

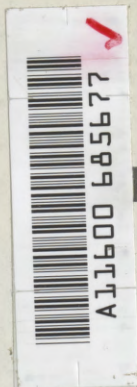
Y 4
.L 11/2
H 34/39

HEALTH FACILITIES LEGISLATION, 1974

93Y4
L 11/2
H 34/39

GOVERNMENT

Storage



HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON
LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
NINETY-THIRD CONGRESS

SECOND SESSION

ON

S. 3577

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO PRO-
VIDE FOR ASSISTANCE FOR THE CONSTRUCTION AND
MODERNIZATION OF HEALTH FACILITIES

S. 2983

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO
PROVIDE FOR EMERGENCY ASSISTANCE TO
URBAN HOSPITALS

JUNE 14, 1974

DOCUMENTS

NOV 25 1975



**THE LIBRARY
KANSAS STATE UNIVERSITY**

Printed for the use of the Committee on Labor and Public Welfare

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1974

38-971 O

COMMITTEE ON LABOR AND PUBLIC WELFARE

HARRISON A. WILLIAMS, JR., New Jersey, *Chairman*

JENNINGS RANDOLPH, West Virginia
CLAIBORNE PELL, Rhode Island
EDWARD M. KENNEDY, Massachusetts
GAYLORD NELSON, Wisconsin
WALTER F. MONDALE, Minnesota
THOMAS F. EAGLETON, Missouri
ALAN CRANSTON, California
HAROLD E. HUGHES, Iowa
WILLIAM D. HATHAWAY, Maine

JACOB K. JAVITS, New York
PETER H. DOMINICK, Colorado
RICHARD S. SCHWEIKER, Pennsylvania
ROBERT TAFT, JR., Ohio
J. GLENN BEALL, JR., Maryland
ROBERT T. STAFFORD, Vermont

MARIO T. NOTO, *Staff Director*
ROBERT E. NAGLE, *General Counsel*
ROY H. MILLENSON, *Minority Staff Director*
EUGENE MITTELMAN, *Minority Counsel*

SUBCOMMITTEE ON HEALTH

EDWARD M. KENNEDY, Massachusetts, *Chairman*

HARRISON A. WILLIAMS, JR., New Jersey
GAYLORD NELSON, Wisconsin
THOMAS F. EAGLETON, Missouri
ALAN CRANSTON, California
HAROLD E. HUGHES, Iowa
CLAIBORNE PELL, Rhode Island
WALTER F. MONDALE, Minnesota
WILLIAM D. HATHAWAY, Maine

RICHARD S. SCHWEIKER, Pennsylvania
JACOB K. JAVITS, New York
PETER H. DOMINICK, Colorado
J. GLENN BEALL, JR., Maryland
ROBERT TAFT, JR., Ohio
ROBERT T. STAFFORD, Vermont

LEROY G. GOLDMAN, *Professional Staff Member*
JAY B. CUTLER, *Minority Counsel*

(II)

DOCUMENTS
NOV 2 1965
THE LIBRARY
KANSAS STATE UNIVERSITY

CONTENTS

Text of:	Page
S. 3577-----	2
S. 2983-----	29

CHRONOLOGICAL LIST OF WITNESSES

FRIDAY, JUNE 14, 1974

Edwards, Charles C., M.D., Assistant Secretary for Health, Department of Health, Education, and Welfare; accompanied by Kenneth Endicott, M.D., Administrator, Health Resources Administration; Harald Graning, M.D., Director, Health Care Facilities Service, Health Resources Administration; Dale Sopper, Legislative Office; and Eugene J. Rubel, Director, Division of Comprehensive Health Planning-----	44
Gehrig, Leo, M.D., vice president, American Hospital Association-----	97
Rose, Marilyn G., attorney, Center for Law and Social Policy, Washington, D.C.-----	146
Affeldt, John, M.D., medical director, Department of Health Service, County of Los Angeles, Calif., accompanied by Dean W. Coston, executive secretary, Council for Urban Health Providers-----	202
Cannon, Joseph E., M.D., director, Department of Health, State of Rhode Island; accompanied by Roger Klein, assistant director-----	207

STATEMENTS

Affeldt, John, M.D., medical director, Department of Health Service, County of Los Angeles, Calif.; accompanied by Dean W. Coston, executive secretary, Council for Urban Health Providers-----	202
American Hospital Association-----	125
Association of State and Territorial Health Officials-----	211
Cannon, Joseph, M.D., director, Department of Health, State of Rhode Island; accompanied by Roger Klein, assistant director-----	207
Prepared statement-----	211
Edwards, Charles C., M.D., Assistant Secretary for Health, Department of Health, Education, and Welfare; accompanied by Kenneth Endicott, M.D., Administrator, Health Resources Administration; Harald Graning, M.D., Director, Health Care Facilities Service, Health Resources Administration; Dale Sopper, Legislative Office; and Eugene J. Rubel, Director, Division of Comprehensive Health Planning-----	44
Prepared statement-----	51
Gehrig, Leo, M.D., vice president, American Hospital Association-----	97
Prepared statement (with attachments)-----	125
Rose, Marilyn G., attorney, Center for Law and Social Policy, Washington, D.C.-----	146
Prepared statement, with comments received from Dr. Harald Graning, M.D., director, Health Care Facilities Service, Health Resources Administration-----	156

ADDITIONAL INFORMATION

Articles, publications, etc.:	
American Hospital Association response to the article: The Financial Position of Private Community Hospitals, 1961-71, from the Social Security Bulletin of November 1973-----	122
Financial Position of Private Community Hospital, 1961-71, from the Social Security Bulletin, November 1973-----	105

IV

Articles, publications, etc.—Continued

Out of State Refuse—A Solution, from Kaleidoscope, vol. 6, No. 2, spring 1974-----	Page 223
"S. 3577: Adequate Investment in an Essential Commodity," research report from the Camden County (N.J.) Planning Department-----	218
Communications to:	
Erwin, Hon. Sam J., Jr., a U.S. Senator from the State of North Carolina:	
Aldridge, Bryant T., administrator, Nash General Hospital, Inc., Rocky Mount, N.C., June 10, 1974-----	227
Mashburn, Fred H., administrator, District Memorial Hospital of Southwestern North Carolina, Inc., Andrews, N.C.-----	228
Thompson, J. Crenshaw, administrator, president-elect, North Carolina Hospital Association, Moore Memorial Hospital, Inc., Pinehurst, N.C., June 10, 1974-----	229
Gravel, Hon. Mike, a U.S. Senator from the State of Alaska, from Frederick McGinnis, Commissioner, Department of Health and Social Services, State of Alaska, Pouch H—Juneau, Alaska, June 27, 1974-----	230
Goldman, Lee, professional staff member, from Frank Rodio, Jr., planning aide, Office of the Department of Planning, Pennsauken, N.J., June 7, 1974 (with enclosures)-----	217
Selected tables:	
Beds needed to be added by State according to Hill-Burton State plans received as of January 1974-----	72
Hill-Burton grant allocations, by category of funds, fiscal year 1969-74-----	70
Hill-Burton projects approved by States for incentive financing (increased Federal share up to 90 percent) as of July 1974-----	88
Listing of outpatient projects funded by modernization funds, fiscal year 1971 and 1972 appropriations-----	87
Listing of projects funded by outpatient funds, fiscal year 1971 and 1972 appropriations-----	78
State data available of options selected by hospitals-----	92

HEALTH FACILITIES LEGISLATION, 1974

FRIDAY, JUNE 14, 1974

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 4232, Dirksen Senate Office Building, Senator Edward M. Kennedy, chairman of the subcommittee, presiding.

Present: Senator Kennedy.

Committee staff present: LeRoy G. Goldman, professional staff member; and Jay B. Cutler, minority counsel.

Senator KENNEDY. The subcommittee will come to order.

Today, we will take testimony from a number of interested groups concerning the appropriate Federal role in the provision of continuing assistance for the construction of health facilities.

For more than 25 years, the Hill-Burton Hospital construction program has assisted States and localities in the construction of hospitals and centers for long-term care. In recent years, this program has turned more and more to the construction of outpatient facilities, and to the modernization of existing inpatient facilities. This shift in emphasis can be interpreted as a result of the success of the program in greatly increasing the number of hospital beds in the United States, and in going a long way toward eliminating the maldistribution of hospital beds which existed at the inception of the program.

Both Senator Javits and I have introduced legislation which would continue Federal assistance for the construction of facilities for the provision of health care services. Senator Javits' proposal concentrates upon the renovation of inpatient facilities intended to service medically underserved populations.

The bill I introduced on June 4 will provide Federal assistance in the form of grants, loans, and loan guarantees for the modernization of inpatient facilities in medically underserved areas, and for the construction of facilities for outpatient care.

[The bill referred to and related bill follows:]

93^D CONGRESS
2^D SESSION

S. 3577

IN THE SENATE OF THE UNITED STATES

JUNE 4, 1974

Mr. KENNEDY (for himself and Mr. HATHAWAY) introduced the following bill;
which was read twice and referred to the Committee on Labor and Public
Welfare

A BILL

To amend the Public Health Service Act to provide for assistance for the construction and modernization of health facilities.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Health Facilities Assist-
4 ance Act of 1974".

5 SEC. 101. Title VI of the Public Health Service Act
6 (42 U.S.C. 291 et seq.) is amended to read as follows:
7 "TITLE VI—ASSISTANCE FOR CONSTRUCTION
8 AND MODERNIZATION OF HEALTH FACILITIES

9 "DECLARATION OF PURPOSE

10 "SEC. 600. The purpose of this title is to assist in meet-
11 ing the costs of construction and modernization of such pub-

1 lie or other nonprofit health facilities as may be necessary,
2 in conjunction with existing facilities, to furnish adequate
3 health care services to all people.

4 "GRANTS FOR CONSTRUCTION AND MODERNIZATION OF
5 HEALTH FACILITIES

6 "SEC. 601. (a) The Secretary is authorized to make
7 grants to any public or private nonprofit entity to assist such
8 entity in meeting the costs of any project for the (1) con-
9 struction or modernization of a public or other nonprofit out-
10 patient facility or (2) modernization of a public or other
11 nonprofit health facility which will serve a medically under-
12 served population.

13 "(b) The amount of any grant made under this section
14 shall be determined by the Secretary, but no such grant shall
15 exceed 75 per centum of the costs of such project except
16 that any grant for a project for the construction or moderni-
17 zation of a facility to be located in an area determined by
18 the Secretary to be an urban or rural poverty area may
19 cover up to 90 per centum of such costs.

20 "(c) No grant may be made under subsection (b) to
21 any entity which is receiving payments under a grant under
22 subsection (a).

1 "LOANS AND LOAN GUARANTEES FOR CONSTRUCTION
2 AND MODERNIZATION OF HEALTH FACILITIES

3 "SEC. 602. (a) In order to assist public and other non-
4 profit entities in meeting the costs of projects for the—

5 "(1) construction or modernization of public or
6 other nonprofit outpatient facilities and

7 "(2) modernization of public or other nonprofit
8 health facilities which will serve medically underserved
9 populations,

10 the Secretary is authorized to make loans to such entities
11 for such projects and guarantee to non-Federal lenders pay-
12 ment of principal of and interest on loans made by such
13 lenders to nonprofit private entities for such projects.

14 "(b) (1) No loan guarantee under this title with respect
15 to any construction or modernization project may apply to so
16 much of the principal amount thereof as, when added to the
17 amount of any grant or loan under this title with respect to
18 such project, exceeds 90 per centum of the cost of such
19 project.

20 "(2) No loan under this title with respect to any con-
21 struction or modernization project may be made in an
22 amount which, when added to the amount of any grant under
23 this title with respect to such project, exceeds 90 per centum
24 of the cost of such project.

1 “(c) The Secretary, with the consent of the Secretary
2 of Housing and Urban Development, shall obtain from the
3 Department of Housing and Urban Development such assist-
4 ance with respect to the administration of this section as will
5 promote efficiency and economy thereof.

6 “FACILITIES ACCOUNTS

7 “SEC. 603. (a) The Secretary shall establish a facilities
8 account for each State and shall for each fiscal year credit to
9 each such account an allotment from the sums appropriated
10 for such year pursuant to section 613 on the basis of the
11 population, the financial need, and the extent of the need for
12 construction and modernization of the facilities referred to in
13 subsections (a) and (b) of section 601, of the respective
14 States.

15 “(b) The allotment to any State facilities account un-
16 der subsection (a) for any fiscal year which is less than
17 \$800,000 shall be increased to that amount, the total of the
18 increases thereby required being derived by proportionately
19 reducing the allotment to each of the remaining States’ facili-
20 ties account, but with such adjustments as may be necesary
21 to prevent the allotment to any of such remaining accounts
22 from being thereby reduced to less than that amount.

23 “(c) Any allotment credited to a facilities account of
24 any State for any fiscal year and remaining unobligated at
25 the end of such year shall remain available for grants, loans,

1 and loan guarantees under this title in such State, for the next
2 two fiscal years (and for such years only) in addition to the
3 allotments credited to the facilities account of such State for
4 such next two fiscal years.

5 "CONDITIONS FOR APPROVAL OF APPLICATIONS

6 "SEC. 604. (a) No grant, loan, or loan guarantee for
7 any project may be made under this title unless an applica-
8 tion therefor has been submitted to the Secretary and ap-
9 proved by him. Such application shall be in such form, sub-
10 mitted in such manner, and contain such information, as the
11 Secretary shall by regulation prescribe.

12 "(b) Each application under this section shall set
13 forth—

14 "(1) a description of the site for such project;

15 "(2) plans and specifications therefor, in accord-
16 ance with regulations promulgated under section 608;

17 "(3) a certification of the total cost of such project
18 and the amount of the grant or loan which is sought
19 under this title or the amount of the loan for which a
20 guarantee is sought under this title;

21 "(4) reasonable assurance that title to such site
22 is or will be vested in one or more of the entities filing
23 the application or in the entity which is to operate the
24 facility on completion of the project;

25 "(5) reasonable assurance that adequate financial

1 support (including, in the case of any project for a facility
2 to be located in an area determined by the Secretary
3 to be an urban or rural poverty area, Federal assistance
4 provided directly to such facility or through benefits ac-
5 corded individuals served at such facility) will be avail-
6 able for the completion of the project and for its mainte-
7 nance and operation when completed;

8 “(6) reasonable assurance that all laborers and
9 mechanics employed by contractors or subcontractors in
10 the performance of construction or modernization on the
11 project will be paid wages at rates not less than those
12 prevailing on similar work in the locality as determined
13 by the Secretary of Labor in accordance with the Davis-
14 Bacon Act, as amended (40 U.S.C. 276a—276a-5);
15 and the Secretary of Labor shall have with respect to
16 the labor standards specified in this paragraph the au-
17 thority and functions set forth in Reorganization Plan
18 Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-
19 15) and section 2 of the Act of June 13, 1934, as
20 amended (40 U.S.C. 276c);

21 “(7) in the case of any application for any grant,
22 loan, or loan guarantee for modernization of any facility
23 (except an outpatient facility), reasonable assurance
24 that when the project is completed the facility will serve
25 a population which had been designated as a medically

1 underserved population prior to the modernization of
2 such facility;

3 “(8) in the case of any application of any nonprofit
4 private entity for any grant, loan, or loan guarantee for
5 construction or modernization of any outpatient facility,
6 reasonable assurance that the services of a general hos-
7 pital will be available to patients of such facility who are
8 in need of hospital care; and

9 “(9) reasonable assurance that at all times after
10 such application is approved (A) the facility or portion
11 thereof to be constructed or modernized will be made
12 available to all persons residing or employed in the area
13 served by the facility and (B) there will be made avail-
14 able in the facility or portion thereof to be constructed
15 or modernized a reasonable volume of services to persons
16 unable to pay therefor. The Secretary shall, in deter-
17 mining the reasonableness of the volume of services
18 provided, take into consideration the extent to which
19 compliance is feasible from a financial viewpoint.

20 “(c) The Secretary may not approve an application for
21 a grant, loan, or loan guarantee under this title to assist in
22 meeting the costs of a project for construction or moderniza-
23 tion of any facility which is or will be located in an area
24 under the jurisdiction of a local health planning agency unless
25 (1) such application has been recommended for approval by

1 such local health planning agency, after application of cri-
2 teria described in regulations promulgated under section 607
3 (a) and (b), and (2) such project has a higher priority (set
4 by such local health planning agency in accordance with
5 regulations promulgated under section 608 (c)) than any
6 other project in such area for which applications are pending
7 before the Secretary for his approval.

8 “(d) The Secretary shall approve any application sub-
9 mitted in accordance with subsections (a) and (b) for a
10 project for construction or modernization of a health facility
11 in any State if sufficient funds are available from the facilities
12 account of such State and if the Secretary finds—

13 “(1) that the application contains such reasonable
14 assurances as described in subsection (b) ;

15 “(2) that the plans and specifications are in accord
16 with the regulations promulgated under section 608 (d) ;

17 “(3) that the application meets the requirements
18 of subsection (c) ; and

19 “(4) in the case of any direct loan or loan for which
20 a guarantee is sought, that (A) the applicant will be
21 able to make payments of principal and interest thereon
22 when due, and (B) the terms, conditions, maturity,
23 security (if any), and schedule and amounts of repay-
24 ment with respect to the loan are sufficient to protect the
25 financial interests of the United States and are otherwise

1 reasonable and in accordance with regulations and with
2 section 606.

3 “(e) Amendment of any approved application shall be
4 subject to approval in the same manner as an original
5 application.

6 “TECHNICAL ASSISTANCE

7 “SEC. 605. The Secretary is authorized to provide
8 (either through the Department of Health, Education, and
9 Welfare or by contract) all necessary technical and other
10 nonfinancial assistance to any public or private nonprofit
11 entity which is eligible to apply for assistance under this
12 title to assist such entities in developing applications to be
13 submitted to the Secretary under section 604. The Secretary
14 shall make every effort to inform eligible applicants of the
15 availability of assistance under this title.

16 “GENERAL PROVISIONS RELATING TO LOANS AND LOAN

17 GUARANTEES

18 SEC. 606. (a) (1) Any loan to any public entity or
19 nonprofit private entity under this title shall require such
20 entity to pay interest thereon at a rate comparable to the
21 current rate of interest prevailing on the date such loan is
22 made with respect to loans to nonprofit private entities
23 which are guaranteed under this title for modernization or
24 construction of similar facilities in the same or similar areas,
25 minus an amount equal to the lesser of (i) one-half of

1 such current rate of interest and (ii) $4\frac{1}{2}$ per centum per
2 annum.

3 “(2) (A) The Secretary shall from time to time, but
4 with due regard to the financial interests of the United States,
5 sell loans made under this title either on the private market
6 or to the Federal National Mortgage Association in accord-
7 ance with section 302 of the Federal National Mortgage
8 Association Charter Act or the Federal Financing Bank.

9 “(B) Any loan so sold shall be sold for an amount
10 which is equal (or approximately equal) to the amount of
11 the unpaid principal of such loan as of the time of sale.

12 “(3) (A) The Secretary is authorized to enter into an
13 agreement with the purchaser of any loan sold under this
14 title under which the Secretary agrees—

15 “(i) to guarantee to such purchaser (and any suc-
16 cessor in interest to such purchaser) payments of the
17 principal and interest payable under such loan, and

18 “(ii) to pay as an interest subsidy to such pur-
19 chaser (and any successor in interest of such purchaser)
20 amounts which, when added to the amount of interest
21 payable on such loan, are equivalent to a reasonable rate
22 of interest on such loan as determined by the Secretary,
23 after taking into account the range of prevailing interest
24 rates in the private market on similar loans and the risks
25 assumed by the United States.

1 “(B) Any such agreement—

2 “(i) may provide that the Secretary shall act as
3 agent of any such purchaser, for the purpose of collect-
4 ing from the entity to which such loan was made and
5 paying over to such purchaser any payments of prin-
6 cipal and interest payable by such entity under such loan;

7 “(ii) may provide for the repurchase by the Secre-
8 tary of any such loan on such terms and conditions as
9 may be specified in the agreement;

10 “(iii) shall provide that, in the event of any default
11 by the entity to which such loan was made in payment
12 of principal or interest due on such loan, the Secretary
13 shall, upon notification to the purchaser (or to the suc-
14 cessor in interest of such purchaser), have the option to
15 close out such loan (and any obligations of the Secretary
16 with respect thereto) by paying to the purchaser (or his
17 successor in interest) the total amount of outstanding
18 principal and interest due thereon at the time of such
19 notification; and

20 “(iv) shall provide that, in the event such loan is
21 closed out as provided in subparagraph (iii), or in the
22 event of any other loss incurred by the Secretary by rea-
23 son of the failure of such entity to make payments of
24 principal or interest on such loan, the Secretary shall be

1 subrogated to all rights of such purchaser for recovery of
2 such loss from such entity.

3 “(4) The Secretary may, for good cause, waive any
4 right of recovery which he has against an entity by reason
5 of the failure of such entity to make payments of principal
6 or interest on a loan made to such entity under this title
7 except that if such loan is sold and guaranteed, any such
8 waiver shall have no effect upon the Secretary's guarantee
9 of timely payment of principal and interest.

10 “(5) After any loan to an entity under this title has
11 been sold and guaranteed, interest paid on such loan and
12 any interest subsidy paid by the Secretary with respect to
13 such loan which is received by the purchaser thereof (or
14 his successor in interest) shall be included in gross income
15 for the purposes of chapter 1 of the Internal Revenue Code
16 of 1954.

17 “(6) Amounts received by the Secretary as proceeds
18 from the sale of loans under this section shall be deposited
19 in the loan fund established by section 607, and shall be
20 available to the Secretary for the making of further loans
21 under this title in accordance with the provisions of such
22 section.

23 “(b) (1) No guarantee under this title of a loan made
24 to any nonprofit private entity shall be approved if the
25 rate of interest payable on such loan exceeds such per

1 centum per annum on the principal obligation outstanding
2 as the Secretary determines to be reasonable, taking into
3 account the range of interest rates prevailing in the private
4 market for similar loans and the risks assumed by the United
5 States.

6 “(2) (A) Subject to subparagraph (B), in the case
7 of a guarantee under this title of any loan made to a nonprofit
8 private entity, the Secretary shall pay to the holder of such
9 loan and for and on behalf of such entity amounts sufficient to
10 reduce the net effective interest rate otherwise payable on
11 such loan by an amount equal to the lesser of (i) one-half
12 of such interest rate and (ii) $4\frac{1}{2}$ per centum per annum. Each
13 holder of a loan, which is guaranteed under this title shall
14 have a contractual right to receive from the United States
15 interest payments required by the preceding sentence.

16 “(B) Contracts to make the payments provided for in
17 this subsection shall not carry an aggregate amount greater
18 than such amount as may be provided in appropriations Acts.

19 “(3) The United States shall be entitled to recover from
20 the applicant for a loan guarantee under this title the amount
21 of any payments made pursuant to such guarantee unless the
22 Secretary for good cause waives such right of recovery, and,
23 upon making any such payment, the United States shall be
24 subrogated to all of the rights of the recipient of the payments
25 with respect to which the guarantee was made.

1 “(4) Guarantees of loans under this title shall be subject
2 to such further terms and conditions as the Secretary deter-
3 mines to be necessary to assure that the purposes of this title
4 will be achieved, and to the extent permitted by paragraph
5 (5), any terms and conditions applicable to a loan guarantee
6 under this title may be modified by the Secretary to the ex-
7 tent he determines it to be consistent with the financial in-
8 terest of the United States.

9 “(5) Any guarantee of a loan made by the Secretary
10 pursuant to this title shall be incontestable in the hands of an
11 applicant on whose behalf such guarantee is made, and as to
12 any person who makes or contracts to make a loan to such
13 applicant in reliance thereon, unless such applicant or such
14 person engaged in fraud or misrepresentation in applying
15 for, making, or contracting to make such loan.

16 “(c) The cumulative total of the principal of the loans
17 outstanding at any time which have been directly made, or
18 with respect to which guarantees have been issued, under
19 this title may not exceed such limitations as may be specified
20 in appropriations Acts.

21 “LOAN AND LOAN GUARANTEE FUND

22 “SEC. 607. (a) (1) There is hereby established in the
23 Treasury a loan guarantee and loan fund (hereinafter in this
24 section referred to as the ‘fund’) which shall be available
25 to the Secretary without fiscal year limitation, in such

1 amounts as may be specified from time to time in appropria-
2 tions Acts, (A) to enable him to make loans under this title,
3 (B) to enable him to discharge his responsibilities under
4 guarantees issued by him under this title, (C) for payment
5 of interest on the loans which are guaranteed under this title,
6 and (D) for repurchase by him of direct loans made under
7 this title which have been sold and guaranteed. There are
8 authorized to be appropriated to the fund from time to time
9 such amounts as may be necessary to provide capital re-
10 quired for the fund. To the extent authorized from time to
11 time in appropriation Acts, there shall be deposited in the
12 fund amounts received by the Secretary as interest payments
13 or repayments of principal on loans and any other moneys,
14 property, or assets derived by him from his operations under
15 this title, including any moneys derived from the sale of
16 assets.

17 “(2) Of the moneys in the fund, there shall be avail-
18 able to the Secretary for the purpose of making direct loans
19 only such sums as shall have been appropriated for such
20 purpose or sums received by the Secretary from the sale of
21 such loans and authorized in appropriations Acts to be used
22 for such purpose.

23 “(b) If at any time the moneys in the fund are insuffi-
24 cient to enable the Secretary to discharge his responsibilities
25 under this title, he is authorized to issue to the Secretary of

1 the Treasury notes or other obligations in such forms and
2 denominations, bearing such maturities, and subject to such
3 terms and conditions, as may be prescribed by the Secretary
4 with the approval of the Secretary of the Treasury, but only
5 in such amounts as may be specified from time to time in
6 appropriation Acts. Such notes or other obligations shall bear
7 interest at a rate determined by the Secretary of the Treas-
8 ury, taking into consideration the current average market
9 yield on outstanding marketable obligations of the United
10 States of comparable maturities during the month preceding
11 the issuance of the notes or other obligations. The Secretary
12 of the Treasury is authorized and directed to purchase any
13 notes and other obligations issued hereunder and for that
14 purpose he is authorized to use as a public debt transaction
15 the proceeds of the sale of any securities issued under the
16 Second Liberty Bond Act, as amended (31 U.S.C. 744), and
17 the purposes for which securities may be issued under that
18 Act, are extended to include any purchase of such notes and
19 obligations. The Secretary of the Treasury may at any time
20 sell any of the notes or other obligations acquired by him
21 under this subsection. All redemptions, purchases, and sales
22 by the Secretary of the Treasury of such notes or other obli-
23 gations shall be treated as public debt transactions of the
24 United States. Sums borrowed under this subsection shall be

1 deposited in the fund and redemption of such notes and obli-
2 gations shall be made by the Secretary from such fund.

3 "REGULATIONS

4 "SEC. 608. The Secretary shall by regulation prescribe—

5 "(a) criteria for determining needs for health facili-
6 ties for which assistance is available under this title;

7 "(b) criteria for determining the extent to which
8 existing facilities, for which assistance is available under
9 this title, are in need of modernization;

10 "(c) the general manner in which each local health
11 planning agency shall determine the priority of projects
12 within the area under its jurisdiction based upon the
13 relative need of various populations and in various sub-
14 areas within such area lacking adequate facilities of the
15 several types for which assistance is available under this
16 title, giving special consideration—

17 "(1) to projects designed to (A) eliminate or
18 prevent imminent safety hazard as defined by State
19 or local fire, building, or life safety codes or regula-
20 tions, or (B) avoid noncompliance with State or
21 voluntary licensure or accreditation;

22 "(2) in the case of projects for modernization
23 of facilities, to facilities serving densely populated
24 areas; and

1 “(3) in the case of projects for construction or
2 modernization of outpatient facilities, to any out-
3 patient facility that will be located in, and provide
4 services for residents of, an area determined by the
5 Secretary to be a rural or urban poverty area.

6 “(d) general standards of construction and equip-
7 ment for facilities of various classes and in various types
8 of locations, for which assistance is available under this
9 title; and

10 “(e) the means by which each entity which re-
11 ceives or has received financial assistance under this Act
12 shall be required to demonstrate compliance with the
13 assurances required to be made at the time such assist-
14 ance was received. Such regulations shall require each
15 such entity to submit periodically to the Secretary
16 reports which specify data and information which
17 reasonably support compliance. No entity shall be ex-
18 cused from such requirement.

19 “PAYMENTS UNDER GRANTS AND LOANS

20 “SEC. 609. (a) Payments under grants made under
21 this title shall be made by way of reimbursement, and on
22 such terms and conditions and in such installments, as the
23 Secretary may determine.

24 “(b) In case an amendment to an approved applica-
25 tion for any project for construction or modernization of a

1 health facility in any State is approved as provided in sec-
2 tion 604 or the estimated cost of any project for construc-
3 tion or modernization of a health facility in any State is
4 revised upward, any additional payment with respect there-
5 to may be made from the facilities account of such State.

6 "WITHHOLDING OF PAYMENTS AND OTHER ACTIONS

7 "SEC. 610. (a) (1) Whenever the Secretary, after
8 reasonable notice and opportunity for hearing to any entity
9 receiving assistance under this title finds that with respect to
10 any project—

11 "(A) there is a failure to comply with any assur-
12 ance required to be given in an application filed under
13 section 604, or

14 "(B) there is a failure to carry out plans and speci-
15 fications approved by the Secretary under section 604,
16 the Secretary shall forthwith order (i) that no further pay-
17 ments will be made under this title with respect to such
18 project or (ii) that further payments will be withheld, in
19 whole or in part, until there is no longer any failure to
20 comply with or carry out any such assurances, plans, or
21 specifications or, if such compliance or other action is im-
22 possible, until such entity repays or arranges for the re-
23 payment of Federal moneys to which such entity was not
24 entitled, and shall notify such entity of such order.

25 "(b) (1) The Secretary is directed, in the administra-

1 tion of this title, to investigate and ascertain, on a periodic
2 basis, with respect to each entity which is receiving or has
3 received financial assistance under this Act for construction
4 or modernization of a health facility, the extent of com-
5 pliance by such entity with the assurances required to be
6 made at the time such assistance was received.

7 “(2) If the Secretary finds that any such entity has
8 failed to demonstrate compliance with such assurances, in
9 accordance with regulations promulgated pursuant to section
10 608 (e), the Secretary shall forthwith (A) take action in
11 accordance with subsection (a), or (B) effect compliance
12 by any other means authorized by law: *Provided*, That no
13 action shall be taken pursuant to clause (B) until the Sec-
14 retary has advised such entity of the failure to comply with
15 such assurances and has determined that compliance cannot
16 be secured by voluntary means.

17 “(c) (1) Any entity which will be adversely affected by
18 any order of the Secretary pursuant to this section may ap-
19 peal to the United States court of appeals for the circuit in
20 which such entity is located, by filing a petition with such
21 court within sixty days after such order. A copy of the peti-
22 tion shall be forthwith transmitted by the clerk of the court
23 to the Secretary, or any officer designated by him for that
24 purpose. The Secretary shall thereupon file in the court the
25 record of the proceedings on which he based his order, as

1 provided in section 2112 of title 28 of the United States
2 Code. Upon the filing of such petition, the court shall have
3 jurisdiction to affirm the action of the Secretary or to set it
4 aside, in whole or in part, temporarily or permanently, but
5 until the filing of the record, the Secretary may modify or set
6 aside his order.

7 “(2) The findings of the Secretary as to the facts, if
8 supported by substantial evidence, shall be conclusive, but
9 the court, for good cause shown, may remand the case to
10 the Secretary to take further evidence, and the Secretary
11 may thereupon make new or modified findings of fact and
12 may modify his previous action, and shall file in the court
13 the record of the further proceedings. Such new or modified
14 findings of fact shall likewise be conclusive if supported by
15 substantial evidence.

16 “(3) The judgment of the court affirming or setting
17 aside, in whole or in part, any order of the Secretary shall
18 be final, subject to review by the Supreme Court of the
19 United States upon certiorari or certification as provided in
20 section 1254 of title 28 of the United States Code. The com-
21 mencement of proceedings under this section shall not, unless
22 so specifically ordered by the court, operate as a stay of the
23 Secretary’s order.

"RECOVERY

1
2 "SEC. 611. If any facility with respect to which funds
3 have been paid under this title shall, at any time within
4 twenty years after completion of construction or moderniza-
5 tion—

6 " (a) be sold or transferred to any person, agency,
7 organization—

8 " (1) which is not qualified to file an applica-
9 tion under this title, or

10 " (2) which is not approved as a transferee by
11 the Secretary, or

12 " (b) cease to be a public or other nonprofit facility,
13 unless the Secretary determines in accordance with regu-
14 lations that there is good cause for releasing the applicant
15 or other owner from this obligation,

16 the United States shall be entitled to recover from either the
17 transferor or the transferee (or in the case of a facility which
18 has ceased to be public or nonprofit, from the owners thereof)
19 an amount bearing the same ratio to the then value (as
20 determined by the agreement of the parties or by action
21 brought in the district court of the United States for the
22 district in which the facility is situated) of so much of the
23 facility as constituted an approved project or projects, as the
24 amount of the Federal participation bore to the cost of con-
25 struction or modernization under such project or projects.

1 Such right shall not constitute a lien upon said facility prior
2 to judgment.

3 "RECORDS AND AUDITS

4 "SEC. 612. (a) (1) Each entity receiving Federal as-
5 sistance under this title shall keep such records as the Secre-
6 tary shall prescribe, including records which fully disclose
7 the amount and disposition by such entity of the proceeds
8 of such assistance, the total cost of the project in connection
9 with which such assistance is given or used, the amount of
10 that portion of the cost of the project supplied by other
11 sources, and such other records as will facilitate an effective
12 audit.

13 "(2) The Secretary and the Comptroller General of
14 the United States, or any of their duly authorized representa-
15 tives, shall have access for the purpose of audit and ex-
16 amination to any books, documents, papers, and records of
17 such entities which in the opinion of the Secretary or the
18 Comptroller General may be related or pertinent to the
19 assistance referred to in subsection (a).

20 "(b) Each such entity shall file at least annually with
21 the Secretary a statement which shall be in such form, and
22 contain such information, as the Secretary may require to
23 accurately show—

24 "(1) The financial operations of the facility con-
25 structed or modernized with such assistance, and

1 “(2) The costs to such facility of providing health
2 services in such facility, and the charges made for such
3 services, during the period with respect to which the
4 statement is filed.

5 “AUTHORIZATION OF APPROPRIATIONS

6 “SEC. 613. (a) There are authorized to be appro-
7 priated for the fiscal year ending June 30, 1975, and for each
8 of the succeeding two fiscal years \$210,000,000 for grants
9 under section 601.

10 “(b) There are authorized to be appropriated for the
11 fiscal year ending June 30, 1975, and for each of the suc-
12 ceeding two fiscal years such sums as may be necessary to
13 make direct loans and guarantee loans under this title.

14 “(c) Of the sums appropriated for any fiscal year under
15 this section, not less than 60 per centum shall be set aside
16 and obligated in such fiscal year for grants under section 601.
17 Sums set aside in any fiscal year for grants under section 601
18 but not obligated in such fiscal year for such grants because
19 of lack of applicants shall remain available for obligation un-
20 der this section in the succeeding fiscal year for grants.

21 “DEFINITIONS

22 “SEC. 614. For the purposes of this title—

23 “(1) The term ‘construction’ includes construction of
24 new buildings, acquisition of initial equipment (including
25 medical transportation facilities) for buildings constructed

1 with assistance under this title, and acquisition of equipment
2 for any building in any case in which it will help to provide
3 outpatient services not previously provided in the area served
4 through such buildings.

5 “(2) The term ‘modernization’ includes the alteration,
6 expansion, major repair (to the extent permitted by the Sec-
7 retary by regulations), remodeling, replacement, or renova-
8 tion of existing buildings (including initial equipment there-
9 of), and replacement of obsolete equipment of existing build-
10 ings.

11 “(3) The term ‘health facility’ means a facility which
12 provides to patients services of licensed physicians and a rea-
13 sonably full range of diagnostic and treatment services.

14 “(4) The term ‘outpatient facility’ means a health
15 facility which offers a reasonably full range of diagnostic and
16 treatment services, which services do not include bed and
17 board.

18 “(5) The term ‘cost’ as applied to construction or
19 modernization means the amount found by the Secretary to
20 be necessary for construction and modernization respectively,
21 under a project, except that such term does not include any
22 amount found by the Secretary to be attributable to expan-
23 sion of the bed capacity of any facility.

24 “(6) The term ‘State’ includes the Commonwealth of
25 Puerto Rico, Guam, American Samoa, the Trust Territories

1 of the Pacific Islands, the Virgin Islands, and the District
2 of Columbia.

3 “(7) The term ‘medically underserved population’
4 means the population of an urban or rural area designated
5 by the Secretary as an area with a shortage of health facilities
6 or a population group designated by the Secretary as having
7 a shortage of such facilities.

8 “(8) The term ‘title’ when used with reference to a
9 site for a project, means a fee simple or such other estate or
10 interest (including a leasehold on which the rental does not
11 exceed 4 per centum of the value of the land) as the Secre-
12 tary finds sufficient to assure undisturbed use and possession
13 for the purposes of construction or modernization and opera-
14 tion of the project for a period of (A) not less than twenty
15 years in the case of a grant under this title or (B) the term
16 of repayment of a loan made directly or guaranteed in the
17 case of such loan or guarantee under this title.

18 “(9) The term ‘nonprofit’ as applied to any facility
19 means a facility which is owned and operated by one or more
20 nonprofit corporations or associations no part of the net
21 earnings of which inures, or may lawfully inure, to the bene-
22 fit of any private shareholder or individual.

23 “(10) The Secretary may not determine that an area
24 is an urban or rural poverty area unless—

1 “(a) such area contains one or more subareas which
2 are characterized as subareas of poverty;

3 “(b) the population of such subarea or subareas
4 constitutes a substantial portion of the population of
5 such urban or rural area; and

6 “(c) the grant, in connection with which such deter-
7 mination is made will be used in a manner which will
8 serve the needs of the individuals residing or employed
9 in such subarea or subareas.”

93D CONGRESS
2D SESSION

S. 2983

IN THE SENATE OF THE UNITED STATES

FEBRUARY 7, 1974

Mr. JAVITS (for himself, Mr. EAGLETON, and Mr. WILLIAMS) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act to provide for emergency assistance to urban hospitals.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Urban Hospitals Emer-
4 gency Assistance Act of 1974".

5 FINDINGS AND DECLARATION OF PURPOSE

6 SEC. 2. The Congress hereby finds and declares that—

7 (1) The achievement of equal access for all people
8 to high quality medical care at a reasonable cost is a
9 priority of the Federal Government.

10 (2) Urban public hospitals provide such health

1 care services to a large segment of the population who
2 would not otherwise be served.

3 (3) Improvements in the financing of these insti-
4 tutions must be made if they are to survive over the
5 next five years.

6 (4) Emergency financial assistance must be pro-
7 vided (a) to prevent the closure of or denial of accredi-
8 tation to urban public hospitals; (b) to provide operat-
9 ing support for patient care activities not otherwise re-
10 imburseable; and (c) to assist in meeting urban public
11 hospitals' costs of training professional and allied health
12 personnel.

13 SEC. 3. Section 600 of the Public Health Service Act
14 (42 U.S.C. 201) is amended by striking the word "and" at
15 the end of subsection (b) ; by striking the period at the end
16 of subsection (c) and inserting in lieu thereof the word
17 "; and"; and by inserting after subsection (c) the following
18 new subsection:

19 "(d) to provide alternate methods of operational
20 financing to public hospitals for patient care and to
21 public or other nonprofit community hospitals for man-
22 power training programs."

23 SEC. 4. (a) Title VI of the Public Health Service Act
24 is further amended by adding after section 610 the following
25 new section:

1 "HOSPITAL FACILITIES RESTORATION

2 "SEC. 611. (a) The Secretary is authorized to make
3 grants to public general hospitals to assist such hospitals in
4 meeting the costs of—

5 "(1) modernization of patient care facilities in
6 urban areas, and

7 "(2) construction or modernization of outpatient
8 facilities of such hospitals located apart from the hospi-
9 tal so that ambulatory care service may be decentralized.

10 "(b) In no case shall a grant under this section exceed
11 75 per centum of the cost of a project and no amount of such
12 grant may be used for the expansion of bed capacity of the
13 facility.

14 "(c) To be eligible for a grant under this section an
15 applicant shall demonstrate to the satisfaction of the Secre-
16 tary—

17 "(1) the ability to serve low-income residents re-
18 siding in the area to be served by such applicant;

19 "(2) that a long-range plan for facilities improve-
20 ment will be implemented with commencement of as-
21 sistance under this section;

22 "(3) that the facility to be modernized or con-
23 structed and the services to be provided herein shall
24 be located in, or readily accessible to, areas with a high
25 density low-income population; and

1 “(4) that such application has been approved by
2 an appropriate unit of local government in which the
3 facility is or will be located.

4 “(d) In making grants under this section the Secretary
5 shall give priority to those applicants who demonstrate the
6 need for such assistance to—

7 “(1) eliminate or prevent an imminent safety haz-
8 ard as defined by State or local fire, building, or life
9 safety codes or regulations; and

10 “(2) avoid noncompliance with State or voluntary
11 agency licensure or accreditation.

12 “(e) No grant shall be made under this section unless
13 the project for which the funds are to be used is approved
14 by the appropriate planning agency or agencies established
15 under this Act and the applicant has established to the
16 satisfaction of the Secretary that the applicant previously
17 proceeded reasonably and diligently to overcome the hazards
18 or noncompliance referred to in paragraphs (1) and (2) of
19 subsection (d), but cannot achieve these stated goals with-
20 out the financial assistance herein authorized.

21 “(1) There are authorized to be appropriated to carry
22 out the provisions of this section \$100,000,000 for the fiscal
23 year ending June 30, 1975, \$150,000,000 for the fiscal
24 year ending June 30, 1976, and \$250,000,000 for the fiscal
25 year ending June 30, 1977.

1 “(g) For each project there shall be submitted to the
2 Secretary an application by the governing body of the hos-
3 pital. Such application shall set forth—

4 “(1) a description of the site for such project;

5 “(2) plans and specifications therefor, in accord-
6 ance with regulations prescribed under section 603;

7 “(3) reasonable assurance that title to such site is
8 or will be vested in one or more of the agencies filing
9 the application or in a public or other nonprofit agency
10 which is to operate the facility on completion of the
11 project;

12 “(4) reasonable assurance that adequate financial
13 support will be available for the completion of the proj-
14 ect and for its maintenance and operation when com-
15 pleted; and

16 “(5) reasonable assurance that all laborers and
17 mechanics employed by contractors or subcontractors
18 in the performance of construction or modernization on
19 the project will be paid wages at rates not less than
20 those prevailing on similar work in the locality as de-
21 termined by the Secretary of Labor in accordance with
22 the Davis-Bacon Act, as amended (40 U.S.C. 276a—
23 276a-5) ; and the Secretary of Labor shall have with
24 respect to the labor standards specified in this paragraph
25 the authority and functions set forth in Reorganization

1 Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C.
2 133z-15) and section 2 of the Act of June 13, 1934,
3 as amended (40 U.S.C. 276c).

4 “(h) Payments under this section may be made in ad-
5 vance or by way of reimbursement, and on such terms and
6 conditions and in such installment, as the Secretary may
7 determine.

8 “(i) If any facility with respect to which funds have
9 been paid under this section shall, at any time within ten
10 years after completion of construction—

11 “(1) be sold or transferred to any person, agency,
12 organization—

13 “(A) which is not qualified to file an applica-
14 tion under this section, or

15 “(B) which is not approved as a transferee
16 by the State agency designated pursuant to section
17 604 or its successor, or

18 “(2) cease to be a public health center or other
19 nonprofit hospital, unless the Secretary determines, in
20 accordance with regulations, that there is good cause for
21 releasing the applicant or other owner from this obliga-
22 tion,

23 the United States shall be entitled to recover from either the
24 transferor or the transferee (or in the case of a facility which
25 has ceased to be public or nonprofit, from the owners thereof)

1 an amount bearing the same ratio to the then value (as de-
2 termined by the agreement of the parties or by action
3 brought in the district court of the United States for the
4 district in which the facility is situated) of so much of the
5 facility as constituted an approved project or projects, as
6 the amount of the Federal participation bore to the cost of
7 construction or modernization under such project or projects.
8 Such right shall not constitute a lien upon said facility prior
9 to judgment.

10 "GRANTS FOR INNOVATIVE CONSTRUCTION

11 "SEC. 644. (a) The Secretary is authorized to make
12 direct grants to public and private nonprofit hospitals for
13 special projects to demonstrate innovations in health care
14 delivery construction which implement quality control or im-
15 prove efficiency in the provision of health services by meet-
16 ing identified needs, and reducing documented inefficiencies.

17 "(b) The Secretary may not authorize the recipient of a
18 grant under this section to use funds under such grant for
19 any construction unless the applicant filed (as appropriate)
20 under this Act for a grant for such construction and such
21 application was not approved or was approved but for which
22 no or inadequate funds were made available under such Act.

23 "(c) There are authorized to be appropriated to carry
24 out the purposes of this section \$25,000,000 for the fiscal
25 year ending June 30, 1975, \$35,000,000 for the fiscal year

1 ending June 30, 1976, and \$50,000,000 for the fiscal year
2 ending June 30, 1977.”.

3 SEC. 5. Title VI of the Public Health Service Act, as
4 amended by this Act, is further amended by adding at the
5 end thereof the following new part:

6 “PART E—SUPPORT OF PATIENT CARE FACILITIES

7 “GRANTS TO HOSPITALS

8 “SEC. 651. (a) Each public general hospital shall be
9 entitled for each fiscal year to a grant equal to 75 per centum
10 of the annual net cost incurred by the hospital for patient
11 care.

12 “(b) To be eligible for an entitlement under this section
13 an applicant must—

14 “(1) demonstrate that it derives at least 15 per
15 centum of its annual budgeted operating expenses from
16 funding that is appropriated for such expenses by a local
17 unit or units of general government from general
18 revenues;

19 “(2) provide assurances that health care services
20 are provided to low-income persons residing in the area
21 of that local unit of government;

22 “(3) demonstrate that it provides a complete con-
23 tinuity of health care encompassing a comprehensive
24 range of health care services commensurate with the

1 hospital's capability to provide the services and the com-
2 munity's need therefor including but not limited to—

3 “(A) emergency medical services,

4 “(B) outpatient services,

5 “(C) maternal and child care services,

6 “(D) family planning services,

7 “(E) psychiatric services, and

8 “(F) diagnostic and treatment services for in-
9 dividuals suffering from alcoholism and drug de-
10 pendence.

11 “(c) There are authorized to be appropriated to carry
12 out the purposes of this section \$50,000,000 for the fiscal
13 year ending June 30, 1975, \$100,000,000 for the fiscal year
14 ending June 30, 1976, and \$150,000,000 for the fiscal year
15 ending June 30, 1977.

16 “(d) If the total of the entitlements for approved appli-
17 cations under this section exceeds the amounts appropriated
18 under this section, the amount for that fiscal year to each
19 such applicant shall be an amount that bears the same ratio
20 to the amount determined for that applicant for that fiscal
21 year under subsection (a) of this section as the total of avail-
22 able appropriations bears to the aggregate amount that would
23 be required to fund all approved applications.

24 “(e) No payments shall be made under this section unless

1 the applicant has demonstrated to the satisfaction of the Secre-
2 tary that—

3 “(1) the applicant has established a viable program
4 for the collection of all third-party payments to which it
5 may be entitled; and

6 “(2) the local unit of government in which the
7 facility is situated, would in the absence of assistance
8 under this section have to supply such funds from its
9 general revenue.”.

10 SEC. 6. Title VII of the Public Health Service Act is
11 amended by adding at the end thereof the following new
12 part:

13 “PART I—URBAN HOSPITAL MANPOWER TRAINING
14 SUPPLEMENTS

15 “GRANTS TO HOSPITALS

16 “SEC. 799B. (a) Each hospital having adopted uniform
17 cost accounting and utilization and reporting systems proce-
18 dures (in accordance with regulations issued by the Secre-
19 tary) shall be entitled for each fiscal year to a grant to assist
20 such hospital in meeting the costs of training residents,
21 interns, except noncitizen graduates of foreign medical
22 schools, and individuals preparing for careers in nursing or
23 the allied health professions in programs approved by him
24 after consultation with the appropriate professional accredi-
25 ting agency or specialty board.

