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COUNCIL OF TEACHING HOSPITALS  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
1346 Connecticut Avenue, N.W.  
Washington, D.C. 20036  
202/223-5364

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AGENDA

COMMITTEE ON MODERNIZATION AND CONSTRUCTION  
FUNDS FOR TEACHING HOSPITALS  
CAPITOL SUITE -- MAYFLOWER HOTEL  
2ND FLOOR  
1127 CONNECTICUT AVENUE, N.W.  
WASHINGTON, D.C. 20036  
202/ DI 7-3000  
FRIDAY, JUNE 28, 1968  
10:00 a.m. - 4:00 p.m.

- ✓ I. Call to Order and Call of Roll: 10:00 a.m.
- ✓ II. Approval of Minutes - Meeting of February 19, 1968 (Tab 22)
- ✓ III. Report on Action Items from Meeting of February 19, 1968 (Mr. McNulty) (Tab 23)
- IV. Report on Distribution of Supplemental Questionnaire to Retest Expressed Expansion Plans for Teaching Hospitals (Tab 24)
- (B) ✓ V. Report: Revenue and Expenditures Control Act of 1968 (Section 109 Tax-Exempt Status of Certain Hospital Service Organizations) (Tab 25)
- VI. Discussion of Two Recent Federal Health Agency Studies:
  - (1) Recommendation and Summary: A Program Analysis of Health Care Facilities (Office of Program Planning and Evaluation Bureau of Health Services) See Folder
  - (2) Legislation Relating to Health Facility Construction and to Special Purpose Project Grants ( Division of Hospital and Medical Facilities - Bureau of Health Services) (Tab 26)

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- ✓ VII. Report by Committee Members of Recent Contact with Assigned Members of President's Advisory Commission on Health Facilities. Staff Report on Washington Activities. (Tab 27)
- VIII. Discussion and Committee Disposition of Proposed "White Paper" on the Need for Modernization and Construction Funds for Teaching Hospitals - Meeting Society's Expectations for Excellence in Service and Education (Most Recent Draft Distributed May 23, 1968) (Tab 28)
- IX. Report on AAMC Study of Facilities for Health Education (Tab 29)
- X. Report on New York Chapter, AIA, Proposal for Health Facilities Laboratory (Tab 30)
- XI. Statement of the Association of American Medical Colleges Before the Subcommittee on Labor - Health, Education and Welfare of the Committee on Appropriations - U. S. House of Representatives (Distributed to Committee on April 30, 1968) See Folder
- XII. Report: Introduction of Bill and Concurrent Resolution by Senator Edward M. Kennedy (D-Mass.); S-3331 and S. Con. Res. 69 - Introduction of a Bill and Concurrent Resolution to Establish a National Health Council and a Joint Congressional Committee on Health (Facilities Aspect) See Folder
- XIII. Informational Copy - Speech by Senator Jacob K. Javits at the National Convention of the Council for Exceptional Children, Americana Hotel, New York City, Thursday, April 18th - (Distributed to Committee Membership on April 30, 1968) See Folder
- XIV . Other Business
- XV. Date of Next Meeting - On Call

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Page Three

XVI. Adjournment: 4:00 p.m.

The Committee will recess for lunch in the same suite at 12:30 and reassemble at 1:30.

The Committee will be joined at lunch by Howard N. Newman, White House Fellow to the Bureau of the Budget. Mr. Newman is on leave of absence as Associate Administrator, Pennsylvania Hospital, Philadelphia, Pennsylvania

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COMMITTEE ON MODERNIZATION AND CONSTRUCTION  
FUNDS FOR TEACHING HOSPITALS  
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MAYFLOWER HOTEL  
10:00 a.m. to 4:00 p.m.

PRESENT:

Richard T. Viguers, Chairman ✓  
Lewis H. Rohrbaugh, Ph.D., Vice-Chairman ✓  
Charles H. Frenzel  
Harold H. Hixson  
Robert C. Hardy ✓  
David Littauer, M. D.  
Richard D. Vanderwarker ✓  
John H. Westerman ✓  
John W. Kauffman, AHA Representative

187  
JOINED AT  
LUNCH BY  
HOWARD N. NEWMAN

STAFF:

✓ Matthew F. McNulty, Jr.  
✓ Grace W. Beirne  
✓ Fletcher H. Bingham  
Elizabeth Burgoyne  
✓ Thomas W. Campbell  
✓ William G. Reidy

VALENTINA  
WEISNER  
PETER A. WEIL

ABSENT:

J. Theodore Howell, M. D. ✓  
John H. Knowles, M. D.

Committee was joined for luncheon at 12:30 p.m. by William L. Kiss-  
ick, M. D., Executive Director, National Advisory Commission on  
Health Facilities.

I. Call to Order.

Chairman Viguers called the meeting to order at 10:00 a.m. Roll  
call was taken as noted above.

II. Welcome to John W. Kauffman, Chairman, AHA Council on Government

Relations:

Chairman Viguers, on behalf of the Committee Members welcomed Mr. Kauffman in his capacity as an AHA representative, and also in a personal capacity as Administrator of the Princeton Hospital in Princeton, New Jersey.

III. Welcome to Thomas J. Campbell, Assistant Director AAMC Division of Operational Studies.

Mr. Viguers welcomed Mr. Campbell to the meeting. At the Chairman's request Mr. Campbell gave a brief summary of the AAMC-HEW study he is involved with. He noted that the study, using 7 medical centers as information resources, will attempt to develop broad principles and methodology on program costs in medical centers.

IV. Approval of Minutes - Meeting of December 12, 1967.

ACTION #1

DR. LITTAUER MOVED THAT THE MINUTES OF THE MEETING OF DECEMBER 12, 1967 BE APPROVED AS PRESENTED. THE MOTION WAS SECONDED BY MR. FRENZEL AND CARRIED UNANIMOUSLY.

