, FISCAL YEARS 1969-72—Continued

State	Total	Modernization	Hospitals and public health centers	Long-term care facilities	Diagnostic or treatment centers	Rehabilitation facilities
1971						
Total.....	171,720,000	50,000,000	16,400,000	20,320,000	70,000,000	15,000,000
Alabama.....	3,583,851	536,706	300,000	391,445	1,958,645	397,055
Alaska.....	1,200,000	300,000	300,000	300,000	200,000	100,000
Arizona.....	1,750,396	300,000	300,000	300,000	707,061	143,335
Arkansas.....	2,310,311	338,807	300,000	300,000	1,140,336	231,168
California.....	8,715,388	2,325,744	300,000	867,725	4,341,761	380,158
Colorado.....	1,966,225	526,417	300,000	300,000	698,258	141,550
Connecticut.....	1,967,408	716,752	300,000	300,000	540,987	109,669
Delaware.....	1,200,000	300,000	300,000	300,000	200,000	100,000
District of Columbia.....	1,200,000	300,000	300,000	300,000	200,000	100,000
Florida.....	5,042,959	1,210,984	300,000	503,278	2,518,208	510,489
Georgia.....	4,124,611	771,818	300,000	434,998	2,176,564	441,231
Hawaii.....	1,233,723	300,000	300,000	300,000	233,723	100,000
Idaho.....	1,317,315	300,000	300,000	300,000	317,315	100,000
Illinois.....	6,005,622	2,431,271	300,000	466,568	2,334,529	473,254
Indiana.....	3,906,922	1,392,815	300,000	315,492	1,578,602	320,013
Iowa.....	2,608,846	920,196	300,000	300,000	905,157	183,493
Kansas.....	2,345,838	785,068	300,000	300,000	798,831	161,939
Kentucky.....	3,201,234	630,159	300,000	323,609	1,619,219	328,247
Louisiana.....	3,857,231	971,174	300,000	368,492	1,843,793	373,772
Maine.....	1,454,903	328,282	300,000	300,000	426,621	100,000
Maryland.....	2,295,896	477,365	300,000	300,000	1,013,147	205,384
Massachusetts.....	4,351,125	2,075,926	300,000	300,000	1,392,843	282,356
Michigan.....	5,248,395	1,676,086	300,000	466,277	2,333,073	472,959
Minnesota.....	3,153,688	1,049,968	300,000	300,000	1,250,267	253,453
Mississippi.....	2,785,582	364,414	300,000	302,249	1,542,339	306,580
Missouri.....	3,940,580	1,319,049	390,000	330,799	1,655,193	335,539
Montana.....	1,278,915	300,000	300,000	300,000	278,915	100,000
Nebraska.....	1,492,746	300,000	300,000	300,000	492,746	100,000
Nevada.....	1,200,000	300,000	300,000	300,000	200,000	100,000
New Hampshire.....	1,254,586	300,000	300,000	300,000	254,586	100,000
New Jersey.....	4,527,306	1,980,923	300,000	320,091	1,601,614	324,678
New Mexico.....	1,466,199	300,000	300,000	300,000	466,199	100,000
New York.....	10,344,755	4,553,297	300,000	781,063	3,908,140	792,255
North Carolina.....	5,128,165	1,201,211	300,000	516,811	2,535,926	524,217
North Dakota.....	1,281,757	300,000	300,000	300,000	281,757	100,000
Ohio.....	6,538,653	1,638,075	300,000	655,545	3,280,095	664,938
Oklahoma.....	2,567,115	604,364	300,000	300,000	1,133,058	229,693
Oregon.....	1,838,826	423,943	300,000	300,000	677,534	137,349
Pennsylvania.....	9,538,650	3,929,849	300,000	756,461	3,785,040	767,300
Rhode Island.....	1,273,925	300,000	300,000	300,000	273,925	100,000
South Carolina.....	2,996,889	594,310	300,000	300,000	1,498,753	303,826
South Dakota.....	1,298,046	300,000	300,000	300,000	298,046	100,000
Tennessee.....	4,233,766	1,112,833	300,000	401,960	2,011,253	407,720
Texas.....	9,504,132	2,616,156	300,000	938,733	4,697,059	952,184
Utah.....	1,454,762	300,000	300,000	300,000	454,762	100,000
Vermont.....	1,200,000	300,000	300,000	300,000	200,000	100,000
Virginia.....	4,125,804	1,174,806	300,000	377,746	1,890,094	383,158
Washington.....	2,461,557	766,321	300,000	300,000	910,633	184,603
West Virginia.....	2,450,982	717,316	300,000	300,000	942,586	191,080
Wisconsin.....	3,265,948	1,010,923	300,000	300,000	1,376,069	278,956
Wyoming.....	1,200,000	300,000	300,000	300,000	200,000	100,000
American Samoa.....	750,000	200,000	200,000	200,000	100,000	50,000
Guam.....	750,000	200,000	200,000	200,000	100,000	50,000
Puerto Rico.....	4,028,467	916,672	300,000	400,658	2,004,738	406,399
Trust Territory.....	750,000	200,000	200,000	200,000	100,000	50,000
Virgin Islands.....	750,000	200,000	200,000	200,000	100,000	50,000

TABLE 1.—HILL-BURTON GRANTS: ALLOCATIONS TO STATES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND RELATED HEALTH FACILITIES, FISCAL YEARS 1969-72—Continued

State	Total	Modernization	Hospitals and public health centers	Long-term care facilities	Diagnostic or treatment centers	Rehabilitation facilities
1972						
Total.....	194,900,000	50,000,000	40,250,000	19,650,000	70,000,000	15,000,000
Alabama.....	4,188,571	526,566	1,014,369	355,837	1,904,969	386,830
Alaska.....	1,200,000	300,000	300,000	300,000	200,000	100,000
Arizona.....	1,819,715	300,000	374,222	300,000	702,783	142,710
Arkansas.....	2,521,617	330,126	580,330	300,000	1,089,852	221,309
California.....	10,969,161	2,357,609	2,385,384	836,785	4,479,716	909,667
Colorado.....	2,149,437	536,814	402,727	300,000	756,316	153,580
Connecticut.....	1,967,424	717,225	300,000	300,000	540,453	109,746
Delaware.....	1,200,000	300,000	300,000	300,000	200,000	100,000
District of Columbia.....	1,200,000	300,000	300,000	300,000	200,000	100,000
Florida.....	6,013,391	1,224,471	1,326,522	465,340	2,491,189	505,869
Georgia.....	4,723,773	757,180	1,098,739	385,434	2,063,416	419,004
Hawaii.....	1,227,026	300,000	300,000	300,000	227,026	100,000
Idaho.....	1,334,854	300,000	300,000	300,000	334,854	100,000
Illinois.....	7,226,850	2,453,126	1,322,313	463,863	2,483,284	504,264
Indiana.....	4,639,957	1,407,044	895,511	314,142	1,681,757	341,503
Iowa.....	2,927,735	929,882	520,920	300,000	978,280	198,653
Kansas.....	2,463,324	781,623	423,921	300,000	796,118	161,662
Kentucky.....	3,669,239	625,092	841,934	300,000	1,581,141	321,072
Louisiana.....	4,400,140	960,342	952,820	334,245	1,789,376	363,357
Maine.....	1,475,010	330,596	306,000	300,000	444,414	100,000
Maryland.....	2,573,699	484,261	549,019	300,000	1,031,050	209,369
Massachusetts.....	4,794,952	2,082,480	740,173	300,000	1,390,034	282,265
Michigan.....	6,367,206	1,691,057	1,295,285	454,382	2,432,535	493,957
Minnesota.....	3,580,635	1,056,987	682,240	300,000	1,281,236	260,172
Mississippi.....	3,078,736	346,767	746,155	300,000	1,401,268	284,546
Missouri.....	4,535,710	1,321,257	890,675	312,446	1,672,673	339,659
Montana.....	1,294,566	300,000	300,000	300,000	294,566	100,000
Nebraska.....	1,523,755	300,000	300,000	300,000	518,472	105,283
Nevada.....	1,200,000	300,000	300,000	300,000	200,000	100,000
New Hampshire.....	1,262,946	300,000	300,000	300,000	262,946	100,000
New Jersey.....	5,151,828	1,985,963	876,385	307,433	1,645,838	334,209
New Mexico.....	1,489,209	300,000	300,000	300,000	489,209	100,000
New York.....	11,642,494	4,527,098	1,970,952	691,403	3,701,418	751,623
North Carolina.....	5,977,674	1,182,071	1,398,984	459,187	2,458,251	499,181
North Dakota.....	1,288,394	300,000	300,000	300,000	288,394	100,000
Ohio.....	8,067,855	1,640,149	1,780,463	624,581	3,343,682	678,980
Oklahoma.....	2,870,251	603,422	603,445	300,000	1,132,260	230,124
Oregon.....	1,957,281	429,874	379,650	300,000	712,977	144,780
Pennsylvania.....	11,341,528	3,935,804	2,051,372	719,615	3,852,446	782,291
Rhode Island.....	1,276,467	300,000	300,000	300,000	276,467	100,000
South Carolina.....	3,342,108	581,376	754,980	300,000	1,417,840	287,912
South Dakota.....	1,299,489	300,000	300,000	300,000	299,489	100,000
Tennessee.....	4,886,243	1,104,934	1,047,416	367,430	1,967,031	399,432
Texas.....	11,333,449	2,598,329	2,419,612	848,793	4,543,996	922,719
Utah.....	1,478,323	300,000	300,000	300,000	478,323	100,000
Vermont.....	1,200,000	300,000	300,000	300,000	200,000	100,000
Virginia.....	4,702,248	1,167,546	979,105	343,467	1,838,748	373,382
Washington.....	2,747,025	772,880	513,646	300,000	964,620	197,879
West Virginia.....	2,627,584	712,289	495,591	300,000	930,711	188,993
Wisconsin.....	3,879,886	1,028,172	782,894	300,000	1,470,263	298,557
Wyoming.....	1,200,000	300,000	300,000	300,000	200,000	100,000
American Samoa.....	750,000	200,000	200,000	200,000	100,000	50,000
Guam.....	750,000	200,000	200,000	200,000	100,000	50,000
Puerto Rico.....	4,671,235	908,588	1,042,246	365,617	1,957,323	397,461
Trust Territory.....	750,000	200,000	200,000	200,000	100,000	50,000
Virgin Islands.....	750,000	200,000	200,000	200,000	100,000	50,000

NOTES

Basis of allocations, per statutory formula (1969):

(a) Total population, as estimated by the Bureau of the Census: (1) Provisional estimates of the United States, July 1, 1967 (series P-25, No. 373, Sept. 6, 1967); American Samoa, Guam, Puerto Rico, and Virgin Islands, provisional estimates as of July 1, 1967, (series P-25, No. 392, May 2, 1968).

(b) Allotment percentages for fiscal years 1968 and 1969, as determined by the Surgeon General Sept. 30, 1966.

Basis of allocations, per statutory formula (1970):

(a) Total population as estimated by the Bureau of the Census: (1) Provisional estimates of the United States, July 1, 1969 (series P-25, No. 430, Aug. 29, 1969); (2) American Samoa, Guam, Puerto Rico, and Virgin Islands, provisional estimates as of July 1, 1968 (unpublished data).

(b) Allotment percentages for fiscal year 1970, as determined by the Surgeon General, Sept. 30, 1968.