1 “(b) Each hospital operating such a program shall be
2 entitled for each fiscal year to an allotment equal to 25 per
3 centum of the hospital's reasonable net cost of such training
4 programs, but in no event shall the total assistance a hos-
5 pital may receive under this section exceed the lesser of (1)
6 the product of \$500 multiplied by the number of patient
7 beds in such hospital, or (2) \$500,000.

8 “(c) (1) There are authorized to be appropriated to
9 carry out the purposes of this section \$25,000,000 for the
10 fiscal year ending June 30, 1975, \$50,000,000 for the
11 fiscal year ending June 30, 1976, and \$75,000,000 for
12 the fiscal year ending June 30, 1977.

13 “(2) Sums appropriated pursuant to paragraph (1)
14 for a fiscal year shall remain available for grants under
15 this section until the close of the next succeeding fiscal year.

16 “(d) If the total of the entitlements for approved ap-
17 plications under this section exceeds the amounts appro-
18 priated under subsection (b) of this section, the amount for
19 that fiscal year to each such applicant shall be an amount
20 which bears the same ratio to the amount determined for
21 that applicant for that fiscal year under this section as the
22 total of the available appropriations bears to the aggregate
23 amount that would be required to fund all approved ap-
24 plications.”.

DEFINITIONS

1

2 SEC. 5. Section 645 of the Public Health Service Act
3 is amended by adding at the end thereof the following new
4 subsections:

5 “(m) The term ‘annual net cost of patient care’ means
6 the total operating expenses of a hospital (including trans-
7 portation, board and room, outpatient care services incurred
8 by a hospital for a fiscal year and directly or indirectly at-
9 tributable to patient care, but no more than the costs of the
10 most efficient institutional provider of health care in the
11 community providing an equivalent range of services, less the
12 amounts received by the hospital from patients, or third
13 party payors on the patients behalf, for such care, but ex-
14 cluding from such reduction (1) payments from general
15 revenues by local units of government or by other public
16 agencies in support of the hospital or specifically for the care
17 of low-income or medically indigent persons, (2) payments
18 by the Secretary under title VI of this Act, and (3) chari-
19 table contributions to the hospital.

20 “(n) The term ‘low-income person’ means any indi-
21 vidual at an income level at or below a level designated by
22 the Secretary after taking into consideration family size,
23 urban-rural and farm-nonfarm differences and other relevant
24 factors.

25 “(o) The term ‘urban’ means a standard metropolitan

1 statistical area as determined by the Office of Management
2 and Budget.”.

3 SEC. 8. Title VI of the Public Health Service Act is
4 further amended by adding after section 646 the following
5 new section:

6 “RECORDS AND AUDITS

7 “SEC. 647. (a) Each recipient of Federal assistance
8 under this part, pursuant to grants, subgrants, contracts, sub-
9 contracts, loans, or other arrangements, entered into other
10 than by formal advertising, and which are otherwise au-
11 thorized by this part, shall keep such records as the Secretary
12 shall prescribe, including records which fully disclose the
13 amount and disposition by such recipient of the proceeds
14 of such assistance, the total cost of the project or undertaking
15 in connection with which such assistance is given or used, the
16 amount of that portion of the cost of the project or under-
17 taking supplied by other sources, and such other records as
18 will facilitate an effective audit.

19 “(b) The Secretary and the Comptroller General of the
20 United States, or any of their duly authorized representa-
21 tives, shall, until the expiration of three years after com-
22 pletion of the project or undertaking referred to in subsec-
23 tion (a) of this section, have access for the purpose of audit
24 and examination to any books, documents, papers, and rec-
25 ords of such recipients which in the opinion of the Secretary

1 or the Comptroller General may be related or pertinent to
2 the grants, contracts, subcontracts, subgrants, loans, or other
3 arrangements referred to in subsection (a).”

4 NONDUPLICATION OF FUNDS

5 SEC. 9. No funds other than those appropriated under
6 the provisions of section 611, 644, 651, or 799B of the Pub-
7 lic Health Service Act, may be used for the purposes of
8 those sections.

Senator KENNEDY. The administration has indicated in the recent past that they favor a complete termination of the Hill-Burton program. They have asserted that an excess of hospital beds exists in the United States at the present time.

While it may be true that an absolute excess of hospital beds exists, such an assertion has very little meaning unless the type, location, and use of such hospital beds is also taken into account.

Many of the hospital beds currently in existence are seriously and dangerously out-moded, and in need of replacement. According to the latest available data from Hill-Burton State plans, more than 167,000 general hospital beds need to be modernized. In addition, nearly 233,000 long-term care beds need to be modernized.

Many experts in the hospital field assert that it is difficult or impossible for health care facilities, particularly in low-income areas, to retain and accumulate capital out of operating expenses, and that Federal funds are the only source of capital assistance realistically available to such facilities.

For that reason, it seems clear that a need for a program of Federal subsidy for the modernization of such facilities continues to exist.

In addition, changing patterns of health care, with increasing emphasis on the provision of health care services in an outpatient setting, a trend which has been encouraged in recent years by Federal programs, has created the need for facilities for the provision of health care services on an outpatient, rather than a relatively more expensive inpatient basis. For that reason, I believe that the Federal Government continues to have an obligation to assist in the construction of such facilities.

Finally, a condition of participation in the original Hill-Burton program was that a reasonable volume of free services be provided by Hill-Burton assisted facilities to members of the community they served. Evidence has accumulated during recent years, that this requirement has not been adequately enforced by the Department. We will hear testimony today with respect to that issue.

It seems to me that such an obligation, once incurred, constitutes a continuing obligation on the part of those hospitals which accepted the grant funds in the first place. Until a comprehensive national health insurance program, which eliminates ability to pay as a barrier to health care, is passed, such an obligation must be adequately enforced.

The program I have proposed gives the Secretary of the Department of Health, Education, and Welfare authority to make grants and loans to public and nonprofit entities for modernization and construction of outpatient facilities. Funds appropriated under the authority created by this bill would be credited to facilities accounts, maintained in the Department of HEW on behalf of the States. Expenditure of the funds would be determined by the Secretary after minimum requirements set forth in the legislation are met, with strong input by areawide and, in accordance with Federal health planning law, State health planning agencies.

Health planning legislation currently under development by the subcommittee would provide the States, and State government in particular, with strong input into the areawide planning process, and

a substantial role in making recommendations to the Secretary of HEW concerning the establishment of priorities within a particular State.

The subcommittee looks forward to receiving testimony from the witnesses today.

We are delighted to welcome as our first witness the distinguished Assistant Secretary for Health of the Department of Health, Education, and Welfare, Dr. Edwards, an old friend of this committee, and I extend a warm word of welcome to him.

We always value your testimony. You have some good associates with you, and we look forward to hearing from you.

STATEMENT OF CHARLES C. EDWARDS, M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY KENNETH ENDICOTT, M.D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION; HARALD GRANING, M.D., DIRECTOR, HEALTH CARE FACILITIES SERVICE, HEALTH RESOURCES ADMINISTRATION; DALE SOPPER, LEGISLATIVE OFFICE; AND EUGENE J. RUBEL, DIRECTOR, DIVISION OF COMPREHENSIVE HEALTH PLANNING

Dr. EDWARDS. Thank you, Mr. Chairman.

I would like to introduce my colleagues. On my left is Dr. Endicott who, as you know is the Administrator of the Health Resources Administration; on his left is Dr. Harald Graning, who is the Director of Health Care Facilities Service, which administers the Hill-Burton program.

On my right is Dale Sopper, who is a Legislative Officer for Health in the Office of Health Legislation.

We appreciate this opportunity to discuss with you today S. 3577, the Health Facilities Assistance Act of 1974, which you have introduced, and S. 2983, the Urban Hospitals Emergency Assistance Act of 1974, introduced by Senators Javits, Eagleton, and Williams.

Before addressing these bills in detail, we would like briefly to review with you the existing program of support and to discuss the need for a continuation of any type of health facility construction support.

The Hospital Survey and Construction Act of 1946, commonly known as the Hill-Burton program, was one of the landmark Federal health programs of the post-World War II period. While other modern Western World countries, such as the United Kingdom and France, enacted general governmental health care programs immediately after the war, the United States did not follow this course. Rather than provide direct services programs, the Congress chose to provide Federal assistance so as to assure the development of adequate health resources through capital investment.

The original enactment of Hill-Burton was based on the desire to increase the number of, and to better distribute, hospital beds. In 1946, while the eight States with the highest income had 4 beds per 1,000 population, there were only 2.5 beds per 1,000 population in the eight States with the lowest income.

Today this imbalance has been corrected and, indeed, the facilities in the poorer States are, on the average, newer facilities. Today the need is not for additional beds and hospitals, but for the modernization, including replacement, of existing hospitals and for increased ambulatory care facilities.

As of December 1973, 11,297 projects had been approved for the construction or modernization of more than 6,475 public and voluntary nonprofit facilities serving 3,941 communities throughout the country. Some 489,500 inpatient beds were provided for hospitals and nursing homes. The total cost of these projects was \$14 billion, of which the Hill-Burton funds were \$4 billion. The matching funds of \$10 billion were provided for the most part by nongovernmental sources, and in some cases by State and local governmental sources.

Under the new Hill-Burton loan and loan guarantee programs, for which final regulations went into effect in January 1972, loan guarantees with interest subsidies may be made to private nonprofit agencies and direct loans to public agencies to aid in modernizing or constructing health care facilities. Some 180 loan agreements and direct loans, totaling \$653 million, had been approved through January 1974. The legislative authorization provides that loans totaling \$1.5 billion may be guaranteed over the 4-year period covered by the statute.

The administration's reasons for recommending the lapse of the Hill-Burton authority for the last 2 years were that an adequate total supply of beds existed in the United States, and that hospitals and other health facilities could generate the necessary funds through patient income, private contributions, and debt financing.

Over the last few decades, health facilities have increasingly turned to debt financing for new construction, and accordingly Government construction grant support has become a very small component of total capital financing. In 1972, Hill-Burton funds accounted for less than 5 percent of health facility construction expenditures.

In 1963, the Hill-Burton funds accounted for approximately 15 percent.

In general, the Department's position has been confirmed. Recent studies have shown: (1) that overall, an adequate number of beds exist; (2) most hospitals have been able to make capital investments through adequate cash flows and the use of private loan markets and revenue bonds; and (3) that the Hill-Burton program was successful in achieving a more equitable distribution of beds.

One study done for the Department this year showed that actual capital expenditures made by all voluntary nonprofit hospitals were greater than that necessary for meeting required modernization and expansion needs.

Since the Hill-Burton program has no financial needs tests, the facilities receiving Hill-Burton assistance have in large measure been those where a need exists and where the front-end money and cash flow are sufficient to meet the Federal financial matching requirements.

However, because of the front-end equity and cash flow problems, there are urban and rural pockets of serious facility needs where the facilities are unable to avail themselves of Hill-Burton assistance.

The continuation of any type of formula grant program intended to correct this problem is an unnecessarily expensive approach, we

believe, because it could require unacceptably large appropriations in order to reach needy areas that exist in many States.

The inconsistency between the over-investment in health facilities for the Nation as a whole, and the existence of structurally deficient health facilities in inner cities is partially explained, as I have noted, by the inability of the Hill-Burton program to target assistance to facilities in greatest need and also by the inability of such institutions to accumulate adequate capital set-aside funds from operating income.

Not surprisingly, therefore, the health facilities with serious structural and safety defects today are predominantly located in poorer communities; both inner city and rural.

The ability of an individual facility to meet its capital financing needs is dependent primarily upon two factors. First, its ability to either accumulate a requisite down payment, or have capital assets that may be used as security so that all funds may be borrowed; second, its ability to generate an excess of revenue over current expenditures.

Nearly all types of health insurance, including medicare and medicaid, Blue Cross-Blue Shield, and other private plans, recognize depreciation as a valid component in the reimbursement of hospital and medical facilities. This aspect of current medical care financing permits most hospitals and medical facilities to either set aside funds for facility improvements or pay back loans for construction over the useful life of the facility.

Imbalances between revenues and expenses can result when there is inefficient management or when a substantial portion of the patient population served has inadequate or no insurance coverage. Data from the Social Security Administration and the American Hospital Association, which spans the years 1968 to 1972, showed 20 to 25 percent of short-term hospitals annually had expenses exceeding revenues, and almost 10 percent of a Social Security Administration sample of hospitals had negative cash flows in 1968. However, these deficits have been made up by financial support from State and local governments.

Many institutions with insufficient cashflows are unable to participate in the FHA loan market or Hill-Burton interest subsidized loan program. Lenders are simply unwilling to take on such high risks. Thus, those hospitals receiving Federal support are not always those in the greatest need, and many of them probably could have financed their investments without Federal support, particularly an interest subsidized loan. Interest subsidies are not cheap. Under the current Hill-Burton program, a \$1-million loan costs in excess of \$400,000 in interest subsidies. Institutions unable to finance necessary repairs and improvements become functionally obsolete, and frequently unsafe.

In December of 1973 HEW conducted a nationwide telephone survey of State Hill-Burton agencies to determine the number of short-term nonprofit general hospitals—of which there are approximately 6,600—that did not meet structural and safety standards for at least 25 percent of their beds. All hospitals so identified for modernization had to have over 100 beds, have been recommended by the Planning Agency for Modernization, and be judged unable to generate the

necessary funds for capital improvements because of insufficient patient payments.

The study found 341 hospitals with serious defects. The less populous States, which through the years received proportionately high amounts of Hill-Burton money, have relatively few, if any, hospitals meeting all the criteria.

In fact, 13 States indicated no such hospitals, and 9 States had only one hospital. Although not all of these hospitals should be modernized because many are operating at too low an occupancy rate, the wide discrepancy found in modernization needs indicates, as I noted earlier, that a formula grant program would be an inefficient and expensive method for addressing the current facility problem.

Speaking just a moment to the administration provision, the passage and implementation of a nationwide health care financing program will improve the cash flow situation for efficient institutions and accordingly, eliminate the need for capital subsidization. National health insurance is the only way to bring about equality of access to equivalent resources.

Once again, I would urge that we work together to achieve passage of a comprehensive health insurance bill this year. Until such implementation, a limited number of facilities may have insufficient cash flows. Some of these may need modernization.

Therefore, we believe a highly selective form of targeted assistance is desirable until the advent of comprehensive health insurance. If a nationwide health care financing program is enacted and implemented during fiscal year 1976, this special program would operate for no more than a few years.

Then, the FHA mortgage insurance loan program would continue to provide Federal assistance to health care facilities in gaining access to construction funds. It is not clear that the FHA program would be widely used.

Currently, 95 percent of the funds applied to improvements are being furnished through private lending institutions.

I would now like to turn to a discussion of the bills pending before your committee.

The bill introduced by you, Mr. Chairman, S. 3577, the proposed Health Facilities Assistance Act of 1974, would replace the existing Hill-Burton authorities with a new 3-year program focused on assisting projects for the construction or modernization of public or other nonprofit outpatient facilities, and the modernization of public or other nonprofit health facilities that will serve medically underserved populations.

In its major outlines, the bill would empower the Secretary to offer three kinds of aid:

Grants to public or nonprofit private entities for up to 75 percent of the project cost, except for projects in urban or rural poverty areas, where grants could cover up to 90 percent of cost;

Federal loans for up to 90 percent of the cost of such projects which, in the case of public entities, would be made at interest rates up to 4½ percent below the prevailing commercial rate for comparable federally guaranteed loans;

Federal guarantees of non-Federal loans for up to 90 percent of the cost of such projects, which, in the case of private nonprofit borrowers, would include an interest subsidy sufficient to reduce the net effective interest rate otherwise payable by up to 4½ percent.

Local health planning agencies in the areas to be served by the projects would determine the priority of assistance, giving special consideration, among other factors now emphasized under the Hill-Burton program, to projects designed to eliminate or prevent imminent safety hazards, or to avoid noncompliance with licensure or accreditation requirements.

Some \$210 million would be authorized to be appropriated for grants each year of the program, and such sums as may be necessary for loans and loan guarantees.

S. 2983, introduced by Senators Javits, Eagleton, and Williams, the proposed Urban Hospitals Emergency Assistance Act, would provide a 3-year authority for four kinds of Federal assistance:

Federal matching grants of up to 75 percent for the construction of ambulatory care facilities and for the modernization of hospitals serving low income persons located in urban areas; grants to public and private nonprofit hospitals for the construction of innovative projects; and operational deficit support for public hospitals; and training support to hospitals.

We oppose direct Federal loans and loan guarantees with interest subsidies because interest subsidies are generally disproportionately expensive in relation to the benefits received.

More importantly, it is questionable whether the ability of a facility to acquire a loan is in any way tied to the existence of an interest subsidy.

Further, to the extent to which a Federal guarantee is needed, such a guarantee can be acquired through the existing FHA mortgage insurance program for private nonprofit and proprietary hospitals.

For example, as of December 31, 1973, \$831 million in hospital facility construction mortgages have been insured by the FHA program.

I think, as you know, through the agreement with HUD, DHEW has the responsibility for determining the need for the hospital construction project in question, and for determining the financial ability of the facility to amortize the loan.

We believe it is structurally unsound to establish in a project grant program, as S. 3577 would do, the concept of State allotments. We see no purpose served by such a scheme, and believe it will result in funds remaining unused because of a lack of qualified projects or being used on low priority activities.

Moreover, such a scheme cannot help but adversely affect the overall ability to fund qualified projects and target available resources on legitimate need.

We believe it is of paramount importance, however, that all institutions take necessary steps to fund depreciation. Therefore, we are examining this concept as a condition of participation in connection with our existing health financing programs.

However, recognizing that there are a limited number of financially high risk health facilities which are in need of direct Federal

grant assistance, we favor a limited program of grant assistance, targeted to institutions where the need is greatest.

As a condition of assistance, the legislature should require that grant recipients agree to fund depreciation. Until comprehensive health insurance is in place, we recognize that in some situations, funding the depreciation could present the institution with the requirement to close its doors, or substantially cut back services in spite of their best efforts to eliminate inefficiencies.

Under such circumstances, we would favor authority for the Secretary to waive the funding requirement to the extent that it exceeds debt service charges for a year at a time up to a maximum of 3 years.

Once we have implemented a national health financing system, capital subsidies—such as we are discussing today—should be unnecessary. All institutions, regardless of the socio-economic population they serve, should at that time be able to finance their own capital needs.

We also believe that it is critical that the States should participate with the Federal Government in providing assistance to the most needy health facilities. With this in mind, we favor legislation to require that the State match equally the Federal contribution after it is approved for Federal funding.

We recommend the Federal share be limited to one-half of the amount of the down payment required to secure a loan for any hospital facility, including outpatient departments, but not more than 12.5 percent of the total cost of the project.

Together, the State and Federal Governments will provide up to 25 percent of the costs as a down payment. We believe the lower Federal share, we are suggesting, more adequately reflects the ability of most institutions in such need to repay loans.

We also recommend that the appropriation authorization be "such sums as may be necessary." To implement this new program in fiscal year 1975, we intend to request a supplemental appropriation of \$100 million. Based upon the above Federal share, we believe that up to \$800 million in construction can be assisted.

In addition, we strongly recommend that facilities must demonstrate that they are unable to acquire a loan in the private market for the desired capital improvement. We believe that the Federal Government should only be the financier of last resort in this grant program, and that \$100 million will be adequate in fiscal year 1975.

The local planning agencies should be required to confirm the statement and the approval of the Governors would also be required. Public facilities should also be required to justify the reason for the inability of the State or local government in question to underwrite the necessary bonds for acquiring the capital.

Finally, the assisted facility should have a policy on nondiscrimination for medicaid and medicare patients, and not reduce the level of free services it was providing.

As it is your intent and our intent to focus on the needs of medically underserved areas, we would not approve as a general rule any request for assistance to facilitate wanting to relocate away from the inner city.

Along with the above conditions, we would require that priority be given to facilities that meet the following standards:

Facilities not meeting medicare and medicaid structural and safety standards;

Innecity hospitals having more than 100 beds;

Facilities which are substantially aged;

Facilities in medically underserved areas that could, with Federal financial aid, improve the access of the low income population in the area to primary care service; and lastly,

Facilities with 80 percent occupancy rates over the past 2 years in medical market areas also averaging 80 percent occupancy rates over the same period.

I would like to comment, very briefly, on S. 2983, the Urban Hospitals Emergency Act. We feel limiting the construction and modernization assistance to public hospitals is unnecessarily restrictive and overlooks the legitimate needs of private nonprofit hospitals in urban areas and public and private nonprofit hospitals in nonurban areas.

Further, we feel that the need for hospital operational deficit assistance as would be provided in this bill is an inappropriate role for the Federal Government with respect to public or nonprofit private institutions and is most appropriately addressed in the context of a comprehensive health insurance program.

The provision is grossly inequitable because it discriminates against hospitals that follow sound management practices and avoid operating deficits. Such operating subsidies will encourage inefficiencies in large complex institutions and discourage other private and public sources of funds which may cover these deficits.

In addition, the hospital training assistance needs of urban hospitals are no different from the needs of other hospitals doing training. Thus, training assistance should be considered within the context of health manpower legislation.

So, Mr. Chairman, we recommend S. 3577 be modified to take the form of a capital assistance effort through direct project grants targeted along the lines identified above. Such grants would be available to public and private nonprofit health care facilities that, among other requirements, serve large numbers of poor patients, and are unable to obtain a loan through the private capital market without Federal capital assistance.

The size of the Federal share would be limited and the grantee institutions would be enabled to participate in the normal debt servicing arrangements. The grants would be limited to provide financial assistance for modernization and replacement of currently existing hospital facilities, including outpatient departments.

Assistance would not be available for the construction of new facilities nor for the replacement of an existing facility if it would worsen the access to those now being served.

Mr. Chairman, we would be delighted to attempt to answer any questions, and I might also say that Dr. Graning and his staff will be delighted to work with your staff on some of the technical issues involved in this highly technical proposed legislation.

Senator KENNEDY. Thank you very much, Dr. Edwards.

[The prepared statement of Dr. Edwards follows:]



FOR RELEASE ONLY UPON DELIVERY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

DR. CHARLES C. EDWARDS

ASSISTANT SECRETARY FOR HEALTH

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

FRIDAY, JUNE 14, 1974

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

It is a pleasure to appear before you today to testify on S. 3577, the Health Facilities Assistance Act of 1974, which you have introduced, and S. 2983, the Urban Hospitals Emergency Assistance Act of 1974, introduced by Senators Javits, Eagleton, and Williams. Before addressing these bills in detail, we would like briefly to review the existing program of support and to discuss the need for a continuation of any type of health facility construction support.

THE EXISTING EFFORT

The Hospital Survey and Construction Act of 1946, commonly known as the Hill-Burton Program, was one of the landmark Federal health programs of the post-World War II period. While other modern Western World countries, such as the United Kingdom and France, enacted general governmental health care programs immediately after the war, the United States did not follow this course. Rather than provide direct services programs, the Congress chose to provide Federal assistance so as to assure the development of adequate health resources through capital investment.

The original enactment of Hill-Burton was based on the desire to increase the number of and to better distribute

hospital beds. In 1946, while the eight States with the highest income had 4.0 beds per 1000 population, there were only 2.5 beds per 1000 population in the eight States with the lowest income. Today, this imbalance has been corrected and, indeed, the facilities in the poorer States are, on the average, newer facilities. Today the need is not for additional beds and hospitals but for the modernization, including replacement, of existing hospitals and for increased ambulatory care facilities.

HILL-BURTON GRANTS

As of December 1973, 11,297 projects had been approved for the construction or modernization of more than 6,475 public and voluntary nonprofit facilities serving 3,941 communities throughout the country. Some 489,500 inpatient beds were provided for hospitals and nursing homes. The total cost of these projects was \$14.0 billion, of which the Hill-Burton funds were \$4.0 billion. The matching funds of \$10.0 billion were provided for the most part by non-governmental sources and in some cases by State and local governmental sources.

HILL-BURTON LOAN AND LOAN GUARANTEES

Under the new Hill-Burton loan and loan guarantee programs, for which final regulations went into effect in January 1972, loan guarantees with interest subsidies may be made to

private nonprofit agencies and direct loans to public agencies to aid in modernizing or constructing health care facilities. Some 180 loan agreements and direct loans, totaling \$653 million, had been approved through January 1974. The legislative authorization provides that loans totaling \$1.5 billion may be guaranteed over the four-year period covered by the statute.

PROBLEMS WITH THE EXISTING PROGRAM

The Administration's reasons for permitting the lapse of the Hill-Burton authority for the last two years were that an adequate total supply of beds existed in the United States and that hospitals and other health facilities could generate the necessary investment funds through patient income, private contributions, and debt financing. Over the last few decades, health facilities have increasingly turned to debt financing for new construction, and accordingly government construction grant support has become a very small component of total capital financing. In 1972, Hill-Burton funds accounted for less than 5 percent of health facility construction expenditures. In 1963, the Hill-Burton funds accounted for approximately 15 percent.

In general, the Department's position has been confirmed. Recent studies have shown: (1) that overall, an adequate number of beds exist; (2) most hospitals have been able

to make capital investments through adequate cash flows and the use of private loan markets and revenue bonds; and (3) that the Hill-Burton Program was successful in achieving a more equitable distribution of beds. One study done for the Department this past year showed that actual capital expenditures made by all voluntary nonprofit hospitals were greater than that necessary for meeting required modernization and expansion needs.

Since the Hill-Burton Program has no financial needs tests, the facilities receiving Hill-Burton assistance have in large measure been those where a need exists and where the front-end money and cash flow are sufficient to meet the Federal financial matching requirements. However, because of the front-end equity and cash flow problems, there are urban and rural pockets of serious facility needs where the facilities are unable to avail themselves of Hill-Burton assistance.

The continuation of any type of formula grant program intended to correct this problem is an unnecessarily expensive approach because it could require unacceptably large appropriations in order to reach needy areas that exist in many States.

RESIDUAL NEED

The inconsistency between the over-investment in health facilities for the Nation as a whole and the existence of structurally deficient health facilities in inner cities is partially explained, as I have noted, by the inability of the Hill-Burton Program to target assistance on facilities in greatest need and also by the inability of such institutions to generate adequate capital set-aside funds from operating income. Not surprisingly, therefore, the health facilities with serious structural and safety defects today are predominantly located in poorer communities; both inner city and rural.

The ability of an individual facility to meet its capital financing needs is dependent primarily upon two factors. First, its ability to either accumulate a requisite down payment or have capital assets that may be used as security so that all funds may be borrowed; second, its ability to generate an excess of revenue over current expenditures.

Nearly all types of health insurance, including Medicare and Medicaid, Blue Cross-Blue Shield, and other private plans, recognize depreciation as a valid component in the reimbursement of hospital and medical facilities. This aspect of current medical care financing permits most

hospitals and medical facilities to either set aside funds for facility improvements or pay back loans for construction over the useful life of the facility.

Imbalances between revenues and expenses can result when there is inefficient management or when a substantial position of the patient population served has inadequate or no insurance coverage. Data from SSA and the American Hospital Association, which spans the years 1968-1972, showed 20 to 25 percent of short-term hospitals annually had expenses exceeding revenues and almost 10 percent of an SSA sample of hospitals had negative cash flows in 1968. However, these deficits have been made up by financial support from State and local governments.

Many institutions with insufficient cash flows are unable to participate in the FHA loan market or Hill-Burton interest subsidized loan program. Lenders are simply unwilling to take on such high risks. Thus, those hospitals receiving Federal support are not always those in the greatest need and many of them probably could have financed their investments without Federal support, particularly an interest subsidized loan. Interest subsidies are not cheap. Under the current Hill-Burton Program, a \$1 million loan costs close to \$400,000 in interest subsidies.

Institutions unable to finance necessary repairs and improvements become functionally obsolete and frequently unsafe. In December, HEW conducted a nationwide telephone survey of State Hill-Burton agencies to determine the number of short-term nonprofit general hospitals--of which there are approximately 6600--that did not meet structural and safety standards for at least 25 percent of their beds. All hospitals so identified for modernization had to have over 100 beds, have been recommended by the CHP(b) agency for modernization, and be judged unable to generate the necessary funds for capital improvements because of insufficient patient payments.

The study found 341 hospitals with serious² defects. The less populous States, which through the years received proportionately high amounts of Hill-Burton money, have relatively few, if any, hospitals meeting all the criteria. In fact, thirteen States indicated no such hospitals and nine States had only one hospital. Although not all these hospitals should be modernized because many are operating at too low an occupancy rate, the wide discrepancy found in modernization needs indicates, as I noted earlier, that a formula grant program would be an inefficient and expensive method for addressing the current facility problem.

ADMINISTRATION POSITION

The passage and implementation of a nationwide health care financing program will improve the cash flow situation for efficient institutions and accordingly, eliminate the need for capital subsidization. National health insurance is the only way to bring about equality of access to equivalent resources. Once again, I would urge that we work together to achieve passage of a comprehensive health insurance bill this year. Until such implementation, a limited number of facilities may have insufficient cash flows. Some of these may need modernization. Therefore, we believe a highly selective form of targeted assistance is desirable until the advent of comprehensive health insurance. If a nationwide health care financing program is enacted and implemented during fiscal year 1976, this special program would operate for no more than a few years. Then, the FHA mortgage insurance loan program would continue to provide Federal assistance to health care facilities in gaining access to construction funds. It is not clear that the FHA program would be widely used. Ninety-five percent of the funds applied to improvements are being financed through revenue bonds and directly through private lending institutions.

I would now like to turn to a discussion of the bills pending before your Committee.

The bill introduced by the Chairman, S. 3577, the proposed Health Facilities Assistance Act of 1974, would replace the existing Hill-Burton authorities with a new three-year program focused on assisting projects for the construction or modernization of public or other nonprofit outpatient facilities, and the modernization of public or other nonprofit health facilities that will serve medically underserved populations.

In its major outlines, the bill would empower the Secretary to offer three kinds of aid:

- Grants to public or nonprofit private entities for up to 75 percent of the project cost, except for projects in urban or rural poverty areas, where grants could cover up to 90 percent of cost;
- Federal loans for up to 90 percent of the cost of such projects, which, in the case of public entities, would be made at interest rates up to 4-1/2 percent below the prevailing commercial rate for comparable Federally guaranteed loans;

- Federal guarantees of non-Federal loans for up to 90 percent of the cost of such projects, which, in the case of private nonprofit borrowers, would include an interest subsidy sufficient to reduce the net effective interest rate otherwise payable by up to 4-1/2 percent.

Local health planning agencies in the areas to be served by the projects would determine the priority of assistance, giving special consideration, among other factors now emphasized under the Hill-Burton Program, to projects designed to eliminate or prevent imminent safety hazards, or to avoid noncompliance with licensure or accreditation requirements.

Some \$210 million would be authorized to be appropriated for grants for each year of the program, and such sums as may be necessary for loans and loan guarantees.

S. 2983, introduced by Senators Javits, Eagleton, and Williams, the proposed Urban Hospitals Emergency Assistance Act, would provide a three-year authority for four kinds of Federal assistance: Federal matching grants of up to 75 percent for the construction of ambulatory care facilities and for the modernization of hospitals serving low income persons located in urban areas; grants to public and private nonprofit hospitals for the construction of innovative

-11-

projects; operational deficit support for public hospitals; and training support to hospitals.

We oppose direct Federal loans and loan guarantees with interest subsidies because interest subsidies are generally disproportionally expensive in relation to the benefits received. More importantly, it is questionable whether the ability of a facility to acquire a loan is in any way tied to the existence of an interest subsidy.

Further, to the extent to which a Federal guarantee is needed, such a guarantee can be acquired through the existing FHA mortgage insurance program for private nonprofit and proprietary hospitals. For example, as of December 31, 1973, \$831 million in hospital facility construction mortgages have been insured by the FHA program. As you know, through agreement with HUD, DHEW has the responsibility for determining the need for the hospital construction project in question, and for determining the financial ability of the facility to amortize the loan.

We believe it is structurally unsound to establish in a project grant program, as S. 3577 would do, the concept of State allotments. We see no purpose served by such a scheme and believe it will result in funds remaining unused because of a lack of qualified projects or being used on low priority activities. Moreover, such a scheme

-12-

cannot help but adversely affect the overall ability to fund qualified projects and target available resources on legitimate need.

We believe it is of paramount importance, however, that all institutions take necessary steps to fund depreciation. Therefore, we are examining this concept as a condition of participation in connection with our existing health financing programs.

However, recognizing that there are a limited number of financially high risk health facilities which are in need of direct Federal grant assistance, we favor a limited program of grant assistance, targeted to institutions where the need is greatest. As a condition of assistance, the legislation should require that grant recipients agree to fund depreciation. Until comprehensive health insurance is in place, we recognize that in some situations, funding the depreciation could present the institution with the requirement to close its doors or substantially cut back services in spite of their best efforts to eliminate inefficiencies. Under such circumstances, we would favor authority for the Secretary to waive the funding requirement to the extent that exceeds current debt service charges for a year at a time up to a maximum of three years. Once we have implemented a national health financing system,

capital subsidies--such as we are discussing today--should be unnecessary. All institutions regardless of the socio-economic population they serve should at that time be able to finance their own capital needs.

We also believe that it is critical that the States should participate with the Federal Government in providing assistance to the most needy health facilities. With this in mind, we favor legislation to require that the State match equally the Federal contribution after it is approved for Federal funding. We recommend the Federal share be limited to one-half of the amount of the down payment required to secure a loan for any hospital facility, including outpatient departments, but not more than 12.5 percent of the total cost of the project. Together, the State and Federal governments will provide up to 25 percent of the costs as a down payment. We believe the lower Federal share, we are suggesting, more adequately reflects the ability of most institutions in such need to repay loans.

We also recommend that the appropriation authorization be "such sums as may be necessary." To implement this new program in fiscal year 1975, we intend to request a supplemental appropriation of \$100 million. Based upon the above Federal share, we believe that up to \$800 million in construction can be assisted.

In addition, we strongly recommend that facilities must demonstrate that they are unable to acquire a loan in the private market for the desired capital improvement. We believe that the Federal Government should only be the financier of last resort in this grant program and that \$100 million will be adequate in fiscal year 1975. The local planning agencies should be required to confirm the statement and the approval of the Governors would also be required. Public facilities should also be required to justify the reason for the inability of the State or local government in question to underwrite the necessary bonds for acquiring the capital. Finally, the assisted facility should also have a policy on non-discrimination for Medicaid and Medicare patients and not reduce the level of free services it was providing. As it is your and our intent to focus on the needs of medically underserved areas, we would not approve as a general rule any request for assistance to facilities wanting to relocate away from the inner city.

Along with the above conditions, we would require that priority be given to facilities that meet the following standards:

- Facilities not meeting Medicare and Medicaid structural and safety standards;
- Inner city hospitals having more than 100 beds;
- Facilities which are substantially aged;
- Facilities in medically underserved areas that could, with Federal financial aid, improve the access of the low income population in the area to primary care service;
- Facilities with 80 percent occupancy rates over the past two years in medical market areas also averaging 80 percent occupancy rates over the same period.

We would like to comment briefly on S. 2983, the Urban Hospitals Emergency Act. We feel limiting the construction and modernization assistance to public hospitals is unnecessarily restrictive and overlooks the legitimate needs of private nonprofit hospitals in urban areas and public and private nonprofit hospitals in non-urban areas. Further, we feel that the need for hospital operational deficit assistance (as provided in the bill) is an inappropriate role for the Federal Government with respect to public or nonprofit private institutions and is most appropriately addressed in the context of a comprehensive health insurance

program. The provision is grossly inequitable because it discriminates against hospitals that follow sound management practices and avoid operating deficits. Such operating subsidies will encourage inefficiencies in large complex institutions and discourage other private and public sources of funds which usually cover these deficits. In addition, the hospital training assistance needs of urban hospitals are no different from the needs of other hospitals doing training. Thus, training assistance should be considered within the context of health manpower legislation.

CONCLUSION

We recommend S. 3577 be modified to take the form of a capital assistance effort through direct project grants targeted along the lines identified above. Such grants would be available to public and private nonprofit health care facilities that, among other requirements, serve large numbers of poor patients and are unable to obtain a loan through the private capital market without Federal capital assistance. The size of the Federal share would be limited and the grantee institutions would be enabled to participate in the normal debt servicing arrangements. The grants would be limited to provide financial assistance for modernization (and replacement) of currently existing hospital facilities including outpatient departments. Assistance would not be available for the construction of new facilities nor

-17-

for the replacement of an existing facility if it would worsen the access to those now being served.

Mr. Chairman and Members of the Subcommittee, this concludes my formal statement. We look forward to working with this Subcommittee on this important legislation.

Senator KENNEDY. What have you been expending under the Hill-Burton program in the last few years?

Dr. GRANING. The appropriation level has been approximately \$200 million per year.

Senator KENNEDY. Have you been expending all that?

Dr. GRANING. Yes, sir.

Senator KENNEDY. None of it has been impounded?

Dr. GRANING. None of it has.

Senator KENNEDY. What is the full expenditure by year starting from 1969? Do you have those figures?

Dr. GRANING. I do not have them readily available. We will provide them for the record, but I would like to make the point that the actual cash outlay from the Treasury is deferred in that we do not pay until work is in place, and we then reimburse.

For this reason there is a delay in the actual expenditures.

When I responded to your question, I did indicate that State agencies have used all the money that has been made available to them during the commitment period for the projects, and the cash flow from the Treasury depends upon when the work was in place.

The annual amount of construction grants from 1969-1974 have been respectively, \$255.4 million; \$172.2 million; \$172.2 million; \$197.2 million; in 1973 the same; and in 1974, the same.

Dr. EDWARDS. Mr. Chairman, we have a table that we will certainly be delighted to provide for the record, which I think not only breaks down the total since 1969, but also breaks down the total into the various categories that have been funded.

[The information subsequently supplied follows:]

Hill-Burton Grant Allocations, by Category of Funds, FY 1969-74

Fiscal Year	Total	Hospitals and Public Health Centers			Long-Term Care Facilities	Outpatient Facilities	Rehabilitation Facilities
		Modernization					
1969	\$267,200,000	\$52,485,000		\$119,285,000	\$66,800,000	\$19,085,000	\$9,545,000
1970	172,200,000	27,100,000		54,200,000	63,600,000	18,200,000	9,100,000
1971	171,720,000	50,000,000		16,400,000	20,320,000	70,000,000	15,000,000
1972	194,900,000	50,000,000		40,250,000	19,650,000	70,000,000	15,000,000
1973	197,200,000	50,000,000		41,400,000	20,800,000	70,000,000	15,000,000
1974	<u>185,440,000</u>	<u>47,500,000</u>		<u>37,430,000</u>	<u>19,760,000</u>	<u>66,500,000</u>	<u>14,250,000</u>
Total all years	\$1,188,660,000	\$277,085,000		\$308,965,000	\$210,930,000	\$313,785,000	\$77,895,000

Program Planning and Evaluation Branch
Division of Facilities Utilization
Health Resources Administration

Senator KENNEDY. In the breakdown of those figures, how much has been spent for new hospital beds, and how much for modernization?

Dr. GRANING. The authorization level for new hospital construction and public health centers is \$45 million; modernization is \$50 million; outpatient facilities is \$70 million.

The States have the authority, however, to transfer money between categories if they can show there is a greater need for one category than the other.

Senator KENNEDY. What have they done?

Dr. GRANING. The States have been transferring money into modernization, and they have not utilized all of the outpatient money.

In 1971 outpatient support was increased to \$70 million from a previous level of \$20 million. The first year in which this happened states actually utilized \$48 million of the \$70 million for outpatient facilities.

In the second year, they used \$58 million for outpatient facilities.

Senator KENNEDY. What do you anticipate this year? Is it going to increase?

Dr. GRANING. Yes, I believe so, sir. In the period from July 1 through December 31, 1973, only 3 percent of our 325 general hospital grant projects was for new facilities.

Senator KENNEDY. I am sorry. Give that to me again.

Dr. GRANING. During the period 1970 to 1973 only 3 percent of our grant projects were for new facilities.

Senator KENNEDY. Where were those new facilities?

Dr. GRANING. They were essentially in growth areas where the States were reporting there were population increments, and where the utilization rates supported the need for additional beds.

The States reflect nationally a need for 47,000 additional hospital beds, but, as was indicated in the opening statement—

Senator KENNEDY. Could you indicate where those areas were, either now or for the record?

Dr. GRANING. We would be happy to, sir.

Senator KENNEDY. Could you elaborate on this transfer of the grants to the States? Which States used the money? How many States?

[The information subsequently supplied follows:]

Beds Needed to be Added by State According to
Hill-Burton State Plans Received as of January, 1974*

<u>State</u>	<u>Beds To be Added</u>	<u>State</u>	<u>Beds To be Added</u>
U.S. & Territories	47,110	New Jersey	2,006
<u>United States</u>	<u>45,387</u>	New Mexico	52
Alabama	2,492	New York	6,093
Alaska	190	North Carolina	2,401
Arizona	127	North Dakota	2
Arkansas	750	Ohio	3,005
California	630	Oklahoma	1,062
Colorado	96	Oregon	86
Connecticut	582	Pennsylvania	291
Delaware	169	Rhode Island	140
Dist. of Col.	146	South Carolina	2,474
Florida	901	South Dakota	265
Georgia	1,283	Tennessee	1,933
Hawaii	79	Texas	943
Idaho	68	Utah	311
Illinois	4,439	Vermont	21
Indiana	1,056	Virginia	1,597
Iowa	454	Washington	43
Kansas	514	West Virginia	70
Kentucky	464	Wisconsin	168
Louisiana	1,037	Wyoming	27
Maine	7	American Samoa	-
Maryland	1,931	Guam	5
Massachusetts	1,391	Puerto Rico	1,281
Michigan	1,173	Trust Territory	104
Minnesota	87	Virgin Islands	333
Mississippi	907		
Missouri	1,065		
Montana	71		
Nebraska	-		
Nevada	44		
New Hampshire	244		

*These figures are calculated as a statistical projection of need for state-wide areas as an aggregate. They imply no specific need in specific locations. This latter determination is accomplished through State "Certificate of Need" processes or Section 1122 (Social Security Act) review which takes place in evaluating individual grant applications.

Dr. GRANING. There have been transfer provisions in the Hill-Burton program for many years. In the 1970 legislation the transfer provisions were increased at the request of the State agencies who had representatives testify before the committee.

The argument was that the State should have the right, with their analysis of State planning and their advisory committees, to decide where the money could be best utilized.

So in 1970 a new provision was added. Prior to that time nothing could be transferred out of rehabilitation, but in 1970 they did permit \$100,000 out of that category.

States have generally utilized the transfer provision very extensively. I would say that there is probably no State in the country that has not at one time or another exercised this prerogative.

Senator KENNEDY. What is your estimate, Mr. Secretary, in terms of modernization and the need for outpatient facilities in the country?

Dr. GRANING. I think there is no question about the fact that there is a very real need for modernization of many inner city hospitals. Along with this I think there is obvious need for both modernization and new construction of ambulatory care facilities that are involved.

I do not mean physically connected with, but those which are functionally linked to inner city hospitals. I think all one has to do is to visit most of the major metropolitan areas of the country to get some idea of the need for these particular areas.

Senator KENNEDY. You are very much aware of the problems that we have faced in this committee in being strapped into the formula which has existed in the Hill-Burton program, are you not?

Dr. EDWARDS. Excuse me. I did not hear you.

Senator KENNEDY. You are aware of the formula which has been traditionally written into the Hill-Burton program?

Dr. EDWARDS. Oh, yes.

Senator KENNEDY. To review the legislative history of this, it has been changed in committee and then changed back on the floor of the Senate: then in conference though we placed greater stress on modernization, and also on need that a study be done. That was the basis, I assume, of some of the recommendations that you made here.

Dr. EDWARDS. Right.

Senator KENNEDY. This was to try to provide greater flexibility to the Secretary.

So it is an approach which I support. I think all of us recognize the political considerations unfortunately which arise on the Senate floor.

Many States do better under this formula without really focusing where the greatest needs are. I think we both recognize the importance of getting the health facilities dollars to the areas of greatest need, and to where we are going to be able to get the finest result.

Perhaps taking into consideration the shifting population, we can do a better job of allocating resources along other lines. I wonder if you or your associates could elaborate a little bit on how you think the approach suggested by the administration can work most effec-

tively in trying to assure that facilities resources are made available to the area of greatest need.

Dr. EDWARDS. I will make a few comments, Mr. Chairman, and then I will ask Dr. Graning or Dr. Endicott to comment.

I think by setting up the proper kind of criteria against which these special project grants will be made we would have a great deal more assurance that the moneys would be going to those areas of greatest needs, and not be subject to some of the political processes that are possible in the formula grant approach.

Through the project grant mechanism we feel we can better direct these funds to the areas of greatest need.

Dr. GRANING. I would support everything that Dr. Edwards has said.

The secret of success in getting the money to the places of need will be in defining the eligible recipients in the legislation.

By defining the potential recipients and excluding the others, the State agencies and the planning agencies would all be zeroing in on those particular facilities in terms of implementation of the program.

The hospitals that can currently take advantage of normal debt funding mechanisms would do it on their own, and would no longer be eligible recipients for assistance.

Dr. EDWARDS. It was brought to my attention, Mr. Chairman, that a good example of how we can adequately set up the proper criteria to determine eligibility is exemplified by our financial distress grants to medical schools.

Over the past several years, using this special kind of project money, we have been able to target in on these schools, and I think over a period of several years have certainly been able to cut the number significantly.

Dr. GRANING. Mr. Chairman, it seems to me that a principal difference between the existing program and the one which is proposed is that in addition to demonstrating a need for beds based on utilization, what we are proposing also requires a demonstration of their inability to build a facility without Federal aid.

Hitherto all they had to demonstrate was that on the basis of population projections, service requirements, they needed the beds.

As a matter of fact, the existing program is operated to the detriment of those which would be unable to afford it.

Senator KENNEDY. How does this tie into the State and area planning agencies, the development of the material upon which you are going to make a judgment?

Dr. EDWARDS. As I indicated, the allocation of these special project funds would be totally dependent upon the approval of the plan, by the local planning agencies. We feel that is an absolute must.

Senator KENNEDY. Does that include State and local?

Dr. EDWARDS. It would be both, really. It would actually require both.

The local agency would also require the approval of the Governor.

Dr. GRANING. As this committee well knows, the planning legislation is also under consideration, and has not finally been resolved by

the Congress, but we would propose planning agencies be required to make prior approval of these applications.

There is some difference, of course, in the various bills under consideration in the Congress.

Senator KENNEDY. It seems to me we almost come closer to what the administration has traditionally asked for. Usually on other programs we are for specialized grant programs, but it seems here we are getting an inverse role.

[Laughter.]

Dr. EDWARDS. I think I would have to agree with you, Mr. Chairman, that we of course do subscribe to the revenue sharing concept.

We think, however, there are special situations that sometimes exist, that we can better deal with via the special project route, and this happens to be one of them.

We do, however, as we have indicated in the testimony, provide for a certain amount of State involvement, namely regulatory and financial.

But I think you are right. Your proposal does move more in the direction of revenue sharing.

Senator KENNEDY. Can you tell me your reaction to the existing formula? You feel obviously that it ought to be altered along the lines that you testified.

I would like to get a clearer statement, if I could, on the record now because I think this is going to be important.

Dr. EDWARDS. We believe that the formula approach is not an approach that will adequately deal with the problem in terms of total existing numbers of beds.

While we have achieved an overall adequate complement of acute beds, we have not achieved this goal in certain special situations. Further, we feel that we must now move away from the formula approach in order to deal properly with these special situations.

I think, as has been pointed out that in our recent survey, we identified 341 hospitals of 100 beds or more, seriously in need of modernization that were also serving low socio-economic areas. There were certain States that had no such hospitals; there were other States that had several. I think a project grant approach is more adapted to addressing this kind of problem.

Senator KENNEDY. What about the possibility of these hospitals accumulating sufficient capital themselves to be able to move ahead in these modernization and construction programs?

What does your study show about this? It seems to me they have an incredibly difficult time accumulating capital for any kind of expansion or modernization.

Dr. EDWARDS. Again I will ask Dr. Graning to address this particular question. He has more of the specifics.

Dr. GRANING. This is completely true for the kinds of facilities that we are hoping to aid through legislation such as that under discussion here today.

Debt financing has become a way of life for the hospital industry, and will be so increasingly in the future. Any hospital that has an

opportunity to accumulate as much as 10 percent of its proposed capital financing need can avail itself of the debt financing market, assuming that it has a clientele that is paying its bills.

The thrust of this legislation is to try to be helpful to those hospitals which cannot accumulate the requisite liquidity as Dr. Edwards pointed out, because of the cash flow problems.

If you were to assume, for purposes of discussion that a hospital was completely free of debt, and that everyone paid its bills, and you funded depreciation and invested it at 6 percent, at the end of 15 years time you would have only 14 percent of your replacement costs.