V. Report on Action Items from last Committee meeting and other outstanding Action Items from previous meetings.

Mr. McNulty referred to Action Items from the December 12 meeting and reported accomplishment as follows:

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Mr. McNulty said that the structural relationship between this committee, the AAMC Committee on Federal Health Programs, and the COTH

Executive Committee has been established with the Committee on Modernization and Construction Funds reporting to the COTH Executive Committee which will, when deemed appropriate, recommend action to the AAMC; FHP Committee.

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Mr. McNulty noted that this discussion also covered the report on Action #5 to the effect that the Federal "Fund Freeze" issue has also been referred to the Committee on Financial Principles.

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Each member of the COTH Committee was assigned a member of the National Advisory Commission on Health Facilities to establish informal lines of communication. At the request of the Chairman, Mr. McNulty commenced going through the list of Commission members first stressing that any contact made has been or should be "low key."

Boisfeuillet Jones, Commission Chairman - Mr. McNulty reported that in his letters and conversations with Mr. Jones, Mr. Jones had

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but in his opinion it is better to establish personal rapport and an awareness of teaching hospitals, probably until the Committee adopts some definite direction at which time a written document may be of more value. He emphasized that if we submitted something now, not only might it be lost in the great amount of material already sent to the Commission, but also the Commission might take an entirely new tack and COTH would not be able to adapt its statement to the new approach.

Dr. Rohrbaugh asked if the Committee had a specific point of view. Mr. McNulty said the staff had not sensed one in terms of a specific mechanism which would satisfy the needs of teaching hospitals and Chairman Viguers noted, saying that there is a general statement in the "White Paper" but no specific funding methodology has been put forth. Dr. Rohrbaugh thought it would be beneficial to propose definite alternatives; Dr. Littauer said this Committee should have a viewpoint somewhat parallel to legislation such as grants-in-aid, loans, etc. in order to accomplish our objectives, especially since legislation is being enacted concerning funding and it is generally agreed that the Commission's Report will doubtless influence legislation.

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Mr. McNulty said a draft has been prepared of a paper and would be covered under Agenda Item No. 9

VI. Recent statement of definitions by American Hospital Association.

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ACTION #2

IT WAS AGREED THAT THE QUESTION OF THE AHA DEFINITION OF "TEACHING HOSPITAL" AS OPPOSED TO THAT OF COTH (AS DETERMINED BY "WHITE PAPER" AND MEMBERSHIP CRITERIA) BE REFERRED TO THE COTH-AHA LIAISON COMMITTEE AND TO THE MARCH COTH-AHA MEETING FOR COORDINATION.

VII. Report: Meeting of the Organization of University Health Center Administrators, January 20-22, 1968.

Dr. Rohrbaugh reported that the OUHCA unanimously decided upon liaison with the COTH Committee on Modernization and Construction Funds for Teaching Hospitals. Mr. McNulty said the backing of that group would be very helpful to the COTH Committee.

VIII. Date of next meeting.

ACTION #3

IT WAS AGREED THAT THE NEXT MEETING OF THE COTH COMMITTEE ON MODERN-

IZATION AND CONSTRUCTION FUNDS BE HELD ON MONDAY, JUNE 17, 1968  
IN WASHINGTON.

IV. Other Business.

Mr. Vanderwarker expressed concern about obtaining joint venture tax exemption for activities which have been merged in an attempt to reduce costs. Miss Beirne clarified that if the hospital is actually involved, it is tax-exempt. If it is operated by a commercial organization, it is liable for taxation.

ACTION #4

MR. HIXSON MADE THE MOTION, SECONDED BY DR. LITTAUER, THAT THE COMMITTEE FORWARD THE QUESTION OF TAX EXEMPTION FOR JOINT VENTURES TO THE COMMITTEE ON FINANCIAL PRINCIPLES, THE AAMC COMMITTEE ON FEDERAL HEALTH PROGRAMS AND THE AHA WITH THE STRONG RECOMMENDATION THAT THESE BODIES EXPLORE THE ISSUE AND GO ON RECORD WITH A STATEMENT OF CONCERN AND SUGGESTION OF REMEDIAL ACTION.

Dr. Rohrbaugh mentioned that he and Mr. Viguers had been asked to visit with Senator Edward Kennedy. Prior to the upcoming visit, Senator Kennedy sent a "batch" of proposed legislation, which Dr. Rohrbaugh reviewed for the Committee members.

The Meeting was adjourned for lunch at 12:30.

The Committee was joined by William L. Kissick, M. D., for lunch. Dr. Kissick outlined the general structure and direction of the Commission and then answered various questions from Committee members.

X. Discussion of proposed "White Paper" on need for modernization and construction funds for teaching hospitals.

Mr. McNulty called attention to the proposed "White Paper", stressing that the draft emphasized philosophy over data and did not propose hard and fast solutions but urged that action be taken soon because of the increasingly growing rate of obsolescence of facilities.

The following points were stressed: (1) Dr. Littauer said he would like to see included a stress on "teaching hospitals" meaning educational, research, patient care and community service activity centers, which tailors itself to a need for certain physical facilities and Mr. Frenzel agreed it could be much more specific as to the needs.

(2) Several members felt the phrase "islands of excellence" sounded rather exclusive. Therefore, it was agreed to replace the word "islands" with, for example, "centers".

(3) It was agreed, following Mr. Viguers' suggestion, that just after the first paragraph, a statement be inserted that describes the total health care system of the United States. In this picture of the continuum it could be shown where the teaching hospital falls.

(4) It was agreed that in part 3 of paragraph 2, some stress of the essentiality of teaching hospitals in the production of physician manpower be made; and that in part 4 the urban location of hospitals be similarly emphasized.

