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HOSPITAL CONSTRUCTION

HEARING
BEFORE
SUBCOMMITTEE NO. 5
OF THE
COMMITTEE ON
THE DISTRICT OF COLUMBIA
HOUSE OF REPRESENTATIVES
NINETIETH CONGRESS
SECOND SESSION
ON

H.R. 6526 and S. 1228

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

JUNE 17, 1968

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

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WASHINGTON : 1968

06-637-36

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HOSPITAL CONSTRUCTION

MONDAY, JUNE 17, 1968

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE NO. 5 OF THE
COMMITTEE ON THE DISTRICT OF COLUMBIA,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m. in room 1310, Longworth House Office Building, Hon. B. F. Sisk (Subcommittee Chairman) presiding.

Members Present: Representatives Sisk (Subcommittee Chairman), Whitener, Walker, and Gude.

Also Present: James T. Clark, Clerk; Hayden S. Garber, Counsel; Sara Watson, Assistant Counsel; Donald Tubridy, Minority Clerk; and Leonard O. Hilder, Investigator.

Mr. SISK. The committee will come to order.

Subcommittee No. 5 has before it this morning certain bills to authorize project grants for construction and modernization of hospitals and other medical facilities here in the District.

Without objection, H.R. 6526, by our distinguished Chairman of the full Committee, Mr. McMillan, will be made a part of the record. Also, S. 1228, by Senator Bible, the Chairman of the Senate Committee on the District of Columbia, together with the Senate Report (S. Rept. 944) thereon, will be made a part of the record, to indicate the extent to which there is a difference in the two bills.

(The bills, H.R. 6526 and S. 1228, and S. Rept. 944 follow:)

(H.R. 6526, 90th Cong., 1st sess., by Mr. McMillan (by request) on Mar. 2, 1967)

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "District of Columbia Medical Facilities Construction Act of 1967".

AUTHORIZATION OF APPROPRIATIONS

SEC. 2. There are authorized to be appropriated for the fiscal year ending June 30, 1967, and for each of the next three fiscal years, such sums as may be necessary to enable the Secretary of the Department of Health, Education, and Welfare (hereafter referred to as the Secretary), to make grants to assist in the modernization of public or nonprofit private hospitals and in the construction or modernization of public health centers, long-term care facilities, diagnostic or treatment centers, rehabilitation facilities, facilities for the mentally retarded, and community mental health centers in the District of Columbia. Sums so appropriated shall remain available until expended.

APPROVAL OF APPLICATIONS

SEC. 3. (a) An application for a grant with respect to any project may be approved by the Secretary under this Act only if an application for a grant with respect to such project has been filed under the Medical Facilities Acts (which for purposes of this Act means title VI of the Public Health Service Act or, where appropriate, title II or part C of title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) and—

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

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

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

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

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

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

PAYMENTS

SEC. 4. (a) Payments under this Act with respect to any project shall be made in the manner provided under the Medical Facilities Act for payments of the Federal share of the cost of projects for which applications are approved under such Acts; except that such payments shall also be subject to such reasonable conditions as the Secretary deems appropriate to safeguard the Federal interest.

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

(1) in the case of a construction project for a long-term care facility, a diagnostic or treatment center, or a rehabilitation facility, 66½ per centum of the cost of such project; and

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

RECOVERY OF PAYMENTS

SEC. 5. Payments under this Act shall be subject to recovery or recapture under the same conditions and to the same extent as is provided under the Medical Facilities Acts with respect to payments made thereunder.

MEANING OF TERMS

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

(S. 1228, 90th Cong., 1st sess., by Mr. Bible (by request) on Mar. 8, 1967)

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

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

AUTHORIZATION OF APPROPRIATIONS

Sec. 2. There are authorized to be appropriated for the fiscal year ending June 30, 1968, and for each of the next three fiscal years, such sums as may be necessary, not to exceed in the aggregate \$36,227,000, to enable the Secretary of the Department of Health, Education, and Welfare (hereafter referred to as the Secretary), to make grants to assist in the modernization of public or nonprofit private hospitals and in the construction or modernization of public health centers, long-term care facilities, including extended care facilities, diagnostic or treatment centers, rehabilitation facilities, facilities for the mentally retarded, and community mental health centers in the District of Columbia. Sums so appropriated shall remain available until expended.

APPROVAL OF APPLICATIONS

Sec. 3. (a) An application for a grant with respect to any project may be approved by the Secretary under this Act only if an application for a grant with respect to such project has been filed under the Medical Facilities Acts (which for purposes of this Act means title VI of the Public Health Service Act or, where appropriate, title II or part C of title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) and—

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

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

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

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

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

(d) An application for a grant under this Act with respect to any project may not be approved unless an opportunity to review the application has been

afforded to a body, found by the Secretary to be a responsible metropolitan area-wide planning body, and any recommendations of such body that were timely made have been considered by the appropriate State agency of the District of Columbia and have been submitted to the Secretary in connection with the application.

PAYMENTS

SEC. 4. (a) Payments under this Act with respect to any project shall be made in the manner provided under the Medical Facilities Acts for payment of the Federal share of the cost of projects for which applications are approved under such Acts; except that such payments shall also be subject to such reasonable conditions as the Secretary deems appropriate to safeguard the Federal interest.

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

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

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

RECOVERY OF PAYMENTS

SEC. 5. Payments under this Act shall be subject to recovery or recapture under the same conditions and to the same extent as is provided under the Medical Facilities Acts with respect to payments made thereunder.

MEANING OF TERMS

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

Passed the Senate December 15, 1967.

Attest:

FRANCIS R. VALEO, *Secretary*.

Referred to the Committee on the District of Columbia, House of Representatives January 15, 1968.

[90th Cong., 1st sess., Senate Rept. No. 944, Calendar No. 929]

DISTRICT OF COLUMBIA HOSPITAL-MEDICAL FACILITIES CONSTRUCTION ACT

The Committee on the District of Columbia, to which was referred the bill (S. 1228) to authorize the establishment of enabling authority legislation for construction and modernization of hospital and other medical facilities in the District of Columbia, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

The amendments are as follows:

(1) On the first page, line 4, strike out "1967" and insert in lieu thereof "1968".

(2) On the first page, line 7, strike out "1967" and insert in lieu thereof "1968".

(3) On the first page, line 8, immediately after "necessary", insert a comma and the following: "not to exceed in the aggregate \$36,227,000,".

(4) On page 2, line 3, immediately after the second comma, insert the following: "including extended care facilities,".

(5) On page 4, line 10, strike out "Surgeon General" and insert in lieu thereof "Secretary".

(6) On page 4, line 25, immediately after the first comma, insert the following: "including extended care facilities,".

PURPOSES OF THE BILL

The purpose of the bill is to authorize supplementary Federal assistance for the District of Columbia government for modernization of public or nonprofit

private hospitals, and for the construction of such health centers, long-term and extended care facilities, diagnostic or treatment centers, rehabilitation facilities, community mental health centers, and facilities for the mentally retarded.

The bill would provide additional Federal project grants to those now available under various programs provided by the Medical Facilities Acts (which for purposes of this bill means title VI of the Public Health Service Act, including the Hill-Burton program, or, where appropriate, title II or pt. C of title I of Mental Retardation Facilities and Community Health Construction Act of 1963).

Briefly, this legislation establishes the administrative and programming machinery for this intended or supplemental aid for projects required to be approvable under construction aid programs—the Hill-Burton program, or the mental retardation facilities of the mental health center construction programs. In summary, the bill provides as follows:

(1) For the funding authorization, for purposes of the act for fiscal year ending June 30, 1968, and for each of the next 3 fiscal years, commencing with the fiscal year ending June 30, 1969, and concluding with the fiscal year ending June 30, 1971.

(2) For a maximum funding authorization of \$36,227,000, or the portion thereof as is necessary and supported by the appropriate national program authority and by approval of the Secretary of the Department of Health, Education, and Welfare.

Supplemental aid would be conditioned upon the sole ground of insufficient funds under the District's allotments under the respective nationwide programs.

(3) For two types of Federal grants to the District of Columbia government:

(a) Supplementary grants to make up the difference between funds provided for a project under the regular, Federally sponsored Hill-Burton, mental retardation or mental health center programs, and the amount of funds required to constitute the higher Federal share authorized by this new legislation; and

(b) Grants for projects enabled to qualify for grants under the Hill-Burton, mental retardation or community mental health center programs, provided an application has been filed for a grant under the appropriate program and has been denied because the project had insufficient priority or because sufficient funds were unavailable in the applicable allotment to the District to permit approval of the application.

(4) For approval of grants for construction of long-term and extended care facilities, diagnostic or treatment centers, or rehabilitation facilities that may not exceed—

(a) 66⅔ percent of the cost of long-term-care or an extended care facility, diagnostic or treatment centers, or rehabilitation facilities; or

(b) 50 percent of the cost of any other project.

(5) For special Federal assistance only if there is compliance with the same terms and conditions (including determination that the project is needed in accordance with the appropriate State plan for health facilities in the District) as are applicable to the grants under the Hill-Burton, mental retardation or mental health center construction programs. Accordingly, such proposed projects would be reviewed to assure compliance with the State plan and priority system required under the Federal Hill-Harris mental retardation or community mental health centers program. Such projects would be required to meet construction and equipment standards contained in regulations adopted to implement such programs.

(6) For a mechanism by which a responsible metropolitan areawide planning body may comment upon the merits of each application. This particular phase is especially noteworthy because it provides a device by which local representatives, both professional and lay, may consider construction proposals in relationship to the needs and plans of other health institutions or programs in the Washington, D.C., metropolitan area, wherein the three jurisdictions of the States of Maryland and Virginia and the District of Columbia are concerned.

BACKGROUND OF FEDERAL AID TO THE DISTRICT OF COLUMBIA

The unique responsibility of the Federal Government to provide financial assistance for the construction of hospitals and other medical facilities in the District of Columbia has been recognized by the Congress for more than 20 years.

In 1946, Congress enacted the Hospital Center Act, authorizing the appropria-

tion of Federal funds for the construction of the Washington Hospital Center as a replacement for three independent, nonprofit hospitals. This act required the District government to pay 50 percent of the net cost to the Federal Government because at that time a serious hospital bed shortage was evident in the District, and Congress felt compelled to meet that emergency.

Later extensions and amendments of that act took place, such as the 1951 amendment authorizing Federal grants of up to 50 percent of the cost of constructing or renovating hospital facilities generally within the District. The District of Columbia government was required to pay 50 percent of the Federal contribution. Such was reduced to 30 percent by a congressional amendment in 1958 to the Hospital Center Act for grants made after that time. Under the 1951 and subsequent amendments, grants totaling \$17,420,453 were made for hospital projects having an estimated total cost of \$44,400,000, with the fact being today that practically every public and private hospital in the District of Columbia having participated in such program. That act expired in 1962.

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

In addition to the Hospital Center Act and Public Law 87-460, both of which applied solely to the District, Federal financial assistance has been given for the construction of hospitals and other medical facilities generally in Washington through two generally applicable Federal programs—the wartime defense housing and public works program, commonly known as the Lanham Act, and the hospital and medical facilities construction program, usually called the Hill-Burton program. Under the Lanham Act, two hospitals in the District received a Federal contribution of \$5,655,000. Under the Hill-Burton program, a total of \$7,194,000 in grants was approved through fiscal year 1966 for 27 projects in the District of Columbia.

LOCAL PRIVATE FUNDING UNAVAILABLE

The medical necessity for the 1946 Washington Hospital Center Act and its amendments thereto arose because of the inability of sponsors within the District of Columbia to raise private capital for hospital construction to meet the statutory matching requirements of the nationwide Hill-Burton program. As a result, the District was unable to use certain funds allotted to it under that program.

Consequently, in 1961 President Kennedy directed the Department of Health, Education, and Welfare to examine into the District's continuing need for special assistance to meet health needs because of the District's unique geographic location. Factually, Washington, D.C., is the central city of a metropolitan area wherein some 40 percent or more of the patients who are required to utilize hospital facilities within the District of Columbia are residents of nearby Maryland and Virginia. This bill is the outgrowth of the findings of the Department of Health, Education, and Welfare originally submitted to the Congress in 1965.

This bill is designed to meet special needs for hospitals and other medical facilities in the District of Columbia by reason of its being the Nation's Capital and the central city of a large metropolitan area, with an estimated 2½ million population expected to increase to 3 billion by 1970.

The special Federal aid made available by the Congress over the past 20 years for construction of District medical facilities indicates that the Hill-Burton, mental retardation and mental health center construction programs provide only a partial answer to the problem of financing the construction of such facilities in the District.

First, sponsors of projects for such construction in the District of Columbia experience serious difficulty in raising the non-Federal share of the cost thereof. Second, the allotment of Hill-Burton funds to the District, which in general is based on per capita income and population, is low in relationship to the facility construction demands, considering that hospitals within the District itself care for a substantial number of residents from suburban Maryland and Virginia.

Nonprofit medical facility groups seeking contributions in Washington do not have available to them much of the important support from corporate gifts which are available in other communities. Corporate gifts generally make up to 60 to 70 percent of the total private funds subscribed for constructing hospitals

in cities the size of the District;¹ and more than half of these corporate gifts come from manufacturing corporations. The District, however, has only about 14 percent of the per capita potential of metropolitan areas of comparable population for receiving contributions from manufacturing corporations.

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

Likewise, unique medical facility utilization and construction problems exist in the District because of the large number of patients from nearby Maryland and Virginia who occupy general hospital beds in the District. A survey conducted in 1958 showed that approximately 40 percent of the patients in District hospitals came from outside the District, primarily from the Maryland and Virginia counties in the metropolitan area.

A study of the residence of patients admitted to general hospitals in the District during the week of February 25-March 3, 1962, showed similar results: only 58 percent of those patients were District residents. If District of Columbia General and Freedman's Hospitals, which are operated locally by the District and Federal Governments, respectively, were excluded from this latter study, a significantly higher percentage of patients in all District of Columbia hospitals from outside the District would be found, ranging up to nearly 60 percent in the case of Georgetown University Hospital. The Hill-Burton, mental retardation and community mental health center construction legislative provisions do not recognize this factor in the allocation of funds. As compared with other States, a wider disparity exists in the District of Columbia between Federal funds available for health facilities construction and the need and demand for such funds.

NEED FOR LEGISLATION

Your committee believes that this legislation is not only a necessary substitute for the outdated Hospital Center Act but in addition, it includes legislative features which (1) take advantage of advances made in recent years in the planning, design, and construction of health facilities; and (2) provide an orderly mechanism for consideration of construction proposals by local, District of Columbia, and Federal officials who are skilled in the planning, design, and construction of hospitals and other health facilities, prior to consideration of such construction proposals by the Congress.

Presently in the District of Columbia, there is a total of 4,879 general hospital beds, with additional facilities for 200 more at George Washington University and Georgetown University Hospitals.

Statistics supplied to the committee by the Health Facilities Planning Council for Metropolitan Washington showed that the total hospital beds in the District of Columbia have an annual utilization rate of 84.7 percent, which means that on a given day of the year an average of 4,147 beds is being utilized and of these, at least 40 percent, or 1,659 beds, are being used by residents of nearby Maryland and Virginia, leaving 2,488 beds for use by District residents. Furthermore, the average length of stay for a patient in any one of these beds is 8.1 days.

Obviously, the Maryland and Virginia residents either prefer the medical facilities located in the District of Columbia or such facilities are not as readily available in their States of residence. Whatever the reason, the District's hospitals face a greater patient influx than would be the case if the District were not the unique geographic and governmental unit it is.

Presently, excessive occupancy of acute hospital beds within the District must continue until such time as sufficient nursing home beds become available. Estimates place this need in the Washington metropolitan area at 3,000 beds of which

¹ "Survey of Municipal Hospital Facilities," by J. B. Steinle (1957), indicating that industrial and commercial concerns account for 70 to 80 percent of all private donations to hospitals.

more than 600 beds can be used immediately in the District. Presently, the District has 2,513 beds in 26 licensed nursing homes which are being occupied near the 100-percent figure throughout the year.

LONG-TERM-CARE FACILITIES INADEQUATE

The need for Federal aid is most acute in the case of long-term-care facilities, one of the principal aims of the medicare program nationally and especially important in the District because Congress is expected to clear this session enabling legislation already passed by both Houses, placing the District under medicare coverage. The lack of private fundraising potential for construction of these facilities is even more pronounced, than in the case of short-term-care facilities—as demonstrated by the fact that the District has been able to use little of the money available to it under the Hill-Burton program for construction of long-term-care facilities, due to inability to raise the required matching funds.

The District of Columbia Department of Public Health advised the committee that 272 additional long-term-care beds are needed and 204 other long-term-care beds require modernization or replacement in the District. Assuming an average cost of \$10,000 per bed, the total cost of construction and modernizing long-term beds amounts to \$4.7 million, whereas the annual Hill-Burton allotment to the District of Columbia for this purpose is only \$200,000.

For the reasons cited above, special Federal assistance for the modernization of hospitals and the construction or modernization of other medical facilities in the District of Columbia is clearly required. To make up for the loss of normal private sources of support in the District, Federal grants should cover up to two-thirds of the cost of construction projects for a long-term-care facility, a diagnostic or treatment center, or a rehabilitation facility. The urgency of the need for such facilities and the relatively greater difficulty in securing financing for the non-Federal share of the cost of their construction, justifies a higher matching ratio than in the case of short-term-care facilities.

Federal grants under this bill would not be available to provide additional short-term acute general hospital beds. The Health Facilities Planning council for Metropolitan Washington has found that additional general beds in the District of Columbia will not be needed until after 1975. If this should change, however, additional authority can be sought from the Congress to construct additional general hospital beds, commensurate with the need existing at that time.

Your committee believes that the emerging patterns of health care nationwide, as already evidenced within the medicare and medicaid programs, point to the need in urban cities, such as Washington, D.C., for medical complexes ranging, from specialized acute care—both physical and mental—to ambulatory facilities, self-care units, and long-term-care facilities providing extended convalescent care. The bill under consideration provides a higher Federal share for long-term and extended care and ambulatory care facility construction as an incentive to the construction of these less costly facilities. This action should help to stabilize the cost of medical care and at the same time reduce the pressures for more acute care beds which are more expensive to construct and operate.

COST OF LEGISLATION

Supplementary Federal grants permitted under this legislation during the period ending June 30, 1971, could not exceed \$36,227,000 under the authorization maximum of this bill. To support the physical need for this bill, the District of Columbia Department of Public Health submitted the accompanying table setting forth current plans for hospitals and other health facilities in the District of Columbia.

While the justification for each of these construction proposals would be required to meet standards laid down in the appropriate sections of the Medical Facilities Acts and the Mental Retardation Facilities and Community Health Construction Act of 1963, the statistical table illustrates the magnitude of the problem as viewed presently without attempting to project the need for 5 of 10 years in this fastest growing metropolitan area in the country. An example of the inadequacy of Federal funds presently available to the District under the Hill-Burton program to construct and modernize needed general hospital facilities is the fact that the Hill-Burton allotment to the District of fiscal year 1968 is \$441,619 compared to the current need of \$36,227,000.

CONSTRUCTION NEEDS FOR DISTRICT OF COLUMBIA HOSPITALS AND MEDICAL FACILITIES

ESTIMATED EXPENDITURES FOR GENERAL AND LONG-TERM HOSPITAL AND MEDICAL FACILITIES UNDER S. 1228 THROUGH JUNE 30, 1971

Name of facility	Current bed capacity		Number of beds to be added		Other facilities to be provided	Planned estimated cost (thousands)	Present estimated Federal share (thousands)		Estimated date of completion
	General	Long term	General	Long term			Total	Hill-Harris	
Hospital:									
Casualty.....	210		40	100	200 Medical education and staffing expansion of physio-therapy and outpatient facilities, 200-bed nursing home,.....	\$12,350	\$6,174	0	\$6,175 (1).
Children's.....	205		11	45	0 Emergency room and basement,.....	5,000	3,333	0	3,333 (1).
Children's Convalescent.....			50	89	0 Emergency power generator,.....	541	271	\$200	71 (1).
Columbia.....	152			2	30 Improvement and expansion of existing facilities,.....	93	47	31	16 October 1968.
					0 New hospital,.....	2,905	146	146	0 December 1967.
					30 Replacement and additional beds,.....	22,000	11,000	0	11,000 1974.
					0 Master plan, phases II and III,.....	1,150	575	575	0 April 1968.
					Emergency generator,.....	2,500	1,333	0	1,333 1973 and 1977.
					Centralized air conditioning for operating and delivery rooms, increase examining rooms, convert pantry to 2-bed room, new flooring for central sterilizing room, alteration of delivery suite, replacement and improvement of heating in nurseries, installation of a pediatric laboratory, and replacement of a roof,.....	55	18	18	0 November 1967.
					Remodeling and expansion of present facilities,.....	154	77	38	39 April 1968.1
Georgetown University.....	377	20	140		Remodeling of 1948 building,.....	414,871	2,435	71	2,364 December 1970.
George Washington University.....	400		10		Remodel emergency room,.....	510,500	3,929	709	3,220 November 1968.
					Remodel premature nursery,.....	474	237	183	54 December 1968.
					Remodel urology,.....	30	15	0	15 Do.
					2d floor north—heart station and pulmonary function and treatment center,.....	50	25	0	25 Do.
						1,500	750	0	750 1969.

See footnotes at end of table.

CONSTRUCTION NEEDS FOR DISTRICT OF COLUMBIA HOSPITALS AND MEDICAL FACILITIES—Continued
ESTIMATED EXPENDITURES FOR GENERAL AND LONG-TERM HOSPITAL AND MEDICAL FACILITIES UNDER S. 1228 THROUGH JUNE 30, 1971—Continued

Name of facility	Current bed capacity		Number of beds to be added		Other facilities to be provided	Planned estimated cost (thousands)	Present estimated Federal share (thousands)		Estimated date of completion
	General	Long term	General	Long term			Total	S. 1228 Hill-Harris	
Hospital:									
Hadley	85								
Morris Garfritz Memorial	298		82		100 Nursing home	\$1,300	\$867	\$578	\$289 (1)
Slipley	309								
Washington Hospital Center	251		99	300	Modernization	276	138	78	60 (1)
					Extended care unit	6,500	4,333	0	4,333 1972.
					Emergency electric powerplant	800	400	0	400 (1)
			235	200	Bed expansion by use of existing porches	1,500	1,000	0	1,000 1972.
Glenn Dale Hospital					Modernization of kitchen, physiotherapy and occupational therapy, and expansion of operating suite	500	250	0	250 1972.
Total hospitals	2,287	438	585	860	Comprehensive health center	83,049	37,354	2,627	34,727
Other: Area B (District of Columbia Department of Public Health facility)						6,000	3,000	1,500	1,500 1971.
Total estimated expenditures						89,049	40,354	4,127	36,227

¹ Not known.

² Includes \$393,000 NIH-funded project.

³ This replaces existing beds and adds 89 new beds.

⁴ \$10,000,000 direct Federal grant for experimental purposes.

⁵ \$2,500,000 congressional appropriation and \$121,158 NIH project.

Note: In summary, it is estimated that the total expenditure for additions and improvements to general and long-term hospital and other medical facilities in the District of Columbia through the end of fiscal year 1971 will be approximately \$89,000,000 of which \$4,100,000 will be covered by the existing Medical Facilities Acts and \$35,200,000 would be provided under S. 1228.

COMMITTEE AMENDMENTS

Amendments 1 and 2 make the necessary date changes.

Amendment 3: Your committee was unanimous in the judgment that an authorization maximum for the amount of supplementary Federal grants permitted by this bill should be written into the legislation. The committee concluded that \$36,227,000 would meet the requirements for the period during which the supplementary grant program would remain in effect for the District of Columbia under this bill. This amount was supported by particular project justifications set forth in the table, entitled "Construction Needs for District of Columbia Hospitals and Medical Facilities," earlier in this report.

Amendments 4 and 6: As reported, these amendments, as set forth on page 1 of this report, would provide clarification of the term "long-term-care facilities" by adding "including extended care facilities." Such amendments would include "extended care facilities" as being available to receive supplementary Federal grants to assist in their construction or modernization along with the categories of facilities covered.

These amendments, advocated by the District of Columbia Medical Society, were supported on the basis that the greatest need in health facilities construction in the District is for extended care facilities. Witnesses testified such would relieve the load on general hospitals and thereby reduce hospital costs to the family, the insurers, and the Government. Availability of extended care facilities would permit patients to be released from general hospitals earlier. "Long-term-care facilities" are ordinarily considered in medical terminology to be domiciliary care for the elderly. Addition of "including extended care facilities" to the term "long-term-care facilities" is designed to insure that the two health facility designations will not be improperly confused and to clarify their differing functions.