This is because construction has been going up 7 percent per year. If you build something this year for \$10 million, and if you build exactly the same thing next year, it will cost \$10,700,000.

It has been going up at this rate for the last 15 years. Last year it went up 9.2 percent.

It is for this reason you do not really accumulate enough money through debt appreciation to pay for what you want to build, but you do through depreciation funding, have the money to pay off the principal on the loan as you get along a little later in loan payments.

So the facilities that need assistance are the ones that this legislation is directed to, and if you are approaching this in terms of minimum amounts of Federal intervention, and being helpful to those who need it most, then the money should be specifically targeted to hospitals of this kind.

Senator KENNEDY. In 1970 we placed priorities on the poverty areas to receive money for replacement facilities. Can you tell us the results of that provision?

What action has been taken to insure that poverty area facilities have gotten money?

Dr. GRANING. The 1970 legislation provided that within the priorities established for service areas there were seven kinds of projects which should get special consideration. Outpatient facilities in poverty areas was one of these.

The legislation did not provide that outpatient facilities in poverty areas had priority if there was not a need for outpatient facilities in the area.

In other words, the special consideration was a second consideration subject to the priority of the service area.

We experienced difficulty in establishing poverty areas. This came about because we had to wait until we got the results of the 1970 Census. It did not make any sense to establish poverty areas on the basis of the 1960 Census.

So it was not until January 1972 that we actually had the poverty area breakouts.

Senator KENNEDY. You could not have been in touch with OEO or other agencies to try to determine the poverty areas?

Dr. GRANING. We were, sir, but our regulations provided that within any given State the lowest 20 percentile of that State would be by

definition in a poverty area, and between the 20 percentile and the 30 percentile with the concurrence of the Secretary it could be established a poverty area.

You could not decide the lowest 20 percentile until you had information from the entire State. This is why we relied on the Bureau of the Census to give us that information.

Now, the legislation also provided that the State could, at its option, support projects in poverty areas up to 90 percent of the project cost. States have not exercised this option to the extent that we would have liked to have seen them do so.

The legislation furthermore provided that a free standing outpatient facility could be funded up to 90 percent, irrespective of whether it was for a poverty area. There has been relatively little utilization of this provision.

We are currently involved in ascertaining the extent to which there are in fact any applications that have been received by Hill-Burton State agencies from a poverty area that did not get funded.

To the best of our knowledge there has been no application that came before a Hill-Burton State agency for funding for an outpatient facility where they had their matching money, where it was not funded, but we are in the midst right now of making a specific determination State-by-State in terms of whether this is the case or not.

Senator KENNEDY. What sort of figures are you talking about?

Are you talking about a thousand, are you talking about ten?

Dr. GRANING. We know of none.

Senator KENNEDY. How many applications have you received?

Dr. GRANING. Many applications have been funded from poverty areas, yes. State agencies have indicated as far as outpatient facility needs are concerned—that for fiscal year 1975 they would be prepared to use \$448 million of Federal funds if they were available and for fiscal year 1976, \$210 million.

I am sorry, sir, but I do not have the information here as to how many outpatient facilities were funded by year.

Senator KENNEDY. I would be interested in what is happening now that you have the 1970 Census. How many requests have come in, how many have been funded, and where have they been funded?

I think this would be useful for us for the record.

We have a provision in here to provide technical assistance. I think part of the problems is that some of the poor communities do not make these applications because they lack the technical knowledge how to make these applications.

Dr. EDWARDS. Mr. Chairman, as I mentioned, Dr. Graning and his group will be delighted to provide you with any kind of specific information from their records that they have.

[The information subsequently supplied follows:]

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROVALS

State	Proj. No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	NEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)
Alabama	D205	Birmingham	Western PHC	341,400	-	5/72	4/71	Yes (X)
	D490	Birmingham	Childrens Hosp	477,245	-	9/72	5/71	Yes (X)
	D505	Montgomery	Montgomery Cy Co Clinic	-	342,000	10/73	12/71	Yes (X)
Arkansas	B210	Little Rock	Ark Baptist Med Center	554,028	2,005	5/71	1/69	Yes (X)
	B224	Texarkana	St Michael Hosp	15,270	-	1/73	4/72	Yes (X)
California	C499	Glendale	Glendale Comm Hosp	1,065,462	-	6/73	3/73	Yes (X)
	O506	Los Angeles	S E Comprehensive HC	-	1,080,169	1/74	2/73	Yes (X)
	O508	El Centro	El Centro Comm Hosp	185,029	75,260	6/73	3/73	Yes (X)
	O509	Visalia	Kaweah Delta Hosp	-	115,235	1/74	12/72	Yes (X)
	O511	San Pablo	Brookside Hosp	-	843,866	8/73	3/73	Yes (X)
	O513	Barstow	Barstow Community Hosp	128,028	-	6/73	1/73	Yes (X)
	O515	San Leandro	San Leandro Mem Hosp	826,778	-	6/73	1/73	Yes (X)
	O517	Fresno	Valley Medical Ctr	1,206,057	29,670	6/73	2/73	Yes (X)
	O520	Duarte	City of Hope Hosp	930,407	-	2/73	12/72	Yes (X)
Colorado	D126	Wheat Ridge	Lutheran Hosp Med Ctr	99,763	-	6/70	12/69	Yes (X)
	D127	Denver	Beth Israel Hosp	156,830	-	6/71	6/68	Yes (X)
	O164	Denver	Mercy Hosp	-	100,000	-	5/73	Yes (X)
Connecticut	A151	Farmington	Conn U Med Dental Sch	289,966	-	6/73	10/68	Yes (X)
	B174	West Stafford	Johnson Memorial Hosp	-	161,757	8/73	10/72	Yes (X)
	O167	New Haven	Comm Health Care Ctr	300,000	-	1/72	7/71	Yes (X)
	O168	New Haven	Hosp of St Raphael	300,000	-	6/73	9/72	Yes (X)
Idaho	C025	Dover	Kent General Hosp	100,000	-	6/69	4/69	Yes (X)
	D033	Dover	T Collins St Serv Ctr	9,406	200,000	6/73	8/72	Yes (X)
	0031	Wilmington	Model City Hlt Serv Ctr	42,494	-	4/73	6/72	Yes (X)
Missouri	B047	Washington	Geor Wash Univ Hosp	270,916	510,501	4/73	2/72	Yes (X)
	0038	Washington	Columbia Hosp for Women	23,484	-	6/70	4/70	Yes (X)

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATION

State	Proj. No.	City	Name of Facility	1971		1972	HEN Final		In Poverty
				HB Funds	HB Funds	HB Funds	Approval	Initial	Area
							Date	Date	(Circle One)
Florida	T044	Mayo	Lafayette Co PHC	-	-	19,070	12/72	7/72	Yes (X)
	B021	Orlando	Orange Memorial Hosp	-	-	650,000	6/70	2/73	Yes (X)
	T030	Miami Beach	Mount Sinai Hosp	312,899	-	-	6/70	5/70	Yes (X)
	T034	Deland	Fish Memorial Hosp	250,000	-	-	3/72	9/71	Yes (X)
	T035	Miami	So Dade Comm Hlth Ctr	1,000,000	-	-	5/73	5/72	No (X)
	T036	Jacksonville	E Jacksonville Clinic	-	-	90,000	9/73	2/73	No (X)
	T038	Gainesville	Shands Teaching Hosp	200,000	-	25,000	6/73	11/71	Yes (X)
	T039	Immokalee	Imkokalee Hlth Care Ctr	-	-	575,000	6/73	8/72	No (X)
	T041	Boynton Beach	Co Emergency Radio/Hosp	20,000	-	9,000	6/73	4/73	Yes (X)
	T042	Sebring	Highlands Hosp	-	-	83,494	10/73	6/72	Yes (X)
Georgia	T047	Pahokee	Everglades Mem Hosp	-	-	29,162	-	11/72	Yes (X)
	T048	Jacksonville	Comm Health Clinic	-	-	90,000	9/73	2/73	No (X)
	T049	Jacksonville	Mount Sinai Hosp	76,462	-	-	6/73	5/73	Yes (X)
	T050	Miami Beach	Med Ctr of Central Ga	-	-	7,500	6/69	5/66	Yes (X)
	D396	Macon	South Fulton Hosp	88,461	-	-	11/70	6/70	Yes (X)
	D450	East Point	City County Hosp	-	-	102,227	5/71	5/70	Yes (X)
	D453	La Grange	Memorial Medical Ctr	-	-	83,493	6/71	6/70	Yes (X)
	D455	Savannah	Americus Sumter Co Hosp	225,000	-	-	10/72	6/71	Yes (X)
	D463	Americus	Banks Jackson Comm	-	-	75,000	-	5/72	Yes (X)
	D474	Commerce	Hutcheson Mem. Tri-Co	325,000	-	70,000	5/73	7/71	Yes (X)
Hawaii	D460	Ft Oglethorpe	Hamilton Mem Hosp	500,000	-	-	11/71	8/71	Yes (X)
	D461	Dalton	Floyd Hosp	300,000	-	-	3/73	7/71	Yes (X)
	D469	Rome	Cobb General Hosp	230,822	-	-	4/72	8/71	Yes (X)
	D470	Austell	Hall Co Hosp	225,238	-	-	2/72	8/71	Yes (X)
	0471	Gainesville	Grady Mem Hosp	-	-	770,000	6/73	5/72	Yes (X)
	0478	Atlanta	Kennestone Hosp	-	-	770,000	5/73	6/72	Yes (X)
	0479	Marietta	Kona General Hosp	133,723	-	-	8/72	4/72	Yes (X)
	0067	Kealahou	Garfield Park Comm Hosp	261,875	-	-	4/73	11/72	Yes (X)
	0301	Chicago	Chicago Osteo Hosp	930,391	-	-	6/73	4/73	Yes (X)
	0302	Chicago	Englewood Neighbhd HC	240,000	-	-	6/73	3/73	Yes (X)
Illinois	0303	Chicago	Beardstown Med Ctr	91,936	-	-	5/73	11/72	Yes (X)
	0304	Beardstown	W Town Neighbhd Hlth Ctr	327,000	-	-	6/73	3/73	No (X)
	0311	Chicago	Provident Hosp	-	-	40,000	-	10/72	No (X)
	0313	Chicago	Ill Dept Ph Hosp CI	49,215	-	-	6/73	9/72	No (X)
	0314	Chicago	U N W A Union Hosp	-	-	244,318	11/73	6/73	No (X)
	0317	N Frankfort	U of Chicago Lying-In	234,112	-	4,932	6/73	2/73	No (X)
	0318	Chicago	-	-	-	-	-	-	-

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj. No.	City	Name of Facility	1971		1972		NEW Final		State Initial Approval Date	In Poverty Area (Circle One)
				HB Funds		HB Funds		Approval Date			
Indiana	A196	Bloomington	Bloomington Hosp	270,335	-	106,179	-	8/71	6/71	Yes	Yes
	B201	Bluffton	Wells Co Comm Hosp	-	-	-	-	-	4/73	No	No
	D189	Merrillville	Broadway Methodist Hosp	333,300	-	-	-	6/72	11/70	Yes	Yes
	O195	Indianapolis	Regenstrief Health Ctr	895,472	-	250,657	-	6/72	12/71	Yes	No
Iowa	0175	Des Moines	Broadlawn Polk Co Hosp	585,298	-	-	-	6/72	9/71	Yes	No
	0176	Des Moines	Neighborhood Hlth Ctrs	378,498	-	-	-	12/72	9/71	Yes	No
	0182	Oakdale	Oakdale Model Rural HC	-	-	224,980	-	-	1/73	Yes	Yes
	0183	Iowa City	Univ Hosp & Clinics	-	-	557,460	-	5/73	2/72	Yes	No

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj. No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	NEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)
Kentucky	B252	Louisville	Norton Childrens Hosp	795,905	-	6/71	4/71	Yes (No)
	D293	Lexington	Univ of KY Med Ctr	823,314	66,303	3/73	9/72	Yes (No)
	O292	Hopkinsville	Jennie Stuart Mem Hosp	-	888,642	3/74	6/73	Yes (No)
	O296	Frenchburg	Menifee Co Ambulant Ctr	-	389,315	-	6/72	Yes (No)
Louisiana	A719	Baton Rouge	Cancer Treatment Ctr	38,360	-	4/70	5/69	Yes (No)
	A720	Zachary	Lane Memorial Hosp	40,000	-	6/71	2/71	Yes (No)
	A721	Ferriday	Concordia Parish Hosp	-	136,334	9/73	8/71	Yes (No)
	A722	Baton Rouge	Earl K Long Mem Hosp	-	900,000	-	10/71	Yes (No)
	A723	New Iberia	Iberia Parish Hosp	-	200,000	-	11/72	Yes (No)
	A724	Shreveport	Confederate Mem Med Ctr	-	175,000	10/72	6/72	Yes (No)
Maine	E075	Rockport	Penobscot Bay Med Ctr	126,621	-	6/73	4/71	Yes (No)
	E076	Farmington	Franklin Co Mem Hosp	100,000	-	5/73	4/73	Yes (No)
	C077	Portland	Maine Med Center	200,000	-	9/72	12/71	Yes (No)
	C080	Houlton	Houlton Regional Hosp	-	174,785	1/74	11/73	Yes (No)
Maryland	B169	La Plata	Physicians Mem Hosp	120,170	-	6/73	10/72	Yes (No)
	O164	Baltimore	E Regional Health Ctr	-	316,478	9/73	5/71	Yes (No)
	O171	Baltimore	Bon Secours Hosp	122,430	-	10/72	2/72	Yes (No)
	O173	Baltimore	Comm Mental Hlth Ctr	316,478	308,522	10/72	9/72	Yes (No)
	B331	Salem	Salem Ltc Rehab Fac	196,643	-	5/73	3/73	Yes (No)
	C473	Loxell	St Josephs Hosp	542,949	-	5/73	10/72	Yes (No)
Massachusetts	C474	Allston	Allston Brighton H C	165,593	62,974	5/73	3/72	Yes (No)
	C475	Boston	Harvard Comm Hlth Plan	344,276	-	5/73	1/72	Yes (No)
	C478	Boston	Charles Drew Family Ctr	-	853,023	-	2/74	Yes (No)
	C479	Roxbury	Roxbury Dental Med Gp	-	250,000	-	4/74	Yes (No)
	A105	Grand Rapids	St Marys Hosp	172,073	-	12/70	11/70	Yes (No)
	A136	Lincoln Park	Outer Drive Hosp	450,000	-	8/72	5/72	Yes (No)
Michigan	B043	Grand Rapids	Blodgett Mem Hosp	500,000	-	6/73	3/73	Yes (No)
	B045	Hart	Oceana Hosp	-	200,000	-	5/73	Yes (No)
	B068	Pontiac	Oakland County PUC	100,000	-	10/72	4/72	Yes (No)
	B182	Detroit	Metropolitan Hosp	270,000	-	9/72	3/72	Yes (No)
	C072	Wayne	Annapolis Hosp	450,000	-	8/72	5/72	Yes (No)
	D246	Benton Harbor	Berrien Co Prov Med Ctr	-	37,500	-	5/73	Yes (No)
	O236	Kalamazoo	Family Health Ctr	341,000	-	6/73	1/73	Yes (No)

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj. No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)
Minnesota	A201	St Paul	St Josephs Hosp	220,451	-	6/72	12/71	(Yes) No
Mississippi	E078	Pascagoula	Singing River Hosp	578,500	-	4/73	12/71	Yes (No)
Missouri	0241	Creve Coeur	St Johns Mercy Med Ctr	-	1,000,000	-	10/73	Yes (No)
Nebraska	0117	Scottsbluff	West Nabr Gen Hosp	55,450	8,069	1/72	6/71	Yes (No)
	0121	Omaha	Univ of Nabr Lions Eye	-	225,660	1/74	8/73	Yes (No)
New Hampshire	6077	Lincoln	Linwood Med Ctr	165,414	67,506	5/73	3/72	Yes (No)
	0072	Littleton	Littleton Hosp	-	285,943	1/74	12/72	Yes (No)
	0073	Manchester	Elliot Hosp	49,586	-	6/73	10/72	Yes (No)
	0075	Newport	Newport Hosp	-	75,000	7/73	8/72	Yes (No)
	0076	Manchester	Notre Dame Hosp	60,000	-	6/73	10/72	Yes (No)
New Jersey	7102	Newark	Martland Hosp	750,000	-	6/73	12/72	(Yes) No
	7110	Toms River	Community Mem Hosp	324,325	-	10/72	9/72	(Yes) No
	7141	Cape May Ct Hs	Burdette Tomlin Mem	127,289	-	4/73	3/73	(Yes) No
	7145	Jersey City	Mt Carmel Guild	400,000	-	5/73	1/73	(Yes) No
	7226	Camden	Cooper Hosp	-	126,000	2/74	12/73	(Yes) No

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj. No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)
New Mexico	A116	Albuquerque Española	Presbyterian Hosp Ctr	78,000	19,162	6/71	4/71	Yes (10)
	A117	Albuquerque	Espanola Hosp	123,308	-	7/72	2/72	Yes (10)
	A123	Albuquerque	S W Valley Health Ctr	-	120,000	6/73	3/73	Yes (10)
	A124	Gallup	Renoboth Christian Hosp	-	100,000	7/73	8/72	Yes (10)
	A133	Albuquerque Chama	Bernalillo Co Med Ctr Dr J I Dunham Mem Cl	-	40,000 68,000	1/74	6/72 12/73	Yes (10) Yes (10)
New York	B357	Norwich	Chenango Mem Hosp	70,000	-	9/72	10/69	No (10)
	B375	Olean	Olean General Hosp	250,000	-	4/72	12/71	No (10)
	B376	Rochester	Genesee Health Service	100,000	-	7/72	1/72	No (10)
	B377	Albany	W M Young Comm Hlth Ctr	888,140	-	1/73	1/72	No (10)
	B378	NY Brooklyn	St Johns Episcopal Hos	1,000,000	-	8/72	5/72	No (10)
	B381	Albany	St Peters Hosp	1,000,000	-	8/72	6/72	No (10)
	B382	Watertown	Mercy Hosp	600,000	-	5/73	10/72	No (10)
	B384	Watertown	Woman's Christian Assn	-	350,000	6/73	1/73	No (10)
	B389	Rochester	Highland Hosp	-	750,000	5/73	5/73	No (10)
	B390	Rochester	Westside Hlth Servs. Ct	-	100,000	11/73	12/73	No (10)
	B393	Groton	Groton Rural Ambulatory Ct	-	325,000	-	7/73	No (10)
	B394	New York	N Y Med College Hosp	-	245,000	-	7/73	Yes (10)
	B398	New York	Misericordia Med Ctr	-	800,000	-	12/73	No (10)
	B399	N Y Jamaica	Mary Immaculate Hosp	-	600,000	-	1/74	No (10)
North Carolina	B453	Winston Salem	N C Baptist Hosp	386,356	-	4/70	12/68	Yes (10)
	B476	Mt Airy	Northern Hosp	-	130,473	8/72	3/72	Yes (10)
Ohio	B379	Zanesville	Bethesda Hosp	88,144	-	6/70	7/69	No (10)
	B344	Cincinnati	Cincinnati Gen Hosp	2,105,605	-	6/73	2/72	No (10)
	B390	Cleveland	E Side Ambulatory Care Ctr	-	1,000,000	-	1/74	No (10)
	B391	Cleveland	E Side Ambulatory Care Ctr	-	1,000,000	-	1/74	No (10)
	B398	Liberty Ctr	Liberty Ctr Migrant H C	-	270,000	-	11/73	Yes (10)
	B399	Georgetown	Brown Co Gen Hosp	295,561	-	6/73	12/72	No (10)
	B401	Cincinnati	West End Hlth Ctr	250,785	-	6/73	2/73	No (10)
	B402	Cincinnati	Winton Hills Med H C	-	270,000	-	11/73	No (10)
	B404	Dayton	Childrens Med Ctr	500,000	-	5/73	11/72	Yes (10)

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 11 & 12 APPROPRIATIONS

State	Proj. No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	State		In Poverty Area (Circle One)
						NEW Final Approval Date	Initial Approval Date	
Oklahoma	A337	Oklahoma City	Presbyterian Hosp	205,000	-	6/73	10/72	Yes
	A338	Idabel	Mc Curtin Mem Hosp	205,000	-	4/72	1/72	Yes
	A342	Lawton	J Taliaferro Comm MHC	489,943	331,000	6/73	10/71	Yes
	A343	Oklahoma City	Hillcrest Osteo Hosp	205,000	-	4/72	2/72	Yes
Pennsylvania	0344	Oklahoma City	Mary Mahoney Mem H C	-	498,000	3/74	2/74	Yes
	0742	Philadelphia	Comprehensive Hlth Ctr	175,762	-	3/71	7/70	Yes
	0745	Johnstown	Mercy Hosp	300,000	-	6/71	8/70	Yes
	0746	Uniontown	Uniontown Hosp	1,375,075	-	12/72	1/72	Yes
Rhode Island	0747	Grove City	Grove City Hosp	184,203	-	5/73	12/71	Yes
	0748	Harrisburg	Harrisburg Hosp	1,000,000	-	6/73	3/72	Yes
	0749	Meadville	Spencer Hosp	750,000	-	6/73	3/72	Yes
	A078	Providence	Rhode Island Hosp	273,925	-	6/69	5/69	Yes

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj. No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)
South Carolina	D318	Charleston	Medical Univ Hosp	329,913	-	6/71	8/70	Yes (X)
	D319	Charleston	Medical Univ Hosp	1,092,608	1,317,840	6/73	6/72	Yes (X)
Tennessee	B429	Greeneville	Greeneville Green Co. PHC	71,406	14,095	1/73	12/71	Yes (X)
	C040	Chattanooga	Baroness Erlanger Hosp	308,606	26,462	12/72	11/71	Yes (X)
	D003	Crossville	Cumberland Medical Ctr	-	260,000	-	1/73	Yes (X)
	D014	Kingsport	Holston Valley Comm	-	167,497	6/73	5/73	Yes (X)
	E009	Jackson	Jackson Madison Co Hosp	-	296,452	10/73	5/73	Yes (X)
	D076	Memphis	Collins Chapel Hosp	-	330,928	-	4/73	No (X)
Texas	D501	San Antonio	Eastside Aux PHC	63,157	-	10/71	6/70	Yes (X)
	D527	Houston	West End PHC	400,000	-	2/73	8/71	Yes (X)
	D530	Marshall	Marshall Memorial Hosp	150,000	-	9/72	7/72	Yes (X)
	D533	Lubbock	Methodist Hosp	858,000	-	12/71	6/71	Yes (X)
	D535	Houston	U of Tex Anderson Hosp	1,000,000	-	11/72	7/72	Yes (X)
	D537	Houston	Lutheran Gen Hosp	325,000	-	5/73	1/73	Yes (X)
	D551	San Antonio	Eastside Neighbor HC	-	50,000	-	1/73	Yes (X)
	D552	San Antonio	Southwest Branch PHC	-	372,000	10/73	7/72	Yes (X)
	D552	Houston	Riverside Neighbhd H C	-	320,000	2/74	1/74	Yes (X)
	D554	Austin	Rosewood Zangosa Ctr	-	120,000	7/73	4/73	Yes (X)
	D575	Rio Grande	Starr Co Mem Hosp	-	315,000	6/73	9/72	No (X)
	D576	Poert	Poert Comm Op Fac	-	9,906	-	8/72	Yes (X)
	D577	Fort Worth	Radiation Center	-	175,000	-	2/73	Yes (X)
	D578	El Paso	El Paso Cancer Rad Ctr	841,450	-	3/73	8/72	Yes (X)
	D579	Houston	San Jose Clinic	-	125,000	-	1/73	Yes (X)
	D582	San Antonio	S Texas Cancer Radi Ctr	198,296	581,454	6/73	1/73	Yes (X)
Vermont	B033	St Johnsbury	N E Vermont Reg Hosp	100,000	110,141	3/70	6/68	Yes (X)
	C041	Newport	North Country Hosp	100,000	98,038	8/71	4/71	No (X)
	0045	Island Pond	Island Pond Med Ctr	-	4,878	6/73	4/73	No (X)

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj. No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)
Virginia	0238	Dante	Hanging Rock Clinic	-	116,992	6/73	3/72	Yes (X)
	0240	Harrisonburg	Rockingham Mem Hosp	-	614,250	6/73	5/72	Yes (X)
Washington	D133	Seattle	University Hosp	-	295,000	6/70	1/69	Yes (X)
	0138	Walla Walla	St Mary Hosp	724,271	567,447	6/73	6/73	Yes (X)
West Virginia	D121	Logan	Logan Gen Hosp	215,027	-	9/72	9/72	Yes (X)
	D123	Ranson	Charlestown Gen Hosp	150,000	23,600	2/73	4/72	Yes (X)
	D127	Glenville	Gilmer Co PHC Clinic	-	337,300	8/73	9/72	Yes (X)
Wisconsin	0189	Racine	St Marys Hosp	-	432,991	6/70	5/70	Yes (X)
	0196	Milwaukee	Milwaukee Children Hosp	72,800	12,204	12/71	10/71	Yes (X)
	0197	Milwaukee	Mt Sinai Medical Ctr	637,482	110,518	3/73	10/72	Yes (X)
	0198	Milwaukee	St Anthony's Hosp	-	1,000,000	10/73	2/73	Yes (X)
Wyoming	D038	Rawlins	Carbon County Mem Hosp	52,161	-	6/69	3/69	Yes (X)
	D039	Laramie	Iverson Memorial Hosp	200,000	12,385	6/71	11/70	Yes (X)
	0041	Riverton	Fremont Co Mem Hosp	-	153,101	11/72	2/72	Yes (X)
	0042	Lander	Bishop Randall Hosp	-	118,132	11/72	2/72	Yes (X)
Yuma	D006	Mangilao	Central Health Services	261,752	-	8/70	3/70	Yes (X)
Puerto Rico	B069	Humacao	Ryder Memorial Hosp	538,302	201,899	9/72	1/72	Yes (X)
	C065	Bayamon	Bayamon Sub Reg Hosp	300,000	1,000,000	6/68	11/67	Yes (X)
	0307	Luquillo	Luquillo Outpatient Fac	556,213	134,874	6/73	5/72	Yes (X)
	0308	Rio Piedras	Rio Piedras Op Fac	500,000	200,000	6/73	12/72	Yes (X)
	0309	Hato Ray	Auxilio Mutuo Hosp	110,223	170,560	5/73	12/72	Yes (X)
Trust Territory	0001	Saipan	Outpatient Fac	750,000	721,949	6/73	2/73	Yes (X)

Division of Facilities Utilization
Program Planning and Evaluation Branch
June 10, 1974

LISTING OF OUTPATIENT PROJECTS FUNDED BY MODERNIZATION FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj.No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)	% Poverty Area Patients (Report 10%)	Physically Connected To Hosp. or Other Health Facility (Circle One)
Florida	M005	Winter Garden	West Orange Mem Hosp	250,000	-	10/72	7/71	Yes	No	Yes
	M007	New Smyrna Bch	Fish Memorial Hosp	241,536	8,464	5/72	7/71	Yes	No	Yes
Louisiana	M162	New Orleans	Charity Hosp of La	-	1,000,000	-	5/72	Yes	No	Yes
Mississippi	M055	Tupelo	No Miss Medical Ctr	34,511	104,489	11/72	12/71	Yes	No	Yes
Rhode Island	B082	Warwick	Kent Co Memorial Hosp	315,657	300,000	5/71	1/71	Yes	No	Yes

Division of Facilities Utilization
Program Planning and Evaluation Branch
June 10, 1974

Hill-Burton Projects Approved by States for Incentive Financing
(Increased Federal Share up to 90%) as of July 1974

<u>State</u>	<u>Total Projects</u>	<u>Ambulatory Facilities</u>	<u>State</u>	<u>Total Projects</u>	<u>Ambulatory Facilities</u>
<u>Totals</u>	<u>100</u>	<u>78</u>			
Alabama	-	-	New Jersey	9	8
Alaska	-	-	New Mexico	6	3
Arizona	1	1	New York	3	3
Arkansas	-	-	North Carolina	-	-
California	-	-	North Dakota	-	-
Colorado	1	1	Ohio	8	8
Connecticut	-	-	Oklahoma	-	-
Delaware	2	2	Oregon	4	3
Dist. of Col.	-	-	Pennsylvania	1	1
Florida	3	3	Rhode Island	-	-
Georgia	-	-	South Carolina	3	3
Hawaii	1	-	South Dakota	-	-
Idaho	-	-	Tennessee	-	-
Illinois	13	11	Texas	6	2
Indiana	-	-	Utah	-	-
Iowa	2	2	Vermont	1	1
Kansas	-	-	Virginia	-	-
Kentucky	-	-	Washington	3	3
Louisiana	2	-	West Virginia	2	2
Maine	-	-	Wisconsin	2	1
Maryland	2	2	Wyoming	-	-
Massachusetts	4	4	American Samoa	2	1
Michigan	5	4	Guam	3	3
Minnesota	2	-	Puerto Rico	3	3
Mississippi	-	-	Trust Territory	1	1
Missouri	1	1	Virgin Islands	-	-
Montana	-	-			
Nebraska	-	-			
Nevada	2	-			
New Hampshire	2	1			

Program Planning and Evaluation Branch
Division of Facilities Utilization
Health Resources Administration

Dr. GRANING. The reasonable volume of care regulations that have been adopted by the Department represent a clarification of an assurance that all Hill-Burton agency facilities have given from the very beginning of the program.

It was to the effect that the hospital, to the extent of its financial ability, would provide a reasonable volume of care to persons unable to pay.

No one had raised the question previously in terms of what constituted reasonable volume of care, and the regulation to which I refer represented clarification of that matter.

The regulations provided that hospitals that had been aided by the Hill-Burton program within the past 20 years would be obligated to respond to the regulation, and they stipulated that the hospitals could meet these requirements in one of three ways.

First, they could tell the State agency that they would have what we call an open-door policy, that is to say, they would admit anyone who came to their doors without reference as to whether they could pay or not.

The second option was that they would give an amount of care equal to 10 percent per year of the Federal grant which they had received, or the Federal grant plus any interest subsidy which the Federal Government would make if they had received a loan.

Under the HEW loan program, for instance, we would compute the amount of interest subsidy that the Federal Government would pay over the 25-year period, and add that to any grant assistance they would receive, and then take 10 percent of that as being the annual amount which they would provide for persons unable to pay.

The third option was that they would promise that they would give care equal to 3 percent of the operating costs of the hospital after you subtract Medicare, Medicaid reimbursement.

The reason we subtracted Medicare and Medicaid reimbursement before applying the 3 percent figure is that unfortunately Medicare and Medicaid do not contribute to charity.

In other words, if the hospital has 25 percent of its patients under Blue Cross, usually Blue Cross will pick up 25 percent of the charity bill, but neither Medicare nor Medicaid participate in charity for anyone other than their own beneficiaries.

If a beneficiary fails to pay the deductibles, the medicare or medic-aid program absorbs this but does not contribute to charity care given to a non-beneficiary.

These three options represented the ways in which hospitals could meet their requirements.

There was a stipulation in the regulations to the effect that if the hospital found that this 3 percent amount was too much, because they could not handle it financially, they would tell the State agency what they felt they could do.

The State agency would meet with some advisors and adjudicate this matter, and then print in the paper serving that area what the decision of the State was going to be.

Consumers then have an opportunity to protest, or the hospital has an opportunity to protest. The State would then reconsider what it had decided on, either reaffirm it or change it.

Then the consumer can again protest, this time to the Secretary, or the hospital can protest.

In terms of implementation of the program up to this point in time, no hospital has appealed to the Department by virtue of a decision made by the State agency.

A surprising number of hospitals have taken the open-door policy. The second most popular commitment has been the 3 percent of operating costs.

Hospitals have been getting publicity in the local papers in many instances, capitalizing on the fact that they provide reasonable volume of care.

In answer to your specific question about how things are going to the present time, to my knowledge there is only one State which has not implemented the reasonable volume of care provisions, and this is the State of California.

The State of California has not as yet written letters to the hospitals asking them what their options would be. We have been working through the regional office on this problem, and we are very concerned about it.

Senator KENNEDY. What percent of the hospitals are opting for the open-door policy?

Dr. GRANING. It varies entirely with the geographical area. A hospital, for instance, that is in a ghetto area never takes the open door policy. The hospitals which take the open-door policy are the ones where they know from experience that this is something which they can handle financially.

Rural farm areas in Iowa, places which have a high per capita income, will take the open-door policy.

Senator KENNEDY. I suppose if you are in Scarsdale, and you have an open-door policy, you are not going to have too many people knocking on your door trying to make applications.

Dr. GRANING. That is right.

Senator KENNEDY. It would be interesting to find out. Do you have information on which hospitals do provide the open-door policy?

Dr. GRANING. We know from State agencies that the number of hospitals that have an open-door policy are far in excess of what they had anticipated. They were predicting most would take 3 percent.

The hospitals, by the way, have an obligation for reporting to the State agency at the end of the fiscal year the extent to which they have provided care.

Senator KENNEDY. I would be interested in how that open-door policy from your point of view has worked.

I would assume, as you have suggested, that the affluent suburban communities would have the policy. If my impression is valid, I would like to be able to substantiate it with information from you.

Dr. GRANING. There are large teaching institutions which have had open-door policy for years and have been running substantial deficits.

Senator KENNEDY. I think that would be interesting as well. I think that would be a commendable situation, and people ought to understand that, too.

I would like to get a breakdown concerning hospitals, that have the open-door policy. What percent are doing it via the Federal Government, and what the 3 percent less medicare and medicaid.

Does that 3 percent cost run less than 10 percent of Federal Government?

Dr. GRANING. I can tell you that in all instances they are opting for the 3 percent rather than the 10 percent, or the 10 percent rather than the 3 percent, on the basis of what would represent the least obligation.

Senator KENNEDY. In order to assess what should be the congressional intention I think we need to know the degree of participation and real contribution in this area. We ought to have a pretty good analysis of how this thing is working in these different areas.

Dr. ENDICOTT. It may take a little time, but we can surely get you something.

[The information subsequently supplied follows:]

STATE
DATA AVAILABLE OF OPTIONS SELECTED
BY HOSPITALS

State	Open Door Policy	3% of Opera- ting Costs	10% of Fed- eral Grants	Negoti- ated Rate
Tennessee	140	47	19	2
Puerto Rico	2	9	2	2
Kansas	Most Hospitals			
North Carolina	73	25	13	0
Indiana	60	9	18	3
Minnesota	109	3	11	0
Mississippi	21	43	8	0
South Carolina	59	40	12	0
Wisconsin	80	3	17	0

Senator KENNEDY. All right. How do you oversee that particular responsibility in the Department? Do you personally do it?

Dr. GRANING. No. The Hill-Burton program is a Federal-State program, and the responsibility is on the State agency. The regulations require the State to receive reports, and so forth, and they in turn report to the Federal Government. Unfortunately, there was no money made available to the States for implementing this. They have had to do it with their existing resources, and in some instances they have been appreciably handicapped.

There are States that have two and three individuals running the entire Hill-Burton program, and in a couple of instances only one person, and they are having problems doing it.

As I say, generally we are pleased with the extent to which the States have moved forward, and we are also generally pleased with the performance of hospitals in this field. Unfortunately, what has happened is a few hospitals which have not done as much as they should were responsible for creating the situation in the first place.

Senator KENNEDY. After it comes through the States, do you have somebody in your shop with special oversight responsibilities in this area?

Dr. GRANING. We have advised regional offices they may not approve any grant applications from any State which has not submitted an acceptable revision to its State plan. This must delineate how it is going to implement the reasonable volume of care regulations.

If they have not submitted a plan revision covering reasonable volume of care, that is acceptable to the regional office, they will not get any grant funds, and we have not approved any projects.

Senator KENNEDY. There is a difference, obviously, in planning for and implementing.

Dr. GRANING. We have to wait until the State has submitted a report to us. You know, State agencies are responsible authorities, and when the State health officer signs the document to the effect that this is what they are going to do, we assume this is exactly what they are going to do.

Senator KENNEDY. And you never find out whether they are going to do it?

Dr. GRANING. We get a report at the end of the year for the first full year. For instance, the State of New York is just getting into its second year, but we are expecting in June, July, and August of this year to get reports from the State agencies.

As I indicated, at the moment the only serious problem we have is California.

Senator KENNEDY. You do not have any procedure where anybody in the Department other than receiving the reports provided by the State departments of health, is actually reviewing what is happening?

Dr. GRANING. Yes, I believe I would have to say that is correct, but I do not want to leave the impression that we are ignoring the obligation.

What I am saying is that the State agencies in terms of reporting on the stewardship of hospitals are finding that the hospitals are meeting the requirements of the reasonable volume of care regulations, and that if the hospital has failed to do it, the hospital has to provide an explanation to the State agency in terms of how this came about. In other words, I am saying, sir, that we are impressing State agencies that this is for real.

Senator KENNEDY. There have been a number of cases, as I understand. It is not an unusual procedure for the Federal Government to send various oversight teams to some of the existing programs.

We just saw this in FEO in the energy crisis. We already had a State agency work with the local FEO office in Boston, but when complaints came about distribution problems, FEO sent up a team to Massachusetts to look around and recommend procedures to insure that these complaints received effective attention in implementing certain types of information that had been ignored.

Dr. EDWARDS. Mr. Chairman, I would like to comment just a moment on that, because I happen to totally subscribe to what you have just said.

I think we have been negligent in many programs, not just in this program, because I think this program per se is a little bit new, to know whether we ought to go out and do our own survey.

But we will be announcing this week or next a plan to do just exactly what you are suggesting in the nursing home field.

We have tended to accept State reports, and do nothing about them really, and we have to get out and really take a canvass, if you will, or see what kinds of reports we are getting, whether the factors are as accurate as they profess they are, and we are going to do this in the nursing home field shortly.

I think certainly we have to watch this program, and maybe the same thing would be indicated, the same kind of crash program, where we go out and see what actually is happening.

Senator KENNEDY. Let me go into one final area, the moth balling of hospital beds in overbedded areas.

Is there an appropriate Federal role in taking beds out of service?

Dr. EDWARDS. We have given this a good deal of thought and discussion. I think again I would defer to Dr. Graning to point up some of the problems.

Dr. GRANING. The overbedding situation in hospitals has had a great deal of public attention in this last year, and I would initially say that in many communities today where there are too many hospital beds, there was not an error in planning on the part of people who lived in that area when they built those beds, because there have been population changes.

Industry has moved to cheaper labor markets, and communities have less population than they had at a given point in time.

For the Federal Government to offer to purchase or buy out existing health care facilities would represent a very dangerous precedent, because actually nationally we are seeing fewer and fewer hospitals every year. We are seeing, and have been encouraging, mergers of

hospitals, and if you cross the bridge that we are going to start to buy out hospitals that we judge are inefficient, or are in areas that no longer need those beds, you really have created a problem in terms of dealing with many urban communities.

We still have some small hospitals in big cities that should be closed, and what is happening to the health care industry as a whole is the same thing that has happened to the farmer years ago who had a few cows and marketed milk.

In terms of competing with, or providing the technology needed today, we do need larger facilities, and we need to effect the economies in terms of health manpower that a larger facility can provide.

So we have been actively encouraging shared services—in fact, the 1970 amendments to the Hill-Burton program provided for financial incentives for mergers of hospitals—we have been urging centralization of services so that hospitals would contract for some things better done by other facilities. Each and every hospital need not be self-sufficient.

It would be expensive. Certificate of need legislation, planning agencies, and licensing laws will take care of overbedding through normal attrition.

Dr. EDWARDS. This is one of the reasons that we are putting so much emphasis on this. It obviously has to be a local phenomenon that takes place, and it has to be based upon the recommendations of the local planning agency, and that is one of the reasons we feel that we have to give the planning agency a more important role in the State government.

Senator KENNEDY. Recognizing that there are too many hospital beds in some areas, which you mentioned, do you recommend to social security that there not be reimbursement on medicare for these beds?

Dr. GRANING. There is a section of the Social Security Act that provides for this. In each State a designated planning agency has this responsibility.

Dr. ENDICOTT. This is not retrospective though. It is prospective.

Dr. GRANING. Yes, this is true. It is prospective.

Senator KENNEDY. What sort of relationship do you have with medicare people on this? Both are Federal taxpayers' funds, and those are Federal agencies.

Dr. EDWARDS. The only program that we have that authorizes us to require that the Social Security Administration withhold funds for reimbursement is under the kidney disease program.

Under social security programs we have no other authority.

Senator KENNEDY. Do you think it would be worthwhile as an Administrator, Mr. Secretary, to try to bring some of this before them?

Dr. Graning knows a great deal about their particular needs and where they exist. Perhaps a greater number of beds are necessary.

Just in terms of effective administration, should there not be greater coordination to some degree?

Dr. EDWARDS. I think you are absolutely right. We are trying to get that. I think if we are never going to get it, we are never going

to get this whole health care cost under a reasonable degree of control.

We are trying more and more in the Department to coordinate what SRS and SSA are doing in the health care field, and have more of a health input, if you will, in some of these planning exercises, and so forth.

I would be the last to even suggest that it is reasonably where we would like it, but I think we are headed in the right direction.

I think the Secretary feels very strongly about this, and has made his intent known amongst all of those who are involved.

So I think we are headed in the right direction, in the direction you would like to see, but we are a long way from being there.

Senator KENNEDY. Do you have any suggestions about what could be done in this area?

Mr. RUBEL. Mr. Chairman, as currently written, Medicare does allow the Secretary discretion in certifying institutions, but merely on the basis of quality, minimum standards that must be met.

There is no authority given to say you are not needed, and we are not going to pay you if the patient walks in your door, and you provide services to him.

I think the great bulk of legislative activity over the last several years has been a relationship to new facilities, new services, and there we do have both under State certificate need programs, as well as under section 1122 a very good handle, and both the administration's national health insurance proposal and your proposal go even further in that regard.

I do not think operationally at any place have we gone the further step of saying to institutions that are already in existence, you may not provide services. There is one exception to that, and this is in the amendments made to the SSA Act in 1972 where reimbursement is available for virtually all patients.

Within the range of kidney disease the Secretary is provided an opportunity to say to an institution, you will not get reimbursement. This is particularly with regard to transplanting services.

Bills pending before this Committee, as well as in the House, do provide for something called recertification of services.

I am not sure that we are ready to do it yet. I am not sure that we know how to do it very well. Our emphasis today has been on trying to look at new facilities and new services that are being added to the supply.

Senator KENNEDY. Very well. Thank you very much.

Mr. Secretary, we want to try to work on that formula approach with you through the Department to see if we can reach some kind of satisfactory approach on that.

I think that it is terribly important.

I am glad to try to work out some kind of arrangement where we do give authority to the Department to try to target in on these areas.

It just seems to me that that formula has become a nightmare in terms of current needs today, so we will try to work with your people.

Dr. EDWARDS. Mr. Samuels will be in touch with your office, Mr. Chairman, and we will provide all the staff reports we can to solve this problem.

Senator KENNEDY. Our next witness is Dr. Leo Gehrig, vice president of the American Hospital Association.

Welcome to the committee, Dr. Gehrig. We are delighted to hear from you.

**STATEMENT OF LEO GEHRIG, M.D., VICE PRESIDENT,
AMERICAN HOSPITAL ASSOCIATION**

Dr. GEHRIG. Mr. Chairman, I am Leo J. Gehrig, M.D., vice president of the American Hospital Association, which represents most of the hospitals in this country. I have a prepared statement which I would like to submit for the record. In the interest of the committee's time, I wish to highlight key points in that statement.

The American Hospital Association appreciates this opportunity to present its views to you and your committee on Federal assistance in financing the construction of health care facilities and to indicate our pleasure with the action which you and Senator Hathaway took in introducing S. 3577 and Senator Javits' introduction of S. 2983.

At the outset, I wish to state that the AHA considers the Hill-Burton program to be a highly successful program which over the years has provided important "seed money" for the development of health facilities throughout the country. Beyond this, its studies of facility needs, development of construction standards and its development of a "partnership" program, between Federal and State Governments are unique and have been invaluable.

This program of Federal assistance in the financing of health care facilities has been, is, and continues to be needed, and we are pleased that this need has been recognized by you, Mr. Chairman and members of your committee through the introduction of pertinent legislation.

In the early portion of our testimony we speak to the need for continued Federal assistance in this area, and recognize that modernization and renovation of hospitals and other health care institutions and the construction and modernization of ambulatory facilities are priority concerns particularly in major urban and rural poverty areas.

Further, we discuss the inability of health care institutions, particularly in these high need areas to cope with this problem under existing health care service reimbursement policies—and thus the necessity for continued targeted Federal grant, loan, loan guarantee, and interest subsidy assistance.

With reference to your bill, S. 3577, Mr. Chairman, we are in agreement with many of its provisions, but would like to make the following specific observations and recommendations.

First I would like to refer to the area of health facilities planning.

When the AHA testified before this subcommittee earlier this year on S. 2994 and related planning legislation, we affirmed our conviction that the planning aspects of comprehensive health planning, regional medical programs, and Hill-Burton should be merged at both local and State levels as a part of the redirection and extension of these programs. We believe that facilities planning should be a function of local and State planning agencies, and should result in a priority-setting process for the capital construction assistance program within a State.

We also recommended previously that certificate of need programs should be developed in every State. The AHA has consistently supported State-level certification of need and is pleased to note the growing number of States—22 at last count—which have moved in this direction. We believe that this process can very effectively prevent the development of unneeded facilities. We would hope that provision will be made for coordination of planning and certification of need activities with the construction assistance program either in this legislation, the planning legislation, or both.

We are pleased to note your proposed continuation in S. 3577 of a formula type allocation process which would provide grant and loan allocations to each State. Health facility construction assistance needs are, in fact, nationwide, and no State is without some need for assistance.

We also agree with elements of the formula specified in your bill, namely: population, financial need, and modernization and construction need.

Next, Mr. Chairman, I would like to refer to the State agency aspect of this program.

Your bill would eliminate the existing Federal-State partnership which has for so long worked effectively to assist construction projects most in need of help. S. 3577 would establish within HEW the responsibility for approving grant and loan applications upon recommendation for approval by local planning agencies and in the primary order set by such agencies, an approach which we oppose for a number of reasons.

It is imperative, in our view, that statewide health construction priorities be set, as they now are through State plans. Without such priorities, the Federal Government will have to make the key judgments as to which projects to fund within those States having more than one local planning area.

We are convinced that this judgment can be made more effectively by State government agencies than by HEW, since the State agencies are closer to the scene, and therefore, more familiar with specific needs and problems.

Moreover, if HEW is charged with making judgments as to the relative merits of several projects within a State—each of which has a number one priority ranking by its planning agency—the responsible Federal agency will have to be quickly and substantially augmented by experts capable of performing the judgments now carried out at the State level.

The State agencies currently performing the Hill-Burton administrative functions are normally a part of the State governmental agencies which often also perform facility licensure functions. By using this expertise within each State the Hill-Burton program has been able to operate with a minimum of staff.

The State Hill-Burton agency has also been able to insure that construction standards are maintained, provide consultive construction assistance to applicants, and in addition, has been able to assist in the determination of the need for modernization or replacement of facilities and equipment.

Local and State planning agencies should have an important role in the Federal construction assistance program. We feel, however, that this role should be one of review and comment on applications to determine consistency or inconsistency with established plans, and that the final determination of how Federal construction assistance funds are to be spent should be a function, as it is now, of the State Hill-Burton agency.

Such determinations of this agency should be based on a State plan which has been developed through comprehensive health planning agencies at the local and State levels.

We recommend continued support for a State construction assistance agency, with the change in the planning process previously indicated. We feel it is essential that the formula allocation of grant and loan funds be made to these agencies, in order to carry out the purposes of this program.

I think, in sum, Mr. Chairman, we are firmly convinced that the State Hill-Burton agencies have done an effective job over the years of the program's existence, and that this is just the kind of proven State effort that the Federal Government should be encouraging, not dismantling.

In targeting construction assistance, another problem, as we view S. 3577, is found in sections 601(a)(2) and 602(a)(2). Those sections provide that grants and loans for modernization can only be used to assist projects which will serve "medically underserved populations."

This phrase is defined in the bill in terms of a "shortage of health facilities." We believe that this definition would result in an inability to fund many badly needed modernization projects. Specifically, if a particular facility is located in an area with adequate numbers of beds, but is in need of renovation, the language of S. 3577 would seem to prohibit use of Federal assistance funds. While this problem could be partially solved by redefining "medically underserved populations," we believe that the needed targeting could be accomplished more effectively by altering the allocation formulas, in addition to a strict adherence to priorities.