TABLE 2.—HILL-BURTON LOAN ALLOTMENT

Fiscal year 1971 loan and loan guarantee allocation to States for modernization and construction of hospitals and other health facilities

Total ----- \$500, 000, 000			
Alabama -----	8, 236, 500	New Jersey -----	\$18, 222, 500
Alaska -----	456, 500	New Mexico -----	2, 151, 000
Arizona -----	3, 247, 500	New York -----	42, 450, 500
Arkansas -----	4, 992, 000	North Carolina -----	14, 544, 000
California -----	26, 721, 000	North Dakota -----	1, 613, 500
Colorado -----	5, 432, 500	Ohio -----	19, 301, 000
Connecticut -----	6, 509, 500	Oklahoma -----	6, 954, 000
Delaware -----	1, 659, 500	Oregon -----	4, 624, 500
Dist. of Columbia -----	1, 355, 000	Pennsylvania -----	37, 465, 500
Florida -----	14, 470, 500	Rhode Island -----	1, 613, 500
Georgia -----	10, 460, 000	South Carolina -----	7, 670, 500
Hawaii -----	1, 323, 000	South Dakota -----	2, 496, 500
Idaho -----	1, 888, 500	Tennessee -----	12, 642, 500
Illinois -----	23, 163, 000	Texas -----	29, 653, 500
Indiana -----	13, 792, 000	Utah -----	2, 509, 000
Iowa -----	8, 813, 500	Vermont -----	1, 098, 500
Kansas -----	7, 577, 000	Virginia -----	12, 842, 000
Kentucky -----	8, 198, 000	Washington -----	7, 679, 000
Louisiana -----	11, 224, 500	West Virginia -----	7, 383, 500
Maine -----	3, 369, 000	Wisconsin -----	10, 508, 500
Maryland -----	5, 748, 500	Wyoming -----	759, 500
Massachusetts -----	18, 478, 000	American Samoa -----	79, 500
Michigan -----	17, 534, 500	Guam -----	435, 500
Minnesota -----	10, 527, 000	Puerto Rico -----	11, 167, 000
Mississippi -----	5, 987, 500	Trust Territories -----	235, 500
Missouri -----	13, 408, 000	Virgin Islands -----	309, 000
Montana -----	2, 703, 000		
Nebraska -----	3, 202, 500		
Nevada -----	912, 000		
New Hampshire -----	1, 894, 500		

Fiscal year 1972 loan and loan guarantee allocations to States for modernization and construction of hospitals and other health facilities

Total ----- \$500, 000, 000			
Alabama -----	8, 041, 500	Illinois -----	23, 637, 500
Alaska -----	460, 000	Indiana -----	14, 114, 500
Arizona -----	3, 255, 000	Iowa -----	9, 039, 500
Arkansas -----	4, 815, 500	Kansas -----	7, 542, 000
California -----	27, 244, 500	Kentucky -----	8, 075, 000
Colorado -----	5, 633, 000	Louisiana -----	11, 021, 000
Connecticut -----	6, 509, 500	Maine -----	3, 423, 000
Delaware -----	1, 720, 000	Maryland -----	5, 836, 000
Dist. of Columbia -----	1, 353, 500	Massachusetts -----	18, 512, 500
Florida -----	14, 506, 000	Michigan -----	17, 853, 000
Georgia -----	10, 101, 500	Minnesota -----	10, 641, 500
Hawaii -----	1, 294, 000	Mississippi -----	5, 613, 000
Idaho -----	1, 936, 000	Missouri -----	13, 456, 500

TABLE 2.—HILL-BURTON LOAN ALLOTMENT—Continued

Fiscal year 1972 loan and loan guarantee allocations to States for modernization and construction of hospitals and other health facilities—Continued

Montana -----	\$2,746,500	South Dakota -----	\$2,501,500
Nebraska -----	3,286,000	Tennessee -----	12,482,000
Nevada -----	937,000	Texas -----	29,176,000
New Hampshire -----	1,924,000	Utah -----	2,579,000
New Jersey -----	18,354,500	Vermont -----	1,102,500
New Mexico -----	2,221,500	Virginia -----	12,671,000
New York -----	41,715,000	Washington -----	7,841,000
North Carolina -----	14,119,000	West Virginia -----	7,317,000
North Dakota -----	1,938,500	Wisconsin -----	10,836,000
Ohio -----	19,445,000	Wyoming -----	794,500
Oklahoma -----	6,944,500	American Samoa -----	68,000
Oregon -----	4,743,000	Guam -----	389,000
Pennsylvania -----	37,638,500	Puerto Rico -----	10,999,000
Rhode Island -----	1,629,500	Trust Territory -----	244,500
South Carolina -----	7,396,000	Virgin Islands -----	325,500

TABLE 3.—SUMMARY OF TOTAL AID TO DISTRICT OF COLUMBIA HEALTH FACILITIES, FISCAL YEARS 1969-72

Type of funds	Fiscal years				Totals
	1969	1970	1971	1972	
Hill-Burton grants -----	\$753,261	\$750,000	\$1,200,000	\$1,200,000	\$3,903,261
Public Law 90-457 grants -----	7,500,000	3,500,000	5,000,000	22,167,000	38,167,000
Hill-Burton guaranteed subsidized loans -----			1,350,000	1,353,000	2,708,500
Public Law 90-457 2½ percent direct loans -----	7,500,000	5,000,000	10,000,000	16,575,000	39,075,000
Total -----	15,753,261	9,250,000	17,555,000	41,295,500	83,853,761

TABLE 4.—DETAILS OF HILL-BURTON GRANTS BY FACILITY

Fiscal year 1969

	<i>Grant</i>
George Washington University Hospital: remodeling -----	\$35,000.00
Hillcrest Children's Home: fourth floor addition -----	47,000.00
Columbia Hospital for Women: renovation -----	220,191.00
Columbia Lighthouse for the Blind: addition and alterations -----	290,300.00
Georgetown University Hospital: third floor renovation -----	160,770.00
Total -----	753,261.00

Fiscal year 1970

Georgetown University Hospital: fourth floor modernization -----	107,000.00
George Washington University Hospital: modernization -----	570,512.05
Columbia Hospital for Women: renovation of surgical suite and nursery (revised by PHS to become part of DC-38) -----	71,758.00
Total -----	749,270.05

Fiscal year 1971 (estimates only)

Georgetown University Hospital:	
Renovation OB-Gyn, nursery -----	318,800
Modernization dietary department -----	308,540
Addition to emergency stair towers -----	97,100
Total -----	724,440
Columbia Hospital for Women -----	77,977
Total -----	802,417
George Washington University Hospital: ¹	
Elevator modernization -----	(111,667)
Radiology expansion -----	(1,665,750)
Total -----	(1,777,417)

¹ Request only. Approved amounts for Georgetown and Columbia, fiscal year 1971, total \$802,717. Total fiscal year 1971 allotment for District of Columbia of \$1.2 million leaves difference of \$397,583 available to apply to George Washington request.

Fiscal year 1972

No projects considered as yet.

No loans have been processed under Hill-Burton guaranteed loan with interest subsidy program, fiscal year 1971-72.

TABLE 5.—DETAILS OF AID TO DISTRICT OF COLUMBIA HOSPITALS UNDER PUBLIC LAW 90-457, FISCAL YEARS 1969-72¹

Institution and fiscal year	Grants	Loans	Totals
Children's Hospital:			
1969.....	\$850,000		
1970.....	579,000	\$457,975	
1971.....	3,250,000	7,200,000	
1972.....	8,720,579	5,741,604	
Total.....			\$26,799,158
Georgetown University Hospital:			
1969.....	3,100,000	5,950,000	
1970.....	1,073,000	2,309,535	
1971.....	520,000	370,000	
1972.....	1,496,000	2,450,465	
Total.....			17,269,000
George Washington University Hospital:			
1969.....	3,250,000	1,400,000	
1970.....	814,000	1,620,000	
1971.....			
1972.....		456,842	
Total.....			7,540,842
Washington Hospital Center:			
1969.....	200,000	100,000	
1970.....	959,000	612,490	
1971.....			
1972.....	6,730,421	3,896,089	
Total.....			12,498,000
Grand total.....			64,107,000

¹ Fiscal years 1969-71 are obligated funds; fiscal year 1972 funds are approved as indicated.

Mr. STUCKEY. Mr. Seggel, one other question. Can these hospitals build the outpatient and the renovation projects that they are speaking of without this bill that is before us?

Mr. SEGSEL. We believe that the necessary requirements can be met under the provisions of the Hill-Burton Act.

Mr. STUCKEY. What impact do you think that this would have on the District of Columbia if these facilities were not built?

Mr. SEGSEL. Well, Mr. Chairman, we haven't really gotten into the evaluation of these particular facilities that are being projected by the local hospitals because we feel that this should go through the local authorities and be judged by them before we comment on them. We are not in a position to comment officially about the program that is being projected by this bill.

Mr. STUCKEY. What would happen to some of the projects that have already begun construction but have not been completed, like the Children's Hospital and I believe Rogers Memorial Hospital, if this bill was not passed and yet these projects do not have the approval of the Secretary of HEW?

Mr. SEGSEL. Well, the projects that have been approved and the financing that has been provided for each are designed to complete the whole project. Now, I understand that there are additional things that

are being projected for these hospitals but the projects that we have approved and financed are whole projects in our view. In other words, they will be completed as we approved them. Also, there are provisions in each one for contingencies against increases in cost.

Mr. STUCKEY. Dr. Graning and Mr. Schaeffer, do you have any comments to add:

Dr. GRANING. Not at this time, sir.

Mr. STUCKEY. Thank you very much.

Mr. SEGGER. Thank you.

(Subsequently, additional information was submitted for the record; see appendix, p. 88.)

Mr. STUCKEY. At this time we will hear from Mr. Robinson, the Assistant Corporation Counsel of the District of Columbia. Good morning.

STATEMENT OF WILLIAM A. ROBINSON, ASSISTANT CORPORATION COUNSEL

Mr. ROBINSON. Good morning, Mr. Chairman.

Mr. Chairman, the District of Columbia has no prepared statement with respect to H.R. 11628. You have before you, however, a report on the bill, addressed to the Chairman, which we ask be included in the record.

Mr. STUCKEY. If there are no objections, it is so ordered and will be included.

(The report follows:)

GOVERNMENT OF THE DISTRICT OF COLUMBIA,
Washington, D.C., December 1, 1972.

HON. JOHN L. McMILLAN,
Chairman, Committee on the District of Columbia,
U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The Commissioner of the District of Columbia has for report H.R. 11628, a bill "To authorize grants and loan guarantees for construction or modernization of hospitals and other medical facilities in the District of Columbia".

The bill extends for four years and expands the program of Federal grants and loans to private nonprofit hospitals and other medical facilities authorized by the District of Columbia Medical Facilities Construction Act of 1968 (Public Law 90-457). H.R. 11628 authorizes the Secretary of Health, Education, and Welfare to make grants for fiscal years 1972 through 1975, of a total not in excess of \$70,000,000, to "nonprofit private entities" for purposes of hospital modernization and construction. The grants may be made for long-term care facilities, including extended care facilities, diagnostic or treatment centers, outpatient facilities, rehabilitation facilities, facilities for the mentally retarded, and community mental health centers in the District of Columbia. In addition, the Secretary is authorized to guarantee payment of loans made for hospital construction and modernization projections, and to provide subsidies in amounts sufficient to reduce the interest rate on such loans to three percent.

Under H.R. 11628, the authorized grants or loan guarantees would be available only if an application has been filed under a "Medical Facilities Act" (Federally-sponsored Hill-Burton, mental retardation, or mental health center programs) and "(1) has been approved under the Medical Facilities Act and the application filed under . . . [H.R. 11628] is for additional funds in connection therewith, or (2) has been denied under the Medical Facilities Act because insufficient funds are available from the allotments of the District of Columbia under the Medical Facilities Act to permit approval of the application.

Unlike Public Law 90-457, H.R. 11628 would provide grants to "nonprofit private entities" only for the benefit of private hospital facilities. This represents a departure from the policy established in the 1968 law which anticipated

that funds might appropriately be made available for publicly-sponsored hospitals and related medical projects in the District of Columbia.