(5) Committee generally felt that the draft should stress potential technological advances that can take place almost solely in the university - hospital complex. Also, they felt the general time limit within the draft for a period of ten years was good.

(6) Dr. Rohrbaugh asked the route of a White Paper. Mr. McNulty said the White Paper, upon approval by this Committee, goes to the COTH Executive Committee, then to the AAMA Executive Council. The Executive Council may, if they feel it controversial or debatable, may refer it to the AAMC Institutional Membership. Once totally approved, the White Paper is distributed to the AAMC mailing list (COTH members, deans, vice presidency, etc.) and to legislators, voluntary and public organizations active in the total health field, etc. Mr. Viguers suggested the possibility of putting the draft on the agenda for a meeting of the COTH-AHA Liaison Committee for comment, and Mr. McNulty concurred. The total process of official approval is three to nine months.

(7) General concluding comments were to the effect that it may be well to divide the paper into two parts, 1) problems, and 2) suggested solutions; that in page 2, paragraph 2, sentence 2, it might be wise to eliminate the word "primary" since it might contradict the AAMC statement on regional medical planning; that it would, as stated earlier, be good to place the teaching hospital in its perspective as part of the continuum.

XI. Review: Proposed study of need of funds for expansion of teaching hospitals.

Mr. McNulty said the questionnaire was to obtain more specific data concerning some of the needs that became evident in the original questionnaire. This survey would, tentatively, solely cover expansion.

Mr. Hixson suggested inclusion of some questions to demonstrate educational activities and the extent to which the institution expects to expand educational programs concurrent with physical expansion.

ACTION #5

IT WAS AGREED THAT COMMITTEE MEMBERS PRE-TEST THE QUESTIONNAIRE IN THEIR OWN INSTITUTIONS AND SEND COMMENTS ON ITS WORKABILITY AND PRACTICABILITY, AS WELL AS RESULTS, TO MR. McNULTY.  
THE MEETING WAS ADJOURNED AT 3:55 P.M.



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ABSENT:

J. Theodore Howell, M. D.  
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Committee was joined for luncheon at 12:30 p.m. by William L. Kiss-  
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Mr. McNulty said this was a "report back" item. Mr. Kauffman said two definitions of the same term often lead to confusion. He asked for any "compromise" that the AHA might consider. Subsequent discussion brought up several points, including the fact that COTH's criteria for membership do not include paramedical education. Mr. Frenzel said that since the difference between the two definitions was so great, there was chance for little compromise beyond inserting a qualifying statement recognizing the peculiar characteristics of the COTH type of teaching hospital. General comments were that some conclusion be reached since it is most practical for the AHA and COTH to be unified on legislative actions.

ACTION #2

IT WAS AGREED THAT THE QUESTION OF THE AHA DEFINITION OF "TEACHING HOSPITAL" AS OPPOSED TO THAT OF COTH (AS DETERMINED BY "WHITE PAPER" AND MEMBERSHIP CRITERIA) BE REFERRED TO THE COTH-AHA LIAISON COMMITTEE AND TO THE MARCH COTH-AHA MEETING FOR COORDINATION.

VII. Report: Meeting of the Organization of University Health Center Administrators, January 20-22, 1968.

Dr. Rohrbaugh reported that the OUHCA unanimously decided upon liaison with the COTH Committee on Modernization and Construction Funds for Teaching Hospitals. Mr. McNulty said the backing of that group would be very helpful to the COTH Committee.

VIII. Date of next meeting.

ACTION #3

IT WAS AGREED THAT THE NEXT MEETING OF THE COTH COMMITTEE ON MODERN-

IZATION AND CONSTRUCTION FUNDS BE HELD ON MONDAY, JUNE 17, 1968  
IN WASHINGTON.

IV. Other Business.

Mr. Vanderwarker expressed concern about obtaining joint venture tax exemption for activities which have been merged in an attempt to reduce costs. Miss Beirne clarified that if the hospital is actually involved, it is tax-exempt. If it is operated by a commercial organization, it is liable for taxation.

ACTION #4

MR. HIXSON MADE THE MOTION, SECONDED BY DR. LITTAUER, THAT THE COMMITTEE FORWARD THE QUESTION OF TAX EXEMPTION FOR JOINT VENTURES TO THE COMMITTEE ON FINANCIAL PRINCIPLES, THE AAMC COMMITTEE ON FEDERAL HEALTH PROGRAMS AND THE AHA WITH THE STRONG RECOMMENDATION THAT THESE BODIES EXPLORE THE ISSUE AND GO ON RECORD WITH A STATEMENT OF CONCERN AND SUGGESTION OF REMEDIAL ACTION.

Dr. Rohrbaugh mentioned that he and Mr. Viguers had been asked to visit with Senator Edward Kennedy. Prior to the upcoming visit, Senator Kennedy sent a "batch" of proposed legislation, which Dr. Rohrbaugh reviewed for the Committee members.

The Meeting was adjourned for lunch at 12:30.

The Committee was joined by William L. Kissick, M. D., for lunch. Dr. Kissick outlined the general structure and direction of the Commission and then answered various questions from Committee members.

X. Discussion of proposed "White Paper" on need for modernization and construction funds for teaching hospitals.

Mr. McNulty called attention to the proposed "White Paper", stressing that the draft emphasized philosophy over data and did not propose hard and fast solutions but urged that action be taken soon because of the increasingly growing rate of obsolescence of facilities.

The following points were stressed: (1) Dr. Littauer said he would like to see included a stress on "teaching hospitals" meaning educational, research, patient care and community service activity centers, which tailors itself to a need for certain physical facilities and Mr. Frenzel agreed it could be much more specific as to the needs.