We recommend that:

1. The existing program of grants to public and nonprofit facilities should be continued, but redirected as follows:

- (a) A modernization grant program should be established which allocates funds to the States on the basis of a formula which re-

flects the State's population, per capita income, and modernization need. These funds, for use throughout the State, should be provided primarily for modernization projects, but States should have the authority to use up to 20 percent of their allocations for construction of new facilities under very firm guidelines.

(b) A special urban facilities grant program should be established which allocates funds to those States having at least one standard metropolitan statistical area of 250,000 or more population for use solely in such areas.

Again, and I shall not repeat, but the formula would be based on the factors which you have included in your bill. Up to 20 percent of the State's allocation should be available for construction of new facilities, with the balance devoted to assisting modernization projects, both to be used only in SMSA's of 250,000 or more population.

If I might digress for a moment, in the first formula you will note that the total population of the State is an important denominator figure, and in the second, which attempts to put aid into major urban centers where there are very real needs, the only population counted would be the population included in the one or more standard metropolitan statistical areas of 250,000 or more.

(c) An outpatient facilities grant construction program should be established which allocates funds to States to assist in the construction of new outpatient facilities and the modernization of existing ones. These funds should be allocated, for use throughout the State, according to a formula which reflects the State's population, per capita income, and need for outpatient facilities.

2. Finally, the existing HEW programs of direct loans and loan guarantees, with interest subsidies, should be extended with the provision that the funds are to be allocated to the States primarily for modernization projects, but with up to 20 percent of such allocations available to assist in the construction of new facilities under strict guidelines.

The bill introduced by Senator Javits, S. 2983, attempts to target a construction assistance program on urban public hospitals. We recognize the great need for such assistance, and we support the purpose of this bill, but we also must point out that other nonprofit urban hospitals have similar needs and problems which must be addressed.

For this reason, we believe the "Special Urban Facilities Grant Program" which I have just described would be an appropriate way to focus on these special problems of major urban centers.

In our view, in addition to the method for grant or loan allocation I have described, the existing priorities listed in section 603(a) of the Public Health Service Act should be retained as a further means of "targeting" onto high-need projects.

I refer especially to the priorities provided for "areas with relatively small financial resources," "facilities serving densely populated areas," and also "facilities which provide comprehensive health care."

Therefore, Mr. Chairman, we strongly support the targeting of Federal facilities construction assistance to high-need urban and rural areas, and earnestly request that the committee give consideration to the recommendations we have made for this purpose.

I have mentioned the matter of reserving 20 percent for new construction. This, as I indicated before, in no way suggests that we do not think the priority is in the area of modernization.

However, we would like to point out to the subcommittee that the situation will sometimes arise in which a new facility is needed in a community, for example, as a result of a population shift.

We recommend that up to 20 percent of a State's allocation for grant and loan support be available, under strict guidelines to be promulgated by the Secretary of HEW, for construction projects to meet high-need, new bed requirements. Should such high-need, new bed requirements not exist in a State, these funds could be used only for modernization of facilities.

I would like now to speak briefly to community service.

Section 604(b) of S. 3577 delineates several requirements in any grant, loan, or loan guarantee application. Subsection (9) of this section requires that applicants provide reasonable assurance that at all times they will provide services to persons residing or employed in their service area, and a "reasonable volume of services to persons unable to pay therefor."

The latter provision requires that an institution assisted under this program must be accountable to the Government, as a contractual obligation without time limit, for providing "free care," as a condition of receiving a grant, loan, or loan guarantee.

I would like to take the opportunity to point out a situation which is well known to the chairman, and that is there is no such thing as free care; someone has to pay for all care rendered in health care facilities.

If an institution is required to provide services for persons unable to pay for them, someone must pay more than his fair share.

Under present reimbursement methodologies of Government and some other third-party payors, this cost can only be spread among a limited number of patients.

Until the advent of a truly comprehensive national health insurance program, "free care" must continue to be provided for certain individuals.

However, we would hope that the Congress is aware that by including such a provision as Section 604(b)(9), it would be in effect, levying an inequitable burden on some hospital patients to pay for the care of others.

This same section of the bill requires that the facility receiving aid under the Federal program must meet these requirements "at all times after such application is approved."

While hospitals have provided, and will continue to provide, community service and care to individuals unable to pay within the limits of the institution's financial capability, the "in perpetuity con-

tractual requirement" for accountability in this provision, we believe, is inappropriate.

Further, such an open-ended requirement is inconsistent with the time-limited (20 years) recovery period for Federal grant assistance should the facility for which support was obtained cease to be operated for the purposes for which it was assisted.

We recommend that successful applicants not be required under section 604(b)(9) to be accountable beyond the period provided for recovery of Federal funding assistance.

Mr. Chairman, to comment briefly on the Federal Hospital Council, S. 3577 provides for the discontinuance of the Federal Hospital Council (FHC) by failing to carry forward its organic provisions and the functions conferred on it in existing law.

The FHC, through its activities as advisor to the Secretary, as well as its approval responsibility for proposed regulations under the Hill-Burton program, has in our opinion provided HEW with a much needed body of expertise in the area of facilities construction and the administration of this program.

The Federal Hospital Council will continue to be needed for its present purposes. We strongly recommend inclusion in this legislation of the provisions for and functions of the FHC as included under existing law.

Mr. Chairman, I would urge that the recommendations contained in our testimony be given serious consideration by the subcommittee.

As you requested when the AHA testified before your subcommittee on March 20 of this year on planning legislation, AHA staff has provided the subcommittee staff with a more detailed summary of the recommendations I have just outlined, as well as some suggested legislative language to implement them.

I would like to emphasize that we continue to stand ready to work with you and your staff in the development of this important legislation.

I thank you for the opportunity of being here, and I will be happy to attempt to answer any questions you may have.

Senator KENNEDY. Thank you very much.

Part of the thrust of your earlier testimony was the importance of maintaining the special agency in the States and the Hill-Burton programs.

If you agree they ought to have an integrated function, what is the rationale for continuing to give that special position for the Hill-Burton facilities?

What we are talking about in terms of health, I would suspect, is that we are going to have some planning agencies for facilities, to be integrated. Why should they apply to the Hill-Burton planning action in the State?

Why should they be given a special kind of provision in terms of the creation of facilities?

Dr. GEHRIG. I may not be clear in what you said. If I understand your question, Senator, we strongly recommend that the planning function, which has been carried out by the Hill-Burton agency in

the past, no longer reside there, but, along with any other development planning, be totally encompassed in the planning at the local and State levels.

So our petition with you in regard to the Hill-Burton State agency function is to remove its planning functions because we believe with you completely that all planning aspects should be combined.

In my full statement I point this out.

Senator KENNEDY. What do you not like about ours? Is that not what we have tried to do, or did we not do it?

Dr. GEHRIG. As I understand your bill—

Senator KENNEDY. Just as to the planning aspects of it.

Dr. GEHRIG. In regard to the planning aspect of your bill—and I am not sure of exactly the State role—our positions may well be close in the planning area, but I think that where you combined the planning functions, the Hill-Burton, or facilities assistance agency, would no longer exist for what I consider to be the other important functions, which they presently carry out, and should continue to be carried out.

Senator KENNEDY. As I understand, there is nothing in it that would prohibit it from existing, nor prohibit the Secretary from giving some weight to the recommendations, but maybe it is more of a difference in semantics. We ought to try to work with you and see what can be done.

What evidence do you have that the need for modernization of existing facilities exists, that the need for construction of outpatient facilities exists? Do you have some good studies that would help us in this area?

Dr. GEHRIG. I think on a national basis, Senator, the best data have been developed and provided over the years by HEW. We relied on, and utilized very very extensively those data.

In addition to that, as we view hospitals in many city centers and some rural poverty areas, hospitals which hardly represent the national sample, the evidence of need is certainly strongly impressed on us. We have looked for the statistical evaluation of the problem to the HEW figures.

Senator KENNEDY. We talked a little bit about the pre-care requirements. Could you tell us what your general evaluation has been of the hospitals over a period of time?

Dr. GEHRIG. I do not have any exact figures as such. As you know, I believe you discussed this briefly with me in testimony about a year or so ago, when the matter of a redefinition of provisions of service for the individual who is unable to pay came up—our general feeling has been that the vast majority of hospitals, as a part of their community responsibilities, have in fact participated very meaningfully in attempting to provide services in this area.

This is not to suggest that I believe there is no hospital in our country which does not meet this obligation. However, I personally feel very proud of the efforts the vast majority of institutions have been making.

I do not believe you are looking to a construction bill to solve an important problem that we must all face in national health insurance, that is, adequate care and access for many who cannot afford it.

The hospitals of this country, if they are to continue as a voluntary system working for their communities, are going to have to remain financially responsible in order to pay salaries, and to pay other expenses. So theirs is not, in any sense, an open-ended ability to pay. Therefore, any so-called free-care provisions must be looked at, I think from this perspective.

I regret that I cannot give you something that represents percentages. I think you will find in your inquiry and the discussions you have had with the Department, that the vast bulk of the community hospitals are, in fact, making a very earnest and real effort, and I think are succeeding in meeting this obligation.

Senator KENNEDY. Are you familiar with the story in the Oklahoma City newspaper in March of this year?

It talks about "Hospital Doors Closed to Poor, Witnesses Say."

We have received letters from an Oklahoma consumer protection agency which says that some people have, in fact, died because they have been unable to pay the \$300 preadmission hospital charge at local private tax-exempt Hill-Burton supported hospitals.

Then, we have had a very strongly worded letter talking about a particular situation in Oklahoma.

First of all, would you want to say anything about the particular Oklahoma situation, if you have any special knowledge of it, and what kinds of complaints you get?

Do you know whether the association feels this type of criticism, to the extent it is valid, is justified?

Dr. GEHRIG. Senator, I am not familiar with that particular instance, and I think it would be unfortunate for me to say anything.

I must say, too, that while I have a very occasional letter with regard to a problem with regard to, as you suggested, the financial aspects of health care, I do not believe that I can present myself as an individual even within the AHA who gets that type of mail, because that is not the responsibility of the office with which I work here in Washington.

I must say, in my experience to date, I have not seen great numbers of complaints in this area. I think it is a part of the whole problem we are trying to resolve, that there is a difficulty with rising hospital costs and with the difficulty, in fact, of many people to meet their obligations.

Senator KENNEDY. Of course, these statistics under the Social Security Administration, and what is happening in terms of investment of incomes is outlined in the Social Security bulletin of November 1973.

I shall have this included in the record at this point.

[The bulletin referred to follows:]

[Excerpt from the Social Security Bulletin, November 1973]

The Financial Position of Private Community Hospitals, 1961-71

by JULIAN PETTENGILL*

This article describes the trends in the financial position of nongovernmental community hospitals in the period 1961-71 and identifies where possible the important causes of net income variation during the period, both overall and between hospitals of different size and ownership. Variations in net income by bed size of hospital were also studied for 1971 in an attempt to shed additional light on factors influencing financial position.

As a result of several factors, including greater third-party coverage and increases in the range and complexity of services, the net income of hospitals improved substantially in 1961-71. Net income as a rate of return on plant assets in non-profit hospitals rose from 1.4 percent to 3.0 percent in the decade; the rate of return in for-profit hospitals increased from 8.9 percent to 16.2 percent. The 1971 data show that net income differentials result from the simultaneous interaction of many factors—from relative prices to the relative efficiency of hospital operation. Among the factors identified, the range and complexity of services, geographical location, and ownership seemed most important in the determination of financial position.

THE DECADE of the sixties was a period of remarkable change in the delivery and financing of medical care. On the one hand, biomedical knowledge and related technology of diagnosis and treatment advanced very rapidly during this period. On the other hand, the entire medical care industry grew tremendously. Total national health expenditures, which amounted to \$28.8 billion or 5.5 percent of the gross national product (GNP) in 1961, had increased to \$79.8 billion or 7.6 percent of GNP by 1971. In addition, important shifts occurred in the sources of payment for medical care services. These shifts reflected the continued growth of enrollment under private health insurance and the large-scale entry of the Federal Government into health care financing with such new programs as health insurance for the aged (Medicare) and medical assistance

(Medicaid) for individuals with low incomes.

The community hospital, as the provider of the largest share of medical services for the treatment of acute illnesses and injuries, has naturally been the focal point of many of these changes. Substantial improvements in technology have occurred in hospital care. Specialized facilities and services that were rare or nonexistent in 1961 are now offered by many community hospitals. Advances in surgical techniques and development of new drugs have also contributed to higher rates of success in dealing with many diseases.

In the financing of hospital care, the growth of third-party payment systems (private health insurance and public programs) has led to significant changes in the sources of payments. Table 1 shows the distribution of total expenditures for hospital care in all hospitals and in nongovernmental general and other special hospitals in 1961 and 1971, by source of funds. For all hospitals, private direct payments by consumers dropped from 18.4 percent of expenditures for hospital care in the earlier year to 9.9 percent in 1971. The decline occurred as part of the burden of paying for hospital care was shifted from consumers to public programs such as Medicare and Medicaid, which began operations in 1966.

Since changes in medical technology or in the methods and sources of financing hospital care can affect hospital expenses and revenues, it is not surprising to find that the financial position of hospitals has changed considerably in the past decade. This subject has been explored in earlier studies.¹

The purpose of this article is twofold: First, to examine trend data to see if the patterns discov-

* Division of Health Insurance Studies, Office of Research and Statistics.

¹ See Karen Davis, *Net Income of Hospitals, 1961-1969* (Staff Paper No. 6), Office of Research and Statistics, Social Security Administration, 1971, and Paul J. Feldstein and Saul Waldman, "Financial Position of Hospitals in the Early Medicare Period," *Social Security Bulletin*, October 1968.

TABLE 1.—Total expenditures for hospital care, by source of funds and type of hospital, 1961 and 1971

Source of funds	1961		1971	
	Amount (in millions)	Percentage distribution	Amount (in millions)	Percentage distribution
All hospitals				
Total.....	\$9,921	100.0	\$31,119	100.0
Private direct payments.....	1,822	18.4	3,087	9.9
Third-party payments.....	8,098	81.6	28,032	90.1
Private health insurance.....	3,786	38.0	11,369	36.5
Public programs.....	4,312	43.2	16,250	52.2
Medicare.....			5,649	34.8
Medicaid.....	1,256	6.3	3,114	19.2
Other.....	8,826	93.7	7,487	46.1
Philanthropy.....	250	2.5	413	1.3
Nongovernmental general ¹ and other special hospitals				
Total.....	\$5,362	100.0	\$19,543	100.0
Private direct payments.....	1,471	27.4	2,190	11.2
Third-party payments.....	3,891	72.6	17,353	88.8
Private health insurance.....	3,214	59.9	9,331	47.8
Public programs.....	427	8.0	7,909	38.9
Medicare.....			4,083	26.0
Medicaid.....	1128	2.4	1,506	8.0
Other.....	299	5.6	970	4.9
Philanthropy.....	250	4.7	413	2.1

¹ Vendor medical payments under public assistance programs.² Including long-term.Source: 1961 data based on *Compendium of National Health Expenditures Data*, Social Security Administration, Office of Research and Statistics, 1973; 1971 data from Research and Statistics Note No. 3, Social Security Administration, Office of Research and Statistics, 1973.

ered in other studies have prevailed in recent years; second, to examine revenue, expense, and net income data in greater detail by bed size for additional insights on the important factors affecting the net income position of hospitals. Because hospital ownership or control frequently has been cited as a factor that influences financial position, comparisons of nongovernmental nonprofit and for-profit hospitals are included.

Community hospitals (non-Federal short-term general and other special hospitals) account for most of the acute medical care provided to the general public in hospitals. Attention is limited here to nongovernmental community hospitals largely because of the character and availability of the published data. Data on the financial experience of State and local government hospitals were not published before 1969; moreover, the funding for these institutions is distinctly different from that for other community hospitals, since they typically receive at least part of their revenue directly from the budgets of State and local governments. The remaining nongovernmental nonprofit and for-profit hospitals ac-

counted for approximately 75 percent of all beds in community hospitals in 1971.

Data for this study are drawn principally from the annual *Guide Issues of Hospitals*, the Journal of the American Hospital Association (AHA). These data are based on the financial experience, as reported in AHA's annual survey, of all nongovernmental nonprofit and for-profit community hospitals registered by the Association. The survey response rate in 1971 was 96.6 percent for nonprofit hospitals, 78.8 percent for all for-profit hospitals. Because the response rate is directly related to size of hospital, the lower rate of for-profit hospitals may result in some bias in the data for these hospitals, especially those with less than 50 beds.

NATIONAL TRENDS

Annual data on revenue, expenses, and net income of nongovernmental community hospitals for 1961-71 are presented in table 2. Total revenue rose from \$5.0 billion in 1961 to \$18.1 billion in 1971, but expenses increased somewhat less—from \$4.9 to \$17.6 billion—during the same period. As a result, overall net income grew tremendously, from \$110 million in 1961 to \$547 million in 1971.

Much of this growth occurred in the second half of the decade, following the implementation of Medicare and Medicaid. The contrast between annual rates of change for both revenue and expenses is perhaps most striking between the periods 1961-65 and 1967-71. Total revenue, for example, increased from 1961 to 1965 at an annual rate of 10.4 percent but went up 16.4 percent a year from 1967 to 1971.

Changes in the financial position of hospitals stem from the simultaneous interaction of three factors: prices for hospital services, costs of producing services, and utilization. As a first step in attempting to understand the trends in financial experience described above, it may be useful to examine data on these three factors for the decade 1961-71.

Data on prices of selected hospital services have been collected routinely by the Bureau of Labor Statistics for inclusion in the Consumer Price Index. Until recently, however, no effort was made to measure the overall price of hospi-

tal care. Among the items priced during most or all of the period studied are semiprivate room charges (room, board, and routine nursing care in semiprivate accommodations), operating-room charges, and charges for X-ray (diagnostic series, upper G.I.). Index numbers and annual percentage increases for these components are shown in table 3.

The prices for these services, with a pattern of

growth like the one that was observed for hospital revenue, increased much more rapidly in the second half of the decade than they did during the period 1961-65. The semiprivate room index, for example, which rose at an average annual rate of 13.0 percent from 1967 to 1971, had increased at an annual rate of only 5.6 percent from 1961 to 1965.

These data suggest that higher prices for hos-

TABLE 2.—Revenue, expense, and net income for nongovernmental nonprofit and for-profit community hospitals, 1961-71

Year	Total revenue (in millions)	Total expense (in millions)	Net income (in millions)	Plant assets (in millions)	Net income ratio		Annual rate of change		
					Total revenue	Plant assets	Total revenue	Total expense	Plant assets
Total									
1961.....	\$4,998	\$4,888	\$110	\$6,767	2.20	1.63	9.9	10.7	6.6
1962.....	5,538	5,345	193	7,344	2.25	1.18	7.2	9.3	7.3
1963.....	6,090	5,907	183	7,895	2.52	1.94	13.1	10.6	8.6
1964.....	6,670	6,533	137	8,541	2.06	1.61	10.1	10.6	8.6
1965.....	7,422	7,153	269	9,381	3.62	2.87	11.3	9.5	9.8
1966.....	8,276	7,989	287	10,018	3.47	2.87	11.5	11.7	6.8
1967.....	9,858	9,480	378	10,781	4.06	3.70	19.1	18.4	7.6
1968.....	11,436	11,036	400	11,799	3.50	3.39	16.0	16.7	9.5
1969.....	13,459	12,969	470	12,911	3.54	3.64	17.7	17.7	9.4
1970.....	15,707	15,231	476	14,265	3.03	3.34	16.7	17.3	10.5
1971.....	18,104	17,557	547	16,810	3.02	3.45	15.3	16.3	10.8
Annual average:									
1961-65.....	6,102	5,965	136	7,958	2.24	1.71	10.4	10.1	8.5
1967-71.....	13,713	13,255	458	13,113	3.34	3.50	16.4	16.7	10.0
1967-69.....	11,694	11,161	533	11,830	3.65	3.56	16.8	17.2	9.4
1969-71.....	15,757	15,259	498	14,329	3.16	3.47	16.0	16.3	10.7
Nonprofit									
1961.....	\$4,675	\$4,584	\$91	\$6,541	1.94	1.39	9.9	10.7	5.9
1962.....	4,996	4,909	87	7,010	1.96	1.04	6.9	9.9	7.2
1963.....	5,522	5,491	31	7,552	2.34	1.74	12.5	9.8	8.3
1964.....	6,154	6,039	115	8,217	1.87	1.49	9.5	10.0	8.2
1965.....	6,870	6,543	327	9,073	3.81	2.60	11.6	10.0	10.6
1966.....	7,674	7,435	239	9,762	3.11	2.45	11.7	11.9	7.4
1967.....	9,146	8,806	340	10,457	3.71	3.24	19.2	18.4	7.2
1968.....	10,653	10,317	336	11,490	3.16	2.93	16.5	17.2	9.9
1969.....	12,587	12,127	460	12,523	3.19	3.19	17.7	17.6	9.0
1970.....	14,551	14,163	388	13,783	2.86	2.81	16.1	16.7	10.1
1971.....	16,801	16,344	457	15,259	2.72	3.00	15.5	16.4	10.7
Annual average:									
1961-65.....	5,963	5,551	112	7,668	1.98	1.46	10.1	9.7	8.5
1967-71.....	12,738	12,553	184	12,702	3.02	3.02	16.4	16.7	9.9
1967-69.....	10,779	10,420	359	11,490	3.33	3.12	17.1	17.4	9.4
1969-71.....	14,680	14,215	465	13,855	2.84	3.00	15.8	16.0	10.4
For-profit									
1961.....	\$323	\$304	\$19	\$216	5.91	8.85	10.1	10.6	7.9
1962.....	362	346	16	233	4.44	6.90	12.1	13.8	8.1
1963.....	437	417	21	275	4.75	7.56	20.8	20.4	17.9
1964.....	515	493	22	325	4.27	6.77	17.9	18.5	18.2
1965.....	552	510	42	303	7.96	13.77	7.1	3.4	-6.8
1966.....	602	563	39	296	8.05	18.18	9.0	8.4	-12.1
1967.....	713	653	60	324	8.38	18.44	15.5	16.1	21.6
1968.....	783	720	64	369	8.12	20.56	9.9	10.2	-4.4
1969.....	922	852	70	387	7.56	17.98	17.7	18.4	25.2
1970.....	1,196	1,068	128	482	7.65	18.35	25.4	25.4	24.6
1971.....	1,303	1,214	89	551	6.87	16.23	12.7	13.7	14.3
Annual average:									
1961-65.....	438	414	24	270	5.46	8.86	14.3	13.8	8.8
1967-71.....	975	901	74	411	7.61	18.07	16.3	16.8	14.2
1967-69.....	806	741	65	340	8.02	19.02	13.7	14.2	9.3
1969-71.....	1,127	1,045	82	473	7.31	17.39	18.9	19.4	19.3

¹ Estimate based on assumption that nonprofit revenue is 93.15 percent of total nongovernmental community hospital revenue as in 1969.

² Estimate based on assumption that for-profit revenue is 6.85 percent of total nongovernmental community hospital revenue as in 1969.
Source: *Hospitals* (annual Guide Issues).

TABLE 3.—Consumer price index and percentage change for selected hospital services, 1961-71

Year	Annual average index (1967=100)			Percentage change from previous year		
	Semiprivate room charges	Operating-room charges	X-ray (diagnostic series, upper G.I.)	Semiprivate room charges	Operating-room charges	X-ray (diagnostic series, upper G.I.)
1961.....	61.1			6.6		
1962.....	65.3			6.9		
1963.....	68.6	77.9	80.0	5.1		
1964.....	71.9	79.4	82.7	4.8	1.9	0.8
1965.....	75.9	82.9	90.9	5.6	4.4	1.3
1966.....	83.5	88.6	94.1	10.0	6.9	3.5
1967.....	100.0	100.0	100.0	19.8	12.9	6.3
1968.....	113.6	111.5	104.3	13.6	11.5	4.3
1969.....	128.8	128.7	109.3	13.4	15.4	4.6
1970.....	145.4	142.4	116.3	12.9	10.6	6.4
1971.....	163.1	166.2	124.9	12.2	9.7	7.4
Average annual increase:						
1961-65.....	5.6	12.2	11.0			
1967-71.....	12.0	11.8	6.7			
1967-69.....	13.5	13.4	4.5			
1969-71.....	12.5	10.2	6.9			

¹ December 1963 value when the index began.² Average annual increase from December 1963 to approximately midyear

1965 (computation assumed a 2-year period, instead of the actual 18 months, so the growth rates are slightly understated).

Source: Bureau of Labor Statistics, *Consumer Price Index*.

pital services were a major source of increase in hospital revenues during this time. It should be pointed out, however, that even though hospital charges did go up substantially from 1961 to 1971, other changes taking place at the same time tended to reduce the importance of price change as a determinant of hospital revenue.

Total expenditures for hospital care in all non-governmental general and other special hospitals, by source of funds, for 1961 and 1971 are shown in table 1.² Private direct payments for hospital services declined from 27 percent of total expenditures of these hospitals in 1961 to only 11 percent in 1971, mostly as a result of the tremendous growth in the share of public programs. Public expenditures represented only 8 percent of the total in 1961, but by 1971 they accounted for 39 percent of all funds. The growth of the public share, despite the decline in the share paid by private health insurance, resulted in a net increase in the share of funds provided by third parties from 74 percent in 1961 to 88.8 percent in 1971.

Such shifts between sources of funds would make no difference if private individuals and third parties paid the same incurred charges. A majority of the reimbursements of third-party payment systems, however, are made on the basis

of negotiated rates or on the basis of defined costs. In addition, the proportion of total expenditures for hospital care paid on the basis of costs has increased significantly during the period studied. Needless to say, as the percentage of expenditures paid on the basis of actual charges declines, so does the significance of price change as a determinant of total revenue.

Utilization is the other important determinant of total revenue. Trends in utilization are influenced by a variety of factors. As the population grows, utilization usually increases. If the demographic characteristics of the population in terms of age, sex, race, or location change, then per capita utilization rates will probably also change. Higher incomes, expanded private health insurance coverage, or new government health insurance programs will also tend to increase the amount of hospital care used by individuals.³ Moreover, utilization rates will tend to change with the discovery of new techniques for diagnosis and treatment of disease. All these factors changed to some degree during the decade of the sixties.

The trends in hospital utilization rates, total and per capita, from 1961 to 1971 are revealed by the annual data in table 4. Data for the first

² This group of hospitals includes long-term general and other special hospitals in addition to the nongovernmental community (short-term) hospitals, which account for approximately 95 percent of the total expenditures shown.

³ See Martin S. Feldstein, "Hospital Cost Inflation: A Study of Nonprofit Price Dynamics," *American Economic Review*, December 1971, pages 853-72, and Karen Davis and Louise B. Russell, "The Substitution of Hospital Outpatient Care for Inpatient Care," *Review of Economics and Statistics*, May 1972, pages 109-20.

TABLE 4.—Trends in total and per capita hospital utilization for nongovernmental nonprofit and for-profit community hospitals, 1961-71

Year	Nonprofit					For-profit				
	Patient days (in millions)	Admissions (in millions)	Outpatient visits (in millions)	Average length of stay	Average occupancy rate	Patient days (in millions)	Admissions (in millions)	Outpatient visits (in millions)	Average length of stay	Average occupancy rate
Total										
1961.....	127.2	17.0	(¹)	7.5	75.1	9.1	1.6	(¹)	5.8	65.4
1962.....	122.4	17.5	45.9	7.5	76.8	9.9	1.7	3.1	5.9	67.3
1963.....	137.7	18.1	55.1	7.6	77.7	11.0	1.8	3.7	6.1	68.0
1964.....	142.6	18.6	59.3	7.6	78.1	11.5	1.8	3.8	6.2	68.3
1965.....	146.3	19.0	59.2	7.7	77.8	11.7	1.8	3.4	6.3	68.6
1966.....	152.6	19.3	60.3	7.9	78.5	12.0	1.9	4.3	6.4	69.0
1967.....	160.1	19.5	73.2	8.2	79.7	12.6	1.8	4.0	6.8	72.7
1968.....	165.9	19.7	76.4	8.3	80.0	12.9	1.8	4.1	7.0	73.9
1969.....	171.0	20.3	82.8	8.2	80.8	13.2	1.9	3.9	6.8	74.6
1970.....	173.2	20.9	91.0	8.2	80.1	13.9	2.0	4.7	6.8	72.2
1971.....	174.2	21.5	103.0	8.1	79.0	13.9	2.1	4.9	6.5	71.0
Per 100 population ²										
1961.....	70.2	9.4	(³)	-----	-----	5.0	0.9	(³)	-----	-----
1962.....	72.1	9.5	25.0	-----	-----	5.4	.9	1.7	-----	-----
1963.....	73.8	9.7	29.5	-----	-----	5.9	1.0	2.0	-----	-----
1964.....	75.4	9.8	31.3	-----	-----	6.1	1.0	2.0	-----	-----
1965.....	76.5	9.9	30.9	-----	-----	6.1	.9	1.8	-----	-----
1966.....	78.9	10.0	35.8	-----	-----	6.2	1.0	2.2	-----	-----
1967.....	82.0	10.0	37.4	-----	-----	6.5	.9	2.0	-----	-----
1968.....	84.2	10.0	38.7	-----	-----	6.5	.9	2.1	-----	-----
1969.....	85.9	10.2	41.5	-----	-----	6.6	1.0	2.0	-----	-----
1970.....	86.9	10.4	45.1	-----	-----	6.9	1.0	2.4	-----	-----
1971.....	86.3	10.5	50.4	-----	-----	6.8	1.0	2.4	-----	-----

¹ For hospitals reporting outpatient visits.² Data not available.³ Population data are for the civilian resident population as of July 1 of each year.Source: Population data from Bureau of the Census, *Current Population Reports*, Series P-23, various issues; utilization data from *Hospitals* (annual Guide Issues), American Hospital Association.

and last years of the period studied, shown below, indicate that overall inpatient utilization measured by patient days increased by more than 50 percent in hospitals operated for profit but the increase in nonprofit hospitals was somewhat

lower (37 percent). This difference reflects the fact that increases in both admissions and average length of stay were greater in for-profit hospitals. The increase in outpatient visits in nonprofit hospitals, on the other hand, was more than twice that in for-profit hospitals during the period.

Increases in total utilization were an important source of growth in total revenue. It should be noted in addition that shifts in use between population groups can also affect total revenues of hospitals. The Medicare program, for example, enabled elderly citizens to obtain hospital care and thus contributed to a significant increase in the share of total inpatient days used by persons aged 65 and over.⁴ Before the program began in 1966, many persons in that age group received hospital care as charity patients or at reduced rates. To the extent that this situation did exist, losses of hospital revenues in the form of bad debts or charity care for the aged must have been nearly eliminated once the program began. No evidence on the trend in utilization by

Hospital utilization	1961		1971		Percentage increase ¹	
	Total (in millions)	Per 100 population	Total (in millions)	Per 100 population	Total	Per 100 population
Nonprofit						
Admissions.....	17.0	9.4	21.5	10.5	26.8	11.7
Patient days.....	127.2	70.1	174.2	85.3	36.9	21.6
Outpatient visits.....	45.9	*25.4	103.0	50.4	*124.3	*99.0
Average length of stay.....	7.5	-----	8.1	-----	8.0	-----
For-profit						
Admissions.....	1.6	0.9	2.1	1.0	33.3	14.6
Patient days.....	9.1	5.0	13.0	6.8	52.4	35.1
Outpatient visits.....	*3.1	*1.7	4.9	2.4	*57.5	*40.0
Average length of stay.....	5.8	-----	6.6	-----	13.8	-----

¹ Percentages calculated from unrounded data.² 1962 data; 1961 data not available.³ Percentage change probably overstated, since data refer to only those hospitals reporting visits and the percentage of hospitals reporting has increased significantly since 1962.Source: Estimated from data in *Hospitals* (annual "Guide Issues, 1962, 1963, and 1972), American Hospital Association.⁴ See Julian Pettengill, "Trends in Hospital Use by the Aged," *Social Security Bulletin*, July 1972.

individuals with low income is available, but the fact that public assistance vendor medical payments went from \$0.1 billion to \$1.6 billion during the decade suggests that Medicaid probably had the same kind of effect on hospital revenues, though perhaps not to the same degree.

Changes in utilization influence the financial position of hospitals in other ways than their impact on revenue. Altered patterns of hospital use often reflect changes in technology and case-mix that, in turn, affect the cost per unit of service. In other words, not only did the number of services produced by hospitals increase, but the mix of services, the methods of producing services, and the mix of patients receiving those services also changed.

These changes, in part, are reflected in both the utilization data and in the trend of expense per patient day or expense per admission. Older persons, for example, have more medical problems than younger persons; their conditions often take longer to stabilize and they may require a longer period of time for recovery. Thus, with fewer financial barriers to medical care, the number of aged persons using hospital care rose and their average length of stay increased following the advent of Medicare, in comparison with earlier periods. As a result, both overall average occupancy (the percentage of beds occupied on an average day during the year) and overall average length of stay increased until 1969 when the trend reversed.

Increases in occupancy rates or average length of stay both tend to influence the cost per patient day. Other things being equal, if occupancy increases then the fixed costs of the hospital are spread over an increased number of patient days and the cost per day will be lower than if occupancy had not changed. An increase in average length of stay has the same effect because most of the expensive ancillary services are given in the first few days of a hospital stay. Therefore, as length of stay increases, these costs are spread over a larger number of patient days and the cost per day falls.⁶

In addition to changes in occupancy rates or length of stay, changes in the character of hospi-

tal services have been shown to have a major effect on expense per patient day.⁶ Growth in the number of employees and in the amounts of capital equipment and supplies required to produce a day of hospital care has been estimated to account for about half the increase in expense per patient day in community hospitals during the period 1960-70. These changes in factor input requirements (amounts of labor and capital used in the production of services) have been primarily associated with improvements in technology and changes in case-mix. The remaining half of the increase in cost per day was associated with increases in wages and prices paid by hospitals.

The proportion of the increase in unit costs attributable to increases in factor input requirements was not constant throughout the entire period. According to the Waldman study, this share declined from an estimated 55 percent during the early period to 44 percent in the period from 1966 to 1970. This decline resulted from an increase in the rate of inflation in the economy generally and a significant rise in the rate of increase of wages and salaries paid to hospital employees during the latter period, rather than any decline in the growth of input requirements.

A more recent study based on sample data for individual community hospitals showed a similar decline in the share of the growth in hospital costs that resulted from increases in the quantities of inputs used to provide a day of care.⁷ It was estimated that increases in quantities of labor, capital, and supplies accounted for 43 percent of the growth of unit costs during the pre-Medicare period 1962-66 but only 29 percent in the post-Medicare years 1966-68.

Some changes of this type in the period 1961-71 can be observed in table 5. Not only did the number of employees per day of care increase substantially, but average annual salaries approximately doubled during this period. Plant assets per census also increased about 70 percent in both nonprofit and for-profit hospitals. Like total revenue and hospital prices, these factors have grown more rapidly during the period 1967-71 than in the earlier years of the decade.

⁶ See Saul Waldman, *The Effect of Changing Technology on Hospital Costs* (Research and Statistics Note No. 4), Office of Research and Statistics, Social Security Administration, 1972.

⁷ See Karen Davis, "Hospital Costs and The Medicare Program," *Social Security Bulletin*, September 1973.

⁵ See *Selected Data on Charge Patterns in Short-Stay General Hospitals Under Medicare* (Health Insurance Note No. 31), Office of Research and Statistics, Social Security Administration, 1971.

TABLE 5.—Employment of labor and capital in nongovernmental nonprofit and for-profit community hospitals, 1961-71

Year	Personnel per 100 census ¹	Average annual earnings per employee	Plant assets per census	Annual percentage rate of change		
				Personnel per 100 census	Average annual earnings per employee	Plant assets per census
Nonprofit						
1961.....	240	\$3,371	\$18,768	3.4	5.0	3.7
1962.....	241	3,510	19,832	.4	4.1	3.0
1963.....	244	3,663	20,120	1.2	4.3	4.1
1964.....	247	3,861	21,090	1.2	5.4	4.8
1965.....	252	4,044	22,645	2.0	4.7	7.4
1966.....	264	4,114	23,333	4.6	2.5	3.0
1967.....	268	4,509	23,630	1.5	11.2	2.1
1968.....	276	4,933	25,347	3.0	10.1	6.4
1969.....	284	5,397	26,737	2.9	10.7	5.6
1970.....	292	6,012	29,053	2.6	11.9	5.7
1971.....	301	6,627	31,978	3.1	11.3	10.1
Annual average:						
1961-65.....	245	3,705	20,457	1.2	4.6	4.6
1967-71.....	285	5,549	27,470	2.9	10.1	7.9
1967-69.....	276	4,686	25,837	2.9	9.4	5.9
1969-71.....	293	6,025	29,272	2.9	10.8	9.4
For-profit						
1961.....	205	\$3,060	\$8,696	4.5	2.7	4.4
1962.....	208	3,124	9,574	1.5	3.0	-5
1963.....	214	3,209	9,146	2.9	6.2	8.7
1964.....	212	3,841	10,334	-9	13.8	13.0
1965.....	218	3,786	9,478	2.8	-7	-8.3
1966.....	234	3,860	8,068	7.3	-2.2	-14.6
1967.....	233	4,085	9,380	-4	12.9	15.5
1968.....	237	4,485	8,758	1.7	6.0	-6.6
1969.....	243	5,071	10,703	2.5	12.9	22.2
1970.....	256	5,610	12,659	6.3	13.0	14.3
1971.....	262	6,114	14,662	2.3	10.7	14.2
Annual average:						
1961-65.....	212	3,455	9,279	1.5	5.1	2.4
1967-71.....	247	5,180	11,270	3.0	10.7	11.4
1967-69.....	238	4,555	9,624	2.1	11.7	6.5
1969-71.....	254	5,621	12,641	3.8	9.8	16.2

¹ Full-time equivalents; full-time employees plus full-time equivalents of part-time employees.

Sources: *Hospitals* (annual Guide Issues), American Hospital Association.

Salaries, for example, increased about 5 percent a year in both types of hospitals between 1961 and 1965; from 1967 to 1971 the rate of increase was approximately 11 percent per year. Employees per 100 census and plant assets per census also showed essentially the same pattern of growth during these periods in both types of hospitals.

Trends in factor input patterns, factor prices, and prices for hospital care are all reflected in the trends of revenue, expenses, and net income per patient day. Revenue per patient day in nonprofit hospitals increased nearly 163 percent between 1961 and 1971 (table 6). Per diem expenses increased slightly less, yielding an increase in net income per patient day from 71 cents in 1961 to \$2.63 in 1971, or 270 percent. Percentage increases in revenues and expenses per patient day in for-profit hospitals were nearly identical to those in nonprofit hospitals. As a result, their net

income per day increased more than 200 percent from \$2.09 in 1961 to \$6.43 in 1971.

Because average length of stay increased during most of the period, revenue, expense, and net income per admission grew even more. Revenue and expense per admission in nonprofit hospitals rose approximately 184 percent and 181 percent, respectively, with the result that net income per admission nearly quadrupled during this period. Increases in for-profit revenue and expense per admission during the same period were even higher (about 200 percent), so that net income per admission went up 250 percent—from \$12 in 1961 to \$43 in 1971.

The comparison between levels of net income per patient day or per admission in nonprofit and for-profit hospitals is interesting. Although the percentage increase of net income per day in nonprofit hospitals was higher than in for-profit hospitals, the latter group has always had

TABLE 6.—Revenue, expense, and net income per patient day and per admission for nongovernmental nonprofit and for-profit community hospitals, 1961–71

Year	Nonprofit			For-profit		
	Revenue	Expense	Net income	Revenue	Expense	Net income
Per patient day						
1961.....	\$36.75	\$36.04	\$0.71	\$35.28	\$33.29	\$2.09
1962.....	37.74	37.77	— .03	36.47	34.85	1.62
1963.....	40.33	39.87	.46	39.88	37.96	1.90
1964.....	43.16	42.35	.81	44.81	42.90	1.91
1965.....	46.95	45.40	1.55	47.30	43.73	3.57
1966.....	50.31	48.74	1.57	50.13	46.10	4.03
1967.....	57.11	54.99	2.12	56.59	51.85	4.74
1968.....	64.21	62.18	2.03	60.57	55.65	4.92
1969.....	73.33	70.99	2.34	69.78	64.80	4.98
1970.....	84.04	81.80	2.24	83.16	76.80	6.36
1971.....	96.47	93.84	2.63	93.66	87.25	6.43
Annual average:						
1961–65.....	41.27	40.45	.82	41.17	38.92	2.25
1967–71.....	75.43	73.15	2.28	73.28	67.71	5.57
1967–69.....	65.06	62.80	2.16	62.42	57.43	4.99
1969–71.....	84.68	82.28	2.40	82.42	76.38	6.04
Per admission						
1961.....	\$275.41	\$270.06	\$5.35	\$266.29	\$194.09	\$12.20
1962.....	284.96	285.13	— .17	216.25	206.85	9.41
1963.....	310.29	303.02	7.27	238.75	227.40	11.35
1964.....	330.58	324.39	6.19	278.81	266.91	11.90
1965.....	361.57	349.61	11.96	299.23	276.62	22.61
1966.....	396.38	385.99	12.39	324.24	298.15	26.09
1967.....	450.05	431.65	17.40	386.78	354.38	32.40
1968.....	541.89	524.78	17.11	436.57	391.92	34.65
1969.....	616.40	596.74	19.66	487.08	450.26	36.82
1970.....	694.43	676.12	18.31	569.29	525.82	43.47
1971.....	780.88	759.62	21.26	624.28	581.42	42.86
Annual average:						
1961–65.....	313.79	307.56	6.23	249.83	236.18	13.65
1967–71.....	624.54	605.80	18.74	533.34	485.06	38.28
1967–69.....	543.40	525.41	17.99	433.95	399.22	34.74
1969–71.....	698.55	679.02	19.53	582.54	521.34	41.20

Source: Hospitals (annual Guide Issues), American Hospital Association.

higher net income and the gap between them has narrowed only slightly.

The figures that follow show the average annual rates of increase in revenue, expenses, and net income per day and per admission for se-

lected periods from 1961 to 1971. Revenue and expense per patient day exhibited much the same pattern of growth as total revenues and total expenses: Both increased much more rapidly during the later half of the decade than in the early years. In contrast, net incomes of both nonprofit and for-profit hospitals rose much more rapidly during the first half of the decade than in the later years. Nonprofit net income per day went up at an average annual rate of 22 percent between 1961 and 1965 and 5.5 percent a year from 1967 to 1971. The net income experience of for-profit hospitals was similar: The rate of increase per patient day dropped from 14.3 percent a year in the early period to an annual rate of 7.9 percent between 1967 and 1971. As a result the gap between nonprofit and for-profit net income per day declined during the early years, but increased again after 1965 and especially from 1969 to 1971.

The financial position of hospitals can be looked at another way with the help of net income ratios—net income as a proportion of total revenue and as a proportion of plant assets. Net income ratios, which are essentially measures of the rate of return earned by hospitals, are estimated for nonprofit and for-profit hospitals in table 2. Examination of these data yields two interesting findings: (1) Rates of return were much higher from 1967 to 1971 than they were in the earlier period and (2) for-profit hospitals have consistently had rates of return at least twice as high as those of nonprofit hospitals.

Clearly, the financial position of hospitals improved considerably over the period. In nonprofit hospitals net income as a percent of plant assets increased from an average of 1.5 percent a year between 1961 and 1965 to an average of 3.0 percent during the period from 1967 to 1971. Similarly, for-profit hospitals increased their average rate of return from 8.9 percent a year during the early years to an average of 18.1 percent per year between 1967 and 1971.

An earlier study showed that net incomes of nongovernmental community hospitals were much higher in the period from 1967 to 1969 than in the first part of the decade.⁸ Comparison of the net income data for recent years with the overall average for the years 1967–71 shows whether this trend has continued. Data from tables 2 and

⁸ See Karen Davis, Staff Paper No. 6, *op. cit.*

5 indicate that net incomes per patient day in both nonprofit and for-profit hospitals did continue to increase, but financial position as measured by the rate of return on either total revenue or plant assets actually declined slightly in the 2 latest years of the period. Even with a slight decrease, however, rates of return of 3 percent in nonprofit hospitals and 18 percent in for-profit hospitals are reasonable by the standard of past experience.

It is also apparent that for-profit hospitals have consistently earned a rate of return more than twice as high as nonprofit hospitals and at the same time had lower revenues and expenses per patient day. In the following section an attempt is made to illuminate, to the extent that highly aggregated data permit, the factors that seem responsible for such differences in the financial position of hospitals, on the basis of net income data by bed size and ownership in 1971.

NET INCOME, BED SIZE, AND OWNERSHIP IN 1971

Neither the nonprofit nor the for-profit hospitals—for which overall national average trends in net income and related factors in the past decade have been presented—are a homogeneous group of institutions. Indeed, nonprofit hospitals range from institutions having only six beds and providing strictly basic medical services to enormous teaching institutions with more than 1,000 beds that provide the most sophisticated and technologically up-to-date services available anywhere in the world. For-profit hospitals also vary considerably in terms of size and complexity of services, although they almost never have more than 400 beds and rarely engage in teaching or research.

Because hospitals are so heterogeneous, the national average trend data may hide important relationships or mislead in other ways. Comparisons between the two groups may be particularly dangerous because nonprofit hospitals tend to be so much larger than for-profit hospitals. If bed size is an important dimension in terms of the types of services delivered and the cost of producing services, then it is important to use net income data distributed by bed size so that hospitals of similar size may be com-

pared. To make such comparisons simpler, an overall weighted average for nonprofit hospitals with less than 400 beds has been computed for most of the data in this section. Using the for-profit bed distribution by size as a set of weights for the nonprofit data yields an approximation of the average value that would have prevailed if beds in both types of hospitals had the same distribution in 1971.

As before, relative differences in the financial position of hospitals by bed size or ownership are determined by the interaction of unit prices and average revenues received from third-party payment systems, utilization, and unit costs of producing services. Table 7 shows data on the revenue, expenses, and net income of nonprofit and for-profit hospitals by bed size in 1971.

The net income ratios or rates of return are particularly interesting. The rate of return on plant assets in nonprofit hospitals rises from zero percent for hospitals with 6-24 beds to 3.6 percent for hospitals with 100-299 beds and declines in the larger bed-size categories. The rate of return in for-profit hospitals, on the other hand, ranges from 11.5 percent in hospitals with 25-49 beds to 21.2 percent in those with 200-299 beds, with no apparent pattern related to increasing bed size. In addition, as noted earlier, for-profit hospitals have a rate of return at least twice as high as nonprofit hospitals. This relationship occurs for every bed-size category for which comparable data exist.

The prices that are charged by hospitals and the revenues that are received from third-party payers may help to explain the patterns of net income observed here. No data are available on the variation in rates paid by third parties to hospitals in different bed-size categories, but there is some evidence on semiprivate room charges.

Data on room-and-board charges in nonprofit and for-profit hospitals, by bed-size category as of January 1, 1972, are shown in the tabulation at the top of page 12; they are estimated from the *Survey of Hospital Charges* of the American Hospital Association and the Health Insurance Council. Since 14 percent of the hospitals surveyed did not respond, there may be some bias in the results. The estimates indicate, however, that hospital charges, with one exception, increase uniformly with bed size. In addition,

Bed size	Semiprivate room charges per day	
	Nonprofit	For-profit
All sizes.....	\$52.96	\$53.21
6-24.....	36.40	40.95
25-49.....	38.31	43.49
50-99.....	43.65	46.56
100-199.....	48.31	55.20
200-299.....	54.34	67.15
300-399 ¹	55.47	54.72
400-499.....	56.55	.....
500 or more.....	59.82	.....
6-399 average ²	46.07	52.07

¹ For for-profit hospitals, 300 or more; only 1 hospital of this type had more than 400 beds.

² Estimated as if hospitals of both types that reported charges had the same distribution of beds by size as that for all for-profit hospitals.

Source: Estimated from data in table A18 of the *Survey of Hospital Charges as of January 1, 1978*, American Hospital Association and the Health Insurance Council, 1972.

for-profit hospital charges are higher in nearly every bed-size category; average semiprivate room rates in hospitals of comparable size are thus \$6 higher in for-profit hospitals than in nonprofit hospitals. Since hospitals typically charge separately for ancillary services, however, these data can only suggest that one reason for higher rates of return in for-profit hospitals may be that these hospitals charge higher prices for services.