Both the 1968 Act and H.R. 11628 specifically refer to affording review of any new hospital projects by a metropolitan areawide planning body. It would be desirable before any further enabling legislation is enacted to have such review to insure that any new facilities are actually needed and appropriately related to existing facilities and services in the entire metropolitan area. One of the central issues with respect to the further development of health care facilities in the District of Columbia is the proper relationship between private and public facilities. This relationship is particularly acute in the case of treatment by private medical entities of residents of the District who are indigent.

In this regard, it should be noted that the District's Department of Human Resources is planning a 1972 revision of its State Plan for the Construction and Modernization of Hospitals to provide in effect that private entities, to conform to the State Plan, must not refer patients to D.C. General Hospital unless absolutely necessary. In addition, it is the Department's position that private hospital facilities should make every effort to treat patients without referring them elsewhere unless because of the nature of their illness they can be better treated in other facilities. Finally, various proposals now pending in Congress and which are national in scope will enable private hospitals to be reasonably reimbursed for the costs of all services rendered to indigent patients.

Since H.R. 11628 would authorize the Secretary of the Department of Health, Education, and Welfare to administer the proposed program of grants and loan subsidies, the Commissioner of the District of Columbia defers to the views of the Secretary on H.R. 11628.

The Office of Management and Budget has advised that, from the standpoint of the Administration's program, there is no objection to the submission of this report to the Congress.

Sincerely yours,

GRAHAM W. WATT,

Assistant to the Commissioner.

(For Walter E. Washington, Commissioner).

Mr. ROBINSON. I think the objectives and purposes of H.R. 11628 have been adequately explained to the committee so I will pass over that and simply refer to certain statements made in the report.

Unlike Public Law 90-457, H.R. 11628 would provide grants to "nonprofit private entities" only for the benefit of private hospital facilities. This represents a departure from the policy established in the 1968 law which anticipated that funds might appropriately be made available for publicly-sponsored hospitals and related medical projects in the District of Columbia.

Both the 1968 Act and H.R. 11628 specifically refer to affording review of any new hospital projects by a metropolitan areawide planning body. It would be desirable before any further enabling legislation is enacted to have such review to insure that any new facilities are actually needed and appropriately related to existing facilities and services in the entire metropolitan area. One of the central issues with respect to the further development of health care facilities in the District of Columbia is the proper relationship between private and public facilities. This relationship is particularly acute in the case of treatment by private medical entities of residents of the District who are indigent.

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make every effort to treat patients without referring them elsewhere unless because of the nature of their illness they can be better treated in other facilities. Finally, various proposals now pending in Congress and which are national in scope will enable private hospitals to be reasonably reimbursed for the costs of all services rendered to indigent patients.

Since H.R. 11628 would authorize the Secretary of the Department of Health, Education, and Welfare to administer the proposed program of grants and loan subsidies, the Commissioner of the District of Columbia defers to the views of the Secretary on H.R. 11628.

Thank you, Mr. Chairman.

Mr. STUCKEY. Thank you, Mr. Robinson.

Are you saying now, then, that a lot of the private hospitals do not properly take care of the patients that are being admitted there?

Mr. ROBINSON. Not necessarily that they do not properly take care of those admitted, but in many instances the indigent patients or those considered public patients are referred to public facilities, primarily D.C. General Hospital. The District, of course, has contracts with certain of the hospitals to treat many indigent patients.

Mr. STUCKEY. Mr. Fauntroy?

Mr. FAUNTROY. On that point, Mr. Robinson, how does your statement fit in with the complaint that I have gotten from some people in the Southeast, for example, that they are not able to avail themselves of services, that, say, Cafritz Hospital often refers to D.C. General in a fashion that they don't feel that they get prompt and adequate treatment?

Mr. ROBINSON. Generally, Mr. Fauntroy, that is a correct statement. As we have indicated, in the consideration of H.R. 11628 further review should be given to that problem to insure that before additional facilities are constructed or additional funds are authorized that those types of activities be reviewed and studied to make certain that the entire medical needs of the entire population of the District are adequately met.

Mr. FAUNTROY. Are you indicating that the funds made available through this bill should carry with them some sort of understanding or agreement that that complaint should not emanate from the people in that community?

Mr. ROBINSON. Yes, Mr. Fauntroy. As I have indicated, the District has under active consideration a plan which in its capacity as the State agency for hospital programs in the District would require such a program.

Mr. FAUNTROY. Thank you, Mr. Chairman.

Mr. STUCKEY. Mr. Robinson, one more thing. If it could be made available for the subcommittee we would like to see the plan that you refer to that the D.C. Government does have.

Mr. ROBINSON. Yes, sir.

(The plan (District of Columbia Plan for the Construction and Modernization of Hospitals, Public Health Centers and Medical Facilities, 1971-1972) was filed with the committee.)

Mr. STUCKEY. Thank you, Mr. Robinson.

Mr. ROBINSON. Thank you.

Mr. STUCKEY. Next we will hear from Mrs. Margaret Ewing, Attorney for the Senior Citizens Clearing House Committee.

**STATEMENT OF MRS. MARGARET EWING, ATTORNEY FOR SENIOR
CITIZENS CLEARING HOUSE COMMITTEE**

Mrs. EWING. My name is Margaret Ewing. I am counsel for the Greater D.C. Area Council of Senior Citizens, the Senior Citizens Clearing House Committee of the District of Columbia and the D.C. Family Welfare Rights Organization in several lawsuits aimed at improving the level of health care received by elderly and indigent citizens.

I strongly believe that greater Federal assistance is needed if all the residents of the District are to receive adequate hospital care. But I do not believe that the proposed legislation does enough to assure that more hospital care will be given to those who need it most—the poor and the elderly. I am, therefore, submitting two amendments to H.R. 11628 for the consideration of this committee. These amendments should enable the elderly and the poor to benefit more fully from this legislation.

First, H.R. 11628 should be amended to make certain that the District Government and HEW enforce the obligations imposed on hospitals which receive Federal assistance. Under the Hill-Burton Act, as under the proposed legislation, hospitals receiving Federal funds are required to provide a community service and a reasonable volume of free and below-cost care. The District Government and HEW have the power to enforce this requirement, but in the past they have failed to do so. This failure is dramatically demonstrated by the situation in several hospitals.

For instance, Cafritz Hospital has received substantial sums of money from the allocated funds under the Hill-Burton Act to meet the hospital needs in the District of Columbia. In order to obtain these funds, it promised to provide a community service and a reasonable volume of free and below-cost care to persons unable to pay. It also represented that it would provide the Anacostia community with a sorely needed out-patient facility.

In fact, Cafritz Hospital has consistently refused to provide any free or below-cost care to the medically indigent. Until this summer, Cafritz billed and attempted to collect from every patient who used the hospital—no matter how poor.

Furthermore, the hospital has refused to sign a medical charities contract with the District of Columbia which would result in its rendering below-cost care to indigents and it has failed to establish the out-patient facilities. In short, Cafritz has largely turned its back on the District: less than 30 percent of its in-patients are District of Columbia residents.

The pattern at several other Washington hospitals is similar. Less than 35 percent of the patients at Providence and Sibley Hospitals, for example, are from the District of Columbia. This suggests that they, too, may not now be meeting their obligations to serve their community and provide a reasonable volume of free services to the poor.

H.R. 11628 now provides that an application for funds must be approved under a Medical Facilities Act or, if denied under such an Act, including the Hill-Burton Act, could be approved by the Secre-

tary only if it complies with the same terms and conditions which would have been applicable under the other Act. In the case of applications under H.R. 11628 for funds for the modernization and construction of hospitals this means that the applicant would have to give assurances that it would provide a reasonable volume of free or below-cost care to persons unable to pay and that it would be made available to all persons residing in the territory surrounding the facility.

The amendment I propose would require that the District Government or HEW enforce such obligations undertaken by the hospitals which receive money under this Act. Such enforcement should include initiation of legal action in the United States District Court when necessary.

My second amendment is a closely related one. It seems foolish in the extreme to provide new million-dollar grants to hospitals which have not lived up to their obligations with respect to previous grants. I propose, therefore, that no hospital receive money under the bill now under consideration unless the District Government certifies and the Secretary of HEW makes a determination that the hospital is meeting its obligations under previous grants. In this way the Congress can assure that its mandates are being respected and that the elderly and the indigent are receiving the hospital care which Congress intended them to have.

I thank the committee for this opportunity to testify and submit two amendments for your consideration.

Mr. STUCKEY. Mrs. Ewing, where are you getting your figures from?

Mrs. EWING. Which figures are you referring to?

Mr. STUCKEY. The 35 percent of the patients at Providence and Sibley Hospitals.

Mrs. EWING. Those are contained in a report by the Hospital Facilities Council of metropolitan Washington area. I can provide those for the record if you would like to have that.

Mr. STUCKEY. I would appreciate it.

(The information follows:)

Mr. STUCKEY. Also you are saying that a lot of the poor are really not receiving the treatment that they should in many of the hospitals and that the hospitals are making efforts to collect on all the bills. Yet we have been provided with figures that there is around \$22 million that goes uncollected each year.

Mrs. EWING. \$22 million goes uncollected?

Mr. STUCKEY. Yes.

Mrs. EWING. Where?

Mr. STUCKEY. At the various hospitals.

Mrs. EWING. In all of the hospitals?

Mr. STUCKEY. All.

Mrs. EWING. That may be true. I am sure hospitals have accounts receivable which they are unable to collect for various reasons from persons who are poor and persons who are not poor, and we don't suggest that every hospital in the city is in violation of their obligations to provide free care, but we do know that some clearly are, and I think neither the District Government nor HEW has sufficient information to know about many of the others. We suggest they get that.

Mr. STUCKEY. Mr. Fauntroy?

Mr. FAUNTROY. Mrs. Ewing, how familiar are you with the Cafritz Hospital situation and the complaints of the community?

Mrs. EWING. Well, I am representing several community groups in a suit against the hospital.

Mr. FAUNTROY. I wonder if you would detail for us the genesis of that action, where you are now?

Mrs. EWING. Well, the action was brought by the three groups which I mentioned at the beginning of my testimony. Two Senior Citizens organizations and the Welfare Rights Organization in the District. It was filed in the District Court in February of this year and assigned to Judge Gesell. Judge Gesell has denied the motion of the defendant, Cafritz Hospital, to dismiss this suit. We are now in discovery and we expect that we should get a decision, or a hearing at any rate, in April.

Mr. FAUNTROY. Would you detail the basis for the suit?

Mrs. EWING. The basis for the suit is that the hospital has received funds under the Hill-Burton Act and the D.C. Hospital Construction Act. It also received property under the Federal Surplus Property Act free of charge from the Federal Government, all on representations that it would serve the Southeast area of Washington and that it would provide a reasonable volume of free services to the poor, and we believe that they have failed to fulfill both of those obligations, that they don't provide free services to persons unable to pay and that they don't make their facilities available to all residents of the Southeast area. Their in-patient statistics indicate that in fact only 26 percent of their in-patients are from the District.

Mr. FAUNTROY. Could you give us a couple of examples of the kinds of experiences the people have had?

Mrs. EWING. People come to the emergency room in many cases and are given emergency treatment when that is needed, and then are either referred or just told that they may not come back to the hospital for any further care unless they can pay. A patient who comes and seeks to be admitted as an in-patient is denied admission unless he has third party insurance coverage, Blue Cross, Blue Shield, or a private insurer, covered by Medicaid or can put up a \$350 cash deposit. There is no other arrangement for the admission of in-patients except for meeting those financial requirements.

Mr. FAUNTROY. What is your estimate of how much money Cafritz would receive if this bill were passed?

Mrs. EWING. I understood that under this bill they were asking for a \$10 million grant and an \$8 million subsidized loan, so it would be an \$8 million grant, as I understand it, largely to finance an out-patient facility which we think is indeed needed.

Mr. FAUNTROY. So you feel it is needed but you would want to assure that the people receive the services?

Mrs. EWING. Yes. The out-patient facility they have now is only available to persons who make an arrangement to see a private physician in that office. You don't walk in off the street and ask to make an appointment in the Pediatrics Clinic, for instance. It does not operate that way.