(2) Several members felt the phrase "islands of excellence" sounded rather exclusive. Therefore, it was agreed to replace the word "islands" with, for example, "centers".

(3) It was agreed, following Mr. Viguers' suggestion, that just after the first paragraph, a statement be inserted that describes the total health care system of the United States. In this picture of the continuum it could be shown where the teaching hospital falls.

(4) It was agreed that in part 3 of paragraph 2, some stress of the essentiality of teaching hospitals in the production of physician manpower be made; and that in part 4 the urban location of hospitals be similarly emphasized.

(5) Committee generally felt that the draft should stress potential technological advances that can take place almost solely in the university - hospital complex. Also, they felt the general time limit within the draft for a period of ten years was good.

(6) Dr. Rohrbaugh asked the route of a White Paper. Mr. McNulty said the White Paper, upon approval by this Committee, goes to the COTH Executive Committee, then to the AAMA Executive Council. The Executive Council may, if they feel it controversial or debatable, may refer it to the AAMC Institutional Membership. Once totally approved, the White Paper is distributed to the AAMC mailing list (COTH members, deans, vice presidency, etc.) and to legislators, voluntary and public organizations active in the total health field, etc. Mr. Viguers suggested the possibility of putting the draft on the agenda for a meeting of the COTH-AHA Liaison Committee for comment, and Mr. McNulty concurred. The total process of official approval is three to nine months.

(7) General concluding comments were to the effect that it may be well to divide the paper into two parts, 1) problems, and 2) suggested solutions; that in page 2, paragraph 2, sentence 2, it might be wise to eliminate the word "primary" since it might contradict the AAMC statement on regional medical planning; that it would, as stated earlier, be good to place the teaching hospital in its perspective as part of the continuum.

XI. Review: Proposed study of need of funds for expansion of teaching hospitals.

Mr. McNulty said the questionnaire was to obtain more specific data concerning some of the needs that became evident in the original questionnaire. This survey would, tentatively, solely cover expansion.

Mr. Hixson suggested inclusion of some questions to demonstrate educational activities and the extent to which the institution expects to expand educational programs concurrent with physical expansion.

ACTION #5

IT WAS AGREED THAT COMMITTEE MEMBERS PRE-TEST THE QUESTIONNAIRE IN THEIR OWN INSTITUTIONS AND SEND COMMENTS ON ITS WORKABILITY AND PRACTICABILITY, AS WELL AS RESULTS, TO MR. McNULTY.

THE MEETING WAS ADJOURNED AT 3:55 P.M.

Report on Action Items from Meeting of <sup>February</sup> ~~January~~ 19, 1968

ACTION #1

Approval of Minutes - Meeting of December 12, 1967

ACTION #2

IT WAS AGREED THAT THE QUESTION OF THE AHA DEFINITION OF "TEACHING HOSPITAL" AS OPPOSED TO THAT OF COTH (AS DETERMINED BY "WHITE PAPER" AND MEMBERSHIP CRITERIA) BE REFERRED TO THE COTH-AHA LIAISON COMMITTEE AND TO THE MARCH COTH-AHA MEETING FOR COORDINATION.

ACTION #3

Setting of Date of Next Meeting of Committee for June 17, 1968

ACTION #4

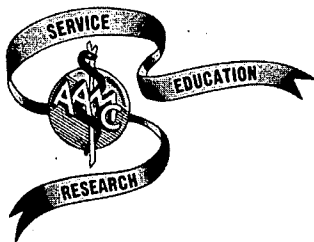
MR. HIXSON MADE THE MOTION, SECONDED BY DR. LITTAUER, THAT THE COMMITTEE FORWARD THE QUESTION OF TAX EXEMPTION FOR JOINT VENTURES TO THE COMMITTEE ON FINANCIAL PRINCIPLES, THE AAMC COMMITTEE ON FEDERAL HEALTH PROGRAMS AND THE AHA WITH THE STRONG RECOMMENDATION THAT THESE BODIES EXPLORE THE ISSUE AND GO ON RECORD WITH A STATEMENT OF CONCERN AND SUGGESTION OF REMEDIAL ACTION. (see Item V, Tab 25)

ACTION #5

IT WAS AGREED THAT COMMITTEE MEMBERS PRE-TEST THE QUESTIONNAIRE IN THEIR OWN INSTITUTIONS AND SEND COMMENTS ON ITS WORKABILITY AND PRACTICABILITY, AS WELL AS RESULTS, TO MR. McNULTY.

~~THE MEETING WAS ADJOURNED AT 3:55 P.M.~~

° (see Item IV, Tab 24)



ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COUNCIL OF TEACHING HOSPITALS  
1346 CONNECTICUT AVENUE, N.W.  
WASHINGTON, D. C. 20036  
202/223-5364

MATTHEW F. McNULTY, JR.  
DIRECTOR

June 24, 1968

214  
27,000  
24,000 - mod

As you may recall, the Council of Teaching Hospitals, during the summer and fall of 1967, conducted a questionnaire survey to determine the extent of modernization and expansion needs for teaching hospitals. We would, at this time, like to thank you for participating in this study by providing a summary of such needs for your particular hospital. We did distribute the results of this survey to the membership on November 8, 1967, under the covering General Membership Memorandum No. 68-2G.

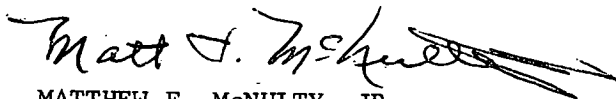
At the present time, one of the several committees of the Council of Teaching Hospitals is the Committee on Modernization and Construction Funds for Teaching Hospitals. This Committee has been charged with the responsibility of developing a realistic assessment of the extent of need of capital financing for teaching hospitals, and the subsequent development of alternative proposals that will best serve to resolve this need. One source of information that is continually being referred to is the above-mentioned survey results.

