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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MEETING ON AREAWIDE PLANNING

Silver Spring, Maryland

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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MEETING ON AREAWIDE PLANNING

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Room 921,
7915 Eastern Avenue
Silver Spring, Maryland
Monday, July 8, 1963

The meeting convened at 9:20 o'clock a.m., Dr. Jack Haldeman presiding.

FR

I N D E X

PROCEEDINGS

DR. HALDEMAN: I wonder if we could get on with our hog killing. I guess everybody is here except somebody from Blue Cross. McErner told me either he would be here or someone from his office would be here.

I don't know whether we need any introductions. I think we might go around and just rapidly call off.

(Introductions were made.)

I think the purpose of this is probably three-fold.

The first purpose, I think, is to get a discussion of methods of implementation of areawide planning. George and I argued over this term "implementation" throughout the deliberations on the so-called Bugbee Committee, and I don't think we ever found, really, a better word.

MR. BUGBEE: The argument was on the semantics, an idiosyncrasy of mine. I don't like the word "implementation", but I have given up.

DR. HALDEMAN: In the Bugbee Committee there was a lot of difference of opinion, and the report as it came out contains very little in terms of specifics in terms of various methods that might be used for implementing areawide planning.

Part of it was deliberate, I think, because we didn't feel we were wise enough to make recommendations in a document such as this that would be applicable universally.

And secondly, I think there might be some real

minority opinions if we had taken one side or another. There were those on the committee that felt very strongly that there should be franchising or the equivalent. There were others that felt equally strongly in the opposite direction. And I think both the Public Health Service and the American Hospital Association that were sponsoring the committee had not taken any particular position in regard to this.

It seems to me like the time has come for setting down and at least discussing various methods that are being used throughout the country to implement areawide planning, what has worked, what hasn't worked, and get a general discussion of the subject.

I myself have mixed feelings on this subject because it seems to me like it is an essentially negative approach and a lot of our hospital planning agencies, a great deal of their time is taken up in stopping construction of one kind or another.

It seems to me like in the course of our discussions, we might want to discuss what are some of the positive elements in planning. I was right impressed with the recent article by Bob Sigmond (?) of Detroit in which he took off in depth on the positive elements of planning.

The second general subject is one of priorities. I would like to make an assumption in this part of the discussion that the areawide planning agency is responsible for the

distribution of capital construction funds, whether they be Hill-Burton or a modernization program, Federal funds, or whether they be capital construction funds raised in the community such as in Columbus.

I think this problem of priority is one which in the future years the Hill-Burton program is going to be faced with muc more than they are now because the current priority system under Hill-Burton which is largely a matter of relative need is fairly simple, and it works relatively well in rural areas, but when you get into a metropolitan area, it obviously breaks down.

And if we get a modernization program, every State Hill-Burton agency and every local areawide planning agency is going to have a problem of priority, not only in the general hospital category, but among categories. And so I would hope that we would take a hypothetical situation, perhaps, in a community and see what we can develop in the way of priority principles.

I have always felt that if we get a modernization program -- Well, first, our specifications for a modernization program do require the areawide planning agency be consulted, but secondly, will not spell out in any detail priority principles, leaving that to the State Hill-Burton agency as well as local Hill-Burton agencies.

I thought probably that the process would be locally

a good deal like an NIH study section would be, pooled professional judgment based against certain general guidelines which are developed.

Now, the third thing I would like for us to take up is whether it would be desirable to have what might amount to a national meeting of personnel of local areawide planning agencies. The American Hospital Association, Hi Sibley, and Public Health Service have just completed a series of seven regional meetings which were intended originally to be sort of a field testing for a cookbook that we had developed, based largely on these committee reports, but going into more detail -- some detail as to the data needed for planning, the analysis of the data and what not.

FR

I don't think any of these meetings really served that purpose. And the reason it didn't serve the purpose was that the groups that participated were, not only people from areawide planning agencies, but were a lot of people that were broadly interested. And they served a useful purpose, I think, in that it stimulated interest in areawide planning.

As I was saying, I think those sessions served a very useful purpose, but it was not as useful in terms of people in areawide planning agencies who are actually doing the work in areawide planning agencies, having an opportunity to get down and discuss more or less detailed questions and to discuss the things that the staffs of areawide planning agencies are

interested in.

So we wondered if there wasn't a need for a meeting that would be pretty well confined to the individuals in working on the staff areawide planning agencies and, if so, how should such a meeting be structured, when it should be and what not. And I would like to take some time in this area.

As far as I am concerned, the meeting these two days is quite unstructured, and if you want to take off and consider other things, that is quite appropriate. I am not quite sure what we will do with the proceedings, but we are having them taken down so that we can develop some sort of a report if it appears that many pearls of wisdom are being dropped.

FR

George, do you want to discuss this from the standpoint of the background as chairman of the Committee on Areawide Planning?

MR. BUGBEE: I think you have covered it very well, Jack. I think we are all conscious of some worry about how far you go with legal sanctions, but I don't know that anybody feels terribly strongly.

It is kind of an academic argument and probably not the most important method of implementation anyway.

So I suppose you go through the whole range. Even in the informal conversation of last evening, it seems to me people are developing quite a little experience in how to put these

things in motion.

I like your idea of positive as well as negative, too.

DR. HALDEMAN: I think when we talk about implementation we might try to bring in this element of positive action. Suppose I just go around the table and comment what you are doing in this area and what you would like to do, what has worked and what has seemed not to work.

Rufus, do you want to lead off?

DR. ROREM: Yes, I would be glad to be first to speak because I am going to be the first to leave. I have a 9:00 o'clock plane tonight so I won't be here tomorrow.

Well, I think that we like to characterize our efforts as primarily being interested in stimulation of individual hospitals to do planning on their own account and then stress in that the fact that the self-interest of an individual hospital means that they must be familiar with and aware of what the other institutions are doing. And we have urged every hospital to appoint a long-range planning committee for its own institution, composed of representatives of the management, of the trustees, and of the attending staff and, if they wish to cooperate, community members -- it is all to the good -- as well.

Conversely, we work with community groups particularly in areas where there is no hospital to study the characteristics of their own area to see whether and what kind of a health

facility may be needed.

Now, one of the things that you will have to take away with you is our work document or guide for the use of long-range planning committees of individual hospitals. And in this, there is a tabulation of the results of our resident survey applicable to the year 1960 which shows in tabulations of 29 districts where the people of that area with hospitals go as inpatients of each of the 29 districts.

In other words, when a person wants to say: Where do the people who live around me go? -- the tabulation shows where each of the 29 districts that are classified here were hospitalized and, conversely, the planning committee of a hospital can see where its patients come from.

We will find, for example, that they might get 40 per cent of their patients or some other figure from a particular geographic area. Yet, they may only serve 10 per cent of the people from that geographic area.

Our idea is that this would serve as the basis for the hospital to plan ahead and as to what areas it wants to be more active in, the areas where it will encounter already entrenched position on the part of other institutions.

This is strictly superficial. It does not devise the services in terms of medical, obstetrics, pediatrics, and in this particular guide does not deal with outpatient service or nursing homes or many of the other important facts.

I mention this as a method because we use this as a backdrop for appraisal of any projects for expansion or for new institutions strictly as a guide and as a backdrop and try to keep this interest going.

I might say that all of our general hospitals have now established long-range planning committees and four of our eight nongeneral hospitals, nursing homes, and things of that kind and rehabilitation centers and homes for crippled children, have also done so.

Just as far as implementation is concerned, we use no implementation except that of persuasion and the announcement of an official position which our organization takes after going through a series of hearings which we call nonlegal hearings.

If a hospital has a program on which they would like to have our opinion, it goes through four steps. They first have a conference I call a conference of the hospitals most likely to be affected.

Now, after three and one-half years, those are very lively discussions and the insttitutions now are getting so their representatives -- these are administrators -- speak up frankly in their own self-interest which for a while they were very self-conscious. It was a log-rolling affair.

Then, it is brought formally between a committee of the administration and hospitals involved. The institutions are

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always there, and that second group actually take a vote as to whether they think it is a good idea.

DR. HALDEMAN: What is the difference between the composition of the two groups?

DR. ROREM: The first group is the hospitals most likely to be affected, which means those are probably contiguous areas. The second is a representative group of all the hospitals in the area elected by them -- seven people. Then, that recommendation goes to all the hospitals in the area.

Euphemistically, I guess I would say that every hospital administration is a member of an advisory committee to us whether he likes it or not. He just is. And that group hear a statement description of it, and they take a vote.

FR

MR. BUGBEE: In a meeting?

DR. ROREM: In a meeting.

DR. HALDEMAN: Open meeting?

DR. ROREM: Open meeting. And they take open votes up to now. We are talking about making it private, but it isn't now.

MR. SIBLEY: How often do you meet?

DR. ROREM: About twice. We meet in between times to hear committee --

MR. SIBLEY: This group meets twice a year?

DR. ROREM: We have met twice this year because of special things that have come up.

DR. KLICKA: May I interrupt you?

Is this meeting structured in such a way that you or your organization makes its recommendations on the basis of your guidelines to this group?

DR. ROREM: That's right.

DR. KLICKA: Before they start their discussion?

DR. ROREM: Not at these points.

DR. KLICKA: What do they base their consideration on?

DR. ROREM: Well, on the merits of the case.

DR. KLICKA: This is what I mean. Who presents the merits of the case in a so-called scientific way? Do you do this or do you permit the hospital that wants to do something to present its case alone?

DR. ROREM: The hospital is present. The hospital really takes over and questions are asked in terms of the standards.

DR. KLICKA: But you don't evaluate this first for the group on the basis of your studies as to whether you think this is good or bad.

DR. ROREM: In the sense of in writing?

DR. KLICKA: No, it wouldn't make any difference, but it would seem to me that the group who were to be affected would first like to have the opinion of the Planning Committee relevant to how this would fit in the scheme of things.

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DR. ROREM: By the time it gets there, they know how or staff understands.

DR. KLICKA: How do you do this?

DR. ROREM: The first meeting, I introduce. The first meeting is really a go-around, just a general talk. The second meeting, by that time, I have an opinion which I give a tentative -- no, it doesn't crystallize until after the third meeting. Then, it crystallizes definitely. And it still is a wandering discussion the first three times around.

DR. HALDEMAN: What is the third one?

DR. ROREM: Then, the third one is with the entire group of hospital administrators.

And then, the fourth is with the Planning Committee of our Board of Directors.

MR. BUGBEE: But each of the three groups has an official vote they pass on to the next one for examination.

DR. ROREM: The very first one has no vote at all, but the representative committee, the advisory committee as a whole, and the Planning Committee, and it goes to the Board with a specific recommendation that is very short. And as it goes along, I make summaries of these which are acceptable to the institution, one-page statement of which they might have had 20 pages. And they accept it as to whether or not it is factual, but not analytical at that time. But after it goes through the third one, we take a very definite position. The

recommendation goes to our Planning Committee. And this is consistent with sound public policy and coordinated planning in our area.

DR. HALDEMAN: What is the composition of your Planning Committee?

DR. ROREM: The Planning Committee is selected strictly from the Board of Directors. It happens to be seven members; it could be eight.

DR. HALDEMAN: What is the composition of your Board of Directors?

DR. ROREM: Our composition of our Board of Directors is all laymen, some of whom may be hospital trustees. They are the presidents of large corporations -- that is, financial, industrial, and mercantile -- plus several clergy and plus some educators.

We have an advisory committee, this representative committee that I spoke of, of hospital administrators. The chairman meets with our Executive Committee and Board of Directors the Advisory Committee of Hospital Administrators and an advisory committee of the medical society, the profession, but it is appointed by the president of the medical society, six people, with the president always ex-officio. And we have quite a few meetings on the side.

As far as priorities are concerned, I might say that priorities are found on page 11 of this report when we get to

it, and these are the ones we have used. They are a little bit generalized if you want to call it that, but the highest priority with almost no quibbling at all is to any programs which will contribute to greater coordination of patient care within the community rather than mere sanction of existing types of facilities and services.

The second program goes to those which will achieve more effective use of existing plant and personnel. Modernization, of course, would be a part of that.

The third is something like the second, those which will prolong the useful lives of existing facilities without jeopardizing the standards and efficiency.

At the bottom of our list are programs which will increase bed capacity because we are caught up. We are dealing from a position of surplus rather than of scarcity.

We all know it is easier to plan for scarcity than it is for surplus. It is like the sailor says with the rope. He was really in a terrible jam because he had a rope that was too long. He didn't know what to do. He said, "If it was too short, I could splice it, but it is too long. I don't know what to do. I don't know where to start.

So for what it is worth, that's what we do. I didn't mean to take so much time.

DR. HALDEMAN: I think we ought to ask questions so we thoroughly understand how it works.

Does your Planning Committee ever override your committee of administration?

DR. ROREM: It has not yet; it might.

They have approved ten projects up till now expressly and disapproved one. And all of those up till now were recommendations of the advisory group.

But I might say that we haven't been brought into court as one of the people last night mentioned they have. We have been brought into the court of criticism and public dissatisfaction on the part of the client that wasn't happy, and they have used up till now their response and method of expressing dissatisfaction as being what the lawyers would call "ad hominum."

FR

They put it, not on my Board of Directors, but on the staff as being unreasonable and intransient.

MR. COUSIN: Jack, may I ask a question?

DR. HALDEMAN: Yes.

MR. COUSIN: Rufus, what does it mean to a hospital in your area if your group gives its approval or turns thumbs down?

DR. RUREM: It means they can quote wherever they see fit the fact it has been approved by the Hospital Planning Association.

MR. COUSIN: Does this have any real impact?

DR. ROREM: Yes, for both small and large contributions,

particularly for large and somewhat small.

MRS. COLEMAN: Has any hospital elected to not ask your opinion?

DR. ROREM: Up to the present time, we haven't moved in and given it anyway, but we are thinking of doing that. If they don't ask our opinion, we are very likely to adopt the position of giving it anyway.

MRS. COLEMAN: How big a project? For small things, I suppose they have no obligation to consult you at all.

DR. ROREM: No, but the Hospital Council of Western Pennsylvania which works very closely with us has expressly and by resolution suggested and admonished the hospitals to report and ask for approval whether or not the public campaign was contemplated and whether or not the amount was large.

We are not defining the word "large."

MRS. COLEMAN: Suppose they just wanted to put in an intensive care unit or something like that. Would that be something they should bring to you?

DR. ROREM: As a matter of fact, one hospital did exactly that about $125,000 they wanted to spend. They did bring it to us. And in the condition like that, it doesn't go through all the channels. It goes straight from the staff to the representative committee and Planning Committee. The Board never hears about it.

MRS. COLEMAN: Suppose it was something that didn't

cost very much money, but was a vital change in scope of the hospital like they wanted to take out pediatrics or put in pediatrics or something like that, but they weren't increasing the beds.

DR. ROREM: The hospitals that want to do anything like that generally take the initiative and want to get some approval because they know they will, probably. And so there is no special problem. And in a few cases, they have done so.

We have a hospital which this week on Friday will announce that it is closing its obstetrical department and that all obstetrical services will be going to a hospital two blocks away as of next Monday. It is a 300-bed hospital with a 36-bed obstetrical unit. And the hospital that is going to pick it up is a 550 bed, mainly maternity hospital. And the doctors have been on both staffs all the time.

They are going to close it. And on that, we worked with them all through this. I can't say we were more than an influence. That hasn't gone through two channels at all. It was applauded from the beginning, and it is now a reality.

MRS. COLEMAN: So whether it goes through channels or not depends pretty much on the amount of money involved. Is that more or less true?

DR. ROREM: I would say so pretty much and whether or not there is to be a public campaign, the two combinations.

One hospital has announced by 1970 it plans to build

a doctors' office and interns and residents home and expand and improve its emergency and outpatient department which obviously would be improved. They have got the money. But they can't spend it until the urban redevelopment association has declared an area that is blighted. So they had to make this statement of this policy in order to help the urban redevelopment.

There is a case where the facts have been known to us, but no formal application. We are just a little bit embarrassed that it broke in the papers, and I have told people I think in their self-interest they ought to have their program on record with us as it develops.

All isn't perfect with us.

FR

DR. HALDEMAN: You say that in ten instances, they approved the contemplated action of the hospital and in one instance they did not, is that right?

DR. ROREM: That's right.

DR. HALDEMAN: So usually, they go along.

DR. ROREM: Usually, the institution goes along.

As a matter of fact, we turned down two. But before it came to a vote of our board, the hospital said, "Would you mind if we just withdrew the application completely," which they did. They came back a second time six months later, and it was approved.

DR. HALDEMAN: If you had it to do over again,

would you use the same mechanism or a different one? It seems to me it has the element of a little bit of back scratching if the decisions are pretty well made by administrators.

MR. BUGBEE: Does it? Or if you have 26 of them or 25 always supercritical of the 26.

DR. ROREM: I might say that this last one, the one that is now coming through a second time, is one that decided to ignore -- This is one that was turned down, went right ahead anyway. It happened they got Hill-Burton money and had that to go on. And they went ahead anyway.

And, incidentally, the two we turned down both received Hill-Burton money because of the particular gerrymandering at that time of the area. And the one that recast its program, we approved. The other one, we haven't approved, and it is well along.

Off the record.

(Discussion off the record.)

MR. BUGBEE: Rufus, to this point Jack raised, though, would you find the 26 administrators when you get to that stage, or as they filter up from representatives, are they fairly judicious, or do they log-roll?

DR. ROREM: Let me tell you what happened this last time. Usually they are unanimous.

This last one is going through the channels a second time. And of 18 out of 26 that could have been present, 11

voted to let the old disapproval stand. Four decided that it ought to be changed. One of those votes was the institution itself. And four decided they didn't want to take a position and abstained. So it is not always unanimous.

DR. KLICKA: As you evaluate this kind of a situation, what is their reasoning based on -- a pretty sound analysis of the material that you presented to them?

DR. ROREM: I would be willing to say yes.

DR. KLICKA: You agreed with it, didn't you?

DR. ROREM: Yes.

Mr. Willis was present at all of these.

Dave, why don't you get into any points as long as we are discussing this? You are at a distance now where you can think back where we could have done something different. Is what I have been saying somewhat similar to what you might have said?

MR. WILLIS: Yes.

DR. ROREM: Up to now?

DR. HALDEMAN: First, I think Jack Cousin had a question.

MR. COUSIN: I wanted to know, do you work with osteopathic hospitals and, secondly, how does Government react to this?

In other words, if there is a city, State or a county institution, or even if there is a health problem involving the city, State, and county, Federal Government. We don't have

much luck except with Hill-Burton, but the city, State and County, for example, if it is a city hospital and they want to cut out pediatrics, does this get to you either from the hospital or from the city council or the Board of Health?

DR. ROREM: Let me say first of all, and this makes us unique, this happens to be a trading area in which there is no local government hospital, the largest one in America by far.

Secondly, there is one 25-bed osteopathic hospital in this whole area.

And the third is that there is no proprietary hospital in the whole area. It makes the issues a little sharper.

Another fact is that at the present time we don't know of any M.D.s who want a staff appointment that don'e have one.

Now, the osteopaths, however, they have a nice hospital, and you go 25 miles out or 30, osteopath hospitals start up again. But in Pittsburgh, they haven't up to now.

MR. COUSIN: What would you do if you had a request for an osteopathic hospital and you could pretty well develop that the osteopathic physicians had much fewer beds available to them than the M.D. hospitals, and they wanted to put a hospital up where there was a surplus of beds, but not of osteopathic beds?

DR. ROREM: I know. I don't know what we would do

at this point. I suppose after we got over the faint, the faint of the first time, we would see what could be done about taking care of these people because our State is very similar to Michigan except that here the M.D.s have the lily-white concept which is pretty well accepted in the general community. That is strictly M.D.

I don't know of any institutions in the immediate area that have any M.D. hospitals that have osteopaths only, not a single one.

MR. COUSIN: We have something like 2,000 osteopathic beds out of 17,000. We have one county where something like 15 per cent of the people in the county are being cared for b osteopaths.

DR. ROREM: We have less than 50 out of 8,000.

MR. COUSIN: And you are not going to change that; we are not.

MR. BUGBEE: I don't want to stop at the osteopath, but I want to ask you, you have been a little elusive about who presents the brief for the hospital.

In fact, as you are describing it, the hospital presents its data and you and all the rest question the data, but it is really the applicant's responsibility to present all the data.

DR. ROREM: Yes.

You understand that this has all reached them before

they come to the meeting.

MR. BUGBEE: That's right, but still, it is their presentation rather than the planning staff.

DR. ROREM: Up until it reaches our Planning Committee, then I am in there giving my opinion pretty strongly.

MR. BUGBEE: Or you might question them or ask them for new data or bring in your own data.

DR. ROREM: That's right.

MRS. COLEMAN: Do you tailor their program somewhat? Do you modify it? In addition to approving or disapproving, do you change?

DR. ROREM: I would say it is fair to say that most of the programs by the time they even reach the representative committee have been changed materially.

Wouldn't you?

MR. WILLIS: Yes.

I think it is part in answer to your question and Mr. Bugbee's to note that there is a working schedule set up. Every hospital must have its long-range planning committee, which committee must announce long in advance of the time it comes to these official committees what its tentative plans and programs are. And then the staff works with them. And most of the modification and so on occurs there in the early planning stages before it ever comes to the committee.

DR. ROREM: I might say we have postponed I would say

at least a dozen projects, not disapproved, just postponed. And just they were out of this world and weren't to be considered at all. One project was for complete rebuilding of a mental hospital. They were going to spend money for renovating first and $5 million for a nonprofit unit of about 300 beds, and it looks now as if they are going to just drop it completely and go out of the nurses home business and set these people up over in their big nurses home. And this is an illustration.

DR. KLICKA: In these meetings, Rufus, is there a complete agreement on the accepted bed need for an area between your organization and the State organization that is responsible for the administration?

DR. ROREM: And the Hill-Burton. There is now.

DR. KLICKA: Do they accept your figures or you accept theirs?

DR. ROREM: They are the same figures.

DR. KLICKA: You are not answering my questions. Are they yours or their figures?

DR. ROREM: We gather the figures for them. There is no conflict as to what the mathematics is.

DR. KLICKA: Who computes the beds? Do you do it or the State do it?

DR. ROREM: For the State plan?

DR. KLICKA: No, for these regions that you are talking about where a hospital comes in and says, "We want to

develop a program that will add 200 beds. Does that 200-bed figure come within your purview or is it the State plan?

DR. ROREM: It isn't cut that fine, really. We typically would accept as available beds some that might have been thrown out as non-fire-proof which are in use. The State uses a strictly mathematical formula for engineering for acceptable and nonacceptable beds. So we would be inclined to have on balance included in the list of beds some that we know to be closed down, for example, which the State wouldn't know because they don't go behind that, and some which the State would regard as nonacceptable.

DR. KLICKA: All right. There is a problem there, but I am talking about the overall bed need for a region. Who compiles that bed need? Do you do it or the State do it to start with? This is a fundamental thing.

MR. WILLIS: The State does it.

MR. BUGBEE: Who said you are flush in beds? You started out a while ago saying you have more beds than you need. Who said that?

DR. ROREM: We assert that on the basis the beds are not used to capacity and on the assumption we keep current records of bed use. And on this simple principle, if beds aren't used to reasonable capacity, there isn't a need for more in the totality. And this isn't just a single figure. The bed vacancy is a composite.

Whatever the bed vacancy, maybe more than half of those are maternity and pediatric and something else, less than half are medical and surgical. And one of the things that we work toward and are trying to bring about is the transfer of medical, obstetrical, and pediatric facilities for use for general beds. And if that were done, it would relieve the need completely even in periods in the winter peaks.

MISS JENKINS: You mean for medical-surgical, diverting O.B. and pediatrics to medical-surgical?

DR. ROREM: Yes, and we are trying to get more hospitals to drop this obstetrical entirely.

I hasten to say the hospital that is doing this isn't doing this as a matter of abstract theory. It is a very practical administrative decision on their part. We don't hope for anything more than enlightened self-interest, at least I don't. I hope every hospital would be guided by what it thinks is best for itself, but would also know what is going on around it so it would be an enlightened self-interest and not a short-sighted one.

MRS. COLEMAN: Do you have very much difference in quality between your hospitals? I mean, do you have very good ones and very poor ones?

DR. ROREM: Yes.

MRS. COLEMAN: This presents a real problem. If a good hospital wants to add beds, but there are enough beds if

you count all these raggedy beds around, what do you do in those instances? You say you can't build any more beds because we have enough beds in this area?

DR. ROREM: You asked what do we do. We do the best we can. But what do we think or what do we say?

MRS. COLEMAN: Yes.

DR. ROREM: We try to take a look at the particular need.

For example, one hospital adding beds for research work in metabolism, we don't consider that as having to compete with the medical-surgical cases.

Likewise, another hospital has added which we approved just recently a building program which is going to add eleven intensive care beds and a few more for rehabilitation. They don't have to scramble for our office's priority concept.

And another one is going to put up, which we approved, a 78-bed chronic care unit right on the grounds of the institution. We don't regard that as being competitive with the addition of general care beds.

MISS JENKINS: Rufus, do you examine those parts such as the chronic and long-term care units and so on on the basis of the hospital's justification, will it be financially sound if they want to do a certain type of research? Do you discuss with them are they going to utilize this facility? It is going to be a charge to the general patients to underwrite it, or do

you go into this at all?

DR. ROREM: The only place that research has come up has been in connection with the university medical school and affiliated institutions.

MISS JENKINS: That's enough said right there.

DR. KLICKA: Do you think that's the role of the Planning Council?

MISS JENKINS: To some extent.

DR. ROREM: We get into the operations, if you mean by that --

DR. KLICKA: I wonder if we could put this on the agenda. I think it is a very important question.

MISS JENKINS: Do you think it is basically wrong, Carl, if they are going to put a particular special service in which they have not well programmed?

DR. KLICKA: We are talking about research?

MISS JENKINS: Oh, no. I am talking about research where it involved beds and what the financing of that research will be. I am thinking only in terms of beds -- that is, beds that would support research.

DR. KLICKA: This wouldn't be very many beds. You are talking about a small 7- or 8-bed ward to support a specific research.

MISS JENKINS: I would not be involved in that. I thought Rufus was talking about something a little bigger than

that.

DR. ROREM: We do have one 24 beds.

MR. WILLIS: I would like to add something to Dr. Rorem's last three comments, first, to Dr. Klicka.

When Dr. Rorem was just getting started, the State agency computed bed needs simply on bed population ratio. And all of their ratios were much higher than locally was believed to be necessary. And this created, you can well imagine, some problems. Money was dangling there and plenty of empty beds around.

Two things occurred to change that situation. First and most important was that the state Hill-Burton began to modify the bed population ratios by direct inclusion of utilization data in their concept of need.

The second was the Hill-Burton areas themselves were redefined so that the city boundary was broken.

Now, in Pittsburgh, as in most cities, there was an excess of beds to population. Once you broke down the city boundaries as arbitrary limits of an area, you throw those excess beds into the suburb calculation and you immediately watered down that need, too.

So both these things happened at the same time. And interestingly, the local hospital when presented with the idea of changing the Hill-Burton areas this way, knowing in advance that this was going to virtually wipe out any Hill-Burton

priorities for general beds, still went along and voted for it. And the express comment was, "We better learn how to use what we have before we ask for more," which was pretty good.

I am not sure all of them really knew what they were voting for, but they did. And the Hill-Burton agency adopted the same areas.

Then the matter of quality. When these areas were redefined, a big teaching hospital and a good hospital was put at the core of each area. So every area has got at least one good hospital and every area has got at least one bad hospital. So the good hospital begins to protect the interests of that area, and it will always be given a higher priority to try to protect that way.

FR

On the matter of getting involved in program and financing, I would like to point out a difference that has impressed me between the way this is happening in New York and the way it happened in Pennsylvania.

In New York, statistically, there is a great unmet need for long-term care beds and virtually every hospital in the Rochester region is putting in an application for nursing home beds and chronic disease beds and so on. This was quite a marked contrast to the situation in Pittsburgh where C. Rorem's group had gotten so involved with each institution pointing out the difficulties in financing and in staffing and in programming and how this will relate to the short-term care and so on.

There were very few tears because they anticipated the problem, whereas in New York they were doing it simply on the basis of beds and available money and nobody is really terribly concerned about how this is going to be financed or what the program is going to be.

One, you have a plethora, and the other one a dearth. I don't know which is better.

MR. COUSIN: Rufus, if I understood you correctly, before a project comes to your attention, each hospital has to have a long-range planning committee and a long-range plan.

DR. ROREM: That's right.