Mr. STUCKEY. Basically, you are in favor of the bill but you just want to be sure that the poor and the indigent receive the case?

Mrs. EWING. Yes. The only point we want to stress this morning is that hospitals ought to be asked to fulfill their past obligations and the assurances which they made when they received funds in the past and

that the obligations which they will undertake under this bill also ought to be enforced by the District of Columbia Government and HEW.

Mr. STUCKEY. If there are no objections we would like to include in the record the two proposed amendments to H.R. 11628. They will be made a part of the record.

(The amendments follow:)

PROPOSED AMENDMENTS TO H.R. 11628

MARGARET EWING, WASHINGTON REPRESENTATIVE, HEALTH LAW PROJECT, UNIVERSITY OF PENNSYLVANIA LAW SCHOOL

1. Add to Section 4(c):

Before any application is approved, the appropriate State agency or District of Columbia shall certify to the Secretary whether the applicant has complied with all terms and conditions applicable to previous grants it has received under the Medical Facilities Act, the District of Columbia Hospital Center Construction Act, the District of Columbia Medical Facilities Construction Act, and any other Acts providing federal or District of Columbia funds for the construction of medical facilities in the District of Columbia and with any assurances made in applications or other documents submitted to any Committee of Congress, the Secretary, the appropriate State agency, the District of Columbia or metropolitan area wide planning body with respect to such grants. The Secretary shall not approve any grant or loan under this Act unless he determines, on the basis of this certification and any other evidence which he obtains or is submitted to him, that the applicant has fully complied with such terms, conditions and assurances.

2. The heading of section 6 should be changed to "Enforcement."

The present text should be subsection (a) and a subsection (b) should be added as follows:

The Secretary and the appropriate State agency or the District of Columbia shall have the responsibility to enforce compliance with the same terms and conditions as are applicable to applications for grants under the Medical Facilities Act and with any assurance made in the application or other documents submitted to the Secretary, the appropriate State agency, the District of Columbia or metropolitan area planning body for grants or loans under this Act. Such enforcement shall include the initiation of legal action in the United States District Court for the District of Columbia to compel such compliance.

Mr. STUCKEY. Thank you so much.

Mrs. EWING. Thank you.

Mr. STUCKEY. At this time we again have Father Collins of Georgetown University, and Mr. Bucher of the Hospital Council.

STATEMENT OF REVEREND T. BYRON COLLINS, S.J., CHAIRMAN, TRUSTEE PLANNING COMMITTEE; ACCOMPANIED BY WILLIAM M. BUCHER, EXECUTIVE DIRECTOR, HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA, INC., WASHINGTON, D.C.

Fr. COLLINS. Mr. Chairman, Mr. Fauntroy, on behalf of the hospitals of the District of Columbia Mr. Bucher and myself would like to respond to the questions and the points raised by the three previous speakers, which will be brief, and then try to answer any questions in your minds.

I would like to first start by stating that in meeting with the hospital representatives that the task that I as Chairman said I would undertake to do was because of a religious reason, to help the poor of the District of Columbia, and that is why I am here.

In terms of the Secretary's representative, the program offered by Mr. Seggel is unrealistic. I believe that five former Secretaries of HEW who were the proponents, sponsors, and augmenters of this bill, could understand his statement in terms of a financial position. In terms of a commitment position I am not so sure they would not raise a question.

To state that the District of Columbia hospitals have a viable means of using the HUD program as a method of construction of out-patient facilities, in my opinion is not correct. The HUD program is a guaranteed 7½ percent program where you go borrow the money from a bank, if you can. Over a 25-year period you guarantee to pay back the bank and they say, "From what sources are you going to get the money for this?"

Out-patient facilities are losers. You can't get the money from the out-patients so you have to get it from the in-patients. What does that do to our costs? What does that do to us in terms of the hospitals, the 29 hospitals that are in this package? There are only 10 in the District but we are a planning group for the whole 29, the whole metropolitan area. The costs in the District of Columbia would be disproportionate to the rest of the hospitals in Maryland and Virginia. That is the first.

The second. We would be at a distinct disadvantage in relationship to the hospitals in all of the States without this program. This is the reason the former Secretaries proposed this.

The allocation of funds that was mentioned by Mr. Seggel is correct. I am involved with the hospitals in trying to portion out these funds, the portion that comes to the private hospitals, because even the District of Columbia hospital must present its needs to participate in the Hill-Burton formula. These are absolutely inadequate.

The reason we had Public Law 90-457 was because of the 12-year backlog created by this inadequacy recognized by the former Secretaries. The reason that the public hospital is not in this, which it had been in the prior bill, was that in the wisdom of the Appropriations Committees the ability of the public hospital to go through its route of appropriation is deferred as under the District of Columbia Government and it is for this reason that no funds were, under the prior law, given to D.C. General or the public out-patient services of the District, because they have their own Federal route and the committees in their wisdom thought this should be maintained. That is the reason we deliberately discussed this with representatives of the District of Columbia Government and decided not to put it in, with their understanding.

To say that the hospitals can without this program continue I believe is not a correct statement. This is a phased program for all of the hospitals. Mr. Bucher and myself together with the hospitals have undertaken the gargantuan chore of taking funds as made available by the Appropriations Committee to achieve what must be done for the District. We have had to phase them.

Two of them, Children's Hospital and Rogers Memorial Hospital, in my opinion, from a knowledge of their financial abilities, cannot finish their project without this bill. None of the other hospitals can without this bill fulfill their obligation to the District of Columbia to meet the out-patient needs which are for the indigent persons of the District of Columbia.

In summary, then, to the Secretary's position, I question why the change. From a financial point of view the program as proposed by the financial elements of the Administration had dropped the grant program of Hill-Burton, was reinstated by the wisdom of Congress, and increased by the wisdom of Congress. The loan provisions were added by the wisdom of Congress.

We are appealing to the same wisdom of Congress that this apply to the District of Columbia.

In terms of the representative of the District of Columbia itself, I think the provisions and the ideas as advanced to him Mr. Bucher and myself had discussed with Dr. Washington and I think he fairly presented them.

I feel that as to the obligations of the hospitals to the poor of the District, if we have been negligent in some cases we must correct them. I cannot defend it, and I think he made that point clear, and whatever wisdom the committee would want to insure in the legislation to see that this is enforced I would gladly accept and the other hospitals that I represent. I have checked with the one which was questioned. They will accept it.

Mr. STUCKEY. Father Collins, let me ask you one question. You are saying that some of the hospitals have not fulfilled their obligations to the indigent and the poor people, as Mrs. Ewing said earlier. Would you agree, then, that the two amendments that she has offered would be necessary to make sure that they do comply with the regulations?

Fr. COLLINS. Under the present regulations if we were to take the ones that were the Hill-Burton and just emphasized them by reiterating them here, I think it is worth serious consideration by the committee.

Mr. STUCKEY. You stated you also know for a fact that several of the hospitals, and particularly the two that were mentioned this morning, have been negligent in fulfilling their obligations?

Fr. COLLINS. No. I know for a fact that Cafritz Hospital has had a dire problem because of the lack of facilities that would be provided for under this law. I know for another fact that they cannot, which they must do. They must do it. The only way they can provide it is by this law. They don't have the ability of funding an out-patient service.

Mr. STUCKEY. So you are saying in this particular instance we are speaking of, Cafritz Hospital, that this is the reason they are not fulfilling this obligation?

Fr. COLLINS. The basic reason is financial. That is the reason.

Mr. STUCKEY. Financial rather than attitude?

Fr. COLLINS. Absolutely. Mr. Bucher?

Mr. BUCHER. Congressman Stuckey, Mr. Gude, and Mr. Fauntroy, I am most appreciative of the opportunity to appear today and I just want to add several points to Father Collins' testimony.

I think that there may have been a question which should be cleared up with regard to the two different approaches to the provision of hospital care. If you have the facilities it doesn't necessarily mean that you can provide the care required by the community. The fact is that you must have operating funds. The representative of the Secretary indicated that the hospitals would have sufficient ability to generate sufficient income to meet their indebtedness. In fact, we are talking about provision of out-patient care. Provision of out-patient care is not a money-making program. The provision of care to people who

walk in off the street is primarily a loss leader to be picked up from funds from other sources.

Because of this there is a question of the ability of any one of the hospitals to provide continuous free care. The funds to offset the cost of the services and the supplies must come from some place.

The representative of the District of Columbia Government testified that there are programs in the District Government which meet these cost needs. Indeed, these programs are identical with comparable programs in other States. They are limited by legislation, law, in the District of Columbia as to those making a certain dollar income or those on certain specific programs. It is not a full coverage of those who need care nor is there any obligation assumed by the District of Columbia Government to meet the entire needs of the public.

The third point has to do with the representative of HEW and it has to do with the fact that the existing loan provisions under the Department of HUD or the Hill-Burton program can meet the needs of these requests that we placed before you in a combined program. The \$70 million grant and the \$60 million in subsidized loans to meet the program that we have designed as a group, metropolitan area and District of Columbia, cannot specifically be met by a guaranteed loan when we cannot generate the income to make the payments, nor can these project needs be met by a Hill-Burton loan, which is approximately one million-plus dollars here for the District of Columbia.

In effect the testimony of the Secretary's representative would provide possibly an assistance to a portion of one of the projects.

The other point that I think is worthwhile mentioning is the allegation that was made by representatives of the Secretary that all would be well, all the needs that we are talking about now, facility needs, mind you, would be met by the passage of a national health insurance act. I have studied some 69 proposed national health insurance programs, and primarily if not totally they relate to the operation funds, purchase of services. They do not provide for the construction of facilities to meet the needs. I think that you are aware that when the Congress in its wisdom generated and approved a program which we now know as Medicare, we, the health care field, were terribly apprehensive about the demands that would be made on our institutions. We found that the needs for the elderly patients covered under this program for the needs of a physician, an out-patient service rather than in-patient. Because of these we have seen the out-patient and emergency room requirements grow substantially. The program that we have designed and are presenting to you today and in our previous hearing is designed to meet these specific needs.

The other program that has been partially supported by Congress is the Medicare Program. This has provided for our medically indigent in the District a good bit of support, opening many doors that otherwise were not completely available to them. However, I think you should be aware of the fact that the Medicare Program is limited, too. It is limited on the basis of the eligibility of each jurisdiction, whether it be the District, Maryland, Georgia or whatever the jurisdiction decides that its obligations are to those medically indigent who would otherwise qualify for a national program assistance under Medicare. Thank you.

Mr. STUCKEY. Mr. Fauntroy.

Mr. FAUNTROY. I wonder if you would care to explain to me, if you can, the reason that public hospitals were not included in this particular bill?

Fr. COLLINS. Mr. Fauntroy, the reason was because of the Appropriation Committee's procedures, that the request for D.C. General appears as a line item in the District of Columbia budget. The inclusion of the public D.C. General in this bill we have no objection to. In fact, we would perhaps welcome it for a different reason, but the method of appropriation is the reason.

Mr. FAUNTROY. Is D.C. General a member of the council? Is it a part of the 29?

Fr. COLLINS. It is not a formal member.

Mr. FAUNTROY. Why is that?

Fr. COLLINS. By their election.

Mr. FAUNTROY. By the election of D.C. General?

Fr. COLLINS. By D.C. General's election. They are informally members of it, but not formally.

Mr. FAUNTROY. Do you have other public hospitals that are members?

Fr. COLLINS. Yes.

Mr. FAUNTROY. Maybe Mr. Robinson would care to respond to that. Why would D.C. General elect not to be a part of this council?

Mr. ROBINSON. I don't think I could answer that, Mr. Fauntroy. It probably has to do with the fact that the council is primarily composed of private non-profit hospitals rather than public facilities.

Mr. STUCKEY. You say there are some public hospitals that are members?