Amendment 5: A technical and clarifying amendment to substitute "Secretary" for "Surgeon General" in the Department of Health, Education, and Welfare.

CONCLUSION

Public hearings were held August 21, 1967, before the Subcommittee of Public Health, Education, Welfare, and Safety. Supporting testimony was received from the Department of Health, Education, and Welfare, the District of Columbia government, the District of Columbia Medical Society, officials of the Hospital Council of the National Capital Area, and the Washington Hospital Center. No opposition was expressed.

Your committee is impressed with the urgency for this legislation because of the manner by which it proposes to mesh with current national programs of Federal aid and its comprehensive approach to orderly and effective implementation of the health care facility planning process and the safeguards included. Therefore, your committee strongly recommends is passage, as amended.

SECTION-BY-SECTION ANALYSIS

The first section sets out the title "District of Columbia Medical Facilities Construction Act of 1968."

Section 2 authorizes total appropriations not to exceed \$36,227,000 for fiscal years ending June 30, 1968, 1969, 1970, and 1971 for the Secretary of the Department of Health, Education, and Welfare (hereinafter "Secretary") to make grants to assist in the modernization of public or private nonprofit general hospitals and the construction or modernization of public health centers, long-term-care facilities including extended care facilities, diagnostic or treatment centers, rehabilitation facilities, facilities for the mentally retarded, and community mental health centers.

Section 3(a) provides that the Secretary may approve grant applications only if an application has been filed under the Medical Facilities Acts (title VI of the Public Health Service Act (Hill-Burton Act) or title II or pt. C of title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963), and such application either has been approved under the Medical Facilities Acts and the application is for additional funds, or it would have been approved under these acts except that sufficient funds from District allotments are not available to permit approval.

Availability of funds under this bill as required to be considered in connection with the possible approval of applications under the Medical Facilities Act.

Section 3(b) directs the Secretary to establish criteria for the order of approval of applications which shall be the same criteria as that developed by the District of Columbia "State agency" pursuant to a plan approved under the Medical Facilities Act.

Section 3(c) provides that applications for grants under the bill may be approved only if they comply with the terms and conditions for applications under the Medical Facilities Act, other than the availability of sufficient funds in the District allotment.

Section 3(d) provides that applications for grants under the bill may not be approved unless the areawide planning body has an opportunity to review it and that body's recommendations have been considered by the District "State agency" and submitted to the Secretary in connection with the application.

Section 4(a) provides that payments shall be made in the manner provided under the Medical Facilities Acts subject to reasonable conditions imposed by the Secretary and section 4(b) specifies that total payments, together with payments under the Medical Facilities Acts, may not exceed—

- (1) 66⅔ percent of the cost of a long-term-care facility including extended care facilities, a diagnostic or treatment center, or a rehabilitation facility; or
- (2) 50 percent of the cost of any other project.

Section 5 provides that conditions for recovery of payments shall be the same as under the Medical Facilities Acts.

Section 6 provides that the meaning of terms used in the bill shall be the same as under the Medical Facilities Acts.

Mr. SISK. In connection with the District Government's position on these bills, without objection a letter dated February 15, 1967, signed by the then President of the Board of Commissioners of the District of Columbia, Hon. Walter N. Tobriner, will be made a part of the record; and also a later letter, dated May 31, 1968, signed by Thomas W. Fletcher, Assistant to Commissioner Washington, will be made a part of the record.

(The letters referred to follow:)

GOVERNMENT OF THE DISTRICT OF COLUMBIA,
EXECUTIVE OFFICE,
Washington, February 15, 1967.

The Honorable The SPEAKER,
United States House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: The Commissioners of the District of Columbia have the honor to submit herewith a draft bill "To authorize project grants for construction and modernization of hospitals and other medical facilities in the District of Columbia."¹

The first section of the bill gives it the title "District of Columbia Medical Facilities Construction Act of 1967".

Section 2 authorizes appropriations for fiscal years ending June 30, 1967, 1968, 1969, and 1970 for the Secretary of the Department of Health, Education, and Welfare (hereinafter "Secretary") to make grants to assist in the modernization of public or private nonprofit general hospitals and the construction or modernization of public health centers, long-term care facilities, diagnostic or treatment centers, rehabilitation facilities, facilities for the mentally retarded, and community mental health centers.

Section 3(a) provides that the Secretary may approve grant applications only if an application has been filed under the Medical Facilities Acts (title VI of the Public Health Service Act [Hill-Burton Act] or title II or part C of title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963), and such application either has been approved under the Medical Facilities Acts and the application is for additional funds, or it would have been approved under these Acts except that sufficient funds from District allotments are not available to permit approval.

Availability of funds under this bill is required to be considered in connection with the possible approval of applications under the Medical Facilities Act.

¹ Introduced as H.R. 6526 by Chairman McMillan (by request).

Section 3(b) directs the Secretary to establish criteria for the order of approval of applications which shall be the same criteria as that developed by the District of Columbia "State agency" pursuant to a plan approved under the Medical Facilities Acts.

Section 3(c) provides that applications for grants under the bill may be approved only if they comply with the terms and conditions for applications under the Medical Facilities Act, other than the availability of sufficient funds in the District allotment.

Section 3(d) provides that applications for grants under the bill may not be approved unless the areawide planning body has an opportunity to review it and that body's recommendations have been considered by the District "State Agency" and submitted to the Secretary in connection with the application.

Section 4(a) provides that payments shall be made in the manner provided under the Medical Facilities Acts subject to reasonable conditions imposed by the Secretary and section 4(b) specifies that total payments, together with payments under the Medical Facilities Acts, may not exceed—

- (1) 66⅔% of the cost of a long-term care facility, a diagnostic or treatment center, or a rehabilitation facility; or
- (2) 50% of the cost of any project.

Section 5 provides that conditions for recovery of payments shall be the same as under the Medical Facilities Acts, and section 6 provides that the meaning of terms used in the bill shall be the same as under the Medical Facilities Acts.

The purpose of the bill is to authorize Federal assistance for the District of Columbia, supplementary to that now available under various programs provided by the Public Health Services Act, including the Hill-Burton program and Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, for modernization of public or nonprofit private hospitals and the construction of public health centers, long-term care facilities, diagnostic or treatment centers, rehabilitation facilities, facilities for the mentally retarded, and community mental health centers.

Private nonprofit medical facilities in the District of Columbia have been unable to take full advantage of the Federal programs for two reasons. First, the allocation of funds is based on a formula which takes into consideration the per capita income of the area. The high per capita income in the District of Columbia results in a proportionately lower allocation of funds than would be the case if per capita income in the District were nearer the national average. Presumably, there is an expectation that the high income group will readily contribute toward meeting the non-Federal share of the cost of the project. Experience in the District of Columbia has indicated, however, that this is not the case. Many of the residents of the District are in a very real sense "temporary residents" (although for an indefinite period) whose loyalties in the matter of contributions to the cost of a hospital project are directed more toward projects in their home States than toward those in the District of Columbia.

The second reason for the inability of the District of Columbia to take full advantage of these Federal programs is the unavailability in the District of corporate donors, who are in other cities the largest contributors to such projects.²

Consequently, less money can be expected to be collected for medical facilities in the District of Columbia than is the case in other jurisdictions where there is a higher degree of permanency of residence and a relatively high incidence of commercial, manufacturing and industrial activities.

Similarly, in the case of public medical facilities in the District of Columbia, the low District allocation of funds under these Federal programs and the substantial percentage of matching funds required from District appropriations have inhibited participation in these programs by the District. One result of the present situation was that the cost of a recent modernization program for D.C. General Hospital was borne almost entirely by District appropriations.

As a result of this situation, representatives of the District of Columbia have for some time worked with representatives of the Department of Health, Education, and Welfare on draft legislation, similar to this bill, which would compensate for these special circumstances by making additional Federal funds

² Survey of Municipal Hospital Facilities by J. B. Steinle (1957), indicating that industrial and commercial concerns account for 70 to 80 percent of all private donations to hospitals.

available for District projects and which would increase the percentage of the Federal share for such projects.

Section 3(d) of the bill requires review of application for grants by a body found by the Secretary to be a responsible metropolitan areawide planning body. There is presently in existence and operation in this area the Metropolitan Washington Health Facilities Planning Council, an areawide planning body sponsored by the Department of Health, Education, and Welfare. The Commissioners are informed that if there were no such body in existence, the Department of Health, Education, and Welfare would consider the requirement of section 3(d) inoperative. The Commissioners consider it advisable, however, that the legislative history of the bill reflect this position of the Department of Health, Education, and Welfare, so that there will be no problem arising at a later date. With this understanding, the Commissioners strongly urge the enactment of this bill in its present form.

The Commissioners have been advised by the Bureau of the Budget that, from the standpoint of the Administration's program, there is no objection to the submission of this proposed legislation to the Congress.

Sincerely yours,

WALTER N. TOBRINER,
President, Board of Commissioners, District of Columbia.

GOVERNMENT OF THE DISTRICT OF COLUMBIA,
EXECUTIVE OFFICE,
Washington, D.C., May 31, 1968.

HON. JOHN L. McMILLAN,
*Chairman, Committee on the District of Columbia,
United States House of Representatives,
Washington, D.C.*

DEAR MR. McMILLAN: The Government of the District of Columbia has for report H.R. 6526 and S. 1228, similar bills, "To authorize project grants for construction and modernization of hospitals and other medical facilities in the District of Columbia."

H.R. 6526 is identical to draft legislation submitted to the Speaker of the House of Representatives by the President of the former Board of Commissioners by letter dated February 15, 1967, a copy of which is attached to this report. For the reasons stated in that letter, the Government of the District of Columbia endorses the enactment of legislation of this nature for the construction and improvement of medical facilities in the District of Columbia.

S. 1228, as introduced, was identical to H.R. 6526. It was, however, prior to its passage by the Senate on December 15, 1967, amended to make necessary changes in dates used in the bill, to include references to extended care facilities for clarification purposes, and to establish a \$36,227,000 authorization maximum for the amount of supplementary Federal grants. (Senate Report No. 944, December 14, 1967)

The Government of the District of Columbia concurs in the amendments made in S. 1228 by the Senate, and recommends that S. 1228 be enacted in lieu of H.R. 6526. If, however, similar amendments were made in the latter bill, the District would also favor its enactment.

The Government of the District of Columbia has been advised by the Bureau of the Budget that, from the standpoint of the Administration's program, there is no objection to the submission of this report to the Congress.

Sincerely yours,

/s/ Thomas W. Fletcher
THOMAS W. FLETCHER,
Assistant to the Commissioner.
(For Walter E. Washington, Commissioner).

PURPOSE AND BACKGROUND OF THE LEGISLATION

Mr. SISK. It is my understanding that the purpose of these bills is to authorize Federal project grants for the construction and moderniza-

tion of hospitals and other medical facilities in the District of Columbia.

From the standpoint of background, the responsibility of the Federal Government to provide financial assistance for the construction of hospital and other medical facilities in the Nation's Capital has been recognized by the Congress for the past 20 years.

In 1946, Congress enacted the D.C. Hospital Center Act (Public Law 648, approved Aug. 7, 1946, 60 Stat. 896) authorizing the appropriation of Federal funds in the amount of \$35 million, or 50 percent of the construction costs of the Washington Hospital Center as a replacement for three independent non-profit hospitals. Since that time, several extensions of and amendments to that Act were added until a total of \$44.4 million had been authorized, on a matching basis, for construction projects in connection with every public and private hospital in the District of Columbia. That Act expired in 1962.

In 1962, Congress enacted Public Law 87-460 (approved May 31, 1962, 76 Stat. 83), authorizing a special Federal grant of \$2.5 million as 50 percent of the cost of construction for an addition to George Washington University Hospital. These funds were appropriated and the project has been completed.

In addition to these acts, Federal financial assistance for the construction of District of Columbia hospitals has been obtained through two generally applicable Federal programs—the Lanham Act and the Hill-Burton Act.

Under the Lanham Act (Title 42, U.S.C. 1521), two D.C. hospitals received a total Federal contribution of \$5.655 million, and under the Hill-Burton program (Title 5, U.S.C. 757) a total of \$7.194 million in grants was approved through fiscal year 1966, for 27 hospital projects in the city.

PRESENT NEEDS

Today there is a demonstrated need for the \$36,227,000 authorized in the bill for the construction of needed medical facilities in the District, in addition to the \$49 million in matching funds which the institutions themselves would be required to provide.

I might say right here it is possible there will be an amendment to further increase that, maybe something like \$4 million.

Under the formula for the allocation of Hill-Burton funds, the District of Columbia will be entitled to only \$441,619 in fiscal year 1968, on a matching basis. The demonstrated inability of District resources to meet these capital needs is the same now as when the Washington Hospital Center Act was enacted.

The most urgent needs of the D.C. medical facilities today are in the area of extended care. This proposed legislation, in addition to assisting with modernization needs, would provide special incentives to D.C. health care institutions to develop these extended facilities and programs by providing Federal matching funds to the extent of 66⅔ percent of the construction costs.

As to the differences in the two bills which I requested be put in the record, S. 1228, which was approved by the other body on December 15, 1967, differs from H.R. 6526, introduced by Chairman McMillan, in only one major respect. Whereas H.R. 6526 would provide for an "open end" authorization for the appropriations, the Senate amended the

legislation to establish a ceiling of \$36,227,000 for these appropriations, which would be authorized over the next three fiscal years.

At this time the Chair would like to place in the record a statement by our colleague, Mr. Joel T. Broyhill of Virginia, who had hoped to be before the committee this morning. Unfortunately, he is unable to be here, and without objection Mr. Broyhill's statement will be made a part of the record at this point.

**REMARKS OF HON. JOEL T. BROYHILL, REPRESENTATIVE IN
CONGRESS FROM THE STATE OF VIRGINIA**

Mr. Chairman: I am delighted to support H.R. 6526 as a Bill that is vitally necessary to provide hospital and medical center facilities in the District of Columbia. This Bill recognizes the pressing and perhaps staggering needs of the hospitals and medical centers that provide essential patient care for the residents of the District of Columbia as well as for the residents in the neighboring Virginia and Maryland nearby areas. This Bill (which is under the sponsorship of the Hospital Council of The National Capital Area) is the result of many years of planning by the individual Hospitals and Medical Centers under the guidance of the Hospital Council as the planning agency for the area hospitals and medical centers. I have recognized that the Hill Burton program for the District of Columbia does not provide either adequate or fair funding for the federally impacted area of Greater Metropolitan Washington. This Bill should be enacted immediately so that the hospitals and medical centers can at once start to meet the patient service needs that exist right now.

This Bill has a well conceived planning structure to provide area wide planning and coordinated effort of the hospitals and medical centers as they struggle to meet the impact of Medicare and the metropolitan area's strident growth.

There is one essential feature to make this program effective which is not in the present form of the Bill. This feature is a provision for federal loans at a low interest rate over an extended period of years.

The hospitals and medical centers need this loan provision if they are to achieve their necessary construction to meet metropolitan area needs.

It would be unrealistic to state that these private institutions could raise the matching money without borrowing, since their public drive support is principally used to meet operating expenses. The exceedingly high rates of interest that these institutions would have to pay from private financing in the present money market places an unbearable burden of increased repayment cost on the hospitals and medical centers which would have to be passed on to the patient, raising the patient costs to unprecedented high charges—perhaps even unbearable.

In order for these private institutions to meet the construction backlog of pressing needs now, they need the availability of these loan funds. To delay the timing of this necessary construction will only increase the costs since construction costs climb every year.

There is another particular point in this Bill in which I am deeply interested. That is the provision of allotment to Georgetown University Medical Center. The provision in the Senate version of this

bill showed Georgetown University at a construction program of \$14,871,000, with a request for \$2,364,000 from funds under this Bill.

Since that time Georgetown University Medical Center has undertaken to start the construction of diagnostic and treatment facilities that are a planned part of the hospital bed renovation program. Also the associated clinical instruction space for the professors and medical and dental students has started.

The costs of these facilities of the Georgetown University Medical Center (undertaken in its efforts to provide health service to the District of Columbia and the metropolitan area) is \$12,461,000. Of this amount Georgetown University is in critical need of \$3,820,000 in the grant portion of this bill to complete its facilities.

What are these facilities? They are new buildings and renovations to provide additional out patient facilities joined together with special facilities for mentally retarded children. Also under construction is a clinical instruction and research building with associated library space and clinical dental building.

Are these facilities which are being built an asset to the District of Columbia and to the Washington metropolitan areas in Virginia and Maryland?

Perhaps a recitation of some of the services that Georgetown University's Medical Center—a privately owned and privately supported institution—provides through its physicians, dentists, residents and clinical students will show how much they are needed and show that indeed they are an asset.

Their faculty physicians, dentists, residents and students serve the metropolitan community at its clinics and hospitals. In addition Georgetown University gives medical services to D.C. General Hospital, V.A. Hospital, Children's Hospital, Arlington Hospital and a variety of clinics and special services of Health departments and private health agencies.

In 1966-67, there were 49,527 indigent D.C. resident clinic visits at Georgetown University Medical Center. To this must be added the several thousands of indigent cases from the Metropolitan Area outside the District boundary line. The costs to Georgetown University above the nominal charges collected was in excess of \$350,000. Together with its in patient services, the uncollected costs were in excess of \$1,000,000.

At D.C. General Hospital twenty-two members of the full-time faculty of Georgetown University School of Medicine supervise sixty-five Georgetown interns and residents and twenty postdoctoral fellows. The hospital swarms with Georgetown students. Many members of the full-time and volunteer faculty serve as visiting physicians, assuring that the least fortunate of our citizens receive the same or better medical care than that received by our more fortunate citizens.

Of the full-time faculty stationed at D.C. General, ten receive no income whatever from the District of Columbia. They are paid entirely by Georgetown University. Georgetown has made a large commitment to service in our city hospital. To be sure, D.C. General provides a magnificent training ground for our medical students and graduate trainees in the numerous specialties of medicine. But Georgetown is there because it wants to be there. Since Georgetown is in the business of rendering health care, it has assumed the obligation of rendering

health care to all citizens of Washington and the Metropolitan Area, regardless of economic status, in its own hospital and in the municipal hospital. (Statistic: In 1965, 5,800 babies were born at D.C. General. Of these, 2,000 were delivered by Georgetown people, teachers and students.)

In its service to the federal government besides that of caring for sick employees of the Federal government, fifty members of the full-time faculty of the School of Medicine and many members of the part-time faculty serve as consultants and committee members in the health and other agencies of the United States government. Many are members of committees and clinical study panels of the National Institutes of Health. Others serve the Armed Services, the Veterans Administration, NASA, the Social Security Administration, CIA and the Civil Service Commission. All serve at significant material and temporal sacrifice. All feel the obligation to assist in the smooth functioning of governmental operations by lending "know how" to the government's programs in health, education, and research.

In the dental clinics 6500 new patients, many of them children, are cared for. Of these 50% are from lower income groups.

In the Georgetown University's instruction and clinical programs there are no restrictions as to race, color or creed.

The graduates of Georgetown University Medical Center provide the Metropolitan area with one-fourth of the area's doctors and 50% of its dentists.

Georgetown University's Medical Center's financial construction need is critical and urgent in order to complete the program it has courageously started in its efforts to provide its share of the Washington Area's health needs.

I recognize this need and the asset Georgetown University's Medical Center is to the community and give my assurance of help to this Bill and Georgetown's additional request for funds.

I wish also to express my strong support for the amendments to this proposed legislation which are being offered jointly by spokesmen for Georgetown University and for the D.C. Hospital Council.

Mr. SISK. I understand Dr. Murray Grant has an appointment this morning and does need to appear as soon as possible so, Dr. Grant, the Committee will hear you to start out this morning and any others you might like to have appear with you at this time. Go right ahead.

STATEMENT OF DR. MURRAY GRANT, DIRECTOR, DEPARTMENT OF PUBLIC HEALTH, DISTRICT OF COLUMBIA; ACCOMPANIED BY DR. REINALDO A. FERRER, ASSOCIATE DIRECTOR FOR MEDICAL CARE, DEPARTMENT OF PUBLIC HEALTH, DISTRICT OF COLUMBIA; AND THOMAS MOYER, ASSISTANT CORPORATION COUNSEL, DISTRICT OF COLUMBIA

Dr. GRANT. Thank you, Mr. Chairman.

I would like first to introduce the two gentlemen with me. To my left is Dr. Reinaldo A. Ferrer, Associate Director for Medical Care,

Department of Public Health, District of Columbia; and to my right is Mr. Thomas Moyer from the Corporation Counsel's Office of the District of Columbia.

PURPOSE OF THE BILLS

Dr. GRANT. The stated purpose of these Bills is to authorize project grants for construction and modernization of hospitals and other medical facilities in the District of Columbia, supplementary to similar grants now available to the States and the District of Columbia under the Hill-Harris and the Mental Retardation Facilities and Mental Health Centers Construction Act of 1963.

DIFFERENCES BETWEEN THE BILLS

The texts of S. 1228 and H.R. 6526 are slightly different with respect to the following sections of the Bills:

1. Under Section 2 of S. 1228, "such sums as may be necessary, not to exceed in the aggregate \$36,227,000," are authorized through June 30, 1971, while under the same section of H.R. 6526, only "such sums as may be necessary" are authorized to be appropriated.

2. Section 2 of S. 1228 authorizes grants for construction or modernization of extended care facilities, but Section 2 of H.R. 6526 does not.

3. Section 3(d) of S. 1228 calls for submittal of applications for grants under this Bill to the Secretary of Health, Education and Welfare, while the same section of H.R. 6526 calls for submittal of applications for grants to the Surgeon General.

4. Section 4(b) (1) of H.R. 6526 excludes extended care facilities, while Section 4(b) (1) of S. 1228 includes extended care facilities.

EFFECT IN THE DISTRICT OF COLUMBIA

These Bills are designed to provide for taking care of special needs for modernization of hospitals and construction or modernization of other medical facilities in the District of Columbia by reason of its being the Nation's Capital and the central city core of a large metropolitan area, now with an estimated 2.5 million population and expected to increase to 3.5 million by 1980.

It is noted that the funds appropriated under the provisions of Section 2 of these Bills are to make grants to assist in the *modernization of public or nonprofit hospitals*, and in the construction or modernization of other medical facilities in the District of Columbia. Section 2 is not in harmony with the intended purpose of both bills—"To authorize project grants for construction and modernization of hospitals and other medical facilities in the District of Columbia."

If the funds appropriated by these Bills are limited to the *modernization of public or nonprofit hospitals*, such provision would preclude their utilization in the construction of a new hospital facility, such as the proposed New Children's Hospital of the District of Columbia, which has been estimated to cost \$40.0 million.

NEED IN THE DISTRICT OF COLUMBIA

It has been determined by Congress many times in the past by special legislation with respect to the expansion, construction, or reconstruction of specific hospitals and medical facilities that there are needs in the District over and above those being met by the various hospital and medical facilities construction Acts, which are applicable to all the States and the District of Columbia.

GENERAL HOSPITAL AND NURSING HOME BEDS

In the District of Columbia there is now a total of 4957 general hospital beds in existence or approved for construction.¹ In accordance with the statistical report for the year ended June 30, 1967 of the Health Facilities Planning Council for Metropolitan Washington, these hospital beds have an annual utilization rate of 84.7 percent compared with a national average of 76.5 percent. This means that on a given day of the year, an average of 4199 beds are being utilized and of these it is estimated that 40 percent or 1680 beds are being used by residents of the surrounding counties, leaving 2519 beds for use by District residents. Furthermore, the average length of stay of a patient in any one of these beds is 8.1 days. Also, for the year 1965² the occupancy rates of these beds per thousand Metropolitan Washington Area residents was as follows:

District of Columbia-----	1886
Maryland -----	477
Virginia -----	565

Comparison of the above utilization data with that of the United States indicates that the beds in the District are being over-utilized. This fact, plus the existing critical shortage of skilled nursing home beds in the District, is now and will continue to be a serious obstacle in meeting the demands for beds under the Medicare and Medicaid provisions of the Social Security Act. Excessive occupancy of acute hospitals beds must continue until such time as sufficient nursing home beds become available. Estimates of this additional need in the District range upward from 600. At present, we have in the District 2490 beds in 26 licensed nursing homes which are being occupied for all practical purposes close to 100 percent throughout the year.³

OTHER RELATED HEALTH CARE FACILITIES

Besides the known need for hospital and nursing home beds, annual surveys made by the D.C. Department of Public Health for the preparation of long range hospital and medical facilities construction plans under the provisions of the Hill-Harris Act (formerly Hill-Burton)

¹ *Hospital and Medical Facilities Construction Plan*, 1968 Revision, D.C. Department of Public Health.