One rather intriguing conclusion that can be ascertained from this survey's results is the high level of expressed need for the bed expansion of teaching hospitals. The results of the survey indicated that over 24,000 beds were to be added by the 142 hospitals that indicated some expansion of bed capacity was desirable. Prior to issuance of the questionnaire, there was a high degree of consensus that a rather obvious need for modernization of teaching hospital facilities was existent, and this was verified by the survey results. The extent of need for expansion of facilities however, while not unanticipated, was somewhat greater than thought existing. Therefore, this Committee would like guidance about the implications of this issue in order that a realistic proposal can be developed.

A copy of the original questionnaire which you submitted is enclosed; number 8-C is called to your attention. In order for us to verify these expansion projections, we would appreciate either your, or a member of your staff's completion of the attached questionnaire. Through this re-evaluation of the need for capital funds for expansion of teaching hospital facilities we hope to be able to continue to work toward development of a program that is both meaningful and productive.

Thank you for your assistance in this regard.

Cordially,



MATTHEW F. McNULTY, JR.  
Director, COTH  
Associate Director, AAMC

Enclosure: Questionnaire on Expansion Needs for Teaching Hospitals



June 20, 1968

Follow-Up Questionnaire on Projected Expansion  
of Plant and Facilities for Teaching Hospitals

Hospital \_\_\_\_\_

Location \_\_\_\_\_

1. Projected Number of Beds by which the Hospital is to be expanded. Please specify the net increase number of beds (total new beds less existing beds phased out).

1968-69-70 \_\_\_\_\_

1971-72-73 \_\_\_\_\_

1974-75-76 \_\_\_\_\_

Total \_\_\_\_\_

2. Number of Beds to be expanded by Service (again net increase).

Medical \_\_\_\_\_

Surgical \_\_\_\_\_

Pediatrics \_\_\_\_\_

Other, Short Term Acute \_\_\_\_\_

Extended Care \_\_\_\_\_

Ambulatory Care \_\_\_\_\_

Specialized Unit Total \_\_\_\_\_

(Please specify type and number of beds)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other, Please Specify \_\_\_\_\_

3. Would you please indicate how these figures were obtained?

Results of  
Internal Survey \_\_\_\_\_  
By Whom

Results of Survey \_\_\_\_\_  
by Consultant

Governmental Agency \_\_\_\_\_  
Which

4. Is this Expansion Program:

\_\_\_\_\_ A totally new facility which will serve  
as a replacement of the entire existing  
hospital?

\_\_\_\_\_ An expansion of the existing plant and facility?

5. Has this Expansion Program been formalized in the development of a Long-Range Master Plan for your Hospital?

\_\_\_\_\_ Yes \_\_\_\_\_ No

6. What Degree of Accomplishment is Attendant to the Long-Range Construction Plans?

	1968-69-70	71-72-73	74-75-76
Discussion Only			
Program in Writing			
% of Funding Available			

7. Has the Governing Board of the Hospital approved specifically the Long-Range Construction Program for each of years?

1968-69-70 \_\_\_\_\_

1971-72-73 \_\_\_\_\_

1974-75-76 \_\_\_\_\_

8. Is the local or state Areawide Planning Agency operational?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes; has the Areawide Planning Agency recommended such Facility Expansion through Years?

1968-69-70 \_\_\_\_\_

1971-72-73 \_\_\_\_\_

1974-75-76 \_\_\_\_\_

9. Please indicate the Expected Source and declare Amount of Funds needed to finance your Expansion Program including Local Funds available and/or being sought. (Use Current Dollar Figures.)

	1968-69-70	1971-72-73	1974-75-76
Federal Government			
State Government			
University Funds			
Owned Funds on Hand			
Other			
Totals			

Although the major purpose of this questionnaire deals with expansion needs at your hospital, we would like to confirm the modernization and replacement needs for your hospital. Would your please indicate the amount of capital funds needed to accomplish the necessary modernization and/or replacement at your institution. (Please use current dollar figures) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

10. Does your hospital participate in the undergraduate teaching  
of medical students?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

If yes, do you anticipate an increase in the class sizes of medical students  
using your facilities?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

Please note:

Number of Medical students now using facilities \_\_\_\_\_  
Anticipated number to (1970) \_\_\_\_\_  
(1975) \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

REVENUE AND EXPENDITURE CONTROL ACT OF 1968  
SEC. 109. TAX-EXEMPT STATUS OF CERTAIN HOSPITAL  
SERVICE ORGANIZATIONS.

(a) *EXEMPTION FROM TAX.*—Section 501 (relating to exemption from tax on corporations, etc.) is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

“(e) *COOPERATIVE HOSPITAL SERVICE ORGANIZATIONS.*—For purposes of this title, an organization shall be treated as an organization organized and operated exclusively for charitable purposes, if—

“(1) such organization is organized and operated solely—

“(A) to perform, on a centralized basis, one or more of the following services which, if performed on its own behalf by a hospital which is an organization described in subsection (c)(3) and exempt from taxation under subsection (a), would constitute activities in exercising or performing the purpose or function constituting the basis for its exemption: data processing, purchasing, warehousing, billing and collection, food, industrial engineering, laboratory, printing, communications, record center, and personnel (including selection, testing, training, and education of personnel) services; and

“(B) to perform such services solely for two or more hospitals each of which is—

“(i) an organization described in subsection (c)(3) which is exempt from taxation under subsection (a),

“(ii) a constituent part of an organization described in subsection (c)(3) which is exempt from taxation under subsection (a) and which, if organized and operated as a separate entity, would constitute an organization described in subsection (c)(3), or

“(iii) owned and operated by the United States, a State, the District of Columbia, or a possession of the United States, or a political subdivision or an agency or instrumentality of any of the foregoing;

“(2) such organization is organized and operated on a cooperative basis and allocates or pays, within 8½ months after the close of its taxable year, all net earnings to patrons on the basis of services performed for them; and

“(3) if such organization has capital stock, all of such stock outstanding is owned by its patrons.