Mr. BUCHER. Yes, sir, we have Malcom Grove that has been a member for a number of years, and we have Freedmans Hospital that until recently was a HEW sponsored hospital. It hasn't been but about eight years since the District Government itself took the question of membership for District General Hospital in the Hospital Council, and they decided that they would not desire to join. This, I believe, was provided for in funding two or three times by the appropriations method, but when it came down to the act of joining with the rest of the community hospitals, to work with them to achieve what we feel must be achieved and what we are achieving now without their direct formal membership is a community well planned for the community's specific needs.

Mr. FAUNTROY. How much does it cost to join the council?

Mr. BUCHER. Approximately thirty-six and a half mills per patient-day, and in the case of the District of Columbia General Hospital, the trusteeship of the hospital council has offered a provision for a substantial discount in this rate, to be applied to District General Hospital, with a specific request that they commence to work with the rest of the community hospitals for a community health program.

Mr. STUCKEY. Is there anyone in the committee room from D.C. General Hospital?

STATEMENT OF MATTHEW F. McNULTY, JR., VICE PRESIDENT FOR MEDICAL CENTER AFFAIRS, GEORGETOWN UNIVERSITY MEDICAL CENTER, WASHINGTON, D.C., AND MEMBER, BOARD OF DIRECTORS, D.C. GENERAL HOSPITAL

Mr. McNULTY. I am Matthew McNulty, Vice President for Medical Center Affairs, Georgetown University. I am a member of the recently

formed Board of Directors of D.C. General Hospital, and could in that sense respond to any questions.

Mr. FAUNTROY. It just puzzled me why D.C. General was not a member of the Hospital Council, over and beyond the question in the Appropriation Committee's judgment as to how each should be assisted.

Mr. McNULTY. I think, Mr. Fauntroy, my response would be somewhat suffering from our just getting started as a board. As I believe you know, the board is not yet one year old, and we initially had difficulty in securing an executive director for the institution, which has now been done. We thought at the time we had lost Dr. Washington, but he now perhaps will be back with the institution.

The board has not addressed itself to this subject. I think the board desires to do so as it goes through a number of priorities of need. I can't speak for the board, but I as a member of the board and several others whom I know rather intimately as members of the board would be desirous and anxious for D.C. General Hospital to join the Regional Hospital Council of the District of Columbia to contribute in planning, in developing services so that we fill all the gaps that do exist for services in the District. I think this issue will come before the board—I wouldn't want to make a prediction but I can say my vote would be for our joining the council.

Mr. FAUNTROY. Thank you, Mr. Chairman.

Mr. STUCKEY. Mr. Gude?

Mr. GUDE. Thank you, Mr. Stuckey. I am sorry to be late, but I have been trying to do work on Metro in between everything else.

I certainly do appreciate the support for our legislation here. These have been very impressive statements. I don't know whether prior to my coming in, Father, this question came up, which Mrs. Ewing had touched on in her statement, about whether there is adequate planning as to where the various monies are to be spent, in order to serve the public indigent sector.

Fr. COLLINS. Mr. Gude, I would just like to outline in response the answer briefly is yes. The analysis of needs of the some 700,000 residents of the District of Columbia are now met by facilities that are inadequate and overcrowded. Cafritz Hospital has been unable to fulfill, which from my knowledge of their board and their administration they are desirous of filling, because of the lack of a facility and the lack of the operating funds. They have a large debt, and they have to face staying in existence. This bill and their portion of it will enable them to have a facility that will provide for this. This plan is integrated in terms of the demand of the total area of the District, and its basic thrust is to double the out-patient capacity of the District of Columbia in a coordinated effort on an informal basis right now with the District of Columbia.

Mr. BUCHER. Congressman Gude, I think it is important that you understand the elements of the direction of the legislation itself, where it does require that the needs of each project, even though they have been planned by the institutions and by the hospital council to meet specific needs must go through a very exacting detailed review process, before they are permitted to proceed, in fact before any funds are authorized to be expended by the Secretary.

The legislation does provide, and this language was developed by the Secretary of HEW and revised by previous Secretaries, it does provide that the Health Facility Planning Council, a Metropolitan area-wide planning council, make a determination as to need. It does provide that the District of Columbia state Hill-Burton Advisory Council make a determination. Also, in the last element, it does provide the opportunity for the Secretary to make a decision as to where the funds shall go and the priorities to be met.

I think this is a unique piece of legislation that has these three elements of planning control. I would assume that this is much stronger than possibly would be faced by most States. Of course, we in Maryland have a secondary program which under the Governor has an exacting control. I think that this is something the District may want to look at at a later date, but certainly at this stage of the game we have three elements that do justify each project and the specific needs of each project, which is an exacting planning mechanism.

Mr. GUDE. It sounds to me as if there were actually four steps in the planning.

Mr. BUCHER. Yes, sir, four steps.

Mr. GUDE. Therefore if anybody would say anything, you actually might say it was over-planned.

Mr. BUCHER. I am afraid that this is the problem in the District. Let me illustrate the fact that the Department of HEW has already approved the Providence Hospital project, but there haven't been any funds made available for it, except for the planning. In the case of Cafritz, there has been approval of a planning effort. At Sibly, there has been approval of a planning effort and funding, and at Columbia Hospital for Women. There are four projects that have been approved for planning, recognizing there is not a penny available to build. That is why you have before you, in the package here, requests for the related construction funds.

Mr. GUDE. So actually you can't fault this legislation for planning.

Mr. BUCHER. Mr. Gude, I think we can be extremely proud of this legislation, because of its degree of planning. It is unique.

Mr. GUDE. Thank you, Mr. Chairman.

Mr. STUCKEY. Father Collins, I have just one more question. Do you feel that the hospitals are in a situation that Cafritz is in, that if H.R. 11628 is passed, that this will provide the necessary funds for them to meet fully the obligations that they are not meeting now?

Fr. COLLINS. Let me respond in two ways: In answer to the first, yes. Without this, we cannot—

Mr. STUCKEY. Even though there is an obligation to pay it?

Fr. COLLINS. We have the obligation. We are service organizations. The second that they are not doing, the amount that is not being done is different in different hospitals. Some are carrying heroic loads. My response is all must carry a heroic load.

Mr. STUCKEY. In conclusion, let me say that the committee does have an obligation to provide the money so that they will fulfill these obligations. If the money is provided and they are not fulfilling these obligations, I think we also have an obligation to cease our funding to hospitals that are not living up to their obligations. It might be that the two amendments which have been offered might well be the one thing

that is needed to assure that they will live up to these obligations. Let me thank both of you for appearing before us this morning. Also in conclusion, if there are any people in the committee room this morning who would like to submit statements for the record or would like to make additional comments, we would be delighted to hear from them at this point. If not, the committee will stand adjourned and will go into executive session.

(Whereupon, at 11:05 a.m., the subcommittee adjourned to meet in executive session.)

APPENDIX

Public Law 90-457
90th Congress, S. 1228
August 3, 1968

An Act

82 STAT. 631

To authorize project grants and loans for construction and modernization of hospitals and other medical facilities in the District of Columbia.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "District of Columbia Medical Facilities Construction Act of 1968".

District of Columbia Medical Facilities Construction Act of 1968.

AUTHORIZATION OF APPROPRIATIONS FOR GRANTS

SEC. 2. There are authorized to be appropriated for the fiscal year ending June 30, 1969, and for each of the next three fiscal years, such sums as may be necessary, not to exceed in the aggregate \$40,052,000, to enable the Secretary of Health, Education, and Welfare (hereafter in this Act referred to as the "Secretary"), to make grants to assist in meeting the cost of projects for the modernization of public or non-profit private hospitals and in meeting the cost of projects for the construction or modernization of public health centers, long-term care facilities, including extended care facilities, diagnostic or treatment centers, rehabilitation facilities, facilities for the mentally retarded, and community mental health centers in the District of Columbia. Sums so appropriated shall remain available until expended.

LOANS FOR THE CONSTRUCTION OR MODERNIZATION OF HOSPITALS AND OTHER HEALTH FACILITIES

SEC. 3. (a) The Secretary may make loans to assist in meeting the cost of projects for the construction or modernization of any hospital or other facility referred to in section 2 of this Act. The Secretary may make a loan under this section only if he determines that the applicant for the loan is unable to obtain the amount of such loan for the project from other public or private sources at reasonable rates of interest. The amount of any loan made under this section may not exceed 50 per centum of the cost of the project for which the loan is sought.

Limitation.

(b) Any such loan may be made only on the basis of an application submitted to the Secretary in such form and containing such information and assurances as he may prescribe.

(c) Each such loan shall bear interest at the rate of $2\frac{1}{2}$ per centum per annum on the unpaid balance thereof and shall be repaid over a period determined by the Secretary to be appropriate, but not exceeding 50 years.

Interest rate.

(d) There is authorized to be appropriated \$40,575,000 to carry out the provisions of this section.

Appropriation.

APPROVAL OF APPLICATIONS

SEC. 4. (a) An application for a grant or loan with respect to any project may be approved by the Secretary under this Act only if an application for a grant with respect to such project has been filed under a Medical Facilities Act (which for purposes of this Act means title VI of the Public Health Service Act or, where appropriate, title II or part C of title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) and—

78 Stat. 447;
81 Stat. 541.
42 USC 291-

(1) has been approved under a Medical Facilities Act and the application filed under this Act is for additional funds in connection therewith, or

291o.
77 Stat. 290;
79 Stat. 427.
42 USC 2681

(2) has been denied under a Medical Facilities Act because insufficient funds are available from the allotments of the District

et seq.
77 Stat. 286.
42 USC 2671
et seq.

32 STAT. 632

of Columbia under the applicable Medical Facilities Act to permit approval of the application.

Availability of additional funds. In determining whether to approve an application for a grant under the Medical Facilities Act for any project in the District of Columbia, the availability of additional funds for such project under this Act shall be taken into consideration. Approval of such application may be made contingent upon the approval of an application or applications with respect to such project under this Act and upon such additional funds being made so available.

Criteria for order of loan approval.

(b) The Secretary shall establish criteria for determining the order in which to approve, under this Act, applications for grants and loans with respect to projects. Such criteria with respect to construction projects for the same type of facility (or for modernization projects) shall be the criteria developed by the State Agency of the District of Columbia pursuant to the State plan approved under the applicable Medical Facilities Act.

(c) In the case of any project with respect to which an application for a grant or loan is filed under this Act and with respect to which an application for a grant has been denied under a Medical Facilities Act, such application under this Act may be approved only if there is compliance with the same terms and conditions (including determination, in accordance with the applicable State plan, that the project is needed) as are applicable to applications for grants under the Medical Facilities Act, other than the availability of sufficient funds in the appropriate allotment of the District of Columbia.

Review of loan application.

(d) An application for a grant or loan under this Act with respect to any project may not be approved unless an opportunity to review the application has been afforded to a body, found by the Secretary to be a responsible metropolitan areawide planning body, and any recommendations of such body that were timely made have been considered by the appropriate State agency of the District of Columbia and have been submitted to the Secretary in connection with the application.

PAYMENTS

SEC. 5. (a) Payments under this Act with respect to any project shall be made in the manner provided under the applicable Medical Facilities Act for payment of the Federal share of the cost of projects for which applications are approved under such Act; except that payments under this Act shall also be subject to such reasonable conditions as the Secretary deems appropriate to safeguard the Federal interest.

Limitation.

(b) The total of the payments of grants made under this Act with respect to any project, together with any payments made with respect thereto under a Medical Facilities Act, may not exceed—

(1) in the case of a construction project for a long-term care facility, including extended care facilities, a diagnostic or treatment center, or a rehabilitation facility, 66 $\frac{2}{3}$ per centum of the cost of such project; and

(2) in the case of any other project (including a modernization project), 50 per centum of the cost of such project.

RECOVERY OF PAYMENTS

SEC. 6. (a) Payments of grants under this Act shall be subject to recovery or recapture under the same conditions and to the same extent as is provided under the applicable Medical Facilities Act with respect to payments made thereunder.