² *Ibid.*

³ *1966 Survey of Extended Care Facilities*, D.C. Department of Public Health.

indicate that there is, and will continue to be, need for additional health care facilities in the following areas: Public Health Community Centers; Diagnostic and Treatment Centers; Rehabilitation Facilities; facilities for the Mentally Retarded; and Community Mental Health Centers within the District of Columbia. Toward the satisfaction of this need, the Department of Public Health has, in the planning stage, a health care facility for the near Northwest Area of the District which will include all the facilities listed. This health care facility will be the prototype for similar facilities in other areas of the City.

The District is also at a disadvantage in the allocation of funds under the Hill-Harris Program because of the formula method used which distributes the funds according to the per capita income and population of a given State. The District of Columbia has one of the highest average per capita incomes in the U.S. but as such it does not reflect the large proportion of the population at or below accepted medically indigent income levels. Also, when classified as a "State" for the allocation of Hill-Harris Federal Funds, population-wise the District is one of the smallest "States" of the Union. Because of the absence of heavy industry in the area, philanthropic contributions are not commonly available to help finance the construction of needed health care facilities. Government, as the major source of employment in the District, must replace the absence of this philanthropic base.

At the present time, the District of Columbia is eligible for approximately \$1 million a year for hospital and medical facility construction as a result of existing Federal legislation. These bills being considered today would enable the District of Columbia to receive additional funds urgently needed for the construction of health care facilities. Our estimated needs for these purposes through June 30, 1971, are reflected in the attached chart. This document indicates that, over the next few years, more than \$90 million may well be needed for health care facility construction in the District of Columbia, and that, of this amount, only a little over \$2 million will be available through existing legislation. We are hopeful, Mr. Chairman, that the bill being considered here today will make available an additional \$40 million in Federal funds, still leaving approximately \$48 million to be secured through other sources.

In summary, Mr. Chairman, we recommend enactment of S. 1228 with the following amendments:

1. In Section 2, the figure of \$36,227,000 should be changed to \$40,434,000.

2. Section 2 should be further amended to provide that these funds shall be available for *construction* as well as for *modernization* of hospitals and other medical facilities.

(The following chart was submitted by Dr. Grant for the record:)

CONSTRUCTION NEEDS FOR DISTRICT OF COLUMBIA HOSPITALS AND MEDICAL FACILITIES
ESTIMATED EXPENDITURES FOR GENERAL AND LONG-TERM HOSPITAL AND MEDICAL FACILITIES UNDER S. 1228 AND H.R. 6526 THROUGH JUNE 30, 1971

Name of facility	Current bed capacity		Number of beds to be added		Other facilities to be provided	Planned estimated cost (thousands)	Estimated Federal share (thousands)		Estimated date of completion
	General	Long term	General	Long term			Total	Hill-Harris and S. 1228	
Hospital:									
Casualty.....	210	40	100	200	Medical education and staffing expansion of physiotherapy and outpatient facilities.	\$12,350	\$6,175	0	\$6,175 (1).
Georgetown University.....	377	20	140	-----	200 bed nursing home.....	5,000	3,333	0	3,333 (1).
George Washington University.....	400	-----	-----	-----	Remodeling and expansion of present facilities 2.....	14,871	2,435	\$71	2,364 December 1970.
					Remodel premature nursery.....	30	15	0	15 1969.
					Remodel urology.....	50	25	0	25 1969.
					2d floor north-heart station and pulmonary function and treatment center.	1,500	750	0	750 1969.
Children's Hospital.....	205	-----	145	-----	New hospital.....	40,000	20,000	0	20,000 1972.
Morris Cafritz Memorial.....	298	82	-----	100	Nursing home.....	1,300	867	578	289 (1).
Washington Hospital Center.....	773	-----	-----	300	Nursing home.....	6,500	4,333	0	4,333 1972.
					Emergency electric power plant.....	800	400	0	400 (1).
Glenn Dale Hospital.....	-----	235	-----	200	Bed expansion by use of existing porches.....	1,500	1,000	0	1,000 1972.
					Modernization of kitchen, physiotherapy and occupational therapy, and expansion of operating suite.				
Total, hospitals.....	2,263	377	385	800		500	250	0	250 1972.
Other: Area B. (District of Columbia Department of Public Health facility).						84,401	39,583	649	38,934
					Comprehensive health center.....	6,000	3,000	1,500	1,500 1971.
Total estimated expenditures.....						90,401	42,583	2,149	40,434

1 Not known.
2 \$10,000,000 direct Federal grant for experimental purposes.

Note: In summary, it is estimated that the total expenditure for additions and improvements to general and long-term hospital and other medical facilities in the District of Columbia through the end of fiscal year 1971 will be approximately \$90,401 of which \$2,149 will be covered by the existing medical Facilities Acts and \$40,434 would be provided under S. 1228 and H.R. 6526.

Mr. SISK. Thank you, Dr. Grant.

Mr. Moyer, do you have a statement or any comments you wish to make?

Mr. MOYER. No. I would like to point out the District's position is stated in our most recent letter of May 31, 1968, which you have included in the hearing record.

Mr. SISK. Do you have a statement, Dr. Ferrer?

Dr. FERRER. No, sir, no statement.

Mr. SISK. To clarify your statement, Dr. Grant, the Senate bill as written actually authorizes a sum not to exceed \$36,227,000, while the House bill is an open-ended authorization, and what you propose is an amendment to raise the authorization by \$4.2 million, is that correct?

Dr. GRANT. Yes, sir.

Mr. SISK. I am not sure I followed the first part of your statement. What is your specific reason for such increase at this time?

Dr. GRANT. Basically, Mr. Sisk, the construction costs for hospitals and other medical facilities are continuing to rise. We have revamped our estimates of what we believe would be the construction costs, and we believe the figures that we have outlined in our statement are the best estimates we can make as to the construction costs of this program.

BEDS AVAILABLE

Mr. SISK. I notice you discuss at some length the relationship between bed occupancy in the District as compared to the national average, which would indicate it is somewhat higher in the District than the national average and would indicate some additional need for hospital beds in the District. Let me ask you whether or not you have figures indicating the number of hospital beds available for M & S—I am talking now about medical and surgical beds—the average number of such beds available per capita in the District of Columbia compared to the national average?

Dr. GRANT. I do not have that immediately available. We can supply that for the record. Our estimate of occupancy rate for those beds in the District would be higher than the national average, and part of this is related to the fact some 40 percent of the beds are occupied by residents outside the District of Columbia. While this is a situation that obtains in other metropolitan areas as well, I would say our average occupancy in the District of Columbia in the medical and surgical beds is higher than the national average.

Mr. SISK. What I was trying to determine, for example, as I understand when applications by States are pending for funds under the provisions of the Hill-Burton Act—or now the Hill-Harris Act—they first go into an area and make an examination of a variety of things, as, specifically, the number of beds compared to per capita population in that area. As I understand, your statement is that use of District of Columbia hospital beds is being made by residents of Maryland and Virginia. So apparently in these two States, particularly in the suburban areas, there is a substantial need for additional hospitals to take care of the residents of those States?

Dr. GRANT. We believe that is true. Those States are attempting gradually to build up hospital beds but we think this is a great need.

Mr. SISK. Under the Medicare and Medicaid programs, what is the relative difference in handling by and between residents of the District and those that are residents of Virginia or Maryland in District of Columbia hospitals?

Dr. GRANT. There is no difference. They would be eligible for admission to hospitals in Washington as has been true previously.

Mr. SISK. You mention the need for nursing home care. It is my understanding, in talking to some people in the past few weeks, that there is a great need in the District for so-called intermediate care or nursing home care. Is that the area in which you find the greatest need?

Dr. GRANT. Yes, sir, I think this is the greatest need and I think it will rise both as the result of the Medicaid program and also because our population in the area is increasingly becoming older. This is true, of course, of the Nation as a whole, and I think the need for facilities to take care of middle and old age people will continue to rise.

Mr. SISK. What percentage of the proposed funds that would be made available under this legislation, along with matching funds made available by the District, would be used for intermediate or nursing home care beds as compared to M & S beds?

Dr. GRANT. It is difficult to answer that, but I would say that obviously the allocation of these funds would have to be in consonance with our State plans for hospital construction, and in those plans we take into consideration some of the factors presently under discussion along with many others.

Mr. SISK. How far along are you on the planning with reference to the new proposed Children's Hospital here in the District? You made a reference to that. Unfortunately, I can't pinpoint it, but I think some \$40 million is proposed in that plan, is that right?

Dr. GRANT. We believe that this is roughly the kind of figure we would be talking about, yes, sir.

Mr. SISK. As you understand, the bills as presently written do not authorize money to meet that need?

Dr. GRANT. I would suggest that the way both of these bills are written at the present time leaves this question up for interpretation, and I think it would be possible, the way they are currently worded, to have an interpretation that funds were not available for these purposes, because the bills indicate clearly the funds would be available only for modernization of hospitals and other medical facilities, and I think that could be construed that if a new hospital were to be built there would be some question as to whether that would come under the provisions of the bills as presently worded. I would suggest an amendment would be in order so that it would not be subject to that interpretation.

Mr. SISK. Is it your feeling that if the bills were passed with an amendment raising it to \$40 million-plus that such an amendment would make it possible for funds to be used in new hospital construction, and would these funds, combined with such other funds that may be available from the District of Columbia in the way of matching funds, make it possible for the construction of that Children's Hospital?

Dr. GRANT. Under the circumstances you cite these funds would be available and could be disbursed to Children's Hospital in order to

assist them in the construction of a new hospital. Obviously they would have to find funds from other sources to match the funds available under this bill.

AVAILABLE FUNDS

Mr. SISK. One final question: What is the total sum, or approximate sum, that will be made available to the District under existing law for medical and hospital needs from the Federal Government?

Dr. GRANT. We receive approximately \$1 million a year at the present time from all sources from existing Federal legislation. Through June 30, 1971, we will have a little over \$2 million available to us from all these sources for new construction.

Mr. SISK. Thank you.

The gentleman from New Mexico.

Mr. WALKER. Thank you, Mr. Chairman.

I have a couple of questions. In S. 1228, on page 1, line 7, I would assume the reason we have the date June 30, 1968, is that was fixed as the date when this legislation was started in the last session. I would think now you would change that to 1969.

Mr. SISK. Yes. That is a technical change we would want to make.

Mr. WALKER. I am not questioning the bill. It is a technical point.

Also, Dr. Grant, I notice you have left out of your list of hospitals with construction needs, the D.C. General Hospital, yet you have included the Glenn Dale Hospital in the program. For the record I wonder if you will point out why Glenn Dale is included and not D.C. General?

Dr. GRANT. This is primarily because we have recently completed a rather large construction and expansion program at D.C. General Hospital, and while it is true we have in mind certain additional construction activities at D.C. General Hospital, I would doubt these would be consummated before June of 1971, which is the date we are discussing. I would assume it would be after that date that we would be making further construction at D.C. General.

NON-RESIDENT PATIENTS

Mr. WALKER. You presented figures showing the number of patients from the suburbs treated in the District of Columbia hospitals. Will you clarify why so many people from the suburbs use the District of Columbia hospitals rather than their own hospitals? Aren't there hospitals in the suburbs?

Dr. GRANT. There are some hospitals in the suburbs, but this relates to a general question applicable to all metropolitan areas. There is a tendency for patients residing in the suburbs to have doctors in the cities, and the doctors are connected with City hospitals and for that reason the patients are placed in one of the City hospitals. In addition to that, there are not enough hospital beds in the suburbs at the present time to accommodate these patients, and until such time as this situation is modified, there would be no alternative than for them to continue to use hospital facilities in the District of Columbia.

Mr. WALKER. The people coming in from the suburbs to use the District of Columbia hospitals contribute something?

Dr. GRANT. Yes, these are predominantly pay patients and they themselves are required to pay or pay through third parties.

Mr. WALKER. So it would not make any difference to them if they were using District of Columbia hospitals or suburban hospitals as far as these funds are concerned?

Dr. GRANT. I am not sure I understand your question, but what I think you are getting at is this: In terms of the development of hospital and medical care facilities, if we were to expand these facilities in the District of Columbia—and we believe this is logical at this time—it would be important for us to take into consideration that we will continue for an indefinite time in the future to serve residents of Maryland and Virginia, and the monies we are requesting therefor would go into the construction of these facilities in the District of Columbia.

Mr. WALKER. I am still a little curious. If the Federal Government furnished these funds to all States, I am curious as to why Maryland and Virginia wouldn't develop their own facilities to provide for their own needs?

Dr. GRANT. They have attempted to do so and are building hospitals and medical care facilities but the population has risen at such a rapid rate it has been impossible for Maryland and Virginia to keep up with this rise to meet the needs under the Hill-Harris Act.

Mr. WALKER. The population in the District of Columbia has risen too?

Dr. GRANT. The population of the District of Columbia has increased greatly. We are continuing to try to furnish hospital beds.

Mr. WALKER. I am not fighting the proposal. I am merely trying to clarify the matter.

Dr. GRANT. I understand.

Mr. SISK. Will the gentleman yield? You mentioned something about the number of Maryland residents using District of Columbia hospitals. Do you have a record of District of Columbia residents who may be using hospitals in Maryland and Virginia? I assume there are some.

Dr. GRANT. We do have some but it is very little. The move is in the opposite direction.

Mr. SISK. Thank you. The gentleman from Maryland, Mr. Gude.

Mr. GUDE. Thank you, Mr. Chairman.

Dr. Grant, with regard to the average length of stay in hospital isn't 8.1 days an excessively high figure?

Dr. GRANT. No, sir. I don't know what it is for the country as a whole but I believe it is about seven for the country as a whole, so we are a little high but not too much.

Mr. GUDE. Does the lack of aftercare homes contribute to this lengthy stay in hospitals?

Dr. GRANT. I think the lack or paucity of aftercare facilities does contribute to this situation.

PATIENT COSTS

Mr. GUDE. What is the cost of keeping a patient in an aftercare facility compared to a regular hospital?

Dr. GRANT. The cost of hospitalization in the acute general hospital in the District of Columbia varies from \$38 to \$83 a day, depend-

ing on the hospital. The cost of taking care of a patient in an intermediate or nursing home facility would range between \$20 and \$30 a day, much less than in a general hospital.

Mr. GUDE. So there would be a considerable saving by having more aftercare facilities?

Dr. GRANT. I would think so, yes, sir.

Mr. GUDE. I understand there is a long waiting period for patients seeking care at the emergency facility at D.C. General Hospital. Are these all emergency cases? I have heard of people having to wait eight hours for care.

Dr. GRANT. We have approximately 70,000 emergency visits at D.C. General Hospital per year. Of this number, 70 percent are not emergencies, but I would like to report to you that for the past two years or more we have developed a system whereby every patient coming in the emergency room at D.C. General Hospital is seen within fifteen minutes. The attempt is then made to distinguish between the cases that are emergencies and those that are not. It is the 70 percent that are not emergencies that sometimes have to wait for a certain length of time.

Mr. GUDE. Is it economical to have these people come to D.C. General Hospital?

Dr. GRANT. We are attempting to develop a system of neighborhood facilities which we believe, when implemented, and when the Medicaid program is implemented, should substantially reduce the number of people who go to the emergency room at D.C. General.

Mr. GUDE. Are you getting the necessary funds for these neighborhood facilities?

Dr. GRANT. We are getting funds to implement the Medicaid program. We are attempting to change our program in order to develop a neighborhood health center program.

Mr. GUDE. Thank you.

Mr. SISK. May I inquire what is the average per bed per day cost at D.C. General Hospital?

Dr. GRANT. The present cost at D.C. General Hospital is \$73.91 per patient per day.

Mr. SISK. \$73.91?

Dr. GRANT. Yes, sir.

Mr. SISK. Per bed per patient?

Dr. GRANT. Yes, sir, per day.

Mr. SISK. We are not talking about any doctor bills or anything of that kind?

Dr. GRANT. No, sir, this is hospital cost.

Mr. SISK. \$73.91?

Dr. GRANT. Yes, sir.

Mr. SISK. How does that compare with the national average?

Dr. GRANT. The national average at the present time is lower than that. The latest figures are for 1965 so we don't have the up-to-date figures, but, as you know, hospital costs are increasing rapidly all over the country and while that figure is a little higher than the national average, I don't think it is much higher. I think you will find that while it is true many hospitals are lower than that, many are higher. Many hospitals are rapidly approaching \$100 a day.

Mr. SISK. Do you happen by any chance to have that same figure for 1960?

Dr. GRANT. Not offhand, Mr. Chairman. I would have to supply it for the record.

Mr. SISK. Can you give me the percentage annual rate of increase for 1962, 1963, 1964 and 1965?

Dr. GRANT. I can give the rate of increase from last year to this year, which was between 16 and 20 percent. It is 16 or 20 percent higher this year than last year.

Mr. SISK. How do you account for that?

Dr. GRANT. Primarily this year because of salaries, particularly for the nursing staff and auxiliary staff. Nurses' salaries have gone up from a starting salary of \$5500 to a starting salary of \$7,000 in the last two years in the whole Washington Metropolitan area. This has contributed greatly to hospital costs because the nursing staff at D. C. General Hospital is between 40 and 50 percent of the total staff.

Mr. SISK. I am aware, of course, of the high cost of medical care throughout the Nation. I know something about it in my home town where we work closely with the managers of the various hospitals. I am curious as to where we are going nationally. I am not sure of the exact situation, but I understand from the press and others that there were much of the facilities in D.C. General Hospital unused for a considerable period of time primarily because you didn't have the personnel. What is the situation today?

Dr. GRANT. We currently have 324 registered nurses at D.C. General. We have 84 vacancies. This is better than was true in January but it is still not good. With this rate of vacancies there are two things we can do. We can either maintain a certain number of beds vacant or we can attempt to recruit sub-professional staff such as nurse assistants to provide the care now furnished by nurses. We have been endeavoring to follow the latter road and would hope to fill the beds by this kind of a program.

Mr. SISK. We are talking here about a construction program during the next three or four years. \$90 million, I believe, is the figure you named as the amount needed for health care facility construction in the District of Columbia. If at the present time 20 or 25 percent of the facilities of D.C. General Hospital cannot be used because of the lack of personnel. What specifically are you and other concerned with this situation in the District of Columbia doing to improve conditions as to recruiting and training of personnel?

Dr. GRANT. I will be glad to relate to this. I would like to clarify something before I report on that. What I have indicated as existing in D.C. General Hospital does not obtain in all hospitals in the District. There is at least one hospital that is worse off than D.C. General, but most are better off than D.C. General.

Mr. SISK. Is that because of salary differentials or other things?

Dr. GRANT. There are a lot of factors involved in that. There is in essence no major salary differential in the Washington area at the present time, but I would hasten to point out you are absolutely correct that one of our most serious problems today relates to a severe shortage of manpower. We have in fact endeavored during the past four years to develop training programs in the District for nurses. We have had refresher programs to bring nurses back in the fold, so to

speak. And we are developing training programs for practical nurses and others, and have been endeavoring to develop a program for practical nurses and others, and have been endeavoring to develop a program for nurses' training and for the training of less highly skilled personnel. I think the next few years will find an increased use of the less qualified personnel to do work presently being done by nurses. We think it is time to reduce the time spent by nurses on non-nursing duties such as delivering reports and doing things that can be done by messengers or less highly qualified personnel. I think we must reduce the non-nursing type duties presently performed by nurses.

I would further submit, looking ahead perhaps ten years, that we will see more practical nurses and nursing assistants taking over many of the duties of professional nurses, and the professional nurses will act as their trainers, because I think even bearing in mind there are additional nurses coming out of nursing schools, the need for them is increasing and we will not be able to have sufficient of them by using only professional nurses.

Mr. SISK. Thank, you Doctor. Congressman Gude of Maryland referred to your testimony that 8.1 days was the average length of hospital stay per patient. Have you noticed any substantial increase in that figure since the enactment and operation of the Medicare and Medicaid programs?

Dr. GRANT. There has been essentially no change in this area of the per diem utilization rate compared to what it was prior to Medicare. There has been relatively no change.

Mr. SISK. You do not feel, then, Dr. Grant, that the passage of Medicare and the services made available under that Act have substantially increased hospital usage over and above the normal need for hospitals?

Dr. GRANT. The big problem relates to one of the things that I have indicated in my testimony, namely, that the current bed utilization rate in the Washington area is so high, roughly 85 percent, that it would be impossible really for additional patients because most hospitals are pretty well occupied. The problem is waiting lists to get into the hospitals. Until and unless we get to the point where we can construct additional beds it is not possible for the utilization rate to go higher because the beds are not available.

Mr. SISK. Thank you, Dr. Grant. I think you have made a very excellent witness.

The gentleman from Maryland?

Mr. GUDE. Dr. Grant, in regard to the \$73.91 per day cost, does this run higher than for other subdivisions of the country, such as States, for example? Could there be a higher cost here because of the high caliber of the facilities whereas in some areas you have hospitals which do not have these types of facilities.

Dr. GRANT. Let me try to respond in a different way. The only valid kind of comparison you can make would be between this and another similar type of hospital, of which there are many throughout the country.

I would suggest to you in making that kind of comparison you would find that some of these hospitals have a per diem rate lower than D.C. General and some would be higher.

Mr. GUDE. My point was whether the fact that in some areas you have general hospitals which do not have facilities for intensive heart care, for example, which are to be found in nearly every hospital in the District—

Dr. GRANT. I really do not think that is the major factor involved. The major factor involved here, I think, is the effect of the Federal Civil Service salary structure upon the salaries of clerical staff, particularly, which tends to be higher in the Washington area than in other areas of the country. That is true of some of the lower G.S. staffs. Our salaries tend to be a little higher than in some other areas but we have to maintain these levels in order to maintain our competitive situation in the Washington area.

Mr. GUDE. Has your Department been able to evaluate the exact cost of a private patient as opposed to the cost of a patient who is on welfare? You have paying patients at D. C. General and then you have patients who are under public care?

Dr. GRANT. That is correct, but we make no distinction between these patients and therefore the per diem cost is identical for both.

Mr. GUDE. Have you ever attempted to evaluate whether the cost is greater in the case of a public patient as opposed to a private patient?

Dr. GRANT. I don't know how we can do that. As an example, we do not even know in most cases whether in fact the patient is a public patient or a private patient until after we have seen them, examined them, made the diagnosis and often treated them. We often do not know that until we have made our financial determination which in many cases is not made until substantially some time after the patient has been admitted, and in some cases even after the discharge. There is no essential difference in the way we handle these patients.

Mr. GUDE. It was my understanding from some of the work I have seen in Maryland that generally the cost of caring for a public patient is greater than that of a private patient.

Dr. GRANT. I think what you are saying is that if we use the well-known dictum that the lower you go down the social economic ladder the higher the prevalence of disease, if you use that, the point is well taken; namely, the tendency would be for the stay to be greater on the part of public patients than private patients for that reason. This point may well be a good one.

Mr. WALKER. I have no questions.

Mr. SISK. Dr. Grant, you have made an excellent witness this morning and we appreciate your statement.

At this time I believe we have witnesses from the Department of Health, Education, and Welfare.

Dr. Graning, I see you have a statement. You may read the statement or you may extemporize.

STATEMENT OF DR. HARALD M. GRANING, DIRECTOR OF DIVISION OF HOSPITAL AND MEDICAL FACILITIES, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY JOHN MOSCATO, SPECIAL ASSISTANT

Dr. GRANING. Thank you. By way of introduction I have responsibility for the construction of Hill-Burton facilities. I have with me Mr. John Moscato, Special Assistant to me.

I am pleased to appear before this subcommittee of the House District Committee to present the views of the Department of Health, Education, and Welfare on H.R. 6526, which is identical to S. 1228, a companion bill that passed the Senate.

They have as their purpose the authorization of project grants that would assist the construction and modernization of hospitals and other medical facilities in the District of Columbia.

The Department's views were previously presented before the Senate Subcommittee on Public Health, Education, Welfare and Safety of the Committee on the District of Columbia. We are in accord with its objectives and principal provisions and as the Agency responsible for administering the proposed grant assistance we recommend its favorable consideration by the Congress.

FEDERAL ASSISTANCE

The responsibility of the Federal Government to provide financial assistance for the construction of hospitals and other medical facilities in the District of Columbia has been recognized by the Congress for a number of years. In 1946 Congress enacted the Hospital Center Act, which authorized the appropriation of Federal funds for the construction of the Washington Hospital Center as a replacement for three independent nonprofit hospitals and required the District government to repay 50 percent of the net cost to the Federal Government.

In 1951 the Hospital Center Act was amended to authorize grants of up to 50 percent of the cost of constructing or renovating hospital facilities in the District. The District of Columbia was required to repay 50 percent of the Federal contribution. This was lowered to 30 percent in 1958 with respect to grants made after that time. Under the 1951 and subsequent amendments, grants of \$17,420,453 have been made for projects having an estimated total cost of approximately \$44,400,000. This act expired in 1962.