For purposes of this title, any organization which, by reason of the preceding sentence, is an organization described in subsection (c)(3) and exempt from taxation under subsection (a), shall be treated as a hospital and as an organization referred to in section 503(b)(5).”

(b) *EFFECTIVE DATE.*—The amendments made by subsection (a) shall apply to taxable years ending after the date of the enactment of this Act.

Section 109. Tax-exempt status of certain hospital service organizations

Section 109 of the conference substitute (which corresponds to sec. 12 of the Senate amendment) adds a new subsection to section 501 of the Internal Revenue Code which, in effect, provides a tax-exempt status for certain cooperative hospital service organizations. In order to qualify for a tax-exempt status, a hospital service organization must be organized and operated solely to perform services specified in the new subsection which, if performed directly by a tax-exempt hospital, would constitute activities in the exercise or performance of the purpose or function constituting the basis for its exemption, and must perform these services solely for two or more tax-exempt hospitals. The new subsection does not grant tax-exempt status if the hospital service organization performs any services other than those specified in the new subsection (for example, laundry services), or performs any services for any person or organization other than a tax-exempt hospital. In addition, such organization must be organized and operated on a cooperative basis and, if it has capital stock, all of its stock outstanding must be owned by its patron-hospitals. Under the amendment, a hospital service organization which meets these requirements and thereby qualifies for tax-exempt status is to be treated, for purposes of the Internal Revenue Code, as a hospital and as an organization referred to in section 503(b)(5) of the Code.

This amendment applies to taxable years ending after the date of enactment of the bill.

Leaves out laundry

RECOMMENDATIONS AND SUPPLEMENTAL DATA

ABSTRACTED FROM

LEGISLATIVE PROPOSALS RELATING TO HEALTH

FACILITY CONSTRUCTION AND TO SPECIAL

PROJECT GRANTS

Prepared by:

Division of Hospital Facilities  
and Medical Facilities  
Bureau of Health Services

LEGISLATIVE SPECIFICATIONS

FOR

HOSPITAL AND MEDICAL FACILITIES

1. RECOMMENDATION:

A Program of Federal Grants to assist in the construction and modernization of hospitals and medical facilities. The Program would provide for a five-year authorization (Fiscal Years 1970-1974) of \$2,215 million: \$340 million for 1970; \$390 million for 1971; \$405 million for 1972; \$500 million for 1973; and \$580 million for 1974. Specifically, the Program would provide for expanded grant assistance to Hospital and Public Health Centers, Modernization of Hospitals and Medical Facilities, Long-Term Care Facilities, Ambulatory Care Facilities (formerly Diagnostic and Treatment Centers), and Rehabilitation Facilities, (see pages 38-40, Program Impact and Program Cost).

The basis for determining the allotments to the several States would be the same for construction grant and modernization categories, taking into consideration the population, financial need, need for additional facilities, and the effective demand for services.

The authority of the state agency, state plan requirements, Federal share, project approval, regulatory requirements, and Federal Hospital Council membership would remain the same as in current legislation, except as modified by "Special Additional Legislative Specifications" (see pages 26-37).

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LEGISLATIVE SPECIFICATIONS

for

INTERFACILITY INCENTIVE GRANTS

for

HOSPITAL AND MEDICAL FACILITIES

CONSTRUCTION AND MODERNIZATION

11. RECOMMENDATION

Authority for a five-year period (1970-1974) to administer a program which would provide for Interfacility Incentive Grants up to twenty percent of, and in addition to, the basic construction or modernization grant. Eligible projects would include shared services for hospitals, jointly sponsored health services, inter-facility cooperation to provide comprehensive health care, and dispersed ambulatory care centers provided by hospitals and other health facilities. The recommended authority would also permit the funding of other types of health facility relationships, as their efficacy is demonstrated (see pages 38-40, Program Impact and Program Cost).

MULTIPLE  
SERVICE  
HEALTH  
FACILITY  
ASSOCIATION

The proposal would provide that the several States administratively earmark a given percentage of the funds allotted for three existing categories (Hospitals and Public Health Centers, Long Term Care Facilities and Modernization) which would be retained for the exclusive use of providing the twenty percent premium for that portion of a project qualifying for an Inter-facility Incentive grant. Ten



percent of these categorical funds would be administratively earmarked in fiscal year 1970 for Interfacility Incentives; fifteen percent in 1971; and twenty percent from each of the subsequent three fiscal years. Funds set aside for Interfacility Incentive Grants would be in addition to, and superimposed upon that portion of the basic grant related to the Interfacility portion of a project. For example, in a State where the Federal share was 33-1/3 percent of the eligible cost, the total-Federal participation could be raised to 53-1/3 percent for that portion of a project eligible for Interfacility Incentive support. Except as modified by "Special Additional Legislative Specifications" (see pages 26-38) existing State plan requirements, project review and approval responsibilities would apply equally to projects involving Interfacility Incentive Grants. However, necessary regulatory changes would be effected to cover such areas as project eligibility requirements and project priorities.

LEGISLATIVE SPECIFICATIONS

FOR

HOSPITAL AND MEDICAL FACILITIES

MODERNIZATION LOANS

*prime*  
*What is*  
*low*  
*6 1/2*

111. RECOMMENDATION:

Authority to administer a five-year (1970-1974) low interest loan program to aid in the modernization of hospital and medical facilities. The recommended authority would authorize an annual (and accumulating) appropriation of \$200 million for this purpose. Loans would be repaid over a period not to exceed twenty-five years, and would bear a low rate of interest. Loans would be permitted up to 90 percent of the total facility cost, upon project completion. Loans and grants in combination would also be permitted up to 90 percent of the total facility cost, upon project completion (see pages 38-40, Program Impact and Program Cost).