MR. COUSIN: Now, has your Planning Council okayed all of these long-range plans because it is conceivable --

DR. ROREM: We haven't even received them all.

MR. COUSIN: It is conceivable to me a hospital could come to you with a short-term project that fits in very nicely with a hospital's long-term planning, but the long-term planning doesn't tie in at all with the long-term community planning.

DR. ROREM: Right, it could be. We do the best we can.

For one thing, we just continually repeat in variations on this theme that it isn't the first cost, it is the upkeep that causes the most of the problems for the institution and the community. A $4 million hospital is going to cost $60 million before it is discarded. Somebody is going to have to

pay that, divided by three for the annual operating budget for rough-and-ready purposes and figure the length of life. And so you aren't just committing yourself to $4 million; you are committing yourself to $64 million, assuming no change in the price level.

MR. SIBLEY: It sounds like marriage.

(Laughter.)

MR. COUSIN: Do you intend to eventually O.K. all of their long-range plans?

DR. ROREM: We aspire to that, yes. I don't want to give the impression that this is -- You know, a guy always can talk more freely away from home. I imagine the rest of you are doing the same thing.

(Laughter.)

DR. HALDEMAN: Rufus, behind your whole discussion and the effectiveness of what you have done, isn't this the fact that there are relatively few major sources of capital construction funds, a few industrialists provide a fairly large bulk?

DR. ROREM: I would like to answer that. That's what I thought when I came there.

DR. HALDEMAN: But it isn't true?

DR. ROREM: It is not true. Big industry provides in the gross something less than -- I thought in the aggregate about a third of all capital funds, corporate contributions. It isn't true. It is not more than 20 per cent, and it is

concentrated in the areas up till now where the big industries have their concentrations of employees. And suburban hospitals, just for general purposes and convenience of travel, have a very hard time getting big corporate support. I mean the new residential suburban hospitals.

Now, a town like Homestead or McKeesport or Sewickley where there are heavy concentrations of employees, they continue to give very, very good support once a thing has gone through.

DR. HALDEMAN: Conversely, if your organization did not recommend that there be an addition to a hospital, would it be very difficult for them to raise the capital construction funds?

DR. ROREM: Yes, it would -- has been.

DR. HALDEMAN: In other words, in the last analysis --

DR. ROREM: Even if they weren't going to give an awful lot anyway, it still throws a pall over the campaign, no doubt about it.

DR. HALDEMAN: But you do in a situation where your real implementing force is the influence on the givers of capital construction funds.

DR. ROREM: Especially big givers.

MR. BUGBEE: The thing you brought out last night that is important, too, you say 20 per cent big givers and 20 per cent small givers, your small earners and bank loans and

bank loans are affected by sanctions, too, you see.

DR. ROREM: That's right.

MR. BUGBEE: I don't know as much as they should be but didn't you and Jack both say that the loaners are beginning to talk about what the recommendation is?

DR. ROREM: That's right.

I might say also that we haven't had a general hospital even give any thought to a big program unless they got Hill-Burton money.

MR. BUGBEE: Unless it got?

DR. ROREM: Yes. And up to now, some are starting to talk about it, but it is all for expansion or for non-bed activities and no bed expansion has even been thought of except in terms of Hill-Burton support.

FR

And up to the present time, there is no difference of judgment between the Harrisburg office and ours.

MR. BUGBEE: You mean from the present on, not up to the present time.

DR. ROREM: No, actually, the very first six months we were there, we disapproved two plans. Both of them a month after we disapproved them were approved by Hill-Burton, both of them. And we are still wrestling with that fact.

We later approved one, and we still haven't approved the other.

DR. HALDEMAN: Off the record.

(Discussion off the record.)

DR. KLICKA: I hope we can come back to this. This question is beginning to be a real problem in Illinois.

DR. HALDEMAN: Well, I don't mind opening discussion. Well, we will put it on the agenda to discuss.

MR. BUGBEE: Let me ask, Rufus, has Hill-Burton designated you? Do they before they grant money now ask your recommendation? Is there any official or unofficial agreement?

DR. ROREM: Yes, in writing, and I have to quote it. They will make no final decision on a request for Hill-Burton funds until they ask our organization whether it is consistent with the broad plan for Allegheny County.

MR. BUGBEE: It hasn't gone long enough for you to tell except those recommendations.

DR. ROREM: After those first two went through, there has been no difference of opinion.

MR. BURLEIGH: What kind of a time interval elapses, Dr. Rorem, the time you first have a project until the time the Council --

DR. ROREM: First brings it to our attention, put it that way.

We don't always live by, but we have set an eight months time lag, eight months lead time. And we have spent that particularly with respect to Hill-Burton recommendations. But sometimes it is two years. Sometimes it is quite a while.

FR

I know I am taking up a lot of the time, but I am getting my money's worth in here because I can't be here tomorrow. But I might say that we had two hospitals that were all ready to go. They were going to apply for Hill-Burton. It was pretty clear they weren't going to get it, so they relaxed. So they are now getting down to the merits. They can get it now.

They were four miles from each other. They had almost identical short-range and long-range problems. The short-range problems, they both had unsuitable facilities being used.

One happened to be the obstetrical department which was in the prime location and was too big and the medical and surgical facilities needed to be replaced.

FR

The other had exactly the opposite. The obstetrical department was in bad space in old buildings and medical and surgical was running high. So they both had to do something quick within five years, also in three years, but also something quick.

So we focused their attention, each one, upon what they could do without -- using the expression -- doing anything, what administrative decisions could be made.

And in cooperation with the Hospital Council and a physician on their staff, we made administrative and space utilizations of what they now got. As a result of the inspection, we turned up the equivalent of about 25 beds in

one institution that could be had just for administrative decisions.

For example, a certain segment of pediatrics could be used for medical and surgical. That's one illustration.

The director of nurses had herself and her assistants right in the middle of the patient care area with empty space in the nursing home 50 feet away. All she had to do was move out and there were eight beds.

Another was an introduction of a discharge timing which by announcement curiously enough was accepted by the doctors and had the equivalent of opening up another eight or ten beds as far as this total was concerned.

So they are back to normal again, but still need to do something.

And the other hospital wasn't full except in the medical and surgical.

The point I am coming to is this simple that at several meetings, I finally got the representatives of the boards of both hospitals together, Willis with me. We had a long session and I talked freely. When I wrote up the minutes, I called it a summary. I even gave it a title -- "Challenge and Opportunity." And the challenge and the opportunity was to work together. And I recommended that they have a list of about 20 things in which the hospitals were alone and seven things that they could do together and recommended they have a

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joint consultant on a program.

And they have agreed to this and are going to pay out cash for a joint consultant. And it will be a physician in our area. They have agreed on someone. It looks now as if it is going to be one of the members of the school of public health, Dean Clark, you all know him.

So we get neck keep into operation and into operating finances. And we have the advantage that there is nothing except sympathy and understanding from the Hospital Council. And Mr. Sigmond's -- who is so interested in this -- main criticism of us is we don't do enough, we don't get deep enough into operations. We should be doing more; we should be pressing harder.

FR

So the criticism we get isn't that we are interfering too much, but we aren't interfering enough, which as a short round is a good criticism to have.

MR. PETERS: I am inclined to say -- you mentioned eight months and as high as two years for a proposed study -- in New York there is a proposed bill which hasn't got a committee yet, but it will probably have a committee this year which says that the regional council should make comments on establishment of new construction in 45 days and 60 days on expansion of facilities. And this has bothered a lot of us because we wondered how with our particular committee structure we could get an opinion out in 45 days that represented anything than an

off-the-cuff opinion.

George can comment on that because George was chairman of one of our committees for years and knows how difficult it is to extract an opinion in 45 days.

MR. BUGBEE: He is probably right. Eight months is about what it takes.

MR. PETERS: That's pretty much our experience, about eight months.

MISS JENKINS: This is consoling, Joe. We had one demanding an opinion next week, and it has been four months now, and we are taking a beating over it. And we are not about to render an opinion yet.

I will go back and quote you.

FR

DR. ROREM: As it goes forward and the other describe their procedures, I would be very much interested to know what reactions you folks have to getting the administrators and representatives of other hospitals involved because as far as I know, we are the only ones that get the other hospitals involved with anything like this depth. And I might say this was written into our bylaws, this advisory committee of hospitals, before I came and at the insistence of the hospitals at that time.

I say "hospitals," the presidents and management.

MRS. COLEMAN: What is the range in size among the hospitals?

DR. ROREM: Our smallest hospital, general hospital, short-term hospital, is 119 beds.

MRS. COLEMAN: And the largest?

DR. ROREM: About 650. We have four of those.

DR. HALDEMAN: I don't want to prolong this. There is one other area, though, I think we ought to get into in relation to each of the communities we are going to talk about. And that is the central city versus suburban problem and what the problems are and how you are meeting it because it seems to me like an areawide planning group, this is one of the hardest problems to tackle.

You may have a surplus of beds in a central city, but you have suburban areas growing up which are going to, in many instances, get proprietary beds if you don't let them have their own beds.

You might speak to that point.

DR. ROREM: We take the position that suburban, through statistical facts which are true which we point out, a number of statistical facts, one is that at the present time there are not many specialists living in suburban areas having offices in suburban areas. They haven't come out there in part because there haven't been hospitals.

But we have suggested that the principle of the satellite hospital be used and even if it is a bed facility that it be an offshoot or be sponsored by one of the larger

institutions in order to reduce overhead costs and duplication of facilities.

There is an emotional appeal in the new areas, of course, for an institution that will be identified and be a part of it. But when the chips are down for money, they don't come forward with the money. And even this institution, this $4 million institution, that is going forward, after three years, they have raised and have got $1 million in pledges, cash some portion of it. And it is not identified. We tried to get them to identify it whether it be an offshoot or branch of one of the other larger hospitals, but it is an old institution with a good name, and they wanted to continue it.

They are moving away from an area of great need, but also an area quite uninteresting to the institution because it is a blighted area.

MR.BUGBEE: You know, Jack, on this issue you raise, it is like the question of the administrators conference, I think. One of our major problems is trying to establish procedures and principles that apply to different sized metropolitan areas.

I suspect New York, Chicago, probably Detroit, Pittsburgh, is probably the size where you can do it, Cleveland, Rochester, Columbus.

DR. ROREM: That's right.

MR. BUGBEE: For the administrators council, but I

think the questions of suburban versus central city are almost equally separated. And we talked last night, and Rufus got this page where he has five regions.

Well, you could make an argument about central city serving the entire area much more validly than you could in Detroit, I would guess. I think your issue is: Do you want your beds spread that way? The old Hill-Burton geography points towards spreading, but I don't know that the travel anywhere here is prohibitive.

DR. ROREM: There isn't anybody who is more than one half-hour from a hospital.

MR. BUGBEE: You at least by travel have the option of having the hospital in the center or outlying. Then, the question comes where it should be and that's the part I don't --

DR. ROREM: I used statistics that I am sure I call attention to in one item of the travel.

One, I point out that after all, these fine roads that cause people to move out to the suburbs run both directions. So, you see, it is just as easy to get back as it was to go out.

And the other is that as far as bed care is concerned, on the average, a person is bedded down at the advice of a doctor about once every eight years. But on the average, he will see a doctor about five times a year. So only one out of 40 that see a doctor. So the important thing is to have doctors in the community that are handy and quick.

We had a situation in our area where a man, a department head of one of our large corporations, worked his heart out on a drive for a hospital that was only going to be a half-mile from his house. He thought, "How wonderful when you wake up in the night and the kid has a cramp and rush him to the hospital." And just before the ribbon cutting, he was transferred to Milwaukee and had to start all over again.

(Laughter.)

So this idea of convenience to a hospital.

And another case, one of the fellows working on this, his wife got sick while up in Butler County and had to come back 20 miles.

MR. BUGBEE: Rufus, you are talking about the five visits versus once in eight years.

Jack, even that little research you did or your department did pointed out that parking was the crucial thing. See, even for the five visits a year, if you had your doctors where there was ample parking, probably the half-hour isn't prohibitive to take the child, leave out the emergencies.

DR. ROREM: In the study of emergencies, we found that the people that are medical emergencies or psychological emergencies where they travel fast to get somewhere, they waited longer before they were seen than they did the time traveling to get there.

MR. SIBLEY: I want to follow Rufus' point a little

more because it leads into a broader subject perhaps which you just ended by saying you are planning for the location of physicians and you are not using physicians at all in your procedure by which you review hospital plans or patient care facility plans. You are using only hospital administrators.

And at this point, the question comes, is the hospital administrator capable of speaking for his medical staff, or are medical staffs willing to abide by the speaking of the administrator when the review takes place?

DR. ROREM: It is up to the institution to have cleared all of this before it comes to us. And some of these bring physicians along to these meetings.

I might say further that we propose from now on because of the interests of this committee of six doctors to use them. They have even said they would be willing to go on record as taking a position on plans.

MR. SIBLEY: So this would be another planning procedural step.

DR. ROREM: It would be a parallel one or participating.

MR. SIBLEY: You gave us four steps. Would you put it in here some place in the four steps?

DR. ROREM: It would be a parallel one. The six doctors are invited to all these meetings. A couple of times, they have come.

MR. SIBLEY: So up to now, your physicians, the

representatives of organized medicine, because I presume this is what they are, have not felt threatened, so they have not begun to appear.

DR. ROREM: That's right, but they say now they are willing to and would like to. There is no provision for them to take an official position, but the chairman has said they would be willing to take an official position. And I have got to bring that to my board and see if we want them to.

DR. HALDEMAN: Jack.

MR. COUSIN: I was going to ask something else, but this physician discussion changed it a little bit.

When we did a patient distribution study, the same as you did, we also did physicians.

DR. ROREM: We did, too, but we can't analyze it statistically. It is too vague.

MR. COUSIN: We are going to do this over again about every five years. But meanwhile, we have done it from time to time in certain study areas for certain specific purposes.

DR. ROREM: You mean just the facts where the doctors have their offices?

MR. COUSIN: Yes.

DR. ROREM: We have done that.

MR. COUSIN: We have discovered a great many more specialists out in suburbia than you seem to indicate.

DR. ROREM: We are getting more, too. The last three

years made a difference.

MR. COUSIN: Getting back to the central city versus the suburbia and probably the size of the city metropolitan area has a lot to do with it, but besides, what about suburbanites not wanting to come downtown because of the parking, and not only because there is this terrific emotional play in having a hospital in X, Y, Z suburb, many of the patients and perhaps even a higher percentage of physicians do not like some of the social changes that are taking place in the metropolitan hospitals.

You could give them the world's best parking lot and you could have all these beautiful highways running back and forth, but they just don't like going to some of these formerly and still well-known top-flight institutions where the complexion of the patient load is changing rather drastically.

MR. COUSIN: The nice people want to be in the country.

MR. BUGBEE: Be sick with other nice people.

MR. COUSIN: And some of these hospitals out in the country are having a higher percentage of specialists than they had previously. And some of the top-flight men at the Harpers and Graces and Mt. Carmels and so forth -- well, Mt. Carmel is semi-suburban -- but some of these top-flight downtown hospitals are losing some of their better men, particularly the fellows 50 years and under who are moving their offices out into the Birmingham's and the Grosse Points and so forth.

So that I am not so sure that the roads and the parking are all the answers.

DR. ROREM: Oh, no.

DR. HALDEMAN: I think we perhaps ought to move on to Southern New York. I do this with a bit of anxiety, you might say.

During the Bugbee Committee deliberations, we had four representatives of this metropolitan area on the committee, and we finally had to pass a rule that New York City couldn't be mentioned in this committee -- (laughter) -- that we would never come up with a report on areawide planning.

In recent weeks, I have had a chance to talk to a number of the people in New York interested in this metropolitan planning group. And that is to the coaching by Doug Coleman. I think I was assured that something could be done in this area.

So, Joe, I wondered if you would lead off, and George might like to speak, anyway you want to present it.

MR. PETERS: Again, we seem to be outnumbering the rest of you three to one, although George is a Chicagoan now.

MR. BUGBEE: Alumni.

MR. PETERS: But a very important alumni.

Actually, as far as New York is concerned, you have got to think in terms of two distinct organizational structures. First is the 24 years continuous existence of the Hospital Council of Greater New York. And then, more recently, during

the past year and a half or so, the Hospital Review and Planning Council of Southern New York.

Even though there is a tie between the two, they are structured somewhat differently, although a good deal of the history of the former has been inherited so far by the latter.

Let me talk first about the Hospital Council of Greater New York which I said had 24 years of existence and which was the first planning council which purported to represent the community and which had a community-based board of directors.

We devised a master plan when Dr. Pastore was there in the middle '40's. This master plan, as you all know, and I won't go into it in detail, is based on the bed-death ratio and established a certain number of beds and made some arrangements for distributing these beds primarily by teaching functions.

Over the years, we found that it was of little use to us. And during Dr. Nickelson's regime, we pretty much discarded it, although we have still continued to use a modified figure based on the bed-death ratio. And I say, "modified", we modify it pretty much the same as you all do on the experience of demand, use. If we find facilities aren't being used, quite obviously, we have a sufficient number of beds.

In New York City in general, I am talking about the five boroughs of New York City, we have a sufficient number of beds, although as is true of probably all of your areas, they

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are very poorly distributed. Manhattan has many, many more beds than it needs and roughly about 60 per cent of all the patient care rendered in Manhattan hospitals is rendered to Manhattan patients. The other 40 per cent of the patients come from all over the city and all over the region and even from all over the country.

So our big problem in New York which parallels pretty much what Dr. Rorem talked about here, we have an area where we have enough beds. We found out that the population of New York City has gone down since 1950 and little change is expected in the next 20 years.

In fact, we have just published, and I am sure all of you have a copy of it, a monograph dealing with the future population of our region. We find that in New York City, as I said, we expect little or no change in numbers of people, although we expect at least a 2 million growth in the other counties outside of New York City, primarily Nassau, Suffolk and a few of the ones up north of the city. So this presents a new problem for the new Council.

First of all, what do you do with New York City? And secondly, what do you do to meet the growing needs in the suburban counties?

We haven't done much about the latter, and one of the big things we have done during this first year of our new existence has been to spend as much time as our small staff

would allow to get familiar with the problems and the characteristics and the hospitals of the other nine counties outside of New York City. And this is a tremendous job. We are talking about now outside of New York City more hospitals than probably any of you have except Dr. Klicka. We are talking about 100 hospitals outside of the five boroughs of New York City and 140 general hospitals in the five boroughs of New York City, a total of 240 hospitals with roughly 115,000 beds, I believe. We are talking about a huge complex.

I dread to think what would happen if our present staff got the long-range plans of every one of these 240 hospitals.

(Laughter.)

I wouldn't know how to file them, much less how to interpret them. It isn't a problem.

Ours is a problem of dimension to a great extent. So let me talk about how the old Council operated and then go into very briefly how the new one hopes to operate.

The old hospital council did not get involved -- correct me if I am wrong, George, because you were on the policy end, I was really on the staff end -- the old hospital council did not get involved in studying hospitals or giving advice unless it was formally asked. This is pretty much like you said your early days were. We did not do any studies. We did not render any opinions. We did not make any recommendations

unless the group or the hospital or the agency wrote to our Board of Directors and our Board of Directors took this up at its next meeting and passed a resolution that the staff should or should not work on the problem.

This was the pattern for at least during my stay there and I am sure it was a pattern for all the 24 years of the old council. This meant and still means that a lot of institutions, a lot of agencies, do what they darn well please because unless they ask us, we have never given our advice. And, unfortunately, an awful lot of hospitals haven't asked us.

In fact, some of the greatest institutions have never asked us about our opinion. And until very recently, none of the proprietary hospitals of which we have about 40 in New York City and another 20 outside to make a total of 60 have never asked our opinion, although in the past year this has changed drastically. But this is not because of any action which our Board has taken, but the action which Dr. Trussel and Doug Coleman of the Blue Cross have taken. That is, they now ask us to give our advice on these institutions.

So we are now advising on the need for proprietary hospitals, but as many people say, it is closing the barn door after the horse has left. We have 60 now. The problem now is to keep those 60 at that number.

I say we did studies. Actually, we did three major types of studies over the years. We studied individual

hospitals at their own requests and I would suspect we have done about 100 of those in the past 24 years. Our batting average has been very good, I think, on the individual hospital studies.

We have had our failures, but we have had some great successes, particularly in recent years.

Now, individual hospitals ask us questions. A usual question, of course, is: Should we add more beds, inaugurate a new service or new program and so forth.

We study those and write a written report which in the old Hospital Council was sent to a committee which we called the Master Plan Committee.

Now, the Master Plan Committee was structured as a combined committee of the Board of Directors and a group of outstanding, for want of a better word, technicians. We had about a dozen people on that committee and about half of them were board men. George Bugbee was the last chairman of the Master Planning Committee. We don't have it any more as such.

And we had men such as the Commissioner of Hospitals of New York City. That is the man responsible for the operation of the city's municipal hospital system. We had some knowledgeable physicians who were engaged in research. We had Blue Cross -- who is on it at this time -- Doug Coleman. Even before he was on the Board, I think. But we had that type of person plus Board people, knowledgeable people, who could give us technical

advice and Board people who could give us the reaction of the community.

DR. ROREM: Any voluntary hospital administrators on that?

MR. PETERS: Yes, we usually had one who came usually as a representative of the Greater New York Hospital Association, which is the trade association. In the past few years, it has been Martin Steinberg who, as you can well imagine, brings a much broader approach than that of a hospital administrator.

The hospital administrators we have had on it have been selected, not primarily because they were hospital administrators, but because they could give us a broad picture. They were not there because they served one hospital or one group of hospitals.

The Master Plan Committee reviewed the staff's recommendation. The staff would write a report and bring it directly to the Master Planning Committee at which time the Master Planning Committee would discuss it at great length. And George can tell you what great length means. They would ask all sorts of questions because you had very knowledgeable people on this committee who could ask very specific questions and give very specific reactions to the report.

In some instances, it was necessary to bring the report back on a second or third occasion until it met the approval of the Master Planning Committee.

MR. BUGBEE: I never was sure whether it was the function of the council, but I would say they were as detailed and probably better than most consultants would do on a community plan. They might have 100 pages in great detail.

MR. PETERS: The average report ran about 30 pages, some went to 100, some reports even went into more than that.

When the Master Plan Committee approved the report, and I might add that they rarely approved the report without putting some sort of word change or something. They always put their hand on the report. It never came out precisely as it went in. There was always some change, either a word change or policy change or adding a recommendation or taking out a recommendation, although in general, the sense of the report always was the same as it went in. I don't know of any time when the staff was completely overruled.

When the report was approved by the Master Plan Committee, it went to the Board of Directors. The Board of Directors, of course, then did the same thing to it, but with not quite the elaborate discussion that you would get in the Master Plan Committee. And this is the report that was sent to the hospital.

Now, the biggest problem we faced then and still face to some extent is how do you assure that the hospital or the group to which you are addressing the report will do what you want them to do. And this was the great problem that

plagued the old Hospital Council.

We did have one great instrument and one which was very helpful over the years. And that is, we with the Hill-Burton agencies were working with the State of New York on a contractual basis to administer Hill-Burton funds locally. So a great deal of our leverage we had during the last days of the old Council was based on this Hill-Burton leverage. We could actually make specific recommendations on where the Hill-Burton money in the five boroughs of New York City should go and this gave us, as I said, a great deal of leverage.

And there are many people who believe that many hospitals asked us for studies merely to get on our good side so they could get Hill-Burton money. I suspect this is true. It is certainly not a bad thing.

It is certainly better to have a hospital come to us for Hill-Burton money after we have made recommendations than have them come to us cold. So we didn't look upon this as such a terrible thing.

We used it, and I think we used it to good advantage in many instances. For that, I would say some of our best Hill-Burton grants came out of the fact we did do a study and some of our worst came out of the fact we didn't know too much of the hospital because we haven't had a chance to study them in depth.

We had our failures, and let me tell you something

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about the failures. You learn a lot by the failures.

One of our most persistent group of failures over the recent years has been what do we do with the specialty hospital of New York City. New York City still has a number of specialty institutions. It has, I believe, four or five well-known institutions which provide care for eye, ear, nose, and throat patients. At least two of these are among the greatest institutions of their kind in the world.

MR. BUGBEE: With the first physical plant.

MR. PETERS: Both of them have old physical plants. One goes back to the 1890's, the other goes back to the early 1900's. Both of these institutions have looked to the Hospital Council for advice.

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One of them has come to us from, I think, the first study the Council did in 1939. It was the New York Eye and Ear Infirmary. And one of the last studies we did prior to taking on the new Council was New York Eye and Ear Infirmary. We did three studies, and in all three institutions we urged them to close down their present plant because it was inadequate and to merge with another institution. The hospital still exists independently, so you can see how successful we have been.

Another hospital, Manhattan Eye and Ear, was a little smarter. They never officially asked our opinion, but they constantly worked with us. They never wrote that all-important

letter to the Board requesting a survey. But their President has worked very closely with us over the years. And again, it has been a failure even though they have had the best of instructions. They have taken every step possible to merge with institutions, but have never been able to work out a program of mutual satisfaction of both institutions.

And the hospital now with the advice of one of the outstanding consultants in America is planning to rebuild next door to its present location.

Those have been two of our great failures. These have been the knottiest problems because I say we are not dealing here with the kind of hospital which we so frequently deal with in New York City -- that is, the inferior hospital. Here, you are talking about great institutions, institutions of world leadership. And I don't think I am exaggerating to say these are world leadership institutions. And this has been the problem. What do you do with the specialty hospital.

We have argued about this. We have long lived with this concept that there is no need for a specialty hospital. Yet, when you get down to a particular institution, particularly a great institution, you begin to wonder what do you do with them.

DR. KLICKA: You succeeded with one, Women's Hospital.

MR. PETERS: Yes.

Well, we succeeded, but it is still occupying its

present plant. Its plan is to merge, but until it actually closes down, we haven't succeeded.

MRS. COLEMAN: It is being merged administratively.

DR. KLICKA: They are building a new building.

MR. PETERS: Yes.

We have succeeded with others, New York Orthopedic and one or two others. It hasn't been all failures by any means, but these two have been the knottiest ones.

MR. SIBLEY: You regard this as a problem because this is criteria you are talking against. You set up a criteria there shouldn't be specialty hospitals.

MR. PETERS: Yes, our Board says we shouldn't have specialty hospitals.

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DR. KLICKA: What if you had a children's hospital? Do you think that Board would be against this?

MR. PETERS: Yes.

MRS. COLEMAN: Not adamantly so. Even though they take a position, they are not married to it to such an extent they want to see good care stopped in order to prove something.

DR. KLICKA: Wouldn't you consider a children's hospital a specialty hospital, but being a little different, really, than an ear, nose, and throat hospital?

MR. PETERS: A children's hospital is really nothing more than a general hospital for little people. We are not against all specialty hospitals. We have certainly not

resisted the movement of the hospital for special surgery.

Of course, they are affiliated with somebody else and are working closely with New York Hospital, New York-Cornell Complex.

What we are trying to do with each of the specialty hospitals is to get them to affiliate with another institution and if and when the time comes to replace their plants to get some sort of geographical proximity. And here is where your problem comes in Nw York City, Manhattan particularly, where land becomes a very expensive commodity.

Well, that's the type of hospital we have had failures with. One of the big problems is everybody hasn't asked our opinion. Unfortunately, some of the greatest institutions haven't asked our opinion, but these are great institutions, and they have tended pretty much to do what is in the best interests of the community.

Now, let's go into the new planning agency, the Hospital Unit Planning Council of Southern New York.

DR. HALDEMAN: Joe, I hate to interrupt, but one or two people have indicated that a break might be in order.

MR. SIBLEY: Jack, I don't think everybody knows Jim Ensign from the Blue Cross Association who has come in.

(Whereupon, a recess was taken.)

DR. HALDEMAN: I wonder if we can get on with our hog killing.

MISS JENKINS: Jack, that typifies you as coming from Oklahoma.

DR. HALDEMAN: Five years from now I won't say that, probably, after being exposed to New York.

DR. ROREM: You will move up the animal kingdom and be sacrificed at some other level.

DR. HALDEMAN: I might even be seen with an umbrella. Where I came from, a man who walked down the street with an umbrella would get laughed off the street.

MR. BUGBEE: I suppose you will appear at the last meeting with a Hamburg

DR. HALDEMAN: O.K., gentlemen.

MR. PETERS: Let me run down very briefly the organization structure of the new Council and then let me give you some background on the criteria that was distributed to you today in this material because I think you might find it of some interest in your work.