If prices are actually higher in for-profit hospitals, this difference may be related to the locations of such hospitals. If for-profit hospitals are more likely than nonprofit hospitals to be located in urban areas where wage rates and per capita incomes are higher, then they may be expected to have higher costs and charge higher prices. The distribution of beds in nonprofit and for-profit hospitals in metropolitan and nonmetropolitan areas by bed size, as shown below, in-

Bed size	Nonprofit			For-profit		
	Total	Metropolitan	Non-metropolitan	Total	Metropolitan	Non-metropolitan
All sizes.....	100.0	76.5	23.5	100.0	77.3	22.7
6-24.....	100.0	10.7	89.3	100.0	29.7	70.3
25-49.....	100.0	17.6	82.5	100.0	44.4	55.6
50-99.....	100.0	33.5	66.5	100.0	72.4	27.6
100-199.....	100.0	55.1	44.9	100.0	83.4	16.6
200-299.....	100.0	84.1	15.9	100.0	91.8	8.2
300-399.....	100.0	88.1	11.9	100.0	100.0	0
400-499.....	100.0	98.2	1.8	.....	.....	.....
500 or more.....	100.0	98.5	1.5	.....	.....	.....
6-399 average ¹	100.0	67.1	32.9	100.0	77.3	22.7

¹ Estimated as if hospitals of both types had the same distribution of beds by size as that for nonprofit hospitals.

Source: *Survey of Hospital Charges as of January 1, 1978*, American Hospital Association and the Health Insurance Council, 1972.

dicates that 77 percent of the beds in for-profit hospitals are located in metropolitan areas. Only 67 percent of the beds in nonprofit hospitals of comparable size (with 6-399 beds) are in such areas.

Higher charges in for-profit hospitals may also be related to differences in the range and complexity of services and case composition in the two types of hospitals. The tabulation that fol-

Service or facility	Percent of all hospitals		Percent of hospitals with less than 400 beds ¹	
	Nonprofit	For-profit	Nonprofit	For-profit
Hospitals reporting (response rate).....	96.8	77.5	96.4	58.6
Emergency department.....	90.7	72.3	89.2	78.8
Blood bank.....	67.5	47.7	62.5	60.2
Histopathology laboratory.....	56.0	30.7	46.9	45.4
Postoperative recovery room.....	81.4	69.5	77.8	82.4
Pharmacy.....	87.9	72.1	85.6	83.5
Premature nursery.....	47.3	18.9	39.1	28.9
Electroencephalography.....	42.2	29.6	30.1	46.8
Intensive care unit.....	61.7	39.1	53.0	64.8
Psychiatric services (inpatient).....	18.3	3.3	10.0	5.6
Renal dialysis (inpatient).....	12.6	3.4	5.9	5.2
Physical therapy.....	72.2	47.0	67.6	60.9
X-ray, therapeutic.....	43.0	17.7	32.6	26.9
Inhalation therapy.....	68.4	55.2	61.4	69.4
Radioisotope, diagnostic.....	49.7	28.9	38.7	42.7
Radioisotope, therapeutic.....	27.0	8.4	17.1	16.4
Cobalt therapy.....	17.2	4.8	8.6	10.0
Radium therapy.....	35.4	11.5	24.1	19.3
Cardiac care unit.....	55.4	32.0	48.2	63.9
Open heart surgery.....	10.1	8	3.7	1.9
Outpatient department.....	23.9	17.7	25.6	14.3
Home-care department.....	9.4	.5	7.2	1.2
Rehabilitation unit.....	7.7	.5	4.2	1.0
Extended-care unit.....	11.1	2.1	10.9	3.5
Social work department.....	42.5	12.9	32.8	20.4
Family planning.....	7.4	1.4	3.9	1.7

¹ Estimated as if both types of hospitals had the same distribution of beds by size as for-profit hospitals.

² Includes pharmacies with either a full-time or part-time pharmacist.

Source: *Hospital Statistics, 1971*, American Hospital Association, 1972.

lows shows the percentage of hospitals reporting the availability of 25 different facilities or services and the estimated percentage of beds in hospitals of comparable size that have such services available, by ownership. The percentage of beds in nonprofit hospitals with a given service available is, in general, higher than it is in for-profit hospitals. The difference is usually not large, however, and in six instances the for-profit beds are more likely to have the service available. If the presence of facilities and services implies anything about the case-mix of a hospital, then it appears that nonprofit and for-profit hospitals of the same size provide essentially similar basic medical care.

On the other hand, the data imply that non-

profit and for-profit hospitals tend to play somewhat different roles in the community. For-profit hospitals are much less likely to provide such community services as outpatient care, emergency services, psychiatric care, rehabilitation services, home care, social work, and family planning. These differences are not likely to contribute much to the explanation of the higher charges in for-profit hospitals. They may help to explain the higher rates of return earned by for-profit hospitals—if community services tend to be relatively unprofitable in comparison with basic inpatient services.

The shorter average length of stay in for-profit hospitals has also been cited as a possible indication that these hospitals treat less serious and possibly less expensive cases than nonprofit hospitals do.⁶ A brief review of the data in the tabulation that follows reveals the fact, however, that the majority of for-profit hospitals and beds are located in regions of the country where

⁶ See Karen Davis, Staff Paper No. 6, *op. cit.*, page 23.

Region and division	Percentage distribution of beds		Average length of stay	
	Nonprofit	For-profit	Nonprofit	For-profit
United States.....	100.0	100.0	8.1	6.6
Northeast:				
New England.....	7.4	2.2	8.2	10.2
Middle Atlantic.....	21.6	17.2	9.3	7.7
North Central:				
East North Central.....	25.2	1.8	8.6	7.7
West North Central.....	10.7	2.2	8.4	7.2
South:				
South Atlantic.....	12.0	14.2	7.8	7.1
East South Central.....	4.5	9.5	7.5	6.8
West South Central.....	6.9	23.8	7.0	6.2
West:				
Mountain.....	3.9	2.6	6.8	6.0
Pacific.....	9.9	26.5	6.6	5.7

Source: *Hospital Statistics, 1971*, American Hospital Association, 1972.

length of stay is generally shorter than elsewhere. More than three-fourths of all for-profit hospital beds are located in the South and West. Indeed, 51 percent of all beds are located in just three States—California, Texas, and Louisiana.

In 1971, the overall average length of stay in all nonprofit community hospitals was 8.1 days, and the corresponding figure in for-profit hospitals was 6.6 days—a difference of 1.5 days. With

TABLE 7.—Revenue, expense, and net income for nongovernmental nonprofit and for-profit community hospitals, by bed size, 1971

Bed size	Total revenue		Total expense		Net income		Plant assets (in millions)	Net income ratios	
	Amount (in millions)	Percentage distribution	Amount (in millions)	Percentage distribution	Amount (in millions)	Percentage distribution		Total revenue	Plant assets
Total									
All sizes.....	\$18,104	100.0	\$17,558	100.0	\$546	100.0	\$15,810	3.0	3.5
6-24.....	72	.4	90	.4	3	.5	66	4.2	4.5
25-49.....	475	2.6	459	2.6	16	2.9	334	3.4	4.2
50-99.....	1,364	7.5	1,311	7.5	53	9.7	1,145	3.9	4.6
100-199.....	3,243	17.9	3,117	17.8	126	23.1	2,909	3.9	4.3
200-299.....	3,454	19.1	3,332	19.0	122	22.3	3,034	3.5	4.0
300-399.....	3,189	17.6	3,090	17.6	99	18.1	2,895	3.1	3.4
400-499.....	2,194	12.1	2,146	12.2	48	8.8	1,980	2.2	2.4
500 or more.....	4,113	22.7	4,034	23.0	79	14.5	3,381	1.9	2.3
Nonprofit									
All sizes.....	\$16,801	100.0	\$16,344	100.0	\$457	100.0	\$15,259	2.7	3.0
6-24.....	31	.2	31	.2	0	0	49	0	0
25-49.....	298	1.7	285	1.7	7	1.5	306	2.4	2.8
50-99.....	997	5.9	969	5.9	28	6.1	1,013	2.8	2.8
100-199.....	2,816	16.8	2,719	16.6	97	21.2	2,715	3.4	3.6
200-299.....	3,272	19.5	3,164	19.4	108	23.6	2,968	3.3	3.6
300-399.....	3,096	18.4	3,009	18.4	90	19.7	2,841	2.9	3.2
400-499.....	2,194	13.1	2,146	13.1	48	10.5	1,990	2.2	2.4
500 or more.....	4,099	24.4	4,020	24.6	79	17.3	3,376	1.9	2.3
For-profit									
All sizes.....	\$1,303	100.0	\$1,214	100.0	\$89	100.0	\$551	6.8	16.2
6-24.....	41	3.1	38	3.1	3	3.4	17	7.3	17.6
25-49.....	182	14.0	173	14.3	9	10.1	78	4.9	11.5
50-99.....	367	28.2	342	28.2	25	28.1	132	6.8	18.5
100-199.....	427	32.8	398	32.8	29	32.6	194	6.8	14.9
200-299.....	182	14.0	168	13.8	14	15.7	66	7.7	15.0
300 or more.....	104	8.0	95	7.9	9	10.1	60	8.7	15.2

Source: *Hospital Statistics, 1971*, American Hospital Association, 1972.

the exception of the Middle Atlantic region, however, the difference between average length of stay in nonprofit and for-profit hospitals was 0.9 days or less in the geographic divisions with a concentration of for-profit hospital beds (South Atlantic, East South Central, West South Central, and Pacific). If these data could be corrected for bed-size differences, the length-of-stay differences would be even smaller since average length of stay in nonprofit hospitals of the same size as for-profit hospitals is 7.3 days—only 0.7 days above the for-profit average stay, with location not taken into account. Despite any real differences in case-mix that may exist, location and size differences seem to account for most of the difference in length of stay between nonprofit and for-profit hospitals.

The direct relationship between hospital charges and bed size, on the other hand, is probably the result of differences between large and small hospitals in the range of services offered and the case-mix treated. The proportion of hospitals reporting the availability of services (histopathology laboratory, intensive care unit, etc.) or facilities increases dramatically with size. Case-mix differences are also suggested by the fact that average length of stay in both nonprofit and for-profit hospitals rises uniformly with bed size.

The fact that hospital charges increase with

bed size may also be related to location. Data from the *Survey of Hospital Charges* suggest that hospitals with 100 or more beds are more likely to be located in metropolitan areas than in nonmetropolitan areas, and the likelihood increases rapidly in the higher bed-size categories of both nonprofit and for-profit hospitals.

Utilization patterns also have an impact on the financial position of hospitals of different sizes (table 8). Occupancy rates, like average length of stay, are higher in larger hospitals. Earlier in the article, it has been suggested that, with other things equal, longer stays and higher occupancy both tend to reduce expenses per patient day. Because other important factors are operating at the same time, however, these effects cannot be seen in the expense data.

Differences between nonprofit and for-profit hospitals in terms of average length of stay and occupancy rates may also contribute to net income differences between them. For-profit hospitals as a group have a shorter average length of stay and higher occupancy rates (6.6 days and 71.0 percent) than nonprofit hospitals of comparable size (7.3 days and 70.8 percent).

Another set of factors undoubtedly has a much more important effect on the unit costs in hospitals of different size. Table 9 shows the number of employees per 100 adjusted average daily census, average annual earnings, and plant assets

TABLE 8.—Hospital utilization statistics for nongovernmental nonprofit and for-profit community hospitals, by bed size, 1971

Bed size	Patient days		Admissions		Outpatient visits		Average length of stay	Occupancy rate
	Number (in thousands)	Percentage distribution	Number (in thousands)	Percentage distribution	Number (in thousands)	Percentage distribution		
Nonprofit								
All sizes.....	174,166	100.0	21,515	100.0	103,016	100.0	8.1	79.0
6-24.....	422	.2	64	.3	297	.3	6.4	47.2
25-49.....	4,064	2.3	614	2.9	2,888	2.8	6.7	61.1
50-99.....	13,428	7.7	1,810	8.4	6,456	6.3	7.4	68.8
100-199.....	32,444	18.6	4,381	20.4	18,419	17.9	7.4	74.9
200-299.....	34,477	19.8	4,387	20.4	22,740	22.1	7.8	80.3
300-399.....	31,249	17.9	3,806	17.7	17,632	17.1	8.2	81.7
400-499.....	21,379	12.3	2,531	11.8	13,390	13.0	8.5	84.0
500 or more.....	36,703	21.1	3,922	18.2	21,193	20.6	9.3	84.4
For-profit								
All sizes.....	13,912	100.0	2,088	100.0	4,856	100.0	6.6	71.0
6-24.....	404	2.9	91	4.4	301	6.2	4.3	61.0
25-49.....	2,244	16.1	358	17.1	1,301	26.8	6.1	64.4
50-99.....	3,903	28.7	639	30.6	1,359	28.0	6.1	71.1
100-199.....	4,545	32.7	636	30.5	1,154	23.8	7.1	71.5
200-299.....	1,796	12.7	234	11.2	528	10.9	7.6	78.6
300 or more.....	959	6.9	130	6.2	215	4.4	7.4	78.8

Source: *Hospital Statistics, 1971*, American Hospital Association, 1972.

TABLE 9.—Employment of labor and capital in nongovernmental nonprofit and for-profit community hospitals, by bed size, 1971

Bed size	Nonprofit			For-profit		
	Personnel per 100 adjusted daily census	Average annual earnings per employee	Plant assets per adjusted daily census	Personnel per 100 adjusted daily census	Average annual earnings per employee	Plant assets per adjusted daily census
All sizes.....	275	\$6,627	\$29,164	245	\$6,114	\$13,500
6-24.....	272	5,034	36,444	278	5,529	13,943
25-49.....	242	5,386	24,301	239	5,403	11,478
50-99.....	244	5,650	25,229	241	5,961	11,480
100-199.....	266	6,060	28,002	245	6,131	14,882
200-299.....	271	6,036	28,921	255	6,959	12,957
300-399.....	274	6,794	30,241	247	7,036	21,461
400-499.....	281	6,927	31,148			
500 or more.....	296	7,186	30,625			
6-399 average ¹	257	5,806	27,033	245	6,114	13,500

¹ For for-profit hospitals, 300 or more; only 1 hospital of this type had more than 400 beds.

² Estimated as if hospitals of both types had the same distribution by bed size as that for nonprofit hospitals.

Source: *Hospital Statistics 1971*, American Hospital Association, 1972.

per adjusted daily census by bed size.¹⁰ These data indicate that factor input levels generally increase with bed size in both nonprofit and for-profit hospitals. In addition to using more employees per day of care, larger hospitals pay higher average salaries and use more capital equipment than smaller hospitals do. These patterns of input use are almost certainly related to the greater range and complexity of services offered by larger hospitals. The higher salaries with greater bed size, on the other hand, probably result from the tendency of large hospitals to be located in metropolitan areas. Of course, some difference between large and small hospitals in terms of the skill-mix of employees may also contribute to the higher salaries in the larger hospitals.

The overall averages for hospitals with less than 400 beds suggest that for-profit hospitals do not hire as many employees although they do pay higher salaries than nonprofit hospitals of comparable size. The predominant location of for-profit hospitals in urban areas may account for these differences. The average plant assets figures, however, show that these hospitals own plant and equipment worth only half as much as that owned by comparable nonprofit hospitals. This puzzling relationship, in view of the comparison of facilities and services made earlier, is discussed later.

¹⁰ Adjusted average daily census is an alternative measure of the daily output of hospitals, similar to average daily census. Adjusted census figures take both the number of patient days and the number of outpatient visits into account. Average census figures are based on patient days alone and therefore understate average output.

All the factors described above are reflected in revenue, expense, and net income per adjusted patient day and per adjusted admission (table 10).¹¹ Revenue and expense per adjusted patient day and per adjusted admission both increase uniformly with bed size in nonprofit and for-profit hospitals. The range is substantial; for the nonprofit hospitals, the difference in per diem revenue between the smallest hospitals (\$63) and hospitals with 500 or more beds (\$102) is nearly \$40. Because average length of stay increases with size, the difference in revenue per adjusted admission is relatively even larger (\$540) with the amounts ranging from \$413 for the smallest group to \$953 for the largest.

Although net income per day increases in a nearly uniform pattern in for-profit hospitals, the highest levels are earned in the middle bed-size categories of nonprofit hospitals, with both very large and very small nonprofit hospitals earning low or even negative net income per adjusted patient day. For-profit hospitals also receive levels of net income per day or per admission at least twice as high as nonprofit hospitals in every comparable size category.

At the same time, for-profit hospitals have higher revenues and expenses per adjusted patient day than do nonprofit hospitals of similar size. In addition, though for-profit hospitals have a shorter average length of stay than nonprofit hospitals, their revenue and expenses per ad-

¹¹ "Adjusted" patient days and "adjusted" admissions are alternative measures of the annual output of services in hospitals. Both measures are adjusted in the sense that they take outpatient visits into account in addition to inpatient days or admissions.

TABLE 10.—Revenue, expense and net income per adjusted patient day in nongovernmental nonprofit and for-profit community hospitals, by bed size, 1971

Bed size	Nonprofit			For-profit		
	Revenue	Expense	Net income	Revenue	Expense	Net income
Per adjusted patient day						
All sizes.....	\$87.98	\$85.58	\$2.40	\$87.44	\$81.44	\$6.00
6-24.....	63.11	63.17	-.06	89.77	83.91	5.86
25-49.....	63.80	62.23	1.57	73.00	69.45	3.55
50-99.....	68.05	66.17	1.88	85.36	79.44	5.92
100-199.....	79.55	76.81	2.74	89.36	83.23	6.13
200-299.....	86.15	83.21	2.94	97.65	90.28	7.37
300-399.....	90.36	87.73	2.63	102.97	93.66	9.31
400-499.....	94.07	92.00	2.07	.....	.....	.....
500 or more.....	101.87	99.90	1.97	.....	.....	.....
6-399 average ¹	74.32	72.12	2.20	87.44	81.44	6.00
Per adjusted admission						
All sizes.....	\$712.19	\$692.80	\$19.39	\$582.37	\$542.38	\$39.99
6-24.....	412.89	413.26	-.37	366.08	372.07	-5.99
25-49.....	429.11	412.67	16.44	456.19	433.96	22.23
50-99.....	504.67	490.73	13.94	532.87	495.91	36.96
100-199.....	589.07	568.80	20.27	638.05	594.24	43.81
200-299.....	670.56	654.24	16.32	737.84	682.16	55.68
300-399.....	741.74	720.15	21.59	780.51	691.71	88.80
400-499.....	785.16	777.63	7.53	.....	.....	.....
500 or more.....	832.73	804.30	28.43	.....	.....	.....
6-399 average ¹	548.84	532.32	16.52	582.37	542.38	39.99

¹ For for-profit hospitals, 300 or more, only 1 hospital of this type had more than 400 beds.

² Estimated as if both types of hospitals had the same distribution of beds by size as that for for-profit hospitals.

Source: Hospital Statistics, 1971, American Hospital Association, 1972.

justed admission remain slightly higher than those for similar nonprofit hospitals.

In an effort to explain the higher net incomes of for-profit hospitals, it has been suggested that these hospitals may operate more efficiently than nonprofit hospitals.¹² Support for this hypothesis may be drawn from the finding that for-profit hospitals use less labor and have lower plant asset values than nonprofit hospitals. On the other hand, though the hypothesis may be valid, the fact that for-profit hospitals have higher expenses per day and per admission does not seem to support it.

A study supported in part by the Social Security Administration, using regression analysis on individual community hospital data for 1965-67, also found that for-profit hospitals had higher costs per patient day. The authors of the study argue, however, that, since these hospitals have a shorter average length of stay, they may utilize their facilities more intensively (and consequently with higher per diem costs) but still pro-

duce hospital care at lower total cost than nonprofit hospitals.¹³

Other factors affecting the financial position of hospitals relate to the sources of hospital revenues and the distribution of expenses by type of expense. Net revenue represents the funds actually received. Gross revenue is the amount that would have been received if all patients had paid actual incurred charges.

The data on patient revenue as a percent of total revenue show that hospitals receive more than 90 percent of actual revenue from payments made by or on behalf of patients (table 11). The loss ratios are of particular interest here because these data show the percentage of gross patient revenue lost as a result of contractual allowances, discounts, bad debts, and free care.

One plausible reason for net income differences between hospitals by size or by ownership may be that hospitals with low net income may give more charity care or have higher bad debts than hospitals in better financial position. If such a relationship exists, it is not readily apparent. These data show that percentage losses are directly related to size of hospital and that for-profit hospitals have somewhat higher losses than nonprofit hospitals of comparable size. Neither finding is consistent with expectations based on the net income patterns observed earlier.

The other side of the financial position of hospitals involves the types of expenditures made by hospitals. Both payroll and nonpayroll expenses per day increase with bed size, but payroll as a percentage of total expense does not appear to be closely related to size of hospital (table 12). These data do indicate, however, that payroll costs account for a much lower percentage of total expenses in for-profit hospitals than in nonprofit hospitals of the same size. About 50 percent of total expenses in these hospitals is spent for payroll, compared with 58 percent in nonprofit hospitals.

The category of nonpayroll costs includes many different expense items: Supplies (drugs, bandages, surgical tools, linens, raw food, etc.); rent, interest, and depreciation; employee health and welfare benefits; payments for contract services (laundry service, food service, computer time-

¹³ Ralph E. Berry and John W. Carr, *Efficiency in the Production of Hospital Services* (final report submitted to the Social Security Administration, June 1973).

¹² Karen Davis, Staff Paper No. 6 *op. cit.*, page 23.

TABLE 11.—Revenue per adjusted patient day for nongovernmental nonprofit and for-profit community hospitals, by source of revenue and bed size, 1971

Bed size	Gross patient revenue ¹						Net revenue						Loss ratio ³
	Total	Inpatient		Outpatient		Total	Patient		Other ²				
		Amount	Percent of total	Amount	Percent of total		Amount	Percent of total	Amount	Percent of total			
Nonprofit													
All sizes	\$93.28	\$84.91	91.0	\$8.37	9.0	\$87.98	\$83.30	94.7	\$4.68	5.3	10.7		
6-24	54.37	49.27	90.6	5.10	9.4	63.11	51.51	81.6	11.60	18.4	5.3		
25-49	61.68	55.96	90.7	5.72	9.3	63.80	57.43	90.0	6.37	10.0	6.9		
50-99	70.07	64.36	91.9	5.71	8.1	68.05	64.34	94.5	3.71	5.5	8.2		
100-199	83.72	76.62	91.5	7.10	8.5	79.55	75.82	95.3	3.73	4.7	9.4		
200-299	92.03	83.49	90.7	8.54	9.3	86.15	82.12	95.3	4.03	4.7	10.8		
300-399	96.81	87.98	90.9	8.84	9.1	90.36	86.20	95.4	4.16	4.6	11.0		
400-499	99.60	91.22	91.3	8.66	8.7	94.07	89.19	94.8	4.88	5.2	10.7		
500 or more	108.55	98.51	90.8	10.04	9.2	101.87	95.36	93.6	6.51	6.4	12.2		
6-399 average ⁴	76.65	69.99	91.3	6.66	8.7	74.32	69.79	93.9	4.53	6.1	8.9		
For-profit													
All sizes	\$96.05	\$91.11	94.9	\$4.94	5.1	\$87.44	\$85.59	97.9	\$1.85	2.1	10.9		
6-24	87.85	82.63	94.1	5.22	5.9	89.77	85.66	95.4	4.11	4.6	2.5		
25-49	74.13	68.68	92.6	5.45	7.4	73.00	71.26	97.6	1.74	2.4	3.9		
50-99	89.96	85.06	94.6	4.90	5.4	85.36	83.61	97.9	1.75	2.1	7.1		
100-199	99.37	94.88	95.5	4.49	4.5	89.36	87.97	98.4	1.39	1.6	11.5		
200-299	122.04	116.76	95.7	5.28	4.3	97.65	95.56	97.9	2.09	2.1	21.7		
300 or more	115.98	110.86	95.6	5.12	4.4	102.97	99.74	96.9	3.23	3.1	14.0		
6-399 average ⁴	96.05	91.11	94.9	4.94	5.1	87.44	85.59	97.9	1.85	2.1	10.9		

¹ Amount that would have been received if all patients paid actual charges for care.

² Amount received from appropriations, contributions, and governmental grants.

³ Percentage losses of gross patient revenue due to contractual allowances,

discounts, bad debts, and free care. Represents 100 (100—net patient revenue/gross patient revenue).

⁴ Estimated as if hospitals of both types had the same distribution of beds by size as that for for-profit hospitals.

sharing, etc.); and miscellaneous other expenses. A recent study found that in 1966 the category of rent, interest, and depreciation accounted for 10.8 percent of the total expenses of for-profit hospitals—nearly double the share of such expenses in nonprofit hospitals.¹⁴ No data are available to show whether this relationship still applied in 1971, but there is little reason to believe that this component of nonpayroll expense has declined for either type of hospital in the interim.

A brief review of earlier findings may help to explain the differences between the expense patterns of nonprofit and for-profit hospitals. The data indicate that for-profit hospitals earn much higher rates of return than nonprofit hospitals of comparable size but have higher revenues and expenses per day of care while appearing to provide services approximately similar in range and complexity. Yet the higher expenses of for-profit

hospitals are puzzling since they employ fewer personnel and have a much lower dollar value of plant assets than nonprofit hospitals. Indeed, payroll expenses per adjusted patient day in nonprofit and for-profit hospitals are nearly identical. The entire difference in per diem total expenses thus results from differences in per diem nonpayroll costs, which are about 33 percent higher in for-profit hospitals than in similar nonprofit hospitals.

In part, this pattern may be related to differences in incentives for nonprofit and for-profit hospitals. For-profit hospitals pay Federal income taxes like other similarly organized business firms; nonprofit hospitals are tax-exempt charitable organizations. As a result, for-profit hospitals may find it advantageous to rent rather than purchase much of their equipment. They may also be more likely to make use of accelerated depreciation. Either practice would help to account for the large differences in the value of plant assets reported by the two types of hospitals of comparable size. In addition, for-profit hospitals may be more inclined to use borrowed

¹⁴ Karen Davis, *Community Hospitals: Inflation in the Pre-Medicare Period* (Research Report No. 41), Office of Research and Statistics, Social Security Administration, 1972.

TABLE 12.—Expenses per adjusted patient day of nongovernmental nonprofit and for-profit community hospitals, by type of expense and bed size, 1971

Bed size	Nonprofit				For-profit			
	Total expense	Payroll		Nonpayroll	Total expense	Payroll		Nonpayroll
		Amount	Percent of total			Amount	Percent of total	
All sites.....	\$85.58	\$49.91	58.3	\$35.67	\$81.44	\$41.03	50.4	\$40.41
6-24.....	63.17	37.58	59.5	25.59	83.91	42.16	50.0	41.75
25-49.....	62.23	35.96	57.8	26.27	69.45	35.31	50.9	34.14
50-99.....	66.17	37.83	57.2	28.34	79.44	39.28	49.4	40.16
100-199.....	76.81	44.24	57.6	32.57	83.23	41.12	49.4	42.11
200-299.....	83.31	49.32	59.2	33.99	90.28	48.59	53.8	41.69
300-399 ¹	87.73	51.03	58.2	36.70	93.66	47.70	50.9	45.96
400-499.....	92.00	53.33	58.0	38.65	.....	.....	.....	.....
500 or more.....	99.90	58.68	58.7	41.22	.....	.....	.....	.....
6-399 average ²	72.12	41.65	57.8	30.47	81.44	41.03	50.4	40.41

¹ For for-profit hospitals, 300 or more; only 1 hospital of this type had more than 400 beds.

² Estimated as if both types of hospitals had the same distribution of beds by size as that for nonprofit hospitals.

Source: *Hospital Statistics, 1971*, American Hospital Association, 1972.

funds and contractual services (food service, laundry service, etc.) than nonprofit hospitals. Greater use of any of these common business practices would explain the higher nonpayroll expenses of for-profit hospitals.¹⁵

Since for-profit hospitals have higher average expenses, the explanation of their higher rates of return must lie in the fact that they are able to generate much higher average revenues—perhaps by obtaining higher prices for services and/or higher average reimbursements from third-party payment systems. Although the exact mechanism is not clear, the ability of for-profit hospitals to generate higher average revenue may depend to some degree upon the structure of the local market for hospital services. These hospitals may concentrate, for example, on providing services that are in high demand and avoid relatively high-cost services less frequently used or less profitable.

This hypothesis may be supported by the fact, established earlier, that for-profit hospitals are less likely to provide such community services as outpatient or emergency services, rehabilitation care, social work, or family planning. They may be able to do this for two reasons: (1) Managers of for-profit hospitals probably have more control over decisions on the role of the hospital or

the services to be provided than their counterparts in nonprofit hospitals and (2) the market for hospital services may be fairly noncompetitive, at least in terms of price, since the physician tends to play a more important role in the choice of hospital than the patient.

SUMMARY AND CONCLUSIONS

In the analysis of trends in financial position, a number of factors appear to have had a strong influence on net income during this period. Among these, shifts in the sources of revenues and increases in the range and complexity of services offered by hospitals seem significant. The growth of private health insurance and public insurance programs, with consequent lower losses due to bad debts and charity care, may have contributed to more stable income for hospitals and simultaneously altered the utilization patterns of hospitals with effects on both case-mix and unit costs. Increases in the range and complexity of services also played an important role by affecting not only the factor input use of hospitals but the case-mix and utilization patterns as well.

As a result of these and other factors, the net income of hospitals improved substantially during the period 1967-71. Net income as a rate of return on plant assets in nonprofit hospitals increased from 1.4 percent in 1961 to 3.0 percent in 1971. During the same period the rate of return in for-profit hospitals nearly doubled—from 8.9 percent in 1961 to 16.2 percent in 1971.

¹⁵ It is possible that some for-profit hospitals have treated their Federal business income tax as an expense item and included the amount as part of the nonpayroll expense and total expense figures sent to the American Hospital Association in response to the Guide Issue survey.

Since both nonprofit and for-profit hospitals are heterogeneous groups of institutions, highly aggregated data may hide important relationships that can have a bearing on financial position. Variations in net income by bed size of hospital were studied in an attempt to shed additional light on the factors that influence the financial status of hospitals.

The data for 1971 indicate that differences in net income result from the simultaneous interaction of a host of factors from relative prices to the relative efficiency of hospital operation. Among the various factors identified, the range and complexity of services, geographical location, and ownership seemed to be most important.

The range and complexity of services has a strong influence on unit costs through input requirements both for personnel and for plant and equipment. Geographical location also affects costs substantially because factor prices differ between regions of the country and between urban and rural areas. In addition, location affects revenues because per capita income varies from place to place. Finally, the characteristics of medical practice differ between one location and

another with a resulting impact on unit costs through differences in treatment methods and average length of stay.

Hospital ownership also has an impact on the financial position of hospitals. For-profit hospitals have much higher rates of return than nonprofit hospitals of similar size. This difference may be related to the ability of for-profit hospitals to generate higher average revenues through higher prices or higher reimbursements from third-party payment systems. These hospitals also allocate their expenditures differently, with much higher nonpayroll costs than nonprofit hospitals, perhaps in response to the incentives in the tax system.

Ultimately, of course, the net income of hospitals is one result of a process that involves all the daily decisions of thousands of different individuals. The decisions of each individual physician on the tests and treatments ordered in each case, as well as the average length of stay, all have an impact on the financial position of the hospital. The factors identified above both influence and are influenced by the behavior of physicians and patients in the market for hospital care.

Senator KENNEDY. So I suppose that you get complaints from many of these groups that are interested and concerned about the problems of the indigent who see, what I think all of us have seen in our travels, in hospitals, in these emergency rooms, a \$15 deposit when you first walk in.

You hear about these other preadmission requirements, and this particular letter alleges that approximately \$300 was required before anyone got any treatment.

Yet, they see, on the other hand, the investment has been going up quite handsomely for the hospitals.

We run into this particular dilemma.

Dr. GEHRIG. Senator, if I may comment on that—and I do not have the figures right in front of me, but I can supply them to you—as a matter of fact, in 1973, the net revenue of hospitals above expenses was the lowest it has been in over a decade. I believe the figure is 1.4 percent.

The other factor I think one might look to is that in the experience over the 3-year period between 1970 and 1972, over 25 percent of the short-term community hospitals not for profit had a negative cash flow in two of those years. Their total annual revenue was less than their expense.

I believe Dr. Edwards pointed to that also.

The truth of the matter, as we look at it, is that we do not see the sort of windfall situations that were suggested in your comment, and I think our data will bear this out.

Senator KENNEDY. Could you provide that for us?

Why not take a look at that Social Security bulletin? I was referring to page 18.

Perhaps you could respond to that and make it part of the record.

I would be interested in what these statistics and figures mean, what yours are, and how you reached those, and have whatever you want to say on that so we have some kind of idea.

[The following information was subsequently supplied for the hearing record:]

THE AMERICAN HOSPITAL ASSOCIATION RESPONSE TO THE ARTICLE: THE FINANCIAL POSITION OF PRIVATE COMMUNITY HOSPITALS, 1961-71, FROM THE SOCIAL SECURITY BULLETIN OF NOVEMBER 1973

The *Social Security Bulletin* article referred to tabulates the net revenue of hospitals in terms of their *plant* assets. When viewed in terms of *total* assets, the net revenue ("profit") figures are substantially lower as illustrated on the Table below. It should be noted that this so-called "profit" margin has been sharply decreasing in recent years. In fact, many hospitals in recent years have shown a *negative* net revenue figure. For example, over twenty-five percent of hospitals reported total net losses in two of the three years from 1970 through 1972, and more than half the hospitals in the country are operating at a deficit at the present time. Moreover, when patient care revenues alone are compared to patient care expenses, the national results show a net *deficit*.

Finally, and most importantly, some measure of net revenue or "profit" is necessary and desirable for nonprofit as well as investor-owned hospitals. This is needed for a variety of purposes, including: working capital; plant asset replacement, modernization and expansion (depreciation allowances by third-party payors are clearly inadequate for this purpose); to offset the effects of inflation; and to partially replace declining philanthropy in the hospital field.

TABULATION OF NET REVENUE OF HOSPITALS IN TERMS OF THEIR PLANT ASSETS

	Net ¹ total revenue	Total expenses	Plant assets	Total assets	(Total reve- nue-total expenses) divided by plant assets	(Total reve- nue-total expenses) divided by total assets
	(In thousands)				(In percent)	
Year:						
1973	\$28,592,832	\$28,372,013	\$24,971,648	\$37,491,951	0.88	0.59
1972	25,826,513	25,462,250	22,362,157	33,520,212	1.63	1.09
1971	22,908,032	22,399,546	20,076,126	29,608,814	2.53	1.72
1970	19,930,207	19,559,675	18,131,783	26,673,700	2.04	1.39
1969	17,010,894	16,613,154	16,516,070	24,153,192	2.41	1.65

¹ Net Total revenue equal net patient revenue plus all other revenue, including contributions, endowment revenue, government grants, and all other payments not made on behalf of individual patients.

Source: "Hospitals, J.A.H.A.-Guide Issue, 1970," "Hospitals, J.A.H.A.-Guide Issue, 1971," "Hospital Statistics, 1971," "Hospital Statistics, 1972," "Hospital Statistics, 1973" (unpublished data).

Senator KENNEDY. Your association recognizes the responsibility, though, of providing a degree of free care, do they not?

Dr. GEHRIG. Yes, sir, within the institution's financial feasibility, it does.

Senator KENNEDY. Do you favor the closing down of beds in the areas where occupancy rates are low?

Dr. GEHRIG. I think we have seen some examples of this. I can think of several things that occur under these circumstances.

We do favor the conversion of beds which are obviously not needed to some other purpose.

I think you mentioned earlier mothballing. I think perhaps that would be the last measure one would like to see if there were an opportunity to attempt to use them for some other purposes.

I think the other area that is important in facing up to this whole matter—you are talking of excess beds or duplications—is the efforts that have moved ahead voluntarily in the area of shared service, which have been significant. Hospitals have made great efforts in group purchasing and in many of the management, engineering and other aspects in which they can share.

This has provided opportunity for some hospitals to get out of particular aspects of the business, and then also to use the leverage of volume.

Senator KENNEDY. You recognize the need for the construction of outpatient facilities?

Dr. GEHRIG. Absolutely.

Senator KENNEDY. Would you elaborate on that?

Dr. GEHRIG. I think as we see movement now toward national health insurance and toward provision of payments for ambulatory services that have been limited under third-party payers in the past, increasing opportunity is available in this direction.

I think efforts, both to assist it and, in fact, to encourage it, are important, as outlined in your bill.

Certainly, where outpatient care can successfully be substituted for inpatient service, it is not only an appropriate, but a very important way in which to move.

I think another aspect of its importance is the extent to which it can also contribute to access. Of course, the construction of outpatient departments is not the total answer. We are also involved in manpower utilization in facilities, but I think this is a direction we are moving in.

I think in the last decade the increase in outpatient visits has gone over 100 percent. I know of an estimate of 35 percent increase as we look to the next 5 years.

I think we are moving this way, and I think the bill should certainly assist and encourage this effort.

Senator KENNEDY. Thank you very much.

[The prepared statement of Dr. Gehrig follows:]

American Hospital Association

ONE FARRAGUT SQUARE SOUTH • WASHINGTON, D. C. 20006

Washington Office

TELEPHONE: AREA CODE 202 393-6066

CABLE ADDRESS: AMERHOSP

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
ON FEDERAL ASSISTANCE IN FINANCING CONSTRUCTION OF HEALTH CARE FACILITIES
BEFORE THE U. S. SENATE
SUBCOMMITTEE ON HEALTH OF THE LABOR AND PUBLIC WELFARE COMMITTEE

June 14, 1974

Mr. Chairman, I am Leo J. Gehrig, M.D., Vice President of the American Hospital Association, representing some 6,000 member institutions (including most of the hospitals in the country; extended and long-term care institutions; mental health facilities; and hospital schools of nursing), and over 20,000 personal members.

We greatly appreciate the opportunity to present the AHA's position on federal assistance in financing the construction of health care facilities. I will address my remarks specifically to the need for redirection and extension of such federal assistance, which has come primarily through the Hill-Burton program, the principal federal effort in this area since the Hospital Survey and Construction Act of 1946 was originally signed into law. Mr. Chairman, I am pleased to note that legislation to authorize such a redirected program has been introduced by you and Senator Hathaway in S.3577, and that another bill, S.2983, has been introduced by Senator Javits. While we have some recommendations regarding this legislation, which I will discuss later, we believe that many of the provisions proposed are highly commendable.

Let me state at the outset AHA's conviction that the Hill-Burton program has been highly successful. Not only has it provided an important funding base for the development of many needed health care facilities and services, it has also proven to be



75 YEARS OF SERVICE TO HOSPITALS

highly adaptable to the dynamic needs of institutional health care. Many of the reasons for this adaptability are due to the unique partnership between federal and state government units in administering the program, a partnership resulting in uniformly high standards in the construction of facilities while allowing the states to set priorities of need for projects to be assisted within broad categories. The need for federal staff has been minimized and local and state-level experts are utilized in establishing the priority for health care projects.

The Hill-Burton program also provided the first systematic inventory of the nation's health care facilities, as well as the first nationwide program for determining need for health care facilities. These developments were made possible through state plans charted by the agencies within each state that are responsible for administering the program. Such agencies are also normally responsible for licensing facilities within the state. The Hill-Burton program continues to provide the only nationwide determination of the need for new or modernized health care facilities, based upon the state plans which must be updated at least annually under the existing legislation.

The Need for Construction of Health Care Facilities

In spite of the success of the Hill-Burton program, the need for construction and modernization of health care facilities has not been eliminated. HEW estimates that \$19.7 billion is needed over the next five years for the construction and modernization of health care facilities.

The need to modernize and renovate facilities is the most pressing, representing \$12.7 billion of the total capital funds currently required. This includes the need to modernize some 196,000 beds in general hospitals, according to HEW. The need for modernizing and renovating facilities is particularly acute in major cities and in

some rural poverty areas where many of the facilities are old and obsolete. Even though these facilities might be inadequate, they often are the only resources for the care of large and economically disadvantaged population groups. The facilities need to be modernized and improved to properly serve these areas. HEW also estimates that \$6.95 billion is required for additional health care facility capacity.

The demand for additional outpatient facilities continues to grow. Outpatient visits at community hospitals increased 116 percent from 1963 to 1973. If the current trend continues, outpatient visits can be expected to increase another 35 percent by 1978. The increase can be expected to be even greater in outpatient departments of hospitals and in free-standing ambulatory care centers with the expanded coverage for these services anticipated under national health insurance. Services that can be successfully provided on an outpatient basis represent an effective alternative to inpatient care. HEW projects that \$945 million worth of additional outpatient facilities are currently needed in addition to a \$750 million need for modernization of outpatient facilities.

The Administration has argued that there is an excess of hospital beds in the nation, and that any federal assistance to health care facilities construction would only add to the "problem." I assume that this argument is based upon a recent decline in the average national hospital occupancy rate. However, it is grossly misleading to use the national occupancy rate as an indicator of the need for health facilities construction assistance. Occupancy rates vary significantly from state to state and community to community, and, while some areas do have excess beds, many institutions -- especially in urban areas -- are operating at occupancy rates well above the national average. An excess of beds in one area does not mean that additional beds are not needed elsewhere.

The application of any single occupancy rate for all hospitals is inappropriate. The desirable occupancy rate for a particular hospital is dependent upon a number of

factors including: the size of the facility, the proximity of other facilities, the types of services, the size of the service area, and the population density. Therefore it is an almost impossible task to establish a universally applicable occupancy rate for the entire nation. In addition, the occupancy rates usually cited are averages for a specific period of time, but on a given day a hospital may be 100 percent occupied or may even be more than 100 percent occupied. Because of the critical nature of hospital services, there must be standby capacity on the average to provide the necessary capacity during the periods of peak demand.

There was a modest decline in the average national occupancy rate in 1970 through 1972. This decline was attributable in part to a reduced average length of stay in hospitals and the greater utilization of outpatient facilities. Length of stay, in turn, is directly related to the age of the population served; that is, the older the patient, the longer the average length of stay in a hospital. Census projections indicate that the number of persons over 40 years of age, especially the number over 60, will increase during the next 20 to 30 years. This increase will result in a greater demand for inpatient services from the older age group.

Financing Construction of Health Care Facilities

Mr. Chairman, the Administration has argued that the Hill-Burton program should not be extended because third-party purchasers of care reimburse hospitals for depreciation expenses, making it unnecessary that federal support be continued for the capital needs of health care institutions. This argument reflects a basic misunderstanding of the concept of depreciation expense. Depreciation is a method of apportioning capital costs previously incurred to those who receive the benefits of the expenditures. Thus, depreciation reimbursement is the recovery of capital funds to serve as a source of replacement of existing facilities. It is not a means of generating new capital funds for the expansion of existing facilities or the development of new facilities and services.

Because of inflation, depreciation reimbursement which is based upon historical cost has not been adequate to replace existing plant and equipment even when hospitals have been able to fund depreciation -- that is, to set aside this reimbursement specifically for the purpose of replacement. Technological advances and capital intensification have resulted in the further inadequacy of reimbursement for depreciation as a source of needed capital funds.

Furthermore, many hospitals are being forced to utilize depreciation reimbursement to pay for direct patient care, as the result of the inadequate reimbursement by governmental programs such as Medicare and Medicaid. In the three years, 1970-1972, at least 25.5 percent of the nation's nongovernmental short-term, not-for-profit hospitals had total revenues which were less than total expenses in at least two of the three years. Many had to use depreciation funds to the extent these were available to offset operating deficits.

The inadequacy of reimbursement for depreciation can be further demonstrated by a study recently completed by our Association, of the sources of capital funds for construction of health care facilities. The results of this study, which was based upon 1,071 projects totalling more than \$3 billion, show dramatic changes in the sources of funds when compared to a similar study based upon construction completed in 1969. Changes in the sources of funds for nonfederal hospital construction in 1973 reflect a substantial decrease in the ability of hospitals to fund depreciation and the relative inadequacy of depreciation reimbursement as a source of capital. The study shows that hospital reserves as a source of construction funds declined from 22.3 percent of the total amount spent for this purpose in 1969 to 15.5 percent in 1973. At the same time, government assistance to nonfederal hospitals for construction declined from 30.3 percent of the total in 1969 to 17.9 percent in 1973; and philanthropy, while at a new high in dollars received by hospitals, declined from 14.4 percent of the total

in 1969 to 10.3 percent in 1973. The remaining source of capital funds for construction of nonfederal health care facilities is borrowing, which increased from 33 percent in 1969 to 56.3 percent in 1973.

A table summarizing the results of this study is included with my testimony, so I will not dwell on them except to point out that debt financing for the construction of nongovernmental short-term, not-for-profit hospital facilities increased from 39.6 percent of the total capital spent in 1969 to 62.3 percent in 1973. These data represent hospitals that had sufficient basic capital to permit the borrowing of necessary funds to proceed with construction. No study has been made of hospitals with the need for modernization or new construction that have not had the necessary financial resources to undertake such construction. It is safe to assume that the lack of capital resources has been a primary obstacle, however.

The Need for Federal Assistance in Financing Hospital Construction

It has been suggested by some that the grant program under Hill-Burton should not be continued and that the direct loan and loan guarantee portion of the Hill-Burton program would be sufficient to meet the needs of health care institutions. Direct loans and loan guarantees with interest subsidies have certainly been helpful in meeting the need for relatively less expensive capital funds necessary for construction and renovation of health care facilities. They have also been successful in opening up mortgage financing to hospitals.

The difficulty with a loan program arises in regard to hospitals that cannot borrow the necessary funds because of failure to demonstrate reasonable ability to repay. Many of these hospitals have demonstrated need for modernization of facilities, or expansion of services or types of services, but because they are situated in economically declining or poverty areas, they lack the capability of borrowing the necessary

capital funds or of raising significant capital funds through philanthropy or internal operations. In such situations the Hill-Burton grant program frequently has proven to be the only resource available. A federal grant can, of course, be used to finance up to 90 percent of a project, but grants under the Hill-Burton program have been more commonly used to reduce indebtedness to levels at which repayment may be reasonably assured.

S.3577

Mr. Chairman, as I indicated at the outset of my remarks, we were very pleased to see the introduction of your bill, S.3577. It is clear that you recognize, as we do, the very real need for a federal program of grant and loan assistance for modernization of health care facilities and the modernization or construction of ambulatory facilities.

Health Facilities Planning

When the AHA testified before this Subcommittee earlier this year on S.2994 and related planning legislation, we affirmed our conviction that the planning aspects of Comprehensive Health Planning, Regional Medical Programs, and Hill-Burton should be merged at both local and state levels as a part of the redirection and extension of these programs. We believe that facilities planning should be a function of local and state planning agencies, and should result in a priority-setting process for the capital construction assistance program within a state.

We also recommended previously that certificate of need programs should be developed in every state for purposes of both the construction and development processes. The AHA has consistently supported state-level certification of need and is pleased to note the growing number of states -- 22 at last count -- which have moved in this direction. We believe that this process can very effectively prevent the development of unneeded facilities. We would hope that provision will be made for coordination of

planning and certification of need activities with the construction assistance program either in this legislation, the planning legislation, or both.

We are pleased to note your proposed continuation in S.3577 of a formula-type allocation process which would provide grant and loan allocations to each state. Health facility construction assistance needs are, in fact, nationwide, and no state is without some need for assistance. We also agree with elements of the formula specified in your bill, namely: population, financial need, and modernization and construction need.

State Agency

Your bill would eliminate the existing federal-state partnership which has for so long worked effectively to assist construction projects most in need of help. S.3577 would establish within HEW the responsibility for approving grant and loan applications upon recommendation for approval by local planning agencies and in the priority order set by such agencies, an approach we oppose for a number of reasons.

It is imperative, in our view, that state-wide health construction priorities be set, as they now are through state plans. Without such priorities, the federal government will have to make the key judgments as to which projects to fund within those states having more than one local planning area. We are convinced that this judgment can be made more effectively by state government agencies than by HEW, since the state agencies are closer to the scene and therefore more familiar with specific needs and problems.

Moreover, if HEW is charged with making judgments as to the relative merits of several projects -- each of which has a number one priority ranking by its planning agency -- the responsible federal agency will have to be quickly and substantially augmented by experts capable of performing the judgments now carried out at the state level.

The state agencies currently performing the Hill-Burton administrative functions are normally a part of the state governmental agencies which also perform facility licensure functions. By using this expertise within each state the Hill-Burton program has been able to operate with a minimum of staff. The state Hill-Burton agency has also been able to insure that construction standards are maintained, provide consultative assistance to applicants, and in addition, have been able to assist in the determination of the need for modernization or replacement of facilities and equipment.