(b) If, at any time before a loan made under this Act has been repaid in full, an event occurs for which (if a grant had been made

under a Medical Facilities Act) recovery by the United States would be authorized, the unpaid balance of the loan shall become immediately due and payable by the applicant, and any transferee of the facility for which such loan was made shall be liable to the United States for such repayment.

MEANING OF TERMS

SEC. 6. The terms used in this Act shall have the same meaning as when used in the applicable Medical Facilities Act.

Approved August 3, 1968.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 1753 (Comm. on the District of Columbia).

SENATE REPORT No. 944 (Comm. on the District of Columbia).

CONGRESSIONAL RECORD:

Vol. 113 (1967): Dec. 15, considered and passed Senate.

Vol. 114 (1968): July 22, considered and passed House, amended.
July 24, Senate concurred in House amendment.

DISTRICT OF COLUMBIA MEDICAL FACILITIES CONSTRUCTION ACT OF 1972

DECEMBER 8, 1971.—Committed to the Committee of the Whole House on the
State of the Union and ordered to be printed

Mr. McMILLAN, from the Committee on the District of Columbia,
submitted the following

REPORT

[To accompany H.R. 11628]

The Committee on the District of Columbia, to whom was referred the bill (H.R. 11628) to authorize grants and loan guarantees for construction or modernization of hospitals and other medical facilities in the District of Columbia, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

Page 2, line 25, strike out "of" and insert in lieu thereof "or".

Page 8, line 2, immediately after the word "areawide" insert "health".

PURPOSE OF THE BILL

The purpose of H.R. 11628, as amended and reported by your Committee, is to authorize supplementary Federal financial assistance to help meet the costs of projects for the modernization of nonprofit private hospitals in the District of Columbia, and of projects for the construction and modernization of long-term care facilities, diagnostic or treatment centers, outpatient facilities, rehabilitation facilities, facilities for the mentally retarded, and community health centers in the city.

In essence, this bill is designed to provide further Federal assistance for such projects in the District of Columbia, in addition to that authorized in Public Law 90-457, approved August 3, 1968 (82 Stat. 631) but which expires at the end of this fiscal year, under which a number of projects are presently in various stages of construction or planning but are now dependent upon further financial assistance for their completion. Also, funding will be provided for certain other projects planned in connection with this long-range program but not yet started.

PROVISIONS OF THE BILL

SECTION-BY-SECTION DESCRIPTION

Sec. 1. Short Title.—This section provides that the bill when enacted may be cited as the “District of Columbia Medical Facilities Construction Act of 1972”.

Sec. 2. Construction and Modernization Grants.—Subsection (a) of this section authorizes the Secretary of Health, Education, and Welfare to make grants to nonprofit private entities (1) to assist in meeting the cost of modernization projects for nonprofit private hospitals in the District of Columbia, and (2) to assist in meeting the cost of construction or modernization projects for other health care facilities in the District of Columbia.

Subsection (b) authorizes appropriations of such sums as may be necessary (but not to exceed in the aggregate of \$70,000,000) for grants under subsection (a) for fiscal years 1972, 1973, 1974, and 1975.

Sec. 3. Loan Guarantees and Interest Subsidies for Construction and Modernization Projects.—Subsection (a) of this section authorizes the Secretary of Health, Education, and Welfare to guarantee loans made by non-Federal lenders for approved construction or modernization projects for the health facilities in the District of Columbia for which grants may be made under section 2. The authority of the Secretary to make loan guarantees extends over the period beginning July 1, 1972, and ending June 30, 1976.

Subsection (b) of this section authorizes the Secretary to pay to the holder of any loan guaranteed under subsection (a) amounts sufficient to reduce by not to exceed 3 percent per annum the net effective interest rate otherwise payable in such loan.

Subsection (c)(1) provides that the United States may recover amounts paid under a loan guarantee unless the Secretary for good cause waives such right. Upon making any payment under a loan guarantee, the United States shall be subrogated to all of the rights of the recipient of the payments.

Subsection (c)(2) provides that loan guarantees shall be subject to such terms and conditions as the Secretary prescribes, and further provides that such terms and conditions may be modified by the Secretary to the extent he determines to be consistent with the financial interest of the United States.

Subsection (c)(3) provides that a loan guarantee shall be incontestable in the hands of the person who received the loan and as to any person who makes or contracts to make a loan to a person in reliance on a guarantee, except in the case of fraud or misrepresentation.

Under subsection (d) a loan guarantee and interest subsidy revolving fund is established in the Treasury. An annual appropriation of \$2,000,000 is authorized for interest subsidy payments, and an authorization of such sums as may be necessary is made to enable the Secretary to discharge his responsibilities under loan guarantees. If at any time the sums in the fund are insufficient to enable the Secretary to discharge his responsibilities under loan guarantees or to make interest subsidy payments, the Secretary, in accordance with appropriation Acts, may borrow funds from the Secretary of the Treasury.

Subsection (e) provides that the Secretary may secure the assistance of the Secretary of the Department of Housing and Urban Development in the administration of the loan guarantee program.

Sec. 4. Approval of Applications.—No application for a grant or a loan guarantee under section 2 or 3 for any project may be approved by the Secretary unless an application for a grant for such project has been filed under a Medical Facilities Act and (1) such application has been approved and the application filed for a grant or loan guarantee under section 2 or 3 is for additional funds for such project, or (2) such application under a Medical Facilities Act has been denied because of insufficient funds. The term "Medical Facilities Act" is defined to mean title VI of the Public Health Service Act or, where appropriate, title II or part C of title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. It is provided that in considering an application for a grant under a Medical Facilities Act for any project in the District of Columbia, the availability of additional funds under section 2 or 3 of this Act shall be taken into consideration and that approval of such an application may be made contingent upon the approval of an application for such project under this Act.

Under subsection (b) the Secretary is to establish criteria for determining the order in which to approve applications under this Act, and such criteria are to be consistent with criteria developed under the applicable Medical Facilities Act.

Subsection (c) provides that if an application for a grant has been denied under a Medical Facilities Act, an application may not be approved under this Act unless it meets the terms and conditions applicable to applications for grants under the Medical Facilities Act (other than the availability of sufficient funds in the appropriate allotment of the District of Columbia).

Subsection (d) provides for opportunity for review by a responsible metropolitan areawide planning body of applications under this Act, and provides also that any timely made recommendations of such body be considered by the appropriate State agency or the District of Columbia and submitted to the Secretary in connection with the application.

Sec. 5. Payment of Grants.—Subsection (a) provides that payments of grants under this Act shall be made in a manner consistent with the applicable Medical Facilities Act and shall be subject to such reasonable conditions as the Secretary determines appropriate to safeguard the Federal interest.

The total of the grants made under section 2 and under a Medical Facilities Act with respect to any project may not exceed (1) in the case of a construction project for a long-term care facility (including extended care facilities), a diagnostic or treatment center, an outpatient facility, or a rehabilitation facility, 66½ per centum of the cost of such project; and (2) in the case of any other project (including a modernization project), 50 per centum of the cost of such project.

Sec. 6. Recovery of Payments.—It is provided that payments of grants under this Act shall be subject to recovery or recapture under the same conditions and to the same extent as is provided under the applicable Medical Facilities Act with respect to payments made thereunder.

Sec. 7. Meaning of Terms.—The terms used in this Act shall have the same meaning as when such terms are used in the applicable Medical Facilities Act.

BACKGROUND OF FEDERAL AID TO HOSPITAL CONSTRUCTION IN THE DISTRICT OF COLUMBIA

1. *Hospital Center Act*

The unique responsibility of the Federal Government to provide financial assistance for the construction of hospitals and other medical facilities in the District of Columbia has been recognized by the Congress for more than 25 years.

In 1946, Congress enacted the Hospital Center Act, authorizing the appropriation of Federal funds for the construction of the Washington Hospital Center as a replacement for three independent, non-profit hospitals. This act required the District government to pay 30 percent of the net cost to the Federal Government because at that time a serious hospital bed shortage was evident in the District, and Congress felt compelled to meet that emergency.

Later extensions and amendments of that act were enacted, such as the 1951 amendment authorizing Federal grants of up to 50 percent of the cost of constructing or renovating hospital facilities generally within the District. The District of Columbia government was thus required to pay 50 percent of the Federal contribution. This was reduced again to 30 percent by a congressional amendment in 1958 to the Hospital Center Act for grants made after that time. Under the 1951 and subsequent amendments, grants totaling \$17,420,453 were made for hospital projects having an estimated total cost of \$44,440,000, with the result that nearly every public and private hospital in the District of Columbia has participated in this program. Grants under this Act, which expired in 1962, totalled some \$40,-818,552 toward projects whose total costs were \$67,628,188. The share of the District of Columbia amounted to \$18,250,475, of which \$5,700,633 had been repaid to the Federal government through fiscal year 1971 leaving a balance due of \$12,549,842.

2. *Public Law 87-460*

In 1962, Congress enacted legislation (Public Law 87-460) authorizing special Federal grants not to exceed \$2.5 million for 50 percent of the cost of constructing an addition to George Washington University Hospital. Funds for this purpose were appropriated by Congress in fiscal year 1964, and the project is now completed.

3. *Lanham Act and Hill-Burton Act*

In addition to the Hospital Center Act and Public Law 87-460, both of which applied solely to the District, Federal financial assistance has been given for the construction of hospitals and other medical facilities generally in Washington through two generally applicable Federal programs—the wartime defense housing and public works program, commonly known as the Lanham Act, and the Hospital and medical facilities construction program, usually called the Hill-Burton program. Under the Lanham Act, two hospitals in the District received Federal contributions totalling \$5,655,000.

Under the Hill Burton program, a total of \$7,194,000 in grants was approved through fiscal year 1966 for 27 projects in the District of Columbia; and for the four fiscal years, 1969 through 1972, a total of \$3,903,261 in grants and \$2,708,500 in guaranteed subsidized loans has been obtained from that source.

4. Lack of other sources of construction funds

After the expiration of the Hospital Center Act of 1962, and until 1968, the construction of hospitals and other medical facilities in the District of Columbia had available only the Hill-Burton and other Federal programs, referred to above, as a source of funds. Unfortunately, the formula for determining the allocation of Hill-Burton funds, equitable though it is in its application to the 50 States, does not apply fairly to the District of Columbia. This is true largely because the District of Columbia is a city, with a population density far higher than that of any State. Therefore, the ratio of hospital beds per thousand population, which is one of the principal criteria for the allotment of Hill-Burton funds, must necessarily be much higher in the District than in any State. The situation is further aggravated by the fact that some 30 to 40 percent of the hospital beds in the District of Columbia are occupied by patients from the suburban communities of Virginia and Maryland.

Despite these facts, however, the District is permitted no variation from the set ratio.

Also, the per capita income level, which is another principal factor in the Hill-Burton distribution formula, is unfair to the District of Columbia. While the per capita income in the District of Columbia is among the highest in the country, the Federal nature of the city is such that a large proportion of those on the upper part of the income scale are temporary residents of the city who do not feel an obligation to support capital improvement fund drives to the same extent that permanent residents do, here or elsewhere, or indeed to the extent that these same temporary Washington residents feel in relation to their "home" communities. For this reason, per capita income is a misleading figure as far as the District of Columbia is concerned.

As a result of this situation, the allocation of Hill-Burton funds for hospital construction in the District of Columbia is a great deal less than that in nearly all the States, as is shown in the following chart of such grant allocations for fiscal year 1972.