In 1962 legislation (Public Law 87-460) was enacted authorizing grants of up to \$2.5 million for 50 percent of the cost of constructing an addition to George Washington University Hospital. Funds for this purpose were appropriated by the Congress in fiscal year 1964 and the project is now complete.

In addition to the Hospital Center Act and Public Law 87-460, both of which applied solely to the District, Federal financial assistance has been given for the construction of hospitals and other medical facilities in Washington through two generally applicable Federal programs—the wartime defense housing and public works program, commonly referred to as the Lanham Act, and the program authorized by the title VI of the Public Health Service Act, commonly called the Hill-Burton program. Under the Lanham Act, two hospitals in the District received a Federal contribution of \$5,655,000. Under the Hill-Burton program, a total of \$7,194,000 in grants was approved through fiscal year 1966 for 27 projects in the District.

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

in the District of Columbia experience serious difficulty in raising the non-Federal share of the cost thereof. Second, the allotment of funds to the District, which takes into account per capita income and population, is now in relationship to the facility construction problem.

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

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

A unique medical facility utilization and construction problem exists in the District because of the large number of patients from other "States" who occupy general hospital beds in the District. A survey conducted in 1958 showed that approximately 40 percent of the patients in District hospitals at that time came from outside the District, primarily from the Maryland and Virginia counties in the metropolitan area. A study of the residence of patients admitted to general hospitals in the District during the week of February 25-March 3, 1962, showed similar results; only 58 percent of those patients were District residents.

If District of Columbia General and Freedmen's Hospitals were excluded from this latter study, a significantly higher percentage of patients from outside the District would be found, ranging up to nearly 60 percent in the case of Georgetown University Hospital.

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

For the reasons cited above, special Federal assistance for the modernization of hospitals and the construction or modernization of other medical facilities in the District of Columbia is clearly required. To make up for the loss of normal private sources of support caused by the presence of the Federal Government in the District, we believe it is necessary to have the Federal grants cover up to two-thirds of the cost of construction projects for a long-term care facility, a diagnostic

or treatment center, or a rehabilitation facility. The urgency of the need for such facilities and the relatively greater difficulty in securing financing for the non-Federal share of the cost of their construction, justifies a higher matching ratio than in the case of short-term care facilities.

Grants under this legislative proposal would not be available to provide additional short-term, acute general hospital beds since the Health Facilities Planning Council for Metropolitan Washington has found that additional general beds in the District of Columbia will not be needed until after 1975. If, however, Mr. Chairman, this contra-indication should change, however, we may, of course, request authority to construct additional general hospital beds, commensurate with the need existing at that time.

PROPOSED AMENDMENTS

While we support the principal provisions of the bill, we would like to suggest two minor amendments. First, since the first fiscal year for which appropriations would be authorized has already ended, an appropriate modification should be made in section 2 of the bill. Second, to conform to the provisions of Reorganization Plan No. 3 of 1966, the reference to "the Surgeon General" in section 3(d), should be changed to "the Secretary." Subject to these minor amendments, we would recommend enactment of the bill.

INCREASED COST OF HOSPITAL CARE

Mr. SISK. Thank you, Dr. Graning.

Dr. GRANING. I shall be pleased to answer questions.

Mr. SISK. I believe you were here and heard my discussion with Dr. Grant with reference to increased hospital costs. He gave us a figure of \$73.91 per bed per day in the District.

In your capacity with the Department of Health, Education, and Welfare, does it fall within your area of interest to make studies on where we are going with regard to these costs of hospital care? Do you have any projections?

Dr. GRANING. Mr. Chairman, we have indeed, and we have been concerned and yet understanding of what has been going on in this field.

Modern technological advances are constantly calling for more advanced ways in which to manage patients. It is true that we have in a sense become hung up on the term "per diem costs."

It is a very unfortunate way of designating costs, and a hospital administrator in one of our large university hospitals has expressly forbidden anyone to use the term "per diem costs", because it is much more reasonable to talk in terms of service charges.

If one thinks in terms of service charges one can readily see that the cost for service will vary tremendously with whatever the particular hospital is proposing to provide.

It should be noted that it was just two years ago or two and a half years ago that the Congress enacted the Minimum Wage Law. The Minimum Wage Law really provided a mechanism for correcting a long-standing social injustice. There were countless hospitals in the

United States in which medical care had in effect been subsidized by the salaries that were being paid to unskilled personnel in the hospitals. Hospitals had been experiencing a very high personnel turnover rate. This has been extremely inefficient. It has been recognized as being a place where you could go to get a position if no other place was available, but as soon as you could aspire to a better job people left these hospitals, and as a result, hospitals were confronted with a situation in which they had complex equipment cared for by unskilled personnel, with high turnover rates; they were cognizant that some of these pieces of equipment were being improperly managed.

A second force has been the introduction of unionization into the hospital field. These union groups have been asking for what they considered an appropriate salary for personnel.

As Dr. Grant pointed out in his testimony, the brunt of the rising costs have been attributable to personal services which in hospital operations represent about 70 percent of the operating costs.

The service charge as carried by the District of Columbia General Hospital is certainly within the range of service charges offered by hospitals of comparable size in the United States.

We have pointed out in our testimony the need for additional long-term care facilities and extended care facilities in the District. Manifestly, if there is a shortage of such facilities it means that patients have to be cared for in an acute care facility where obviously the service charge will be much higher than in a long-term care or extended care facility.

Thus, by building more extended care facilities one could expect to make a contribution toward reducing the total cost for hospitalization.

I would like to point out, sir, that while the service charge has been going up in hospitals the length of stay has been going down, so the cost of illness in many instances has been much less, or it has not been increasing at any rate. You can pay more but you stay a shorter period of time. Thus theoretically the return of a person to a useful occupation comes about at an earlier point.

We also feel that there has been far too much attention given to the care for the horizontal patient and not enough care for the vertical patient. In this regard hospital communities are given increasing attention to the provision of ambulatory care facilities, and you will notice in the legislation before you that the higher participation percentage is included at 66 and two-thirds percent for long term care facilities, for ambulatory care facilities (or diagnostic care facilities) and rehabilitation facilities because we view these as being of greater public interest.

Mr. SISK. Thank you, Dr. Graning.

Mr. WHITENER. I have no questions.

Mr. WALKER. I have no questions.

Mr. GUDE. Dr. Graning, in your testimony you mentioned that in some areas they have corporate support of hospital facilities. Could you give us some specific examples compared to the situation here in the District of Columbia?

Dr. GRANING. I can offer this bit of information. Last year in terms of philanthropy for various causes throughout the entire United States health became the second cause—religious causes were first,

education has been second, and health has been third. Last year, however, for the first time philanthropy contributed more to health than it did to education.

As I indicated in my testimony, corporation giving in the fund drives which normally take place in communities where nonprofit hospitals are proposed, represents the great bulk of the money that is raised as the matching share.

As I tried to point out in my testimony, the District of Columbia does not, according to people who are knowledgeable on such matters, have the potential for corporate giving that Detroit, Chicago, New York, Cleveland, New Orleans, and other big cities would have.

MR. GUDE. Do you think you would be able to supply for the record a comparison of what some of these large cities receive in this area?

DR. GRANING. We would be very happy, sir.

MR. GUDE. Compared to what is received in the District of Columbia?

DR. GRANING. I would be happy to.

MR. GUDE. Mr. Chairman, it seems to me it might be important to have information provided regarding the Federal-local fund ratios with regard to Federal programs.

DR. GRANING. Mr. Gude, at the present time, and I was cognizant of this as I was thinking about appearing this morning, the Federal share for the country as a whole ranges from one-third to two-thirds for the construction of facilities.

Here in the District the present practice has been to give one-third Federal share for the construction of new hospitals and for modernization and 50 percent for long-term care, diagnostic and treatment facilities and rehabilitation facilities.

The amount of money which has been made available has not been adequate and the Federal share has not been enough particularly with reference to long-term care facilities. This legislation proposes to make 66 and two-thirds percent available for the three categories I mentioned earlier.

One clarifying point. I heard the discussion with Dr. Grant regarding modernization and the interpretation of modernization, and also what could or could not be built in connection with this legislation.

SCOPE OF LEGISLATION

MR. SISK. Will you comment on that, then, in connection with the language in your statement at the top of page 6 with reference to the uses which could be made of the moneys authorized in this proposed legislation?

I assume that you were saying in this first sentence that there was not an intention that such funds would be used for the construction of the new Children's Hospital.

I don't want to put words in your mouth but in line with what you were about to say I thought you might expand on that.

DR. GRANING. I appreciate that. The term "modernization" includes complete replacement, and modernization as administered in the Hill-Burton Law and as proposed to be administered here, could include a complete replacement of a facility at another location.

As far as expansion is concerned, if they wish to add additional beds as that particular project does, then the additional beds could not be paid for out of this legislation but the replacement of the facilities with the same number of beds could be supported in its entirety by this legislation. Whether the amount of money made available would permit it is something else again, but the authorizing legislation has no contra-indication in it to paying for the modernization of any facility which includes total replacement. As long as they abandon the facility they have and move to a more appropriate site and build the facility that will continue to serve this interest, taking advantage of modern technology, and so on, improving their services, this is entirely in accordance with the law.

MR. SISK. I appreciate having your interpretation. In other words, it would be permissible under the language of this bill, assuming there were sufficient money available, to replace a 500-bed hospital outright by a new facility at a new location or even at the present location.

DR. GRANING. That is right.

MR. SISK. But if you were to add 250 beds to an existing 500-bed facility you could not do it, under your interpretation of the language within this bill?

DR. GRANING. That is correct.

MR. SISK. I am sure you heard Dr. Grant also with reference to the proposed amendment to increase the amount by about \$4,200,000, which would bring the total to over \$40 million rather than \$36.2 million.

Do you support that amendment?

DR. GRANING. I would think this would be a very conservative figure, sir. We would support the amendment.

MR. SISK. If there are no further questions, thank you very much for your appearance this morning, Dr. Graning.

We have next a representative from the Metropolitan Washington Health Facilities Planning Council, Mr. William Hannan.

We are pleased to welcome you, Mr. Hannan.

Without objection your statement can be made part of the record and you may read it or you may extemporize, which ever you prefer.

STATEMENT OF WILLIAM HANNAN, PRESIDENT, METROPOLITAN WASHINGTON HEALTH FACILITIES PLANNING COUNCIL, ACCOMPANIED BY JOHN MCKINNEY, EXECUTIVE SECRETARY

MR. HANNAN. The Executive Secretary of the Metropolitan Washington Planning Council, Mr. John McKinney, is here to give me and you whatever technical information our discussions might bring forward.

I should like to submit the statement as written by the Health Facilities Planning Council.

With your permission I should like to take a few pieces from it and then briefly comment on them.

I am William T. Hannan, Chairman of the Board of the Health Facilities Planning Council for Metropolitan Washington. The Council appreciates this opportunity to appear in support of the proposed "District of Columbia Medical Facilities Construction Act of 1968" now before you as H.R. 6526 and the Senate passed bill S. 1228.

H.R. 6526 is identical in substance with H.R. 15070 in the 89th Congress. Its companion in the Senate, S. 1228, was amended in Committee and passed by the Senate on December 15, 1967. I will comment on the Senate changes a little later on.

PURPOSE OF LEGISLATION

As did their predecessors, these bills embody the Administration proposals for a temporary program of supplemental aid for modernization of hospitals, and for modernization and construction of other types of health facilities in the District of Columbia. To qualify for such supplemental aid projects would have to be approvable under construction aid programs—the Hill-Burton program, or the Mental Retardation Facilities of the Mental Health Centers Construction programs. Supplemental aid would be conditioned upon such approval or the denial of approval upon the sole ground of insufficient funds under the District's allotments under those programs.

SENATE AMENDMENTS

The Senate amendments make two substantive changes in the proposal. First, an aggregate ceiling of \$36,227,000 is imposed on the 4-year appropriation authorization; and second, clarifying amendments assure that extended care facilities are included in the types of facilities for which supplemental grants are authorized. The Council has no disagreement with these changes.

NEED FOR LEGISLATION

The proposed legislation grew out of growing concern for the pattern of special aids for individual hospital construction projects in the District—under the Washington Hospital Center Act of 1946 and later extensions and amendments of that Act. This pattern arose because the ability of District sponsors to raise private capital does not square with the basic premises of the nation-wide Hill-Burton program and, as a result, the District was unable to use considerable sums allotted to it under that program. In 1961 the Department of Health, Education, and Welfare was directed by the President to look into the District's continuing need for special assistance of this kind. The proposed legislation is the outgrowth of the Department's findings. The District's special difficulties in obtaining the necessary capital financing for health facilities are amply documented in the Department's July 22, 1965 transmittal letter of the original draft legislation. The Council emphatically agrees with the Department's conclusion that there is great need for special assistance for construction and modernization of health facilities in the District and that such an assistance program should be put on an orderly basis, subject to review under the same type of procedures that govern project approval under the basic construction programs.

The Planning Council was established in April, 1962 with the assistance of the Public Health Service and under the sponsorship of the Metropolitan Council of Government. Its purpose is to encourage area-wide planning for health facilities within the Metropolitan Wash-

ington community in order to further effective expenditure of available construction dollars and to avoid unnecessary operating costs. The bill would strengthen such planning efforts by making review of applications for supplemental grants by a responsible metropolitan area planning body a required stage in the project approval procedures. The recommendations of such a body would have to be taken into account by the District's Hill-Burton agency and submitted to the Surgeon General; the planning group's views would not be controlling, however.

AMENDMENT FOR ADDITIONAL BEDS

The Council again urges the Committee to give serious consideration to broadening the bill to permit supplemental grants for construction of additional beds. Unless the suburbs can build additional beds to keep pace with their population growth the pressures on District hospitals will increase. District hospitals provide annually about two thirds of all patient days of hospital care in the entire metropolitan area. Furthermore, with emerging patterns of care that tend to concentrate the more costly and complex procedures in institutions which are at the heart of urban complexes, there may be special expansion needs in central city hospitals that cannot well be brought under the "modernization" category. We believe this suggested relaxation in the uses permitted for supplemental construction grants would make for a more flexible program without encouraging over-building in the District. Required review procedures and current planning efforts, under this and other programs, should continue the impetus toward health facility construction in nearby suburbs.

Passage of the "Demonstration Cities and Metropolitan Development Act of 1966" (P.L. 89-754) authorized a program of supplemental aid for metropolitan development projects. Under title II of the Act, it would be possible for a hospital or health facility project that was in accordance with and would further metropolitan area-wide comprehensive planning and programming to obtain a supplemental grant of up to 20% of the cost of construction, with an overall ceiling of 80% for total Federal contributions. It is our understanding, however, that no appropriations have so far been made to carry out this program.

After July, the designated area-wide comprehensive planning agency would also review applications for projects within the metropolitan area for construction grants under the basic construction programs, including the Hill-Burton program. Thus that Act strengthens over-all metropolitan area planning and provides additional incentives, through supplemental grants, for an economic and balanced distribution throughout the area of needed facilities in the Federally assisted categories (including health facilities).

The partnership for Health legislation further strengthens efforts toward sound planning for an effective use of our costly health care resources.

In conclusion, the Council reaffirms its strong support for H.R. 6526 and S. 1228 and urges prompt enactment. With the passage of legislation to enable the District to participate in the Federally-aided

medical assistance program under Title XIX of the Social Security Act it is essential to overcome the District's deficit of long-term beds. The program authorized by the Bills before you should provide substantial encouragement for sponsors of such projects. The proposal itself recognizes the great need for such facilities by including them within the group for which there is a higher matching ceiling—66⅔%.

Mr. Chairman, the Metropolitan Council of Governments is completely non-governmental. We have to go to the private sector of the community to get budget support. We are a low budget organization with a huge amount of work done by leading volunteers of the city in professional field.

We heard Dr. Grant state that as the bill is written there is no provision for additional beds. You could build a whole new hospital but you cannot build additional beds.

We feel that this amendment is very much called for.

Mr. SISK. Are you saying that the amendment should be changed to make it possible for enlargement?

Mr. HANNAN. Yes, sir.

Also, with emerging patterns of care that tend to concentrate the more costly and complex procedures in institutions which are at the heart of urban complexes, there may be special expansion needs in central city hospitals that cannot be brought under the modernization category. There are real vital issues. There are serious problems facing some of our in-town hospitals just in this particular consideration, such as George Washington University Hospital.

EXTENDED CARE

Now to comment on that which we feel is of uppermost need with relation to this legislation:

First, there are the extended care facilities. That is the half-way bed from the hospital. It takes very little observation to conclude that we cannot longer in this community nor in this country proceed to give \$70 to \$80 a day care for patients who could be taken care of in a \$20 to \$30 facility. This is for the patient passed through the critical post-operative stage. This could immediately solve two things—first, a huge cost of hospitalization; and, secondly, the crowding of those acute beds which we have at the present time.

We feel in the Council that there is a need in the metropolitan area, and an immediate need, for 2500 such extended care, or so-called long-term, beds to relieve the acute facilities and to cut in half the cost of the treatment.

Third, it would make more available the under-trained—not the graduate nurse but the under-trained. In this the District has a high hope. If we can implement the program with our new Washington Technical School whereby you can have two-year programs in this, it has been demonstrated that we have ample labor potential in the District of Columbia particularly suited for this.

Therefore we urge that this be made available and that the bill be adopted in the way it is now presented and with the suggested amendments.

Mr. SISK. Thank you for your statement, Mr. Hannan.

As I understand it, you say that an amendment is needed to permit the addition of beds to already existing hospitals, and that an amendment is also necessary to permit nursing home care or extended care?

Mr. HANNAN. We feel, Mr. Chairman, that an amendment is required so as to permit, for example, the suburbs to expand their bed capacity, and having in mind that the bill provides that this should always be done under a viewing body, a planning body, who would see to it that there was no over-expansion, that you did not get out of line with the needs of the whole metropolitan area.

Secondly we feel that the bill as written does permit for extended care facilities construction, new construction.

However, if there is any doubt in anyone's mind, and it is too late after it is written, I should like—

Mr. SISK. I would like to get this pinned down. As you know, we discussed to some extent with Dr. Grant and with Dr. Graning.

I see Dr. Graning shaking his head a bit. I hesitate to get out of order, but, Dr. Graning, did your answer to my question earlier cover Georgetown Hospital, for example? Let us assume they desired to build 200 extended care beds as an addition to that hospital. Would they be precluded from using this money for that purpose in your opinion?

Dr. GRANING. Yes, as I understood it, the witness spoke to the need for being able to build additional beds in a suburban area. We recognize the need for additional beds in the suburban area, but this would have to be funded under the regular Hill-Burton construction program. There is no intent that this money would be made available for building anything in a suburban area. This is limited specifically to the District.

Mr. SISK. That is right. Certainly all this money has to be spent in the District of Columbia.

Dr. GRANING. I support the point of the witness that there is need for additional beds in the suburban area, but those beds would have to be funded through the Hill-Burton Program.

Mr. HANNAN. That is right.

Dr. GRANING. As far as additional beds in the District are concerned, this legislation does not provide for additional acute care beds, and as the witness stated it does provide for additional long-term care beds or extended care beds.

Perhaps the witness can clarify his answer.

Mr. HANNAN. We are in agreement on this.

Mr. SISK. Maybe I am the one who is a little slow in the uptake.

I thought I understood you to say, Dr. Graning, in answer to my initial question, that it would not permit Georgetown—and I cited it as an example—to build 200 additional beds to their present hospital for extended care.

Dr. GRANING. For extended care this is possible, yes.

Mr. SISK. All right. I want that clarified. Perhaps you did not hear that portion of it. I added "for extended care." I was thinking of this intermediate care situation which Mr. Hannan was discussing.

You do take the position that this bill does provide for intermediate care beds to be made additional to an existing hospital under the terms of this legislation?

Perhaps my terminology is not correct, Dr. Graning. When I say intermediate care I refer to the long-range care, extended care, or what we call nursing home care at times.

Dr. GRANING. With that interpretation of your meaning of "intermediate care" the bill does provide for the construction of such beds, yes, sir.

Mr. SISK. Thank you. I wanted it clear for the record.

Mr. HANNAN. We are agreed, then, sir.

This completes our statement, Mr. Chairman.

Mr. SISK. Do you support the additional \$4 million-plus in the proposed amendment to this legislation?

Mr. HANNAN. Absolutely. We, too, feel this is a low figure.

Mr. SISK. Thank you, Mr. Hannan.

The gentleman from North Carolina, Mr. Whitener.

NON-RESIDENT PATIENTS

Mr. WHITENER. Mr. Hannan, as I understand your testimony, two-thirds of the patient load in the District of Columbia hospitals comes from outside the District of Columbia. Is that correct?

Mr. HANNAN. Our survey shows that.

Mr. WHITENER. Has there been any program for additional fees to a non-resident in any of these hospitals?

Mr. HANNAN. First of all, the majority of those people who come in are ordinary paying patients so that they are treated like everybody else. This is the great majority of them.

Mr. WHITENER. Is there any additional charge made for a non-resident for hospital service in the District of Columbia?

Mr. HANNAN. No, sir.

Mr. WHITENER. We have had other hearings here which indicate that a great many of the physicians and surgeons maintain their offices in the District of Columbia as a matter of convenience but maintain their residences in the suburban areas, and patients are directed to Washington hospitals by physicians and surgeons in many cases because of the convenience of the particular hospital in the pattern of practice of that physician or surgeon without regard to the residence of the patient or physician.

As I interpret your statement you are asking that the taxpayers of North Carolina and California be asked to supply funds for the people of Maryland and Virginia which are not available to people in North Carolina or California. Is that what you are asking?

Mr. HANNAN. First of all, of these funds come from all over the country, and it could be from anywhere.

Specifically, however, these patients come because they have available to them the medical services that that particular hospital and that particular doctor furnishes.

Mr. WHITENER. That the doctor prefers them to have.

Mr. HANNAN. Prefers medically.

Mr. WHITENER. The same medical facility may be available in Virginia, near the residence of the patient, but the patient does not make the decision to come to the hospital in the District. The surgeon makes that decision because it best accommodates the physician or surgeon. Is that so?

Mr. HANNAN. Frankly our surveys do not encompass this point. I am not qualified to answer that.

Generally speaking, however, it is because the particular suburban hospital didn't have the facility that this patient was required and this doctor thought he could be best taken care of in the District. All of this stems from the nature of Washington.

As Dr. Grant said, we have no large corporations here. We have a completely governmental employee makeup both in Washington and in Metropolitan Washington.

These people we are talking about are all the same. Indeed, when you speak of the Virginia hospitals and Maryland hospitals, we are talking here of the metropolitan hospitals.

Mr. WHITENER. What I am talking about is what the taxpayer in North Carolina who has no connection whatever with the Washington metropolitan area is called upon to do for the metropolitan area here that which the government will not do for the sick people in North Carolina.

Mr. HANNAN. Because they are not the Federally oriented people that the metropolitan area of Washington is, whether they are inside the District or out.

LOCAL RESPONSIBILITY AND FINANCING

Mr. WHITENER. The record shows that in the District of Columbia and in its metropolitan area you have the highest per capita income. I have counties in my district which do not have medical facilities. What you gentlemen are asking is that the resident of one of my counties, which has the second lowest per capita income of any county in North Carolina, pay taxes to help the high income population of the District of Columbia and the metropolitan area here to get something which is not available to that taxpayer in his own State.

Mr. HANNAN. Hill-Burton funds are available to your people, too, aren't they?

Mr. WHITENER. They are available, but there are not enough Hill-Burton funds to meet the needs. For your information the people of my county, who are 80 percent textile workers, have just voted a \$10 million bond issue to build a hospital in my home county. Why are they not entitled to a little bit of help in addition to Hill-Burton?

Mr. HANNAN. The point is this: We may have the highest average income, but I assure you we have the highest mobility of any population. These people have their roots in your place and not our place. These people feel they have their roots there and do not contribute for capital things in Washington because they do not consider Washington their home.

They may have lived here for twenty years but it is not their home. They still vote in your county and not here.

Mr. WHITENER. That is not an accurate statement. We have testimony here from the District Government asking us to relieve those people you are talking about from paying any taxes on certain things which you and I would pay taxes for. If this is so distasteful that you have a mobility of population then the District Government is taking an inconsistent position when they testify on the revenue bill and when they testify on the hospital bill.

Mr. HANNAN. Now I am out of my field.

Mr. WHITENER. Of course, our field is to see that justice and equity is done. I cannot conceive of an area which has the highest per capita income in the Nation not being a more fertile area for public subscription to private hospitals than would be true in a low income area. This is the thing I just do not follow.