Local and state planning agencies should have an important role in the federal construction assistance program. We feel, however, that this role should be one of "review and comment" on applications to determine consistency or inconsistency with established plans and that the final determination of how federal construction assistance funds are to be spent should be a function, as it is now, of the state Hill-Burton agency. Such determinations of this agency should be based on a state plan which has been developed through comprehensive health planning agencies at the local and state levels.

We recommend continued support for a state construction assistance agency, with the change in the planning process previously indicated. We feel it is essential that the formula allocation of grant and loan funds be made to these agencies, in order to carry out the purposes of the construction assistance program.

Mr. Chairman, we are firmly convinced that the state Hill-Burton agencies have done an effective job over the years of the program's existence, and that this is just the kind of proven state effort that the federal government should be encouraging, not dismantling.

Targeting Construction Assistance

Mr. Chairman, another problem we see with S.3577 is found in sections 601(a)(2) and 602(a)(2). These sections provide that grants and loans for modernization can only be used to assist projects which will serve "medically underserved populations."

This phrase is defined in the bill in terms of a "shortage of health facilities." We believe that this definition would result in an inability to fund many badly needed modernization projects. Specifically, if a particular facility is located in an area with adequate numbers of beds, but is in need of renovation, the language of S.3577 would seem to prohibit use of federal assistance funds. While this problem could be partially solved by re-defining "medically underserved populations," we believe that the needed targeting could be accomplished more effectively by altering the allocation formulas. We recommend that separate grant allocations to the state agencies be established for public or other nonprofit 1) construction and modernization of outpatient facilities; 2) modernization of health facilities in urban areas; and 3) modernization of health facilities throughout a state. The details of this recommendation are spelled out in an attachment to my statement entitled "Health Facilities Construction Assistance."

The bill introduced by Senator Javits, S.2983, attempts to target a construction assistance program on urban public hospitals. We recognize the great need for such assistance, and support the purpose of this bill, but we also must point out that other nonprofit urban hospitals have similar needs and problems which must be addressed. For this reason, we believe the "Special Urban Facilities Grant Program" spelled out in our recommendations and the attachment to this testimony would be an appropriate way to focus on these special problems of major urban centers.

In our view, the existing priorities listed in section 603(a) of the Public Health Service Act should be retained as a further means of "targeting" onto high-need projects. I refer especially to the priorities provided for "areas with relatively small financial resources," "facilities serving densely populated areas," and "facilities which . . . provide comprehensive health care."

Therefore, Mr. Chairman, we strongly support the targeting of federal facilities construction assistance to high need urban and rural areas, and earnestly request that the Committee give consideration to the recommendations we have made for this purpose.

New Hospital Construction

We are in full agreement that the greatest area of need for construction assistance is modernization and that this should be the primary thrust of a federal assistance program. However, we would like to point out to the Subcommittee that situations will arise in which a new facility is needed in a community, for example, as the result of a population shift or to satisfy an existing unmet need. We recommend that up to 20 percent of a state's allocation for grant and loan support be available, under strict guidelines to be promulgated by the Secretary of HEW, for construction projects to meet high-need, new bed requirements. Should such high-need, new bed requirements not exist, these funds could be used for modernization of facilities.

Minimum State Allocation

S.3577 provides for a minimum state allocation of \$800,000. AHA feels that this is too low in view of current construction costs. We believe that a more adequate minimum allocation is needed and recommend that the minimum in the existing law, \$1.2 million, be retained.

Administrative and Judicial Appeal

In order to assist in the equitable administration of this program and consideration of priorities that are established for construction assistance, we recommend that the legislation include adequate mechanisms for administrative and judicial appeals.

Community Service

Section 604(b) of S.3577 delineates several requirements in any grant, loan, or loan guarantee application. Subsection (9) of this section requires that applicants provide reasonable assurance that at all times they will provide services to persons

residing or employed in their service area, and a "reasonable volume of services to persons unable to pay therefor." The latter provision requires that an institution assisted under this program must be accountable to the government, as a contractual obligation without time limit, for providing "free care," as a condition of receiving a grant, loan, or loan guarantee. I would like to take the opportunity of this hearing to point out that, in fact, there is no such thing as "free care"; someone has to pay for all care rendered in hospitals. If an institution is required to provide services for persons unable to pay for them, someone else must pay more than his fair share. Under present reimbursement methodologies of government and some other third-party payors, this cost can only be spread among a limited number of patients.

Until the advent of a truly comprehensive national health insurance program, "free care" must continue to be provided for certain individuals. However, we would hope that the Congress is aware that by including such a provision as section 604(b)(9), it would be in effect, levying an inequitable burden on some hospital patients to pay for the care of others.

Section 604(b)(9) of S.3577 requires that the facility receiving aid under the federal program meet these requirements "at all times after such application is approved."

While hospitals have provided and will continue to provide community service and care to individuals unable to pay within the limits of the financial capability, the "in perpetuity contractual requirement" for accountability in this provision is inappropriate. Further, such an open-ended requirement is inconsistent with the time-limited (20 years) recovery period for federal grant assistance should the facility for which support was obtained cease to be operated for the purposes for which it was assisted.

We recommend that successful applicants not be required under section 604(b)(9) to be accountable under these provisions beyond the period provided for recovery of federal funding assistance.

Authorization Level

We believe that the authorization level for grants in this legislation is not adequate. In order to more realistically meet the needs as previously described, we would recommend an authorization of twice that level.

Federal Hospital Council

S.3577 does not provide for the continuation of the Federal Hospital Council (FHC) by failing to carry forward its organic provisions and the functions conferred on it in existing law. The FHC, through its activities as advisor to the Secretary as well as its approval responsibility for proposed regulations under the Hill-Burton program, has provided HEW with a much-needed body of expertise in the area of facilities construction and the administration of this program.

The Federal Hospital Council will continue to be needed for its present purposes. We strongly recommend inclusion in this legislation of the provisions for and functions of the FHC as included under 42U.S.C.A.291k and 291d(b).

Recommendations

In conclusion, Mr. Chairman, I would like to make the following recommendations regarding federal health facilities construction assistance:

1. The existing program of grants to public and nonprofit facilities should be continued, but redirected as follows:
 - (a) A modernization grant program should be established which allocates funds to states on the basis of a formula which reflects the state's population, per capita income, and modernization need. These funds, for use throughout the state, should be provided primarily for modernization projects, but states should have authority to use up to 20 percent of their allocations for construction of new facilities.

- (b) A special urban facilities program should be established which allocates funds to those states having at least one standard metropolitan statistical area of 250,000 or more population for use solely in such areas. The allocation formula should reflect the following factors in such metropolitan areas: population, per capita income, and modernization need. Up to 20 percent of the state's allocation should be available for construction of new facilities, with the balance devoted to assisting modernization projects, both to be used only in SMSAs of 250,000 or more population.
- (c) An outpatient facilities construction program should be established which allocates funds to states to assist in the construction of new outpatient facilities and the modernization of existing facilities. These funds should be allocated, for use throughout the state, according to a formula which reflects the state's population, per capita income, and need for outpatient facilities.
2. The existing HEW programs of direct loans and loan guarantees, with interest subsidies, should be extended with the provision that the funds are to be allocated to the states primarily for modernization projects, but with up to 20 percent of such allocations available to assist in the construction of new facilities.
3. The present partnership between federal and state government units in administering the program should be maintained. This partnership has proven to be most effective in regard to the manpower requirements and has worked well at the state government level.
4. Grant and loan funds should be allocated to the state agencies for administration, consistent with planning priorities developed through comprehensive planning at the local and state levels.

5. The assurances which construction assistance applicants must provide regarding accountability for the provision of community services and a reasonable volume of services to persons unable to pay therefor, as outlined in section 604(b) (9) of S.3577, should take into account the financial feasibility of an institution to meet such assurances and be time limited to the period provided for the recovery of assistance funds under the program.
6. We believe that the existing special considerations for establishing priority of projects for high-need areas, as included in section 603(a) of the Public Health Service Act, should be retained. Such priorities are needed for urban and rural areas with relatively small financial resources, facilities serving densely populated areas, and facilities to provide comprehensive health care including outpatient and preventive care as well as hospitalization.
7. We recommend that the minimum state allocation of federal health facilities construction be maintained at least at its present level of \$1.2 million.
8. We recommend that the Federal Hospital Council in its present organization and function, as provided for in existing law, be continued.
9. The existing program in the Public Health Service Act of grants for construction and modernization of emergency rooms in general hospitals should be extended. The Congress last year passed an excellent Emergency Medical Services Systems Act. The authorities established by that legislation do not contain the provisions in the existing Hill-Burton law for construction and modernization of emergency rooms. In the interest of the full implementation of the Emergency Medical Services Systems Act, we recommend continuation of this provision.

Mr. Chairman, I would urge that the recommendations contained in our testimony be given serious consideration by the Subcommittee. As you requested when the AHA

testified before your Subcommittee on March 20 of this year on planning legislation, AHA staff has provided the Subcommittee staff with a more detailed summary of the recommendations I have just outlined as well as some suggested legislative language to implement them. I would like to emphasize that we continue to stand ready to work with you and your staff in the development of this important legislation.

We will be happy to answer any questions you may have.

Percentage of Capital Funds Used
for Hospital Construction by the
Sources of Funds¹

Hospital Classifications	Government		Philanthropy		Hospital Reserves ²		Debt	
	1969	1973	1969	1973	1969	1973	1969	1973
United States Total	32.3	20.9	13.9	9.9	21.7	14.9	32.0	54.3
Federal	100.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Nonfederal	30.3	17.9	14.4	10.3	22.3	15.5	33.0	56.3
Long Term	86.6	49.4	4.8	8.9	2.4	2.3	6.0	39.4
Short Term	26.1	15.7	15.1	10.4	23.8	16.4	35.0	57.5
Nongovernmental, Not-for-Profit	16.6	8.3	17.9	11.8	26.0	17.6	39.6	62.3
For-Profit	.2	4.0	1.1	0.0	36.9	15.7	52.9	80.3
State & Local Governmental	65.9	44.5	6.6	5.3	13.8	11.5	13.7	38.7

¹ 1969 data based on construction completed in that year, 1973 data is for construction begun in 1973.

² Includes equity for investor owned facilities.

DEH & JAH: 5/31/74

HEALTH FACILITIES CONSTRUCTION ASSISTANCE

(Hill-Burton Program)

Background

The American Hospital Association recommends that the program of medical facilities construction and modernization be extended for an additional three years with amendments.

The nation's needs in the health facilities area have changed since the beginning of the Hill-Burton program in 1946 and the program has been altered to meet these changed needs. Further changes should occur now, but basic needs have not been eliminated. Therefore, it is of crucial importance that the program be continued, but in modified form.

The most pressing need is for modernization of existing facilities; hence the proposed change in formula and program emphasis. HEW estimated that approximately \$12.7 billion worth of modernization projects currently need to be accomplished in this country.

The desirability of, and need for additional outpatient facilities continues. Outpatient facilities are highly cost-effective. Continued special emphasis on outpatient facilities that are linked to the health care system is clearly needed.

The need for facilities modernization is especially great in large urban areas where many of the existing facilities in the inner cities are obsolete and inadequate but serve as an only resource to large and often poor population groups. This special need could be met by a special program focused particularly on these areas.

It is becoming increasingly obvious that the many federal health programs being administered at state, regional, and local levels lack one quality absolutely vital to their long-range effectiveness: Coordinated Planning. Development of this coordination is crucial to the success of the programs.

Health facility construction or modernization, which is carried out with or without federal assistance, should be permitted only in those circumstances where there is a recognized community need. To assure that all proposed construction meets such requirements, certificate of need programs should be established at the state level, which meet federal standards.

Specific Proposals

A. Grants

In recognition of changing needs, there should be just three program categories of grants:

1. Modernization Grant Program

This program would support modernization of hospitals and public health centers, long-term facilities, and rehabilitation facilities in any location in the state.

- Funds would be allocated to the states under the Modernization Grant Program according to a formula reflecting the following factors: estimated modernization need, population, and per capita income.
- Despite the overwhelming need for modernization, construction of new facilities where none exist will occasionally be a priority item in special circumstances. Therefore, each state would have the authority to use up to 20 percent of the funds allocated to it under the Modernization Grant Program for the purpose of supporting construction of new facilities under controlled circumstances described in federal regulations.
- The authorization levels for the Modernization Grant Program would be: \$180 million for Fiscal Year 1974; \$180 million for Fiscal Year 1975; and \$180 million for Fiscal Year 1976.

2. Special Urban Facilities Program

- This grant program would support modernization of hospitals and public health centers, long-term facilities, and rehabilitation facilities only in metropolitan areas having a population of 250,000 or more.
- Funds would be allocated under the Special Urban Facilities Program only to those states having at least one metropolitan area with a population of 250,000 or more. The allocation formula would be based on the following factors, as they exist only in metropolitan areas with populations of 250,000 or more: modernization need, population, and per capita income.
- To cover special circumstances, the states would have the authority to use up to 20 percent of the funds allocated to it under the Special Urban Facilities Program for the purpose of supporting construction of new facilities under controlled circumstances described in federal regulations.
- The authorization levels for the Special Urban Facilities Program would be: \$150 million for Fiscal Year 1974; \$150 million for Fiscal Year 1975; and \$150 million for Fiscal Year 1976.

3. Outpatient Facilities Construction Program

- This grant program would support construction of new outpatient facilities and modernization of existing facilities.
- Funds would be allocated to the states under the Outpatient Facilities Construction Program according to a formula reflecting the following factors: estimate of need for outpatient facilities, population, and per capita income.
- The authorization levels for the Outpatient Facilities Construction Program would be: \$70 million for Fiscal Year 1974; \$70 million for Fiscal Year 1975; and \$70 million for Fiscal Year 1976.

B. Loans

1. The existing authorities for loan guarantees with interest subsidies and for direct loans to public institutions (Title VI, Part B of the Public Health Service Act) should be extended at their existing levels. This includes the authority to combine loans and grants to cover up to 90 percent of the cost of a project.
2. Allocations for the guarantee-subsidy program and the direct loan program should be based on the following factors: modernization needs, population, and per capita income.
3. Funds allocated under the guarantee-subsidy program and the direct loan program should be used primarily to support modernization of existing facilities. To cover special circumstances, however, the states would have the authority to use up to 20 percent of their allocations to support construction of new facilities.

C. Priorities

1. The determination of priority of projects supported, as outlined in section 603(a) of the Public Health Service Act, should be maintained.
2. Two additional "special consideration" factors should be added to section 603(a), as follows: Priority should be given by the states to those grant, loan guarantee, and direct loan projects that involve the coordination of more than one institution, with special emphasis on projects that are geared toward combining existing resources into new health systems that would bring health services more effectively to underserved areas. Priority should be given by the states to projects for modernization of facilities serving areas with relatively small financial resources.

D. Construction and Modernization of Emergency Rooms

1. Part C of Title VI of the Public Health Service Act, providing for special project grants for the construction or modernization of emergency rooms of general hospitals, should be extended at the existing level of authorization: \$20 million per year.

E. Certification of Need

Control of health facility construction or modernization at the state level through certification of need is an essential aspect of this program. The state agency which approves or disapproves requests for certificates of need will depend heavily on the review and comment on such proposals which are provided by effective planning agencies at the local and state levels (314(a) and 314(b)).

F. Study of Methodology for Determining the Need for Health Facilities and Services

Provision should be made in this legislation for studies to be conducted and reported back to Congress in one year which will improve the methodology for determination of needs for health facilities and services.

* * * * *

Senator KENNEDY. Our next witness is Ms. Marilyn Rose, an attorney for the Center of Law and Social Policy here in Washington, D.C.

We are looking forward to your comments.

STATEMENT OF MARILYN G. ROSE, ATTORNEY, CENTER FOR LAW AND SOCIAL POLICY, WASHINGTON, D.C.

Ms. ROSE. Thank you, Senator Kennedy.

I would like to thank the subcommittee for the invitation to appear before it today, to testify on the bill to provide for the construction and modernization of health facilities.

My name is Marilyn Rose. I am an attorney and member of the bars of the District of Columbia and of the State of California.

Since mid-1966, I have been concerned with the legal problems of the poor and minorities in gaining access into the health system of the United States.

From mid-1966 until early 1968, I was the health civil rights attorney for the U.S. Department of Health, Education, and Welfare.

From October 1969 through February of this year, I was associated with the national health law program, which is the legal service back-up center concerned with the legal aspects of the health problems of the poor.

Currently, I am an attorney with the Center for Law and Social Policy, a foundation-supported public interest law firm, and have continued working in the area of legal aspects of health problems of the poor.

I also head health-civil rights task forces for the American Public Health Association and the Leadership Conference on Civil Rights.

In a more relative sense, I am sitting here as a surrogate representative of the many people I have met and have represented in court whose testimony would be much more dramatic than mine because they face these problems every day.

My testimony is a result of the experience and particular perspective that these positions and representatives have given me of the health problems of the poor and minorities, and of the failure of responsible Government agencies to enforce the legal obligations of health facilities to these persons.

The objective of my testimony is an improvement of the mechanisms by which these legal obligations should be enforced.

There are three premises upon which my testimony is predicated:

First, that the mainstream health systems in the United States has been built and expanded in major part during the past 25 years with Federal dollars under the Hill-Burton program, with specific contractual and statutory obligations to "afford a reasonable volume of service to persons unable to pay," and to "serve all persons in the territorial area;"

Second, that these commitments which lay moribund until discovered by legal service and public interest attorneys in 1970 are

still being ignored by the grantees of Hill-Burton moneys, and the agency charged with enforcing these obligations is proceeding without any clear direction, or conception of its regulatory function.

Third, and I think this is significant to you as a sponsor of national health insurance legislation, that until provision has been made to eliminate poverty as a barrier to the receipt of health services, these legal obligations to serve the poor must be enforced. They are all that poor people have.

Before discussing in detail the proposals which I suggest to meet the problems which I have encountered, let me give a brief background.

As I am sure this subcommittee is aware, the Hill-Burton Act was born out of the recognition that there was a serious deficiency in health facility resources across the United States during and immediately after World War II. At that time, some 40 percent of the counties across the country lacked any hospital beds, and a significant portion of the remaining counties were served by obsolete facilities.

The inability of localities to cope with the cost of building needed facilities was recognized across the political spectrum.

Groups as diverse as the American Medical Association and the CIO agreed with the concept of using Federal dollars to aid localities in constructing hospital facilities.

At that same time, President Truman proposed national health insurance, and the spokesman for that program in the Senate—Senators Murray, Wagner, and Pepper—argued for the inclusion of national health insurance as an indispensable part of any package of Federal health legislation.

The coalition of forces which supported Federal aid for hospital construction in 1945 did not coalesce around adding national health insurance to the legislative package.

Instead, during executive sessions of the Senate subcommittee, there was added to the Hill-Burton bill the provision that grantees would, as a condition of each grant, agree to provide a "reasonable volume of services to persons unable to pay."

This clause might be viewed as the "sop" given to the Senate liberals rather than national health insurance. It might also be viewed as reflecting the traditional notion of the non-profit hospital as a charitable institution, which serves both rich and poor.

Significantly, Senator Robert Taft noted at the time that:

I imagine every hospital of a general nature would be lucky if they did not have 20 percent of indigent patients.

In the next quarter, the Hill-Burton program aided over 6,000 health facilities in the United States, producing over 35 percent of the general hospital beds existing in the United States today.

Everyone of these grantees, some of whom received multiple grants, made commitments to afford a reasonable volume of services to persons unable to pay and to provide a community service by being available to all persons in the territorial area.

However, the sophistication of modern medicine and the uncontrolled growth and often duplication of expensive health services

in these institutions helped contribute greatly to the escalation of costs.

For those institutions looking to cut costs, the most vulnerable department was not that new coronary unit to compete with the new suburban hospital but outpatient clinics and other services for the indigent.

Where did the service to the indigent of which Senator Taft spoke go?

In mid-1972, after litigation forced HEW to promulgate some standards and guidelines for the enforcement of these free care commitments, upon the request of HEW the American Hospital Association did a survey of nonprofit hospitals which received Hill-Burton moneys. A questionnaire was sent to every 10th hospital in its list of 2,267 nonprofit hospitals which received Hill-Burton moneys.

The responses to this questionnaire revealed that 70 percent of the hospitals did not provide free service equivalent to 3 percent of their cost of operations after deductions for medicare and medicaid reimbursement, and over 40 percent provided less than 1 percent.

These, most significantly, are the figures they give. It is their own interpretation of when the unpaid-for service, was free service, including write-off of old debts. We can assume they would maximize the figures.

Senator KENNEDY. Have you examined those 2,267 forms?

Ms. ROSE. I have never seen them, and I do not even know if Dr. Graning has seen them.

It has never been clear to me whether these figures were contained in a formal report AHA gave to Dr. Graning.

Senator KENNEDY. Have you ever requested to see them?

Ms. ROSE. I do not know if I ever specifically requested to see them. I have taken Dr. Graning's oral report at face value.

Indeed I think the actual statistics may be worse, but at least those figures confirmed what we already knew from our experiences.

We can furnish case after case of the horror stories, from New Orleans to Los Angeles, from eastern Kentucky to Colorado. In the interest of time, I shall confine my special horror studies to two cases, which are contained in the appendix to this statement. These stories are by no means atypical. Similar stories have been reported by legal service attorneys across the country.

Moreover, even for those poor covered by medicare and medicaid, there has been a similar lack of access.

We have encountered Hill-Burton hospitals using as a preadmission deposit the medicare deductible, which I think now is \$134 for both part A and part B; \$134 for somebody living on social security benefits is a total barrier.

We have encountered Hill-Burton hospitals which refused to participate in medicaid or provide only minimal services to medicaid beneficiaries. Not until the U.S. District Court for the Eastern District of Louisiana ruled in 1973, did HEW even begin to consider that the community service obligation of Hill-Burton required non-discriminatory access to medicaid and medicare beneficiaries into Hill-Burton constructed facilities.

Even after 1 year, HEW has still to follow that court order.

They just bounce back and forth in the bureaucracy, a most minimal proposed regulation; there has been no enforcement action.

Ironically, the lawsuits which forced HEW to promulgate more specific standards and guidelines have thereby created new barriers to enforcement of the obligations.

The very creation of the administrative apparatus raises the spectre of primary jurisdiction, that is, that complaints must be brought and processed by the administrative agency with only limited review in the court. This result would not be a major problem if the agency, in fact, recognized that it had a regulatory function and exercised it.

I heard Dr. Granning testify that maybe only one or three people were operating it.

However, the regulations themselves are, in the first instance, inadequate and, in some instances, of questionable legality.

Further, even these inadequate regulations are meaningless, because the concept of enforcement is lacking.

HEW has left enforcement responsibilities in the hands of grantors of money, rather than assigning these responsibilities to regulators. The significance of this failure is measured in the minimal activities which have followed.

Senator KENNEDY. What would you do if you had your choice?

Ms. ROSE. My statement gets into this.

I would set up a regulatory agency along the lines found in title VI of the Civil Rights Act that attempts first to get voluntary compliance.

If that fails, then there is specific enforcement action the agency must take.

I would also have the provision found in title VII of the Civil Rights Act, which allows the individual complaining parties, if nothing occurs within 6 months, to go to court. I think it is the only way really to have enforcement of these obligations.

I will try to skip over the rest of my statement and just insert it for the record.

I think it is clear from your questions to HEW and their answers that HEW does not really know what has been done.

We also note that it is really difficult for us to find out what has happened.

First, only after HEW informed the State agencies in March 1974 that they would not be able to spend the recently released Hill-Burton moneys unless they had approvable amendments to their State plans dealing with "free service" did many States finally get around to "finalizing" "free service" amendments.

Reports from legal service attorneys and our own review of the files of HEW in mid-May indicate that a large number of States have not filed any amendments on the "free service" subject, and others have only recently filed such amendments.

Incidentally, Hill-Burton moneys were impounded until December 1973.

The States were told in March 1974 that they would not be able to spend the money when released unless they had approvable amendments to their State plans dealing with free service. That came

about because we wrote to them and asked them what they were going to do about it.

The vast majority of the States had not amended their plans. They were sitting on them, and they were doing nothing. And reports from legal service attorneys around the country, and our own review of the files at HEW, indicate there are still a large number of States that have not filed amendments.

Third, and this is very significant, a significant number of States have submitted amendments which have been approved, but these approvals are meaningless because they do not even approach compliance.

I have attached appendices—and my footnote 13 goes into this.

In my review, I just took the first two off the pile, so I picked on Alabama and Arkansas, and I find on the face of them there are provisions that are illegal. They are meaningless, but HEW has approved them.

Senator KENNEDY. What sort of things?

What do you mean by that?

Ms. ROSE. For instance—let me get into the footnote.

HEW recognizes those people covered by medicaid are not supposed to be included as “free service” people.

However, the Arkansas plan identifies medicaid beneficiaries as people to be included. Therefore, if a hospital in Arkansas had 3 percent medicaid patients, they would not have to treat anybody free.

The Alabama plan clearly states no sanctions whatsoever. The HEW regulation requires the States to provide specifically what each would do if noncompliance is found. Alabama states that it will report to HEW, and leave the matter to HEW.

There is something else in the Alabama plan which clarifies, I think, why so many hospitals, to Dr. Graning’s surprise, are checking the box that they would turn no one away.

The Alabama plan and many others do not require the hospitals that check that box to send any detailed budget information. All you have to do is check that, and that is all you have to do. There is no way for the State agency to get what they require, i.e. the information of how many poor people were actually served.

We may have that hospital up in Scarsdale you refer to that may be far away from poverty areas. We may have hospitals only 3 or 4 miles away from a poverty area, just enough that people are not going to come to its emergency room, and far enough away that it can check that box.

Unless it really had an open door, nothing would happen.

Senator KENNEDY. Are you suggesting that some of these plans, just on their face, violate the regulations that have been established by HEW?

Ms. ROSE. Yes, on their face, I do. And, as I said, I took the first two off the pile, and I have them attached.

To some extent, I think we can go through all the ones we have gotten. The thing is that the records that are in Rockville are incomplete, and they are incomplete because many States have not submitted anything.

Senator KENNEDY. The testimony is they just not have gotten to California.

Ms. ROSE. That is not true. That is not what we have found.

It is my understanding that California takes the position until it passes State implementing laws, there is nothing that it can do. But we have found that many States have submitted the most limited amount of paper, and it is marked approved.

We only went by what they said, and then they have done nothing else.

As recently as April 1974, my legal service colleague in New York was told by the New York administrator that a letter was sent to all the hospitals in New York, asking which one of the three guidelines each hospital would follow, and that is all he intended to do.

That is one of the States where we brought a lawsuit, and in that lawsuit, in the *Corum v. Beth Israel* case, the Judge stated that the State agencies have the responsibility not only to determine the quantum of services but to determine the needs of the community and decide what kinds of services should be given.

The suit was brought because Beth Israel closed its outpatient department to people who could not pay, who were covered by medicare or medicaid, so the indigent who had no insurance or no coverage were completely foreclosed.

Judge Lasker said the State agency had a responsibility to look at this. Yet, in April 1974, the person who runs the program in New York told the lawyer in the *Corum* case that is not what they understood; they had gotten no direction from HEW in this regard, and they were not doing anything about it.

Our review does not focus upon the inadequacies which are generated by the HEW regulation itself.

My "favorite" is that of "public notice."

That is a real catch 22.

Now, I think Dr. Graning and Dr. Edwards talked about the poor consumers being given an opportunity to comment when the plan is submitted, that they can make their comments because there will be a notice in the newspapers giving them such an opportunity.

I do not know about you, Senator, but I have yet to see a notice in the Washington Post or the Washington Star about the hospitals in the metropolitan area that are Hill-Burton hospitals. Possibly there has been notices buried in the legal notice section, and I do not know who reads the legal notices.

But, in other States, I have seen copies of them, and that is where they are put.

My request to the District of Columbia agency to publish notices where poor people may see them has gone unheeded. And what about the poor person who happens to show up at one of these Hill-Burton hospitals?

Under the HEW regulations, in most instances followed verbatim by the States, the poor person shall only learn about free services if he happens to request a copy of the Hill-Burton free service requirements from the hospital.

How one who is unfamiliar with the regulation knows about it is not clear. Catch 22 all the way.

I have a very interesting story of a welfare rights organizer who was very much into this, who went to the GW emergency room in an emergency situation, and she was asked, "Well, what money do you have?"

Because she was a little bit up with this, she had a copy of the Hill-Burton Project Register, which I had given her, and she pulled out this register and started telling them her rights. They "hustled" her off very quickly to a separate examining room.

I am not saying this is not what would have happened in any case, but this was just one person who knew the obligation of the hospital; most poor people do not know, and there is no way that the legal service network has been able to get out to the community this kind of information.

I suggested to HEW that they require every hospital to publish this, to have an announcement on their bulletin boards informing people of their rights. But HEW and the States and the hospitals are not requiring this.

There are a few States that have done this, that have responded to the local legal services' pressure, and their plans are a little bit better, and this notice is one I have seen in a couple of the plans.

Overall, we have found the regulations to be very ineffectual.

I have already mentioned New York. I have also found inadequacies in Louisiana and in the District of Columbia. These are also States where, because of the litigation, you would think there would be a little consciousness raising in the State agency, but those States still have inadequate plans, and there is lack of enforcement in the States.

Many of the States do not even have legal service programs so that they cannot get into the major law reform that one of these law-suits takes.

I can almost correlate from the plans I have looked at the degree to which there has been legal service action, and in those States plans are better. However, in all cases enforcement is lacking at both the State and HEW levels.

Whatever the intention of the draftsmen of the regulation, this procedure has become a sham, and I have already stated I would suggest a more regulatory mechanism along the lines of title VI and title VII, and that responsibilities be assigned by the Office of the Secretary to that kind of mechanism, and not to people who are grantors rather than regulators.

I have a few more comments I would like to make about the bill.

I agree with the thrust of the bill to limit construction grants to outpatient facilities and modernization grants either to outpatient facilities or to other health facilities which will serve medically underserved populations.

The former is a continued recognition by this Subcommittee of the emphasis which should be placed upon ambulatory rather than in-patient services.

The latter is, I assume, a recognition that inner city hospitals, most often those which serve as both physician and hospital to ghetto residents, are the most in need of modernization while so many cities have their own financial crises which prevent them from supplying the needed funds.

Although there may be hospitals in rapidly growing suburbs needing such funds—such as the rapidly growing new communities—I do believe that the inner city hospitals which serve those poverty populations should be given a priority to receive the modernization funds. New suburbs and new communities have greater borrowing power than impoverished innercities.

I suggest that the bill be so amended to make this intention clear.

You asked Dr. Graning several questions, as to what occurred with the 1970 amendments. I have a great deal of disagreement with Dr. Graning as to what occurred.

In 1970, this committee very strongly endorsed the concept of having poverty areas getting a priority for health facilities, the model was the neighborhood health centers that were set up by OEO.

The intention is very clear in the legislative history of the hearings of this committee and of the testimony of several Senators who testified, including yourself, as I recall, and Senator Javits and Senator Percy. What has happened, in fact, is that vast portions of that money have gone elsewhere.

Dr. Graning talked about that without regulations, and with the Census Bureau information they could not identify poverty areas.

They themselves proposed regulations locked into the Census Bureau. That, again, is a Catch 22.

I think one can identify a poverty area without going to the Census Bureau, and I know the California State agency personnel told me they proposed to HEW that they use alternative data they had available, and the idea was rejected.

I just sort of shake my head when I hear this Catch 22 kind of argument. What happened with the 1971 money is that it was virtually all used—I use the term “ripped off”—by other types of institutions.

Some 24 of 53 State agencies transferred virtually all of their outpatient money to other types of facilities. Even in the States that did not transfer their money—for instance, the State of Georgia was one, the money did not get into poverty areas.

Their outpatient facilities went to suburban hospitals in 1971—and we obtain that information because, after many months of frustration with HEW, we sent out our own questionnaire, and it is amazing the degree to which you will get people to answer questions, even to somebody they identify as a gadfly.

On the basis of the answers they gave us, 11 of 14 of the States giving detailed information indicated they had illegally spent their 1971 money.

Senator KENNEDY. What do you mean by illegally spent their 1971 money?

Ms. ROSE. If there is supposed to be a priority for poverty areas, and we get the answer that they did not award the money to poverty areas because they did not have enough information about poverty areas, and because Dr. Graning said they could ignore these poverty areas until the Census information came out, and if the grantees they list are all in the suburbs, we believe that this is illegal.

We have made an issue of this in a case here in the District of Columbia.

We have also seen money transferred. There are transfer provisions in the Hill-Burton Act, but they are restricted—and, for instance, new hospital construction can only get money for modernization. That category cannot get money except a maximum allocation of \$300,000 from the outpatient category.

But the State of Minnesota, for instance, told us it transferred money from the outpatient category to modernization. Then it transferred the modernization to new hospital construction. And with its 1971 outpatient money, it built two new hospitals or aided in building two new hospitals.

That is what we believe to be illegal.

There is one more provision I would like to refer to. It is section 605. I think it is technical assistance.

We think that is very important.

We found—and I think you asked the very correct question of Dr. Graning—many of the members of the National Association of Neighborhood Health Centers told us they never even knew the money existed until we sent out information and told them so.

These State agencies did not reach out to the communities. They did not inform the communities. They dealt with people that they always deal with, which are the hospital administrators, and then they said no one applied.

Nobody applies if you do not tell them the money exists.

I have attached to my statement the affidavits from two of the experts who helped put together the Neighborhood Health Center programs of OEO with great success, and their comments are the comments of everyone I have talked to who ran the program.

They said it is absolutely necessary to have outreach, and it is absurd to think of anything else.

I would like to express my disagreement with two statements made by Dr. Gehrig. One of them is set forth in his statement.

Dr. Gehrig would continue the Federal Hospital Council with the extraordinary power of approving or having a veto power over Federal regulations.

We have found nothing of this kind in existence. It is amazing.

The Secretary proposed regulations on the free service issue. The Council demanded that two provisions be put into those regulations, the 20-year restriction Dr. Gehrig talked about, and that there be an absolute maximum of the service—the 3 percent of cost and 10 percent to the grant, whichever is less—and the Secretary, in order to have the regulations become final had to agree with what the Council demanded.

The Council members are essentially private people. They are consumers and health providers. There are two hospital administrators on the current Council, whose hospital has Hill-Burton grants, so it is to his own self-interest that the regulations be limited.

I think if the shoe were on the other foot, Dr. Gehrig would say it was astonishing to have six members of the National Welfare Rights organization demanding 20 percent of the hospitals' patients have to be served free.

I think it should be looked at on both sides. We do not think anybody in a private capacity should have this power.

We also think a 20-year restriction put in by a hospital council is clearly illegal, and if it is not illegal, it is very bad policy.

I think other parts of the Hill-Burton Act contemplate these facilities going on for 50 years. They have to give assurance to HEW that they will have a fee for 50 years in order to continue.

I think this is very wrong to have this restriction; we have hospitals built in 1952 that never gave free service; the grant being over 20 years old when the regulations came in, HEW now says, "We cannot enforce anything against them."

Senator KENNEDY. Have you done any kind of evaluation of these three, the open door policy, the 10 percent of Federal Government, and 3 percent of operating costs, to draw any conclusions as to which is being used, which is not being used, the reasons for it, the reasons where it is being used?

Ms. ROSE. Senator Kennedy, systematically I have not, but in reviewing and seeing the reports—we sent out a questionnaire—that is what we can do in monitoring—we have seen the States that have the greatest number checking the open door are those States where there is no legal service available and therefore no enforcement action by poor people.

By checking that box, by not reporting to the State agency what they really do, by having no compliance, they have just gone back to doing what they did in 1947.

As for the hospitals that picked the 3 percent or 10 percent, (they pick whichever one is less), and we find maybe it would be the hospital in the innercity where there is some community action and they want a maximum.

Senator KENNEDY. I wonder if we asked GAO to do a study of that, to find out what action is really costing in terms of particular provisions, whether that might be helpful.

Ms. ROSE. Senator, I think that would probably be a very good idea, and I think there should be a couple of specifics clearly covered, including the degree to which the services are really write-offs of old bad debts or charitable service of the known indigent. That is a very important ingredient.

Senator KENNEDY. I think we will do that. Maybe it will be helpful to us just in terms of developing a request.

Maybe our colleague from New York will join in that so we have a nonpartisan approach.

Thank you very much. Your testimony has been very stimulating and also very troubling.

I see Dr. Graning is here. I wonder if I could ask him to respond at this time, but we are going to send over the testimony and ask you to make what comments you would like.

Dr. GRANING. We would be very pleased to, sir.

Senator KENNEDY. Very good.

We will make that a part of the record.

[The prepared statement of Ms. Rose along with the comments received from Dr. Graning follows:]

STATEMENT OF MARILYN G. ROSE TO THE
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE
ON LABOR AND PUBLIC WELFARE, U.S. SENATE,
June 14, 1974, ON S.3577, A BILL TO AMEND
THE PUBLIC HEALTH SERVICE ACT TO PROVIDE
FOR ASSISTANCE FOR THE CONSTRUCTION AND
MODERNIZATION OF HEALTH FACILITIES

I would like to thank the Subcommittee for the invitation to appear before it today, to testify on the bill to provide for the construction and modernization of health facilities. My name is Marilyn Rose. I am an attorney and member of the Bars of the District of Columbia and of the State of California. Since mid-1966, I have been concerned with the legal problems of the poor and minorities in gaining access into the health system of the United States. From mid-1966 until early 1968 I was the health civil rights attorney for the U.S. Department of Health, Education and Welfare. From October 1969 through February of this year I was associated with the National Health Law Program, which is the legal service back-up center concerned with the legal aspects of the health problems of the poor. Currently I am an attorney with the Center for Law and Social Policy, a foundation-supported public interest law firm, and have continued working in the area of legal aspects of health problems of the poor. I also head health-civil rights task forces for the American Public Health Association and the Leadership Conference on Civil Rights

My testimony today is a result of the experience and particular perspective that these positions have given me of the health problems of the poor and minorities and of the failure of responsible government agencies to enforce the legal obligations of health facil-

ities to these persons. The objective of my testimony is an improvement of the mechanisms by which these legal obligations should be enforced.

There are three premises upon which my testimony is predicated:

(1) that the mainstream health system in the United States has been built and expanded in major part during the past twenty-five years with Federal dollars under the Hill-Burton program, with specific contractual and statutory obligations to "afford a reasonable volume of service to persons unable to pay" and to "serve all persons in the territorial area";

(2) that these commitments which lay moribund until discovered by legal service and public interest attorneys in 1970^{1/} are still being ignored by the grantees of Hill-Burton monies, and the Agency charged with enforcing these obligations is proceeding without any clear direction or conception of its regulatory function;

(3) that until provision has been made to eliminate poverty as a barrier to the receipt of health services, these legal obligations to serve the poor must be enforced.

^{1/} See Comment, Provision of Free Medical Services by Hill-Burton Hospitals, 8 Harv. Civ. Rights-Civil Liberties Law Review, 351, 352-3 (1973); Rose, The Hill-Burton Act - The Interim Regulation and Service to the Poor: A Study in Public Interest Litigation, 6 Clearinghouse Review 309 (1972).

-3-

BACKGROUND

Before discussing in detail the proposals which I suggest to meet the problems which I have encountered, let me give a brief background. As I am sure this Subcommittee is aware, the Hill-Burton Act was born out of recognition that there was a serious deficiency in health facility resources across the United States during and immediately after World War II. At that time, some 40% of the counties across the country lacked any hospital beds, and a significant portion of the remaining counties were served by obsolete facilities.^{2/} The inability of localities to cope with the cost of building needed facilities was recognized across the political spectrum. Groups as diverse as the American Medical Association and the C.I.O. agreed with the concept of using Federal dollars to aid localities in constructing hospital facilities.

At that same time President Truman proposed national health insurance, and the spokesmen for that program in the Senate

^{2/} Hearings before the Committee on Education and Labor, U.S. Senate, 79th Cong., 1st Sess. (1945) on S.191, hereinafter "Senate Hearings - 1945". During the course of these hearings on February 26, 27, and 28, and March 12, 13, and 14, 1945, the dire shortage of hospitals (with 40% of the counties in the United States without any hospitals), the obsolescence of existing hospitals, the need for physicians to have modern hospitals in order to carry on the modern practice of medicine, and the appalling record of draft rejects from those areas suffering most acutely from those shortcomings created a unanimity of support for the principle of providing federal monies for construction purposes for nonprofit as well as public hospitals. Senate Hearings - 1945, pp. 10, 49, 76, 130-1, 177, 189-90, 237-8.

-4-

(Murray, Wagner, and Pepper) argued for the inclusion of national health insurance as an indispensable part of any package of Federal health legislation.^{3/} The coalition of forces which supported Federal aid for hospital construction in 1945 did not coalesce around adding national health insurance to the legislative package. Instead, during executive sessions of the Senate subcommittee there was added to the Hill-Burton bill the provision that grantees would, as a condition of each grant, agree to provide a "reasonable volume of services to persons unable to pay."^{4/}

This clause might be viewed as the "sop" given to the Senate liberals rather than national health insurance. It might also be viewed as reflecting the traditional notion of the non-profit hospital as a "charitable" institution, which serves both rich and poor.^{5/} Significantly, Senator Taft noted at the time that:

"I imagine every hospital of a general nature would be lucky if they did not have 20 percent of indigent patients."^{6/}

3/ Senate Hearings - 1945, see pp. 177, 190; Separate statement of Senator Murray attached to Senate Report No. 674, 79th Cong., 1st Sess., 1945, pp. 20-21.

4/ Compare Bill at beginning of hearings (Senate Hearings - 1945, pp. 1-5) with Bill as it appears in the Report of the Committee, October 30, 1945, Report No. 674, 79th Cong., 1st Sess., p. 9.

5/ See Eastern Kentucky Welfare Rights Org. et al., v. Shultz, et al., 370 F.Supp. 325, 331 (D.D.C., 1973).

6/ Senate Hearings - 1945, p. 190.

In the next quarter century the Hill-Burton program aided over 6,000 health facilities in the United States, producing over 35% of the general hospital beds; some 60% of the hospitals in the United States have some Hill-Burton money.^{7/} Everyone of these grantees, some of whom received multiple grants, made commitments to afford a reasonable volume of service to persons unable to pay and to provide a community service by being available to all persons in the territorial area.^{8/} However, the sophistication of modern medicine and the uncontrolled growth and often duplication of expensive health services in these institutions helped contribute greatly to the escalation of costs. For those institutions looking to cut costs, the most vulnerable department was not that new coronary unit to compete with the new suburban hospital but outpatient clinics and other services for the indigent.

Where did the service to the indigent of which Senator Taft spoke go? In mid-1972, after litigation forced HEW to promulgate some standards and guidelines for the enforcement of these free

7/ In the first twenty years of the program it produced over 424,000 inpatient beds, some 312,000 of which were in general hospitals. (Facts about the Hill-Burton program, July 1, 1947-December 31, 1968, U.S. Dept. of Health, Education and Welfare, Public Health Service, p.6). Hospitals, the Journal of the American Hospital Association, August 1, 1969 edition, listed some 5880 general, short-term hospitals in the United States in 1968, with 894,416 beds. As a significantly large number of the hospitals, however, only received part projects, sometimes for additions to existing facilities, a review of the facilities which received Hill-Burton funds indicates that over 60% of existing facilities have received Hill-Burton monies.

8/ HEW so acknowledged in Answers to Interrogatories in the case of Cook vs. Ochsner, Civil Action No. 70-1969 (E.D. La.).

-6-

care commitments,^{9/} the American Hospital Association did a survey of nonprofit hospitals which received Hill-Burton moneys. A questionnaire was sent to every tenth hospital in its list of 2267 nonprofit hospitals which received Hill-Burton monies. The responses to this questionnaire revealed that 70% of the hospitals did not provide free service equivalent to 3% of their "cost of operations" (after deductions for Medicare and Medicaid reimbursement); over 40% provided less than one percent.^{10/}

Thus the AHA's own survey confirms what the legal service and public interest attorneys had witnesses in various communities -- the virtual elimination of free and below cost care by non-profit hospitals. We can furnish case after case of the horror stories, from New Orleans to Los Angeles, from eastern Kentucky to Colorado. In the interests of time I shall confine my special horror stories to two cases, which are contained in the Appendix to this Statement. These stories are by no means atypical; similar stories have been reported by legal service attorneys across the country.

9/ See Rose, The Hill-Burton Act - The Interim Regulation, and Service to the Poor: A Study in Public Interest Litigation, 6 Clearinghouse Review 309 (1972). HEW implicitly acknowledged thus in the Preface to the Hill-Burton regulations issued in January 1972 (37 Fed. Reg. 182).

10/ See Comment, Provision of Free Medical Services by Hill-Burton Hospitals, 8 Harv.Civ.Rights-Civ.Liberties L.Rev. 351, 352, fn. 8. "In a survey of 187 hospitals, ten were providing no free services, sixty-eight were expending less than one percent of their operating costs (less Medicare and Medicaid costs) in the form of free services, fifty were contributing between one and three percent of operating costs, while fifty-nine (or 31.5%) of the hospitals spent more than three percent on free services. Letter from Harald M. Graning, M.D., Chairman of Federal Hospital Council to Lawrence A. Schneider, March 1, 1973, on file at the Harvard Civil Rights-Civil Liberties Law Review." At the November 14, 1972 meeting of the Federal Hospital Council Dr. Graning stated that this survey was done by A.H.A. at the suggestion of HEW.

Moreover, even for those poor covered by Medicare and Medicaid, there has been a similar lack of access. We have encountered Hill-Burton hospitals using as a pre-admission deposit the Medicare deductible, now well over \$100 for both Part A and Part B. We have encountered Hill-Burton hospitals which refused to participate in Medicaid or provide only minimal services to Medicaid beneficiaries. Not until the U.S. District Court for the Eastern District of Louisiana ruled in 1973, did HEW even begin to consider that the "community service" obligation of Hill-Burton required non-discriminatory access to Medicaid and Medicare beneficiaries into Hill-Burton constructed facilities. Even after one year, HEW has still to follow that Court Order. A most minimal regulation is still only a proposal and there has been no enforcement action.

ENFORCEMENT OF THE OBLIGATIONS

Ironically, the lawsuits which forced HEW to promulgate more specific standards and guidelines have thereby created new barriers to enforcement of the obligations. The very creation of the administrative apparatus raises the spectre of "primary jurisdiction", i.e., that complaints must be brought and processed by the administrative agency with only limited review in the Courts. This result would not be a major problem, if the Agency in fact recognized that it had a regulatory function and exercised it. However, the regulations themselves are in the first instance inadequate, and in some instances of questionable legality.^{11/} Further, even these inadequate regulations are meaningless, because

^{11/} The U.S. District Court for the Southern District of New York has held that the provision of the regulation which permits hospitals to delay making determinations of eligibility until after patients have been "billed" is invalid under the Act. Said the Court,

"If a hospital is not obliged to make a determination of indigency prior to the rendition of services, many truly indigent persons may incur liabilities to it in the hope of qualifying for free or below cost services, which they will later be hard pressed to pay if the hospital declines to treat them as beneficiaries of its Hill-Burton assurance on the ground that by the time of billing its requirement has been satisfied. Furthermore, plaintiffs argue, many such persons will be discouraged by the uncertainty of their status from seeking any medical assistance at all. The results suggested by plaintiffs as likely to flow from the regulation do not appear to us, as they do to the federal defendants, as a fantastical "parade of horrors." ... To the contrary, it is difficult to conceive how any other consequences could follow, or be expected to follow from it." Corum v. Beth Israel Hospital, Civ.Act.No.72-2654, Jan. 17, 1974, Order as amended April 30, 1974. HEW has not filed to date a Notice of Appeal, which is still timely.

the concept of enforcement is lacking. HEW has left enforcement responsibilities in the hands of grantors of money, rather than assigning these responsibilities to regulators. The significance of this failure is measured in the minimal activities which have followed. To the extent that we have been able to monitor the actions of the Federal and State Hill-Burton Agencies in the nearly two year period since HEW published its free care regulation,^{12/} we have found limited, reluctant action at best, and approval of non-action or questionable action to be the rule. HEW chose to place the principal enforcement responsibility upon the State Agencies, with some minimal supervisory responsibility remaining with it. The Federal regulation requires each State Agency to amend its Hill-Burton plan to provide certain standards and procedures, including:

- (1) setting forth the criteria for determining persons eligible, subject to the approval of the Secretary;
- (2) establishing a procedure for evaluation and enforcement, and for the investigation of complaints;
- (3) setting forth effective sanctions which may include license revocation, the termination of State assistance, and Court action.

The Federal regulation also provides that the State agency shall report, not less often than annually, its evaluation of each facility's compliance.