The new Hospital Planning Council of Southern New York is a successor agency to the old Hospital Council. It officially came into being last spring which makes it over a year old now. It covers 14 counties, the five counties or boroughs of New York City, and the nine outlying counties which take it out as far as Montauk Point on Long Island and a little bit north of Poughkeepsie in New York. It is the southern tier of counties in New York.

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There were many problems in structuring this, and there is nobody more qualified to tell you about the problems that were faced in this than George Bugbee because he was the chairman of the group that brought this about.

For your information, George, there are still some unresolved problems.

MR. BUGBEE: I know.

MR. PETERS: Particularly with relationships of one of the subgroups in the area which is constantly giving indication they would like to break loose and go out on their own, saying they would like to plan for the 2 million people in their area which makes a pretty good sized planning area, by the way, 2 million people. But they originally consented to join us, and one of the big problems in the immediate future is going to be how can you work with these people, still giving them some degree of autonomy in their local affairs and still bringing them into the whole regional complexion.

This is going to be perhaps one of the most difficult organizational problems that the Council is going to face in the coming months. But the new Council, as I said, covers 14 counties, and it was structured so we would get representation from the entire region.

We have a Board of Directors of 43 people, 36 of whom are elected and seven are so-called ex-officio members who represent county commissioners of health, county commissioners

of welfare, and the various commissioners in New York City. It is much larger than the old Council.

The old Council Board, as I recall, was about 30. This is 43. Although it is very encouraging to say that the attendance even though some of these men come from 150 miles away, has been remarkably good. I certainly can't say that the Board is too big in terms of attendance. We certainly are getting 30, 31, people at every meeting, more than that. And some of the ones who don't come are the ones locally.

In fact, the ones from out of the city have been very diligent in attending, and we certainly have no problems in that.

As to whether the Board is too big to manage, so far, it has been no problem, but it is conceived that it might be a problem in the future. We had a master plan committee before which acted as sort of an Executive Committee in that it reviewed all the studies and made recommendations prior to giving it to the Board. That committee has officially been abandoned, but in its place, we have set up one of a proposed four committees -- the Facilities Planning Committee, which will represent one of the major functions of the Council, and this will be the committee that will be dealing with problems of expansion, affiliation and so forth. We plan to set up three other committees and three otheroperating divisions - financial planning, medical services,

and administrative services.

MR. SIBLEY: Would you define each one a little more?

MR. PETERS: Sure.

Facilities planning will deal with the problems of construction, expansion, location of hospitals in accordance with measures the committee needs. They will probably be pretty much in the entire area te old Council stressed. That is, resources, physical resources, how you distribute them and so forth. This is nothing more than an expansion of our old role.

We are hoping to get into the whole area of medical services. Here, we are thinking in terms of the problem that Ann Coleman raised, the problem of quality, quality of medical care, which is a bit of a problem in New York City because in New York City, you have, I won't call it unique, but certainly its dimensions are greater. You have some of the world's greatest institutions side by side with some hospitals which wouldn't pass muster in some of your rural areas, even. You have got a lot of small hospitals.

Rufus said the smallest hospital was 119 beds. I wish we could say that in New York City. We can't say that. We have a lot of them 80, 90, 75 beds. A lot of these are proprietary hospitals. Particularly in Brooklyn, there are a good number of small voluntary hospitals. Some of these are good institutions, some of them are not so good.

A large number of the proprietary hospitals have not

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even met the standards of the Joint Commission on Accreditation of Hospitals. And even though they have passed those standards, it still leaves much to be desired as far as good hospital care to the community is concerned.

We are concerned about this, and we are also concerned about another problem which Rufus doesn't seem to have. And that is the problem of medical staff appointments. I wish we could say that every doctor in New York had the appointment he wanted or has an appointment.

DR. ROREM: Not the one he wanted. They have got some.

MR. PETERS: Some appointment.

We found on the studies we have done that 70 per cent of all the doctors in New York City do not have a voluntary or municipal hospital appointment.

I mean, 70 per cent have and 30 per cent do not have. Seventy per cent have a municipal or voluntary appointment and 30 per cent do not have.

This does not say that 30 per cent do not have proprietary appointments or do not have courtesy appointments. We have no way other than contacting each doctor individually of knowing this.

At the present time, the medical directories in New York State do not give courtesy appointments or proprietary hospital appointments, although we have been led to believe that

the new directory which comes out this year will give proprietary hospital appointments. So we will get a little better picture this year when we get the new directory in.

So we have the problem of what do you do with these 30 per cent of the doctors who do not have voluntary or municipal hospital appointments. This is another problem which we hope the medical services division will be dealing with, and the whole problem of medical education and so forth would be part of the function of this medical services division, together with the problem of utilization, studying of utilization, under utilization, overutilization.

We also hope to set up a Division of Financial Planning, and this will entail bringing together, coordinating, many of the activities of other agencies which are presently doing some work in this field. With the exception of Blue Cross which is responsible for 17 counties, 14 of the 17 counties, there is nobody in the area, in the region, that collects data, financial data, or autopsy data from all the hospitals in the region because we have three major groups of hospitals. We have proprietary hospitals which pretty much act on their own. We have a whole complex of governmental institutions of which the largest is 18 or 20 hospitals operated by the New York City Department of Hospitals. And then, we have five State hospitals which are all mental in New York City and a couple more in the region. And then, we have a large number of

government institutions which are beyond this that we have no relationship to speak of at the present time.

MR. BURLEIGH: To what extent are the proprietary hospitals a relatively regional --

MR. PETERS: The proprietary hospitals have been with us in New York City since the 19th century. And prior to the onset of the Depression, there were more proprietary hospitals than there are now in terms of number of hospitals. There are less hospitals now, but more beds. A good many of these have come about since World War II and even a great flurry in the past three or four years.

Part of the flurry of proprietary hospitals in New York City took place because of changes in the zoning laws in New York City. And the date was set up ahead. So in order to get under the wire, a great many of these plans were filed to get under the deadline so they could make best use of the space prior to these requirements.

So you have had, I would expect, around 1,000 built in the past few years, but around 1,000 proprietary beds in New York City.

MRS. COLEMAN: But the point is really what caused it, not the zones -- that was just the timing -- but what caused it, we had a growth of population in one particular borough without a corresponding increase in voluntary hospital beds.

DR. KLICKA: This is Queens?

MR. PETERS: The Borough of Queens, yes. This is the most rapidly growing borough of the five in New York City. And there were a small number of voluntary hospitals, none of which were very strong economically.

MRS. COLEMAN: Only one of which was very good medically.

MR. BURLEIGH: I was wondering about the absence of staff privileges in voluntary hospitals.

MR. PETERS: There is no question but this has something to do with it. How you measure it, I don't know. This has a great deal of bearing, but I find in many institutions, the ones in private are also on voluntary staffs in the same area.

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MR. BUGBEE: It could also be with a lot of foreign professionals and this is sort of the European pattern with the big teaching hospitals. The big hospitals in Manhattan have 50 per cent in wards and free care. There isn't much room for private patients in them. It is the sort of nursing time thing that they have on the Continent and England where I guess it goes back to that part.

DR. HALDEMAN: How much of it is due to the fact that in the suburbs, the voluntary effort just hasn't caught up?

MRS. COLEMAN: That's certainly true in Queens.

MR. PETERS: Queens up until recently was a suburban type of borough of New York City, and that's where you have had

your growth because your population has grown spectacularly with the small number of voluntary hospitals, but poor financial condition, couldn't move fast enough.

And in this respect, the proprietary hospitals, for all we have said against them, have had one great virtue, and that is they have met a need and met a need very rapidly because you can get a proprietary hospital built and occupied in two years. You can't even get the committee of a voluntary formed and working in that time.

DR. KLICKA: Yes,you can.

MR. PETERS: But it Queens it wasn't very easy to do. Queens is a peculiar borough. It is a middle-class borough. You go through the entire borough, you see very little wealth. It is a low middle-class borough. Some areas have high middle class, but there is no real money in the borough of Queens like there is in some of the older sections of New York City such as parts of Brooklyn and Manhattan.

MRS. COLEMAN: And it was probably overbedded with municipal beds so that the poor population could be taken care of in municipal hospitals.

MR. SIBLEY: I am going to lead you back to financial planning because I am interested in what you people see as your role in financial planning in New York City.

The Commissioner of Insurance has required you to review Blue Cross, hasn't he?

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MR. PETERS: Yes. We will get into the whole problem.

One of the major things we see ourselves doing immediately is capital financing which is pretty much akin to our present role of planning, but we are hoping to get involved as all regional councils are expected to get involved in New York State in judging the adequacy of Blue Cross rates, Blue Cross payments to the hospitals and all the other things that so-called studies of efficiency, studies of the cost of hospital care and so forth which we have been instructed to get into by the governor's administrative order.

MR. SIBLEY: Are you going to do this for the State Welfare Department as well?

MR. PETERS: We haven't worked anything out in this area at all. This is one area we have merely set down as a potential division. The relationships are extremely complex. You have United Hospital Fund which represents 80-some voluntary hospitals in the five boroughs of New York City, but does not represent voluntary hospitals in the other nine counties. You have the Department of Social Welfare which collects financial data on all hospitals for which the government pays for care, which in this instance is voluntary hospitals and also municipal hospitals. They don't collect any material from proprietary hospitals so far as I know with maybe one exception which does take care of some government indigent patients.

DR. ROREM: You say, "proprietary hospitals can

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accept indigents."

MR. PETERS: It so happens Manhattan General does.

DR. ROREM: Nothing in the statute of limitations that avoids it?

MR. PETERS: This was raised at the last Board meeting, this very question. There is nothing that prevents them from taking care of indigent patients if they are given to them. We have to get the approval of the Commissioner of Hospitals and so forth.

We have financial data collected by the United Hospital Fund for voluntary hospitals in five counties, and not all the voluntary hospitals, only those that are members of the Fund.

You have the Department of Social Welfare collecting financial statistical data for all the voluntary hospitals which accept city charges and mental institutions. But then, you have got Blue Cross which collects financial data from all the hospitals. So that is the only source at the present time of financial data from all the hospitals in the 14 counties.

The big problem of the new Council would be when it sets up its division, how much are we going to do and how much are we going to have to take from somebody else. Obviously, you have got people doing it. Blue Cross has got a legal responsibility. They collect data anyway for their own operation. So you are going to have to work with Blue Cross. You are going

to have to work with the Department of Social Welfare and with the United Hospital Fund which, again, has a chartered responsibility to do certain work in this field.

They would have to change their whole role if they didn't do this. So it is going to be a very delicate arrangement.

Fortunately, we have very good working arrangements with all these groups, particularly Blue Cross, which finances us to a tune of one-third of our annual operating expenses. United Hospital Fund finances us to the tune of about one-sixth of our operating expenses. So you have a working relationship there. It is a matter of who is going to do what and how.

Certainly, we are going to have to do substantially what we have done in the past,but how far we are going to go on this is a matter of development and evolution. It is going to be a slow process.

The medical service division, on the other hand, is one that our Board has given the highest priority other than our present activities, getting involved in that area, quality, standards of care, medical staff appointments.

And the other would be administrative services. This one has been tabled. This one is the area where so far as the official position of our Board of Directors is concerned will await further discussion. And this is not anticipated this would be started for some time.

MR. SIBLEY: How did that one get included? What

was the thinking behind it?

MR. BUGBEE: I think the whole question of the economics of operation. Also, I think under there is concern with teaching, nursing, and all kinds of educational projects and the hope for a general drive on economy or, at least, a medium for use by the hospital.

MR. PETERS: It gets in the whole area of nonprofessional staffing and professional staffing other than doctors. Certainly, you have to take into consideration your planning procedures.

MR. SIBLEY: I want to get on this because it is for a purpose. These are all considered in your agency to be planning, you see. This is a very broad definition of planning.

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MR. BUGBEE: It is Trussel's definition. You may recall it is his planning and review council. And the review assumes operations and quality.

I think there is one other thing that has some interest here and that is the Blue Cross is planning, not only to support it, but probably to contract with this agency. And I would guess that probably they are patterning it to some degree after what you are doing, Jack, in Detroit, but with the thought that enforcement of economic sanctions against construction and various other things could better be handled by Blue Cross contracting through this agency than Blue Cross trying to do it itself.

They have talked about contracting in support up to half a million dollars. I don't know whether it will, but it would make possible the staffing of some of these other ventures if they do.

MR. PETERS: At the present time, Blue Cross has guaranteed us $100,000, but not to exceed one-third of the total of our contributions from all sources, including themselves. So last year we got $95,000 or some such figure, $94,000. So we are pretty close to getting the 100 per cent contribution from Blue Cross as they presently see it, but this is only an interim contribution. It is not for all time, we hope.

MR. BUGBEE: I think the other unique thing is you get about $30,000 from the State as your function at the Hill-Burton agency.

DR. HALDEMAN: Jack, did you want to speak?

MR. COUSIN: Yes. I have a question.

Because what you are planning to do there in some ways is what we are planning to do except you formalize it a little more than we have and you are apparently going into it a little deeper than we have.

MR. PETERS: We are only formalized in our paper, Jack, so far.

MR. COUSIN: This may be an embarrassing question, but --

MR. PETERS: If it is so embarrassing, I won't answer

MR. COUSIN: What does this do to your other Hospital Council in New York?

The reason why I am asking it is because my organization does planning, but it is also the trade association. And while some of our administrators feel that we should have planning in the trade association separate, our public representatives who are the ones that pretty much control us feel that we are better off in the long run in doing planning and all the trade association work because you can't divorce the two.

They tell me what we are really doing is health economics, not planning.

MR. PETERS: First of all, I am on the board of the Greater New York Hospital Council. The Executive Director of the Council is automatically ex-officio member of the board and the association.

We don't see any real conflict. First of all, they are admittedly the spokesman for the voluntary hospital system. It is their job to see that the interests of the voluntary hospitals as a group are promulgated. Our job is to look at the thing from a different point of view, the point of view of the community.

This may not be the same as the interests of the voluntary hospital either collectively or individually. Fortunately, it has been, but it is not necessarily the same thing.

We look at things differently. We don't go down to

the city hall nor to the State chambers to lobby for passage of a certain bill or lobby against the passage of a certain bill like the association does. We are not involved in the whole problem of unionization of hospital employees, which they are. We are not involved in seeing at the present time the voluntary hospitals get the most advantageous raise for Blue Cross when the third party pays.

We will be involved in rates, but from the point of view of whether the community is getting the best value for its money, not in terms of whether the hospitals are getting the most they can from the agencies. It is a different point of view, and I think there is room for both.

MR. BUGBEE: There is another thing, Jack. This is as touchy as anything, and the Greater New York was very concerned with this development, but the fact remains they have never done anything but representation. They have never done economic activities or joint purchasing or any of the things that are conceived to be a Council function except representation. And maybe there is a role for them in representation in relationship to Council, but they were worried to a degree it pre-empts part of the assignment that should have been theirs.

MR. PETERS: George, since you left, the Greater New York Hospital Association was studied. Like most hospitals, they got their study, too. So they brought in an outside

consultant to look at what the role of the Greater New York Hospital Association would be. And even though they are structured in a very complex way, the consultant recommended a very complex structure. Actually, there wasn't quite as much conflict as one would think would arise.

Sure, they would have a Division of Financial Planning. But this is purely from the point of view of representation to gather material from the hospitals to present a brief to the city or to Blue Cross or to any other third party for getting better reimbursement patterns for the voluntary hospitals which they represent.

They are talking about studying personnel, but their study of personnel is going to be a little different than ours. They are talking about salary, salary and wage procedures, policies regarding employment, collectivization so they can work with unions because as of July 1st, the hospitals of New York City are no longer exempt. So they have to live with unions and like it as of seven or eight days ago. So there is a different type of thing.

Even though they are expanding just as we are expanding, I still see very little conflict except in this one area of administration.

MR. COUSIN: Which you have taken.

MR. PETERS: Which we have taken, but partly because of this because this is a very, very delicate area, and this

is the area where we are going to have to, over a period of time, our committee has recommended we have joint conferences with the Greater New York Hospital Association and United Hospital Fund which also does work on administrative research.

For example, on methods of improvement and things like that which Charlie Roswell has done with Government aid. There is where your great area of conflict may be. This is the area where it is conceivable we may never be operate.

MR. SIBLEY: Joe, we are already into this area of administration, and this is why I am particularly interested in how we look at the images of our job, which is really what you are describing, how you compare your image with the image of the association. And we got caught into it.

I think for a number of reasons, but the one that came out was when Frank Gromer was president, he insisted there must be a code of conduct of hospitals which was in the organization management end of things. And we have developed now what we call organization and management standards which are going to our House of Delegates in New York in August.

We realize that they are going to be revised many times and worked over many times, but they are now in very definitive form, very specific. There are about five general headings and about seven to ten under each one. But we don't know how to administer them, and we have been discussing this.

Our Board discussed it at considerable length. You

see, this was a promise that Frank Gromer made to the Blue Cross Association that the quid pro quo was between hospitals and Blue Cross. And I think it is probably the same with the insurance commissioners and welfare departments around the country that the hospitals have to demonstrate, or there has to be some mechanics of demonstrating, that they are doing the things, they are being well organized and well managed. That is, if they then proceed to say that good patient care gets some good organization and good management, which I think we accept as a basic premise, although we are not sure that this is correct.

So we have moved into this field rather gingerly ourselves because we are not sure, but we felt we couldn't wait any longer and with the Trussel report kind of activity -- that is, if you follow out the concept of that report. And as far as I am concerned, in my thinking, these are all facets of the more general problem that hospitals, not being in the profit-making activity, have to find mechanisms for demonstrating they are using the money which comes to them which is, in a sense, in trust, in trust for Blue Cross or in trust through taxes, or in trust through insurance or in trust whatever the mechanism is.

We answer that question we are taking the necessary steps to use this money wisely, and this is basically, I suppose, what you are set up to do.

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MR. PETERS: By the way, this is not to say that the Hospital Council has had blinders insofar as these other aspects of hospital planning are concerned. I think if you look at the study which we prepared a few years ago -- about a year or two ago -- on the so-called municipal voluntary hospital relationship study where we analyzed the role of the voluntary and municipal hospitals in New York City, which came out as a 600-page book in the beginning of this year, you see, we at that point had come to the awareness that we just could no longer think in terms of facilities and services. We had to talk in terms of organization, administration, availability of personnel, standards of care, all these things, finances.

In fact, if you look at that book, you find that more than one-third of that book deals with finances. The role of government money, voluntary money, philanthropic sources and private payment goes to one-third of that book over and over again.

We also talked about the ability of the municipal hospital system to administer itself properly, the organization of municipal hospital system, and how it should relate to the organization in voluntary hospitals. And we talked about all these things, and this was the first time where we officially really got way beyond our previous limited scope.

Do you think so, George, when we got into this

municipal voluntary, maybe not to live with it, but maybe accidentally. We got into all the areas.

DR. ROREM: I would like to ask a question, technical question.

Did I understand you to say the municipal hospitals do not have membership in or are not represented by the Greater New York Hospital Association?

MR. PETERS: Yes, they are.

MR. BUGBEE: Proprietary are not.

MR. PETERS: Municipal are, but actually, if you look at the Board of Directors of the Greater New York Hospital Association, you see that the Commissioner of Hospitals is like I am, an ex-officio member of the Board, and he is the only administrative hospital person that is on that Board.

So even though there are 18 hospitals, 18 hospital superintendents, they play a very negligible role in the policy-making of the association. So even though they are members, they come to all the general meetings, but as far as the Board of Directors, as far as holding office is concerned, historically the municipal hospital executive had played no role.

DR. ROREM: Except their primary concern is with the voluntary hospital.

MR. PETERS: No question. The other ones don't even pay the same dues.

For want of a better word, they would be an associate

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type of membership because the problems that the Greater New York Hospital Association deals with are primarily the problems in the voluntary hospitals.

DR. HALDEMAN: Is there an association of proprietary hospitals?

MR. PETERS: Yes, there is at least one. There is one, anyway, Association of Private Hospitals, Inc.

MR. SIBLEY: Are you on their Board, Joe?

MR. PETERS: No, but they are on our Board. And George can tell you about all the travail that went through on that one. They are on our Board, and I may say that I feel sorry for Dr. Berson who represents it because when the vote comes 40 to 1, he has long since now just stopped and sits and listens.

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All it does, really, in many respects, is assure that they will know what we are doing, not that we know what they are doing. In other words, any time we prepare a document, you can be sure that the Executive Director of the proprietary hospitals has a copy of it on his desk the minute it is off our press because we send it to our Boardman. He probably gives it to him. So it is a one-way communication at the present time.

But certainly, I would say that it was a wise move to bring him on. If you are going to try to get them to upgarde their standards, you ought to at least let them have some voice

in it because one man can't dominate the group. Hopefully, we try to let him see the broad picture and are hopeful he will bring this back to his members.

Let me get to the criteria because this is a good point.

DR. KLICKA: One question before you do that. Either I missed it or you didn't make it clear. I think I missed it.

In all of this structure, are you talking about planning as it relates to hospitals, or as it relates to total health facilities which include nursing homes?

MR. PETERS: Total health facilities.

DR. KLICKA: And long-term care facilities, all of these things?

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MR. PETERS: We have done a little bit of work in nursing homes, and we occasionally have some relationship with other types of institutions, but this has been more accidental than deliberate in the past.

Dr. Coleman, who was our Association Director prior to going to Johns Hopkins was farmed out for a period of time, working with the Department of Mental Health Council which represents the Department of Hospitals, Health, Welfare, and Mental Hygiene, in New York City. And he did some work on nursing home facilities. And he came out with a figure that in New York City we need approximately 15,000 more nursing home beds by 1970.

So we have some guideposts in this area to work with. This was done, not by the Council as a council, but one of the staff members loaned out. As I recall, that wasn't even approved, didn't even go to our Board of Directors, his report. It went directly to the group, but we have used it, and it does represent a landmark which we can work under. We need more nursing home type facilities in New York City, and we have been working a great deal with hospitals on this trying to get individual hospitals to expand their scope. And I suspect we are going to get involved in other things. We have to get involved in this. We certainly can't limit ourselves to the general hospital.

If we did, we would be limiting ourselves to only just one segment. It is hoped we can get more involved in the whole problem of care for the mental disease patients, care of the aged. We find ourselves getting working time with homes for the aged.

Mrs. Coleman worked with some last year, as I recall.

DR. KLICKA: I am going to ask you a ridiculous question. Does anyone have the opinion you are extending yourselves too far and trying to do too much in your organizational structure?

MR. PETERS: I would suspect there are.

DR. KLICKA: I am asking a serious question.

MR. PETERS: Seriously, first of all, I told you about the

fact many believe we are trying to extend ourselves too far geographically.

DR. KLICKA: No, I am talking about --

MR. PETERS: That's one area. I am sure that I could think of at least one member of our Board of Directors who must think we are out of our mind getting involved in this medical services concept. He has very often spoken up that the problems of medical care are the domain of the medical society and doctors that practice medicine. And since we have very few doctors on our Board that even touch a patient, therefore, what right do we have to make pronouncements about quality of medical care? This is a medical problem, and you laymen, no matter how well intentioned you are, should get away from this. And he has spoken this out at every single Board meeting he has been at.

I would suspect there are one or two other members of our Board who are also physicians, and I might even say one or two of our lay members, who would say he is perfectly right. This is one area where we know there is some controversy, at least some doubts, in the members of our own Board of Directors.

I know that there is at least one member of our Board of Directors who thinks -- at least one, maybe more than one -- the idea of the whole new Council, its structure, its organization, its concepts, its geographic responsibilities, is all wet.

And he will not come, he doesn't come, to any Board meetings. I would say one of our best Boardmen, one of the men who could make some real substantial contributions.

So I would suspect there are many individual hospital administrators who would say that we are out of our minds. Particularly ones we leave the area of facilities and get into anything beyond facilities, there are a lot of people I am sure who are going to resist us.

We haven't met that resistance officially because we haven't gotten into these areas as yet, but I suspect we will get it. And I don't think the committee, when they formed this Council, ever thought it was going to be an easy job. They realize the problems, and it is going to be difficult.

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DR. KLICKA: O.K., you answered it.

DR. HALDEMAN: Could we go on to the principles?

MR. PETERS: We got involved in this criteria.

As I say, we know quite a bit about New York City. After all, we have been working in New York City for 24 years, but to be completely frank, there are a lot of things we don't know. But we know quite a bit about it.

As of a year ago, we knew nothing about the eight counties outside of New York City. So one of our first jobs, as I said earlier, was to broaden our knowledge of the 100-odd hospitals outside of New York City to get some idea of all the things that were happening that affect medical care and

hospital care outside New York City.

Quite apparently while you are getting this information, you still have got to make decisions. If an agency is going to wait until it gets all the facts and is not going to make any decisions until all the facts are in, he is not going to do anything. We have got to plan regardless even with our limited knowledge.

Once we were organized, people started asking us questions, and we had to give answers to these questions. So it was quite obvious that we had to have some broad outline criteria to guide the Facility Planning Committee and the Council as a whole in making decisions both for New York City and for the other nine counties outside the city.

So we had criteria, one-page criteria on New York City which we assembled about two years ago. And this, we were operating under for the past two years. When we became a new regional council, it became quite obvious that we had to broaden our principles to take into account the other nine counties and the differences between the other nine counties and New York City.

As I said, the other nine counties have an expected population growth. New York City is expected to remain static. So we were told to expand our principles for New York City to cover nine counties.

There was some thought that perhaps we would have to

have two sets of principles, one for New York City and one for the expanding nine counties. We thought that it would be possible to develop a set of principles which would apply to the region as a whole, it was no longer feasible to try to make distinctions. We ought to start thinking as an integrated region rather than as three separate groups within the region. So staff devised these criteria. And as you will notice, they are very general.

I suspect there is nothing in here which is new with perhaps one exception, and that is the very strong position that was taken on the fact that every hospital should attempt to serve all income groups within the population. This is quite a dramatic jump in New York City because, as I say,,we have municipal hospitals to serve the indigent. We have proprietary hospitals which serve the pay patient or Blue Cross patients. And we have voluntary hospitals which serve all patients, but as George pointed out, they carry a large share of the indigent patient load in the city.

This is not true outside the city because there are no local government hospitals outside New York City. There are one or two, but they are a very small group compared to New York City.

The problem was we felt that to perpetuate hospitals with such limited functions in serving limited segments of the community made our planning a great deal more difficult and

probably resulted in a need for more beds if you are going to start splitting the community up into small groups because you have lost one element of flexibility automatically by having hospitals which take care of the pay patient and hospitals which take care of the poor and hospitals which do both because these populations are not static, they change. As the economy changes, the number of people who require care in municipal hospitals, at least theoretically, changes. And what happens in New York City is we find, particularly as areas change, an area could be a middle-class area today, ten years from now could be a blighted area or slum. It could have enough hospital beds, but supposing all these hospital beds were proprietary hospital beds? Who is going to take care of the needs of these changed areas?

Or, conversely, suppose the area was a slum and through redevelopment became a good area and you had a municipal hospital servicing it. Who is going to take care of the needs of the private patients in that area because, by law, the municipal hospitals are limited primarily to care for the indigent, although they can take emergency cases for pay patients.

So we wanted to recognize two problems, the problem of changing economic conditions and changing community conditions, the declining neighborhood or area that was changing for better or for worse. So we felt in our future planning, we should

attempt to have hospitals that would service whatever type of patients were there at the time.

In other words, hospitals that would take care of the indigent and the pay patient in various proportions, depending on the need at the time.

So this, in essence, really meant that we were going on record as being against private hospitals.

MRS. COLEMAN: And municipal.

MR. PETERS: And municipal, but you notice on page 1 under "flexibility", we put a little out on municipal hospitals by saying, "It is recognized that, because of local traditions and statutory policies, there are often marked differences in the roles of government institutions in servicing various groups within the population."

We left a little loophole there, although I might say we have been pretty much in the past few years discouraging, and in this, Dr. Trussel shares our views,completely, the addition of more municipal hospital beds in New York City.

DR. HALDEMAN: Is there any move to open up municipal hospitals to paying patients?

MR. PETERS: There has been talk about it as far back as the hospital survey of New York which was in the ear ly '30's. One hospital in New York City, Sydnum Hospital., which was a voluntary hospital in the Harlem area which face d great financial difficulties, and in the late -40's became a

municipal hospital with the stimulation that probably 100 per cent of its 200 beds would be for private patients, but this was a recognition of the peculiar problem facing the Negro doctor in the Harlem area.

DR. HALDEMAN: I am thinking of the situation in Kansas City where the municipal hospital is now opening its doors to pay patients.