The allotment to the several States would be in a manner which is equitable to each State taking into consideration population, financial need and need for modernization. Except as modified by "Special Additional Legislative Specifications" (see pages 26-37), existing state plan requirements, and project review and approval responsibilities would apply equally to projects funded under a modernization loan program.

Regulatory changes that would be effected in order to incorporate the necessary provisions to administer a loan program would include, among other provisions, that monthly payments would be made to a project sponsor during construction in the same manner as loans from banking institutions, including Federally guaranteed loans. Also, that the 90 percent loan provision would be limited to 90 percent of the project sponsor's equity in the cost of the total facility upon project completion.

LEGISLATIVE SPECIFICATIONS

FOR

SPECIAL PURPOSE PROJECT GRANTS

IV. RECOMMENDATION:

Authority for a five-year period (Fiscal Years 1970-1974)  
for special purpose project grants directed to the adoption of  
health facility program innovations related to patient care  
activities. This broad authority would be requested in order  
to provide flexibility in terms of operational grants for  
shared services between health facilities, hospital-based or  
affiliated home care services, or the establishment of a new  
basic service in critical-need communities. It would also per-  
mit operational grants for outpatient services for Inner City  
Hospitals. Minor facility renovation associated with such  
projects would also be eligible for Federal participation.

Eligible projects would be supported with Federal partic-  
ipation up to 100, 85, 70, 50 and 25 percent for a maximum of  
five year support (see pages 38-40, Program Impact and Program  
Cost).

Implementing regulations would be developed to cover var-  
ious requirements, such as reasonable assurance that the  
project would continue after Federal support has ceased.

Operational grants for outpatient services would be limited to  
Inner City Hospitals that would agree to provide evening and  
Saturday clinics.

The Regulations would also permit the Department of Health, Education and Welfare to develop an annual priority of the types of projects to be supported in order to maintain the necessary program flexibility to concentrate on areas of need as they develop.

SPECIAL ADDITIONAL LEGISLATIVE SPECIFICATIONS

FOR

HOSPITAL AND MEDICAL FACILITIES

CONSTRUCTION GRANT AND MODERNIZATION LOAN ASSISTANCE

V. RECOMMENDATION:

Planning Agency Approval. Provides, as a condition precedent to the approval of an application, that the project proposal must be reviewed by the appropriate Areawide Health Planning Agency and that the recommendations of the Areawide Health Planning Agency would in turn be submitted to the State Hill-Burton Agency.

VI. RECOMMENDATION:

Licensing Requirement: Provides that State statutes shall give authority to State Hill-Burton Agencies to license all health care facilities and that such licensing shall be contingent upon appraisal of need for the facility, and upon satisfactory provision for staff and operating budget. The licensing requirement would also provide that construction plans for new facilities and construction plans for the expansion of existing facilities shall be reviewed and approved by the State Hill-Burton Agency prior to the onset of construction.

VII. RECOMMENDATION:

Minimum Hospital Size. Provides that legislation should include a requirement that each Hill-Burton State Plan shall reflect, by planning areas, a minimum hospital size commensurate with the population of the planning area.

VIII. RECOMMENDATIONS:

Modernization Assistance Requirement. Provides a requirement that the use of modernization grants and loans be limited to those service areas within each State in which agreement has been reached as to which specific facilities should be expanded, modernized, remain at their present state, or be phased out.

IX. RECOMMENDATION:

Acute Care Assistance Requirement. Provides for all acute care General Hospitals requesting construction grant or loan assistance to show evidence that they have made provision for long-term services as part of the applicant's own facility, or by formal agreement with a separate long-term facility.

X. RECOMMENDATION:

Allotment Formula. Provides that the basis for computing State allotments for all construction grants and modernization loans be, to the greatest practicable extent, the result of a formula comprising population, health facility needs, effective demand for services, and the financial need of the State.

XI. RECOMMENDATION:

Funds for Administration of State Plans. Provides for authority to increase from \$50,000 to \$100,000, the amount available from the annual state allotment which may be used by the State Agency in the administration of the Hill-Burton State Plan.

XII. RECOMMENDATION:

Equipment-Only Projects. Provides for equipment-only projects whether associated with, or without, construction if the equipment is needed in order to institute a new service within the community. Present legislation permits assistance to equipment-only projects only if the project is associated with construction or modernization.

XIII. RECOMMENDATION:

Site Interest and Recovery. Provides for the sponsor's site interest to be reduced to twenty years only. However, in the case of a loan, the site interest requirement and recovery provision would necessarily be conterminous with the length of the loan, i.e., at least twenty years, but no more than 25 years. Present legislation requires that a project sponsor must have fee simple title to the site or such other estate or interest for not less than 50 years. Yet, Department of Health, Education, and Welfare recovery rights for the facility proper is limited to twenty years.

XIV. RECOMMENDATION:

Right of Federal Recovery. Provides for DHEW authority to waive for good cause, the 20 year right of Federal recovery for projects approved prior to the enactment of Public Law 88-443, the Hospital and Medical Facilities Amendments of 1964. This existing Hill-Burton legislation provides this authority for projects approved after its enactment (August 18, 1964).



XV. RECOMMENDATION:

Staff Privileges. Provides for health facilities seeking construction grants or loan assistance to make staff privileges available to all equally licensed physicians on the basis of justification.

XVI. RECOMMENDATION:

Physician Examining Rooms. Provides that the construction of examination rooms for physicians be made eligible for grant or loan assistance.

