

represents only one piece of the puzzle—parents still have to contend with music, video games, Internet sites, and movies which may be inappropriate for kids.

I think our goal should be to make available whatever information and technology is helpful to parents. Neither a rating system nor government regulations can—or should—substitute for the good judgment of parents.

TRIBUTE TO HAROLD G. HALL

HON. WILLIAM J. COYNE

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 12, 1997

Mr. COYNE. Mr. Speaker, on Wednesday, February 19, 1997, Harold G. Hall will receive the prestigious Metcalf Award at the 113th Annual Banquet of the Engineers' Society of Western Pennsylvania. The award is named for William Metcalf, ESWP's first president (1880–81) and is presented each year to an individual who has made significant lifetime contributions in the field of engineering.

Harold G. Hall was born and raised in Pittsburgh, PA. He entered Penn State University to pursue a degree in ceramic engineering, but left college to enter the U.S. Army Air Force where he became a pilot in the Alaskan theater. After 3 years in the service, he returned to Pittsburgh and earned his degree as a mechanical engineer at Carnegie Tech (now Carnegie-Mellon University).

Mr. Hall founded Hall Industries in the 1960's. His interest in manufacturing led him to help other small manufacturers who were devastated by the crash of the steel industry in Pittsburgh, and Hall Industries became a collaboration of 11 small companies which had been struggling to stay in business.

Today, Hall Industries has three facilities in western Pennsylvania and one in Greenville, SC. Its 120 employees serve national markets in the aviation and rapid transit industries, and they also produce precision industrial parts. Hall Industries has also been coordinating engineering studies by Lockheed Martin, the Pennsylvania Maglev Corp., Sargent Electric, Union Switch and Signal, P.J. Dick Corp., and Mackin Engineering that are part of an initiative to develop a magnetic levitation transportation system in Pittsburgh.

Mr. Hall continues to contribute his expertise to Hall Industries and to other companies. His next project is the evaluation of a machine facility in Beijing, China.

Harold G. Hall joins a large, distinguished group of previous Metcalf Award winners. He is an individual of gifted insight, imagination, and special abilities. He is richly deserving of this award. I commend him on the occasion of this notable achievement.

ESSENTIAL HEALTH FACILITIES INVESTMENT ACT OF 1997

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 12, 1997

Mr. STARK. Mr. Speaker, today I am introducing the Essential Health Facilities Investment Act of 1997. This legislation will provide a financial helping hand to those hospitals and

health centers that are in the front lines of dealing with our national health care crisis. This legislation allows for the expansion of community health services and the capital needs of safety-net health care facilities while at the same time attempting to limit the further duplication of unnecessary high technology services.

This bill is similar to legislation that was introduced in the 103rd and 104th Congresses and which was included in the national health reform legislation that was approved by the Ways and Means Committee. It is my hope that this new Congress will work toward passage of this bill.

At a time when we are faced with continually shrinking budgets and fiscal austerity, it is more important than ever to appropriate Federal moneys in the most cost-effective manner available while providing the most benefit to all our citizens. In terms of health care, this includes establishing and expanding community health programs designed to provide low-cost primary care to underserved populations to avoid subsequent high-cost emergency room visits. In addition, we must help to support those not-for-profit and public hospitals that deal with a disproportionate number of uninsured patients. In one comparative analysis, urban public hospitals averaged over 19,000 admissions, 242,000 outpatient visits, and nearly 4,000 live births per hospital. The urban private hospitals in the same areas registered just 7,000 admissions, 50,000 outpatient visits, and 760 live births. These safety-net facilities—the public and not-for-profit hospitals that serve a disproportionate share of uninsured and low-income patients—are in essence the family doctor for many in our country. Though it would be far better to incorporate the uninsured into our national insurance pools and give them access to any health care facility they choose to visit, the stark reality is that they are dependent upon these safety-net hospitals for any and all of their health care.

But the importance and benefits associated with public hospitals do not end there. In addition to caring for our Nation's most vulnerable populations, these hospitals provide a great deal of specialty care to their communities. Services such as trauma, burn units, and neonatal intensive care units are frequently found in these hospitals. Many of these services are too costly for other hospitals to provide.

These hospitals are expected to provide quality care under extraordinary circumstances. As an example, they are frequently confronted with tragedies associated with our Nation's obsession with guns. Roughly half of all urban safety-net hospitals are equipped with a trauma center and serve as the first-line treatment facilities for victims of gun violence. The Federal Centers for Disease Control and Prevention predict that, by the year 2003, gunfire will have surpassed auto accidents as the leading cause of injury and death in the United States. Unlike victims of auto accidents who are almost always privately insured, 4 out of 5 gunshot victims are on public assistance. More than 60 urban trauma centers have already closed in the past 10 years. This means that less than one-quarter of the Nation's population resides near a trauma center. Gunshot wounds account for fewer than 1 percent of injuries in hospitals nationwide, yet account for roughly 9 percent of in-

jury treatment costs. It is estimated that for every 1 of the 40,000 patients who die from a gunshot wound annually, 3 others suffer injuries serious enough to require hospitalization.

Serving as a safety-net hospital and community provider places public hospitals at great financial risk. With threatened cutbacks and changes in the Medicare and Medicaid programs, coupled with tightened local budgets, public hospitals face an erosion of traditional sources of funding. Additionally, changes in the health care market, particularly the evolution of managed care and increased competition among providers, have further added to the financial pressures faced by these hospitals. Managed care's ability to attract tougher competition to the health care sector has decreased the urban safety-net hospital's ability to cost-shift some of the heavy losses incurred while providing uncompensated care. As a result, according to a June 1996, Prospective Payment Assessment Commission [ProPAC] report, hospitals in urban areas with high managed care penetration saw their payment-to-cost ratio decrease by 2 percent from 1992 to 1994. Declining margins have resulted in many urban hospitals cutting their level of charity care. In fact, ProPAC found that uncompensated care fell by 4.5 percent during the same time period. This represents clear evidence that more and more of the burden for providing charity care is being shifted to the public safety-net hospitals.

As safety-net providers, public hospitals have historically provided large amounts of uncompensated care. In 1995, for instance, 67 of the member hospitals of the National Association of Public Hospitals [NAPH] provided \$5.7 billion in bad debt and charity care, averaging \$85,060,641 per hospital. Additionally, bad debt and charity care charges represented 25 percent of gross charges at these hospitals in the same year. According to data from the American Hospital Association [AHA], \$28.1 billion in bad debt and charity care was provided nationwide. The NAPH member hospitals represent less than 2 percent of hospitals in the U.S., yet provide over 20 percent of bad debt and charity care nationally.

During the last 15 years, public hospitals have been shouldering a greater portion of the uncompensated care burden. Additionally, private hospitals have begun competing for Medicaid patients which further erodes support for the public providers. Public hospitals rely heavily on payments from Medicare and Medicaid patients to cross-subsidize care for the indigent. As dollars from these programs move from the public to the private hospitals, the ability to function as a safety-net provider is severely tested.

OUTLINE OF THE ESSENTIAL HEALTH FACILITIES INVESTMENT ACT OF 1997

In title I of this legislation, Medicare's Essential Access Community Hospital Program [EACH] would be expanded to all States and a new urban Essential Community Provider Program [ECP] would be created. Funding would be provided for the creation of hospital and community health clinic networks that improve the organization, delivery, and access to preventive, primary, and acute care services for underserved populations.

In title II, financial assistance for capital needs would be provided by the Secretary of HHS to safety-net facilities which serve a disproportionate share of uninsured and low-income patients. Funds for this legislation would