MR. PETERS: There has been talk about it, but the Council has resisted it pretty much officially, and there has been very little talk about it in recent years.

DR. ROREM: In New York States, as I understand it, upstate, a number of these so-called county hospitals are open to the general public.

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MR. PETERS: Herkimer.

DR. ROREM: Are any of those in the lower tier like that?

MRS. COLEMAN: There is one in Westchester that will take special types of patients.

MR. PETERS: Alcoholic, mental disease.

MRS. COLEMAN: It was used when we had polio.

DR. ROREM: Nothing like the one in Utica, for example.

DR. HALDEMAN: Joe, I wonder if we could go on and get some of the various methods that are being used to try and implement because, as I understand it, there are a number of forces, not all within the Council, but within cooperating

groups such as Ray Trussel's authority in relation to licensure of proprietary hospitals that are having an impact on it -- the use of the 5 per cent funds in the Blue Cross and other things that amount to trying to implement good planning that are bringing forces to bear from a variety of directions.

MR. PETERS: The Hospital Council has traditional authority in terms of there were three ways in which we could influence hospital planning.

And first of all, that was moral suasion. The other was through financial controls, contributions and so forth. And a third was legal sanctions and government authority. We have used all three, but have relied primarily on the first, moral suasion.

So far as government is concerned, it is a very complicated pattern in New York City area on government controls, and there is a document available which summarizes all the various ways government gets into the picture.

But the one way which I think you would be interested is most, in New York City, the Commissioner of Hospitals, Ray Trussel in this instance, licenses proprietary institutions at his discretion. And he has interpreted this to mean he can withhold a license to a proprietary hospital and discourage their expansion or even discourage their opening in the first place. And he has relied on Council to assist him in giving advice under which hospitals should be approved and should not

be approved so far as opening, so far as new construction or expansion is concerned.

And we have in the past year in particular -- two years, actually -- been advising him on a number of proprietary hospitals. All we do is advise him. He has not been able to make all of these stick. He has had to give in.

DR. KLICKA: Why? How does he give in? Is he sued or how does he give in?

MR. PETERS: He hasn't been sued, but apparently all kinds of pressures have been placed upon him.

MR. BUGBEE: He moved in when some of these were already in construction. That was a little hard to stop.

MR. PETERS: He came in too late in some instances. Others, a little give and take. Some others, he let add a small number of beds.

Here is the problem they face. We talk about efficiency of operations. Some of them were small and wanted to become a little bigger, wanted to add 50 beds, and also wanted to add ancillary services. But to add the ancillary services, economically, they couldn't do it unless they had the beds. So he would have to give in and say, "O.K., 20 beds, but make sure you build up your X-ray department and modernize your obstetrical department or modernize your operating room suite," or such things as that.

He realizes in some instances asking the man merely

to do one without doing the other was economically impossible for them. So he had to face the problem if you want a second-rate hospital with inferior ancillary services that continue to exist, or do you want to upgrade them a little bit, let them expand their ancillary service, but also expand their beds to some limited extent. And he gave in there to some extent.

But, on the other hand, I think we have done a great deal to discourage. I think the day of explosive expansion of proprietary hospitals is past so far as New York City is concerned so long as you have a Commissioner of Hospitals who is willing to put his neck out. If and when you get a Commissioner of Hospitals who is not willing to take drastic action, no one can tell. But I think the day is -- but you have another control, you have Blue Cross.

DR. KLICKA: He has just made one of the most important statements that have been made today, though, and I would like to emphasize this. He talked about courage. And believe me, don't ever discount this in this field.

Go ahead.

MR. PETERS: Courage?

DR. KLICKA: That's right.

MR. PETERS: I think Ray Trussel is an outstanding example of courageous action.

DR. KLICKA: That's right. That's why I wanted to

give it emphasis.

DR. HALDEMAN: What other methods are being used in the area?

MR. PETERS: Then, of course, these are legal. Theoretically, on the books, according to the administrative procedures of the Department of Social Welfare, the Department of Social Welfare -- this is administrative now, on its administrative code -- in considering an application for the granting of a charter to a new hospital should take into consideration need, the need for the hospital. This is not in the law; it is in their working arrangements. And in the past two years, the Department of Social Welfare has come to us and asked us our opinion.

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But I might also add that they have disregarded our opinion after we gave it to them.

MR. BUGBEE: Licensure is a jungle. It is between the municipal, delegated to the Commissioners of Hospitals, or the State. You would have to read the book because for proprietary and voluntary in the five boroughs and out, the rules are all different, aren't they?

MR. PETERS: It is a very complicated structure. But suffice it to say that the Department of Social Welfare has within its rights the ability to withhold a charter to an institution that is not needed, a voluntary institution which is not needed.

DR. ROREM: I might say in Pennsylvania the law now States that a voluntary hospital has to have a certificate of need and a proprietary does not.

MR. PETERS: Proprietary in New York does not either, except in New York State, the Department of Social Welfare can withhold the charter to a new voluntary membership corporation which wants to start a hospital.

They have not for some reason or another in our region. We have on three or four occasions in the past two years told them this hospital is not needed, and they have chosen to go ahead anyway and give the charter out. So that means we do have some legal control, but the Department of Social Welfare for some reason or another does not choose to follow it.

MR. BUGBEE: You have some other idiosyncrasies. The Department of Social Welfare is a board, nonpolitical and nonapproachable through administrative controls or anything else. So they have done pretty much as they want.

MR. PETERS: As far as the proprietary hospitals are concerned and municipal hospitals, we have the Commissioner of Trusts of Municipal Hospitals, Department of Hospitals.

Take the municipal hospitals. We have worked with all the commissioners over the past years very closely, and they have come to us asking our advice about the building of municipal hospitals. We have a lot of municipal hospitals that

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are in inadequate facilities, and there has been some discussion whether they should be closed or replaced. We rendered our own opinion on a number of these.

Dr. Trussel has agreed completely with us that we were right, but here again, we got into the whole area of political forces and both Dr. Trussel and we have been defeated.

I think that Fordham Hospital, which was a hospital we said should be closed, Trussel said it should be closed, all the knowledgeable people said it should be closed, but local political pressures have kept it open.

I think of Gouverneur Hospital which we said many years ago should be closed, Trussel said should be closed, he closed it. But as of a week ago, we have reversed our decision. It is now going to be built.

MR. BUGBEE: Who has reversed this decision?

MR. PETERS: The hospital council because of the fact we were going to make Bellevue Hospital smaller.

MRS. COLEMAN: Don't try to understand it.

MR. BUGBEE: Ninety million isn't enough for Bellevue Hospital?

MR. PETERS: The problem with some of these things here, you mentioned before about location of the hospital -- I think it was Dr. Rorem mentioned -- this is a problem we faced.

The planner can say, "Thirty minutes traveling time,"

and Gouverneur-Bellevue is a good example. Gouverneur Hospital was a small hospital which lost accreditation, small municipal hospital, with 200 beds in the tip of lower Manhattan. Within 15 or 20 minutes travel time by bus, you came to Bellevue Hospital which is the same type of hospital except ten times as big, staffed by three great universities -- Cornell, Columbia, and New York University medical schools -- one of the great hospitals of the world that was actually servicing this area anyway in unsuitable facilities, going to be rebuilt.

The question was should you rebuild an X-sized Bellevue Hospital or an X-minus 200-bed Bellevue Hospital with 200 new beds down in lower Manhattan?

We said, "No, build the X-sized Bellevue Hospital and forget about the 200-bed satellite down in the southern part of Manhattan which, don't forget, had lost its accreditation, lost its approval, all its residency approvals, a poor institution. But the Mayor had promised in his first campaign they would get a new Gouverneur Hospital. And despite what you say about the Mayor, in this instance, he was tenacious. He kept to his promises. He never gave in. And Trussel advised him to close it, and he closed it, but nobody could make it stick.

Here, you have the local community very vocal, demanding something and the planning agency and all the knowledgeable people saying, "No, you don't need this, it is

not for your best interests." How do you reconcile this problem? We are a community agency. We purportedly speak for the community, but are we speaking for the community when the community says they want this and we say no, you don't need it?

DR. ROREM: If this had been a voluntary hospital, you could have made it stick.

MR. PETERS: How?

DR. ROREM: They have to get the money from somewhere.

MR. BUGBEE: They wouldn't have raised it down there either.

DR. KLICKA: You didn't change your position?

MR. PETERS: We changed it the last meeting because of the rearrangement of cutting down, if they cut down Bellevue.

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DR. ROREM: You saved face by cutting Bellevue back 200 beds?

MR. PETERS: Yes.

DR. HALDEMAN: Is there affiliation with Bellevue?

MR. PETERS: No, they are going to affiliate with Beth-Israel, which is in the area. It is a peculiar thing. We are going to get a Department of Health, Welfare, Hospitals, and Mental Hygiene to work together. It is very unique. They are planning on an interdepartmental complex to make certain pioneer efforts in providing care locally.

MR. BUGBEE: They are rationalizing the Mayor's commitment.

DR. HALDEMAN: I think their batting average may be pretty good. There are at least two or three municipal units that are being built around and will be operated by a voluntary nonprofit hospital. And it does always seem to me like in the last analysis, you usually have to compromise some things in order to get the major things you want.

MR. PETERS: Let me get into the idea of how we work with voluntary hospitals. This is the area where we have done a great deal of our work in the past. And here is where we probably have had the greatest success, partly because, as I said, people ask us to study them. So the mere fact they ask us indicates they may abide by our recommendation. They don't have to ask us under the present circumstances.

They ask us for our recommendation. We do a study. We come up with an answer.

In this instance, I think the greatest tool we have had to use has been Hill-Burton money, being the local agent for Hill-Burton for the State and five boroughs of New York City which has given us a tremendous weapon, actually a weapon far beyond the actual amount of money involved. You are talking on an average of $1.5 million or $2 million a year, most of the grants being made half a million dollars, $300,000, $200,000, relatively small grants in terms of the total amount of money which is being expended for capital construction.

Here is where we have influenced hospitals a great

deal and gotten hospitals to do largely what we would like to see them do. Here we have gotten beyond merely the approval of a grant. We have told them to add outpatient departments, new services. We have attempted in many ways to get them to do substantially more than they intended to do originally, and I think they have been very successful here.

DR. ROREM: I would like to ask a question. You said originally that no approval or disapproval was expressed unless requested by the institution. Is that still the case?

MR. PETERS: Yes, with the exception now that Dr. Trussel was coming to us asking about specific proprietary hospitals.

DR. ROREM: Somebody asks you, though.

MR. PETERS: And Blue Cross is coming to us, so somebody is asking us at the present time.

DR. ROREM: You don't move in on the basis of sound public policy,you feel you ought to move in on a situation?

MR. PETERS: I think in time, it is the intent we will move in.

DR. ROREM: I have a reason for asking. I am importuned, don't wait until they ask you. Tell them first.

As the day goes on, I want to hear more about that.

MR. PETERS: Actually, if you look at the new structure of the Council, what it stands for, there is no question about it. It was the intent that we move in before we are asked.

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DR. HALDEMAN: Staffwise, you really wouldn't be able to.

MR. PETERS: Right now, we have got a small staff. We have got a backlog of requests. We have so much work to do just to keep abreast of all the official requests. We have got half a dozen we are working on right now, and our staff has not grown since the Council has expanded.

DR. KLICKA: How many studies have you done of this type in the last three or four years?

MR. PETERS: Last three or four years? I guess about 25 or 30 in the past four years. We do about seven a year.

DR. ROREM: Special studies, specific institutions.

MR. PETERS: And also special studies of specific problems or community problems.

For example, we are still studying the hospital needs of a certain area. It is the converse way of going at it because a local group says, "Study the area." And we look and evaluate the area needs and the hospital's role in meeting these, and we do special problems, particularly voluntary relationship, which is a very complicated one in New York.

Several years ago, we studied problems of providing ambulance service to New York City residents. Things like that. We get involved in all types of studies, but as I said, the bulk of them are studying an individual hospital's program for the future, whether they should affiliate, close, merge,

expand, relocate.

We have relocated several hospitals in New York. There are two that were relocated very successfully, both of which have expanded upon relocation -- Misericordia Hospital and Booth Memorial in Queens. Here, we took existing hospitals in Manhattan, which is substantially overbedded, and told them the plants were inadequate, not to build where they were, go somewhere else where they are needed more. We did this on two occasions in recent years so successfully these hospitals were expanded, but they were too small when they moved.

We have kept one hospital from moving away from a deteriorated neighborhood, and this, I think, has been one of our greatest successes. Here is an area that went bad. Here was a hospital that was doing a service. They wanted to go out to the suburbs where the nice people are, and we said, "No, stay where you are because this is an area of great need, impoverished."

DR. ROREM: In Manhattan?

MR. PETERS: In Brooklyn. We have areas of Brooklyn that are just as bad as some of the areas of Manhattan.

DR. HALDEMAN: You have had several instances where hospitals have consolidated, haven't you, two or three hospitals together to build a new hospital?

MR. PETERS: We have one recently, Prospect Heights, which was a hospital in Brooklyn, a bad plant, one of the

kind of hospitals that was mentioned give us concern about the quality of care rendered. The hospital was old, almost 100 years old. We got them to close and merge with another hospital. The other hospital is still operating as a satellite, but in time they will close the building. The building is no good.

We have done this on other occasions. Ann is working on one right now which gives every hope of maybe three hospitals merging.

MRS. COLEMAN: Three hospitals and an old-age.

MR. PETERS: A related facility.

We have done this thing that Dr. Rorem mentioned, instead of replacing a municipal hospital on its present site which has problems in staffing, problems in getting doctors, good doctors to give sufficient amount of time because they can't bring their patients there anyway, we have got these inferior plants to get these hospitals rebuilt on the grounds of voluntary hospitals or else to get voluntary hospitals to aid these institutions in staffing. And we have been very successful in that.

We have one hospital in the Bronx that is going to move with a great voluntary hospital, and we set the pattern. I think this is one of the best contributions we have made so far as relations between the two types of hospitals are concerned in the past years. I think probably Hay Nickelson's greatest

contribution to the Council was in getting this concept across. It was essentially his concept.

DR. HALDEMAN: To get back to implementation, what about the Blue Cross, the 5 per cent fund, the Blue Cross collection?

MR. PETERS: We have done nothing on that.

DR. ROREM: What is that?

MR. PETERS: In the recent Blue Cross formula, the hospitals can put away 5 per cent, but this cannot be expended without approval. It can only be expended for replacement or expansion. It cannot be used to underwrite deficits. And this is, as you can well imagine in a city which has so much money expended for medical care as New York City or the 17 counties of the New York area which Blue Cross is responsible for, a tremendous amount of money. It has been going on now for about two years accumulating. And within a few years, you are going to be talking about millions and millions of dollars.

DR. ROREM: Is this 5 per cent paid over to the hospital or given --

MR. PETERS: Given to the hospital, but they have to set it aside. They have to fund it or they may.

MR. PETERS: They have to.

DR. HALDEMAN: And isn't it also true the purposes for which it can be funded have got to meet approval of Blue Cross?

MR. PETERS: Blue Cross.

DR. KLICKA: Blue Cross or the Council? Please repeat. Blue Cross, not the Council yet.

DR. HALDEMAN: The feeling, as I understand it, is they may ask the Council's advice, but I think there is a legal question which Jim might raise later on as to whether they could turn over the responsibility to the Council. I think there is a question whether that would be legal.

MR. PETERS: One of the problems they face is the fact how much autonomy these other agencies can give up. Blue Cross can ask our opinion.

DR. ROREM: Is this actually a 5 per cent plus over and above depreciation allowance?

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MR. PETERS: No, this is the equivalent.

DR. HALDEMAN: Jim, would you want to touch on this?

MR. ENSIGN: I want to say Doug Coleman's concern has been all along with some parallel action on the Blue Cross Board, advice given it by the planning agency. And the opinion that has been given them by the legal counsel is if they merely accept as their ruling the opinion of the planning agencies, they might be in trouble with restraint of trade or collusion. And so, therefore, I guess the approach is they ask the advice and then act upon that advice.

MR. PETERS: Trussel faces the same problem as Commissioner of Hospitals, precisely the same problem.

MR. BUGBEE: And the welfare,too.

MR. PETERS: Welfare does, too.

MR. ENSIGN: And I think in Michigan, Jack can probably comment on this, Blue Cross gets advice from the Detroit area Hospital Council or Hill-Burton authority, other State areas, and acts accordingly and may use other evidence that they gather themselves to reach the decision they finally reach. But usually, it is in line with recommendations of the planning unit.

DR. HALDEMAN: Are those pretty well all the implementing devices that there are available to the Council or in New York?

MR. PETERS: Of course, there is also the fact that groups like United Hospital Fund and so forth can use certain sanctions, depending, to implement our recommendations, but United Hospital Fund at the present time doesn't get involved in construction, merely giving contributions for free care.

But if United Hospital Fund gets involved in a capital fund drive, which they have been seriously considering for years and which officially they are going to probably get involved in next year, it is their intent that in distributing the monies raised, they will turn to the Council again as Doug Coleman turned to us for advice.

Whether they will take our recommendations 100 per cent is the same problem that was raised before, but they will

turn to us because we have the mechanism to determine need, and they haven't got it. They have got the money. They have got to give it out according to some rational basis.

They will turn to us, seeing they will support us anyway to the tune of $80,000 a year, turn to us for advice on how to distribute this money. They are talking about tremendous sums of money.

DR. ROREM: I would like to ask just so I get it straight, I have suggested from time to time on my own as I am concerned with a broad problem that Blue Cross depreciation allowances might very well be made in a central fund to be used for general hospital construction as an institution need may appear instead of paid out to the individual hospital. Has that been picked up and laid down or not picked up?

MR. ENSIGN: There has been a lot of discussion on it.

MR. PETERS: I can say you wouldn't be elected man of the year by the voluntary hospital boards.

MR. ENSIGN: We discussed this and did some legal research on the question, and it was found you run into some problems like with withholding money ostensibly which belonged to and was the right of the hospital to receive as a proper reimbursement, diverting it into a central pool.

I don't know that it has ever been tested. I don't think it has. It is something people talk about, but they are all afraid of.

DR. ROREM: There are things, too, whether or not a big responsible agency like that does not have an obligation to see that the total properties are kept in balance rather than the individual's.

DR. HALDEMAN: How about priority and principles? What have you other than these basic principles?

MR. PETERS: We haven't enunciated anything in writing, but we operate pretty much with priorities, and the Board operates.

Obviously, we are always interested, for example, in replacing unsafe facilities. This is one of the priorities which has been given. We have always given a great deal of emphasis to this both in administration of our Hill-Burton program locally and in our studies. We have always given a great deal of stress to hospitals which exercise a great influence on the region.

For example, the great university teaching institutions. We try to strengthen them as much as possible because when you build up a Columbia-Presbyterian or New York-Cornell Medical Center, you are not talking about a hospital now which is servicing a local community. You are talking about a hospital which services the entire region, both in terms of patient care insofar as many of the very difficult cases are sent there. It is leadership in terms of medical education and research. And these institutions, there is no question you get a great

deal of support from the Council.

In other words, what we are trying to do if we could do it, we would like to build up the strong and starve out the weak because it is awfully difficult, we find in the past, to try to build up the weak, particularly if they are occupying some poor plants.

MR. COUSIN: Mr. Chairman, I would like to ask a question. We, I think, tend to have a little bit of that philosophy except that you can then be accused, you know, of backscratching, and we are occasionally.

What do you do when you have a suburb where they have all the dough in the world and they have an awful lot of the good medical staff that are in these so-called great institutions. And you know darn well that this new hospital is starting out, it may be 200 or 300 beds, but that eventually, in the future, it probably, too, will become a great institution.

Now, do you encourage it to go up to 400, 500, 600, 700? There is need out there. Or when a great institution in downtown New York where there is a surplus of beds wants to go from 1,000 beds to 1,300, you just give them your papal blessing because they are so-called great hospitals? You tell them, O.K., automatically, go an extra 300 beds where actually those 300 beds you could put up a good argument they should be in Bronxville or Queens or some other place?

DR. HALDEMAN: In other words, you are entering another

dimension, the suburban and central city.

MR. PETERS: I have been talking primarily in terms of what I know about the most, New York City. Getting into the suburban area, you have an entirely different problem, no question about it. You certainly don't expect them to come from Poughkeepsie to go to downtown Manhattan to get their medical care. You have to provide a lot locally and no questions about it. You are going to have to strengthen the suburban hospitals the best you can.

But when you come to the other problem you mentioned, there are decisions you have to make.

MR. COUSIN: The decision we have in our area, Ford Hospital came to us and wanted to put up 300 or 400 beds. We have to admit it is a great hospital, but on the other hand, it is in an area where we have got -- I can't remember offhand -- 2,00 or 3,000 surplus beds.

MR. PETERS: I would tell them not to do it, then, if you can get away with it.

DR. KLICKA: If we can ask Mr. Peters to summarize the points of strength of implementation and the points of frustration, areas that he wished they had greater support than frustration, see if he can put them into a concrete ball of wax for us here.

MR. PETERS: I would say one of the things we wish we knew about the most is we could know the plans earlier,

the plans of all the hospitals, what they intend to do, because I think this is one of the things we are weakest on. We don't find out about things until it is too late to do anything about them. And if we could have a mechanism whereby we would be assured that -- I am not talking about after the plans have been approved by the Board; I am talking about when the first seed comes in somebody's mind -- we would like to do something that we would know about it and we would be able to give our reaction to it. I said, "our reaction", either our approval, disapproval, caution, or whatever we want to do. But if we could get a mechanism where we could get that for all the hospitals, I think we would be a great step forward. It wouldn't solve all our problems by any means, but it would certainly be a great deal better than what we are doing now because now we find it is half done sometimes.

MR. SIBLEY: You must have that for a very high percentage of your hospitals already, don't you?

MR. PETERS: Yes, but we don't have all of them.

MR. SIBLEY: What you mean is you don't have every one. You have a lot. You sounded as if you didn't know.

MR. PETERS: We don't have them for all of them.

MR. SIBLEY: You have got to find ways of cultivating the hospitals that so far haven't cooperated.

MR. PETERS: I am talking about at the present time we get a great deal of it through our inventory. Once a year,

we take an inventory of all hospitals, and we ask them, "What are you planning to do?" A great deal of the information we get has already been approved by their Board. They have hired an architect or they have got a consultant working. We would like to get down even before that.

MR. SIBLEY: I agree, but once a hospital sets up a master plan for itself, you are pretty much aware of what direction it is going.

MR. PETERS: Yes, but it maybe would not be what we would like to see them do.

MR. SIBLEY: You do on a master plan.

MRS. COLEMAN: We don't get that.

MR. SIBLEY: I realize this is one of the techniques we are talking about, certainly. One Hill-Burton agency I know of will not consider a hospital proposal until they have seen the master plan of that hospital.

MR. PETERS: There are darn few hospitals in New York that have master plans in that sense.

MR. SIBLEY: This is long-range.

MR. PETERS: Very few of them do have.

MRS. COLEMAN: When they apply for Hill-Burton, that's narrow.

MR. PETERS: It is much more the immediate program.

MR. BUGBEE: I think there is one point to be made here, though, about reviewing. And I think Rufus is beginning

to get individual plans. The New York area exaggerates it, but everyone of them, you can't just read a plan and say yes or no and add any depth to it. If you are going to go out and really look into it, you are talking about a lot of staff time as well as a good deal of wisdom.

So if they all came at you, I don't know what you would do because you can't hardly cope with those that do come to you as a staffing job.

MR. PETERS: Certainly, if they gave me all the plans tomorrow, we would probably put them all in the file case because we don't have the staff to analyze through and pick up as we need it. But as we grow and develop, I would hope we could get this type, being advised as early as possible as to the planning of each individual hospital.

DR. ROREM: I would like to make one observation there. I wouldn't think you would have to be completely frustrated if you got a flock of plans. Just an arithemtic alignment of what they added up to would probably show you it was impossible and just to let the other hospitals know that the one up the street is planning the same thing you are has a tremendous chilling effect.

The very first thing we did when we got in Pittsburgh, we did this. We asked for the plans. It added up to a tremendous amount of money, in this case, a small area, $90 million and 2,000 additional beds. We just added them up. We didn't

evaluate them at all. And we reported them to the group, this advisory committee as a whole.

You would have thought, goody, goody, think of all that money. They said, "My god, we will all go broke together." That was the reaction.

MR. BUGBEE: It sounds like to you are answering: "I am not right in this." You may be able to make such an answer, but when you come to work with them as alternatives, then you are just not talking about an office procedure by a long shot.

MR. COUSIN: Another problem you get into, because we did this very same thing. We did just add them all up, and we came out with a $125 million. What did this do? This had a chilling effect on the voluntary, the truly voluntary system, particularly the corporate givers. But it had a blow-torch effect on the hospitals that didn't intend to ever hit the corporate givers anyhow.

We didn't do this, but what happened was that the better hospitals had to suffer about a six-year moratorium before they could get any money while the Hospital Council studied the situation. But approximately an equal amount of unsatisfactory beds of a quasi-proprietary nature were built.

MR. BUGBEE: What conclusion do you draw from that, Jack? What do you mean? You would be opposed to announcing the $125 million until you had your study or --

MR. COUSIN: No. I think we finally resolved the situation, but it was after the horse was stolen. And that is, we got the Blue Cross eventually put through its standards that they wouldn't take anybody on as a participating hospital until they had been approved. So now, if we were to announce $125 million worth of construction, any of these guys who do not intend to hit the community for philanthropic funds or even hit Hill-Burton, they would still be faced with the fact that if they built their hospital, they would eventually have to go to Blue Cross for participation and Blue Cross would turn to us, and we would say we never heard of this hospital.

DR. HALDEMAN: What type of hospital?

DR. KLICKA: I would answer that more specifically because we have the data, and we wouldn't publish it for this reason. The very worst thing that we have in Chicago is the State survey and planning as an example of this because we think it exaggerates the need for beds in our whole metropolitan area. And the people who shouldn't be building beds are continually pointing to this State survey and plan as their justification for doing it.

MR. PETERS: I can tell the New York City experience with the same thing. They had a meeting just the other day on this very subject.

MRS. COLEMAN: The problem is we have a high figure on bed requirement on the State plan, and we know it is high.

FR

I am quite sure that if our beds were properly distributed, we could lower the bed requirement figure by as much as perhaps 4,000 beds. But the point is we do not operate under these circumstances.

We have too many maternity beds. We have too many specialized beds in specialized hospitals. We have too many beds in small hospitals. And under these circumstances, we do need approximately what is called for in the State plan.

Doug Coleman raised the point that the people are quoting this figure to him, this bed requirement figure. So we sort of compromised on disclaiming the figure by a footnote. Actually, it shouldn't be used as a planning figure. It is what we need now.

FR

MR. BUGBEE: Are these Hill-Burton figures, the beds per thousand ratio without adjustment for use, or what are they?

DR. HALDEMAN: No, even with adjustment --

MR. BUGBEE: Still high.

DR. HALDEMAN: -- they are still high.

I don't think the purpose of this meeting is to go into Hill-Burton planning, but we are working very hard, as you know, George, revising our procedures and policies. We want to get away completely from ratios. We want bed need determined on the basis of projected population, taking into consideration utilization by major service.

The main problem is the small one, even in New York

City, lack of manpower. The tendency on the part of Hill-Burton agencies is to go in and study areas that they know they are going to have to project in the next two or three years, and they are kind of treading water with this thing.

As a result, here in Washington, D. C., for example, Hill-Burton plans for Maryland and Virginia greatly overstate the need in the suburban areas which are growing rapidly and can take additional beds. But at the same time, you can go to the plan, and it is very unrealistic planning.

Getting this thing over onto a more realistic basis is a more complicated thing than we had originally anticipated. We have had a committee meeting almost monthly now for about a year and a half particularly considering such things as, first, what is the definition of a bed capacity because Hill-Burton agencies have agreed to develop a uniform bed capacity so one State's plan can be realistic in terms of another State's plan.

For instance, if you just change a minor definition on State plan, you may overnight change the bed need factor by several thousand beds.

Secondly, the definition of suitable or unsuitable has varied all over the place. California until this year hasn't admitted there is an unsuitable bed in the State from the standpoint of fire safety. If they license it, it is suitable. Whereas in New England, about 20 per cent of the beds in the

State agencies are declared unsuitable. And this is an extremely complicated subject which we are moving on as rapidly as we can, but which with the present state Hill-Burton agencies staffs is going to take time to develop in each community because there is no substitute for detailed study of the individual community.