FISCAL YEAR 1972 GRANT ALLOCATIONS TO STATES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER HEALTH FACILITIES

States	Total	Moderniza- tion	Hospitals and public health centers	Long-term care facilities	Outpatient facilities	Rehabilitation facilities
Total	\$194,900,000	\$50,000,000	\$40,250,000	\$19,650,000	\$70,000,000	\$15,000,000
Alabama	4,188,571	526,566	1,014,369	355,837	1,904,969	386,830
Alaska	1,200,000	300,000	300,000	300,000	200,000	100,000
Arizona	1,819,715	300,000	374,222	300,000	702,783	142,710
Arkansas	2,521,617	330,126	580,330	300,000	1,089,852	221,309
California	10,969,161	2,357,609	2,385,384	836,785	4,479,716	909,667
Colorado	2,149,437	536,814	402,727	300,000	756,316	153,580
Connecticut	1,967,424	717,225	300,000	300,000	540,453	109,746
Delaware	1,200,000	300,000	300,000	300,000	200,000	100,000
District of Columbia	1,200,000	300,000	300,000	300,000	200,000	100,000
Florida	6,013,391	1,224,471	1,326,522	465,340	2,491,189	505,869
Georgia	4,723,773	757,180	1,098,739	385,434	2,063,416	419,004
Hawaii	1,227,026	300,000	300,000	300,000	227,026	100,000
Idaho	1,334,854	300,000	300,000	300,000	334,854	504,264
Illinois	7,226,850	2,453,126	1,322,313	463,863	2,483,284	341,503
Indiana	4,639,957	1,407,044	895,511	314,142	1,681,757	198,653
Iowa	2,927,735	929,882	520,920	300,000	978,280	161,662
Kansas	2,463,324	781,623	423,921	300,000	796,118	321,072
Kentucky	3,669,239	625,092	841,934	300,000	1,581,141	363,357
Louisiana	4,400,140	960,342	952,820	334,245	1,789,376	100,000
Maine	1,475,010	330,596	300,000	300,000	444,414	

FISCAL YEAR 1972 GRANT ALLOCATIONS TO STATES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS
AND OTHER HEALTH FACILITIES—Continued

States	Total	Moderniza- tion	Hospitals and public health centers	Long-term care facilities	Outpatient facilities	Rehabilitation facilities
Maryland	2,573,699	484,261	549,019	300,000	1,031,050	209,369
Massachusetts	4,794,952	2,082,480	740,173	300,000	1,390,034	282,265
Michigan	6,367,206	1,691,057	1,295,285	454,382	2,432,525	493,957
Minnesota	3,580,635	1,056,987	682,240	300,000	1,281,236	260,172
Mississippi	3,078,736	346,767	746,155	300,000	1,401,268	284,546
Missouri	4,536,710	1,321,257	890,675	312,446	1,672,673	339,659
Montana	1,294,566	300,000	300,000	300,000	294,566	100,000
Nebraska	1,523,755	300,000	300,000	300,000	518,472	105,283
Nevada	1,200,000	300,000	300,000	300,000	200,000	100,000
New Hampshire	1,262,946	300,000	300,000	300,000	262,946	334,209
New Jersey	5,150,828	1,986,963	876,385	307,433	1,645,838	100,000
New Mexico	1,489,209	300,000	300,000	300,000	489,209	100,000
New York	11,642,494	4,527,098	1,970,952	691,403	3,701,418	751,623
North Carolina	5,907,674	1,182,071	1,308,984	459,187	2,458,251	499,181
North Dakota	1,288,394	300,000	300,000	300,000	288,394	100,000
Ohio	8,067,855	1,640,149	1,780,463	624,581	3,343,682	478,980
Oklahoma	2,870,251	603,422	603,445	300,000	1,133,260	230,124
Oregon	1,967,281	429,874	379,650	300,000	712,977	144,780
Pennsylvania	11,341,528	3,935,804	2,051,372	719,615	3,852,446	782,291
Rhode Island	1,276,467	300,000	300,000	300,000	276,467	100,000
South Carolina	3,342,108	581,376	754,980	300,000	1,417,840	287,912
South Dakota	1,299,489	300,000	300,000	300,000	299,489	100,000
Tennessee	4,886,243	1,104,934	1,047,416	367,430	1,967,031	399,432
Texas	11,333,449	2,598,329	2,419,612	848,793	4,543,996	922,719
Utah	1,478,323	300,000	300,000	300,000	478,323	100,000
Vermont	1,203,000	300,000	300,000	300,000	200,000	100,000
Virginia	4,702,248	1,167,546	979,105	343,467	1,838,748	373,382
Washington	2,747,025	772,880	513,646	300,000	964,620	185,879
West Virginia	2,627,584	712,289	495,591	300,000	930,711	188,993
Wisconsin	3,879,886	1,028,172	782,894	300,000	1,470,263	288,557
Wyoming	1,200,000	300,000	300,000	300,000	200,000	100,000
American Samoa	750,000	200,000	200,000	200,000	100,000	50,000
Guam	750,000	200,000	200,000	200,000	100,000	50,000
Puerto Rico	4,671,235	908,588	1,042,246	365,617	1,957,323	397,461
Trust Territory	750,000	200,000	200,000	200,000	100,000	50,000
Virgin Islands	750,000	200,000	200,000	200,000	100,000	50,000

Source: Office of Program Planning and Analysis, Health Care Facilities Service, Aug. 16, 1971.

The private and institutional hospitals and other medical facilities in the District of Columbia are further financially disadvantaged, in comparison with such institutions in the various states, in that the latter obtain substantial funding from state and municipal sources in the form of matching funds, loans, and the sale of bonds. None of these, of course, are available to the private medical facilities in the District of Columbia.

5. D.C. Medical Facilities Construction Act of 1968

In response to the established need for further Federal financial assistance in meeting the costs of essential hospital construction in the District of Columbia, the Congress enacted Public Law 90-457, which was approved August 3, 1968. This Act authorized Federal grants not to exceed a total of \$40,052,000, and a loan authorization of Federal funds not to exceed a total of \$40,575,000, repayable by the recipients over a period not to exceed 50 years, at an annual interest rate of 2.5 percent, such repayment to start when the construction projects are completed. This Act will expire on June 30, 1972.

The following is a brief legislative summary of Public Law 90-457.

Purpose.—To authorize project grants and loans for construction and modernization of hospitals and other medical center facilities in the District of Columbia, to correct an eight year backlog of demand caused by Federal legislative inequities in the Federal Health Facilities

Acts as they apply to the District of Columbia, and to provide a program to meet these needs in the most effective, economical manner.

Grant need.—1968 and subsequent annual Federal Legislation for construction of such facilities in the District of Columbia amounts to \$441,619 which is to be compared to a demonstrated researched and phased need of \$40,052,000 of grants-in-aid.

Loan need—matching requirement.—As the special Federal aid previously given for construction of District medical facilities indicates, the Hill-Burton, mental retardation, and mental health center construction programs provide only a partial answer to the problem of financing the construction of such facilities in the District. Sponsors of projects for such construction in the District of Columbia experienced serious difficulty in raising the non-Federal share of the cost thereof.

Nonprofit medical facility groups seeking contributions in Washington do not have available to them the important support from corporate gifts which is available in other communities. Corporate gifts often make up from 60 to 70 percent of the total private funds subscribed for constructing hospitals in cities the size of the District; and more than half of these corporate gifts come from manufacturing corporations. The District, however, has only about 14 percent of the per capita potential of metropolitan areas of comparable population for receiving contributions from manufacturing corporations.

The demonstrated inability of private local resources to provide the necessary matching requirements because of the lack of area industry and the transient nature of Washington area population requires the majority of the matching funds to be borrowed in order that this backlog program could start within a reasonable time.

The high interest rates made it infeasible to borrow money on private market without raising hospital charges to an unreasonably high rate.

Therefore, the matching requirement of \$40,575,000 in repayable loans was supplied by long term, low rate Federal borrowing as a method comparable to that offered by other states, counties, and cities by their bonds and loan programs and also comparable to other Federal programs in education and housing.

The need for Federal aid is most acute in the case of long-term care facilities. The lack of private fund-raising potential for construction of these facilities is even more pronounced than in the case of short-term facilities—as demonstrated by the fact that the District has been unable to use much of the money available to it under the Hill-Burton program for construction of long-term care facilities due to inability to raise the required matching funds.

For the reason cited above, special Federal assistance for the modernization of hospitals and the construction or modernization of other medical facilities in the District of Columbia clearly required to make up for the loss of normal private sources of support caused by the presence of the Federal Government in the District. It was necessary to have the direct Federal loans at a low rate of interest on a long-term basis if these pressing needs were to be constructed.

Accomplishment.—Public Law 90-457 has accomplished the first phase of the most critical backlog need. Specifically, the Rogers Memorial and Children's Hospitals construction programs have been

initiated. Therefore, programming to eliminate non conforming facilities has been started. Another priority met is the construction of a 300 bed extended care facility at the Washington Hospital Center. Projects then underway at the Georgetown and George Washington University Medical Centers as part of their clinical facilities have been completed. Funds to effect the necessary consultation and planning were provided for the Cafritz Memorial Hospital, Columbia Hospital for Women, Providence Hospital, and Sibley Memorial Hospital.

The following exhibit, submitted to your Committee on November 11, 1971, by the Hospital Council of the National Capital Area, Inc., shows the schedule of funds for achieving this community program. As is shown, there are five construction and four planning projects involved within the priority program established.

	Appropriation allotment		
	Grant	Direct Federal loan	Total
A. CONSTRUCTION PROJECTS			
1. Children's Hospital of the District of Columbia..... The Children's Hospital has received approval from area health advisory groups, encouragement from government and counsel from consultants to move from its present non-conforming uneconomical building complex to the grounds of the Washington Hospital Center. Within its 1st phase, it is in process of constructing the replacement of its existing beds and support facilities. The second phase is to provide for the completion of space for its outpatient diagnostic, treatment and research areas and its pediatric mental health section.	\$13,399,579	\$13,399,579	\$26,799,158
2. Georgetown University Medical Center..... As an essential part of its community responsibility to supply medical personnel fully trained and experienced as well as its responsibility to provide services for the community, the Georgetown University Medical Center embarked upon a multiphase construction program. The four projects involved are constructionwise nearly completed and include a Diagnostic Treatment Facility with special emphasis for services to mentally retarded children, a new outpatient facility for dental services and modernization and expansion of the antiquated basic Clinical-Science Service Facility. These facilities, together with the central utilities system required have been completed. The equipment and instrumentation phase will be completed upon receipt of the fiscal 1972 funding.	6,189,000	11,080,000	17,269,000
3. George Washington University Medical Center..... In order to attempt to meet in a phased program the service requirements of both its in and outpatient public, as well as to attempt to meet continuously growing needs of the emergency service as an in-town hospital, the George Washington University Medical Center embarked upon programs of significant size and cost in three areas. It enlarged its emergency room facility and expanded the necessary supportive services. A modernization and equipment updating of diagnostic and treatment areas within the hospital such as the heart station and intensive care units took place. It purchased and renovated the multi-story Keystone apartment building adjacent to its medical center to offer comprehensive outpatient diagnostic and treatment services under a physician-team service program.	4,064,000	4,976,842	9,040,842
4. Rogers Memorial Hospital (formerly Casualty)..... The family physician to a large low income center city population, as well as the emergency station for a large area, the Rogers Memorial Hospital has the responsibility to modernize and enlarge its emergency, outpatient and supportive service to the inner city. Its project received priority approval and includes such areas as physiotherapy, electroencephalography, coronary care, medical and surgical intensive care, as well as the emergency and clinic areas. A second high priority project under development provides for eliminating 72 non-conforming beds, and modernization and extension of ancillary services. This first phase is under construction.	6,510,000	6,510,000	13,020,000

	Appropriation allotment		
	Grant	Direct Federal loan	Total
A. CONSTRUCTION PROJECTS—Continued			
5. Washington Hospital Center..... One of the 10 busiest hospitals in the Nation with a Board of Trustee commitment to accept the community responsibility of a 300-bed extended care facility, the Washington Hospital Center will have completed its planning during the current year and arrived at a position of bids early within the fiscal 1971 year. It will also have completed the installation of an emergency generator system which will provide essential standby electrical power under this legislation. The provision of the fiscal 1972 funding budgetary authority will permit the orderly progression of planning, bidding, and construction of these high priority projects.	7,889,421	4,608,699	12,498,000
B. PLANNING PROJECTS			
1. Cafritz Memorial Hospital..... A health facility specializing in obstetrics and gynecology, the Columbia Hospital for Women must program the complete replacement of its antiquated facility.	500,000	-----	500,000
2. Columbia Hospital for Women..... A general acute hospital servicing the far Northeast, Providence Hospital must bring its ancillary and service facilities up to date to maintain local and national accreditation standards and to provide the necessary support programs.	500,000	-----	500,000
3. Providence Hospital..... A general acute care hospital requiring substantial modernization of its limited basic support service areas and its professional diagnostic and treatment and business service areas in order to meet required minimal standards and to achieve a more economical and efficient plant.	500,000	-----	500,000
4. Sibley Memorial Hospital.....	500,000	-----	500,000

NEED FOR LEGISLATION

This proposed legislation is essential to continue the program of construction and modernization of hospitals and other medical facilities in the District of Columbia, which has been started under the authorizations provided by Public Law 90-457, by authorizing Federal grants and loan interest subsidies sufficient to meet the costs involved in the correction of a twelve-year backlog of need for improvement and modernization of health facilities in the Nation's capitol, and to provide a program geared to current national progress format in order to meet those needs in the most effective manner.