^{12/} HEW published the regulation as an "interim" measure on July 22, 1972 (37 Fed.Reg.No. 142), and as a final regulation with only minor changes in June 1973 (Fed.Reg.No.). It was effective by the terms of the interim regulation, on August 6, 1972.

-10-

A state-by-state analysis is difficult, for several reasons. First, only after HEW informed the State Agencies in March 1974 that they would not be able to spend the recently released Hill-Burton monies unless they had approvable amendments to their State plans dealing with "free service" (an action which was generated by our inquiry on the subject), did many States finally get around to "finalizing" "free service" amendments. Reports from legal service attorneys and our own review of the files of HEW in mid-May indicate that a large number of states have not filed any amendments on the "free service" subject and others have only recently filed such amendments.

Secondly, a significant number of States had submitted amendments, which in many instances were marked "approved", but did not even begin to approach compliance.^{13/}

^{13/} I have attached hereto copies of two such plans as examples. One, the Arkansas plan, totally lacks procedures for evaluation or for the investigation of complaints, and does not mention sanctions for violations. Although it sets forth criteria for persons ostensibly eligible for "free service", these are the persons eligible for "Medicaid", and the HEW regulation itself, recognizing them as the "paid-for" poor, excludes them from exclusion as free service eligibles. (See 42 CFR 53.111(f)(ii); they would be covered by the "community service" requirements).

The Alabama plan, which is marked approved by HEW, is more detailed, but equally unacceptable. It requires annual compliance statements and a financial report showing "uncompensated services" during the prior period, but excludes from that requirement hospitals which certify merely "that they will turn no one away." Its "plan" for evaluation and enforcement excludes any information from those hospitals which certify they will not turn anyone away. If the State Agency determines that a hospital is not in compliance, its sanctions consist of informing the Secretary "for any action he deems necessary", despite the requirement in the HEW regulation that each State employ sanctions.

-11-

Our review does not focus upon the inadequacies which are generated by the HEW regulation itself. My "favorite" is that of "public notice". Ask yourselves, Gentlemen, how many of you have seen either Notices of State Hill-Burton plans, or "free service" notices by individual Hill-Burton hospitals for hospitals in this area or your home states? Presumably in this area such notices have been published in accordance with the HEW regulation, buried deep into the legal notices section of the Washington Post and Washington Star-News, hardly the place where poor people needing hospital services are likely to look. My request to the D.C. Agency to publish notices where poor people may see them has gone unheeded. And what about the poor person who happens to show up at one of these Hill-Burton hospitals? Under the HEW regulation, in most instances followed verbatim by the States, the poor person shall only learn about free services if he happens to request a copy of the Hill-Burton free service requirements from the hospital. How one who is unfamiliar with the regulation knows about it is not clear. Catch-22 all the way.^{14/}

^{14/} At a very minimum it would appear appropriate that notices be posted at admittance desks and similar places in Hill-Burton hospitals. In E.K.W.R.O. v. Shultz, 370 F.Supp. 325, 331 (D.D.C. 1973), pending appeal, involving the obligation of IRS in granting tax exempt status to hospitals as "charitable" institutions while relieving them of obligations to serve the poor, the Court voided the IRS action, and ordered notices to be posted at every hospital eligible for tax exempt status as a condition of continued eligibility.

-12-

How effective has the regulation been over-all? In my experience not very. Ironically, even in those States where there has been litigation, and therefore one would hope some "consciousness-raising" on the part of State Agencies we have seen little understanding and action. In D.C., where one of the cases was brought, a number of the nonprofit hospitals were reported by the news media in 1973 to have gotten together and decided to limit service to indigents because the D.C. government did not pay them enough money. To the best of my knowledge no officials pointed out that these hospitals had received millions of dollars under Hill-Burton and the D.C. Hospital Construction Act with commitments to serve poor people. In Louisiana, where the lead case was brought, the State Agency admittedly permitted one of the more financially able hospitals to cut its obligation in half, because it believed that that was the only way to get an "agreement", ignoring the fact that a regulatory function has been assigned to it. In New York, where a Federal Court ruled that State Agency must determine the kind as well as the amount of service which must be afforded, the State Agency takes the position that that is not its understanding of the requirements of the regulation, and it has not received any instructions from HEW to that effect.

Whatever the intention of the draftsmen of the regulation, this procedure has become a sham. A regulatory function should be placed in a regulatory framework, and be administered by regulators. Having given some considerable thought to the subject,

we would suggest that the Secretary be empowered to enforce these commitments in a more formal manner, along the lines which are authorized by Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d); and further, that persons who are aggrieved may bring their own action in Federal Court, possibly after a lapse of time allowing HEW to act, along the lines which are authorized by Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e). I note that sections 610(b) and (c) of the bill do make provision for enforcement. However, those sections do not require APA-type hearings or actions by "private attorneys-general" as I am suggesting herein.

It should be noted that these suggestions for a more formal enforcement mechanism for the "free service" obligation also relate to the "community service" obligations of these hospitals. The U.S. District Court in New Orleans found that the commitments to serve all persons in their territorial area required non-discrimination against Medicaid beneficiaries. Even in a system of universal health insurance such discrimination may still be possible, and it may be linked more to "class" discrimination than to "racial" discrimination, which is covered by Title VI of the Civil Rights Act. Establishing such a mechanism would therefore provide a means to enforce the community service obligation of Hill-Burton hospitals beyond the day that national health insurance becomes a reality.

As noted in the beginning, as long as access to health care may be barred to the poor because of financial barriers, the legal obligations of facilities which were constructed with Hill-Burton monies should be enforced. That is the only way the poor can be part of the mainstream health system.

-15-

GENERAL COMMENTS

Before closing, I would like to make some general observations concerning various aspects of the Bill.

I agree with the thrust of the Bill to limit construction grants to outpatient facilities and modernization grants either to outpatient facilities or to other health facilities which will serve medically under-served populations. The former is a continued recognition by this Subcommittee of the emphasis which should now be placed upon ambulatory rather than inpatient services. The latter is, I assume, a recognition that inner city hospitals, most often those which serve as both physician and hospital to ghetto residents, are the most in need of modernization while so many cities have their own financial crises which prevent them from supplying the needed funds. Although there may be hospitals in other areas needing such funds (such as the rapidly growing new communities), I do believe that the inner city hospitals which serve those poverty populations should be given a priority to receive the modernization funds. New suburbs and new communities have greater borrowing power than impoverished inner cities. I suggest that the Bill be so amended to make this intention clear.

There are several provisions in the Bill which recognize the special needs of poverty populations. Section 601(c) permits 90% funding for facilities which will be located in poverty areas (and by virtue of §614(10)(c), must agree to serve the poverty

-16-

population); §601(a)(5) recognizes that poverty area facilities must rely upon Federal assistance programs and benefits in order to assure continued adequate financial support; §608(c)(3) continues the priority for poverty areas to receive construction and modernization monies for outpatient facilities. We agree with these provisions and support them. These provisions underscore the recognition that was given to the health needs of poverty areas by the 1970 Amendments to the Hill-Burton Act. The Hearings before this Subcommittee on those Amendments made clear the intention of Congress that the neighborhood health centers which were developed by the Office for Health Affairs of OEO and similar comprehensive health centers were principal potential grantees for such construction monies.^{15/} Unfortunately, our monitoring of the implementation of the 1970 Amendments revealed that much of the monies for fiscal years 1971 and 1972 were transferred out of the poverty areas and were given to suburban hospitals. There is currently a lawsuit on file in the U.S. District Court for the District of Columbia challenging various actions taken by HEW in this regard.^{16/}

^{15/} Hearings before the Subcommittee on Health of the Committee on Labor and Public Welfare, U.S. Senate, 91st Congress, 1st Session on S.2182 and H.R.11102 (June 12, 17, and 19, 1969).

^{16/} National Association of Neighborhood Health Centers, et al., v. Weinberger, et al., Civil Action No. 74-52.

Without the necessity of the Committee commenting upon the merits of the lawsuit (which is at a very early state of discovery) it would seem appropriate to make doubly clear that the Sub-committee does not intend that the Agency ignore the poverty priority.

There is one provision of this Bill which shall certainly assist in assuring that poverty area grantees receive this money. That is §605 which provides for technical assistance to grantees and outreach activities. We believe that such concepts were implicit in the original amendments. Indeed, the Office of Health Affairs of OEO recognized that concept in developing the neighborhood health centers without specific, detailed direction by Congress. I have included in the Appendices the Affidavits of two of the key physicians who helped develop the neighborhood health centers; these Affidavits (which were submitted to the Court in the NANHC v. Weinberger case) demonstrate the importance of technical assistance and outreach. I think that this Sub-committee should make clear to HEW that this is what they intended in 1970, and that this provision is a reaffirmation of such intentions.

There is one provision which is ambiguous and might be construed to deprive poverty areas of the benefits otherwise intended. Section 604(b)(5) provides reasonable assurance from grantees that adequate financial resources will be available after completion of the project. There is a parenthetical clause which recognizes that in a poverty area such assurance relies upon Federal assistance. This intention should be made clear. As written it may be viewed as more onerous rather than deeming such assistance as the equivalent of reasonable assurance of maintenance and operation monies.

In closing, we note that the Subcommittee has placed the responsibility for promulgation of regulations upon a full-time public official, the Secretary of H.E.W. That departs from the present provision, in the law since its original enactment, that placed a veto power over regulations in the Federal Hospital Council, a group of persons who are essentially private individuals with fulltime employment which often places them in a conflict-of-interest role with their occasional public responsibilities. This power raised serious constitutional issues. We have been unable to identify any similar body of private parties being delegated such legislative authority. We agree with the elimination of this anomalous delegation of power.

Again, I would like to thank the Subcommittee for the opportunity to testify before you today.

APPENDIX A

Colloquy between Senators Taft, Pepper, and Ellender, and Farm Security Agency Administrator Frederick Mott -- Hearings before the Committee on Education and Labor, U.S. Senate, 79th Congress, 1st Session (1945) on S.191, p. 190.

- Senator Taft: Let me suggest something else. You would say a hospital accepting aid of this kind should have an obligation to take care of a certain number of indigent patients. Most of them do, but I mean if they are going to have Federal money, should there not be a definite obligation to handle a certain number of indigent patients?
- Dr. Mott: Senator, I would think there would certainly be an obligation to meet the needs of all the people of that hospital service area for which the hospital was designed, which would of course, include many indigent and medically indigent.
- Senator Taft: In a city we have a general hospital into which the indigents ordinarily go, and a lot of private hospitals would also wish to expand and share in the fund. I think pretty near all of them do handle indigent patients. Where they are religious hospitals they handle patients of their own religion that are indigent. I wonder if there should be a requirement that a certain number of patients should be handled without charge in the same way?
- Dr. Mott: Of course, that might be a burden which an individual institution, as such, could not bear. This involves the whole question of welfare agency support and other organized methods of payment for hospital service.
- Senator Pepper: This is what occurred to me, Senator -- if you allow me to interrupt -- that in determining the burden which the hospital would be expected to carry, they might not be able to get Federal aid unless they agreed to take a fixed number of indigent patients.
- Senator Taft: That is what I mean. I imagine every hospital of a general nature would be lucky if they did not have 20 percent of indigent patients.
- Senator Ellender: If people in all locations were able to pay for hospitalization there would be no need for this bill. It seems to me that our primary purpose should be to devise means to take care of those who cannot take care of themselves. My reason for supporting a bill providing for Federal aid to build hospitals is to make it easy for the community in which a hospital may be built

Senator Ellender:
(cont'd)

to give aid to the indigent. Unless some method is provided whereby the indigents and those unable to pay for hospitalization can be taken care of, I would not be much interested in providing Federal funds to build hospitals in various parts of our Nation."

APPENDIX B

Case Studies of Poor Persons Denied Access into Hill-Burton
Constructed Hospitals.

Clifford Breaux - The first of the Hill-Burton lawsuits was filed in New Orleans, against ten hospitals, in July 1970. It is styled Cook vs. Ochsner, and the original opinion is reported at 319 F.Supp.603. However, as originally drafted the first named plaintiff was a 57 year old Black man, suffering from congestive heart failure, who died before the Complaint was filed. On five occasions from mid-May until mid-June, the Breaux family attempted but could not get him admitted into Charity Hospital of Louisiana at New Orleans. The over-crowded conditions at that Charity hospital results in 35 to 50 persons a day, who, in the opinion of the admitting physicians, would ordinarily be admitted as in-patients at private hospitals, not getting admitted. (See Affidavits of Drs. Mary, Lauro, Yeager, and testimony of Dr. Lauro, in the case Cook vs. Ochsner). On one of these occasions the intern on duty got the Breaux family in contact with the local legal service program. In mid-June Mr. Breaux's brother borrowed \$200 and got him admitted into Ochsner, which had refused him admission a few days earlier because of lack of money. He died in Ochsner Hospital; his autopsy report reads like a compendium of medical illnesses. Two years later, while in the course of discovery in the case, and utilizing the general authorization given to us by Mr. Breaux to examine his medical records, we inspected the records of Ochsner. In Breaux's file we discovered that he had been a patient of one of the Ochsner Clinic physicians who had on the 1st of May, before he ever attempted to get admitted to Charity, written:

B-2

"This patient needs to be hospitalized and he can't afford OFH. Will write a letter to Charity Hospital and hope that they will take him. /s/ Hatch, M.D."

Pikesville Methodist Hospital - Pike County, Kentucky is in the poverty belt of Appalachia. The 1970 Census reports that 32% of the population lived on incomes below the OEO poverty guidelines. The only hospital in the County is a new facility built with Federal monies under the Hill-Burton and supplemental monies under EDA or the special Appalachian program. When officers of the Eastern Kentucky Welfare Rights Organization met with the Administrator of the Pikesville Methodist Hospital in June 1971 to discuss the hospital's policy on service to the poor they were told that "the Pikesville Methodist Hospital treats Floyd County people just like they treat Pike County people - if they don't have the money, they don't get in." (Affidavit of Eula Hall in E.K.W.R.O. v. Shultz, 370 F.Supp.325). In August 1972 Lards Collins, a disabled miner living on social security disability benefits was sent by his physician to Pikesville Methodist to be admitted for a gall bladder operation. He was told that he had gallstones and could bleed to death. When he told the hospital that he had only \$80 a month income and no health insurance, they refused to admit him. When he asked what would happen if he died, he was told that this physician was not running the place. (Affidavit of Lards Collins in EKWRO v. Shultz, 370 F. Supp.325). Ironically, IRS

B-3

(which is the Defendant in the EKWRO case) itself has supplied the overall figures of Pikesville Methodist's treatment of the poor - in a county where 32% of the population lives below the poverty guidelines, it admittedly served only 24 free inpatients out of 8,110 patients in its fiscal year which ended on September 30, 1972. (See letter of Pikesville Methodist, sworn as an affidavit, to IRS, filed in EKWRO v. Shultz, 370 F.Supp.325).

Regional Health Director, HR
HRA/Facilities Planning
Attn: Regional Program Director
Dallas, Texas

APR 4 1974

Public Health Advisor
Office of State Plans, DFU

Section in State Plans on Administration of the
Reasonable Volume of Care

This office has reviewed your recently submitted copy of the Arkansas proposed amendment to its State Plan regarding subject matter. We concur with your appraisal of its acceptability as an approvable section.

Henry S. Desjarlais

OSP:HDesjarlais/4/4/74/bjd
cc: Dr. Graning
Mr. Desjarlais

(Recd 3/25/74) RO 6 - Arkansas.

Amendment No. 1 to the Arkansas Fiscal Year 1973 State Plan
approved 6/26/73. AMENDMENT NO. 1

Arkansas

FY 73 ARKANSAS STATE PLAN FOR THE CONSTRUCTION OF HOSPITALS AND RELATED
 FACILITIES
 Revised 7-25-73

Community Service; Service for Persons Unable to Pay

The State Agency shall discharge the duties and responsibilities required of State Agencies as specified in Volume 37, Number 142 of the Federal Register dated Saturday, July 22, 1972. The aforementioned issue of the Federal Register is attached and made a part of this Amendment.

The following criteria shall be used to identify persons unable to pay for services and it is pointed out that these criteria include persons who are otherwise self-supporting but unable to pay the full charge for needed services:

1. The health and medical care insurance coverage, personal or family income, the size of the patient's family, and other financial obligations and resources of the patient or the family in relation to the reasonable cost of the services;
2. Generally recognized standards of need such as The State Standard for the Medically Needy as determined for the purposes of the Aid for Families with Dependent Children Program. Where these criteria are used the standard of need shall be adjusted upward making the "unable to pay 150%" column on the attached the applicable criteria.

The following group of persons are generally considered eligible

for care under the program:

- a. Recipients of Old-Age Assistance (OAA), Aid to the Blind (AB), Aid to the Permanently and Totally Disabled (APTD), and Aid to Families with Dependent Children (AFDC).
- b. Persons who would be eligible for OAA, AB, APTD, OR AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.

DEPT OF
 ARKANSAS
 HEALTH SERVICE

APPROVED
 JUN 26 1973

Date JUN 26 1973
 by [Signature]
 Regional Health Director

CRITERIA FOR IDENTIFYING PERSONS UNABLE TO PAY FOR SERVICES

Criteria Used is the Arkansas SS Manual, 1-15-73, 2322, 2322.1.2, 2322.2, 2322.3

AFDC	STANDARD OF NEED	UNABLE TO PAY 150%
1 adult and 1 child	\$199	\$299
1 adult and 2 children	243	365
1 adult and 3 children	287	431
1 adult and 4 children	331	497
1 adult and 5 children	375	563
1 adult and 6 children	419	629
1 adult and 7 children	463	695
1 adult and 8 children	507	761
2nd adult - add \$60		

Rec. 4/8/74. R.O. IV - Alabama.
R.O. has approved.
Page 1-19-a of 27 Pages

Alabama, 1973
Approved

Section O - Service for Persons Unable to Pay

- 115.1 Reference. Federal Regulation 53.111.
- 115.2 Applicability. All recipients of Hill-Burton grant funds for the past 20 years and all future recipients of loan and/or grant funds will be required to provide "Services for Persons Unable to Pay".
- 115.3 Assurance. Prior to and as a condition of approval of an application for a Hill-Burton Grant and/or Loan, the applicant must give assurance that the facility to be constructed or modernized will provide a reasonable volume of services to persons unable to pay therefor.

115.4 Definition. "Reasonable volume of services to persons unable to pay therefor" means a level of uncompensated services which meets a need for such services in the area served by an applicant and which is within the financial ability of such applicant to provide.

115.5 Presumptive Compliance Guidelines. A facility is presumed to be in compliance upon certification to the State Agency that it will provide "Services for Persons Unable to Pay" the volume of such services having been determined by one of the following three methods:

a. Certification that the facility will not exclude any person from admission to the facility on the ground that such person is unable to pay for needed services and that needed services will not be denied after admission.

b. Submission of an annual budget for the support of, and make available on request, uncompensated services at a level not less than 3% of operating costs for that year after medicare and medicaid reimbursement have been deducted.

c. Submission of an annual budget for the support of, and make available on request, uncompensated services at a level not less than 10% of all Federal assistance provided to or on behalf of the applicant under the Hill-Burton Act.

115.6 Periods of Commitment. Any applicant who has heretofore given or hereafter will give the assurance required in Paragraph 115.3 commits himself for the period set forth below:

J a. Grant. Twenty (20) years from the date of completion of construction or modernization of a facility for which Hill-Burton funds have been paid.

b. Direct or Guaranteed Loans. The life of the loan from the date of completion of construction or modernization of the facility for which loan funds have been paid.

115.7 Compliance Report Required. Annually after the initial selection of the method of compliance and not later than 120 days after the end of its fiscal year, a facility to which this regulation is applicable will file with the State Agency the following documents:

J a. The official admission policy adopted by the hospital authority. This policy shall include inpatient, outpatient and/or emergency patients.

b. The official selection of one of the three (3) presumptive compliance methods for the ensuing year.

c. If the facility selects presumptive Guideline two (2) or three (3), Paragraph 115.5, then it must submit the following:

1. The proposed budget for the ensuing year setting forth the funds to be made available for services for persons unable to pay.

2. A copy of the audited or unaudited financial statement for the preceding year. If an unaudited statement is forwarded it will be replaced immediately upon completion of an audit for that period. The financial statement will set forth the amount of uncompensated services provided during the period covered.

3. If the level of services provided is less than that which was budgeted, the facility will also submit:

- a. A justification for the lower level of services.

- b. A description of the steps it proposes to take to bring to the attention of the public the availability of such uncompensated services and the conditions of eligibility.

- c. The criteria established by the facility for identifying "Persons unable to Pay for Service".

- d. Any other material deemed appropriate by the facility, the State Agency, and/or the Secretary, DHEW.

115.8 Criteria for Identifying "Persons Unable to Pay for Services." Identification of "Persons Unable to Pay for Services" will be the responsibility and prerogative of each facility to which this regulation is applicable. Each facility will establish its own list of factors to be considered in reaching its decision as to the ability of an individual to pay for services. Each case will be different and should be judged on its individual merits taking into consideration all information presented by that individual. The following items will be included in the list of factors arrived at by the facility but should not be considered all inclusive.

A. Income

1. A basic tool for consideration of ability to pay is income. The OEO Poverty Income Guidelines will be used as the basic poverty income guide.

<u>Family Size</u>	<u>Nonfarm Family</u>	<u>Farm Family</u>
1	\$2,100	\$1,800
2	2725	2325
3	3450	2950
4	4200	3575
5	4925	4200
6	5550	4725
7	6200	5275

For families with more than 7 members, add \$650 for each additional member in a nonfarm family and \$550 for each additional member in a farm family.

2. Consideration must be given to those individuals whose income places them above the poverty level but who because of other financial obligations are unable to pay hospital bills. These "medically indigent" individuals must be given an opportunity to present their case for review.

- B. Size of Family. The size of the family must be considered in respect to the income. This will also be a consideration for the "medically indigent".
- C. Insurance. The availability of insurance does not in itself indicate ability to pay. The coverage provided will be considered along with the patient's other assets.
- D. Assets. An individuals assets other than income should be considered; however, it is not the intent of this regulation to force a person into poverty before they become eligible for assistance.
- E. Other Factors. Any other factor which will assist the facility in identifying persons unable to pay for services should be listed.
- F. Request for Criteria Factors. A copy of the criteria for identification of "persons unable to pay for services" will be make available to any patient or former patient and to any person seeking services from the facility who request a copy thereof.

115.9 Identification of Uncompensated Services.

- A. A facility may consider the following as uncompensated services for compliance purposes:
 1. Services provided to an individual when it has been determined that the individual meets the qualification for "persons unable to pay for services" and no collection efforts have been made other than the rendition of bills.
 2. The difference between medicare reimbursements and the actual operating cost of the entire facility as determined in accordance with applicable rules under Title XVIII of the Social Security Act.
- B. A facility may not consider the following as uncompensated service for compliance purposes:
 1. Any amount which the facility has received or is entitled to receive from the third party, insurer, or under a governmental program.
 2. Any amount that would be available under a governmental program in which the facility, although eligible to do so, does not participate.

115.10 Alternate Determination of Level of "Services for Persons Unable to Pay Therefor". If the facility does not desire to select one of the "Presumptive Compliance Guidelines", they may request in writing that the State Agency determine a level of uncompensated services for the facility. This determination will be made by the State Agency utilizing prior audits, future budgets, and other related documents. Prior to final approval, the level determined shall be made known to the general public and may be the subject of a public hearing. Final approval shall rest with the Secretary, DHEW.

115.11 Publication of Method of Compliance. Once the selection of the method of compliance with this regulation has been made and approved, the facility will be furnished a suggested notice to be published in a newspaper of general circulation in the area served by the facility.

115.12 Evaluation and Enforcement.

- A. The State Agency shall annually evaluate each facility as to its compliance with this regulation. The evaluation will be made from those items submitted in accordance with Paragraph 115.7.

- B. The State Agency shall, upon determination that a facility is not in compliance with this regulation, notify the Secretary, DHEW of the non-compliance for any action he deems necessary.

115.13 Reports.

- A. The State Agency shall annually report to the Secretary, DHEW, each facility's compliance with this regulation.
- B. The State Agency shall report the disposition of each complaint received against a facility with reference to this regulation.
- C. The State Agency shall report any legal action against a facility involving compliance with this regulation.

AFFIDAVIT

I, Robert Kalinowski, M.D., being duly sworn, depose and state as follows:

1. I am a graduate of Tufts University School of Medicine, and received my M.D. in 1959. I interned at Hartford Hospital (1959-61), spent two years with the U.S. Public Health Service (1961-63), then two years as Medical Director for the Peace Corps in the Philippines (1963-65), and completed a residency in anesthesiology at Hartford Hospital (1965-67).

Presently, I am an Associate Professor of Anesthesiology and Associate Professor of Community Medicine at Georgetown University, School of Medicine. I also am Senior Program Consultant for Ambulatory Care, Robert Woods Johnson Foundation.

2. From 1967 through 1971 I was employed by the Office of Health Affairs, Office of Economic Opportunity (CEO) in program development. From 1969-71 I held the title of Deputy Director for Program Development. The function of my office was to develop ambulatory health centers in poverty communities. With a staff of four employees (including myself), five regular and five sporadic consultants, we developed approximately fifty (50) neighborhood health centers and six "networks" in poverty communities in those four years, from rural poverty areas such as Beaufort-Jaspar Counties, South Carolina, to large urban ghettos such as the Cardozo section of Washington, D.C.. One thing these places had in common were poor people lacking sources for primary health services. (A "network" may consist of a central health center and multiple satellite facilities, which may or not be owned and administered by the central health facility.).

The purpose of the neighborhood health centers was to provide community-based, primary health care delivery systems or projects in areas with a paucity of such services for poverty level people.

3. From my experience in program development, as described below, it is clear that technical assistance, at several different stages in the development of a successful grant proposal from a poverty community, is crucial:

(a) Target Identification

Targets were identified in a variety of ways. In a major number of cases communities brought their needs to our attention after they had already begun organizing and developing a program locally; in other cases a community or regional office may have contacted us at a very early state with a minimum of development. In some instances a community's plight may have been called to our attention because of a combination of outside forces and the desires of important segments of the community that these problems be ameliorated. There was never a shortage of potential applicants for funds from eligible projects in poverty areas. In all cases technical assistance would be required if we determined that the particular project was feasible.

Feasibility depended, first, upon a community's own desire to upgrade its health system. Local priorities and a sense of local evaluation of needs are critical as a safeguard against imposition of standards beyond the local communities' desires. It is important, however, to emphasize that this policy did not reduce OEO's recognized ongoing responsibility to inform communities across the country with the availability of funds and assistance to develop neighborhood health centers.

A second element of feasibility was an early recognition whether the community's desires could be put into a project realizable through our program. This was not necessarily a limiting concept. For example, we developed not only transportation aspects of projects (i.e. where there were no roads, jeeps provided a method of transporting persons into health centers, and we would include in a program the provision for training drivers as well as obtaining the jeeps). However, in certain instances the basic concept was impossible. We recognized a responsibility of informing the community early of the nonfeasibility of the proposal. (One such instance was the rejection of a request to develop a mobile train unit in West Virginia).

The third element of feasibility depended upon the prior existence of some medical service within the community, e.g. solo practitioners or a hospital, even if these resources were not then serving that poverty community except on an emergency basis. Part of our responsibility in the early stages was to obtain input and collaboration with some part of the local medical community in the development of the project.

(b) Developing the Proposal

A significant number of projects already had some local impetus, and had contacted either us or our regional offices trying to ascertain the availability of funds. We did not need a formal application, and indeed, even with a project with a great deal of prior local development, sending out a cold package of application documents would turn off the local group. The governmental standards and criteria are so complicated, and changing, that to put together the right package takes a lot of sophisticated knowhow.

If the "proposal" appeared feasible, we would go into the community to help develop the project. I might be the one who would go, or a member of my staff, or a consultant. One of the first needs was to develop the right group, which necessarily meant people with credibility with the establishment but willing to work with the community group and able to interact with that group and get accepted by it. It was important to develop a group with the right mix of medical competence and community identity. A prototype of such a mix is the Cardozo project we put together here in Washington, with three groups -- Group Health Association, Howard Medical School and CHANGE (a community-based group).

Our consultants served the multiple functions of working within the community on developing a fundable application, providing back-up representation in Washington, and keeping abreast of the constantly changing status of monies, timetables, and grant criteria promulgated by Washington agencies. As plans crystallized, it became of increasing importance to identify those persons in the community with particular medical, administrative, and other skills who would be interested in long-range commitments to the program. A consultant would work with this group (be paid by OEO), who knew the grant game, knew the medical game, and knew what dollar amounts were reasonable and how much service such dollars would produce. Without such assistance there would not have been fundable applications.

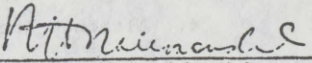
The grant application would be developed locally with assistance from OEO staff or consultants, then sent into headquarters and reviewed by me. I would send out a consultant who would proceed to work with the group in refining the proposal into an acceptable grant application. The consultant would usually be on-site 2 to 3 days a month for some 3 to 4 months. I might also go to the community during this process. It usually took 4 to 6 months to

complete the application. During this time the engineering branch at OEO would have also made preliminary judgments as to what it would take to renovate facilities.

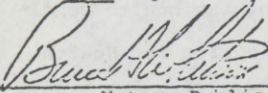
The acceptable project would then move "away" from the Program Development Branch to the Operations Branch. Operations would take over the project and help it through its start-up period. Operations also had its consultants, making on-site visits to assist in hiring a Medical Director, the Administrator, and other key personnel, and help with the process of informing the community of the Neighborhood Health Center and what it had to offer the community in health services.

4. Although the majority of projects were locally initiated, there were some projects which originated in Central Office rather than the impetus coming from the local community. One such example is the Beaufort-Jasper project, in South Carolina. The area has been featured on the CBS story "Hunger, USA", and Senator Hollings expressed concern about the health conditions there to Tom Bryant, Director of the Office for Health Affairs, and myself. I went down to South Carolina and worked with the community to develop the group which applied for the neighborhood health center which OEO funded. Numerous meetings with various community groups (from a Black-led cooperative, local political figures, and medical community figures) a group formed, including a physician, a banker, the local insurance agent, members of the Black cooperative, and a private attorney, which formed a corporation. An OEO paid consultant worked with this group several days a month for a few months, and helped it to put together an acceptable project. I also went back and forth between Washington and South Carolina during this time.

5. We were always looking for aid from other government agencies to provide moneys for services needed by our projects. Construction funds were a big need. We got a far greater amount of assistance from the FHA loan guarantee program in construction facilities for the neighborhood health centers than we did from the Hill-Burton program. We were aware of the amendments to the Hill-Burton Act which provided a priority for poverty areas to receive outpatient moneys. At the time I left OEO (in 1971) the effects of these amendments had not been experienced by the centers looking for construction funds.


Robert Kalinowski, M.D.

Sworn to and subscribed before
me this 4 day of ^{April} March, 1974.


Notary Public
My Commission Expires 3/27/77

AFFIDAVIT

I, Stephen C. Joseph, M.D., being duly sworn, depose and state as follows:

1. I am a graduate of Yale University School of Medicine and received my M.D. in 1963. I interned at Boston Children's Hospital and did a residency in pediatrics at the same institution. I received the degree of Master of Public Health in 1968 at Johns Hopkins. Presently I am Director of Medical Education Planning, University of Wyoming, and am responsible for the planning and development of a program of undergraduate, graduate and continuing medical education for the State of Wyoming. From January 1971 through July 1973 I was Professor of Pediatrics and Community Health at the University Center of Health Sciences, Yaounde, Cameroon and project manager for A.I.D., assisting in the development of a school to train physicians and other health workers.

2. From June 1969 through December 1970 I was Director of Comprehensive Health Services, Office of Health Affairs, Office of Economic Opportunity, after having served as Senior Consultant in Medical Care to the same organization from January to June of 1969. I was responsible for program operations and technical assistance for approximately 75 neighborhood health center projects funded by OEO. A major problem for these centers was the need for adequate physical facilities, about 15 developing new health facilities and some 50 to 60 undergoing, renovation or modification of existing structures.

3. My office was responsible for negotiations of refunding of the centers, monitoring the program activities, and providing technical assistance to new and on-going programs. These responsibilities fell into four technical categories:

- (a) health services
- (b) organization and administration
- (c) community organization and consumer participation
- (d) facilities development as related to project objectives and services

4. With respect to construction, virtually all the programs were in nonexistent or inadequate facilities. Some of the programs had absolutely no facilities. Others were in such facilities as storefronts. Even those in local health departments and hospital outpatient departments were inadequate for the neighborhood health center programs in view of the wide range of services and training activities of the health center. We needed to assist in the development of appropriate facilities to match program needs and to provide the mix of service at appropriate and accessible geographic locations for the population to be served.

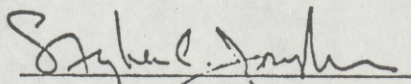
5. The orientation of the neighborhood health centers requires a different type of facility than any that previously existed, including the outpatient departments of general hospitals. All neighborhood health centers have social service functions and a wide variety of health education, and personnel training programs. The Centers need physical arrangements for the provision of such social services and training which one does not normally find in hospital outpatient departments, as well as areas for health service delivery. The storefront and other converted buildings were often grossly inadequate to provide this broad range of services in a dignified and appealing setting.

6. The basic staff component in the unit I directed was that of Project Analysts, who were generalists rather than technicians. They served as the focal point for technical assistance needs and refunding, and would identify the need for physician or other specialized consultants or for people from other NHC projects who had specific experience relevant to the problem at hand. The need for adequate facilities was a consistent and major problem especially in new projects. The staff would assist in identifying sources of construction moneys and providing the technical assistance to obtain such moneys. Further, new construction would often take three or four years, and while the new construction was being developed, there was a need to house the program in temporary facilities -- money for such construction was also needed.

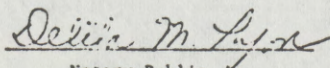
iii

7. There is no question that technical assistance is necessary to assure that poverty communities get adequate facilities and services. Winding your way through governmental hierarchies and having grantsmanship skills is a technical skill, and communities open do not have the available expertise especially in highly technical areas such as health facilities development. If grant-making agencies want to see full implementation of these objectives, they must be prepared to take an active role in assistance to individual grantees in program development and operations.

8. As for the long term viability of these projects, there can be no absolute guarantee that a given community is going to continue to operate one of these projects, though I feel certain that the future of such projects is assured, especially in view of the growing importance of pre-paid and health insurance programs, of group practice and team health care, and of health promotive and health maintenance activities. Important indices in the case of an individual center include the quality of staff attracted to the project, and the quality of the relationship between health center staff, local health institutions and the consumer community itself. However, even in communities where there was hostility on the part of local health providers, neighborhood health centers were established and did become viable programs delivering health and social services in the poverty community.


Stephen C. Joseph, M.D.

Sworn to and subscribed before
me this 22nd day of March, 1974.


Notary Public

Comments on Testimony of Marilyn Rose Developed by Dr. Harald Graning at
Invitation of Senator Kennedy for Inclusion in Transcript of Hearings

Miss Rose stated her testimony was predicated on three premises--
I would respectfully disagree with two of them. It is not true that
"the mainstream health system in the United States has been built and
expanded in major part during the past 25 years with Federal dollars under
the Hill-Burton program." There has been at least twice as much hospital
construction built outside the Hill-Burton program as the construction in
which Hill-Burton participated. For the portion in which Hill-Burton was
involved, the Federal share was approximately one third. It therefore
follows that the Federal government has contributed only 1/9 rather than
the major part.

There is to the best of my knowledge no basis for the contention that
commitments "lay moribund until discovered by legal service and public
interest attorneys in 1970." Quite to the contrary, it has become apparent
that most hospitals have as a matter of standard operating practice provided
a great deal of care to persons unable to pay. During the deliberations
associated with the development of regulations on this subject we received
many letters from hospitals which stated that they had never turned anyone
away because of inability to pay.

I am nevertheless pleased that public interest attorneys brought suit
in Louisiana, Colorado, Florida, New York, and the District of Columbia for
starters. They used instances of non-admission to care as a vehicle for
calling attention to the fact that the promise to provide a reasonable volume
of care to persons unable to pay had been given by all hospitals receiving
Hill-Burton assistance but the Federal government had never provided a yardstick

-More-

for evaluating whether a hospital was complying with its commitment. This has now been accomplished through the adoption of regulations which have the effect of law. State Hill-Burton agencies have been advised that they may not use either fiscal 73 or 74 funds (the only funds made available since adoption of the regulation) until their state plan is amended to reflect their intent to initiate a program that would obtain compliance from aided hospitals.

Miss Rose made reference to a survey conducted by the American Hospital Association and stated, "70% of the hospitals did not provide free service equivalent to 3% of their 'cost of operations' after deductions for Medicare and Medicaid reimbursement." Two facts are needed to properly interpret her statement. First, the hospitals that had been operating on an open-door policy--that is they did not deny anyone care because of inability to pay--had no dollar figures to provide on the extent to which they were providing uncompensated care. A second fact is that hospitals in the midwest and far west tended as a matter of fiscal practice to group care for those unable to pay with bad debts. Hospitals on the eastern seaboard appeared to be more conversant with the extent to which they were serving those unable to pay. The survey made by the American Hospital Association at my request and at no cost to the Federal government was conducted with the understanding that the individual responses would remain anonymous. Its principal value to us was that it established the fact that there were indeed some hospitals that admitted that even though they had received Hill-Burton assistance, they were not providing care to persons unable to pay. This

-More-

survey done prior to the development of regulations also served to help convince some that the options included in the regulations would call for a higher level of performance than some hospitals were rendering.

It is obvious that Miss Rose is displeased with both what she assumes to be the way in which state agencies are administering the reasonable volume of care regulations and she mentioned in her testimony that HEW should initiate a monitoring program with a special staff patterned along the Office of Civil Rights. She expressed strong feelings as to adequacy of the public notices called for in the regulations as a mechanism for alerting consumers to their opportunity to protest the proposed level of uncompensated care and to the reality of the obligation that hospitals must provide a reasonable volume of care to persons unable to pay.

We provided for the public notice initially because we wanted to give consumers an opportunity to protest in the event a hospital contended it could not meet one of the three options and wished to have the state agency accept some figure less than the 3% of operating cost, less Medicare and Medicaid reimbursement. Much to our surprise, hospitals have in what we judge to be 98 or 99% of the cases taken one of the three options. If they do so there is no basis on which the consumer can protest. We agree with Miss Rose about the futility of public notices in informing lower socio-economic income people and have suggested to state agencies that hospitals should be encouraged to give some publicity--multi-lingual if necessary to what the hospital plans to do. We have in fact suggested that hospitals should as a matter of good public relations make the matter of the extent to which they serve those unable to pay a matter of public information.

-More-

Lest there be any misunderstanding as to either HEW or state agency attitude, let me reiterate that state agencies have without additional financial resources done well in fulfilling their obligations to elicit information from previously aided Hill-Burton hospitals as to which option they would select in fulfilling their reasonable volume of care obligations. The first full year of operation under the new regulation will not be completed for many hospitals until September 1, 1974. As evidence of the manner in which hospitals have selected options, I enclose a table representing information made available from selected states.

SUMMARY OF OPTIONS SELECTED BY
HOSPITALS IN SPECIFIC STATES

State	Open Door Policy	3% of Opera- ting Costs	10% of Fed- eral Grants	Negoti- ated Rate
Tennessee	140	47	19	2
Puerto Rico	2	9	2	2
Kansas	Most Hospitals			
North Carolina	73	25	13	0
Indiana	60	9	18	3
Minnesota	109	3	11	0
Mississippi	21	43	8	0
South Carolina	59	40	12	0
Wisconsin	80	3	17	0

-More-

Miss Rose has repeatedly demonstrated as she again did before the committee that she believes that the 1970 legislation stipulated that outpatient facilities in poverty areas were to receive priority. Our Office of General Counsel agrees that priorities are established in relation to need among service areas and that special consideration is to be given to applications that fall into one of seven itemized situations. One of these is location in a poverty area. Furthermore, she apparently does not understand that in the absence of otherwise approvable projects a state agency is entirely within the intent of law and regulations by proposing the transfer of funds to another category.

Finally, it should be understood that the original Hill-Burton legislation and all subsequent amendments made it clear that the provision of uncompensated care to persons unable to pay is an obligation only to the extent the hospital is financially able to provide the care. Selection of and adherence to an option constitutes compliance with the regulations.

If on the basis of option selected a hospital promised to provide \$150,000 worth of uncompensated care in one year, it must be borne in mind that:

1. The hospital may pro rate this by month, by quarter, or could handle on a first come first served basis.
2. Once a hospital has used its quota for the month or the quarter, it may with complete justification deny admission to all elective cases until they come into another time period.
3. The hospital may utilize the uncompensated care provision for those who have no funds as well as for those who are part pay.

-More-

4. If a hospital is located in an area where there are many poor, there will continue to be those who are denied care because of inability to pay.

I hope that the Congress will enact a National Health Insurance Program because nothing short of that will remove the financial barriers to health care.

Senator KENNEDY. Our next witness, representing the Council for Urban Health Providers, is Dr. John Affeldt, medical director of the Department of Health Services of the County of Los Angeles, who has traveled a long way to be with us this morning. We appreciate that very much.

STATEMENT OF JOHN AFFELDT, M.D., MEDICAL DIRECTOR, DEPARTMENT OF HEALTH SERVICE, COUNTY OF LOS ANGELES, CALIFORNIA; ACCOMPANIED BY DEAN W. COSTON, EXECUTIVE SECRETARY, COUNCIL FOR URBAN HEALTH PROVIDERS

Dr. AFFELDT. Senator Kennedy and members of your staff, I am John Affeldt of the Department of Health Services in the County of Los Angeles, and also chairman of the Council for Urban Health Providers.

Also with me today is Dean W. Coston, who is executive secretary of the Council for Urban Health Providers.

As background for the base from which I draw my observations for my presentation—the Department of Health Services in Los Angeles County does represent a merger of four former health functions, namely public health, hospitals, mental health and veterinary services.

It is of significant size in terms of providing health care for the poor.

Just a couple of figures to indicate the size—3,700 beds; admissions per year, \$1.3 million; births, 12,000 per year.

We run approximately 2½ million visits just to the emergency room and ambulatory clinic. That is not counting the outpatient visits.

For health manpower, just in terms of interns and residents alone, we have 1,400 house staff in training in these publicly operated health facilities.

To go back to the problem which we faced after Medicare and Medicaid came into being, the public hospitals found themselves in trouble.

They looked around to see what was happening and they found themselves on the decline, scheduled for extinction.

They pulled together a group. We looked around to try to find somebody who could speak for them, and we found no voice. Out of this came the Council for Urban Health Providers which represents the major public hospitals in the metropolitan areas such as New York, Chicago, Boston, St. Louis, Cleveland, Kansas City, Atlanta, San Francisco and others.

They decided that they needed a voice; they needed to document the problems, so they set up priorities of defining the problems, and then seeking solutions.

In trying to define the problem, a study was made at UCLA with a grant from HEW. The study limited itself to just the major public hospitals defined as those with a minimum of 300 beds, and those providing a minimum of 300,000 outpatient visits per year.

This identified a total of 51 such hospitals in the United States.

In looking at the type of service those 51 public hospitals provide, just looking at the Hill-Burton service area in which they are identified, it was found that they provide 20 percent of the hospital admissions in those areas, and that they provide 40 percent of the outpatient visits.

It turned out, as we all know pretty well, that these facilities are the prime source of health care to the poor. They are the physicians for the poor, the hospitals for the poor. They are a source of preventive care, if they are getting it; they are a source of health education if they are getting it.

We looked at the distribution of patients on an ethnic basis in these hospitals, and found 35 percent of them are white, 42 percent black, and 20 percent are Spanish.

We also found, as it is pretty well known but good to document, that these public hospitals are one of the major providers for the development of health manpower, particularly the house staff, the interns and residents, for medical schools.

We found of these 51 hospitals, 85 percent of them have medical school affiliation.

We also found they train 35 percent of all interns and residents in the country. That is just 51 hospitals that have one-third of the training base for the interns and residents, the future doctors and specialists in the United States.

Los Angeles alone, just looking at our one service base, trains over 7,000 health professionals a year at local expense. That is without support.

Then, we say if this is so, what is the problem?

The problem is we have no constituency. Congress was not interested. The Public Health Service was not interested. Health planners, State legislators, local governments, comprehensive health planning agencies, were not interested. Because there were the problems, there would no longer be a need for these public facilities and, therefore, they would disappear, and should disappear, and so attention, planning, financing went elsewhere.

The local governments were happy to get some relief through revenue from Medicare and Medicaid, and they said, "We can now shift our resources to our great needs, such as fire, schools, parks, police, roads.

The poor were not a constituent because they were unhappy with the poor facilities, the environment in which they worked, the welfare concept, the hard benches, the dirty floors, the open wards.

So, over a 6-year period since Medicare-Medicaid came into being, we experienced 25 to 30 percent shift of patients into the private sector which was one of the intents and hopes. But, that left 70 percent that did not shift, a 70 percent residual, which is a pretty good residual, remained with the public facilities.

We also found that the outpatient visits increased by at least one-third, and are still going up. So, as inpatient care decreased, outpatient care increased, and we are still on that trend line.

The facilities deteriorated further. The patients found they were not welcome in the private facilities, and they could not go there.

We looked at health manpower, and I have given you the figures on that already. We found no trend line there.

The hospitals are not shifting school affiliations. The medical schools are not shifting to the private hospitals for their training base. The interns and residents are not shifting. They have remained with the deteriorating public facilities.

We found that Medicare and Medicaid have no provisions to support training in our hospitals. We do not find legislation until now, which you are bringing forth and a few others that begins to recognize this problem.

So, here we are—deteriorating facilities with a large patient load, a large training program, and struggling as to what to do about it.

We do believe that the legislation being proposed and the national health insurance, as you have proposed—and others—will be a means of helping this situation, but this is still some time off, and we are in trouble now.

We look to the transition period. We do believe that these public facilities need to be given recognition and support.

In Los Angeles alone, just to give you some feel we have just completed a 10-year projection for the modernization of our facilities.

We have projected a \$50 million capital construction need for 10 comprehensive ambulatory centers.

We have bids for a private consulting firm to indicate those places in Los Angeles County where they should be sited, where the need is the greatest, and where they will provide the best accessibility of care to those in the poverty areas.

Our next priority is to replace and modernize those hospital facilities which are now obsolete. I can give you just an example.

We warmly refer to the county hospital as that Stone Mother.

We are reducing the size of that facility by at least one-third. We are projecting that we need 1,200 beds for the future of that facility, but it presently has over 2,000. That is a considerable reduction in beds. But it will cost us \$160 million to replace that facility which originally cost, when it was occupied in the early 1930's, \$20 million.

You can talk about amortization. You can talk about ability to put money aside for modernization of these facilities under the Medicare formula where private hospitals will normally have 6½ percent in their per diem costs.

This \$20 million has been amortized over these many years and now can only bring about 2½ percent on our per diem.

Our county administrative officer has projected revenue through the ability to sell bonds, has looked at the local property taxes, and has told us that between now and 1980 they can wrestle up \$180 million. But our projections are a need for \$400 million of which \$50 million is just for ambulatory care. Yet, we are told the lid is \$180 million.

I believe that gives you the picture which we in public health sector across the country find ourselves in, and we welcome the relief which is being proposed in the legislation.

Senator KENNEDY. What about the position of the administration

that you cannot get these loans from FHA and other guarantee loan programs?

Dr. AFFELDT. We cannot use the loan mechanism in the public sector. We are pretty well limited to grants.

We have the problem, whether it is a loan or bonds, where there are financing charges. The State of California has enacted a ceiling on the property tax, so that whenever we take financing into account we have to include that into the costs to the county, which immediately shoves us above the ceiling and, therefore, that cannot be considered.

Mr. COSTON. Senator, if I may make one general comment.

I think HEW has traditionally and consistently misunderstood the nature of municipal finance.

They base their loan provisions on the theory that the power to borrow is unlimited at the municipal level. In fact, there are all kinds of restrictions on municipal borrowing powers.

First of all, public hospitals generally are not legally permitted to build up capital reserve funds. They cannot save money and put it in a fund which will be dedicated to future construction.

Secondly, every State has a bonded debt limitation placed on municipalities within the State. Most municipalities are at or very close to the current bond limitation.

Thirdly, if the limitation has not yet been reached, in most municipalities, the question of raising money to construct facilities has to be voted in general elections, and in recent years bond elections for all purposes—schools, parks, as well as hospitals—have been going down to defeat because of the burden on the local property tax in most areas has become very, very difficult for the property taxpayers to support.