Now, our hope is that the areawide planning agencies are springing up all over the country literally. Today, we invited purposely representatives from areawide planning agencies that have been in existence and had some experience, but we have got, as you know, a large number of agencies that are coming into being.

DR. ROREM: Did you count the list that Hi sent us, 21 full-time and 19 part-time?

DR. HALDEMAN: What will happen five or ten years from now, I think will be much different, and I think in most instances, the State Hill-Burton agency will utilize the plans as developed within a State.

I think the State agency is faced with developing areawide planning agencies that will approach a problem somewhat consistently.

You take Ohio, Columbus, Cleveland, Akron, Cincinnati, all use different definitions of what is beds or different principles in evaluating projects, not that every community has to do the same.

And I think what has been said today illustrates the fact your approach in areawide planning has got to be different according to the characteristics of your community. But there are certain overall principles, at least. These certainly are going to be tremendous when they start handing out the money for a modernization program because Cincinnati might get twice as much per capita merely on the basis of your criteria for evaluating obsolescence being different in one community than in another. But this is a hard pull.

Now, we have not given any demonstration grants in areawide planning where there hasn't been a cooperative arrangement worked out between the State Hill-Burton agency and the local areawide planning group. I don't think they can completely give up their responsibility, the State can't, but I think in almost all instances, they will take the recommendation of the local areawide planning agencies.

MR. DRENNAN: This past year, we worked very closely with the boys in that. The weekly utilization, we turned up occupancy rates and utilization they used in formulating the areawide State planning as far as our particular area was concerned.

MR. BUGBEE: Did it change the bed requirement?

MR. DRENNAN: Slightly. It reduced it because we learned a lot about occupancy rates of small hospitals and so forth during the past year.

DR. HALDEMAN: I think we have got a lot more to learn about what constitutes bed need. We have had two national conferences on this subject which at least from my point of view -- I don't know how you felt -- it showed up the problem areas more than any solution because I can't for the life of me understand why Indiana should only have 2.7 beds per thousand and Missouri have 4.5 beds per thousand. There is the same disparity between Idaho and Montana, for instance. And it isn't all in connection with the way they determine what is a hospital bed.

There are some factors we simply don't know about. That's why I feel so strongly that bed need should be determined based on a local study, using utilization, but using judgment factors that can't be derived from figures.

Because if you get a new highway going out in an area, it is going to have an impact, or, you know, a big industry is coming in. Those things aren't derived from statistics.

In the last analysis, bed need, I think, in the light of our present knowledge has to be the analysis of available data plus pooled professional judgment.

I think perhaps we should break for lunch. Let's try to be back at quarter of two.

(Whereupon, at 12:40 o'clock p.m., the meeting recessed, to reconvene at 1:45 p.m. the same day.)

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AFTERNOON SESSION

1:45 p.m.

DR. HALDEMAN: The meeting will convene again.

Are there any further questions any of you want to ask Joe Peters about the New York program?

Anything further, Joe, that you or Ann would like to add?

If not, I think we ought to go on to Sue Jenkins and see still another distinct variety of planning activity.

MISS JENKINS: I will try to make this brief because we are dealing with a much smaller area and problems that look big to us, but I can see them shrinking in size. This is a consoling thought.

SR

I will briefly describe the characteristics of the area, the hospital and nursing home situation of the planning agency, the methods of implementation, and share with you some of my apprehensions about some of the points of establishing priorities and in the possible light of coming Federal funds for modernization I should like to share them with you, too, if I may.

Our area is one of 1,200,000 people involving five counties in two states; three counties in Missouri, two counties in Kansas. In that area there are twenty-two hospitals if we include our Veterans Administration Hospital and our United States Air Force Base Hospital which are not involved

in planning except the USAF hospital was and wanted to add twenty OB beds and we stymied it through contacts of the Bureau of the Budget in Washington, they did not think they had the OB beds.

These twenty hospitals range in size from the smallest of forty-five beds to the largest of 500 beds. There is one medical school hospital there at the present time, the University of Kansas, which draws its patient load from all over the State of Kansas as well as the metropolitan area and Missouri.

A new and illuminating factor which Dr. Haldeman is very familiar with and has served as consultant to is our municipal hospital system which has gone under a private voluntary board operated under contractural relationship with the city which now is affiliated with the University of Missouri School of Medicine presently located in Columbia but extending post graduate work and looking ultimately, Jack, in the last few weeks even towards the faster coordination of a medical school in Kansas City.

We have no proprietary hospitals with the exception of one little twenty bed osteopathic proprietary hospital. We have succeeded in killing three proprietary projects. We do not anticipate that we will always have such a good batting average.

DR. HALDEMAN: How did you kill them?

MISS JENKINS: Two of them through the planning

agency. One of them in the suburban areas simply by communications with and about a twenty-page report to a couple of the medical leaders simply scared the pants off of them about the possibility of their ever being able to operate at a financial level that would permit it to pay itself out. The other two through simply conferences with the planning group which we were able to persuade them not to go ahead with it. We do have the two Federal hospitals, the USAF Base and of course the Veterans Administration hospital.

This five county area contains the four city and all suburban areas. The suburbs do not yet go beyond the periphery of the five counties. We do have a very close relationship with the two state Hill-Burton agencies; an excellent one with Kansas, not too good with Missouri, but at least a working relationship. We have been dealing very heavily in the past six months in the nursing home picture where we are ceding, as most urban areas are, a tremendous surge of the building of the proprietary nursing home, many of them with FHA secured loans or reaching through the Small Business Administration, some with private financing.

The planning agency itself was established by the hospital organization.

DR. KLICKA: You do not get into the control of that at all?

MISS JENKINS: The what?

DR. KLICKA: The nursing home field.

MISS JENKINS: Yes, indeed. We are working almost exclusively.

DR. KLICKA: You have approved them?

MISS JENKINS: In Kansas we have a relationship with the State of Kansas that they will not approve any nursing home project in the two county urban area on the Kansas side that does not have our approval first.

DR. HALDEMAN: What is that?

MISS JENKINS: They try to make it for licensing. If private finance comes in and wants to build in that area, they check first with the Kansas State Board of Health, their Facilities Division, for what they will require for life insurance and so on. They are referred to us before the Kansas agency will even talk with them practically. Whether we could stop them has not come to a test yet of those that are totally privately financed so we have not had any built yet.

For FHA they have to have our approval on the Missouri side. We could not get the state to say they would not issue a certificate of need unless a need could be demonstrated. They blanket issue a certificate of need in Missouri. Simply, if their quota says there is a need, they issue it. We got around this by establishing really a very fine working relationship with the FHA people who have decided that they

will not talk with them until they have come and talked with us and had a report on it.

MR. BUGBEE: Have you said no to anybody?

MISS JENKINS: Yes, to I expect a half dozen.

MR. BUGBEE: Not on need but on sponsorship?

MISS JENKINS: Actually we are right up at what we may consider the top area of need insomuch as the market demand indicates this because most of these big promoters are coming in with a high priced home up in the four, five, six hundred dollars a month bracket. We have a report we will be sending to you hopefully within the next week to ten days of a research study in which we cooperated with community studies on the market demand for nursing homes which gives a pretty fair picture of the existing licensed homes, all of those that are projected and those that are in the process of construction and those that are in the dreaming stage and have just barely contacted us about them.

We have gone into, I think, a pretty fair analysis of demographic data, income brackets, those on old age assistance, what the Blue Cross plan does, what the insurance programs do and so on. We have been dealing then with a planning agency that is involved in facilities and services in the hospital and nursing home area. We have not gone beyond that.

The planning agency itself, the planning committee, the basic committee, is a fifteen man committee which has been

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functioning since 1957. It is required that a majority, actually I think nine of the fifteen, are now totally non-hospital related individuals. We are most inadequately staffed. The staffing is a little different than it looks on paper in that we do have a very able and very highly recognized non-profit research organization in the area of community studies incorporated with whom we collaborate in research and who produce some research for us. We also have a relationship with the Blue Cross plan which provides us mimeograph, address-ograph, photocopying, handling of all mail and all this type of thing which we do not have to staff for.

Blue Cross does all of our IBM work, all of our statistical work. We do have a continuous reporting program which is now in its seventh year, and this is all on IBM and is maintained for us by Blue Cross.

SR

The planning committee functions in a relationship to the hospital organization in, I think, a very comparable way with Jacques Cousins in Detroit. He has complete economy; it is not controlled by vested interests, it is not a corporate structure, it shares staff and it is inadequately staffed.

MR. BUGBEE: You are going too fast. I thought there was one structure that did both.

MISS JENKINS: Yes.

MR. BUGBEE: You are doing both?

MISS JENKINS: Yes.

MR. BUGBEE: I see. But in spite of that 50 per cent of your board is public members rather than hospital members?

MISS JENKINS: No, the planning committee must be maintained at over 50 per cent non-hospital related.

MR. BUGBEE: I see.

MISS JENKINS: The over-all board of directors of the hospital organization is a public trustee medical staff and administrative.

DR. HALDEMAN: Does your planning committee report directly to the public?

MISS JENKINS: Directly to the public, never to the board. It makes no report to the board, it has no strings to the board at all. Its principal relationship to the board is that the board has to see that it is provided with staffing. The board appoints the chairman, no others of the planning agency.

MR. BUGBEE: Who does appoint him?

MISS JENKINS: Actually, the nucleous of the planning committee was first named by the board. Beyond that it is a self-appointive body.

MRS. COLEMAN: Responsible to whom?

MISS JENKINS: Responsible to itself and the community I should say. It is no different than if it were separately incorporated actually in this respect. Represented on it are trustees and physicians but it is dominated by your industrial

and your civic representatives.

It was possible to get at least all of the major hospitals to develop their long range planning committees. The first couple of years actually the function of this planning committee was conferences, not only one but several, with each individual hospital regarding the development of the planning committee in an effort to determine to the extent the planning group could the desires and aspirations of this particular hospital; the direction it hoped to go, the type of service in which it was interested, whether it was in expansion of its teaching programs, development of research and the chronic long term care or what it might be.

We have certain peculiar problems, the osteopathic thing is one of them. Jack, I did not realize you have this to the extent you apparently have. We have in Kansas City one of the osteopathic colleges, of which I believe there are still five in the country, are there not?

DR. HALDEMAN: Michigan is trying to establish another one.

MISS JENKINS: Are they really?

MR. COUSINS: Yes.

MISS JENKINS: Where?

MR. COUSINS: In Michigan.

MISS JENKINS: Goodness.

DR. HALDEMAN: Of course it is quote possible that in Kansas City that this osteopathy school will become the

medical school at the Kansas City Medical Center.

MR. BUGBEE: Kansas City?

DR. HALDEMAN: Yes. There is talk of it.

MISS JENKINS: We have encouraged it. We have had the municipal system actually have four hospitals, now have three. They did have General No. 1 for white and General No. 2 for Negro. It has been integrated for several years now.

MR. BUGBEE: Which state is that?

MISS JENKINS: Missouri.

Actually, we have in the area four major municipalities. There are some eighty lesser incorporated municipalities that make up the urban comples in this area.

MR. BUGBEE: Does Kansas City, Kansas, have a municipal?

SR

MISS JENKINS: No, Kansas City, Kansas, has a long and conditional relationship between the hospitals and the care of the patients, also the University of Kansas City. The University of Kansas has done a great deal of this work for the Kansas side. The Missouri side has had the General Hospital which is now the General Hospital Medical Center.

The osteopathic situation is one of the problems of planning. We have fewer than one one bed for osteopath and five for the MD's. There is no crossover at the present time except out in the region. Not within the planning area but within the region we have some of the small county hospitals with both the

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MD and osteopathic on the staff.

As Dr. Haldeman mentioned there has been some talk, and we have been doing some talking, about the Kansas City College of Osteopathy and Surgery forming a nuclear of a new medical school. Whether this can come to fruition, Jack, within the time necessary is the factor there. There does not appear to be the major resistance of the organized medical profession against it that there was, say, even five years ago.

Another problem relates to three very small Negro hospitals in an area that has made very forward steps toward integration within the past ten years. Each of these Negro hospitals wants the community to build a new hospital, each three times the size that it presently has, when they are running two of the smallest ones, only about 40 per cent occupancy at the present time.

SR

This is a difficult one to deal with, not in size but in all of the sociological aspects of the thing. We are hopeful, Jack, that we can help resolve the Negro thing through the General Hospitals taking pay patients. Many of the Negro group that are in the largest of the small Negro hospitals, 100 bed, are very marginal cases. This hospital is operating at four dollars per day below its cost structure and its charges at the present time without any means of supporting it financially except the Catholic Diocese. We are hopeful that the small segment of the Negroes who do not have a place to

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practice may be accepted by the General and thereby manage to close.

Somebody here commented how difficult it is to close a hospital that has ever had existence. If anybody knows any easy way to go about taking out an entity that is in miserable financial condition, that is carrying a far below optimum patient load and all and still take them out of existence, I don't know.

Of this group of hospitals there were only two specialty hospitals, one a children's hospital and the other a 75 bed psychiatric hospital. The children's hospital situation has been reasonably resolved again through the really very good work of the planning agency in that it will affiliate with the General as a part of this Missouri University complex now.

SR

DR. HALDEMAN: Not only affiliate, they are going to replace the two hospitals with a single physical structure.

MISS JENKINS: What are you referring to as the two hospitals?

DR. HALDEMAN: The children's hospital and --

MISS JENKINS: You mean Mercy?

DR. HALDEMAN: Yes.

MISS JENKINS: That will provide the facility. It will maintain separate operation, however.

DR. HALDEMAN: But there will not be a duplication

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of kitchen or X-ray laboratory or whatnot. At least, that is the hope. I thought that was nailed down.

MISS JENKINS: I thought it was nailed down, too, but it is not nailed down at all. They are even saying they are going to build their own labs, X-ray, kitchen and everything else.

DR. HALDEMAN: It is very interesting experience where we talk for a day and a half, a half dozen foreigners sitting down with the planning group and the board trustees of these two hospitals, and at the end of it I thought they had agreed to build only one new structure and maintain the identity of Children's Hospital.

MISS JENKINS: But to share, not to put in laundry, not to put in power plant. They are still abiding by these two. They are not abiding by the fact they are not going to have their own X-ray and their own laboratory and their own kitchen and all that, except a factor coming to light within the past two to three weeks may reinstate your hopeful prognostications on this.

SR

This hospital first was talking about 200 beds and the planning committee kept pushing them back and pushing them back on it. They decided to build 115 beds. They have 103 beds at the present time and the General Hospital and Medical Center has 40. They agreed upon 115 finally. It was not easy to get it to that but they came out that this 115 bed hospital

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was going to cost $5 million. They started on a fund drive for three and a quarter million dollars saying that the balance would come out of their endowments and what they could recover from some of their properties at the old site. The fund drive has been going on for many weeks now and instead of just pouring money into it, Jack, as they felt the community would do, they have about $700,000 on the three and a quarter million. It is not likely, perhaps, that they may be able to go beyond a million on the fund drive.

MR. BUGBEE: Did your agency endorse their fund drive?

MISS JENKINS: Yes. Not for that amount of money, I am sorry. I should not have said that, George. They endorsed the project because they had over a period of three years a very strong hand in the location of this hospital. It had intended first in locating in a relationship with the University of Kansas Medical Center. We very strongly opposed this for some very good reasons.

SR

Missouri will not pay any welfare payments outside the State of Missouri at all. They would have lost their whole welfare picture out of Missouri, they would have lost much of their properties in Missouri. They have some very fine acreage in Missouri but a good portion of this would have reverted to the heirs who gave it to the hospital had they moved the hospital outside the state.

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MR. ROREM: Did you give the area and number of hospitals before I came in?

MISS JENKINS: Our area is one of 1,200,000 people involving five counties in two states. In that area there are 22 hospitals representing approximately 5,000 beds.

MR. ROREM: Thank you.

MISS JENKINS: The 22 hospitals include the United States Air Force Base hospital and the Veterans Administration hospital.

MR. ROREM: Are they big?

MISS JENKINS: The Veterans Administration hospital is a 500 bed hospital, it is a very little hospital, and the Air Force Base 50.

SR

MR. ROREM: How many?

MISS JENKINS: Fifty, somewhere around there. It may even be fewer than that. All we know about them, as I mentioned, Rufus, they wanted to add 15 or 20 beds to the OB departments and all the OB departments on the south side of the city were running a low occupancy. We could not get anywhere with them so we went to the Bureau of the Budget and they never got the appropriation for it. That was a sneaky thing to do and I do not know yet whether the USAF hospital knows we did it or not. All they know is that they did not get their money. It would have been rather pointless, really, because most of these people on the base live in the city anyway.

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DR. KLICKA: I take it you did not send it to the hospital.

MISS JENKINS: We did not. The hospital is our member and one of our dues paying members and one of the most cooperative in the Hospital Association that we would hope to have. We felt like heels about it. They were very fine to work with. We felt like heels about the little sneaky deal.

MR. BURLEIGH: Don't feel you have it licked yet.

MISS JENKINS: This is so little I cannot imagine Congress concerning itself with it, frankly.

The osteopathic problem and the Negro problem and the problem of how you develop in harmony and in coordination with a private voluntary hospital system a new medical center

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and potentially a new medical school is a very difficult thing. We have had very little cooperation and planning from the University of Kansas Medical Center because it serves the whole statewide area. We had our first request from them here within the last six months when they felt that the planning committee could be of help to them.

The Shriners were going to build four burn centers over the country, and one of them they were thinking about building in Kansas City, Kansas. K. U. came right straight to us to exert what pressures we could on getting this institution in connection with theirs. It is a small number of beds which would deal with out of area patients entirely.

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The planning agency approved it and K. U. thought it was wonderful. The next time they want something they may be back, I don't know.

With the General Hospital and Medical Center their cooperation with planning has been excellent and I think it will continue to be so. It represents problems which frankly we do not know how to cope with and which the private voluntary hospitals of the area are extremely apprehensive about, Jack, as you could well imagine, in the taking of pay patients, part pay patients and so on in this big facility.

MR. BUGBEE: Is your area over-bedded?

MISS JENKINS: It is over-bedded on general beds. We have never had a problem with Hill-Burton regarding general beds because we have not had a priority for a general bed in the area since 1949 except that we did work with the two state Hill-Burton agencies in the redistricting where Missouri had a base area line that cut right through the corporate municipality of Kansas City, Missouri, and in the Kansas side the the two counties of Johnson and Wyandotte. Johnson County, the suburban county, where the population shoves right up against the line, that was a base area line and we got them to revise their base areas to include the five county, two state area as a single area for planning. That was good cooperation.

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Jack, didn't you sit with the planning committee

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when they heard Shawnee Mission of the suburban area in Johnson County that already had a Hill-Burton grant approved and they went ahead and built a 65 bed hospital in the suburban area to which we were opposed not only in conference but publicly and through public disclosure they built it anyway? It is interesting to note it will probably be the best example of what not to do in suburban areas that we have.

They built a 65 bed hospital and a nursing home. They cannot get the occupancy of 80 per cent of the nursing home. The occupancy of the 65 bed hospital has been running 40 to 50 per cent. Their financial problem is simply incredible. They have been open a year and they have not even paid for the roof that went on the nursing home which was the first unit that was built three years ago. They are operating at

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$43 a day on the short-term hospital where the hospitals with a full array of service are $35 to $36 a day. They are going to add 75 to 150 more beds, they say, if they could get anybody to finance them. I would say their costs would shoot to at least $50 a day on the thing.

MR. BUGBEE: How did they get the Hill-Burton grant?

MISS JENKINS: They got the Hill-Burton grant before this redistricting was done when the line was still one county and one district and another. The grant was secured about 1958 before we got the redistricting taken care of, so they went ahead and built. I don't know, we now are probably going

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to get them back before the planning agency with, What do we do now?

There are two or three hospitals that would have some willingness to attempt to operate a satellite operation on this but taking this indebtedness would be a horrible factor. I don't know how they would live with it. I don't know how they are going to live with it.

MR. BUGBEE: Who loaned them the money, insurance or banks?

MISS JENKINS: George, I don't know. I don't know. They have put out a brochure now to any financing house who will even consider this on a basis of refinancing. I do not see really how anybody can refinance it. Actually the factor is an implementation which is used or persuasion, public disclosure, where one has to. It is unpleasant and has not been done in two instances.

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DR. KLICKA: How do you do this, newspaper?

MISS JENKINS: Newspaper.

DR. KLICKA: Do you send out a release?

MISS JENKINS: Actually, one of the officials of the Kansas City Star, which is our only newspaper, is a member of the planning agency, one of the non-hospital related individuals on the planning agency.

DR. KLICKA: So he sends a reporter out to see you?

MISS JENKINS: In fact, he writes the story. He and

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I sit down and write the story with a reporter.

MR. BUGBEE: And I suppose you dramatize it on a television program.

MISS JENKINS: No. The largest voluntary hospital in the area was actually done by the reporter on this except it was the planning agency's decision to and this was not over any major thing. It was a hospital that desired to add in its modernization program 100 beds when it had been approved to add only 27 beds in a part of the reshuffle of the modernization program.

They went out for $2 million, hopefully going to get about $3 million. Their fund drive was completed over a year ago. They have not got the $2 million yet because we have a little control. That is your next factor in the implementation, indirect control over funds. Our areas, you probably all know, attempted to put on a united campaign three years ago and it fell through primarily because of one or two hospitals that felt they could get more money on their own, including this one big one really, but major industry is pretty well represented on the planning agency.

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For example, Ford and General Motors are represented with top executives of both and the corporate giver will not give unless the project has been approved by the planning agency. The report is issued to the hospital and condensed into a letter, and also a letter given to them which they

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quote from, use. One hospital in fact blew the letter up into a one page ad and bought advertising space in the Kansas City Star. This was research, Jack, on the big hospital. So you have some element of help and implementation there. We have a great deal of help, we feel, through the Hill-Burton agencies.

In Missouri if anybody files an application that we have not seen, we try to know what these are before they go in. The state Hill-Burton agency advises us and furnishes us with a copy of the project. We may then call the hospital in and talk about it. We give a report to the state on every project which is before them, and up to this point neither state has ever approved one that we said not to approve. I think again this is possibly luck in good part but they have never approved one over our state disapproval.

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MRS. COLEMAN: How do you state your disapproval? Committee action?

MISS JENKINS: Committee action.

MRS. COLEMAN: A letter to the Hill-Burton agency?

MISS JENKINS: A report, yes. We write a report on each project.

MRS. COLEMAN: At the Hill-Burton request?

MISS JENKINS: Yes.

The nursing home situation, as I say, is one that is creating a great deal of problems. Many hospitals have desires

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to move in the direction of chronic and long-term care in the nursing home and so on. It takes a hospital so very much longer to plan a project than for Holiday Inn to come in and say we are going to build three of these now, United Convalescent Hospitals in California say we are going to come in and build a big one.

MR. BUGBEE: Is that proprietary?

MISS JENKINS: These are all proprietary.

I think we have heard from most of them but the real problem is if you approve very many of these you do satellite your area with nursing home beds. Then when a hospital comes along probably we have one hospital that has been working for five years in cooperation with the planning agency on the development of long-term beds and it is a hospital that is

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adjacent to another big hospital and we started them on the road toward an urban redevelopment project which would clear a big area right in the center of Kansas City and let them share parking lots and laundry and various things and let this one hospital build a sizable number of nursing home type beds. It has taken them five years to get their plans in shape practically for this, and by the time they get around to asking for Hill-Burton money we may have filled the area with proprietary nursing home beds.

DR. HALDEMAN: Sue, isn't it really skimming the cream off the crop; they have filled up the demand for those

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that can pay three or four hundred dollars but you still have this group of public assistance and others that cannot afford three or four hundred dollars that have a real need?

MISS JENKINS: That is right. This is what our report will show. However, we are getting some proprietaries. We had a staff conference with one just a couple of days ago that wants to move into the urban area operators that operate two homes in small towns in Kansas, very good homes. I mean we checked their operation, checked them out with the Kansas State Board of Health. They are going to build facilities that will price $130 to $200, possibly $250 at the top.

MR. OREM: What is that?

MISS JENKINS: Nursing home care. These are the ones that we want to encourage and do encourage. The ones

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that are asking four, five and six hundred dollars a month are going to lose their shirts, I don't think there is any question about it. They still make your area look as if you have an adequate supply of nursing home beds under Hill-Burton when it comes to approving hospitals, do they not?

MR. OREM: I have a theory that the nursing home problem is going to be solved not at all by voluntary philanthrophic services but by actions of the two extremes, straight commercial investment for profit at one end and governmental institutions at the other end. I think we can make some passes maybe here and there where it can be done reasonably

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well. A general hospital might have a unit.

MISS JENKINS: I think it is a limited number probably.

MR. ROREM: I bet that is not going to be the problem.

DR. HALDEMAN: Apropos of that, Rufus, I was very surprised at our recent survey of homes in the nation. It has not been published yet except for the summary that showed the number of nursing home beds has almost doubled since 1954 when we did our last survey but the ratio between non-profit, government and proprietary has remained almost constant. I thought the trend would be a higher percentage. Still about 7 out of 10 beds are proprietary and about 9 out of 10 homes are proprietary. So you cannot analyze them that way, you do not detect the trend.

SR

MISS JENKINS: Yes.

MR. ROREM: You do not detect it towards non-profit?

DR. HALDEMAN: Either way.

MR. PETERS: They are keeping pace with each other.

MR. ROREM: It varies.

DR. HALDEMAN: Take Minnesota, for instance; 70 per cent of the beds are voluntary.

MISS JENKINS: I don't know what the answer is going to be. I am surprised at the naivete and lack of sophistication of some of these big promoters on nursing homes who really

have not the slightest concept when you sit down and talk with them of what it is to provide care. They think of it in terms of another motel and you hire an RN to be around once in a while and that is the limit. At lunch time I asked if they have a recreational program and they said yes, they have a swimming pool.

I don't know. These are all in anticipation that there will be a Federal program that will pay nursing home care for the aged and they simply want to be in there and on the bandwagon. We really feel if we can provide enough information showing what the market demand is in the area that they may quiet down a little bit in the building of this more expensive type of facility; at least they are reasonable to talk with.

SR

We are spending an immense amount of staff time in talking with them, I never saw so many people in my life. They apparently want to start building nursing homes. In Chicago I had seen a tremendous surge of building. Carl, you no doubt wish to comment on that. I talked to Miss Nickelson in Chicago a week or two ago and she bore this out, the low occupancy in these beautiful big new homes and how they are going out and building back to back and in areas that could not possibly sustain them.

DR. KLICKA: There are 2,000 empty beds and the trend is to convert them into hospitals.

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MISS JENKINS: This would be the most alarming thing we might run into in this.

MR. BUGBEE: Portable X-ray.

MISS JENKINS: We do not have the support of Blue Cross that Jack has in Detroit. We hopefully are moving in this direction. If we can get our Blue Cross board to have the courage and the guts to go ahead with something on this, this is what it certainly is going to require. All that we are doing now, Jack, is a bit of a cutback on this Shawnee Mission. They are taking a cutback under a special contract at Blue Cross which causes them to lose more money as they go along. I think when Jack reports to you his story on the decision in Michigan on this maybe it will persuade more Blue Cross plans to do this.

SR

However, when we move into the era for funds for modernization in the urban areas and priorities, I can see this develop as one of the finest dog fights we could ever expect to have, and I am sure this will occur in any metropolitan area. Surely there will not be enough money to do any more than a drop in the bucket job at the start on a program such as this.

MR. BUGBEE: Such as what now?

MISS JENKINS: Federal funds for modernization and renovation of aging hospitals or plants.

MR. BUGBEE: You have plenty of them?

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MISS JENKINS: Yes, we have plenty of them. How you will decide who is up for grabs on this money is going to be an extremely difficult thing. In our area we have a big new General Hospital and Medical Center going up with a replacement building and medical school. Undoubtedly they are going to feel they ought to get these funds; they are already saying this when they come through.

You have some hospitals that are going to have trouble getting matching funds for money. Maybe their need is very great, maybe you cannot do very much towards seeing that they get matching funds for it.

David Willis posed a question over a good hot sandwich during lunch, at a delicatessen incidentally, Should this money become available, do you spread it through your area

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giving a little piece here and here and here, or do you try naturally to determine priorities and try to do a full and complete job with one of them if your money is limited? The determination of priority such as this concerns us very much. Hopefully I thought some of the great brains around this table would have some very enlightening ideas about it.

MR. ROREM: You came too late. Three years ago we could all have told you.