This program encompasses the individual and collective efforts of the non-profit community health care institutions in the District of Columbia to meet expressed and researched community needs. In addition, it will bring District facilities into conformance with licensing and accreditation standards. Further, it will provide for the completion of several projects which are currently under construction but lack essential funding because of the inadequacy of funds available under Public Law 90-457. H.R. 11628 provides for areawide planning concepts, as well as legislative requirements that each project meet community facilities priorities and those of the Secretary of HEW.

A dynamic and critical approach to meeting community needs as set forth within this proposed legislation emphasizes the provision of outpatient diagnostic and treatment facilities and the use of low cost extended care services. The legislation will provide for the replacement of outmoded, uneconomical, and inefficient facilities and therefore

will compel cost consciousness. Incentive matching fund ratios emphasize this point by providing 66% percent for modernization and new construction.

The following is a listing of the projects presently contemplated under the funding which H.R. 11628 would authorize, as presented to your Committee by the Hospital Council of the National Capital Area.

PROPOSED PROJECTS UNDER H.R. 11628

	Federal grant	Hospital loan	Program total
Cafritz Memorial Hospital..... To provide for a new ambulatory and family care center as well as to provide for the expansion of necessary diagnostic and ancillary supportive services.	\$10,000,000	\$9,000,000	\$19,000,000
Childrens National Medical Center..... To provide for completion of programed construction under Public Law 90-457 inclusive of specialty pediatric facilities for mental health.	12,400,000	12,400,000	24,800,000
Columbia Hospital for Women..... To provide for the total replacement of the existing hospital and to permit reasonable options for expansion.	4,000,000	4,500,000	8,500,000
George Washington University Medical Center..... To provide for expansion of radiological facilities, modernization of elevators and the addition of a major ambulatory care center.	7,600,000	4,800,000	12,400,000
Georgetown University Medical Center..... To provide for modernization and space revisions within the existing hospital and to provide additional space for outpatient services.	9,500,000	6,500,000	16,000,000
Providence Hospital..... To provide essential expansion and modernization includes air conditioning, elevators, extended care beds, and an ambulatory care facility.	12,200,000	8,800,000	21,000,000
Rogers Memorial Hospital..... To provide for the completion of programed construction delayed because of financial limitations under Public Law 90-457 inclusive of a multistory ambulatory care and referral center and the addition of extended care beds.	6,300,000	6,300,000	12,600,000
Sibley Memorial Hospital..... To provide for the modernization of ancillary and service areas of the existing hospital and to provide for the more effective utilization of the training school building.	3,500,000	3,500,000	7,000,000
Washington Hospital Center..... To provide for a neighborhood health center, expansion of nuclear medicine department, outpatient and emergency departments, and to provide for the expansion and relocation of the ancillary service departments.	3,000,000	2,700,000	5,700,000
Hadley Memorial Hospital..... Situating in the Anacostia area urgently needs funds to provide modernization and expansion of its outpatient facilities in order to have sufficient space for carrying out the services it is now rendering.	1,500,000	1,500,000	3,000,000
Total.....	70,000,000	60,000,000	130,000,000

The need for additional Federal financial assistance to assure the completion of this overall project, which is a vital need for the Nation's capital, remains substantially as great as it was three years ago, when the District of Columbia Medical Facilities Act of 1968 was enacted. The Secretary of Health, Education, and Welfare supported that legislation because of the inequity in Hill-Burton allotments to the District, and despite the 1971 amendments to the Hill-Burton Act which authorize loan guarantees and interest subsidies at 3 percent, as well as grants, this inequity with respect to the District of Columbia still exists.

While it is true also that Section 242 of the Housing and Urban Development Act of 1970 provides for substantial construction loans to nonprofit and proprietary hospitals under certain circumstances, neither this nor any other total borrowing program would provide a solution to the problem which is the subject of H.R. 11628, because the ability to borrow such total money does not exist to the hospitals

in the District in this construction program. It should be emphasized that no new additional hospital beds are to be constructed under this program. This proposed legislation provides only for the modernization of existing beds and for increasing outpatient services. To borrow the total money required would increase the local hospital bed rates to the extent that insurance companies would not approve them, and so repayment would not be feasible. Also, a program of total borrowing would place the District of Columbia private hospitals at a disadvantage as compared with those in Maryland and Virginia, which have state, county, and municipal funds to aid in their financing of construction costs, as indeed is the case with respect to private hospitals in every state.

The fact is that without the enactment of H.R. 11628, the private nonprofit hospitals in the District cannot continue to meet the researched needs of the city, which they are obligated to do for residents and visitors alike to the Nation's capital. In this sense, certainly the District of Columbia is indeed the Federal city.

DIFFERENCES BETWEEN H.R. 11628 AND P.L. 90-457

While the purpose of H.R. 11628 is to enable the programs initiated under Public Law 90-457 to be carried forward and completed, there are two principal differences between this bill and the Act of 1968. First, whereas P.L. 90-457 authorized assistance to both publicly-owned health facilities and to private nonprofit health facilities, H.R. 11628 limits such assistance to the latter category of facilities. And secondly, instead of the program of Federal long-term, low-interest loans to the institutions authorized in the 1968 Act, H.R. 11628 authorizes Federal guarantees and interest subsidies up to 3 percent on non-Federal loans. Precedent for this authorization exists in the 1971 amendments to the Hill-Burton Act.

CONCLUSIONS

In reporting this proposed legislation, your Committee recognizes the continuing need for Federal support for the development and renovation of health facilities in the District of Columbia. Because of the unique economic characteristics of the District, we believe that Federal support is essential if these institutions are to continue to serve the residents of the Nation's capital and to a lesser extent the other communities in the Metropolitan area.

Accordingly, your Committee urges support for the enactment of this vital legislation.

HEARINGS

Public hearings on this bill were conducted on November 11 and December 1 of this year. Testimony was received from members of Congress, the former Speaker of the House of Representatives Honorable John W. McCormack, and spokesmen for the District of Columbia government, the Department of Health, Education, and Welfare, the Medical Society of the District of Columbia, the Health Facilities Planning Council, and the Hospital Council of the National Capital Area.

COMMITTEE AMENDMENTS

The Committee amendments to this bill are purely technical in nature, and do not make any substantive changes whatever.

COSTS

The enactment of this bill will involve the expenditure of Federal funds over the five-year period starting with fiscal year 1972, in the amount of \$70 million in grants and \$10 million in loan interest subsidies, for a total expenditure of \$80 million.

AMENDMENTS TO H.R. 11628, AS REPORTED

(OFFERED BY MR. STUCKEY AND APPROVED BY THE HOUSE, DEC. 13, 1971)

Page 3, line 8, after "loan." insert the following:

The Secretary shall approve an application for a guarantee of a loan under this section only if he determines that the terms, conditions, maturity, security (if any), and schedule and amounts of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable and in accord with regulations, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States.

Page 8, immediately after line 5, insert the following:

(e) Before any application for a grant or loan guarantee is approved under this Act, the appropriate State agency or the District of Columbia shall certify to the Secretary whether the applicant has complied with all terms and conditions applicable to any previous grant it has received under a Medical Facilities Act and any other Act providing federal or District of Columbia funds for the construction or modernization of medical facilities in the District of Columbia and with any assurances or commitments made in applications or other documents submitted to any Committee of Congress, the Secretary, the appropriate State agency, the District of Columbia, or metropolitan area wide planning body, with respect to such grant. The Secretary shall not approve such application unless and until he determines, on the basis such certification that the applicant has fully complied with such terms, conditions and assurances.

Page 9, line 4, insert "(a)" immediately after "Sec. 6."

Page 9, immediately after line 7, insert the following:

(b) The Secretary, the appropriate State agency, and the District of Columbia shall have the responsibility to enforce compliance by a recipient of a grant or loan guarantee under this Act, with the same terms and conditions as are applicable to applications for grants under the applicable Medical Facilities Act and with any assurance made in the application or other documents submitted to the Secretary, the appropriate State agency, the District of Columbia, or metropolitan area health planning body for grants or loan guarantees under this Act. Such enforcement shall include the initiation of appropriate legal action in the United States District Court for the District of Columbia to compel such compliance.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, January 19, 1972.

Hon. JOHN L. McMILLAN,
Chairman, Committee on the District of Columbia,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: In response to your letter of December 18 regarding my testimony on H.R. 11628, I am happy to forward the following information:

1. The "estimated \$304 million in low interest subsidized loans" referred to in my testimony was based on the premise that the \$2 million loan subsidy money for each year under H.R. 11628, was to be new subsidized loans. Since \$2 million would subsidize approximately \$66 million at 3 percent interest, the estimated total of subsidized loans through the four year life of H.R. 11628 was presented as four times \$66 million, or \$264 million. To this figure was added the \$40.6 million already appropriated under P.L. 90-457 for 2½ percent interest direct loans which raised the total to approximately \$304 million. This correction was made and forwarded to the Committee Clerk December 3, 1971.

2. The grand total figure of "more than \$460 million in capital project support" was a misprint in the testimony. The figure should have been \$420 million, again based on the premise outlined in point 1, above. Adding the grant figure of \$70 million proposed under H.R. 11628; the \$40 million in grants appropriated under P.L. 90-457; and the \$6.6 million in Hill-Burton grant assistance to the District from FY 69-72, all added to the previous figure of \$304 million in loan funds, totals \$420.6 million.

It will be recalled that there was a relatively short time span between the introduction of H.R. 11628 and the hearings on the measure.

It became evident from testimony presented by other witnesses at the hearing that the actual intent of the legislation was that the \$2 million interest subsidy authorization was proposed as an annual amount to cover a *total* loan authorization of \$66 million or less.

Had this information been made available to the Department prior to the hearings, our testimony would have made reference to \$66 million in low interest subsidized loans. A recapitulation would be as follows:

	<i>In millions</i>
The proposed grant authorized in H.R. 11628.....	\$70
The proposed loan guarantee amount in H.R. 11628.....	66
Grants previously authorized in Public Law 90-457.....	40
Loans previously authorized in Public Law 90-457.....	40.6
Grant appropriated under Hill-Burton, Fiscal Year 1969-72.....	3.9
Subsidized loans authorized under Hill-Burton, Fiscal Year 1969-72----	2.7
Grand total.....	223.2

The corrected figure for the grand total likewise was forwarded to the Committee Clerk on December 3.

I trust the above information will meet the Committee needs.

Sincerely yours,

RICHARD L. SEGGERL,
Deputy Assistant Secretary for Health Policy Implementation.

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