I am very interested in helping the Nation's Capital, but I think it is easier to come here and testify for 30 minutes and get millions than it is to roll up your sleeves and go out and launch a public subscription campaign to get the money. That may be the problem.

If my district came here and made the presentation that you are making for itself because it is a poor area I do not think they would even get off the ground and nobody would pay any attention to them.

Mr. HANNAN. Of course, we cannot have a bond issue without this Committee's agreement. In the past this never has been done here for the reasons I have already stated. We are not allowed to promote a bond issue here.

Mr. WHITENER. You have a right, and the government does, to fix taxes on real estate. They have the same fund raising opportunities that others have.

I might point out that my district does not have any Federal Payment, either, from which you derive a substantial amount of money.

I believe our folks would trade their right to vote bonds on which they have to pay taxes to liquidate in exchange for a Federal payment. I might submit that issue, too.

I am not hostile to hospitals but I just do not understand why it seems to be the attitude that people here should do nothing for themselves but that the people who work in the cotton mills of my district or on the tobacco farms with less than an acre's allotment or working in a furniture factory should be paying the cost of hospitalization for two-thirds of the patients who live in other areas and who constitute a population which has the highest per capita income in the country. It does not make sense to me.

I think I can mount a platform in any area outside the metropolitan area and make any member of Congress who felt that way look pretty stupid.

Mr. HANNAN. Of course, I do not know your county, sir.

EXTENDED CARE

Mr. WHITENER. And you talk about extended care. Do you know what they are doing all over this country? Medicenter, a private enterprise organization, is building extended care facilities in my hometown and all over the country to take care of the problem that you talk about. Private enterprise can do that and apparently make a profit out of it.

Has anything been done here on that?

Mr. HANNAN. Apparently Medicenter has been to Washington and surveyed this area and found, first of all, that the cost of land is so high as to send them back before they start. I have spoken to those people and attempted to have them interested in some of our places.

Secondly, our zoning laws are such as to preclude in many instances the establishment of this type of center upon the areas which usually surround our hospitals in the residential areas.

Mr. WHITENER. You mean this is the only regulation which would preclude the building of a domiciliary facility near a hospital? Who wrote those laws? Congress did not.

Mr. HANNAN. Yes, it did.

Mr. WHITENER. I think we should look at that, Mr. Chairman.

Mr. HANNAN. It comes closer to being a motel. Obviously zoning laws would preclude putting a motel anywhere near a hospital.

Until this is clarified, and our planning council is already working on this, we are afraid it will deter the establishment by private funds of these facilities.

Mr. WHITENER. Thank you.

Mr. GUDE. I can appreciate Mr. Whitener's concern. I think it might well be pointed out that many of the Federal establishments we have here just do not serve the metropolitan area. The Department of Defense, the Department of State, the Department of Commerce, for example, are established to serve all of the citizens of the country across the board.

Mr. WHITENER. If the gentleman will yield I might point out—

Mr. GUDE. Let me finish my point here.

I know that each area has its problems. I know we have our problems around Washington.

Our neighbor, Baltimore County, where they have a tremendous company, Bethlehem Steel, perhaps the largest single steel plant in the world, it makes quite a substantial contribution to community facilities. I know we have nothing in this area comparable to it. I think the Federal Government stands somewhat in place of such an establishment in our community.

I do not know about the future manufacturers or the textile manufacturers or those in these other areas and what their concern is here.

Mr. WHITENER. Your argument could be used by the Fort Bragg area. There is not just the local interest, but there is the military hospital and the responsibility of that community for medical and hospital facilities of this type. There is no special program for that other than Hill-Burton which would help them.

The same might be said of Cherry Point Marine Base and Camp Lejeune Marine Base. That argument does not add a great deal of weight because it is a bigger burden on the people of a little community than it is for this whole metropolitan area here.

Mr. SISK. If I am comment briefly on this, the anticipated need is approximately \$90 million for the next three or four years. This bill would provide only some \$40 million even if the amendment is adopted.

Without joining the discussion there is a substantial contribution on the part of the local area which will have to be made. They will have to come up with some \$50 million, although this is a special type of legislation in addition to the Hill-Burton law.

Mr. WHITENER. There is one little town in my home county where the doctors have traditionally taken their patients to Charlotte, North Carolina because of the convenience to the doctors. They have been considering putting an additional fee on any residents of counties other than the county where Charlotte is located. They raised the money by public subscription to provide these hospital facilities along with Hill-Burton and other state assistance programs.

I personally have never argued with our neighbors that they were not right in considering this. It is my feeling that my home county should not become a burden to our neighboring county. However, I am a great advocate of hospitals and have a great affection for these institutions of learning here which are interested in this.

However, I think we will have to try to in some way reach a solution other than testifying before Congress for three days and getting funds from the taxpayers of North Carolina and the 50 States.

Mr. GUDE. One of the reasons I am such a strong supporter of the impacted aid bill is because I think this is a great help to communities such as yours, those which suffer with military installations. I think this also can be extended to other things such as hospitals and other burdens put on the community because of the location of these Federal installations. I agree.

I also might say that I feel many citizens in our area do not have enough community spirit and do not support some of the facilities we have here, and Children's Hospital is a good example. We have a wonderful modern facility for children which more of our citizens should be aware of and support because you can get the best medical care for a child there than anywhere else in the world.

Mr. WHITENER. Let me say this. I voted against the impacted aid bill a few days ago because it has been my experience that every time the government starts to cut out one phase of any one of these operations that the people say are such a burden to them, we have delegations from North Carolina of people wanting us to talk to the Department of Defense to preserve them. If you started to move one of these agencies of government out of Maryland or Virginia they would be over here marching on the Capitol protesting that it is a great burden.

Mr. SISK. If the Chair might intervene, this legislation will be discussed in executive session. I appreciate the attitude of my good friends from North Carolina and Maryland.

Mr. Hannan, we appreciate very much your being here this morning to give your testimony.

I would like to proceed now with Dr. Ecker, Past President of the D.C. Medical Society, and I understand a group may come up with Dr. Ecker. The House has gone into session but I would like to proceed, if we could, and see how nearly through we could get this morning.

Mr. BUCHER. Mr. Chairman, immediately after Dr. Ecker finishes his testimony we can present the testimony of the Hospital Council of the National Capital Area.

Mr. SISK. Very well, Dr. Ecker, you may proceed.

STATEMENT OF DR. HENRY D. ECKER, IMMEDIATE PAST PRESIDENT, MEDICAL SOCIETY FOR THE DISTRICT OF COLUMBIA

Dr. ECKER. Thank you. Mr. Chairman, I am here to present the position of the Medical Society of the District of Columbia with reference to H.R. 6526. The Medical Society of the District of Columbia wishes to be placed on record as endorsing HR 6526, the "District of Columbia Medical Facilities Construction Act of 1967,"

with certain suggestions which we believe will make the enactment of such legislation more effective.

The greatest need in health facilities construction in the District of Columbia is for extended care facilities both long term and short term. HR 6526 includes—

Grants to assist in the modernization of public or nonprofit private hospitals and in the construction or modernization of public health centers, long-term care facilities, diagnostic or treatment centers, rehabilitation facilities, facilities for the mentally retarded, and community health centers.

While continuing to update and increase all health facilities is important, primary emphasis in this supplementary-grants bill should be on facilities designed to relieve the load on the general hospital. Despite all efforts by the medical profession to help reduce hospital costs to the family, to insurers, and to government, we all recognize that many patients could be released earlier from general hospitals to less costly facilities, either the short term requiring less expensive personnel and equipment, or the long-term nursing home type with a general hospital affiliation. This situation will be aggravated when title XIX of the Social Security Act is implemented in the District of Columbia.

Whether such emphasis or priority can be included in HR 6526 or should be made a part of the intent of Congress, is a matter for your committee to ascertain. We do believe, however, that some such emphasis or priority is essential to best serve the immediate needs.

With reference to the terminology as presently stated in the bill, I would like to make this comment. The medical society objects to the "long-term" phraseology because what hospital boards and hospital administrations and the medical profession are trying to develop in these days is progressive care. This range is in the spectrum from the intensive care unit to the domiciliary care type for elderly people who are unable to care for themselves. The greatest gap in this chain of progression from intensive care of a seriously and a critically ill patient to the well patient is in the extended care phase of movement. The general hospital is still taking care of people who do not require the sophisticated nursing care and equipment that exists on the acute wards. They are not quite able to go to self-care units which have been developed in a number of hospitals.

So, they are kept in the standard ward environment and it is not only costing them more but they are depriving other potential patients from entry into our already overcrowded hospital system. Therefore, we would prefer to see the term "extended care" substituted for the term "long care."

I would be happy to answer questions, if there are any.

Mr. SISK. Thank you, Dr. Ecker.

Does the gentleman from North Carolina have any questions?

Mr. WHITENER. No questions.

Mr. SISK. Thank you, Dr. Ecker. I appreciate your statement this morning. I believe there will be no questions at this time.

Now we have the Hospital Council of the National Capital Area. You may proceed, Mr. Bucher.

STATEMENT OF WILLIAM M. BUCHER, EXECUTIVE VICE PRESIDENT AND DIRECTOR, HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA, INC., ACCOMPANIED BY: DR. CHARLES W. ORDMAN, PRESIDENT OF THE MEDICAL STAFF, WASHINGTON HOSPITAL CENTER; RICHARD M. LOUGHERY, ADMINISTRATOR, WASHINGTON HOSPITAL CENTER; FATHER R. BYRON COLLINS, VICE PRESIDENT FOR PLANNING AND PHYSICAL PLANT, GEORGETOWN UNIVERSITY; AND WALLACE WERBLE, PRESIDENT, CHILDREN'S HOSPITAL

Mr. BUCHER. Mr. Chairman, my name is William M. Bucher. I am the Executive Vice President and Director of the Hospital Council of the National Capital Area, Inc. If I may, I would like to call the next four witnesses to sit with me here. They are: Dr. Charles W. Ordman, Mr. Loughery, Father Collins, and Mr. Wallace Werble.

I have a statement which I would like to have entered into the record, and I would like to make other housekeeping comments as we proceed.

Mr. SISK. I believe there are four statements. You have a statement, Mr. Bucher, and there are statements by Dr. Charles W. Ordman, Richard M. Loughery, Father Collins, and

Mr. BUCHER. Mr. Werble.

Mr. SISK. I don't have one for Mr. Werble.

Mr. WERBLE. Here it is.

Mr. SISK. Actually there are five statements?

Mr. BUCHER. Yes.

Mr. SISK. Without objection, those five statements will be made a part of the record at this point.

STATEMENT OF WILLIAM M. BUCHER, THE HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA, INC.

Mr. BUCHER. Mr. Chairman, my name is William M. Bucher, Executive Vice President and Director of the Hospital Council of the National Capital Area, Inc.

I am pleased to have the opportunity to testify in support of HR-6526 as the subject matter of this proposed legislation is of considerable importance to the continued provision of economical health care in the District of Columbia. My statement will be brief and will cover primarily the urgent need for this enabling legislation at the earliest possible date.

Within the District of Columbia there are only a token number of extended care facilities available for the treatment of patients who do not require expensive acute general hospital services. For example, the only non-governmental facilities which could provide the acute general hospital some relief in the care of such patients are nursing homes which are continually occupied at capacity. However, even if nursing home beds were available, this type of facility does not meet the specific needs of most extended care facilities. It has been estimated in the Washington metropolitan area that upwards of 20% of our patients could be moved immediately into an extended care facility, if it were available.

I am sure you will appreciate the tremendous savings to be effected by the construction of extended care facilities rather than general hospital facilities when you are aware of the difference in cost. The average cost of construction of an extended care bed is less than 35% of the cost of an acute general hospital bed. In addition, the expense per day to the patient may run as little as one half of the expense of care in an acute general hospital. This principle was soundly recognized by the Medicare legislation which provides for benefits within the extended care facility. Also, placement of patients in an extended care facility will enable acute general hospitals to ease the shortage of nurses and other limited personnel categories by using such individuals where they are needed most—in the care of the acutely ill.

Because the District of Columbia is a unique Federal jurisdiction, the remedies available to the states do not solve the problems here. Under the Hill-Burton Hospital construction program, the District of Columbia receives an extremely limited annual allocation of approximately \$400,000 per year for all types of health facility construction. We support the contention of the Metropolitan Washington Health Facilities Planning Council in that the existence of neighboring State boundaries contiguous to the District of Columbia is inconsequential when related to service programs of our Washington hospital centers.

You will recall that the Presidential Commission on Hospital Costs called for sweeping innovations in the health care system to reduce the costs involved. We believe that this program for construction of extended care facilities coordinated with or adjacent to the major hospital centers is just such a dynamic new approach.

I should like to express, on behalf of myself personally and on behalf of the entire hospital community, our deep appreciation and thanks to House District Committee Chairman McMillan for his continuing interest and effective assistance over the years in assisting this community to meet its health care facility needs.

STATEMENT OF DR. CHARLES W. ORDMAN, PRESIDENT OF THE MEDICAL STAFF WASHINGTON HOSPITAL CENTER

Dr. ORDMAN. Mr. Chairman, thank you for the privilege of appearing at this hearing.

My name is Charles W. Ordman. I am President of the Medical Staff of the Washington Hospital Center and I appear with our Administrator, Mr. Richard M. Loughery, to testify in favor of HR 6526 because of this community's real need for this proposed legislation.

The Washington Hospital Center is a private voluntary nonprofit hospital and serves in fact the greater Metropolitan Washington area, some 50% of our patients coming from outside the District of Columbia itself. The Center has now approximately 820 beds, and since its opening has kept abreast of the changing needs of medical practice and advancements in patient care by its addition of several units: Self Care, Medical and Surgical Intensive Care and Coronary Care and a recently endowed research facility. Because of the virtual explosion in knowledge pertaining to diagnosis and treatment of disease and the facility requirements concurrent in this progress, we are planning to enlarge and expand those areas for the treatment of the acutely ill patient. We have conducted our activities with some modicum of

success in the past and will, hopefully, continue to do so as the science of medicine and care of our patients advance. What we have not been able to do is to provide that facility required for after-care. The sub-acute patient whose condition has been stabilized in the acute hospital and who now needs controlled convalescence and/or rehabilitation before being referred to a nursing home or to his own home. This facility gap has caused a break in our being able properly to implement the concept of progressive patient care. This concept, providing for the right care at the right time at the right place and at the right price, means that the patient admitted to the hospital acutely ill needs more vigorous care than he does as his illness wanes and that he can be exposed to decreasingly intensive yet graded care as he convalesces. We who practice in general hospitals are forced to keep our patients in the general acute hospital at regrettably higher costs than necessary for a longer period than necessary simply because there is no appropriate facility available for that period of their care preceding their ability to be self-sufficient or to be cared for at home or in a nursing home. These patients no longer need the intensity of services provided in the acute hospital, but they do need professionally conducted and controlled care for an extended period of time. This phase in our patients' program of care could be more properly served and it could be served at considerably reduced cost to the patients and to the community.

We of the Medical Staff of the Washington Hospital Center have been vitally interested in this potential for many years. Through appointed committees of the Medical Staff we have conducted research and an analysis of our patient's needs and have developed evidence indicating the true extent of this problem and the urgency for its recognition. Although the average stay of an acutely ill patient in the Center is less than 8 days, detailed analysis of our patients staying in the general hospital over three weeks showed their length of stay to be from 34 to 55 days, with an average of 41 days. Our Utilization and Audit Committees point out that this is an improper use of our acute hospital beds. There is usually little need for the orthopedic patient following a hip nailing, the medical patient who is recovering from a coronary attack or admitted because of uncontrolled diabetes and its complications, or for many others with postoperative situations whose conditions are stabilized to remain in a high cost facility were an extended care facility available. Our analyses further showed that the specialties of Medicine, Surgery and Orthopedics accounted for some 75% of these longer-staying patients and that 50+ percent of them would be ambulatory in a facility encouraging convalescence and rehabilitation. Our surveys were conducted exclusively on the Hospital Center's patient population. They indicated then a potential of some 75,000 patient days annually at the Center alone. This situation pertains to other Area hospitals and the magnitude of our patients' need becomes quite impressive. Should the plans of our Medical Staff and the administration of our hospital become a reality through favorable action of this proposed bill, it would be our intent to serve as much of the Washington community's Area hospitals' total need as is possible.

Thank you, Mr. Chairman, for this opportunity to express on behalf of our Medical Staff our concern and interest in this bill.

STATEMENT OF MR. RICHARD M. LOUGHERY, ADMINISTRATOR
WASHINGTON HOSPITAL CENTER

Thank you, Mr. Chairman, for the privilege of appearing at this hearing.

Today, hospitals are faced with increasing pressures to find ways and means to reduce the costs of hospital care. These are legitimate pressures. We for some time have been deeply concerned with rising hospital labor costs needed to keep pace with wages paid in the community as well as those increasing costs caused by the rapid progress of medical science. It is an acknowledged fact that the quality of care and the saving of lives have advanced notably in the last decade alone. We in hospital management have not been able to institute some of the measures which would control these rising costs.

Dr. Ordman has indicated the professional views of our Medical Staff, their justifiable concerns for their patients, and their efforts to determine a better way to serve their patients. Concurrent with the actions of the Medical Staff, we began planning in the early 1960's with the assistance of nationally known consultants and architects to design a facility appropriate for the extended care patient. This planning cost in excess of \$30,000 but did result in a program and detailed plans for appropriate and effective medical care at reduced costs. Our research further indicated that:

- 1) A survey by the Hospital Advisory Council to the District of Columbia Department of Public Health showed only 26% of needed long-term care beds were available in 1964 and recommended 300 to 400 convalescent rehabilitative beds at the Hospital Center.

- 2) Survey of District of Columbia Medical Society physicians showed doctors overwhelming urged expansion of long term (extended) care beds.

- 3) 25% of the Hospital Center's patient days were represented by patients who could be better and more economically served in an extended or after-care facility.

- 4) Professional activity study of patients 65 years and older in 100 U.S. short term general hospitals showed a 21% rise in bed use by our elderly, Medicare patients (this trend will continue).

In August of 1967, our studies showed that for the first six months of that year we could have, with the right kind of facility, provided "extended care" for over 2000 of these patients at considerably reduced costs for the over 32,000 days they required in our hospital. This situation is costly to the patient, the community, and the taxpayer. Further it is an inefficient system for providing needed health care and should be improved.

Our proposal is simply to preserve crucial, highly trained medical manpower and avoid duplication of facilities by extending these existing adequate services of our general acute hospital to our planned convalescent-rehabilitative care facility.

By this I mean the whole range of supportive services, i.e. dietary, housekeeping, engineering, computerized accounting and reporting, medical records, purchasing, laboratory, X-ray, and so on—to name but a few. By doing this we are able to provide a very real savings to the patient and the community. We expect these savings—consistent

with Secretary Marion B. Folsom's recommendations made in 1965 to represent at least one third of current general hospital costs.

Because the Hospital Center is in fact a creation of the Congress, and because provisions of Hill-Burton legislation in the District are inadequate, we have continued to seek the Congress's support since the early 1960's. Our particular plan has been carefully conceived and has the endorsements of the Health Facilities Planning Council, our own Medical Staff, GHI (Blue Cross and Blue Shield), and the findings of the Hospital Advisory Council to the District of Columbia Department of Public Health. Past testimony by the Department of HEW and District of Columbia Director of Public Health vouch both for the validity of the need and our program.

We strongly favor the legislation now being considered as we see it as the only way to overcome the major obstacle of capital financing for this type of needed facility in the District of Columbia. The nature of this federal community makes it particularly difficult for us to promote by fund drives the matching funds required under existing legislation. Almost 50 percent of our patients come from outside the District and their interest in fund drives, quite understandably, remains in their local communities. This proposed legislation would alleviate this dilemma. It provides specifically for the particular type of facilities especially needed. We have been and are ready now to immediately build a modern extended care, convalescent-rehabilitative facility to better serve at lower costs the well documented need of these patients in the metropolitan community. We urge favorable action and any such measures necessary to allow us to immediately proceed.

Thank you, Mr. Chairman. I will do my best to answer any question you may have.

STATEMENT OF REV. T. BYRON COLLINS, S.J., GEORGETOWN UNIVERSITY

Father COLLINS. Mr. Sisk, I am T. Byron Collins, S.J., Vice President for Planning and Physical Plant of Georgetown University.

Georgetown University is vitally interested in H.R. 6526. The funds requested in the grant portion of this bill are so necessary to the program of construction that has already started in our Medical Center that without Congress' help in this Bill our construction program will be unable to be completed.

Why should Georgetown University Medical Center appeal to Congress for help to finish its construction program? First, let us look at the facilities that are being constructed. They are out-patient facilities which will enable us to increase our services by 50 to 100 percent. The demand for the services in the planned program for Georgetown's share in providing metropolitan area health service is absolutely necessary.

In addition, a facility for mentally retarded children and instruction of the parents of these children is being provided.

Associated with this facility is additional space for teaching medical students, residents and interns and faculty in a building that is designed to teach students how to diagnose and treat patients and then have them actually do this in their educational program. Another

building will be a new dental clinical building. What is the purpose of these buildings? These privately owned and privately supported medical and dental schools are the largest in the District of Columbia. Present entering classes: Medical—121; Dental—111. Expansion program will increase enrollments. 1970 entering classes: Medical—145; Dental—131. Student body from 50 states, over 100 different colleges, with no restrictions as to race, color or creed. These schools produce the physicians and dentists for the Washington Metropolitan Area; one-half of the practicing dentists and one-quarter of the practicing physicians are Georgetown graduates.

Faculty physicians and dentists, resident and students serve the community in Georgetown University clinics and Hospital; D.C. General Hospital; the V.A. Hospital; Children's Hospital; Arlington Hospital; and a variety of clinics and special services of Health Departments and private health agencies.

6,500 new patients are seen each year in the Dental clinics. Eighty percent of these patients have family income levels below \$10,000; and 50 percent are from family units of four or more persons.

In 1966-67, there were 3,980 indigent D.C. resident inpatient days at Georgetown University Hospital. Over and above reimbursements, the cost to the University was \$112,300.

In 1966-67, there were 49,527 indigent D.C. resident clinic visits at Georgetown University Hospital. Over and above reimbursements, the cost to the University was \$302,600. In addition, indigent patients from the metropolitan area increased our costs to in excess of \$350,000. Together with indigent inpatient service, our unrequited cost was in excess of one million dollars.

Georgetown University Hospital is not a community hospital in the usual sense of the term. It is a university teaching hospital with special educational and research objectives. In order to best fulfill these objectives, it is obliged to provide the very best patient care, and in its beds, laboratories, operating rooms and clinics it has touched intimately the lives of hundreds of thousands of residents of the Washington area. Many hearts continue to beat, many kidneys continue to purify the blood, and many minds continue to function creatively because of the special talents offered by scientists and teachers of Georgetown.

Hundreds of physicians of our faculty serve their patients in hospitals affiliated with our medical school—District of Columbia General Hospital, Veterans Administration Hospital, Children's Hospital, Arlington Hospital, and others. These hospitals provide superior medical care because of the education and research atmosphere created in them through the inquiring presence of our faculty, interns, residents, and medical students.

The District of Columbia General Hospital (more popularly known as D. C. General: is a 1,250-bed general hospital which serves as the municipal hospital for the District of Columbia. It is operated by the D.C. Department of Public Health, which receives its financial support directly from the Congress. Medical care at D.C. General ranks with the very best of the municipal hospitals in the United States. Twenty-two members of the full-time faculty of Georgetown

University School of Medicine supervise sixty-five Georgetown interns and residents and twenty postdoctoral fellows at D.C. General. The hospital swarms with our students. Many members of the full-time and volunteer faculty serve as visiting physicians, assuring that the least fortunate of our citizens receive the same or better medical care than that received by our most fortunate citizens.

Of the full-time faculty stationed at D.C. General, ten receive no income whatever from the District of Columbia. They are paid entirely by Georgetown University. Georgetown has made a large commitment to service in our city hospital. To be sure, D.C. General provides a magnificent training ground for our medical students and graduate trainees in the numerous specialties of medicine. But we are there because we want to be there. Since Georgetown is in the business of rendering health care, it has assumed the obligation of rendering health care to all citizens of Washington, regardless of economic status, in its own hospital and in the municipal hospital. (Statistic: In 1965, 5,800 babies were born at D.C. General. Of these, 2,000 were delivered by Georgetown people, teachers and students.)