MISS JENKINS: Really, it is I think a very serious problem. If Uncle Sam were going to cut loose with enough money to do a complete job with all urban areas in the country,

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this would not pose any problem realizing that it will be an infinitesimal fraction of the job to be done. If you do get such funds, then the determination of these guide lines for priorities become very important. If you don't get them established and reasonably accepted, you could break up some very good planning agencies over this type of thing.

DR. HALDEMAN: You have several communities that have had to face up to that and have faced up to it. We have one here, Columbus, Ohio. You may not agree with their solution but at least they faced up to it. Rochester, New York, is another one that has.

MR. BUGBEE: I think you are a little pessimistic, Sue. I think a little money might be able to cope with it better a little at a time than it might all at one shot.

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MISS JENKINS: Frankly I would like to cope with it a little at a time, even in an area no larger than ours. We are not very apprehensive about it.

MR. BUGBEE: I did not mean to indicate you were not entitled to that.

DR. HALDEMAN: Any questions?

MR. BUGBEE: For the minutes, I think the long range planning committees in each hospital -- I do not know that Rufus' Appendix B answers all the problems but it is an awfully nice outline of how to constitute such a committee. If they ever write this up and want to look at it, it is in his

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Alleghany County book, Appendix B.

MR. BAUM: On your fund raising campaign that you are talking about, was this not conducted at the same time in Kansas City, Kansas, or Kansas City, Missouri?

MISS JENKINS: On a united effort that did not get off the ground, is that the one you are referring to?

MR. BAUM: It did not get off the ground?

MISS JENKINS: No.

MR. BAUM: That answers my question.

MR. BUGBEE: You mean by that you never got to the money raising part?

MISS JENKINS: It was a totally separate organization. It was a community organization, you see. It was not either our hospital organization or the planning agency, it was a community organization set up to hopefully get the capital funds necessary to implement the recommendations of the planning agency. The planning agency did not put price tags upon these projects. The community organization left much to be desired in its structuring.

SR

The planning agency in the area hospital association certainly endorsed it wholeheartedly. It did not get any job done, however. As a consequence each individual hospital went out on its own -- not each, several of them did. Out of the several that did and are still planning to go out on their own, only one of these broke the line with the recommendations

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of the planning agency. This was the one that went to the public disclosure and did not get all of its money.

DR. HALDEMAN: Any further questions?

If not, Dave, you may proceed to talk about the Rochester regional planning board or about Monroe County if you prefer.

MISS JENKINS: What is Monroe County?

MR. WILLIS: It is the home county for New York. It is a trade association made up of hospitals and related facilities, all of a voluntary nature and governmental, not private, covering eleven counties. It includes Rochester, no other very large cities, and some sizable towns scattered around Elmira and Corning.

SR

For some years the Council has had a relationship similar to the Hill-Burton which Mr. Peters had in New York. In Rochester though, unlike New York City, there was a trade association that had a planning function as a delegated representative of the state Hill-Burton agency.

Starting now the regional hospital council has set up a separate review and planning committee within the structure of the hospital council with membership of about forty people on this committee with a smaller steering committee of twenty people. The size of the committee structure I think is important as an asset and a limitation at the same time.

I think rather than tell you specifically about the

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projects that have been undertaken I would like to discuss some of the problems that I see in here and I think may be related to some other areas as well.

First as to the matter of whether or not an eleven county area wherein the central core of the area is about 120 miles away from its farthest point constitutes significantly a single service area, I think it is questionable. A three hour drive from one end to the other, especially when your medical center is that far distant, I question whether or not this can really be done to the fullest extent. The old concept of regionalization, if it is to get beyond just a matter of grading the size of facilities as you proceed out from the core and if it is to get on into a functional differentiation and rational utilization of these, has got to obviously depend upon medical organizations and medical staffing.

SR

All of the specialists in this eleven county area, or virtually all of them, are concentrated 120 miles away from the more rural areas. In the Rochester area it is a rather stable population. There are some developing suburbs, none of them mushrooming. It is largely a clearcut distinction between urban areas and rural areas. The rural areas jealously guard their differences from the urban areas and the county boundary is a very important social, political and economic unit to those areas.

Every time you have a committee, or at least the

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feeling so far is you cannot constitute committees based upon problems or proposed solutions to problems but you must establish committees based on geographical representation. With eleven counties you start off having at least eleven people on every committee. You then have within the urban area such a wide gulf between the medical school and the hospital and the other hospitals that you have a twelfth representative on every committee.

Then you must bear in mind that in New York State the Department of Social Welfare and the Department of Health have been battling for some time and the battle as assumed recently is a rather heated debate in the press and in any public meeting, so you have got to have in each of these counties someone from Health and someone from Welfare. So you are now up to twenty-four members on any committee.

SR

The matter of supervision of hospitals, some of the facilities are supervised by Welfare, some are supervised by the Health Department. I don't know, in New York City we may have been able to overcome some of this. In Upstate New York it has been rather difficult to date. Therefore, I wonder whether such a broad area necessitating such large committee structure for any action has not got in itself some built-in needs of its own making, but be that as it may I don't know yet.

We have the forty member review and planning

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committee which now acts as the Council's screening and approving body for all of Hill-Burton applications. The steering committee reports back to the reviewing committee which reports to the executive committee which reports to the entire board of the Rochester Council and then in turn to the state Hill-Burton agency. The Hill-Burton agency has really been quite wonderful. I just had my first experience in sitting with Jack Burke and seeing how they determine bed need. It is a weird and wonderful thing that defies description but I have not yet seen a formula which approaches it for good soundness of the end result.

DR. KLICKA: Those are inconsistent statements.

MR. WILLIS: We will argue later.

SR

The approach to date is that before they had a full blown planning function the Rochester area has been largely a numerical legalistic sort of planning, largely a determination as to the size and location of facilities with very little inquiring except into the content of medical care programs. Recently the major part of the retention has been developed to two essential problems, nursing home and related long term care facilities and psychiatric facilities.

Quite interestingly in the Rochester region these two problems have been brought to focus largely because of the presumed threat of proprietary facilities going into the area. Aside from a single psychiatric unit of Strong Memorial Hospital,

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which is the teaching hospital in Rochester, there is not one hospital in the entire eleven county area which will overtly admit patients requiring psychiatric care aside from the state institution. A proprietary group wanted to build a psychiatric facility and this caused a re-evaluation of the entire program. Now everyone wants psychiatric facilities, anything to keep the proprietary people up.

MR. SIBLEY: Did you put this group up to this?

MR. WILLIS: No, but I bless them for it. I cannot say that in Rochester but I say it here.

The same thing with nursing homes. I do not think this is unrelated to what Sue Jenkins mentioned there.

MR. ROREM: With respect to what? Who is concerned over sponsorship rather than service?

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MR. WILLIS: I think the Regional Hospital Council and the civil leaders have been taught to be more concerned with whether or not it is voluntary, non-profit or proprietary rather than is the service needed or do we have a better alternative now or in the foreseeable future. I think in Rochester we come up with the same answer that was implied in Sue Jenkins' comment, we would rather do without services than wait for non-profit.

MISS JENKINS: No, I did not mean to imply that. We have no objection at all to the good proprietary or commercial nursing homes, they are very helpful.

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MR. WILLIS: My charter does not admit proprietary facilities to its membership, which does not put it in a very good position to work with proprietary groups to encourage them to amend their programs and so on to fit in with some overall planning. The Regional Hospital Council has also taken sides in this fight between Welfare and Health.

MR. BUGBEE: Which side, the Health?

MR. WILLIS: Yes. They have publicly cast their lot with the Department of Health which means that they are on the outs with the Department of Welfare and get very little cooperation from that department which is the department overseeing most of the proprietary facilities. This is a kind of unfortunate situation. I do not know how you have handled this thing in New York City.

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MR. PETERS: We have not taken sides at the moment although if the vote were taken I think probably Health because of the composition of our board -- probably, I am not sure -- the state hospital association of New York.

MR. SIBLEY: So your association does not agree with your state association?

MRS. COLEMAN: Our group is not quite clear in its mind.

MR. PETERS: They might go for Health, I think.

DR. HALDEMAN: I was interested in the concept which I have never heard you enunciate, Hi, in implying that an area

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wide planning agency was a local arm of a state hospital association. You didn't mean that, did you? If we are consistent with our concepts, it seems to me we have to say it is an independent entity.

MR. ROREM: Are you pulling his leg or do you think he said this? I did not hear him say it.

MR. WILLIS: He took the position.

MR. PETERS: He said we are in New York State so therefore we have a New York State association.

DR. HALDEMAN: I think this is an important concept because I do not think an areawide planning agency should look upon itself as a sister organization, as another hat for the hospital association. It seems to me they have to maintain that relationship with the state hospital association.

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MR. PETERS: It is partly when you have the dual role like Jack has and Sue and so forth that you come in contact with the state association. We have no contact at all with the state association.

DR. HALDEMAN: I say it was in that context that you made your remark.

MR. SIBLEY: As long as it is in your state, that is all.

MR. BUGBEE: Since you are at a dead end, let me add one thing that has been on my mind for months. I wish we would stop talking about the trade associations when what

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we mean are the traditional functions of hospitals.

MISS JENKINS: Three cheers. I do not like to call them trade associations.

MR. BUGBEE: I don't know who started that. I do not like trade associations used for hospital associations. I trust they are not trade associations.

MISS JENKINS: We are not a trade association.

MR. BUGBEE: Member association.

MR. WILLIS: I agree with you, it would be nice if most of them were.

MR. BUGBEE: All right. Do you want to take over on another argument?

MR. WILLIS: Touche'.

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MR. BUGBEE: That is a dangerous viewpoint for planning.

MR. WILLIS: I would just like to add a few more points. To go back for a moment to the size of an area encompassed by one planning activity, we run into the problem that we span three different Blue Cross plans, four different medical society organizations in addition to eleven county organizations, three different Welfare Department districts, four different Health Department districts and so on. Whether or not this naturally forms a single area I do not know but it is difficult to margine all four. This will be true in any very large region I think.

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So far as the role of the hospital and planning goes, we are going to be aiming at much the same sort of thing that Dr. Rorem outlined, to get the hospital outlined in its own planning. Further, the idea is to get each logical grouping of counties to set up their own areawide planning council or conference which will be unofficially an arm of the regional planning group but can keep a greater contact with local problems, local needs and relate better both ways.

MRS. COLEMAN: Excuse me. How many people are in your area?

MR. WILLIS: About 1,300,000 in the eleven counties.

MR. ROREM: How many short term hospitals, Dave?

MR. WILLIS: About thirty-five.

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MR. BUGBEE: You say how many, 1,300,000?

MR. WILLIS: Yes. About 600,000 in Monroe County. It is rural area with a few little towns.

DR. HALDEMAN: I think you have to use one more statistic on that. How many beds?

MR. WILLIS: I don't know.

DR. HALDEMAN: One thing that I think is in their minds in that area is the manner in which capital construction funds are raised and are distributed. I can say that if the planning council is going to have a force in the distribution of locally raised capital construction funds, the overall eleven county council, the local group will not accept the

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dictates for the total final decision on that. Even though Meriam Folsom is chairman of both the planning council for the region and the planning council for Monroe County, I heard him say more than once that the determination of how that money is spent has got to be largely in the hands of Monroe County.

Now what would have happened historically if the regional council had gotten off the ground prior to the Monroe County, I don't know. Inasmuch as Monroe County came first and was a strong organization from the standpoint of planning when the regional council came along, it posed a real problem for the regional thing.

MR. ROREM: You mean to say there are two hospital councils there now?

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DR. HALDEMAN: There was a regional council which had a membership function and has a long tradition of very excellent service to the member hospitals. Then Monroe County prior to the time the regional councils were given review and planning functions had a very strong patient care planning agency which in effect was a hospital planning --

MR. PETERS: In New York City, isn't it, pretty much?

DR. HALDEMAN: Yes. It does not have a long history but they had control of all capital construction funds and were able to implement what they did, and I think that has had an impact on the Rochester region. I think it is probably

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a sound provision. Where you have a large regional area, if your funds are going to be raised locally there has to be a relationship developed locally with the region. What that is I am not so sure. I think it will follow some pattern, but the local people will not hold still for every decision being made in Rochester, Rochester being a hundred miles away.

MR. WILLIS: You have the fund raising in Monroe County which is the patient care planning committee. We hope to set up in other areas, too, which may report to their local communities so far as the local needs of the programs go but which report to the program councils as far as the Hill-Burton goes because that is not the official designee.

DR. HALDEMAN: But you hope to provide the staff services for these local planning groups, the data collection and analysis?

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MR. WILLIS: Yes, that is right.

MR. PETERS: You are facing exactly the same problem where we had three local Hill-Burton councils, one which was in New York and the others in Long Island, which had a hospital administrator working X number of hours a year on a per diem basis part time, which still exists in Long Island. That was a Hill-Burton council with a part time executive secretary an hour or two a week. These two still continue to exist. They are theoretically part of us but have their own stationery.

The one in Long Island has recently incorporated,

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become a membership corporation of the State of New York, continues to exercise the Hill-Burton functioning with our blessing. But how do you keep them from breaking away and exercising the total function without our blessing? In other words, we are talking about in Long Island, for example, two million people more in population than Dave has, and Dave has a problem. I can see right now you can imagine what the problem is with Long Island with two million people and possibly double within the next twenty years.

DR. HALDEMAN: I think we are going to hear from the Columbus regional area. They perhaps have not had their local committees organized long enough to evaluate but at least they are the only area in the country that I know of where there are local committees established in relationship to a region wide planning body that is in operation. I think it will be interesting to hear that.

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MR. PETERS: It depends on which comes first. The sequence of events I suppose is very important in this whole thing.

DR. HALDEMAN: They fortunately did not have to contend with a previously established group.

Do you have anything further, Dave?

MR. WILLIS: No.

MISS JENKINS: May I ask what is your relation to decision making out in these areas removed from Monroe County?

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Are you going to allow them a degree of autonomy in making their own local decisions or do they have to be approved by your group in Rochester?

MR. WILLIS: If we are going to have any concept of a regional group, at some point it should have some approval from Rochester. I think the greatest responsibility and a good deal of autonomy should go to the local areas. I am convinced myself that you cannot go on indefinitely sticking to counties as meaningful areas, the people just don't live their lives accordingly.

DR. KLICKA: Is this the way the state plan is set up?

MR. WILLIS: On counties. At best they are willing to accept individual areas, groups of counties.

SR

MR. BUGBEE: Yes, but your whole area is a region for the state plan.

MR. WILLIS: It is a region, and the areas within the region are counties.

DR. KLICKA: In other words, your planning would show specific bed needs for each one of these counties?

MR. WILLIS: That is right, by county.

MR. PETERS: That is right. If you get the state plan which is published each year, you will see it is a tabulation of all the counties of New York State listed according to need with the ones of the greatest need being on top county

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by county; number of beds, percentage of bed needs and so forth.

MRS. COLEMAN: Except in New York City where five counties are treated as one.

MR. WILLIS: Yes.

MR. BUGBEE: There is no simple way to do it. There might be wiser and more acceptable ways but I do not think anyone had any data.

MRS. COLEMAN: No.

MR. WILLIS: I think the best thing that can be done now is work towards perhaps groupings of counties, but on the county boundaries sticking to county boundaries. All the data is only available by the county basis.

SR

DR. KLICKA: You use, of course, state lead figures in your planning, do you not?

MR. WILLIS: Yes, they are worked out with the state.

DR. KLICKA: So there is complete agreement here.

MR. WILLIS: We just sat around the table and went back and forth and in a couple of hours had all the problems solved.

DR. KLICKA: Shows what people with good will can do.

DR. HALDEMAN: Go ahead, Dave.

MR. WILLIS: It looks like, to summarize, what I think are in the operation of one agency the major problems we have got to reckon with the first few years. I don't know

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what the answers are. One is what do you do in the interim? Until you have got your principles and priorities and some concept of a plan laid out, how are you going to handle the backlog of requests for projects? How large can the area effectively be? What is the role of the medical school and teaching center? Aside from saying this is the place where you send your special cases, what influence is this really going to have on the operation of the individual hospitals?

I think in most areas the medical school is a little bit diffident of anything that smacks of community service in an effort to preserve our teaching and research functions. I don't think we can go on indefinitely holding back some of the other areas because of feed back.

SR

MR. BUGBEE: North Carolina has some research but I don't know if they can get out beyond it, can they?

MR. WILLIS: The thing I have in mind is a hospital that is a 200 bed hospital half a mile from a medical school. Any kind of logical finding should be different from a hospital which is 200 miles from the medical school, yet I dare say it is the rare exception where the proximity to a medical school is really affecting the nature of the hospital, its program and so on.

Unless there be a very real and close affiliation, which I think is going to be the exception, what should the role of medical schools be. aside from just saying that their

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roles are going to preserve the selectivity of what they want to take in and what feed back they are going to have?

DR. HALDEMAN: Again in North Carolina there has now been set up an office so the university teaching hospital is playing what I think will be an increasing role in community hospitals outside the state. They are working on standardization of laboratory techniques and a great many things and I think it is possible but you have to set up an independent activity. It can't be integrated very well. I think there in Rochester you have several examples that are coming about as a part of the patient planning care council that is markedly expanding the role of the medical school within the Rochester area.

SR

MR. THEWLIS: Dave, you mentioned the medical school itself. I was thinking throughout the country, and this thought has occurred to some of us in the larger teaching hospitals, whether they are associated with the medical school or not, what impact can they have or do they have with the hospitals?

MR. WILLIS: Yes, I mentioned the considerations. This is not just an academic question. When you get out into an area such as the Rochester area you get into rural areas and the smaller towns. There becomes a very real question as to how much and how far you can expect these smaller groups to go towards limiting their medical care programs and referring

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things in because in every case the referring doctor is going to lose the case.

Now much of this is going to ultimately have to involve our planning not just facilities but I dare say going to have to involve some planning on medical staffing and the use doctors are making of the respective facilities to which they are entitled to practice. We find in some areas, for example, right in the City of Rochester that the hospitals that have some affiliation with the medical school are the very ones that are endeavoring to duplicate everything that is in the medical school. Their medical staffs have a taste of some of the things which are available, yet they cannot make full use of all of those things in the medical school setting because of the restrictions on privileges, so they go back to their other hospital and that is where they are agitated.

SR

I think it is where they are closest with the medical school they use the greatest energy to duplicate. Where the hospital is far removed from any kind of affiliation it is as if it is less interested and less duplicated in expensive facilities and services.

With that I will quit.

DR. HALDEMAN: Any questions?

MRS. COLEMAN: This is not a question but I think distance has really no part of this, we see the same picture in New York City right within one borough. The little hospital

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is not very ambitious, the one that needs an affiliation the most is the least interested in it.

MR. PETERS: It can be a four or five blocks walk away.

DR. HALDEMAN: I think the activities of the Rochester phase in planning their council is an excellent example of a situation where the planning council does control the distribution of funds for capital construction and it has a tremendous impact on the area. Initially the hospitals added up the total bill and it came to something like forty-five or fifty million dollars short range needs of the Rochester hospital.

The planning committee knew that they could probably only raise at this phase of the construction program about $13 million. The projections, based on utilization and population growth, indicated a need in the next three or four or five years of some 500 additional short term beds. In addition, they had one hospital that was quite obsolete and needed to be replaced.

SR

The significant step they took, I think, is the study of the in-patient population, a review by both inside physicians and physicians from outside of Rochester of the patient population characteristics. In other words, how many patients were in the hospital that did not need to be there by virtue of the medical needs of the patient, and if not what

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type of institution should there be? In some cases it was perfectly evident they could be in their own home, others a home care program, others on a long term care program and whatnot.

The upshot of it was that they decided to change the method in which they were going to cut the pie. They got three of the hospitals to agree to establish what I believe they are calling continuation care, you might say, for patients that do not need the services of short term hospital but do need active medical care, with the thought they would go ultimately to nursing homes.

They have instituted a home care program which has grown very rapidly. Last week I was in a meeting with the Visiting Nursing Association. She said there are about 200 patients on their own care program, a large percentage of which would be using beds. They are only expanding about 125 beds as contrasted to 500 beds.

SR

They have done a lot of other things that go into patient care. They have developed with the community college an associate degree nursing program which all the major hospitals are associated with. They are establishing a common laundry. They have considered the possibility of centralizing certain expensive laboratory tests, and I think that is still under study although I think there is an agreement in Rochester where they have had a long history of cooperation where certain

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hospitals would do a given test and other hospitals would send samples in to them.

They have worked out a program for eliminating the tuberculosis hospital and transferring the residual hospitals to a county infirmary. They have worked out an affiliation between the university teaching hospital and the county infirmary to upgrade the medical care. They are in the process of transferring the municipal hospital which was a part of the university teaching hospital to the university so that they would be operated as a single unit.

These are just some of the activities that the patient planning care council, and I must admit I think it is the top lay leadership because in talking to the health officer and some of the physicians I doubt if the physicians would really have gone along, because they wanted more beds, if it had not been for the caliber of the lay leadership in the community.

SR

Do you want to add anything to this?

MR. WILLIS: I think there are some interesting differences between what goes on in Monroe County and what we are doing in the western region because the Monroe County planning commission is largely community representation and it has not a label locally nor is it in fact an arm of the hospitals, which means that many of these accomplishments you speak of have been accomplished in spite of the hospital. The

governmental people have an intereating rezction. They said, Isn't it wonderful to see what can be done when you get the good lay leadership to back up the government, which has been their reaction because many of these things are things they wanted to accomplish.

When the planning is more closely related to the hospitals it takes on a slightly different coloration. They are trying to bring the government in to face the purveyors of health care rather than the other way around. I do not know which one is going to have the pattern for the future but it is quite different.

DR. HALDEMAN: Well, we might go on to Columbus then. Grant, do you want to proceed.

MR. DRENNAN: I think the previous speakers have all outlined the problems we have and are contending with in Columbus. I think Dave's situation is probably closest to our own. The type of organization regional planning is a department of the federation which is a triple headed monster and community oriented and a non-profit organization. Our board is composed 25 per cent of hospital administrators, 25 per cent hospital trustees and 50 per cent members at large which represent manufacturers, religion, medicin, purveyors of insurance, both Blue Cross and private insurance companies.

Our Blue Cross coverage is less than 30 per cent in the general area. The population is somewhere around a million

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and a half in the regional area, 700,000 of it in Franklin County which is our base county in which the federation has been operating for eighteen years in the planning, financing and council services field. We have a regional planning committee which operates with the federation and under the federation's board of trustees.

I should say here that what I am saying now is outlined in our guide lines and is being tested. We have three years to make up our mind what sort of structure we are actually going to use when we get through with the demonstration grant and the study. Thus far most everything that we have set out in the guide lines was found to be workable.

The regional committee was not started first. We have gone down to the grass roots, so to speak, the same as in Pittsburgh. We have asked each hospital to set up a planning committee or building committee. In some places they call it a building committee, in others a hospital planning committee for the individual hospital. That is for each hospital within a community.

Then we have gone to the county level and asked that each hospital have a representative of its board of trustees, representative of its medical staff and its administrator to serve on the county committee. Along with that we ask the County Health Commissioner, in some cases we have District Health Commissioners which serve two or three of the smaller

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counties, a representative of the County Medical Society, one representative representing all the nursing home operators in the county, and members at large which may be named from industry and others.

DR. HALDEMAN: How many counties?

MR. DRENNAN: Thirty-six.

Six of those counties have no hospitals and most of them are too small probably to have a hospital, at least we are trying to convince them of that fact. We are going to do some special studies in that area.

MR. ROREM: How many short term hospitals?

MR. DRENNAN: Fifty-five.

I think there are 200 some nursing homes; probably 50 are nervous, mental, tuberculosis and so forth. These are all listed in the guide lines.

SR

MR. BUGBEE: Have most of them got county homes?

MR. DRENNAN: Yes, but not all of them have county hospitals. We have a couple that have a combination in geriatrics, or it may be somewhat acute in its function for the presence of the home.

We got to the county committee. These county committees are already functioning in almost all of the 36 counties. They discuss problems, shoot us requests for information and also send us some of their difficult problems. The osteopathic problem is the one we mentioned. In rural areas

we are operating joint staffs, newly built hospitals. In one case the other day the Administrator said it was just working wonderful.

MR. ROREM: You mean a general hospital?

MR. DRENNAN: These are two general hospitals that have osteopaths on their staff. The osteopaths are probably in a minority. In each case it will be an M.D. and be acceptable for accreditation by the joint commission.

One case is working out well and another is the suit being filed now to break the lease I think on the hospital because they are not admitting osteopaths in their hospital. So we have all kinds of problems there.

In the county committee all the hospital voluntary non-profit administrators or governmental administrators are in at the county level.

SR

MR. BUGBEE: How often do those county committees meet?

MR. DRENNAN: As often as they can. We do not staff the county committee meetings at all. We provide data and information.

MR. BUGBEE: Do you have difficulty having them meet?

MR. DRENNAN: Probably one-third of them are metting pretty regularly now. Others, it depends on how serious their problems are. If there is more than one hospital in the

county, they are probably meeting more often to discuss their problems.

Then we come to a zone committee which is a combination of three, four or five counties which we thought were geographically located. Six months study indicated we better reorient some of our zones because the hospital patients are going more to another zone than the one that we had in mind.

DR. HALDEMAN: You set them up before you did your study on patient origin?

MR. DRENNAN: Yes. We took the 36 county area which is the central district of the Ohio Hospital Association and actually the same counties.

MR. BUGBEE: Hill-Burton region, too?

SR

MR. DRENNAN: No, sir, the Hill-Burton region extends all over the map. There are three Blue Cross plans within the region. I don't know how many Health districts, a great number of them.

At the zone committee we have the chairman and each vice chairman so at most you have at least ten officially designated representatives that come to the zone committee plus members at large, primarily from industry or from the community power structure.

MR. BUGBEE: Do you staff those zone committees?

MR. DRENNAN: Yes, sir, every one of them.

MRS. COLEMAN: Regular meetings?

MR. DRENNAN: Regular meetings every two months or so.

Dr. Volpe is a roving ambassador, our organizer in our meeting with zone committee people. Ed Lentz does a great deal of the writing. While I wear two hats, I am very much interested in what goes on in regional planning.

MR. ROREM: Full time for each zone committee?

MR. DRENNAN: Full time staff members, yes, sir. They go out to the meetings. We have ten zones. Right now we have two staff members. Their time is divided. We are in an advisory capacity. They do not meet without Dr. Volpe or Ed Lentz.

DR. HALDEMAN: We did have an application that would provide for three positions in this area.

SR

MR. DRENNAN: Four. We are hiring on that basis.

DR. HALDEMAN: I did not include the statistician.

There were some wonderful opportunities to do some special studies but we had another purpose in this. With the shortage of personnel with experience in this field we would like for some of the areawide planning agencies that have on-going programs to have some young people that are doing a good job but actually looking towards increasing the manpower in this area. The greatest problem we are facing is getting trained personnel for areawide planning agencies.

MR. ROREM: Could I just quiz you a little further

on that. Do you mean there are provisions by which, assuming there is work to be done, people can be engaged for jobs for some sort of pay without going through the regular routine of a grant?

DR. HALDEMAN: No, it has to go through the regular routine of a grant but it is a special demonstration sort of a grant and is the criteria which we evaluate it as different. You have to write up a study of some kind or a service program of some kind. On the other hand it is with the thought of having two objectives, one to strengthen the agency but secondly to provide a training ground for some bright young people in areawide planning.

MR. DRENNAN: I have one from Cornell but little experience in the health and hospital planning field, and his primary subject will be investigation of what to do with counties that have no hospitals. He will be going out and meeting with the county and zone committees under Pete Volpe's guidance but all the time his major concentration will be on providing services for counties without hospitals. He will acquire all the techniques in the planning field and the other studies that go along with it.

DR. HALDEMAN: One of the interesting things their initial study showed was that the counties that did not have a hospital, the utilization of hospitals by the residents of those counties was 120.

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MR. BUGBEE: Comparable counties or compared with --

MR. DRENNAN: These are all rural counties that have no hospitals.

MR. BUGBEE: Is that typical of a rural county, that it has 120?

MR. DRENNAN: There is no typical one in our region, George, actually because we have some down on the border line of Ohio and West Virginia where 65 per cent of their admissions come across the border. So when you link that to the county population figures, you are all out. They have over six beds per thousand down there and it is not enough when you base it on county population alone.

Their occupancy rate is still only in the neighborhood of 75 to 80 per cent of the roll. That is not typical but these admissions, it just happens that we have some that are surrounded by territory on which we have reports. We have nothing outside the region to compare it with, but in these counties that have no hospitals they are all in the 80 per cent admissions that were admitted to hospitals within our region.