We have squeezed the property tax about as dry as we can squeeze it locally, so it just is not feasible to try to borrow money to construct the facilities.

Senator KENNEDY. You are speaking of Boston just as clearly as Los Angeles.

Mr. COSTON. And we are speaking of St. Louis and Miami and Chicago and New York.

Senator KENNEDY. It is the same situation.

Mr. COSTON. I think you are well aware of the serious problems that Boston City has faced over many years in trying to stay afloat, and yet Boston City provides a level of health care that is of very high quality. And it is provided to people who are not financially able because they are either not insured at all, or they are completely uninsured who seek care in the private sector.

Senator KENNEDY. I think you have touched on this a little about the prohibition against the accumulation of funding.

This is a point which the administration relies upon to some extent.

What are the practical realities?

Mr. COSTON. The practical realities are that agencies of both city and county government cannot accumulate capital reserves.

Municipal financing policies in the United States generally do not require a depreciation account to be established at the municipal

level. You do not depreciate things like fire engines and police stations and hospitals and schools.

You rely on bond issues and continuing tax financing to prepay capital expenditures in advance, and rather than accumulate capital reserves, which you then use after you have accumulated enough to replace the facility. Most States have laws which prohibit excessive accumulations of capital by any subunit of State government, so it is not possible to save money.

If you have money left over at the end of the year, it reverts to a general fund and is used for whatever purpose the municipality needs it.

Public agencies generally appropriate funds to meet current requirements, and to the extent there are funds left over, those are considered in the next appropriation, much as the Congress appropriates.

Dr. AFFELDT. If I could use figures, for example, in Los Angeles County with our public hospitals, 65 percent of the cost of operation is local tax money. It is only 20 percent that comes from Federal funds such as medicare and medicaid, so the cost far exceeds the revenue.

There is nothing to set aside if you could.

Senator KENNEDY. Just very briefly, about your knowledge of the need for the renovation of urban health facilities, even in a virtually newer community like Los Angeles—it is significant, is it not?

Dr. AFFELDT. \$400 million is the projection for the 10 years which, as I said, is replacement on a significant one-third reduced number of beds. So this is not expansion.

These are modernization and replacement.

I would really like to stress the way I am using the term "replacement," because it would cost more to modernize than to replace. And California, again because of the earthquake hazard and the new laws which were established because of the recent earthquakes, if you do any significant modernization you have to do such an extensive job that replacement actually is cheaper.

Senator KENNEDY. Your attitude about the integration of planning and health care facilities into comprehensive health planning as a whole, attempting to integrate the planning program for the construction facilities with the delivering of health care as well—do you favor an integration of these responsibilities?

Dr. AFFELDT. Yes.

I wish Dean would speak to this.

Mr. COSTON. Senator, we have been working over the past two or three weeks with a group of public and private nonprofit organizations, including the Conference of Mayors in cities, the National Association of Counties, the county and State governments, put together with the RMP organizations, and in consultation with the American Hospital Association, to arrive at some set of principles to which we could all agree as to what relationship of planning to operation and to regulation ought to be.

In general, we believe there should be a very strong local planning requirement in all facilities, construction and delivery activities,

with a coordinative role for the States in being sure that local plans are all consistent with each other with respect to the State programs.

I think we would prefer to see the three functions separated at the State level; that is to say that the planning function has some problems if it is considered by the same agency which carries out operations and construction, and certainly has severe problems if it is carried on by the same agency which is charged with the regulation of the delivery system.

What we would hope for would be a mechanism which would provide a planning function, a developmental function for both services and construction and a regulatory function, separate administration of these so they would not conflict in interest, as you know you have with a number of State programs combined under a single administrative head, but with a coordination function, either by a council system or directed by the Governor to insure there was consistency of performance through the agencies.

I cannot say there is universal agreement among the coalition members on these points, but the principles are quite generally agreed upon, that there ought to be enough separation between planning and operations to permit the planners to retain a level of independence which they could not always have if they were part of an operational organization.

SENATOR KENNEDY. Thank you very much.

Your testimony has been very helpful.

Our final witness, representing the Association of State and Territorial Health Officials, is Dr. Joseph E. Cannon, director of the Department of Health for the State of Rhode Island, who is appearing on behalf of the Association of State and Territorial Health Officials.

STATEMENT OF JOSEPH E. CANNON, M.D., DIRECTOR, DEPARTMENT OF HEALTH, STATE OF RHODE ISLAND; ACCOMPANIED BY ROGER KLEIN, ASSISTANT DIRECTOR

Dr. CANNON. Mr. Chairman, I am Joseph E. Cannon, director of the Department of Health for the State of Rhode Island.

I would like to introduce Roger Klein, who is our assistant director.

I will try to be very brief.

I am here today on behalf of the Association of State and Territorial Health Officials and, in that capacity, thank you for the opportunity to testify concerning S. 3577, a bill to provide Federal assistance for the cost of construction and modernization of public and nonprofit health facilities.

We have studied your statement of explanation submitted when introducing S. 3577, and agree generally with your chronological overview and assessment of the Hill-Burton program.

We laud many of the concepts and objectives of this proposed legislation. We endorse fully your enlightened effort to provide Federal financial support through grants, direct loans and loan-guarantees for needed facilities for medically underserved populations.

You are to be commended for your interest in aiding municipal hospitals, many of which unquestionably have to be modernized.

Moreover, we concur with the priorities incorporated into S. 3577, through which emphasis is to be focused upon ambulatory care and outpatient services with provisions for that segment of the public unable to pay for health services.

We also strongly believe that Federal construction money should be directed to fulfill changing patterns of utilization and need. Incentive moneys should be provided to encourage integrated care modes, mergers, shared services, neighborhood service centers, day care centers, and, most particularly, HMO's.

Mr. Chairman, there are several legislative proposals now pending before Congress designed to improve the planning and regulatory process for health facilities and services.

Of the bills we have examined, the critical issues are (a) the relationships of planning to regulation; and (b) the role Federal, State, county, and municipal governments will perform in the determination of a community's health care delivery system. It would be redundant of me to go into detail and review the position expressed by State and local governmental people regarding these bills.

We are concerned, nevertheless, that State officials participate in the decisions which determine how a community's health care resources are to be allocated. Also, it would seem both logical and in the public interest to make compatible the goals, concepts, and organizational elements of S. 3577 with the provisions contained in whatever planning and regulatory legislation is enacted.

To adopt a health facilities construction and renovation statute, while deliberations are in progress for a Federal health planning and regulatory law, could create serious administrative problems if inconsistencies exist in either of these two critically important proposals.

To be somewhat more specific concerning S. 3577, most States have considerable competence as a result of their administration of Hill-Burton programs. These agencies serve as a focal point through which expert consultation is provided when health care facilities are to be planned and developed.

It would duplicate the work of existing State agencies to require similar functions to be carried out at the areawide local or regional level.

I would be glad to submit for the record a list of the functions presently performed by State Hill-Burton agencies. Whether that is the name for it or not, I do not know.

Another point which you may want to consider relates to the provision which precludes modernization programs for health facilities not serving medically underserved populations.

For example, such a restriction could exclude hospitals having a legitimate need to modernize because of fire code deficiencies. If no financial means are provided through which such facilities can achieve compliance, such communities could, in fact, become medically underserved.

Senator KENNEDY. Are not the facilities in the relatively affluent

areas able to generate capital through private means?

Dr. CANNON. No, I do not think so.

In our State, for example, we have a fire code which is even more rigid than the 1967 code, and we have reviewed hospitals to see how they comply. And they are in serious trouble, a good many of them, and need modernization to meet those codes.

Senator KENNEDY. I was thinking not so much of the fire code but just the facilities that are in relatively affluent communities.

Can they not develop the kind of resources which are necessary?

Dr. CANNON. Senator, I would say there are hospitals—and I would just talk of my own State—that have substantial endowments, and they could use those endowments to do whatever is necessary.

At the present time, however they are using some of those endowments to develop new programs, particularly one I am thinking of, in ambulatory care.

They are thinking of using some of those funds to start an HMO which will be hospital based.

Most of the hospitals in our State have very little endowment, and operate on quite a marginal basis.

Senator KENNEDY. What is the possibility for borrowing?

Dr. CANNON. The possibility for borrowing are quite few if the Loan Act is continued.

We also have in the State of Rhode Island a law which permits State backup of a loan to hospitals and other health facilities.

In addition, we strongly recommend that the definition of outpatient facilities include public health centers as defined under existing laws.

Mr. Chairman, we therefore have three brief recommendations concerning S. 3577, the proposed health facilities construction legislation:

(1) That action on S. 3577 be deferred until the enactment of a Federal health planning and regulatory statute, thereby insuring compatibility.

(2) That the Hill-Burton authorization be extended 1 more year.

(3) And that legislation regulated to health facilities construction continue to provide Federal financial support to States for administrative purposes so that technical assistance can be provided to communities.

With your permission I would like to submit for the record a list of specific comments related to the provisions of S. 3577.

We thank you for the opportunity of expressing our views concerning this vitally important bill, and trust that our comments have been helpful.

Senator KENNEDY. If we could just focus for a few minutes on your own views about the State planning agency and its relationship to the area planning agency, the types of responsibilities they are to have, both for facilities and provision of health care, how do you see this?

Dr. CANNON. I am in a position in my State of not having any B agencies. I have a voluntary health planning council which does not fit the concept of a B agency, but is very useful for the department of health, which is the A agency.

I know of areas where B agencies are doing an outstandingly successful job in community planning, not only for facilities but for services.

Their input to the A agency, or whatever the top State agency is, is of inestimable value.

I think, Senator, if I may, I would love to have some B agencies in Rhode Island, but we are too small. There are some areas where the geographic area is so great and the population so small that it becomes very difficult, to fund and staff them adequately.

Senator KENNEDY. How do you think we ought to proceed then?

How should we, as the writers of the legislation in dealing with it, insure that you are going to have integration of planning and programming of both facilities and services?

Dr. CANNON. I must say that I do not envy your job

[Laughter.]

Dr. CANNON. It seems to me you must have the wisdom of Solomon and the patience of Job. I have neither.

I do think this, that we have worked very closely over the years, and I think they sent me down here because I am probably the oldest and dumbest of the health officers, but I am always convenient to Washington.

Senator KENNEDY. I think, on the contrary. From what I am learning, you are probably the wisest and shrewdest.

Dr. CANNON. My State is a little different, as you are well aware. We only have one health department. We have many responsibilities wrapped up into one package.

I think that we have worked closely, or tried to work, as was previously mentioned, with the Association of State and Territorial Health Officials, with the county and municipal governments, and I think our biggest concern is that we do feel State governments should play a major role in any planning, regulatory, or construction process, not necessarily the total role, but Governors should have some say as to what goes on in their States.

Senator KENNEDY. As you are aware, in our planning bill, we spell this out in very considerable degree, particularly the responsibility for the State planning agency, and this, of course, expressed my view on it and I think pretty much the view of the other members of the committee.

It is not as elaborately spelled out in this legislation as I understand you would desire, having it more carefully defined in the legislation, but we appreciate those views, and I am sure we can achieve the goal that is desired by the agencies themselves as we develop both pieces of legislation.

We had a very nice visit with your Governor at the Governors Conference. I am looking forward to being up in Rhode Island.

Dr. CANNON. We look forward to having you, believe me.

Senator KENNEDY. Thank you very much.

You testimony has been very helpful, and we will be staying in touch with you. Thank you very much.

[The prepared statement of Dr. Cannon and additional material subsequently supplied for the hearing record follow:]

Statement of the
Association of State and Territorial Health Officials
on
S. 3577
Before the
Subcommittee on Health
Committee on Labor and Public Welfare
U. S. Senate

Mr. Chairman, I am Dr. Joseph E. Cannon, Director of the Department of Health for the State of Rhode Island. I am here today on behalf of the Association of State and Territorial Health Officials, and in that capacity, thank you for the opportunity to testify concerning S. 3577, a bill to provide Federal assistance for the cost of construction and modernization of public and non-profit health facilities.

We have studied your statement of explanation submitted when introducing S. 3577, and agree generally with your chronological overview and assessment of the Hill-Burton program. We laud many of the concepts and objectives of this proposed legislation. We endorse fully your enlightened effort to provide Federal financial support through grants, direct loans and loan-guarantees for needed facilities for medically-underserved populations. You are to be commended for your interest in aiding municipal hospitals, many of which unquestionably have to be modernized. Moreover, we concur with the priorities incorporated into S. 3577, through which emphasis is to be focused upon ambulatory care and outpatient services with provisions for that segment of the public unable to pay for health services.

We also believe that Federal construction monies should be directed to fulfill changing patterns of utilization and need. Incentive monies

- 2 -

should be provided to encourage integrated care modes, mergers, shared services, neighborhood service centers, daycare centers, and, most particularly, HMO's.

Mr. Chairman, there are several legislative proposals now pending before Congress designed to improve the planning and regulatory process for health facilities and services. Of the bills we have examined, the critical issues are (a) the relationships of planning to regulation; and (b) the role Federal, State, county and municipal governments will perform in the determination of a community's health care delivery system. It would be redundant of me to go into detail and review the position expressed by State and local governmental people regarding these bills. We are concerned, nevertheless, that State officials participate in the decisions which determine how a community's health care resources are to be allocated. Also, it would seem both logical and in the public interest to make compatible the goals, concepts, and organizational elements of S. 3577 with the provisions contained in whatever planning and regulatory legislation is enacted. To adopt a health facilities construction and renovation statute, while deliberations are in progress for a Federal health planning and regulatory law, could create serious administrative problems if inconsistencies exist in either of these two critically important proposals.

To be somewhat more specific concerning S. 3577, most States have considerable competence as a result of their administration of Hill-Burton programs. These agencies serve as a focal point through which expert

- 3 -

consultation is provided when health care facilities are to be planned and developed. It would duplicate the work of existing State agencies to require similar functions to be carried out at the areawide or regional level. I would be glad to submit for the record a list of the functions presently performed by State Hill-Burton agencies.

Another point which you may want to consider relates to the provision which precludes modernization programs for health facilities not serving medically-underserved populations. For example, such a restriction could exclude hospitals having a legitimate need to modernize because of fire code deficiencies. If no financial means is provided through which such facilities can achieve compliance, such communities could, in fact, become medically underserved.

In addition, we strongly recommend that the definition of outpatient facilities include public health centers as defined under existing law.

Mr. Chairman, we, therefore, have three brief recommendations concerning S. 3577, the proposed health facilities construction legislation:

- (1) That action on S. 3577 be deferred until the enactment of a Federal health planning and regulatory statute, thereby insuring compatibility;
- (2) That the Hill-Burton authorization be extended one more year; and
- (3) That legislation related to health facilities construction continue to provide Federal financial support to States for administrative purposes so that technical assistance can be provided to communities.

- 4 -

With your permission I would like to submit for the record a list of specific comments related to the provisions of S. 3577.

We thank you for the opportunity of expressing our views concerning this vitally important bill, and trust that our comments have been helpful.

Specific Comments Related to S. 3577

1. There is an inordinate amount of power placed in the hands of the Secretary of HEW. There is a tendency to bypass States by not allowing them to have input. Even local planning agencies have only review and comment authority rather than approval authority. Because the State perspective is often very different from local areas, opportunity should be provided for States' input to consider overall needs.
2. There is no attempt made in this legislation to coordinate with existing Federal and State agencies or legislation; i.e., State certificate of need laws. Does Section 1122 of Public Law 92-603 apply? Section 223 of the Social Security Act requires hospitals to develop a 5-year plan. Is this section applicable?
3. There is no indication as to who the administrative agent will be under this proposed legislation.
4. There are several areas of definitions that remain unclear. Among these are:
 - (a) Reasonable full range of services
 - (b) Reasonable volume of services
 - (c) Types of services to be made available
5. In the introductory remarks Mr. Kennedy addressed to the Congress, he spoke to the need for long-term care facilities, but the definitions of health care facilities as contained in this bill do not indicate any application of loan or grant funds to long-term care facilities.
6. The legislation does not arrange for manpower planning for these facilities. The bill places emphasis on the establishment of outpatient facilities in local and urban areas where medical and technical staffs are already inadequate.
7. This bill places the responsibility for implementation and administration of the program with the local health planning agencies. This means that each areawide agency will need to establish or maintain:
 - (a) Planning functions and staff
 - (b) Fiscal and accounting staff for fund control, allocation and disbursement
 - (c) Engineering and technical staff
 - (d) Statistical service staff to acquire data and develop priorities

- 2 -

This means duplication of efforts in the local agencies. Currently a central State staff does carry out these functions with fewer people than will be required to perform these same functions in each area-wide agency. I was unable to see where this bill provides any administrative funds to establish the above capabilities.

8. This bill fails to provide administrative funds for phase-down of current State administrative programs for Hill-Burton agencies. This proposal allocates a lower limit of \$800,000 for grants. This amount does not seem adequate.

9. The section pertaining to "prevailing rates" seems unrealistic. If an agency is to use Federal funds with all their drawbacks, there should be some interest concessions. Also, it is doubtful that many poverty area facilities can meet these rates.

10. There is no mention of shared services in this bill. To hold down costs and duplication, this measure seems essential.

11. This bill seems to overlook what are now considered suburban hospitals. If no help is provided for them, a great many of these facilities will soon be in serious trouble and will require financial assistance.

OFFICE OF THE
DEPARTMENT OF PLANNING



Camden County

2276 N. 43rd Street, Pennsauken, N.J. 08110

JOSEPH T. PATERMO, AIP, PP
Planning Director

M. ALLAN VOGELSON, FREEHOLDER - DIRECTOR
*Chairman,
Committee on Administration*

June 7, 1974

Mr. Lee Goldman, Staff Director
United States Senate Subcommittee on Health
U.S. Senate Committee on Labor and Public Welfare
Room 4228
New Senate Office Bldg.
Washington, D.C. 20510

Dear Mr. Goldman:

This is pursuant to a telephone conversation I had on June 7, 1974 with one of your staff members. I am enclosing a research report on Senate Bill 3577 introduced by Senator Edward Kennedy and Senator William Hathaway on June 4, 1974 entitled "The Health Facilities Assistance Act of 1974." I shall sincerely appreciate it if you could arrange to have it inserted into the printed record of the Senate Bill 3577 hearings transcript.

Please notify me by writing of your reception of my research report and that it will so be published in the hearings record.

Please send me four (4) copies of the Senate Bill 3577 hearings.

I am editor of the Camden County Planning Department quarterly newsletter KALEIDOSCOPE, a complimentary copy of the latest issue being enclosed for your files and not for publication.

Thank you for your cooperation in this matter.

Very truly yours,

Frank Rodio, Jr.

FRANK RODIO, JR.
Planning Aide

FR/ds 6-7-74
Enc: Report
Kaleidoscope

OFFICE OF THE
DEPARTMENT OF PLANNING



Camden County

2276 N. 43rd Street, Pennsauken, N.J. 08110

JOSEPH T. PATERMO, AIP, PP

Planning Director

M. ALLAN VOGELSON, FREEHOLDER - DIRECTOR

Chairman,

Committee on Administration

"SENATE BILL 3577: ADEQUATE INVESTMENT
IN AN ESSENTIAL COMMODITY"

A RESEARCH REPORT PREPARED FOR THE
SUBCOMMITTEE ON HEALTH OF THE UNITED STATES SENATE
COMMITTEE ON LABOR AND PUBLIC WELFARE
ON SENATE BILL 3577
THE HEALTH FACILITIES ASSISTANCE ACT OF 1974

By Frank Rodio, Jr.

Planning Aide, Camden County Planning Department

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE ON HEALTH:

Why there should be prolonged debate on legislation that is long overdue of this nature is beyond my comprehension. What we are talking about is an investment in an essential commodity: namely, everyone's health.

According to a 1947 New Jersey Department of Institutions and Agencies Source Book on Hospital and Public Health Resources in New Jersey, Congress in 1946 enacted Public Law 725, "The Federal Hospital Survey and Construction Act." Under Public Law 725 "a single state agency," - - namely, the Department of Institutions and Agencies, - - was designated by the Governor and the Legislature to administer Public Law 725.

Public Law 725 defines "adequate facilities" for public health as follows:

1. Tuberculosis hospitals - - 2½ beds per annual death from tuberculosis.
2. Mental hospitals - - 5 beds per 1,000 population. 3. Chronic disease hospitals - - 2 beds per 1,000 population. 4. Public health centers - - 1 per 30,000 population.
5. General hospitals - - 4½ beds per 1,000 population.

As of 1947 in New Jersey general hospitals were to be planned on an area basis, setting a pattern for a coordinated hospital system. The "base area," with a large hospital - - if possible, associated with a medical school - - serves several "intermediate areas" having smaller general hospitals. Each of these, in turn, serves neighboring "rural areas" with more limited facilities.

The ratio of beds to population was graded so that there are proportionately more beds in the larger medical centers where more complete service is available. On the basis of the above criteria for the consideration of "adequate facilities" the following facilities would be required for New Jersey circa 1947.

1. General hospitals - - 18,720 beds; 2. Tuberculosis sanatoria - - 4,640 beds; 3. Mental hospitals - - 20,800 beds; 4. Chronic disease hospitals - - 8,320 beds; 5. Public health centers - - 135 health centers. Needless to say, gentlemen, the above statistics did not take into account the postwar baby boom and the resultant economic, political and social dislocations. After all 1947 is not 1974.

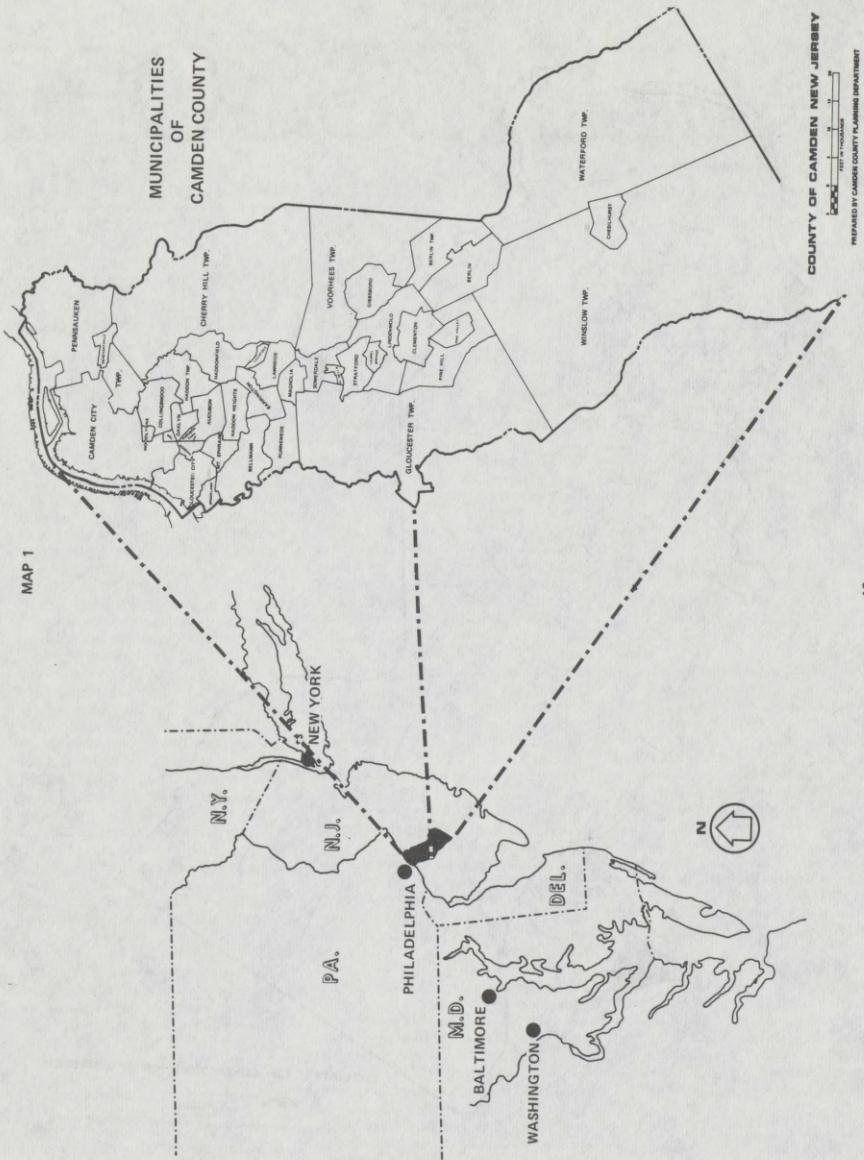
For more than a quarter of a century the Hill-Burton program has been providing financial assistance to the states for the construction and modernization of health care facilities. Hill-Burton has extended assistance to more than 11,000 projects. These projects have provided 489,000 in-patient beds in hospitals and nursing homes as well as approximately 3,276 other facilities, including 1,340 public health centers, 1,244 ambulatory care centers, 593 rehabilitation centers and 43 state health facilities.

According to the latest available Hill-Burton State plans, more than 167,000 general hospital beds need to be modernized or while only 47,000 general hospital beds need to be added; nearly 233,000 long-term care beds need to be modernized and more than 122,000 long term beds need to be added.

Among public health centers, out-patient facilities and rehabilitation facilities, about 2,800 are in need of modernization, while 2,500 need to be added. In dollar terms there is a \$20 billion total backlog in health care facilities with \$13 billion for modernization.

Senate Bill 3577 is an essential element to provide adequate health care facilities. I recommend its enactment into law.





KALEIDOSCOPE



PUBLISHED BY CAMDEN COUNTY PLANNING DEPARTMENT
VOLUME 6 NUMBER 2

SPRING 1974

OUT OF STATE REFUSE - A Solution

FREEHOLDERS VOTE TO BUY 977 ACRES

Camden County increased its park land by about 50% in March when freeholders voted to purchase 977 acres of land situated along the Egg Harbor river in Winslow Township. This park which will consist of the Berlin Park with the New Brooklyn Park will cost approximately \$1.5 million.

"By adding these 977 acres to the park's present 1,657 acres," said Freeholder Director M. Allan Vogelsson, "we are not only assuring balanced growth in one of the county's fastest developing areas, but we are protecting our environmental heritage."

Half of the purchase price of the land which is located on both sides of the Egg Harbor River, will be paid with state Green Acre funds.

Vogelsson noted that the land is in one of the fastest growing sections of the county. A total of 100,631 persons are to be expected to be living in the area by 1980. There were only 54,313 residents in 1970.

The acquisition of this area was supported by the Camden County Planning Board, Park Commission and County Environmental Commission and conforms to the County Planning Board adopted plan for Parks and Open Spaces adopted in January of 1974.

F.R.

The New Jersey Legislature recently tried to halt the importation of out-of-state refuse for disposal in New Jersey's sanitary landfills. This legislation, which was signed into law in January of this year, was recently struck down by the N.J. Superior Court on the grounds that it was in direct conflict with Interstate Commerce. One can evaluate the problem of out-of-state refuse and see three distinct arguments either for or against the matter at hand.

The first is New Jersey's viewpoint, which maintains that its lands should not be the dumping ground for two of this country's largest metropolitan centers, i.e., New York and Philadelphia. Is it right to force New Jersey to be the recipient of New York's and Philadelphia's product of society, namely the ever increasing production of household, commercial and industrial refuse? State surveys indicate that at least 30,000 tons of refuse per week are being imported into New Jersey by out-of-state sources. New Jersey has argued that there is an extreme limit to the availability of its existing sanitary landfill acreage and by accommodating the out-of-state refuse load is not only depleting these disposal resources at an increasing rate but degrading the environment as well.

It would stand to reason that the out-of-state dumpers will argue the fact that we have a regional problem on our hands and it should be attacked at a regional level. This argument implies that state boundaries should not be considered when attempting to find a solution to the solid waste disposal problem.

An argument can also be made based on economics. The current technique of solid waste disposal used in New Jersey by the out-of-state dumpers is the so-called sanitary landfill. Today the sanitary landfill disposal technique is generally the cheapest method of refuse disposal, barring an open dump. The economic argument is made by asking the question, why should Philadelphia and New York waste taxpayers dollars and provide disposal systems costing \$8 to \$12 per ton, when refuse disposal can be obtained in very close proximity to these cities across state boundaries, at a cost of only \$1 to \$3 per ton.

The disposal site owner has also a say in this entire matter. He must look out for his livelihood. It has been documented that some sanitary landfills in New Jersey are receiving as much as 80% out-of-state refuse. The private landfill owners maintain that if out-of-state refuse is banned from New Jersey Sanitary Landfills, there would not be enough solid waste remaining to keep all of the existing operations in business. This goes hand in hand with the private landfill operators' right to engage in interstate commerce.

The State of New Jersey should take the necessary steps to adopt and enforce stringent regulations to control the disposal of solid waste. If existing disposal sites (sanitary landfills) in New Jersey were up-graded to safeguard against the degradation of New Jersey's environment, satisfactory disposal services could be provided.

Today most refuse disposal sites throughout the state are not

(Cont'd Page 2)

the most pleasant places to be around. For the most part there is no real concern for the environment. There is no real consideration for the prevention of contamination of water supplies and production of gases, nor harmony with surrounding land uses.

The State of New Jersey's first major effort to regulate refuse disposal came in 1970 with the revision of Chapter 8 State Sanitary Code. Some inroads have been made over the past 4 years toward the regulation of existing sanitary landfills, however, there is room for much improvement.

There are two areas currently being considered by New Jersey that could change the entire practice of refuse disposal in years to come. The Department of Environmental Protection (DEP) has drafted a revised copy of Chapter 8 State Sanitary Code which deals with refuse disposal facilities. Stringent measures are called for toward the future regulation of Solid Waste disposal. Major points covered by the proposed code include the protection of water supplies, maintenance of water quality, provision of gas venting systems and weighing of all refuse for adequate record keeping. If these proposed regulations are promulgated and enforced by the DEP, a serious step will have been taken toward the necessary regulation of refuse disposal. Certainly, the proposed regulations will be meaningless if adequate funding and manpower is not provided for policing and enforcement.

The other area that could have a profound impact on the solid waste disposal problem throughout the state is the passage of N.J. Senate Bill 624. This legislation calls for the necessary planning and implementation of solid waste disposal systems at the county level. Special attention is given to the development of resource recovery in future disposal operations. The State, through legislation, can force local government to take a serious look at its present refuse disposal practices and implement new or upgraded disposal techniques that will not only provide adequate disposal practices but also take into account the environment and resources of the county in which we live.

The real answer to the problem of out-of-state refuse lies then in major upgrading of solid waste disposal systems throughout the state. New Jersey does not have to turn its back to out-of-state refuse, but merely take a serious look at the current refuse disposal state of the art and plan, engineer, and implement adequate disposal systems to not only adequately handle refuse production throughout the state, but at the same time provide a viable solution to a major regional problem.

L.L.W.

From The Director's Desk

The energy crisis affects all aspects of community life. The Camden County Planning Department is attempting to realistically deal with all facets of this phenomenon.

Our planning efforts, even prior to the energy crisis, were geared towards accomplishing objectives which would conserve energy in the longrun.

Your County Planning Department is attempting to encourage a more rational energy efficient land use pattern which would maximize the use of public transportation facilities. Our Housing Location Plan will address itself in part to the subject of encouraging job-linked housing.

The County's Public Facility Plan is designed to encourage the location of new county facilities in areas accessible by public transportation. The recent county acquisition of the Lits Building exemplifies this objective. Our County Highway Plan suggests higher priorities for the reconstruction of county roads which serves the PATCO stations. Other transportation alternatives to conserve energy are also being evaluated by the Planning Department: (a) use of mass transportation with bus feeder; (b) encourage the more efficient use of the family car by encouraging car pooling.

There is no doubt that the energy crisis has and will continue to affect different segments of our County's population. In fact, our

whole life style will be affected in terms of where we live and work, the size of cars we drive, how we spend our discretionary income and what we do in our leisure time.

Energy shortages will also tend to cause long range shifts in our county's economy. Thus, job training should focus on these shifts. The energy crisis no doubt will reduce the opportunities in the range of choices of our citizens since mobility will be restricted. However, this could lead to more rational choices in the long run or solutions to many of our urban problems, i.e. traffic congestion, air pollution and core city deterioration. Company towns or self contained communities such as the Urban Center at Echelon will become more popular in terms of a development strategy.

There are, however, some benefits which may come from this energy crisis. Our neglected urban core area (Camden) may be given a new birth because of its compact settlement pattern; its superior access to job opportunities and because it contains a wide range of public facilities and services.

As we reflect on the energy problem, one point comes across loud and clear, and that is that if we are to meet the energy demand of the future we must take steps now to provide alternate energy sources such as nuclear, thermal, wind, wave, solar, coal and others and to take steps through planning to better conserve on the energy we now use.

J.T.P.

KALEIDOSCOPE

Published Quarterly by the
CAMDEN COUNTY PLANNING DEPARTMENT
2276 N. 43rd Street, Court House Annex
Pennsauken, New Jersey 08110
609-964-8700 Ext. 359

JOSEPH T. PATERMO, Planning Director

FRANK RODIO, JR., Editor

Free to all governmental agencies
Circulation: 800 copies to Municipal Officials,
Libraries, and miscellaneous mailings

Available to non-governmental agencies at a
subscription rate of \$1.00 per year.

Additional copies available after subscription at
a reduced rate.

COURT ACTION ON COUNTY SITE PLAN REVIEW

In July, Judge Alexander C. Wood, 3rd, of the Superior Court of New Jersey, heard a court action suit brought by the Exxon Company, U.S.A., against the County of Burlington. It was the contention of the Exxon Corporation that dedication of extra width requirements made by the Burlington County Planning Board as a condition to County site plan approval for two separate applications, were unconstitutional and represented a taking of property without due process of law.

Judge Wood upheld the constitutionality of the Planning Board's requirements with the following findings: "Any land owner who seeks site plan approval for the development of land is seeking special advantage not accorded to all landowners. Any such development may potentially have an effect — more or less far reaching — on the development and use of all surrounding lands."

In response to the contention that dedication requirement is one which may be imposed on every applicant for site plan approval respecting lands fronting along County roads, plaintiff's argument that such requirements amount to a denial of equal protection of the laws is equally ill-founded.

The Exxon-Burlington County case is the first such action contesting the County's site plan review authority, and one which has set a precedent regarding the County's authority to make such requirements as conditions to County Site Plan approval.

BUS Feeder Service Preview

The establishment of an effective transportation and circulation system within Camden County has been a continuing concern of the Planning Board. A report prepared by the County Planning Board, entitled "The Master Plan for Highways," is an essential component of the Master Plan adopted by the Freeholders in January.

The difficulties evidenced during the recent fuel crisis have made it apparent that much more attention must be devoted to the establishment of an effective mass-transit system. Accordingly, it is proposed that the Camden and Burlington County Planning Departments undertake a joint study of all transportation needs in the two-county area.

An important component of this inquiry will be an investigation into the feasibility of comprehensive bus feeder service focused on high-speed line stations. Application has been made through the Delaware Valley Regional Planning Commission for federal funds to finance this mass transit study.

J.K.

CITATION OF MERIT

The Camden County Planning Staff expresses its gratitude and appreciation to Mrs. Jean Lustman for her dedicated service and contribution she has made to this department over the past 10 years.

Her devotion to the department, and particularly in her role as secretary to the Planning Director have not gone unrecognized. The planning staff wishes to commend her for her prior years of service and looks forward to her continued service for many years to come. J.T.P.



THE NEW FORGOTTEN AMERICANS

Camden County voters were amongst those throughout the State of New Jersey, who on November 6th, approved a \$25 million bond issue to provide facilities for the handicapped people.

Statistics tell us that there are, in the U.S., 13 million 390 thousand handicapped people, coupled with 28 million senior citizens over age 65, totals more than 33 million Americans who are, in reality, second-class citizens.

"Hire the handicapped" is a slogan which is given lip service only. Employers do not hire the handicapped. The handicapped are also discriminated against by the lack of adequate public transportation facilities. This is especially prevalent in the Camden County — South Jersey region.

Thus it can be said that there exists in the Camden County — South Jersey region an apparent policy of "benign neglect" adopted by all governmental levels towards the problems of the "New Forgotten Americans." President Richard Nixon signed into law on September 26, 1973 Public Law 93-112 H.R. 8070 The Rehabilitation Act of 1973.

Public Law 93-112 establishes an Architectural and Transportation Barriers Compliance Board which authorizes all public buildings which use federal funds to be accessible to the handicapped.

Right now Camden County is in the laborious process of modernizing and renovating County facilities and structures. This undertaking is being carried out under the direction of the Board of Chosen Freeholders Committee on Building and Utilities. Deputy Freeholder Director William J. Simon is in charge.

In 1973 Camden County purchased the Lit Brothers Department Store for \$2.5 million. Camden County will be utilizing the terms of Public Law 93-112 in a bold and dramatic effort in making the Lit Brothers and other County office complexes accessible to the handicapped.

F.R.

ANNUAL REPORT

The Planning Department has recently completed its Annual Report for 1973. This report provides highlights of the major activities in which the Department was involved, presents a summary of the accomplishments of the Planning Board and Planning Department for 1973 and briefly describes the planning program for the coming year.

An analysis of the subdivision and site plan reviews conducted by the Planning Department during 1973 is included in the Annual Report. The total volume is broken down by type of development and by municipality.

Copies of the Annual Report may be obtained from the Camden County Planning Department, 2276 North 43rd Street, Pennsauken, New Jersey 08110.

R.O.

PROFILE

Frank Rodio, Jr. joined the Department Staff as a planning aide in February, 1974. He is involved in several projects including a study of the physically disabled of Camden County and the renovation of County facilities for their use. He is the new editor of KALEIDOSCOPE. Frank resides with his parents in Winslow Township.

F.R.

KALEIDOSCOPE

Published Quarterly by the
CAMDEN COUNTY PLANNING DEPARTMENT
2276 N. 43rd Street, Court House Annex
Pennsauken, New Jersey 08110
609-964-8700 Ext. 359

~~~~~

## NOTICE TO ALL MUNICIPAL PLANNING BOARD CHAIRMEN, PLANNING BOARD SECRETARIES AND MUNICIPAL CLERKS

*Requirements for Plans  
to be filed with the  
County Register of Deeds*

Signatures on translucent ink drawings and cloth prints of plans to be filed with the County Register of Deeds must be hand signed. A simulated signature by means of a rubber stamp is not admissible according to the Map Filing Law.

Paper prints, however, may be executed by simulated rubber stamp signature. Moreover, the required signatures, dates and impressed seals must conform to the map filing provisions and appear on the translucent, cloth and all paper prints.

Your County Planning Board has always made every effort in various ways to facilitate steps in your municipality's planning process. This is one procedural step, however, from which deviation cannot be made.

~~~~~



RESOLUTION

WHEREAS, FRANK N. OLIVO has recently completed six years of distinguished service as a member of the Camden County Planning Board; and

WHEREAS, during his tenure on said Planning Board he has faithfully and diligently served as a member of the Budget, Bylaws, Subdivision and Site Plan Review Committees and made significant contributions to Camden County; and

WHEREAS, the Camden County Planning Board desires to formally recognize the efforts and accomplishments of Frank N. Olivo as a member of said Board.

BE IT, therefore, RESOLVED by the Camden County Planning Board that Frank N. Olivo be commended and lauded for his faithful and distinguished service as a member of the County Planning Board and for his invaluable contributions in that capacity to the County of Camden.

Bulk Rate U.S. Postage Paid Pennsauken, N. J. Permit No. 392



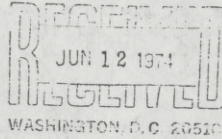
BRYANT T. ALDRIDGE
ADMINISTRATOR

NASH GENERAL HOSPITAL, INC.
ROCKY MOUNT, NORTH CAROLINA

27801

June 10, 1974

The Honorable Sam J. Erwin
Senate Office Building
Washington, D. C.



Dear Senator Erwin:

This letter is a request for your support for the continuation of the Hill-Burton program of grants and loan guarantees for hospitals and other health facility construction, which is scheduled to expire June 30, 1974.

It is my opinion that to remove at this time the financial support for the construction of health facilities in our country, at a time immediately preceding the anticipated passage of a national health insurance program, would be a mistake. The passage of a national health insurance plan will create an unprecedented demand for medical and health services. Furthermore, the rapid technological changes resulting from research and development toward improving medical and health services necessitates continued modernization of our existing hospital facilities. Our country stands on the threshold of being able to provide the highest level of medical and health care ever experienced by people in any country at any time throughout history.

I believe that the health industry has made remarkable progress in recent years in the efficient management and operation of our hospitals and other health facilities. We need the continued support, understanding and prodding of our elected representatives to help us further attain the high quality of care being demanded and expected by the greatest country on earth.

May I take this opportunity to thank you for your continued support of all these vital health programs.

Sincerely yours,

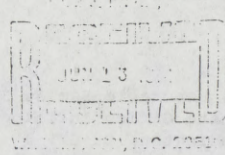
Bryant T. Aldridge
Bryant T. Aldridge
Administrator

BTA/s

NASH GENERAL HOSPITAL'S EMBLEM REPRESENTS THE "SYMBOL OF LIFE"

DISTRICT MEMORIAL HOSPITAL

of

SOUTHWESTERN NORTH CAROLINA, INC.
ANDREWS, NORTH CAROLINAFRED H. MASHBURN
ADMINISTRATOR*The Honorable Sam J. Ervin, Jr.
337 Old Senate Office Building
Washington, D. C. 20510*

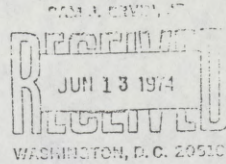
Dear Sir:

*We feel Hospitals are being falsely represented.**We need low interest grant loans and other funds for hospitals.**Did we have cost overruns of over \$23 billion last year? No. Our government continues to be a chief critic of mounting hospital cost, but have greatly contributed to the rising cost problem. The legislation that would increase the minimum wage to \$2.00 and \$2.30 will amount to \$84,000 to \$95,000 for each 100 employees.**We spend in this country, as you know, over \$100 billion a year for recreation. Our total hospital and health care will come to about \$95 billion this year and what do we hear. A great yell. Why the records of the National Safety Council show we lost and spend more for accidents each year than we do for hospital care.**For years District Memorial Hospital suffered and the community for the lack of physicians to render good medical care. Now that we are getting doctors it looks like we will not be able to add on the needed beds.**We spent in 1970 more on whiskey and beer than we did for the total care of the medicare and medicaid patient. We spent more on furniture and appliances in that year and some 115 billion on cars, accessories and parts.**A year or so ago we spent \$170,000 to kill each enemy soldier. In 1964 an M-1 rifle cost \$31.00 and today the M-16 cost \$150. Who is to blame for the increase in cost?**Our hospital charges amount to about \$2.50 an hour. At \$108.00 for a patient day this comes to \$4.50 an hour. Is hospital cost really as high as it is presented? Look at the average union wage.**We want better medical care and at as low cost as humanly possible. But let us not take hospitals down the road of the post office and the railroads.**Please keep on helping us.**Sincerely,*
Fred Mashburn
Fred Mashburn, Administrator

Moore Memorial Hospital, Inc.

Pinehurst, North Carolina 28374

June 10, 1974



Senator Sam J. Ervin, Jr.
United States Senate
Washington, D. C. 20510

Dear Senator Ervin:

I am sure that you are aware that the Hill-Burton Program of grants and loan guarantees for hospital and other health facility construction expires June 30, 1974. The Hill-Burton has meant more than any single program to date in providing adequate health facilities for the people of North Carolina.

Most areas now have an adequate number of beds but there is a critical need for the replacement of many beds, modernization of many facilities and the expansion of ambulatory care facilities (including hospital out-patient facilities).

Since the Hill-Burton Program has been administered so effectively here in North Carolina and the need for federal assistance is critical, I urge you to support legislation for the continuation of the Hill-Burton Program. It appears that some form of National Health Insurance will become a reality in the not too distant future. This will surely increase the patient loads in ambulatory care (including all out-patient hospital facilities) and existing inpatient facilities. Many of our hospitals need major renovations rather than total new construction.

Your interest and support of legislation to continue the Hill-Burton Program beyond June 30, 1974 will be greatly appreciated by everyone here in North Carolina.

Very truly yours,

J. Crenshaw Thompson
Administrator
President-Elect, North Carolina Hospital Association

JCT:ba

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

WILLIAM A. EGAN, GOVERNOR

POUCH H — JUNEAU 99801

June 27, 1974

Honorable Mike Gravel
United States Senate
4107 Dirksen Building
Washington, D. C. 20510

Dear Senator Gravel:

We have received a copy of S. 3577, a bill to provide Federal assistance for the cost of construction and modernization of public and non-profit health facilities. We laud many of the concepts and objectives of the proposed legislation and endorse fully the effort to provide Federal financial support through grants, direct loans and loan-guarantees for needed facilities for medically-underserved populations. However, in reviewing the legislation we note many areas of concern.

Specific comments concerning S. 3577 are:

1. We are very concerned that Senate Bill 3577 removes the State Hill-Burton agencies from any administrative functions and that sole authority for the approval of the project within any state rests with Secretary of HEW without any prior selection of projects by the state agency and in accordance with a definitive priority established by a facilities plan. We are very much in favor of review by local planning agencies but final authority for selection of projects to be submitted to HEW should be the prerogative of the state agency which was created 23 years ago and has the experienced staff to do just that.

We support the concept that all functions under the general heading of Health Planning should be included within a single element of State Government. This should include not only Hill-Burton, Regional Medical, Comprehensive Health Planning, Medicare/Medicaid certification, but also facility licensing.

2. We strongly oppose any federal authority which requires or authorizes the delegation or transfer of regulatory authority from public entities to private corporate entities. The concept for establishing Health Service Agencies as local planning entities to

provide advisory recommendations is supported. Such entities should not have authority to mandate their recommendations, however. The state level public entity should have final action authority and accountability to the Federal Government.

This organization supports the concept of single, coterminous planning areas for all health programs.

3. Grant funding is particularly essential for the construction of health facilities which historically have operated at a loss, or would operate at a loss, such as neighborhood health centers, outpatient facilities, rehabilitation centers and facilities for mental health, as well as modernization of all types of facilities to bring them in compliance with federal standards, and for the provision of health facilities in low income areas.
4. Senate Bill 3577 does not specifically address itself to ongoing programs. This leaves unanswered the questions of who will administer supervision over projects under construction or the continuing responsibilities of recipients of Hill-Burton assistance to provide a reasonable volume of free or below cost care. If there is no provision for federal financial support, these activities will probably cease.
5. There is no indication as to who the administrative agent will be under this proposed legislation.
6. In the introductory remarks Mr. Kennedy addressed to the Congress, he spoke to the need for long-term care facilities, but the definitions of health care facilities as contained in this bill do not indicate any application of loan or grant funds to long-term facilities.
7. This bill places the responsibility for implementation and administration of the program with the local health planning agencies. This means that each areawide agency will need to establish or maintain:
 - (a) Planning functions and staff
 - (b) Fiscal and accounting staff for fund control, allocation and disbursement
 - (c) Engineering and technical staff
 - (d) Statistical service staff to acquire data and develop priorities

This means duplication of efforts in the local agencies. Currently, our central State staff does carry out these functions with fewer people than will be required to perform these same functions in each

Honorable Mike Gravel

-3-

June 27, 1974

areawide agency. I was unable to see where this bill provides any administrative funds to establish the above capabilities.

8. Another of our concerns relates to the provision which precludes modernization programs for health facilities not serving medically-underserved populations. For example, such a restriction could exclude hospitals having a legitimate need to modernize because of fire code deficiencies. If no financial means is provided through which such facilities can achieve compliance, such communities could, in fact, become medically-underserved.
9. In addition, we strongly recommend that the definition of outpatient facilities include public health centers as defined under existing law. These centers are needed in our bush areas.
10. This bill allocates a minimum allotment of \$800,000 for grants. Under present legislation we are receiving \$1,200,000 for grants and are hard pressed to assist in modernization of hospitals and other health facilities due to our extremely high construction costs.
11. The increase in population due to economic development of the State is being felt in Fairbanks and other areas of pipeline impact. This bill does not provide funds for additions to present hospitals which will be needed.

It is our position that legislation to extend Hill-Burton should continue the State role in planning and administration of health facility construction programs, continue financial support for State Hill-Burton agencies, and continue formula grants as well as allotments among states of amounts for direct loans and loan guarantees. We agree that outpatient facilities and modernization should have priority.

We recommend that action on S. 3577 be deferred for further study and that the Hill-Burton authorization be extended for one year.

Sincerely,

Frederick McGinnis
Commissioner

FM: LWS: bal

cc: Office of Comprehensive Health Planning

Senator KENNEDY. The subcommittee is now adjourned.
[Whereupon, at 12:30 p.m., the subcommittee adjourned, subject
to the call of the Chair.]