Fifty members of the full-time faculty of the School of Medicine and many members of the part-time faculty serve as consultants and committee members in the health and other agencies of the United States government. Many are members of committees and clinical study panels of the National Institutes of Health. Others serve the Armed Services, the Veterans Administration, NASA, the Social Security Administration, CIA, and the Civil Service Commission. All serve at significant material and temporal sacrifice. All feel the obligation to assist in the smooth functioning of governmental operations by lending "know how" to the government's programs in health, education, and research.

Why did Georgetown University undertake this program? We felt we must supply our share of the health resources necessary for the Washington area. Georgetown University was confronted with the question *go or stop*. We *went*, in the spirit of faith and hope. I trust that this Committee will enable us to fulfill this faith and hope.

STATEMENT BY WALLACE WERBLE, PRESIDENT, CHILDREN'S HOSPITAL

Mr. WERBLE. As president of Children's Hospital, I am grateful for the opportunity to appear before you on behalf of our board, medical staff and sick children.

When you get right down to the heart of the matter we are discussing today, it is appropriate to point out that, whenever the board of a hospital makes a significant money decision, it most often involves, in one way or another, a single, but difficult question: How much is life worth?

At Children's Hospital, the underlying question always confronting the board is: How much is the life of your child or grandchild worth? My child or grandchild? Or Joe Smith's child or grandchild?

Boards of general hospitals are confronted with the question of how much is the life of any human being worth—your life, my life?

If you think this is putting the subject in terms that are too strong or too dramatic, let me be very candid with you. Ninety to ninety-five percent of the patients handled by Children's and the other excellent hospitals in the Washington area would recover if our institutions were only half as good and three-fourths as costly as they actually are.

Looking at the situation pragmatically, this becomes a matter of some importance, if you or I happen to be caught in that extra five or ten percent that is responsible for the additional costs which are always increasing in the continuing effort of hospitals to deliver the highest quality health care and medical service.

Lets take the example of a child suffering from leukemia. I think that Children's is the major community resource for the handling of these unfortunate cases. When I first became associated with the hospital 20 years ago in a volunteer capacity, the average span between the diagnosis and death of a child suffering from leukemia was 18 months.

Though we unfortunately have no cure for this dread disease, I understand that it is now possible to keep children suffering from leukemia alive for as long as six years. This is expensive. Why do we do this?

One reason we do this is that the saving of a human life as long as reasonably possible is a basic ethic of our western civilization.

But, to be pragmatic again, there is even a more practical reason. Who knows when our vast national biomedical research program will produce the miracle of a true cure or treatment for leukemia. It could happen today, tomorrow, next month, or next year.

Every child suffering from leukemia today should be given a chance to benefit from this miracle—if and when it comes—and therefore every effort is made to keep every patient alive as long as possible because you or I never know what today or tomorrow will bring.

This is not intended as a plea for—or a defense of—unrestrained increases in the costs of delivering medical care. As we all know, there has been an explosion in this area as costs catch up with the advances in biomedical sciences and what I choose to call the end of "slave labor" in our hospitals.

But it is intended to put into context one of the reasons why Children's and the other hospitals that have a vital interest in this bill are here today. We are not only faced with the constant problem of delivering better medical care to more people, in an era of rising costs, but we are also confronted with the kind of extra expenses involved in maintaining the emergency and other life-or-death services that, frankly speaking, involve only a relatively small percentage of our patients.

I do not believe there is any quick, sure or miracle cure for the dramatic rises in the costs of medical and hospital care. It is something that everyone in this area must work at—day-in and day-out.

But I have a personal view that, over the long haul, the best hope for cutting the costs of hospital care, nationwide, is the development of a new plant with every possible cost-saving device built in.

If you were the owner of a steel plant, and found that your costs of operation were pricing your product out of the market, you would be confronted with a cold business decision on whether to go out of

business or build a new plant that could meet competitive costs. Under these circumstances, to stay in business, you would go to banks, the stock market or some other element in the private financial community for the money to rebuild.

But hospitals can't do that. When confronted with the same situation, they have to go to the community, and more recently to the government, for their financial resources.

Lest anyone get the mistaken idea that I am advocating the enactment of this bill on the promise that it will cut costs of hospital care in the Washington area, let me make it clear that the measure we are considering is designed primarily to increase plant capacity to the point where it can handle patient load—the one in existence today and the one we can anticipate from demographic studies for the next decade.

Our expert consultants tell us that the pediatric population in the Washington metropolitan area will more than double by 1980. Our own Children's Hospital is already overcrowded, and we are spilling over into rented buildings and even garages in the neighborhood to maintain current research, teaching and health care programs.

Because of the million-and-a-half dollar annual deficit we are incurring from the handling of charity and welfare patients, we have not until now been able to give adequate attention to the future.

Despite the day-to-day financial and other problems of keeping our institution going at its current level of quality medical service, we have finally been able to begin to plan for the future. As you may have noticed in the newspapers, we have accepted an offer of land from the Washington Hospital Center for the construction of a new children's medical center.

If we had the money today, we would still be from three to four years away from opening the doors to a new Children's Hospital. Without the money provided in the bill we are discussing today—and without the loan authority sought in an amendment to it—a new children's medical center for the Washington Metropolitan Area is impossible.

Even with enactment of this bill—and inclusion of loan authority—we will still have to go to the national and local community for millions of dollars of voluntary contributions in order to provide the metropolitan area with the kind of children's medical center that our children and grandchildren deserve.

The volunteer board of Children's Hospital is willing to make this massive effort, once the Congress gives us the clear signal that the dream can become a reality. For the future of our own institution and all other hospitals in Washington—and for the benefit of the patients we all serve—we hope you will look with favor on the bill pending before you.

Mr. BUCHER. In addition to that I would like to have submitted for the record a spread sheet of estimates and various statistics, both financial and other details, that has been placed before you, and attached thereto are the statements of several organizations proposing amendments to the legislation which I will be pleased to speak to.

Mr. SISK. Without objection, the material referred to will be made a part of the record at this point.

(The material follows:)

H.R. 6526—ESTIMATE OF FEDERAL FUNDING REQUIREMENTS
(For inclusion in Report by William M. Bucher)

(Dollar amounts in thousands)

Name of Facility	Current Bed Capacity		Number of Beds to be Added		Other Facilities to be Provided	Planned Estimated Cost	Present Estimated Federal Share		
	General	Long-Term	General	Long-Term			Total	Hill-Harris	H.R. 6526
Hospitals:									
Casualty.....	210	40	100	200	Medical education and staffing expansion of physiotherapy and outpatient facilities.	\$12,350	\$6,175	0	\$6,175
					200 Bed Nursing Home.....	5,000	3,333	0	3,333
Children's.....	205	11	45	0	Emergency Room and Basement.....	541	71	\$200	71
					Emergency Power Generator.....	93	47	31	16
Children's Convalescent.....	(205)	(11)	339	11	Improvement and expansion of existing facilities.	1,905	146	146	0
		50		30	New Hospital.....	22,000	11,000	0	11,000
				30	Replacement and additional bed.....	1,150	575	575	0
Columbia.....	152		2		Master Plan Phase II and III.....	2,500	1,333	0	1,333
					Emergency Generator.....	55	18	18	0
					Centralized air condition for operating and delivery rooms; increase examining rooms; convert pantry to 2 bed rooms; new flooring for central sterilizing room; alteration of delivery suite; replacement and improvement of heating in nurseries; installation of a pediatric laboratory; and replacement of a roof.	154	77	38	39
Georgetown University.....	377	20	140		Remodeling and expansion of present facilities in diagnostic treatment and Medical Center Instruction areas.	\$27,340	6,260	71	6,189
George Washington University.....	400		110		Remodeling of 1948 building.....	\$10,500	3,929	709	3,220
					Remodel Emergency Room.....	474	237	183	54
					Remodel Prenatal Nursery.....	30	15	0	15
					Remodel Urology.....	50	25	0	25
Morris Cafritz Memorial.....	298	82		100	2nd Floor North—Heart Station and Pulmonary Function and Treatment Center.....	1,500	750	0	750
Washington Hospital Center.....	813			300	Nursing Home.....	1,300	867	578	289
					Modernization.....	276	138	78	60
					Extended Care Unit.....	6,500	4,333	0	4,333
Glenn Dale Hospital.....		235		200	Emergency Electric Power Plant.....	800	400	0	400
					Bed expansion by use of existing porches.....	41,500	1,000	0	1,000
					Modernization of kitchen, physiotherapy and occupational therapy and expansion of operating suite.	4,500	250	0	250
Department of Public Health.....					Comprehensive Health Center.....	46,000	3,000	1,500	1,500
Area D									
Total Funding Requirements.....						101,518	44,179	4,127	40,052
Grant.....									40,052
Loan.....									44,700,000

¹ Includes \$393,000 NIH Funded Project.

² \$10,000,000 direct Federal Grant for experimental purposes.

³ \$2,500,000 Congressional appropriation and \$121,158 NIH Project.
⁴ D.C. Funds Ineligible for Loan \$3,750,000.

PROPOSED AMENDMENT—LOANS FOR CERTAIN HOSPITAL AND HEALTH FACILITY
CONSTRUCTION

Section —(a)

In order to alleviate hardship on any recipient of a grant under section () of this title, to assure the immediate planning and construction of those projects to meet demonstrated community needs, to meet Congressional directives to control the costs of health care services, and to meet increased constructional costs (over the estimated cost of such project on the basis of which such grants were made and those previously estimated) through no fault of such recipient, the Secretary is authorized to make a loan to such recipient not to exceed 50 per centum of such project costs, as determined by the Secretary if the Secretary determines that such recipient is unable to obtain such an amount for such purposes from other public or private sources.

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

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

(d) There are hereby authorized to be appropriated \$44,700,000 to carry out the provisions of this section.

FURTHER COMMENTS

Mr. BUCHER. In addition to that I would like to call your attention to the fact that while we do not have all the participating financial hospitals present here, we have representatives in the audience of the three hospitals not participating:

Miss Elizabeth M. Rogers, President of Casualty Hospital.

Mr. Victor F. Ludewig, Administrator of George Washington University Hospital.

And Mr. George T. Stafford, Administrator, Morris Cafritz Memorial Hospital.

Mr. SISK. Will they please stand?

(The persons named stood.)

Mr. BUCHER. There is also present Dr. Robert Parrott, Director of Children's Hospital.

I would like to attempt to answer some queries that were not answered.

Mr. Walker spoke of the proportion of the amount of funds we are talking about relating to aftercare facilities. Approximately \$33 million out of the \$42 million is related to the extended care or nursing care facilities. The combination of a portion of these funds and the remaining funds is related to modernization.

The additional point Mr. Whitener made concerning the use of funds available here in the District and not available to his home State, I think should be looked into in terms of the allocation to the major medical center in North Carolina wherein funds similar to what we are talking about here may have been made available by the Federal Government over and above the matching funds available to the State.

In connection with the point that Mr. Gude raised on the availability of educational programs to staff some hospitals, I would call your attention to training programs in the District of Columbia through my organization which have turned out in excess of 300 new hospital employees within this past year. We are supported by the Department of

Labor, on-the-job training contracts, nursing refresher contracts, and under the recent Heart, Cancer and Stroke legislation we have a full-time staff working on this very point of increasing the numbers and the quality of hospital personnel available to man the hospitals we are contemplating building.

The fourth point I call to your attention is the point made by Mr. Whitener that there was within his own environment a \$10 million bond issue floated to meet the needs above the needs provided by the Hill-Burton legislation. I would like to call your attention to an amendment which we are asking in the legislation here, that there be a comparable addition to the existing legislation of some \$40 million. And if I may, would you be good enough to turn to the second sheet of the spread sheet which shows that while local hospitals under H.R. 6526 would receive upward of \$2,052,000 in grant, there still remains a total of \$44,700,000 yet to be received in order to make these hospitals operate. In Mr. Whitener's home environment the \$10 million bond issue was set forth by the government to meet this very classification, this requirement, in addition to the donations from the local population.

PROPOSED AMENDMENTS

Furthermore, as was set forth in the hearing on the legislation on the Senate side, I ask that the amendments suggested by Secretary Cohen be added to the bill and that the adjustments in the language of the Senate Bill be accomplished in the House in H.R. 6526 as follows:

First, since the first fiscal year for which appropriations would be authorized has already ended, an appropriate modification should be made in section 2 of the bill.

Second, to conform to the provisions of Reorganization Plan No. 3 of 1966, the reference to "the Surgeon General" in section 3(d) should be changed to "the Secretary".

There are three other specific amendments I would like to call to your attention.

For clarity of intent Section 2, line 2 on page 2, should also include the terms "and medical centers".

Mr. SISK. You are talking about the House bill now?

Mr. BUCHER. Yes, sir.

Mr. SISK. Would you repeat that last statement? It is on line 2 of page 2?

Mr. BUCHER. Yes. For clarity of intent, after the word "hospitals" add "and medical centers".

Again, Mr. Gude asked Dr. Grant what type of facilities we are talking about. I do agree that we might put in the definition as it stands now.

Also, for a similar purpose, on line 3 page 2, add the words "and medical" before the term "centers".

Again these are polishing amendments that should make clear the question raised about Children's Hospital and its construction.

The fourth amendment is in accordance with the national legislation revisions in process in the Department of Health, Education and Welfare. We would like on line 13, page 2, after the words "Title VI", add "and Title VII" so it would read "Title VI and Title VII". This

has come about primarily because of the revision in the duties and responsibilities and format of the Department of Health, Education and Welfare.

I am reminded this also is the vehicle which Senator Lister Hill has introduced for nationwide legislation in order to assure that funds under each title will be used as Mr. Hannan suggested, that all Federal funds should be used most effectively and not geared to separate sections or titles or separate types of facilities.

We ask that the loan provision attached to this document which you here already made a part of the record, be added at the appropriate place within the bill. I believe you have that attached to your spread sheet. The suggested language for the loan amendment was forthcoming from Senator Hill's bill which is before the Senate and which will apply to nationwide legislation. Specifically, what this does is what Dr. Grant and several others have mentioned. While we have funds forthcoming under the Hill-Burton legislation to provide matching funds for construction, we are in the same position as, for illustration, Mr. Gude is in Maryland, where the State has provided some \$70 million of loan funds in order to permit the individual hospitals to obtain sufficient funds to complete their construction.

I would like to turn now to ask Father Collins, on my right, who is deeply involved in both health care and the hospital end of it, to support only the one particular point as to the availability of loan funds for health care and educational facilities. After that I would like to turn this discussion over to Dr. Ordman to proceed with testimony of the Washington Hospital Center.

Mr. SISK. All right, Father Collins.

GEORGETOWN UNIVERSITY HOSPITAL

Father COLLINS. The purpose of this legislation is to enable the hospitals and medical facilities in the District of Columbia to supply a need that is upon us now. This program has been under study for seven or eight years. All of us have participated through the centralized planning efforts in the District of Columbia and in truth the entire metropolitan area in the planning for health facilities and health care.

The specific problem which I would like to illustrate from experience at Georgetown University Hospital, which I know also to be the case of other private institutions in the District, is in answer to Mr. Whitener's quest: "Why does not the community of the Greater Metropolitan Area respond to the needs that is so obvious?"

I can only answer from experience of the Georgetown University Hospital in three years of an intensive nationwide effort trying to supply funds to meet critical needs in its shared responsibility with the District, that there is no response from the Washington area. I don't know if that is because of the transient nature of the area, but the fact is that the funds are not forthcoming even though a great deal of effort has been made by myself and others at Georgetown University in the Washington area. Our own analysis is that it is because of the turnover, that the roots of the people here are at the places from which they come.

So I think the responsibility for supplying these needs should be on the ones who cause the needs. We all owe a service to the Federal

Government. The District of Columbia services the people of North Carolina; it serves Mr. Gude's State of Maryland; and it serves my own State of Pennsylvania. So that would be my basic answer to him.

The responsibility of putting up these facilities requires the availability of loans in order for all of us to start our projects that are ready to go. Other States, other communities, provide these funds from either local grants from the State of North Carolina or from his own county, or from interest rate subsidized loans of State funds, and this precisely is our request here. We ask the District of Columbia to recognize the unique position that Washington is to the entire country and make available to us loans that will be provided in legislation at a later date for the entire country, and the same principle on which these loan dollars would be available would be mainly there is a need of our local government, which in a sense really is our Federal Government, to supply this need for us to go on with the job we have at hand.

Thank you.

Mr. SISK. Thank you, Father Collins, for your statement. As I understand, according to this memorandum I have here showing the various needs within the Washington, D.C. area for the various hospitals, Georgetown University Hospital proposes to add 140 beds to its present facilities. These would be GM&S beds rather than long-term extended care beds.

Mr. Bucher, do the amendments you propose now qualify these for such funds as would be involved?

Mr. BUCHER. No, they do not. The total cost of construction at Georgetown University Hospital amounts to \$27 million. Out of the current legislation, either Hill-Burton or Hill-Harris and H.R. 6526, there is a total of about \$6,300,000.

Mr. SISK. What portion of that \$6.3 million would come as a part of the grant under this proposed legislation? What I am considering here is the interpretation of the uses of these funds as indicated by Dr. Graning awhile ago. I am trying to clarify for my personal knowledge exactly what the status would be, because it is not my understanding that as to this proposal for Georgetown—and the same would be true of George Washington University—they would qualify for these funds without amendment to the pending legislation.

Mr. BUCHER. Mr. Chairman, there is no provision in this legislation that would permit construction of brand new additional general acute hospital beds. All the funds you see here, including some of the statistics you see here, may include them because they are part of the over-all project of construction, but they are not included in the dollar grant provisions. In other words, we have set forth the authorization for Georgetown, that they plan to add 140 general beds. We have set forth that part of the total cost of these 140 beds is in the \$27 million, but the participation in both pieces of legislation we are speaking to will not provide matching funds for the 140 beds. It is purposely set forth this way to give us the illustration that these hospitals are not limited.

Mr. SISK. I understand that, but to get back to what will be done with the \$40 million-plus that we make available, if we do make it available under this legislation, I wanted to have a clear understanding in my own mind as to what that portion of that would go to

Georgetown University or George Washington University or any of the other hospitals dealing in what we call general beds. I am sure you are aware there will be questions raised on this legislation in executive session and I am trying to clarify the facts. To the extent money is made available under the pending legislation, of course, there will be matching funds required, and I am trying to determine how much of these funds, if they were made available, would be used or could be used in the proposed construction set forth on this sheet.

Mr. BUCHER. The answer to that is in the last three columns. The funds requested under this legislation are requested in addition to the Hill-Burton language, and the second column on your sheet is a total column. This means a total grant in aid. The first column is the over-all planned construction cost.

Mr. SISK. The first column is \$27,340,000. The next column is \$6,260,000. \$71,000 of Hill-Harris deducted from the \$6,260,000 comes to \$6,189,000. Are you saying that out of this \$40 million they would receive a grant in this amount if this legislation was passed?

Mr. BUCHER. Yes, sir.

Mr. SISK. Now in line with the discussion earlier, that \$6,189,000 will have to be used for extended care or for those types of facilities and not GM and S beds.

Mr. BUCHER. Specifically it will be used for the purposes as set forth just to the left of that. It may be extended care facilities or diagnostic treatment, medical center instructional areas, and those which are diagnostic care facilities and the types of facilities and service programs which will keep the patient out of a general acute bed. That is the entire thrust of this.

Mr. SISK. I think I have it clear. For the record I want to be sure of exactly what we are talking about.

Does anyone else have a statement now?

Mr. BUCHER. Dr. Ordman.

Dr. ORDMAN. Thank you for the privilege of appearing. My statement was submitted earlier, Mr. Chairman.

Mr. SISK. Thank you, Dr. Ordman.

I believe we now have Mr. Werble, of the Children's Hospital.

All of these statements, gentlemen, have been made part of the record. We have only a very few moments left because of quorum call.

Is there anything you wish to add, Mr. Werble?

CHILDREN'S HOSPITAL

Mr. WERBLE. We have a slightly different problem from the others. I certainly support Dr. Grant's amendment, to make it clear that new beds can be built with this money.

We currently have 225 beds we hope to relocate in the Washington Hospital Center. If in the doing of that it becomes wise and prudent and economic for the long term future to add some beds we would like not to be barred from doing that and just replacing 225.

I would like to make this comment, too:

I do not believe that anyone could win an argument with Mr. Whitener because it is a basic philosophical discussion. I can share some sympathy for the way he feels, however.

As the volunteer president of a Volunteer Board we lose each year one and a half million dollars taking care of charity and welfare patients for whom we either get no pay at all or inadequate pay because we operate under an 1870 charter which requires us to give service to anyone who comes to our door without regard to race, creed, color, or ability to pay.

We have seen this happen year in and year out. How do we do this? First we go to the community and we raise about \$700,000 a year in voluntary contributions. The rest of it comes from unearmarked bequests that people give us. If a bequest is earmarked for some purpose our trusteeship will not spend that on operating expenses, but we are somewhat in the same position here. We have been spending money that should be going into capital funds. These bequests we get should have gone either into an endowment or building fund and we have been taking care of our charity loads.

I would like to make one more comment. The idea of the Washington hospitals, all of them that are included, or virtually all of them included in this bill, work on what is known as the regional concept. It is the new concept in the delivery of medical care.

The regional concept adds something to medical care. It also takes into account a standard of excellence, a striving for excellence. I am not saying that all hospitals do not give good care but some hospitals do give specialized care. I think Children's veers toward the life and death type case. If anyone troubles to read my seven-minute statement he will see it is pretty much a tear-jerker, but it is not out of bounds.

In North Carolina you have two regional centers, one at Durham-Duke and one at Chapel Hill.

These centers got funds outside of the Hill-Burton structure. The people in Mr. Whitner's district do go to those centers when they need open heart surgery and they will continue to go there even after their new hospital, I daresay, is built with this \$10 million bond issue.

Washington is an unusual situation. Every metropolitan center in the country faces the problem of regionalization. Here we face it doubly because of the unique District of Columbia boundary. You can no more run economic quality health care facilities in the Washington metropolitan area without a regional concept than you could run the airports and the seaport of the New York area without the New York Port Authority compact. This is what we are here for.

Give me one minute more for the sick kids. We talk about \$40 million. If this bill were passed we get \$11 million in grants. If we were lucky enough to get the loan authority it would be \$22 million. If we sold our current property we would have five, 22 and 5 are 27. There is \$13 million shy. Here is a lay board of just interested citizens who are in effect willing to undertake to try to raise, in spite of all that we are told you cannot raise it in the District of Columbia, \$13 million. We hope to get it nationally because of this regional concept.

We will talk about treating patients, yes, from as far south as North Carolina. By taking a regional approach to the fund-raising we hope we will be able to raise the rest of the money necessary to do a job for the community of Washington.

Thank you, Mr. Chairman.

Mr. SISK. Thank you, Mr. Werble.

(Subsequently, Dr. Werble submitted the following additional information:

CHILDREN'S HOSPITAL OF THE DISTRICT OF COLUMBIA,
Washington, D.C., June 27, 1968.

The Honorable, B. F. SISK,
Chairman, Subcommittee No. 5, House District Committee, U.S. House of
Representatives, Washington, D.C.

DEAR CONGRESSMAN SISK: I hope this supplementary statement can be made a part of the record of your hearing, held June 17, by your subcommittee on HR 6526 dealing with government grants and loans for the construction of hospital facilities in the District of Columbia.

As you may recall, I filed a brief general statement, as president of Children's Hospital, and added several moments of oral comment at the tag end of your hearing.

Primary purpose of this statement is to furnish additional information on the tabulation of funding requirements, placed in the record by Mr. William M. Bucher, as spokesman for the Hospital Council of the National Capital Area. This tabulation lists the estimated cost of a new Children's Hospital at \$22 million. It is based on a figure supplied by our institution to the Hospital Council many months ago when work on this legislation was first initiated.

This figure represents our earliest estimate, calculated before we had moved very far into the planning process. According to the latest estimates from the hospital planning consultants we have retained, the figure will be in the range of \$30 million to \$40 million, probably closer to the latter.

This is important because the point was raised during the subcommittee hearings on the willingness of residents of the Metropolitan Washington Area to undertake voluntary action to match government aid in developing and maintaining the kind of hospital and medical facilities that are required for the Nation's Capital and the area that surrounds it.

Assuming a cost figure of \$35 million for rebuilding Children's Hospital on the Washington Hospital Center grounds, the funds authorized by HR 6526 would provide a federal grant in the order of only \$11 million, based on the Hospital Council's tabulation that was made part of the Senate committee report on the companion bill which has been passed.

If the House bill is amended to include loan authority, proposed by the Hospital Council and supported by a number of institutions—including Children's, we might become eligible to borrow another \$11 million for 50 years at a low rate of interest.

This would give us a base of \$22 million. To this, we can add an anticipated yield from the sale of our present property—perhaps several million.