SR

This much we know. We do not know how many are outside but the captive ones, I am sure this is accurate.

MR. ROREM: Have you said in other similar rural counties, similar in every respect but having a hospital, how much higher was the annual admission fee?

MR. DRENNAN: We had admission rates of ninety.

MR. ROREM: Ninety?

MR. DRENNAN: Yes.

MR. ROREM: That is what I am saying.

MR. DRENNAN: Others, 105 or 135.

DR. HALDEMAN: It was the average that he was talking about.

MR. DRENNAN: One hundred twenty.

MR. ROREM: I wanted to ask, do you have any theory as to why these particular ones?

MR. DRENNAN: I don't know. We hope to find out within the next year.

MR. ROREM: I mean are they a different kind of people, older or younger, or richer or poorer?

SR

MR. DRENNAN: Over 65 or 75 had no relationship in the hospitalization except we know that the over 65 patients stay twice as long.

MR. ROREM: What is the ratio of doctors?

MR. DRENNAN: We are in the process of finding that out, too. Some of these counties are coal mining, strip mining areas, others are just forest areas and they vary from about 12,000 in population.

MR. ROREM: Are these counties of that general nature?

MR. DRENNAN: Twelve and twenty thousand.

MR. OREM: The reason I ask that, in suburban areas a district of ten to twenty thousand, a medium sized district, which is a very small district as far as we are concerned, there seems to be no correlation at all between districts, from the hospital and number of admissions per thousand. If we probe that a little we might see a difference in the character as far as the number of admissions does not seem to affect it. I don't know why.

Where there are variations there are two kinds of explanations; there are different kinds of people, older or younger, and we do not have other data. They go elsewhere.

MR. DRENNAN: We know from what county every patient came and for our purposes at the moment we think this is enough. We have a big work sheet map of the counties showing the number in a six month period that went into each county from another county, and it is amazing. They travel 120 or 140 miles to come for neurosurgery or open heart surgery or things of this kind. We are only getting into this. We have some data now, we can begin to investigate a little more thoroughly.

We are back at the zone committee level. Then from the zone just the chairman of the zone committee is represented on the regional committee from each one of these zones, ten members there. So we have screened it out. This may be a hospital administrator. He is the best man in his zone. We

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have no objection to his being on the regional committee, or it may be a health commission, or it may be the owner of a pottery or an Ohio power company is very influential in our rural areas. We have representatives on some committees in the Ohio Power Company.

MR. BUGBEE: How many administrators are there among the ten on your present committee?

MR. DRENNAN: I think there is one actually.

MR. ROREM: Big city man?

MR. DRENNAN: Yes, as a matter of fact, and he represents all the administrators in Franklin County.

Then we get into the other state power structures or the branches of the state in the region. The United States Medical Association has a doctor in the academy of general practice. We have one labor representative in that group. The Ohio Hospital Association has a representative in that group.

SR

MR. BUGBEE: These are the ten zone representatives that you have mentioned and you are mentioning the others?

MR. DRENNAN: Yes. We hope the ten we have from the zones are going to be tentacles of the power structure of the zone that they represent.

DR. KLICKA: What is your score plus or minus? Have you encouraged successfully or discouraged?

MR. DRENNAN: I could not enumerate. We have gotten

rid of a burn center that was tried to be brought in, two hospitals. The newspaper story created quite a sensation; the university wanted it and Children's wanted it and so forth. It ended up I think neither one of them will get it.

We discouraged the cancer hospital.

DR. HALDEMAN: You have a differentiation between Columbus and the other counties. He has not mentioned it but that Columbus community supervised the distribution of $70 million in the Columbus area since the war and there has been literally no construction in general hospitals in the Columbus area that has not been recommended by that council. Also, you have handled the actual distribution of funds.

MR. DRENNAN: That is right.

DR. HALDEMAN: You are awarding the distribution of funds out of that office.

MR. DRENNAN: But the choice of architects and whether they want a yellow brick or red brick or whatever.

DR. HALDEMAN: It is unique in the country in this regard to the control, really. The only other place that comes close to it is Rochester, New York.

MR. DRENNAN: He asked some of the failures. We did have 66 beds that were built there by a group of doctors who were not welcome on the other hospital staffs. Started out as a proprietary until they got the loan and got it built and then they took advantage of Blue Cross and other things.

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MR. BUGBEE: In processing applications from the 36 counties now?

MR. DRENNAN: Yes, sir.

MR. BUGBEE: Are they tuning in?

MR. DRENNAN: Yes, sir. We were designated before as an approval. We did not hand out funds for Hill-Burton. That was Dr. Dubois' provision. He did a fine job. We were designated by the Ohio Hill-Burton authority as the approval agency for Franklin County. This has been back two or three years now and we had reasonably good success with that. For the 36 counties at least nothing happens down there within our area that Bill Worp or Dr. DuBois or some of our staff are not conversant with or getting argument for or against. It has been wonderful cooperation.

SR

MRS. COLEMAN: What do you do about Franklin County and the rest of the counties? How do you get these two groups into it?

MR. DRENNAN: Well, we have not really brought them together and yet we have not kept them apart. We have brought representatives together but we would not try to get 55 administrators together. The representatives, we tried to stimulate these local communities and counties to do a job.

MRS. COLEMAN: The counties have some form of organization that meets once in a while?

MR. DRENNAN: Yes.

MRS. COLEMAN: Then the zones?

MR. DRENNAN: Yes, four or five counties. One person from each zone.

MRS. COLEMAN: Who comes from Franklin County? How do you get Franklin County into this scheme?

MR. DRENNAN: Franklin County is part of Zone 1. There are five or six counties that surround Franklin County plus one that is somewhat remote and still very much related to Franklin County. We were originally going to carve Columbus out as a separate zone. We decided against that before we went into the organization. So Franklin County is part of Zone 1 and when they meet one representative comes to Franklin County representing the administrator's council.

SR

MRS. COLEMAN: You have two-thirds of your population represented by one person and the other one-third represented by ten?

MR. DRENNAN: No, less than half. Less than half of Franklin County compared to about a million and a half.

MRS. COLEMAN: But Franklin County is not the whole of Zone 1?

MR. DRENNAN: No. That is right.

MRS. COLEMAN: How many people are represented by Zone 1 population?

MR. DRENNAN: Oh, boy.

MRS. COLEMAN: It does not matter really but the

point is --

MR. DRENNAN: There are other representatives from Franklin County who come to Zone 1. They have representatives from city planning.

MRS. COLEMAN: From city planning only one person comes.

MR. DRENNAN: We make an exception in this case.

MRS. COLEMAN: Yes.

MR. DRENNAN: In this one zone we do have members at large primarily from Franklin County. If we find people of the caliber and experience in planning groups and civic groups outside of Franklin County, they will be brought into the zone committee. Since the zone committee is not a determining policy committee level you are not too worried actually except keeping it a reasonable size. We are not bothered about the balance of power. Regionally we are, very definitely.

SR

Now where did we get to? We got the regional committee representing medical, labor, Blue Cross, insurance companies, manufacturing and so forth. All of the zones are represented and this committee meets about every three months.

MRS. COLEMAN: That must be a pretty large committee.

MR. DRENNAN: About thirty-five.

MR. BUGBEE: When you say they are representing all those zones, they are large but they may come from Franklin or down south or anywhere.

MR. DRENNAN: Yes. Ten zone chairmen are there representing the zones. Then the others are people like Margaret Dubois who are there from Hill-Burton in an advisory capacity. There is one labor representative.

DR. HALDEMAN: In relation to Franklin County you do really control the distribution of capital construction funds. What is going to be the relationship in some of these other counties?

MR. DRENNAN: We are probably going to be an advisor to hospitals and other groups outside of Franklin. When I say "advisor," you have heard very much about the Hoffman Act which permits counties to hold bond issues to construct hospitals which can be leased back to non-profit organizations. Right now we are advising Cleveland County on that implementation.

SR

We will do the same thing for the counties within our region in advising Margaret Dubois or Bill Worp or whoever is going to be in Ohio of the amounts of money that are available from Hill-Burton, from the bond issues which the county might put on, plus any other sources of funds, plus the campaign council if they do not have that information to advise them as to two or three companies that we know that are in the business of fund raising and might assist -- not one, but we will do the same as architects, we will name three good ones and approved and let them make their choice.

We do not collect information at this time on

operating funds, expenses, or sources of revenue. The Ohio Hospital Association does this with the Ohio Health Department. They are taking their data such as needed for planning purposes.

You ask what the county committees do at the meetings. We have sent out about three planning requirements memoranda. The first one was on what are their plans for the next five years. It was informal but still stated in writing as to how many pediatric beds, how many medical-surgical beds and so forth do they anticipate they will need by 1970. Also, how many private, semi-private, ward accommodations? What is their anticipated cost? What are their anticipated sources of revenue? Does the hospital hand down funds from which this is obtained?

I don't know what we have now. Probably thirty of them are in. At each one of the zone meetings Pete Volpe is collecting from the representative. County-wide nursing homes and health care centers of all kinds are included in this memorandum. That is one form.

SR

The other is a manpower needs requirement memoranda which has to do with medical staff and per medical personnel. If they are going to have 500 beds in 1970, how many X-ray technicians, how many nurses, how many doctors and so forth do they anticipate they will need? We are backing this up with a print out from a company in Chicago from all the medical people in the 36 counties which we now have and which we are going over and checking against staff affiliations. So we have them

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by specialty and we have them by age and so on and so forth.

Someone mentioned the importance of planning for medical but we want to know where they are. The communities know to some extent where they are. The county in Athens tells us now that they have three or four that are up to age 70, they are going to retire, and where are they going to get some more? The Ohio State Medical Association has given their cooperation to a very full extent in this study and they are also working with us on determination of medical levels, regional center and so forth. If we have a regional medical center in Columbus and Zanesville and Springfield and so forth, what is given there and on down to Marietta or Cambridge or some of the outlying communities.

MR. BUGBEE: Do you discuss what they should do or what surgery should not be done there?

SR

MR. DRENNAN: I do not know what is going to come out of that but I would say something like open heart surgery, neurosurgery, some of the other procedures they would recommend to keep in Columbus. Once again we are not doing this, the medical profession is doing it. They are giving us the advice and all we are doing is putting it down and talking it over with various counties. It may be theoretical or idealistic but we think it is fundamental in the staffing of beds and so forth and the kind of beds you need.

MR. BUGBEE: Remarkable.

MR. DRENNAN: We are trying lots of things, let's put it that way.

We are not doing anything in the disease field now because the City Health Department has a grant from the State Health Department and the facilities for care of both by voluntary health agencies and the hospitals are cooperating and the state institutions are cooperating. When we know something more about their methodology and the success of it -- Ed Lentz happens to be the Project Administrator on that study -- then we may try and apply the 36 county area.

We have unfortunately stayed out of the nursing home area because we have been besieged with Holiday Inns and Nursing Inns of America and so on. We did I think block a 300 bed nursing home right opposite Riverside Methodist Hospital by the Nursing Inns of America. I think it was twelve stories high and had provisions in it for surgery. Our architect discovered this for us. It could have been very easily converted to a 300 bed hospital with general care. They were doing it entirely under the guise of a nursing home.

SR

General beds were tight, medical-surgical beds are running about 90 per cent in Franklin County and about 85 per cent outside. Like some of the others we are trying to discourage any building of maternity beds and converting wherever possible. One hospital in Columbus has given up its ten bed maternity section and another one of the rural counties we hope

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is going to shortly. Twenty miles to the next nearest maternity section.

Now Columbus, we have been collecting data there for eighteen years. We are pretty well certain as to what the trends are there. We will need about 500 general beds by 1970. Some of them are already in the stages of construction. One satellite hospital is coming up with about 125 beds. We expect to build another 200 bed hospital in the far eastern part of the county.

MRS. COLEMAN: How do these satellite hospitals work?

MR. DRENNAN: I don't know, ask Rufus. Ours won't be open until October 1. It will have no maternity, no pediatrics, no medical-surgical. The laundry will be at the main plant. Mostly administration will be at the main plant.

SR

MR. ROREM: I might say I had quite a time getting a project director or the hospitals to allow that name to appear in his final total. He wanted to call it multiple unit hospital. I said that is all right for a scientific document but put satellite hospital first and then submit it because satellite means one of several hospitals under the same management. Sometimes the satellite becomes bigger than the home office, but the main thing is the joint management. Sometimes their specialization of patients is quite common, let us say obstetrics can be done at the one.

MRS. COLEMAN: Do you arrange this by mergers or by

hospital?

MR. DRENNAN: You are talking about satellites we have treated?

MR. ROREM: Except one is under construction now. That is strictly an outpost of an existing institution.

DR. HALDEMAN: They have had a grant to study existing satellite institutions and have a publication out if you are interested.

MR. ROREM: Just out within the last month.

MR. DRENNAN: This satellite that is going into operation is osteopathic. They have 225 beds now and their present site will not lend itself to expansion. They have a concentration of the staff members in the far western part of the county so it seemed like an ideal situation to experiment on it.

SR

MR. BUGBEE: Are you going to give medical staff appointments, one staff?

MR. DRENNAN: As far as the osteopaths are concerned, I am not sure. We are coming very close in some circles in Franklin County of excellent cooperation between the osteopaths and the others but there was no need for it because we had a very, very fine osteopathic hospital in Columbus which took care up to the present time of all the staff needs of the osteopath. As they continue to grow there may be more and more pressure. Throughout the Ohio area where the hospitals are

developing there is more and more willingness to accept these kinds of positions on their staff.

MRS. COLEMAN: I was not aware of that. Are they?

DR. HALDEMAN: The number of graduates has remained fairly constant up to last year when the school in California was converted to a medical school, so the numeric drop in them was by virtue of that. This will be offset by the new school in Michigan if they go through, but I think the trend is going to be towards conversion of osteopathic schools to medical schools.

MR. DRENNAN: I think our choice has been the individual patient's choice, and once we buy that premise then the community has a responsibility to provide hospitals for osteopaths as well as M.D.s.

SR

MRS. COLEMAN: I was a little surprised because we have them in New York City but they are not important.

DR. HALDEMAN: I have very mixed opinions and feelings on this. As I know some of you know, I have been working in terms of planning for medical facilities for the last three years. I have mixed feelings. Today post graduate training in medical residency is more and more important in the training of a physician. If you look at even the university teaching hospitals for osteopathic schools there are institutions of 100 beds, and you look at the residency or training opportunities and they are relatively nil.

I think we should aim in the long range for upgrading the school of osteopathy. On the other hand, I think I agree with Grant that with the present shortage of physicians that there should be places for them to practice. I would much rather it would be done through opening the existing hospitals to osteopaths rather than continue the osteopath hospital.

It is just like the problem of your small Negro hospital. In Kansas City I think that it would be much better for them to be given staff privileges at Kansas City General in spite of the fact that some of their practice would have to be limited rather than perpetuating a specialized hospital.

MR. DRENNAN: This is one good reason for having M.D.s on your planning committees. As you notice we have one from each hospital, a representative from the County Medical Society, plus the County Health Commissioner, all on this level where staff privileges may be discussed.

We have a number of communities that are refusing them in their hospitals so the M.D.s want to build another hospital with in-patient beds. It is a problem that we are continually facing. If you do not have the cooperation, I do not know how you are going to solve the problem.

MISS JENKINS: Do you have any osteopaths on your operating group?

MR. DRENNAN: Yes.

DR. HALDEMAN: How late do you want to go this

SR

afternoon? I am taking count as to where we stand.

I would like to complete the circuit this afternoon if we could and maybe work until five thirty, because in the morning I would like for us to approach this question of implementation from a more theoretical standpoint rather than what you are actually doing, what are the areas that have promise, and sort of list them.

I do not think we need to perhaps talk about priorities to any extent because it is evident that our mind has not crystalized far enough on this. I would like to then have a chance to talk about whether there is a need for a type of meeting of individuals from staffs of area-wide planning agencies sometime this fall, and if so, I would like for us to have enough time to maybe just structure such a meeting.

SR

I was hoping we could work through in the morning until say one o'clock and get away. Does that seem like a reasonable arrangement?

All right.

In view of the fact we are going to five thirty, we will take a five minute break.

(Whereupon, a short recess was taken.)

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DR. HALDEMAN: Dave, do you want to proceed?

Hi, I don't want to pass you up.

MR. SIBLEY: Go ahead.

DR. HALDEMAN: You don't represent a planning council.

Jacques, do you want to tell us about Detroit?

MR. COUSINS: Yes. In sitting here and listening to the other side of the table I feel like the President of Dogpatch Airlines comparing his operations with Pan Am or TWA or American Airlines. We don't do a lot of these things. I guess we ought to and maybe we will but right now we don't.

We have about 4 million people. We do the traditional assosication type work and then the hospital planning. The hospital planning is conducted by a planning committee which is made up of about two dozen or more people, somewhat over half of whom are public representatives and the others are distributed among other hospital trustees and hospital administrators and we have the county health officer, the Dean of the Medical School, and the President of the Hill-Burton Advisory Commission on our Planning Committee, all with votes.

SR

The staff of the Hill-Burton Agency is invited to attend all of our meetings, and unless there is snow on the ground they do attend all of our meetings.

Likewise, I seem to have an invitation to attend any of their meetings whenever they discuss Detroit.

pk 2

We started out by doing population studies and by doing engineering studies of all of our physical plants and then while we were doing this we developed you might say, some criteria or general policies.

One has to do with the size of the hospitals. We like 200 beds of a minimum in the metropolitan area although we will make exceptions in certain circumstances.

DR. HALDEMAN: What are the circumstances?

MR. COUSINS: Primarily if it is out in the more rural parts of the area or if it is in a situation where we are faced with being able to put up a 125-or 150-bed hospital, well, we cannot put up any more but if we don't put that one up or encourage it, some fly-by-night or 50-bed institution will get in there, so we kind of bend over backwards.

SR

Usually we try to merge the two groups together and we have been successful in a few instances in doing this.

We have been doing patient distribution study since about four or five years ago so we know where our physicians are and where our patients are, and I hope we will be doing it next year again.

MR. SIBLEY: Do you have any relation of those?

MR. COUSINS: No, we just counted noses, where the patients come from and where the physicians have their offices.

MR. SIBLEY: But you have not drawn any critera from that?

pk 3

MR. COUSINS: No, we really have not. We have broken it down so that, for instance, we know how patients pay their bills, you know, length of stay, what kind of specialist they go to and so on and so forth.

We have never written anything up on these statistics. We use them almost daily.

MISS JENKINS: On your doctors did you get their age and specialty?

MR. COUSINS: The age of the physician?

MISS JENKINS: Yes.

MR. COUSINS: We can get that. We don't have it on the IBM card. In other words, you can name any physician in Detroit and we can tell you where he has his patients in six months.

SR

MISS JENKINS: We maintain an IBM card on that.

MR. COUSINS: We discovered that some hospitals that we thought they were getting the bulk of the man's work were not getting nearly as much and we were able to predict with considerable accuracy what happened to your hospital, and by physician we can tell you what happened.

MR. PETERS: Contact the doctor himself? How did you get the information, contact each doctor individually?

MR. COUSINS: No, we told the hospitals we were going to do this and we did it.

MR. PETERS: You got it from the hospitals?

pk 4

MR. COUSINS: Yes, we had bushels of mail coming in every night showing all the discharges.

MR. ROREM: You mean you do this currently?

MR. COUSINS: We did it during the six-month period.

MR. ROREM: 225,000 discharges? How many?

MR. COUSINS: 225,000 discharges, all on IBM cards. It is very helpful.

Well, on a quarterly basis the staff gives to this Planning Committee, which incidentally over the past seven years has not changed very much, continuity on that Committee now, we give them on a quarterly basis an analysis of need based on population and this does not change very much.

Then we show them the number of acceptable beds, the total number of beds in the 10 study areas that we have in our six counties, the number of beds under construction, the number of beds that we have approved for construction -- this differs sometimes -- the number of projects that they have approved for future construction, the number of projects and the number of beds that the Committee has approved for future construction, the number of beds that are being tabled or under study by name of hospital, and then we have another column which is all the projects that have come to the attention of the staff.

SR

We have about two projects a month; that is about the average comming to our attention. I would say about 20 percent

pk 5

of them never get beyond the staff because we usually are able to say to these people, "Well, you want an area where they are over-bedded," or we point out some of the financial problems involved.

So about 20 percent of the projects never get beyond us, although any project coming to our attention and they write us a letter and insist on meeting with our Planning Committee, they do meet with our Planning Committee.

Now our Planning Committee meets, oh, anywheres from six to 30 times a year, it depends on the volume of work involved. Sometimes they have various projects to consider and sometimes it is strictly housekeeping work that they perform.

Now I think probably the area in which we have been most successful has been in the implementation of this and I

SR

think the reason for it is because of the power structure in Michigan or Detroit. We are somewhat like in Pittsburgh.

You get a few corporations and a labor union to agree on something and it is pretty difficult to buck it, at least for any major project. This creates other problems.

For example, when we were first set up to do planning these same corporations and the union set up a capital funds corporation called the Metropolitan Detroit Building Fund and these people took about five years to raise $15 million which was then spent pretty largely on our recommendations after we had spent five years studying the needs in the area.

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pk 6

They didn't take our recommendations in toto and they double-checked us by hiring Jim Hamilton and Associates to come in and do a double survey. They didn't follow Hamilton's recommendations 100 percent either.

Hamilton's recommendations and ours were almost identical. Our number two choice might have been his number five choice.

MR. BUGBEE: Why didn't they follow it?

MR. COUSINS: Well, there were a couple of reasons. There were one or two instances of honest differences of opinion where Hamilton thought our recommendation was wrong and we thought his was wrong.

Then there were a couple of other problems. The capital funds corporation covered only three counties in our six-county area.

SR

Hamilton, of course, studied only the three counties, we studied six. So in our recommendations to the Building Fund we told them if the corporations in their budgets set up "X" amount of money contributions to hospitals they should donate to the Building Fund "X" minus a certain amount because there were three counties outside of this area that have legitimate needs.

So you have some responsibilities to these other counties and this is another place where we have a difference, but by and large, I think you have to say that Hamilton used

our figures so it is really a matter of judgment more than anything else.

The other area in which we have been able to implement things has been excellent cooperation with our State Hill-Burton program. I cannot think of any project that we turned down that Hill-Burton gave any monies to. I can think of a few projects that we approved that Hill-Burton didn't give money to but not the other way around.

The other thing is that we have had a very good working relationship with Blue Cross. The first document that we ever published had a list of about 11 philosophical expressions of the new hospital planning.

One of them was that we should work closely with Blue Cross, one with the size business that I mentioned, and another one was that hospitals should be truly community oriented and not corporate setups, that we have so many hospitals where a proprietary type corporation operates a voluntary non-profit corporation.

We also said that we should give priority to completing hospitals that had been recommended for expansion before we build new hospitals if everything else happens to be equal.

We also said that we didn't like to see any expansion of hospitals that had not been built originally for hospitals and that we would turn down automatically any hotel conversion job or motel or private home.

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Then Blue Cross came along a few years later, about three years ago, and set up standards for newly participating hospitals. In these standards for newly participating hospitals one of the standards says that the hospital has to be built in response to demonstrated community need.

So when a new hospital applies for participation in Blue Cross, Blue Cross writes us a letter and says, "Is this hospital needed?"

I guess we have had about 18 of these letters in the past three years. I guess we have said probably "yes" to about 10 or 12 and we said "no" to the rest of them.

Blue Cross has backed us up on every single one of them except one and that is one where the hospital had started construction just about the time these new standards came in. Now it has reached the point where anybody who wants to start a hospital and addition --

SR

MR. BUGBEE: Either a new hospital or an addition?

MR. COUSINS: Well, within the past three weeks unless Michigan Blue Cross has adopted new standards, the standards for existing participating hospitals and the additions to existing hospitals are going to have to be approved by us or approved by Blue Cross.

Blue Cross will turn to us and Hill-Burton for advice.

DR. HALDEMAN: Could you get those criteria and send

it to us? I got a copy from McCarthy a couple weeks ago but I don't know what happened to it.

Have they been formally adopted by Blue Cross in Michigan or was it just a draft we were looking at?

MR. COUSINS: No, they have been adopted now.

MISS JENKINS: Have they been adopted as that draft indicated?

MR. COUSINS: Yes.

MR. ROREM: I don't remember having received any.

MISS JENKINS: I received one.

DR. HALDEMAN: I might say that I hope that all of you perhaps would take the mailing list -- do we have a mailing list of this group? -- and send to us copies of any written material that you have about what you have been talking about.

I know in a number of instances you do have it written up in one form or another. Is there a mechanism for getting information around?

MR. ROREM: None that has been formalized that we know of.

MR. SIBLEY: Since I left Chicago or since I left theoffice, which is practically two weeks, we have made out a list of the 40 Planning Councils which have executives that we know of and asked them to do the thing that we require, we ask our State hospital associations and Metropolitan hospital membership councils to do, which is to put each other on their

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mailing list so that anything they have to mail goes automatically without coming through our office.

That has now just been initiated and we will send this revised list out, I guess, semi-annually.

DR. HALDEMAN: Is there some way we can get on that mailing list? I don't know. Ken, do we get it?

MR. BAUM: No, we don't.

MR. SIBLEY: I have already written it down, it is in my pocket.

DR. HALDEMAN: All right.

MR. DRENNAN: I think everybody in New York gets our mailing list. We send it routinely and I think we send you several copies.

SR

DR. HALDEMAN: We get lots from Columbus.

MR. DRENNAN: Nonprofit mailing franking.

DR. HALDEMAN: Well, pardon me for the interruption.

MR. COUSINS: Now it has gotten to the point where it is almost impossible for anyone to think about starting a hospital in southeastern Michigan without getting tangled up with the State Health Department, Blue Cross or the Hospital Council, because whenever any one of these three agencies even hears about a project -- when I say "hear" I mean I was in Chicago the other day speaking to a group of the House of Delegates of the Osteopathic Association, and I heard about a project.

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Well, copies of this have already gone to our State Health Department and to Blue Cross. Now nothing may come of this but we alert one another immediately and we always tell anybody that contacts us that we have to contact the other two people.

So the net is pretty well drawn and it is almost impossible to get around this.

Now we have problems. Our problems are osteopaths, small hospitals that do not ever intend to receive philanthropic funds or even Hill-Burton funds, and who in the past have always been able to secure adequate financing.

Now this is beginning to tighten up a little bit because as a result of what I guess the community thinks is a reasonably objective job I would say, that every major bank in town, many of the national insurance companies, the larger ones, particularly those that have some sort of a group office or district office in Detroit, contact us whenever they are asked for a mortgage.

SR

This has been remarkably effective judging by the number of times we get called by different banks as we keep saying we either never heard of this project or we disapprove of it.

The hospitals apparently have to hunt a little longer to get this money. So this is helpful.

DR. KLICKA: Did this just grow or did you do

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something?

MR. COUSINS: This grew. We talked about doing something but our attorneys told us we would get into serious difficulties if we ever called a meeting of the banks and insurance companies to talk about it.

But through our service association type work and our relationship with the Health Insurance Council and other groups such as that, this is how it has spread.

We are having nursing home problems now. We hope to get into this.

We have Negro problems, that is one of our real big ones.

We have a problem in timing. As you may recall a few moments ago, I said that we send out these quarterly reports for a Planning Committee showing what the need is in the different sub-areas and how close we are to meeting that need.

SR

Well, a hospital will appear before us in 1959 and it wants to build something. Well, we don't like what they want to build or we don't like the corporate setup and we don't tell them "no".

In some instances we do tell them. Let's say in one instance we don't tell them "no"/ We tell them that if they revise their project, the corporate structure, we will then consider them.

We have a few of these that over the past couple of

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years because of our prodding, because of Blue Cross' prodding, because of some work done by the McNearny group in Ann Arbor, they have revised their corporate setup and they have revised their projects.

They are now coming back to us but the need has changed in this area. In fact, from here I am going back to a meeting where we have to decide what to do with one of these which is now as clean as a hound's tooth but there is no need and he owns the land. I don't know what we are going to do.

Another problem that we have, although I think it is beginning to change a little bit, is with governmental officials. Originally they paid no attention to us, the city and county level. Now they are beginning to pay a little more attention to us.

SR

Certainly the City of Detroit is now asking us to sit in as members of various committees appointed by the State Council or by the Board of Health to decide what to do with the Board of Financing of indiginent care, providing psychiatric facilities in the city hospital, in relationship of the city hospital to the Medical School and other things, but we earned this, I think, over the past six or seven years.

Suburban officials are still extremely leery of a "Detroit group" telling them what they should do, but I think there are some improvements made along that line.