But the difference between this and the \$35 million to \$40 million anticipated total cost would have to be raised by a vigorous voluntary fund campaign, undertaken in the Metropolitan Area and, hopefully, on a national basis. The raising of \$10 million to \$15 million is a massive undertaking for the citizens of the community who serve as volunteer members of the Children's Hospital Board. An effort to explain the motivation for this effort was made in my brief prepared statement, already a part of the record.

Children's also would like to go on record as favoring the proposed amendment permitting the use of funds for the construction of new beds, as well as the replacement of existing ones.

We now have a 225-bed hospital. Our consultants tell us that this number does not permit the most economical operation of a regional medical facility that seeks to achieve excellence in the kind of situations which might mean the difference between life and death. We are advised that a 350-bed hospital may be required for efficient and effective operations.

We appreciate the time and thoughtful consideration given by you and the members of your subcommittee to the problem of maintaining adequate medical facilities in the Nation's Capital to serve the surrounding area and region.

Sincerely yours,

WALLACE WERBLE, *President.*

Mr. SISK. Now we have Dr. Burke.

STATEMENT OF DR. F. G. BURKE, MEDICAL DIRECTOR, HOSPITAL FOR SICK CHILDREN (FORMERLY CHILDREN'S CONVALESCENT HOSPITAL)

Dr. BURKE. Mr. Chairman, I am Dr. Frederic Gerard Burke, Medical Director of the Hospital for Sick Children, formerly the Children's Convalescent Hospital in Washington, D.C. I appreciate the privilege of appearing before this committee to support your favorable consideration of the proposed legislation (HR 6526) to provide supplemental aid for modernization of hospitals in the District of Columbia. We are particularly in support of those parts of the proposed legislation that identify the needs for extended hospital care facilities.

The Hospital for Sick Children, formerly the Children's Convalescent Hospital in Washington, D.C., is the only intermediate stay pediatric facility providing multidisciplinary hospital care for children suffering from a variety of illnesses in the Washington Metropolitan area. The patients admitted to this thirty to ninety day, with extensions, hospital are largely referred from the several acute short stay hospitals in the area.

The medical needs and programs for children afflicted with long-term sicknesses are considerably different from those provided in acute short stay hospital units and are the basic therapeutic thrust of our hospital staff. These deal with the important psychologic and socio-behavioral needs besides the medical and surgical ones.

The Hospital for Sick Children is now in its 85th year of operation and recently changed its name from the Children's Convalescent Hospital in order to comply with the semantics suggested by the Blue Cross Association in order to obtain a hospital contract with that pre-pay organization. The word "convalescence" has become associated with nursing homes in current times and ours is a licensed intermediate stay and rehabilitation hospital.

Under the Hill-Burton program we are just completing an eighty bed addition to the hospital which will help us meet the extended hospital care needs of this community's small children. Because of shortage of Hill-Burton funds when this building program finally got underway, the modernization and renovations of the older structures and other sharp curtailments of our building plans had to occur.

Specifically, the lack of sufficient funds to modernize and replace the old and decrepit beds and facilities resulted in elimination of beds for thirty to forty adolescent children. In addition, the proposed ambulatory and rehabilitation facilities for outpatients suffering from chronic illness was eliminated. It is estimated that approximately three million dollars will be required to modernize the existing hospital to accomplish this building program.

In addition to meeting the specific medical needs of these sick children, with chronic heart, lung, bone and neurologic diseases to name a few, the reduced medical costs and opportunities for training of medical and paramedical personnel must be stressed in a pediatric extended care facility. The costs are generally one-third those of acute short-stay hospitals, a not inconsiderable savings. Pre and post doctoral training programs are conducted for physicians, and nursery, and other hospital aids are trained to help meet the medical manpower

shortages in many areas. These training plans will be greatly expanded in our new facilities.

The proposed legislation (HR 6526) and (S 1228) would significantly encourage the construction of much needed, low operating cost extended hospital care program for children in this area and I heartily endorse your favorable consideration.

Mr. SISK. I am sure there are questions we could ask of you gentlemen.

Mr. Gude, do you have a question?

Mr. GUDE. No, sir.

Mr. SISK. I am sorry we had to rush this portion, but I am anxious to get these hearings completed. Your complete statements are in the record, and the Committee can take a look at them.

I have great sympathy for the problems you have, and I am hopeful that from all this we can develop something that will be of benefit to the community.

I appreciate all of you gentlemen joining together and giving us the expression of your views.

I know of the concern Children's Hospital has and I am inclined to be sympathetic to giving you some flexibility.

Thank you, gentlemen.

The record will be kept open for one week that we may include various material requested, and any other matters received for the record.

Also, there will be included in the record at this point certain correspondence sent to Chairman McMillan in support of this proposed legislation.

(The matters referred to follow :)

HEALTH FACILITIES PLANNING COUNCIL,
FOR METROPOLITAN WASHINGTON, D.C.
Washington, D.C., May 16, 1967.

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

DEAR MR. CHAIRMAN: The Health Facilities Planning Council for Metropolitan Washington wishes to make known to your committee its great interest in H.R. 6526, a bill "To authorize project grants for construction and modernization of hospitals and other medical facilities in the District of Columbia."

This proposal is identical in substance with H.R. 15070 in the 89th Congress. The Senate District Committee held hearings last year on the companion bill, S. 2622. By letter of January 8, 1966 and again in an oral statement at the hearings, the Planning Council strongly supported this urgently needed measure.

As did its predecessor, H.R. 6526 embodies the Administration proposals for supplemental aid for modernization of hospitals, and for modernization and construction of other types of health facilities in the District of Columbia. To qualify for such supplemental aid, projects would have to be approvable under construction aid programs—the Hill-Burton program, or the Mental Retardation Facilities of the Mental Health Centers Construction programs. Supplemental aid would be conditioned upon such approval or the denial of approval upon the sole ground of insufficient funds under the District's allotments under those programs.

The proposed legislation grew out of growing concern for the pattern of special aids for individual hospital construction projects in the District—under the Washington Hospital Center Act of 1946 and later extensions and amendments of that Act. This pattern arose because the ability of District sponsors to raise

private capital does not square with the basic premises of the nation-wide Hill-Burton program and, as a result, the District was unable to use considerable sums allotted to it under that program. In 1961 the Department of Health, Education, and Welfare was directed by the President to look into the District's continuing need for special assistance of this kind. The proposed legislation is the outgrowth of the Department's findings. The District's special difficulties in finding the necessary capital financing for health facilities are amply documented in the Department's July 22, 1965 transmittal letter of the original draft legislation. The Council emphatically agrees with the Department's conclusion that there is great need for special assistance for construction and modernization of health facilities in the District and that such an assistance program should put on an orderly basis, subject to review under the same type of procedures that govern project approval under the basic construction programs.

The Planning Council was established in April, 1962 with the assistance of the Public Health Service and under the sponsorship of the Metropolitan Council of Governments. Its purpose is to encourage area-wide planning for health facilities within the Metropolitan Washington community in order to further effective expenditure of available construction dollars and to avoid unnecessary operating costs. The bill would strengthen such planning efforts by making review of applications for supplemental grants by a responsible metropolitan area planning body a required stage in the project approval procedures. The recommendations of such a body would have to be taken into account by the District's Hill-Burton agency and submitted to the Surgeon General; the planning group's views would not be controlling, however.

The Council again urges the Committee to give serious consideration to broadening the bill to permit supplemental grants for construction of additional beds. Unless the suburbs can build additional beds to keep pace with their population growth the pressures on District hospitals will increase. District hospitals last year provided 63% of patient days rendered in the entire metropolitan area. Furthermore, with emerging patterns of care that tend to concentrate the more costly and complex procedures in institutions which are at the heart of urban complexes, there may be special expansion needs in central city hospitals that cannot well be brought under the "modernization" category. We believe this suggested relaxation in the uses permitted for supplemental construction grants would make for a more flexible program without encouraging over-building in the District. Required review procedures and current planning efforts, under this and other programs, should continue the impetus toward health facility construction in nearby suburbs.

Passage of the "Demonstration Cities and Metropolitan Development Act of 1966" (P.L. 89-754) authorized a program of supplemental aid for metropolitan development projects. Under title II of that Act, it would be possible for a hospital or health facility project that was in accordance with and would further metropolitan area-wide comprehensive planning and programming to obtain a supplemental grant of up to 20% of the cost of construction, with an overall ceiling of 80% for total Federal contributions.

After July, the designated area-wide comprehensive planning agency would also review applications for projects within the metropolitan area for construction grants under the basic construction programs, including the Hill-Burton program. Thus that Act strengthens over-all metropolitan area planning and provides additional incentives, through supplemental grants, for an economic and balanced distribution throughout the area of needed facilities in the Federally assisted categories (including health facilities).

In conclusion, the Council reaffirms its strong support for H.R. 6526 and urges its prompt enactment. With the expected passage of legislation to enable the District to participate in the Federally-aided medical assistance program under title XIX of the Social Security Act (S. 3469, and H.R. 3972 on which hearings have been held in the House) it is essential to overcome the District's deficit of long-term beds. The program authorized by H.R. 6526 should provide substantial encouragement for sponsors of such projects. The bill itself recognizes the great need for such facilities by including them within the group for which there is a higher matching ceiling—66⅔%.

Sincerely yours,

WILLIAM T. HANNAN,
Chairman.

FEDERATION OF CITIZENS ASSOCIATIONS OF THE DISTRICT OF COLUMBIA

RESOLUTION

Subject: S. 1228

WHEREAS S. 1228 is a bill to authorize project grants for construction and modernization of hospitals and other medical facilities in the District of Columbia, and

WHEREAS this bill will authorize appropriations for each of the next three fiscal years, such sums as may be necessary to enable the Secretary of the Department of Health, Education, and Welfare to make grants to assist in the modernization of public or non-profit hospitals and in the construction or modernization of public health centers, long-term care facilities, facilities for the mentally retarded, and community mental health centers in the District of Columbia, and

WHEREAS, with Medicare in operation, there will be an increasing need of the above-mentioned medical facilities, now, therefore, be it

RESOLVED that the Federation of Citizens Associations of the District of Columbia, in regular meeting on June 8, 1967, does recommend passage of S. 1228.

Approved by the Federation June 8, 1967.

Dr. EDWARD A. KANE,
Chairman, Health Committee.
MABEL E. MORRIS,
Mrs. Edward B. Morris,
Secretary.

GOVERNMENT OF THE DISTRICT OF COLUMBIA,
PUBLIC HEALTH ADVISORY COUNCIL,
Washington, D.C., May 12, 1967.

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

DEAR MR. CHAIRMAN: I acknowledge receipt of your letter dated May 8, 1967 replying to my letter of May 2, 1967 which transmitted the plea of the Public Health Advisory Council for an early and favorable action upon H.R. 6526—a bill to authorize project grants for the construction and modernization of hospitals and other medical facilities in the District of Columbia.

The statement that the enactment of H.R. 3972—a bill to enable the District of Columbia to participate in the health and medical assistance benefits made available by Title XIX—P.L. 89-97, would not require additional health care facilities and might reduce the requirement for these facilities by providing medical attention before critical health problems develop, is a correct one when viewed only within the context of the immediate and long range objectives pursued by the proposed Medical Assistance Program of the District of Columbia under Title XIX—P.L. 89-97.

The immediate implementation of this Medical Assistance Program calls for the effective and orderly utilization of existing health care facilities and other health care resources. Therefore, no additional new facilities are required or are new available for its immediate implementation. Likewise, by attempting to develop and utilize now new alternatives for patient care, such as private physicians' offices and services, medical care at home and through organized public and private ambulatory clinic facilities, the Medical Assistance Program could contribute to reducing the future need for inpatient care facilities, hospitals and skilled nursing homes within the District of Columbia.

Thus, any unjustified deterrent to the immediate implementation of this Medical Assistance Program is a force now enhancing the future need of additional health care facilities and programs within the District of Columbia.

H.R. 3972, if enacted, would permit the District of Columbia to provide medical assistance to the categorically and medically needy under the provisions of Title XIX—P.L. 89-97 within the existing public and private health care facilities in the District of Columbia. Conversely, the enactment of H.R. 6526 would provide a more effective fiscal vehicle for financing the additional health care facilities that may be needed in the years ahead to satisfy the health needs of the total population within the District of Columbia.

The future need of inpatient beds, whether public or private, to satisfy the health needs of the total population of the District of Columbia including the categorically and medically needy population, under the proposed D.C. Medical Assistance Program—Title XIX, for the years 1968–71, is estimated by the D.C. Department of Public Health to be as follows:

	1968	1969	1970	1971
General medicine-surgery.....	4,958	5,085	5,085	5,225
Mental health.....	333	352	374	374
Long-term care.....	445	475	475	475
Tuberculosis.....	472	472	472	472
Totals.....	6,208	6,384	6,406	6,546

Under the financing formula provided by H.R. 6526, the construction cost of these additional new beds that could be needed is conservatively estimated to be as follows:

a. Construction cost per each type of bed:	
General medicine-surgery.....	\$35,000.00
Mental health.....	25,000.00
Long term care.....	20,000.00
b. Total new beds needed by type and year:	

	1969	1970	1971
Gen med-surg.....	127		140
Mental health.....	19	22	
Long term care.....	30		
Tuberculosis.....			
Total.....	176	22	140

c. Total construction costs (estimate) of needed beds by type and year:

	1969	1970	1971
Gen med-surg.....	\$4,445,000		\$4,900,000
Mental health.....	475,000	\$550,000	
Long term care.....	600,000		
Total.....	5,520,000	550,000	4,900,000

d. Distribution of construction costs of needed beds under financing formula of H.R. 6526:

	1969		1970		1971	
	S.S.*	F.S.**	S.S.	F.S.	S.S.	F.S.
Gen med-surg.....	\$2,222,500	\$2,222,500			\$2,450,000	\$2,450,000
Mental health.....	237,500	237,500	\$225,000	\$225,000		
Long term care.....	200,000	400,000				
Total.....	2,660,000	2,860,000	225,000	225,000	2,450,000	2,450,000

*S.S.=Sponsor's share of the cost.

**F.S.=Federal share of the cost.

I hope that this information will contribute to the favorable consideration of H.R. 6526 by your committee.

Sincerely yours,

LORIN E. KERR, M.D.,
Chairman.

GOVERNMENT OF THE DISTRICT OF COLUMBIA,
PUBLIC HEALTH ADVISORY COUNCIL,
Washington, D.C., June 12, 1968.

Re S. 1228—A bill to authorize project grants for construction and modernization of hospitals and other medical facilities in the District of Columbia.

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

DEAR MR. CHAIRMAN: The Public Health Advisory Council consists of a group of 21 members, residents of the District of Columbia who advise the Director of Public Health in matters pertaining to health and medical care. This Council is very actively engaged in considering matters relating to the evolution of a comprehensive health and medical care program for the District of Columbia, particularly under the provisions of P.L. 89-97 and P.L. 89-749.

In the process of these recent deliberations this Council has discerned an alarming gap in the continuum of services requisite to the operation of a medical care program that will be capable of providing an acceptable quality of care at the level needed by each person who is cared for in the District of Columbia.

This gap is the result of a deficiency in the number of acceptable long-term care and skilled nursing home beds in the District of Columbia. Estimates of additional need in the District for such beds, which were made prior to the enactment of P.L. 89-97 (Medicare-Medicaid), showed the need for construction of 600 additional extended care beds. The extent to which the need for utilization of this type of facility will be increased as a result of the forthcoming implementation of the District's Medicaid Program under P.L. 89-97 is not yet known, but there is no doubt that this increased need will be substantial.

As a result of the insufficient number of extended care beds, much more costly short-term hospital beds are occupied by patients who could be moved to extended care beds if they were available. The adverse conditions resulting from this excessive utilization are further compounded by the need by 1970 for the modernization of existing short-term hospital beds.

Only by encouraging the construction and modernization of medical facilities can we hope to have available an adequacy of beds to meet the needs of the people of the District of Columbia. It has been many times demonstrated in the past by the enactment of special legislation that the needs of the District of Columbia are over and above those which can be met by the various existing medical facility construction Acts.

For these reasons, the Public Health Advisory Council endorses this proposed bill and urgently recommends that it be approved.

Sincerely yours,

ROBERT S. JASON, M.D.,
Acting Chairman.

(Whereupon, at 12:40 p.m. the hearing adjourned.)

(Subsequently, the following additional documents were filed for the record:)

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

JUNE 28, 1968.

To The Honorable B. F. SISK,
*Chairman, Subcommittee #5,
Committee on the District of Columbia.*

Mr. Chairman, I desire to submit the following additional information on the program for HR 6526. I have organized the text information in the following categories:

- I. Legislative Summary
- II. Justification for Construction and Fund Requirements
 - A. Hospital and Medical Center Facilities Program
 - B. Funds
 1. Grant—\$40,052,000
 2. Loan—\$40,575,000

III. Construction and Fund Requirements

A. Individual Institutions

B. Summary

IV. Similar Programs in Certain States Compared to the District of Columbia for fiscal 1966 and 1967

A. Specific State Funds

Fed. Grants-----	\$149, 000, 000
Public Grants-----	130, 600, 000
Public Bonds-----	533, 600, 000

B. District of Columbia

Fed. Grants-----	\$882, 000
Public Grants-----	0
Public Bonds-----	0

V. Status of Legislation

HR 6525 Comparison to the Companion Bill, S 1228 passed by the Senate

VI. Specific Questions about HR 6526

I. LEGISLATIVE SUMMARY OF HR 6526

Heard Monday, June 17, 1968, by Congressman B. F. Sisk, Chairman, and members of the House District Subcommittee #5.

PURPOSE OF LEGISLATION

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

NEED FOR LEGISLATION

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

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

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

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

SPECIAL EMPHASIS IN LEGISLATION

The dynamic and critical approach to meeting community needs as set forth within this legislation emphasizes the use of low cost extended care facilities within the existing hospital and medical center complexes inclusive of the replacement of outmoded, uneconomical and inefficient facilities. Inducement to obtain the programs and resulting community services includes adjustments of Federal matching fund ratios to 50 per centum of modernization construction and 66⅔ per centum for extended care and other low cost facilities.

HISTORIC BACKGROUND

This legislation represents the eight-year accumulation of individual and collective efforts of these health care institutions to meet the expressed and researched community needs. Areawide regional planning concepts as well as the endorsement of these plans has been accomplished. The legislation requires that each project submitted meet the community facility plans and those of the Secretary of HEW. This process is a continuous one for each of the grant and loan requests.

ROLE OF FEDERAL GOVERNMENT AS A STATE-COUNTY GOVERNMENT FOR THE DISTRICT OF COLUMBIA

In local city, county, and state jurisdictions throughout the country, financial assistance to meet matching funds is forthcoming from the government itself in addition to individual and industrial contributions. The requested loan amendment is equivalent to the bond issues in other jurisdictions. Because of the uniqueness of the Nation's capital where upwards of 70% of the population is employed by the United States Government or by its supportive service industries, no such possibility exists.

II. JUSTIFICATION FOR CONSTRUCTION FUND REQUIREMENTS

A. HOSPITAL AND MEDICAL CENTER FACILITIES PROGRAM

This bill is designed to provide for special needs for hospitals and medical center facilities in the District of Columbia by reason of its being the Nation's Capital and the central city core of a large metropolitan area, now with an estimated 2.5 million population and expected to increase to 3.5 million by 1980.

General Hospital and Nursing Home Beds

In the District of Columbia there is now a total of 4957 general hospital beds in existence or approved for construction. In accordance with the statistical report for the year ended June 1967, of the Health Facilities Planning Council for Metropolitan Washington, these hospital beds have an annual utilization rate of 84.7 percent compared with a national average of 76.5 percent. This means that on a given day of the year, an average of 4199 beds is being utilized and of these it is estimated that 40% are being used by residents of the surrounding counties, leaving 2519 beds for use by District residents. Furthermore, the average length of stay of a patient in any one of these beds

is 8.1 days. Also, for the year 1965 the occupancy rates of these beds per thousand Metropolitan Washington Area residents was as follows:

District of Columbia-----	1886
Maryland -----	477
Virginia -----	565

Comparison of the above utilization data with those of the United States indicates that the beds in the District are being over-utilized. This fact, plus the existing critical shortage of skilled nursing home beds in the District, is now and will continue to be a serious obstacle in meeting the demands for beds under the Medicare and Medicaid provisions of the Social Security Act. Excessive occupancy of acute hospital beds must continue until such time as sufficient extended care and nursing home beds become available. Estimates of this additional need in the District range upward from 800. At present, we have in the District 2490 beds in 26 licensed nursing homes which are being occupied for all practical purposes close to 100 percent throughout the year.

Other Related Health Care Facilities

Besides the known need for hospital and nursing home beds, annual surveys made by the D.C. Department of Public Health for the preparation of long range hospital and medical facilities construction plans under the provisions of the Hill-Harris Act (formerly Hill-Burton) indicate that there is, and will continue to be, need for additional health care facilities in the following areas: Public Health Community Centers; Diagnostic and Treatment Centers; Rehabilitation Facilities; facilities for the Mentally Retarded; and Community Mental Health Centers within the District of Columbia. Toward the satisfaction of this need, the Department of Public Health has, in the planning stage, a health care facility for the near Northwest Area of the District which will include all the facilities listed. This health care facility will be the prototype for similar facilities in other areas of the city.

Because of the previously noted medical care shortages, it is estimated that the following are required to alleviate the existing inadequacies:

1. Extended Care Beds—\$17,950,000—860 beds. The basic patient bed need of District of Columbia Hospitals and Medical Centers in serving the Metropolitan Area is to provide new extended care beds, i.e., nursing and convalescent beds. This type of bed is less expensive to build and costs much less to operate. Costs to the hospital patient will be reduced since an estimated 20% of patients do not need full hospital bed care or costs but should be in extended care beds. These facilities should be constructed and operated by existing hospitals or medical centers in order to keep the charges to the patient as low as possible. The present structure of medical practice in the District, wherein doctors are affiliated with specific hospitals and medical centers, makes a private hotel approach for this type of facility impractical in the District.

2. Outpatient, Mentally Retarded, and Health Instruction Facilities—\$40,903,000. Additional diagnostic and outpatient treatment facilities are urgently needed to meet the expanded population of the District as indicated in surveys by the Health Facilities Planning Council.

3. Bed Replacement and Renovations—\$42,665,000. Certain beds existing in old facilities are inefficient and ineffective for the practice of modern medicine and should be replaced. Where economically feasible, other facilities are to be renovated to meet Public Health Facilities standards. It has been determined by Congress many times in the past by special legislation with respect to the expansion, construction, or reconstruction of specific hospitals and medical facilities that there are needs in the District over and above those being met by the various hospital and medical facilities construction acts, which are applicable to all the States and the District of Columbia.

B. FUNDS

1. Grant for HR 6526—\$40,052,000. The responsibility of the Federal Government to provide financial assistance for the construction of hospitals and other medical facilities in the District of Columbia has been recognized by the Congress for a number of years. In 1946 Congress enacted the Hospital Center Act, which authorized the appropriation of Federal funds for the construction of the Washington Hospital Center as a replacement for three independent nonprofit hospitals and required the District Government to repay 50 percent of the net cost to the Federal Government.

In 1951, the Hospital Center Act was amended to authorize grants of up to 50 percent of the cost of constructing or renovating hospital facilities in the District. The District of Columbia was required to repay 50 percent of the Federal contribution. This was lowered to 30 percent in 1958 with respect to grants made after that time. Under the 1951 and subsequent amendments, grants of \$17,420,453 have been made for projects having an estimated cost of approximately \$44,400,000. The Act expired in 1962. In 1962 legislation (P.L. 87-460) was enacted authorizing grants up to \$2.5 million for 50 percent of the cost of constructing an addition to George Washington University Hospital. Funds for this purpose were appropriated by the Congress in the fiscal year 1964 and the project is now complete. In addition to the Hospital Center Act and P.L. 87-460, both of which applied solely to the District, Federal financial assistance has been given for the construction of hospitals and other medical facilities in Washington through two generally applicable Federal programs—the wartime defense housing and public works program, commonly referred to as the Lanham Act, and the program authorized by Title VI of the Public Health Service Act, commonly called the Hill-Burton program. Under the Lanham Act, two hospitals in the District received a Federal contribution of \$5,655,000. Under the Hill-Burton program, a total of \$7,194,000 in grants was approved through fiscal year 1966 for 27 projects in the District. The allotment of funds to the District, which takes into account per capita income and population, is low in relationship to the facility construction problem.

2. Loans for HR 6526—\$40,575,000. As the special Federal aid previously given for construction of District medical facilities indicates, the Hill-Burton, mental retardation, and mental health center construction programs provide only a partial answer to the problem of financing the construction of such facilities in the District. Sponsors of projects for such construction in the District of Columbia

experience serious difficulty in raising the non-Federal share of the cost thereof.

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

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

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

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

For the reason cited above, special Federal assistance for the modernization of hospitals and the construction or modernization of other medical facilities in the District of Columbia is clearly required to make up for the loss of normal private sources of support caused by the presence of the Federal Government in the District. It is necessary to have the Federal loans at a low rate of interest on a long-term basis if these pressing needs are to be constructed when they are needed now and over the next 3 years.

The low interest rate allows the borrowed money to be paid back with no appreciable increase in the per diem rates to the patients. This type of program of Federal borrowing exists in the field of education and student housing, where the need is perhaps even less critical. The rate proposed is $2\frac{1}{2}\%$ at 50 years in accordance with a similar bill in current nationwide legislation in Senate Committee.

III. CONSTRUCTION AND FUND REQUIREMENTS

	H.R. 6526 grant	Hill-Harris	H.R. 6526 loan	Total Federal loans and grants
Casualty.....	\$9,579,000	\$200,000	\$8,112,000	\$17,891,000
Construction of a 200-bed extended care facility, expansion of physiotherapy and outpatient departments, and renovation of the emergency room and basement areas will fill a 10-year lag in construction in this inner city neighborhood hospital.				
Children's.....	11,016,000	177,000	11,412,000	22,998,000
Replacement of present antiquated 205-bed building with a modern structure on Washington Hospital Center grounds, plus 11 extended care beds. Private funds will be used for 45 additional beds, need demonstrated by continual high occupancy.				
Hospital for Sick Children (formerly Children's Convalescent).....	1,333,000	575,000	1,742,000	3,650,000
Replacement of 50 extended care beds and construction of an additional 60 extended care beds for a total of 110 beds for children requiring long-term treatment or rehabilitation efforts.				
Columbia Hospital for Women.....	39,000	56,000	114,000	209,000
A number of small renovation projects will modernize and improve efficiency, such as centralized air conditioning for operating and delivery rooms.				
Georgetown University.....	6,189,000	71,000	11,080,000	27,340,000
Remodeling and substantial enlargement of outpatient and medical center instruction facilities including a unit for the mentally retarded. An additional 140 beds required by demonstrated need will be constructed with funds from an experimental grant.				
George Washington University.....	4,064,000	892,000	4,976,842	12,554,000
Remodeling a 1948 building will renew its capability to serve as a modern hospital. Areas also slated for remodeling are the emergency room, premature nursery and urology. 2d floor north will be site for construction of a heart station and pulmonary function and treatment center.				
Morris Cafritz Memorial.....	289,000	578,000	433,000	1,300,000
Construction of an adjacent nursing home would increase extended care beds by 100 in the far southeast section of the city.				
Washington Hospital Center.....	4,793,000	78,000	2,705,000	7,576,000
An extended care unit of 300 beds will relieve acute beds for urgently ill—at the same time effecting a saving of roughly 50 percent for those not requiring the complicated equipment and care needed instantly in acute care areas. Funds are also needed for modernization and for an emergency electric powerplant for the entire Hospital Center complex.				
Glenn Dale.....	1,250,000	0	0	1,250,000
The number of extended care beds would be increased by 200 by remodeling existing porches. Funds are also requested for modernization of kitchen, physiotherapy and occupational therapy areas and expansion of OR suite.				
Department of Public Health.....	1,500,000	1,500,000	0	3,000,000
Comprehensive Health Center area D.				
Total.....	40,052,000	4,127,000	40,574,842	93,518,000

¹ Includes \$393,000 NIH funded project.

² \$10,000,000 direct Federal grant for experimental purposes.

³ \$2,500,000 congressional appropriation and \$121,158 NIH project.

B. SUMMARY

Eight voluntary hospitals and two D.C. Government hospitals have requested a total of \$40,052,000 in *grant* funds under HR 6526. In addition *loans* requested by these institutions under HR 6526 total approximately \$40,575,000. Hill-Harris funds required but available only in part, amount to \$4,127,000.

Total Federal loans and grants (including \$13,014,158 in other Federal monies from NIH and special appropriations) amount to \$93,518,000.

In addition to the loan monies requested above, individual hospitals must seek out an estimated \$20-\$30 million from private resources. Children's Hospital must raise, for illustration, a sum of \$13,000,000. Georgetown University Hospital must raise over \$3,500,000. The above funds are inclusive of the essential initial operation fund advance.

IV. SIMILAR PROGRAMS IN CERTAIN STATES COMPARED TO THE DISTRICT OF COLUMBIA¹

[Dollars expressed in millions]

State	Hill-Harris allotment, 1967-68	State, county, or municipal matching funds	Additional State, county, or municipal funds allotted, 1967-68	State, county, or municipal loans or bonds authorized, 1967-68
California.....	\$29.2	\$21.8	(¹)	(¹)
Georgia.....	11.1	19.8	\$8.2	(¹)
Indiana.....	12.8	29.7	(¹)	(¹)
Maryland.....	6.8	10.8	2.9	\$50.0
Minnesota.....	10.1	3.6	(¹)	3.6
New Mexico.....	3.5	2.7	(¹)	(¹)
New York.....	30.8	8.2	(²)	500.0
North Carolina.....	19.5	10.2	12.7	³ 12.7
Ohio.....	25.2	(¹)	(¹)	(¹)
Total, 1967-68.....	149.0	\$106.8	\$23.8	\$553.6
District of Columbia.....	.8	0	0	0

¹ County, municipal amounts not available.

² Not applicable.

³ Funds provided by bond issues or tax levies at local level.

Source: Information provided by appropriate State agency, June 1968.

CONCLUSION

Because it is a federal district, D.C. hospitals would receive through loans and grants from the federal government the funds normally provided by the States for health care facilities within their constituencies.

V. STATUS OF LEGISLATION

HR 6526—Companion Bill to S 1228 Passed by the Senate. The sponsors of HR 6526 find no objections to the amendments adopted by the Senate. Since the introduction of the legislation, because of a critical re-evaluation of the institutional financial abilities in terms of the current loan market and in order to make language fit current national programming, the following amendments are proposed.

1. Proposed Loan Authority Section. See Attachment A for working detail.

2. Proposed amendments: Add for clarity, line 2, page 2, "for medical centers" and the words. On line 3, page 2, add, "and medical" prior to the word "center". On line 13, page 2, add "and Title VII" in accordance with national program changes.

ATTACHMENT A.—LOANS FOR CERTAIN HOSPITAL AND HEALTH FACILITY CONSTRUCTION

Section —(a) In order to alleviate hardship on any recipient of a grant under section () of this title, to assure the immediate planning and construction to meet demonstrated community needs, to meet Congressional directives to control the costs of health care services,

and to meet increased constructional costs (over the estimated cost of such project on the basis of which such grants were made and those previously estimated) through no fault of such recipient, the Secretary is authorized to make a loan to such recipient not to exceed 50 percentum of such project costs, as determined by the Secretary if the Secretary determines that such recipient is unable to obtain such an amount for such purposes from other public or private sources.

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

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

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

VI. SPECIFIC QUESTIONS ABOUT H.R. 6526

1. Why should taxpayers of the other states supply funds to people of the District that are not available to the people in other states?

The District of Columbia metropolitan area is a federally created being which serves all states. The people in the District metropolitan area should have the same opportunity to have proportionate medical center facilities that the 10 states represented by the members of this subcommittee have.

The present Hill-Harris grant formula for the District prevents this. This bill makes the D.C. area residents who serve all states equal to the state citizens. The loan provision in the bill takes the place of state, county and municipal grants and bonds in these states.

2. Why do not the D.C. Hospitals and Medical Centers roll up their sleeves and raise the facility money?

The D.C. Hospitals and Medical Centers have done this. They have struggled to raise money to meet operating deficits with some success.

They will have to raise some \$20,000,000 in addition to the funds in this bill for programs associated but not in this bill. Of special note is the effort of Children's Hospital requiring the raising of some \$13,000,000.

The fund raising potential to meet such capital requirements as provided by this legislation simply does not exist elsewhere.

3. Why do not private profit organizations such as Medi-center construct the extended care facilities?

Two institutions in the District have considered this approach in depth and found it infeasible here. There are two basic reasons that militate against this approach in the District.

The first is that the private entrepreneurs raise the per diem costs by cost of land and private borrowing rates and profits to the point that no sizeable economy would be available to the patients. The second reason is that the medical professions' affiliation and association with the existing medical care institutions make affiliation with a profit-making corporation very difficult. The anticipated ease of transfer of patients has been the basic problem where such private motel-type facilities have been constructed.

HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA, INC.,
Washington, D.C., June 24, 1968.

Re H.R. 6526.

The Honorable B. F. SISK,
Chairman, Subcommittee #5,
Committee on the District of Columbia,
Washington, D.C.

DEAR MR. SISK: Your letter of June 20th requests some information which I regret is not immediately available in this office. After a conversation with Staff Clerk James Clark, I believe that the detail will be forthcoming from Dr. Granning of HEW who also testified at the hearing.

I note, however, that under the Lanham Act, two District hospitals received a total of \$5,655,000. Through 1966 a total of \$7,194,000 has been made available by the Hill-Burton program. The Washington Hospital Center Act, with amendments, and special grants to each of the medical school affiliated hospitals have also been made.

In response to your second question, I have included the cost information under a separate letter of this date.

Again, many thanks for your help.

Sincerely yours,

WILLIAM M. BUCHER,
Executive Vice President and Director.

HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA, INC.,
Washington, D.C., June 24, 1968.

The Honorable B. F. SISK,
Chairman, Subcommittee #5,
Committee on the District of Columbia,
Washington, D.C.

DEAR MR. SISK: I have gathered additional financial data to illustrate the magnitude of that section of the hospital industry involved in H.R. 6526.

Listed by hospital are the total annual operating costs as well as the most recent per patient day operating Costs. The range in operating costs is justified by the variable levels of quantity and quality of services, the composition of such services, the relationship with the medical center and other factors.

1. Children's Hospital of the District of Columbia:	
a. Patient day operating cost (1/1/68), \$70.65	
b. Annual operating cost (4/30/68) -----	\$6, 939, 431
2. Morris Cafritz Memorial Hospital:	
a. Patient day operating cost (4/30/68), \$78.71	
b. Annual operating cost (fiscal 1968) -----	544, 349
3. Eastern Dispensary and Casualty Hospital:	
a. Patient day operating cost (4/30/68), \$58.59	
b. Annual operating cost (Estimated 1968) -----	3, 878, 513
4. Columbia Hospital for Women:	
a. Patient day operating cost (12/31/67), \$80.69	
b. Annual operating cost (Estimated 1968) -----	3, 482, 904
5. Georgetown University Hospital:	
a. Patient day operating cost (5/31/68), \$76.78	
b. Annual operating cost (Estimated 1968) -----	11, 454, 590
6. The Hospital for Sick Children, (formerly Children's Convalescent Hospital):	
a. Patient day operating cost (12/31/67), \$34.59	
b. Annual operating cost (fiscal 1968) -----	544, 349
7. George Washington University Hospital:	
a. Patient day operating cost (3/31/68), \$71.43	
b. Annual operating cost (fiscal 1968) -----	11, 800, 000
8. Washington Hospital Center:	
a. Patient day operating cost (5/31/68), \$80.35	
b. Annual operating cost (fiscal 1968) -----	22, 000, 000
Annual Operating Cost Total -----	68, 954, 737

As you well know, the operating costs many times exceed the construction costs of such an operation. I do hope the above information will be helpful to you.

We all are indeed grateful to you for your assistance in moving H.R. 6526 through the legislative procedures.

Sincerely yours,

WILLIAM M. BUCHER,
Executive Vice President, and Director.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
Silver Spring, Md., July 10, 1968.

Hon. B. F. SISK,
*Chairman, Subcommittee No. 5, Committee on the District of Columbia, U.S.
House of Representatives, Washington, D.C.*

DEAR MR. SISK: Attached is some additional data in support of my testimony before the Committee regarding H.R. 6526 and S. 1228.

The American City Bureau/Beaver Associates is widely respected in the area of fund-raising consultation, and we believe their information files and sources to be thoroughly reliable. The percentage of total campaign funds raised by the business community in each of the four cities of comparable size to Washington, D.C., further illustrates the wide gap in available community resources between the District of Columbia and other similar localities.

We hope this information will be of use to the Committee.

Sincerely yours,
Enclosure.

(s) HARALD M. GRANING.

CONTRIBUTIONS BY INDUSTRY IN JOINT HOSPITAL CAMPAIGNS

Location	Year campaign completed	Approximate population	Amount raised at time of report	Amount given by major firms	Percent of amount raised	Amount given by commerce and industry	Percent of amount raised	Total amount given by business community	Percent of amount raised
Cincinnati, Ohio	1957	495,000	\$12,100,767	\$5,964,139	57.5	\$1,143,653	9.5	\$8,107,792	67.0
Indianapolis, Ind.	1967	515,000	14,644,434	7,052,937	48.2	349,990	2.4	7,402,927	50.6
Minneapolis, Minn.	1959	450,000	17,068,814					8,123,844	47.6
Newark, N.J.	1968	385,000	12,863,625	5,528,000	43.0	349,120	2.7	5,877,120	45.7

Note: Population was taken from the "Rand McNally Atlas," 43d edition, 1967. "Employee giving" the final campaign report, except for Newark, which was based on the campaign progress report (i.e., payroll deductions for pledges, etc.) is not included in these figures; all data was taken from dated June 12, 1968.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
July 3, 1968.

Hon. B. F. SISK,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. SISK:

This is in reply to your letter of June 21, 1968. We are enclosing a complete summary by year of initial approval of all Hill-Burton grants made to medical facilities in the District of Columbia from the beginning of the Hill-Burton program to date. You should also be aware that the Division of Hospital and Medical Facilities provided \$230,000 in 1964 and \$6.9 million in 1966 to Georgetown University Medical Center under the experimental construction category of our research and demonstration grant program.

We also enclose a summary of all assistance provided to District of Columbia hospitals by the General Services Administration under the D.C. Hospital Center Act.

Concerning the Lanham Act which was administered by the Federal Works Agency and was succeeded in 1947 by the Hill-Burton program, we have been able to secure the following information:

Both George Washington University Hospital and Georgetown University Hospital participated in that program. George Washington received a grant in 1944 for approximately \$2.5 million. Georgetown received approximately the same dollar amount at about the same time.

We hope that this information will be helpful to you.

Sincerely yours,

HARALD M. GRANING, M.D.,
Assistant Surgeon General, Director,
Division of Hospital and Medical Facilities.

GRANTS UNDER D.C. HOSPITAL CENTER ACT (P.L. 221, 82ND CONGRESS) TO THE DISTRICT OF COLUMBIA

Year of grant	Name of hospital	Total cost	Federal funds	Type of construction
1953.....	Children's Hospital.....	\$3,502,318	\$441,913	New hospital building.
1957.....	Children's Hospital.....	873,542	234,000	New research building and other hospital improvements.
1953.....	Providence Hospital.....	8,265,467	4,097,040	New 350-bed hospital.
1953.....	Eastern Dispensary and	3,526,971	1,300,000	2 new 4-story wings and moderniza-
1956.....	Casualty Hospital.			tion work.
1958.....				
1957.....	Georgetown Hospital.....	7,302,780	2,170,000	Nurses' home, new diagnostic build-
1960.....				ing, medical-dental dormitory,
				modernization work and research
				reading room.
1954.....	Columbia Hospital.....	3,000,792	2,290,000	New wing and modernization work.
1957.....				
1959.....				
1958.....	Sibley Memorial Hospital...	8,777,197	4,374,000	New 350-bed hospital, nurses' home
				and school and interns' residence.
1953.....	Washington Hospital Center.	23,405,849.35	23,405,849.35	New 800-bed hospital.
1962.....	Southeast General Hospital	9,188,000	3,375,000	New Hospital.
	(New Cafritz Memorial			
	Hospital).			
Total.....		67,842,916.35	41,687,802.35	

Source of information: General Services Administration, Feb. 8, 1966.

GRANTS UNDER PUBLIC LAW 82-221 ADMINISTERED BY GENERAL SERVICES
ADMINISTRATION

Purpose and Description

This Act modified Public Law 79-648, approved August 6, 1946, which authorized funds for the construction of the Washington Hospital Center.

Public Law 82-221, approved October 25, 1951, authorized Federal loans or grants for the construction of hospitals in the District of Columbia. Subsequent amendments named the particular hospitals which were to receive assistance and the amount of funds allowed.

The Act provided for outright grants to hospitals. However, the District of Columbia must repay either 50 percent of the Federal grant or 30 percent of the

grant depending on the percentage specified in the legislation. The original legislation provided a 30 percent repayment. Act was later amended to 50 percent but was not made retroactive.

The District of Columbia is not required to pay interest on the loan portion.

SUMMARY OF APPROVED PROJECTS IN THE DISTRICT OF COLUMBIA UNDER THE HILL-BURTON PROGRAM FOR 1949-68 FISCAL YEARS

Name of facilities	Total cost	Federal share	Beds provided
D.C. General	\$3,757,161	\$924,014	308
Childrens Hospital	4,977,272	1,480,255	1 20
Warwick Cancer Clinic	668,996	18,414	
Childrens Convalescent Home	1,907,884	830,862	134
George Washington University Hospital	2,734,572	933,781	
Georgetown University Hospital	4,740,308	1,258,208	20
Casualty Hospital	1,248,886	577,072	40
Davis Memorial Rehabilitation	1,459,515	150,000	
Childrens Treatment Center	301,254	127,917	
Columbia Lighthouse	290,462	19,841	
Childrens Hearing Speech	605,338	296,929	
Cafritz Memorial Hospital	2,720,377	1,295,244	78
Hillcrest Childrens Center	1,829,404	595,963	12
Columbia Hospital for Women	55,700	18,567	
Washington Hospital Center	187,746	62,582	
Sibley Memorial Hospital	303,000	14,290	13
Total	27,787,875	16,376,579	725

APPROVED DISTRICT OF COLUMBIA PROJECTS UNDER THE HILL-BURTON PROGRAM, BY FISCAL YEAR OF INITIAL APPROVAL

Name of facility	Total cost	Federal share	Category	Beds provided
1949 fiscal year: D.C. General	\$2,432,909	\$525,914	General	128
1950 fiscal year: Childrens Hospital	3,556,393	814,929	do	98
1953 fiscal year:				
D.C. General EQ	7,800	2,600	do	
Warwick Cancer Clinic, EQ	668,996	18,414	do	
Total, 2 projects	676,696	21,014		
1954 fiscal year:				
Childrens Convalescent Home	420,276	255,862	Long-term care	50
George Washington University Hospital ASF	224,534	30,000	General	
Total, 2 projects	644,810	285,862		50
1955 fiscal year: Georgetown University NH	1,591,390	314,138	do	
1957 fiscal year:				
Casualty Hospital	864,511	432,255	do	40
Davis Memorial Rehabilitation	1,459,515	150,000	Rehabilitation facilities	
Georgetown University DTC	2,286,421	575,000	Diagnostic centers	
Georgetown University RF	237,981	50,000	Rehabilitation facilities	
Total, 4 projects	4,848,428	1,207,255		40
1958 fiscal year: Child Treatment Center RF	301,254	127,917	Rehabilitation facilities	
1959 fiscal year: Columbia Lighthouse RF	290,462	19,841	do	
1960 fiscal year:				
Children's Hospital	113,282	34,581	General	22
Georgetown University	56,982	27,523	do	20
Georgetown University DTC	454,034	220,414	Diagnostic centers	
Total, 3 projects	624,298	282,518		42
1961 fiscal year:				
Child Hearing Speech RF	305,828	151,184	Rehabilitation facilities	
Children's Hospital DTC	1,214,297	599,645	Diagnostic centers	
D.C. General Hospital	1,316,452	395,500	General	180
Total, 3 projects	2,836,577	1,146,329		180

Footnotes at end of table.

APPROVED DISTRICT OF COLUMBIA PROJECTS UNDER THE HILL-BURTON PROGRAM, BY FISCAL YEAR OF INITIAL
APPROVAL 1—Continued

Name of facility	Total cost	Federal share	Category	Beds provided
1963 fiscal year:				
Cafritz Memorial Hospital.....	623,461	311,731	Diagnostic centers.....	
Do.....	1,966,817	918,464	General.....	78
Total, 2 projects.....	2,590,378	1,230,195		78
1964 fiscal year:				
George Washington University Hospital RF.....	252,819	122,326	Rehabilitation facilities.....	
George Washington University Hospital DTC.....	694,819	342,034	Diagnostic centers.....	
Total, 2 projects.....	947,638	464,360		
1965 fiscal year:				
Hillcrest Childs Center.....	697,133	174,074	Mental.....	12
Do.....	1,132,271	421,889	Diagnostic centers.....	
Total, 2 projects.....	1,829,404	595,963		12
1966 fiscal year:				
Cafritz Memorial Hospital.....	130,099	65,049	Long-term care.....	
Child Hearing Speech.....	299,510	145,745	Rehabilitation facilities.....	
Total, 2 projects.....	429,609	210,794		
1967 fiscal year:				
Children's Convalescent Hospital.....	1,487,608	575,000	Long-term care.....	84
Columbia Hospital for Women.....	55,700	18,567	General.....	
George Washington University Hospital.....	150,000	44,605	do.....	
Do.....	600,000	200,000	do.....	
Washington Hospital Center.....	187,746	62,582	do.....	
Total, 5 projects.....	2,481,054	900,754		84
1968 fiscal year:²				
Children's Hospital.....	93,300	31,100	General.....	
Georgetown University Hospital.....	103,300	34,433	do.....	
Do.....	110,200	36,700	do.....	
George Washington University Hospital.....	474,200	144,816	Diagnostic treatment center.....	13
Do.....	338,200	50,000	Rehabilitation facility.....	13
Sibley Memorial Hospital.....	303,000	14,290	General.....	13
Casualty Hospital.....	384,375	144,817	Diagnostic or treatment center.....	
Total, 7 projects.....	1,806,575	456,156		13

¹ Fiscal years included only if there were approved projects in the year.

² July 1, 1967, through June 27, 1968.

Source: Department of Health, Education, and Welfare, Public Health Service.

GOVERNMENT OF THE DISTRICT OF COLUMBIA,
DEPARTMENT OF PUBLIC HEALTH,
Washington, July 11, 1968.

Hon. B. F. SISK,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN SISK: This will reply to your letter of June 20 and will, I believe, provide additional information to amplify and further clarify my testimony before Subcommittee No. 5 of the House District Committee in respect to H.R. 6526 and S. 1228 on hospital construction.

1. The present estimated cost at D.C. General Hospital of \$73.91 per day *does* include the cost of the medical staff. The hospital admits between 23,000 and 30,000 patients per year and sees some 160,000 patients in its outpatient clinics; in addition, approximately 70,000 patients visit the emergency room each year. Approximately 7% of the total cost of patient care at D.C. General Hospital has been reimbursed each year by the patients themselves or through insurance companies through fiscal year 1966. Beginning, however, with fiscal year 1967 with the advent of Medicare, this figure is now rising to approximately 14%. This percentage will increase still further as we begin to implement the Medicaid (Title XIX) Program.

2. The estimated cost per day at Glenn Dale Hospital at the present time is \$30.89. I should hasten to point out that this is not really comparable with the figure at D.C. General Hospital because Glenn Dale Hospital is a chronic disease

and tuberculosis hospital which cannot really be compared in terms of per diem cost with a general hospital. The estimated per diem rate at Freedmen's Hospital is \$67.00.

3. The national average hospital cost per patient day for *general hospitals* is \$60.71.

4. D.C. General Hospital has received federal funds for new construction and modernization under the Hill-Harris Act (formerly the Hill-Burton Act) as follows:

Project	Year	Total cost of project	Federal share of project
Children's building.....	1948-49	\$2,432,909	\$525,914
Air conditioning operating room.....	1952	8,250	2,600
Psychiatric convalescent rehabilitation building.....	1960-1961	1,316,451	395,500

5. With respect to federal funds available under other legislation, the D.C. Government hospital has benefitted as follows:

Manpower Development & Training Act of 1962..... \$13,101

NURSE TRAINING ACT OF 1964

	Available for student loans	School reimbursements
Fiscal year:		
1966.....	9,000	7,500
1967.....	9,000	11,250
1968.....	9,000	16,900

During the course of my testimony you asked for information concerning occupancy rates at different hospitals. May I indicate that the national average for hospital occupancy rates for the year ending September 30, 1967 was 77.6%. In the District of Columbia the average was 83%.

I do hope this information will be of assistance to you. If there is any further information you desire we shall be most happy to try to provide it.

Very sincerely,

MURRAY GRANT, M.D., D.P.H.,
Director of Public Health.