Another problem that we face is in relationship with

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county medical societies. We have one big one, the Wayne Medical Society, and while our relationship and service association is excellent with them, in the planning work the relationship is very good with some of the members but the County Medical Society is a very difficult animal to work with. They will never commit themselves, at least ours won't.

They change their leadership every year and this can mean a 100 percent change in the philosophy of the County Medical Society. Sometimes the guys that are in leadership positions don't represent really what the membership feels. So we have some problems there.

By and large, I guess you would have to say that as far as implementing things were concerned we have as tight control, I think, as any other area which had hospital council and this bothers me, frankly, because I am not so sure that we are that right all the time.

SR

One paradox, as a result of our work we have probably delayed the construction of needed good facilities because everybody says we have to study this thing, and meanwhile, somebody else has sneaked in and filled up the vacuum.

I think this is changing a little bit, particularly due to Blue Cross' standards and the fact we won our lawsuit. This means that these fly-by-night operators, I think, are going to have to think twice before they think to build hospitals in Michigan.

I must say that when the corporation set up this United Fund drive, capital financing, then we had a recession in 1958, I kept telling the chairmen of Ford and Chrysler that they were crazy to let a minor recession delay this fund drive for about two years for the very simple reason that if they didn't kick in the money in capital fund-raising they were going to pay for facilities anyway, because somebody would build these additional facilities.

Since Blue Cross in Michigan is financed largely by the big-3 and since Blue Cross in Michigan allows for depreciation, the corporations are in a peculiar position. If they don't give the money, they bargain for it over the bargaining table with the UAW and they wind up paying for it anyway. So this $15 million drive which was supposed to produce about 800 new beds, I think in modernization about 500 or 600 other beds, this thing was delayed for a couple of years and meanwhile, we saw almost an equal number of beds put up in situations that we didn't think particularly desirable.

MR. BUGBEE: What sort of situations, small hospitals that had an accumulation?

MR. COUSINS: Yes, 50-bed hospitals that decided to become 125-bed or 150 that decided to become 210 or a new out-and-out construction project.

An osteopathic hospital in Pontiac, a new hospital just 10 miles from Ann Arbor and a few other hospitals of this

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nature, but none of these people are going to the corporations for funds and most of them are not even going to the Hill-Burton for funds.

I don't know whether in the future we are going to be able to control this any more. I know that our United Foundation has recently set up a capital gifts provision which intends to set up a blueprint to study and then to provide the financing for 20 years worth of needs in health, welfare and recreational activities in the greater Detroit area.

Now how effective this is going to be I don't know.

MR. SIBLEY: This being a part of the giving scheme on the part of corporations?

MR. COUSINS: Yes, five years and they fill up the pot and the pot would be empty.

SR

MR. SIBLEY: But it is regular giving each year?

MR. COUSINS: Yes, and they would hope by doing this they could then control things even more than they do now. See, we are faced with a developing medical center that is going to hit the community somewhere for $180 million. Some of this will be Government money but a lot of it will not be Government money. This has to be tied in.

The last two capital fund drives have been largely in suburbia. Now we are beginning to pay attention to what has to be done downtown.

MR. SIBLEY: Do you recall this positive planning,

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Jack?

DR. HALDEMAN: Yes.

MR. SIBLEY: I certainly agree with you. Now we have to face large amounts of money that are going to be needed and not just let it slide along.

MR. COUSINS: In a nutshell, Jack, I have pretty well covered what we do.

DR. HALDEMAN: I am interested a little more about the implications of the court decision. I don't know, Jim, whether you were going to talk about that. Is it going to be appealed or is this just the first bout, the first round of a fight that will go on?

MR. COUSINS: Well, the court decision was rendered now I think about two weeks ago, and the losers had 20 days in which to appeal either for a new trial -- boy, I sure hope they don't -- or to appeal to the Supreme Court.

SR

This court decision was the situation wherein an existing downtown hospital that had been a group participating hospital for 30 years set up a new corporation and created a satellite hospital in a building that was 35 years old and in the eyes of our Planning Committee and Hill-Burton did not warrant having any money put into it in an area where neither Hill-Burton nor our area Council thought there was need.

The hospital finally came to our Planning Committee in order to secure our advice but the first thing they told us

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was that they had already bought the land, hired the architect, it cost them $700,000 and regardless of our decision they were going to go ahead and do it.

We told them they were nuts, that it would cost them more than $700,000, probably close to a million. We were wrong, they have spent a million and a half already and the hospital is not open yet.

They then went to Blue Cross to get the participation, and based largely on our findings and on the findings of the Hill-Burton Agency, Blue Cross turned them down.

The hospital then sued Blue Cross and we were in court, I think, for the better part of five weeks. Carl was an expert witness on behalf of Blue Cross and Charlie Laturno was an expert witness on behalf of the hsopital.

SR

Charlie set it up beautifully for Carl and for me because our attorneys asked him how did he know that this hospital needed to be built and he said, "Well," he had driven around the neighborhood for an hour and the kind of houses that were going up were very similar to those in Chicago where they needed new hospitals.

So then they asked him had he ever done any area-wide planning and he said, "Yeah, hundreds of times."

We then asked him how he did it and he told us how he did it. We asked if he did it for this particular project and he said, "No," he had not.

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Then Carl came along and said how he did it and we told how we did it. Charlie gave a textbook approach to the thing although he had not done it for this particular hospital.

Interestingly enough, an important decision which was favorable to Blue Cross was favorable on the point of law and that is that the Blue Cross Enabling Act may contract hospitals.

The judge said that it was not within his province to stipulate that they must contract but then he tore into -- I don't think you are named in the findings by name, I am.

The judge disagreed on our determination completely and said we were all wrong and he arrived at his own determination. He just took the population from Macomb County and multiplied by 3.5 or 4.0 and he came up with a figure.

SR

MISS JENKINS: The judge did?

MR. COUSINS: Yes. What the judge ignored was that Macomb's population is all along the southern border of the county and there is a whole string of hospitals anywhere from a quarter of a mile to three miles just south of that line and this is where most of those people go.

Personally, as far as we are concerned, there is no reason why they should not go.

MR. BUGBEE: When is the 20 days up?

MR. COUSINS: I think the end of this week. I think Friday or Monday.

MISS JENKINS: Do you think they have the money to

pk 20

continue the litigation on it?

DR. HALDEMAN: They have in the Detroit area a very difficult time of filling many beds without the assistance of Blue Cross.

MR. COUSINS: Yes, but they get only $15 a day from Blue Cross. Now this has some very serious implications because we have a couple of other projects that are under construction right now.

MISS JENKINS: But you were not sustained on the basis of the plan, you were sustained only that Blue Cross does not require?

MR. COUSINS: We have another court decision involving that. Now this is the reverse. This is a situation of where we approved of a hospital and the Community Planning Commission of this particular community also approved the hospital and the Zoning Board approved the hospital but the City Council turned it down, so there the hospital is taking the City Council to court to force the City Council to give them a permit to build.

SR

MR. BUGBEE: Why did the City Council object?

MR. COUSINS: The City Council objected because they got something like 10 square miles and they have just had three new hospitals under construction there and they don't want any more nonprofit organizations in the community.

When we testified in court it was interesting to hear

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the judge in his opening remarks say that he didn't want anybody from Hill-Burton testifying because he was sick and tired of Government intervention in the county and he didn't want anybody from the Hospital Council and he didn't want any outside experts, this was a matter for citizens.

It is still in litigation.

MR. ROREM: You know they say you have not arrived until you have been sued a couple of times so that will be next.

Have you been hauled into court yet, yourself?

MR. COUSINS: No, the Hospital Council has not. It has always been Blue Cross or the hospital or a unit of Government hauled into court but we are always asked to testify.

SR

I was in three different courts in two consecutive days and I had to get my stories straight because I had to reverse it in court hearings.

DR. HALDEMAN: Off the record.

(Discussion off the record.)

DR. HALDEMAN: My theory on the record is that the way you win these cases you just worry about them enough. It seems to me we had something on Hill-Burton every month it comes up, just felt like we were never going to get solved and I worried about it enough.

MR. SIBLEY: I thought you made John and Bill do your worrying for you?

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DR. HALDEMAN: I do, but we worry.

Further comments?

Questions?

MR. ENSIGN: Jack, the judge's discussion on the need for the hospital was based on cutting up the area-wide pie in terms which seemed to fit the plaintiff's pattern, the plaintiff gerrymandered this thing to make it work for himself.

MR. COUSINS: Yes.

DR. HALDEMAN: What is the implication of this ruling, Jim?

MR. ENSIGN: It is difficult to say because it was decided only on a point of law which happens to be in Michigan, enabling legislation. It means different things for different plants, some of which have no control whatsoever in the contract with them and some plans laid down in the statute with the contract, all licensed institutions and others. The language is different.

SR

I would say that we would be very happy about it had the judge supported the concept of area-wide planning. We hope that the case would come up where that ruling takes place but if it comes up the point of law is not present.

This one would have been turned down and this would have had serious implications.

DR. HALDEMAN: There are other Blue Cross groups that

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are planning on taking need and consideration?

MR. COUSINS: There are, indeed.

MR. ENSIGN: In Arizona, the Arizona plan adopted the same exact language that the Michigan plan has in spelling out what a participating hospital must pay which states that the hospital must have been planned and built in response to a clearly evident need for additional beds in its community and so forth.

Just because you didn't know that this was the rule does not let you off the hook, so there are a number of plants that are picking up this kind of thing.

In Arizona, it would help to head off the eight per-centers. In fact, it has caused a lot of bondholders heart-ache.

SR

MR. COUSINS: Trying to be objective, I sat through most of this trial. If I had been the judge, I don't know which way I would have gone because Dr. Klicka confused me, Hill-Burton confused me, the expert on the other side confused me.

My own County Health officer was adamant that it was wrong and immoral. Macomb County mothers had to go to another county to be delivered of babies.

The president of my County Medical Society said that there was a need for beds, and by applying the formulas used by myself and Dr. Klicka and forgetting about all the hospitals

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that were a quarter of a mile to three miles outside the area I would very easily arrive at a very fantastic need for Macomb County.

That judge must have been bored silly or thoroughly confused because I think I know what I am doing, I will tell you after having been cross-examined and after having to say why did we use this formula, what formula did they use in Pittsburgh? what did they use elsewhere? why were they different? how did I arrive at 175 population for these particular sub-areas of the county when Hill-Burton arrived at 192,000? why was there a difference?

You know, you get a lot of experts together and a guy who just depends on ordinary common sense just says the hell with all the experts.

SR

MR. BUGBEE: That is what he said, I guess.

MR. COUSINS: That is what he said, took several pages to say it.

So we have a lot of work to do in the selling and the public relations end of this thing.

DR. HALDEMAN: Well, I think we better get on.

Any other questions? I will go to Carl.

DR. KLICKA: I will kind of make mine brief, I will have to.

MR. SIBLEY: Ten minutes, Carl.

DR. KLICKA: Ten minutes.

I think it is of some interest to tell you that very early in my work with the Council -- I have been there now four years as of the first of July -- I was impressed by the fact that we had no committee organization at all. We had a Board of Directors and that was it. So everything was flush with the hospital field knowing what they did in New York.

I proposed a number of special area committees that included on the membership a number of professional experts and laymen who were active in the health field.

There were, I think, five or six of these committees and I was very proud of them, I thought I had structured them very well.

Well, this recommendation went over like the proverbial lead balloon and I can still remember Mr. Ryerson accepting my recommendation graciously but saying, "Carl, we are not going to run this Council this way. We want you and your staff to do the work, you make your recommendations to this Board or to the Executive Committee which we will form," which they subsequently formed an Executive Committee, this smaller group made up primarily of the officers. Let's see what happens.

Well, since that time we have reviewed 161 hospital proposals. Now of this 161, 78 were proposals for brand-new hospitals. Of the 80 proposals that were for revisions of programs of existing hospitals, whether they would be expansions

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or contractions or relocations, all but three followed the recommendations that were finally made by the staff and endorsed by the Executive Committee.

I want you to know that the key here in being able to do this and to have such a turnover has to do with the fact that we do not do studies in depth as they do in New York.

We have been the greatest thing that ever happened to Chicago, I guess, as far as professional consultants are concerned, because in most of these instances we have urged them to have thorough surveys done.

In the early days this got us into trouble because we found ourselves getting into more and more disagreement with the phase of the study that related to bed need and this is because these consultants used the only material that they could and this was the State survey and plan.

SR

The more our research staff came up with data the more we began to appreciate that the State survey and plan was much too generous and inconsisten.

We began telling consultants as they came into the area that we would provide them with the bed need recommendations and rely on them to do everything else in the hospital which had to do with detailing of the long-range program, internal organizational studies, in relationship to various relationships that they might establish for other agencies in the community and so forth.

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Then what we have done is to have taken these studies, to have reviewed them and then to have discussed them with our Executive Committee. We have worked very closely with the professional consultants that have come into the area and as far as I can tell, they have been just as happy as we have been and we have been very happy with the relationship that has been evolved.

Now with the new hospital proposals we have had a little different set of circumstances. Of the 78 proposals, about 60 of them were proprietary in nature. Every single one of these were proposed by people who had had vast experience in establishment of discount houses and shopping centers.

SR

Without exception they wanted to place them in areas where we thought the need was already well met or was to be met by programs that are already jelled and moving along.

Sponsorship was not only by the real estate developers but in most instances there were a few doctors who were part and parcel of these organizations.

It was difficult to get the details of the organizations but most of them were the small corporations of 10 people or less. This is the same kind of a partnership arrangement you know that permits the owners to take advantage of depreciation on their income tax venture and which is really the big appeal in this whole thing.

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Well, of the 18 voluntary efforts for new hospitals we encouraged 90 and most of these are already under construction or have been built and are in operation.

One of them is postponed to a later date, one of them is going to end up being a satellite hospital to another one and it is under planning. The remaining ones we discouraged primarily through what we call logical persuasion and they bought the persuasion.

Sixty proprietary instituations got actively discouraged. Of this 60 that we actively discouraged one was built, and this one I don't think would have been built had it not been for the fact that it was financed pretty largely by crime Syndicate money. That hospital is still in operation; however, it is really on the ropes and having a very difficult time.

SR

There again, although it is not known, it presumably is being perfused by crime Syndicate money.

MR. BUGBEE: What does that mean?

DR. KLICKA: This means it is being fed. Pardon me for using a little medical jargon.

Now 59 therefor have been discouraged and I think most of them successfully discouraged. Now I would like to tell you a little bit about how we did it because this is the implementation. I would like to use the blackboard for this.

One of the things that we have discovered is that

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the local officials in the community can be extraordinarily helpful. I won't go through the historical development of this but I will bring you up to one that we worked with in the last six months that we think is most interesting and this was one that was a hospital that was proposed in Northbrook, a real nice northern suburb.

We learn about these and we learned about this one through our scouts. Our scouts throughout the metropolitan area are primarily hospital administrators. They pick up facts relating to the establishment of these hospitals in various ways. This one was picked up by -- I think this particular scout happened to be Dave Kinzer who was Director of the Illinois Hospital Association. He saw a small squib in the newspaper up there where a group had gone to the Zoning Board and had asked for a zoning variation to permit them to build a hospital.

SR

Dave called our office and said, "Carl, do you know about this?" I said, "No, thank you very much." The next move was to write a letter to the Mayor of Northbrook telling him that we had heard about this and asking him if he knew about the services of the Hospital Planning Council for metropolitan Chicago, and if he didn't we would be very happy to work with them in determining whether or not the establishment of a hospital in Northbrook would be in the best interest of the community.

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We subsequently heard from the attorney of the village saying, "Thank you very much, this is going to come up in the Village Council meeting where the Zoning Board is going to submit their opinion regarding the advisability of giving a zoning variation to this group and you will be permitted to come up and talk to us at the same time."

In the meantime, we did a little bit of scouting of our own. We found out what the physicians in the area thought about this and we learned, fortunately, that they knew nothing about it, which was good because you see, this indicated that these people had not even bothered to talk with the doctors in the area.

We found that they were not at all in favor of this, they all had staff positions in their hospitals. They knew some things about the man who was primarily the sponsor here and they didn't think that he would be a fit sponsor, actually, for a hospital in their area.

SR

So when it came to the Council meeting we talked first on the basis of our studies indicating that there was a lack of need, we thought, and that if a hospital were established it would definitely cause a hardship to the hospitals that were already supporting this area for reasons well-known to this group.

We also felt that the sponsorship of the hospital left something to be desired and we reviewed this. Finally, we

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pointed out that the plans, and we had seen the plans, were minimum and although they could be approved by the State because they met their minimum requirements, they were vastly undersized.

That is, the hospital was vastly undersized. Totally, it only provided for something like 450 square feet per bed, and for a 150-bed hospital we thought they would end up with a kind of hospital that would not be consistent with the other facilities in Northbrook.

Anyway, we developed a case. The doctors spoke from the audience and they made some objections. They felt that if there was to be a hospital certainly they should have been advised of it. They had not been asked whether there was a need and they also didn't like the idea of someone coming in and establishing a hospital and possibly bringing doctors up from the City of Chicago, doctors who already were not there.

SR

This is vested interest but this is all right because this is all part of the pattern.

Finally, Dave Kinzer got up and he spoke against this hospital from the point of view of just good general principles of community hospital planning and the fact that this did not fit into it at all.

The attorney for the defense did get up and he talked up and pointed up that in this particular area there

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was a need for some 300 beds and this was in contradiction to our recommendations indicating that there was a lack of need of new beds and that the area was already well supplied.

This was unfortunate but he was able to do this.

I don't want to prolong this, but the Village Council took a vote and voted eight-to-nothing against the establishment of this hospital. They were subsequently sued by the sponsors and we had to go through all of our testimony again before the judge, it was a District Court proceedings. The judge has not yet announced his decision but we are hoping that it will be in favor, of course, of Northbrook.

Now this technique of using village councils has been extremely effective and we have used it many, many times. The whole case, of course, is that we try through education to get the village to make a decision relevant to whether or not they wish a hospital in their area. After they have had an opportunity to review the total picture we think they are in a better position to do this than they would be if they had not had this exposure.

SR

Actually, the Mayor raised this question: In the course of our discussion he said, "Dr. Klicka, why do we need to worry about this, why not let Dr. Yoder in Springfield make the decision whether we need a hospital or not up here?" I said, "That is your privilege, but it seems to me you make quite a thing about local government, that you should retain

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the decision whether you want a hospital in your community of any type."

DR. HALDEMAN: Carl, what authority would the State Health officer have? Could the licenser program take consideration in Illinois?

DR. KLICKA: That is right. If we were not in this picture, if we had not projected ourselves in this picture, the next step would have been for assuming the variation had been given for this group to subnit their plans to Springfield.

If Springfield would approve their plans on the basis of the physical nature of the plans, then they would proceed to build.

SR

DR. HALDEMAN: Do you have authority to disapprove the application based on lack of need for the facility?

DR. KLICKA: No. This is right but they could disapprove it on the basis of it being an inadequate facility and this would be the only way they could do it. I am going to come to that example right now.

MR. SIBLEY: Could they not do it also on the inadequate financing or not?

DR. KLICKA: It is possible that they could now.

MR. ROREM: Nonprofit corporation? Proprietary?

DR. KLICKA: No, no; this is the new model, this is the pseudo-voluntary group. This had two corporations. This

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was to be owned by a small group of seven or eight men and then they were going to lease this on a long-term lease arrangement to a nonprofit corporation who would pay rent to this group, but there was an interlocking board.

All these members were also on the board of this corporation.

MR. COUSINS: That is the Detroit picture?

DR. KLICKA: I thought this was the Chicago pattern. Most of them are coming up this way now, this is the fashion.

DR. HALDEMAN: They have not any trouble at all with Internal Revneue with this?

DR. KLICKA: No, not yet.

MR. COUSINS: Not so far.

SR

MR. BUGBEE: The owners must pay tax on the property.

DR. KLICKA: These people pay property tax. They pay property tax, of course, on this hospital but that is the only tax they pay.

One of the biggest things they want this for, though, is to fool the public into thinking they have themselves not only something for nothing but they have themselves a good nonprofit hospital and they are naive enough to think this is so. and it maybe, I don't know.

Now this has worked out very well until recently and we are having a serious problem. I want to jump to this because down here at a little place called Lyle, it is in

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Gladwin County, there is a doctor who was unable to get staff privileges at the Hinesdale Hospital, he had a residency there but they didn't consider him good enough to have staff privileges.

Another hospital here, he is on the staff of this hospital but he is always on probation because he never has his records up-to-date and also when it comes his turn to take call for the emergency room he is never available. So he is always on probation but he wishes to establish a 150-bed hospital.

Now he started this program about two years ago and we were working very nicely with the State on this and I thought the thing was well scotched. The reason it was scotched is because he was making some serious mistakes. He

SR

was putting it in the wrong kind of a structure.

For instance, he was trying to attach this to his Medical Arts Building and his plan was terribly inadequate, so it was primarily on the plan that he just was not getting anywhere at all.

We thought it was abandoned but all of a sudden here in the last few months we find he is very active.

I called the State and talked with Dr. Yoder. After I had talked with his two lieutenants, George Lindsly and Roger Sondag, more or less trying to get a progress report on where this thing stood, I got a total clamming up. He said, "What

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has happened? I found that Dr. Yoder is having very severe pressure brought on him by both Republican representatives and Democrat representatives to permit this fellow to go ahead and develop his hospital and the argument that they are using is free enterprise.

"We cannot interfere with free enterprise in this country, this man should be permitted to build this hospital."

Now, unfortunately, the State plan shows that presumed need for about 300 beds in this area. This hospital in Hinesdale was a 200-bed hospital and just added 150 beds and now has 350.

Neighborville has 150 beds and are ready to add as many beds as needed when needed. They are running very comfortably.

SR

Up here there is another hospital, Winfield Hospital, which is one we have been working very closely with, tuberculosis, in the process of converting it. It will be open in a year adding 125 beds. This is quite a ways out from Chicago.

As you talk with these three groups it is obvious to them that the State survey and plan is way, way off and they are very concerned about this. Dr. Yoder said, "Carl, if you are going to do anything about this you better do it real fast because they are moving along with a new set of plans that I am going to have trouble starting."

So a new form of implementation.

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I met with the Joint Conference Committee of this hospital and I have met with the Administrator of this hospital who is carrying the message to his Board of Directors. This hospital is taking an action and they have written a letter to Yoder protesting the development of this hospital. The doctors on the staff individually are now writing.

This hospital, the Board of Directors are sticking with Yoder. I don't know whether we are going to get any of the doctors to write. It is a very interesting story.

There is confusion here as far as the medical staff is concerned, because there are three general practitioners on the staff of that hospital who are using lies and all other forms of defamatory statements against community hospital planning, some of it in protesting against the medical staff taking any position on this.

SR

These doctors are suspect of being part of the financial picture of this hospital. We don't know what they will do but we believe that they will also take an action protesting the construction of this hospital.

DR. HALDEMAN: The only fly in the ointment, Carl, is that the State Hill-Burton Agency administering a licensure act is pretty well obligated to approve a plan which meets their minimum standards of construction and equipment.

DR. KLICKA: That is right.

DR. HALDEMAN: I recognize there is a little gray

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area in there where they may have a little latitude but they have got to act with a fair degree of consistency. This thing has worried me in the administration of the Hill-Burton Act because our act says you shall approve the hospital if it is in accordance with the State plan.

DR. KLICKA: There is something even worse than that.

DR. HALDEMAN: I am not saying that is necessarily bad, it is bad that we don't have our State plans in better order.

DR. KLICKA: Let's recognize and not say it is good or bad, just say it exists. Let's assume we can be the people who take the brunt of any --

SR

DR. HALDEMAN: I was wondering why you didn't aim them at the local officials the way you did at Northbrook.

DR. KLICKA: Because Dr. Sinovitz(?) here controls the City Council.

MR. ROREM: If you had said that earlier we would have understood.

DR. KLICKA: Always leave a question for dramatic effect.

DR. HALDEMAN: Have you not been hitting pretty hard at the people who have the money for these types of enterprises?

DR. KLICKA: I want to make one point and I will

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answer.

One of the big problems that we are having here in trying to help Yoder, recognizing the fact that he has some limitations, is that he has not kept us informed about this particular program.

They usually have talked to us about other programs that have gone on but this one he has not. Now I recognize that he has been under such great pressure down there regarding this.

When I pressured him as to why he didn't keep us informed he astounded me by saying on that they have to maintain confidentiality on some of these cases.

They refer to the Hospital Licensing Act, and I am going to quote: "The Department shall make or cause to be made such inspections and investigations as it deems necessary.

SR

"Information received by the Department through filed reports, inspection or otherwise authorized under this Act shall not be disclosed publicly in such manner as to identify individuals or hospitals except in a proceeding involving the question of licensure or revocation or in other circumstances that may be approved by the Hospital Licensing Board."

This is something I think we will want to get into tomorrow. The only reason I am making this point is that in trying to implement you have to use all kinds of methods, even to the point of trying to get around, if you will, legal

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obstacles to what I sincerely say are probably good attempts at Regional Hospital Planning.

Now in our monthly report we make a point which I keep referring to relevant to the relationship with the State agencies.

This is another reason, George, that I am going into this in some detail, only to point out to you the obstacle that we have here in trying to implement something which we believe is proper.

MR. BUGBEE: Haven't you got any Democrats or Republicans on your own Board?

MR. SIBLEY: This is the next step. I think what we have to do if we cannot get this changed is not on our own Board but to get people down in the legislature whom we can use to counter pressure the Director of the Health Department, push this where necessary.

SR

DR. HALDEMAN: I must be defensive of the State Hill-Burton Agency, Mr. Sibley, because I have to administer a Hill-Burton Act presently.

There is lots in it I don't like and believe me, we get a lot of pressure on certain projects in which we are powerless to act. I think the answer is to change the legislation and not to require the Hill-Burton Act or try to get the Hill-Burton Agency to do something which is contrary to Dr. Yoder.

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MR. SIBLEY: I am all for that.

MR. BUGBEE: I don't think the pressure is an adhesive member of the Administration. I am assuming that if this fellow has pressure it is the Governor or somebody like that.

DR. HALDEMAN: I happen to feel that Frank Yoder tries to do what his best.

Off the record.

(Discussion off the record.)

DR. KLICKA: I want to make just one last point.

I am really mixed up at the moment with four years of experience now with regard to voluntary license, voluntary planning relevant to franchise planning. I think if I am on one side or the other I am stronger for the voluntary side now than I ever have been before, particularly with my recent experience with this.

SR

MR. ROREM: What do you mean on the voluntary side?

DR. KLICKA: I am talking about the system we use.

MR. ROREM: I don't quite know. As opposed to what?

DR. KLICKA: As opposed to having the decision as to whether a hospital can be built or not in a manner that can be determined by law by some State agency.

One of the things that we are not is that we are not subject to pressures.

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MR. ROREM: Do you mean, though, that the State agency now has too much power or too little or which?

DR. KLICKA: I am saying this: that with the powers they have they must administratively be subject to the types of pressures that a political politician can bring against any politic party.

MR. ROREM: But you leave it that way, you get your pressure in there too, is that it? I am serious, Carl. I am not trying to be funny.

DR. KLICKA: I know you are. I say this: this is, I think, the way it has to be done.

DR. HALDEMAN: Well, I would like to paraphrase what Mr. Sibley has said, that I don't think implementation can be either public or private, I think it has to be a combination. We have got to use all means, and some of those are Government and some of those are not.

SR

I would not want it in either one hand or the other, but I would want it in an effective combination of private and public.

DR. KLICKA: This is precisely why I am not unhappy with the situation as it exists at the moment. In other words, I am saying that now what we do have is a combination of both and I think we have to be very careful before we throw more authority for implementation into the law because of the dangers of political pressure in this field. I think this is a very,

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very dangerous area.

For many, many, many years people have pointed to the Savings and Loan Act in Illinois as being an example of the way this could be done. I realize now that the Savings and Loan Act is running into great problems -- that is, the Administration in Illinois -- and the people who are running savings and loan organizations in Illinois are saying that the law is not effective because when the chips are down the director who has the ability to determine whether or not the savings and loan institution will be built on the basis of need finds himself subject to such political pressure that unfrotunately, he goes in the direction of the greatest need.

DR. HALDEMAN: I think we are going to have to adjourn.

SR

Do you want to reconvene at 8:30 in the morning?

(Whereupon, at 5:30 o'clock p.m., a recess was taken until Tuesday, July 9, 1963, at 8:30 o'clock a.m.)

pk/Short