XVII. RECOMMENDATION:

Motel-Like Accommodations. Provides for the construction of motel-like room accommodations to be made an eligible cost within, or as a part of a hospital complex to serve outpatients who must remain in the hospital setting for diagnostic tests and for inpatients who do not require the diagnostic tests and treatment procedures associated with an acute hospital bed.

XVIII. RECOMMENDATION:

Home Health Services. Provides that the construction of space for all phases of home health services be made eligible for grant or loan assistance.

XIX. RECOMMENDATION:

Site Cost. Provides that the cost of the site for modernization projects be made eligible for Federal participation.

PROGRAM IMPACT

(Prospective Program Volume of Projects and Beds, FY 1970-74)

Grants for Construction of Health Facilities.

1. Hospitals, public health centers--615 general hospital projects providing 43,700 beds; 135 health center projects.  
Relation to need--9 percent of the 477,000 general beds needing to be modernized or added, currently and over the next five years.
2. Long-term care facilities--1,360 nursing home and chronic disease projects providing 76,680 beds.  
Relation to need--16 percent of the 485,000 long-term care beds currently needing to be added or modernized or accruing need in the next five years.
3. Ambulatory Care Facilities (formerly Diagnostic and Treatment Centers), 520 projects.  
Relation to need--16 percent of the 3,200 centers needing to be newly built or modernized, currently and in the next five years.
4. Rehabilitation facilities--190 projects.  
Relation to need--about 25 percent of the 720 rehabilitation facilities needing to be newly built or modernized, currently and in the next five years.
5. Modernization of health facilities--915 projects providing 59,020 modernized beds (56,065 general and 2,955 other).  
Relation to need--56,065 equals 17 percent of the 338,000 general hospital beds needing modernization now and over the coming five years.  
The 2,955 other beds, if all applied to long-term care facilities, would modernize only 1 percent of the 275,000 beds currently in the backlog or accruing in the five-year period.

6. Interfacility incentives--525 projects.

Loans for Modernization of Health Facilities

Direct modernization loans--320 projects modernizing 20,900 beds (assuming 90 percent loan and 50 percent of loans being utilized for loan only projects).

Relation to need--6 percent of the 338,000 general hospital beds in the modernization backlog or accrual, in addition to those modernized through grant projects.

Special Purpose Project Grants

Health facility program innovations--1,140 projects initiated and funded through 1974.

56,065  
20,900  

---

76,965

17%

23%

6%

OUR STUDY

10 YEARS  
REPLACE 27,500  
ADD 24,500  

---

51,500

Criteria for Computation of Program Impact:

1. The five-year estimated volume for all health facility construction formula grants, except Interfacility Incentives, are based on the most recent two-year pattern per \$1 million of Federal funds, discounted for construction cost increase.
2. FY 1970-1974 prospective volume for (1) hospital and health centers, (2) long-term care facilities, and (3) grants for modernization of health facilities--assume that 10 percent of the funds for these categories are authorized and utilized for interfacility construction incentives in 1970, 15 percent in 1971, and 20 percent in 1972, 1973, and 1974. It is also assumed that the same percentages of the project volume for these categories will take advantage of the incentives.
3. The health facility program innovations estimate assumes that \$100 million will be used for initial grants in 1970, \$110 million in 1971, and \$120 million in 1972, 1973, and 1974. Federal participation in the grants would be 100, 85, 70, 50, and 25 percent in their life of five years.

ESTIMATED COSTS OF PROPOSED HEALTH FACILITY PROGRAMS

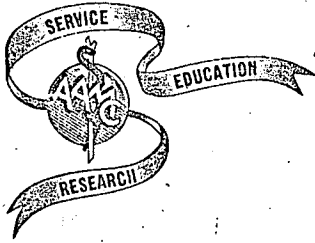
(Thousands of Dollars)

	1970	1971	1972	1973	1974
<i>Providing Facilities and Equipment:</i>					
1. Grants for construction of health facilities:					
(a) Hospitals, public health centers, etc.....	125,000	125,000	125,000	125,000	125,000
(b) Long-term care facilities.....	100,000	130,000	130,000	175,000	175,000
(c) Ambulatory Care Facilities.....	25,000	30,000	35,000	35,000	35,000
(d) Rehabilitation facilities.....	10,000	15,000	15,000	15,000	15,000
(e) Modernization of health facilities.....	80,000	90,000	100,000	150,000	230,000
(f) Interfacility incentives 1/.....	<u>(30,500)</u>	<u>(51,750)</u>	<u>(71,000)</u>	<u>(90,000)</u>	<u>(106,000)</u>
Sub-Total.....	340,000	390,000	405,000	500,000	580,000
2. Loans for modernization of health facilities:	200,000	200,000	200,000	200,000	200,000
<i>Improving Organization and Delivery of Health Services..</i>					
1. Special purpose project grants:					
Adoption of Health Facility Program Innovations..	<u>100,000</u>	<u>195,000</u>	<u>283,500</u>	<u>349,000</u>	<u>386,000</u>
Total.....	640,000	785,000	888,500	1,049,000	1,166,000

Funds shown in parentheses as available for interfacility incentives will be taken from categories (a), (b) and (e) at the following percentages: 1970 - 10%, 1971 - 15%, 1972, 1973, and 1974 - 20%. Funds remaining in the interfacility category after an 18-month period may be returned for use to the categories from which they were originally taken.

<sup>3</sup>  
 3640  
 785  
 888.5  
 1049  
 1166  
 4532.5

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VI

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**  
COUNCIL OF TEACHING HOSPITALS  
1346 CONNECTICUT AVENUE, N.W.  
WASHINGTON, D. C. 20036  
202/223-5364

**MATTHEW F. McNULTY, JR.**  
DIRECTOR

June 25, 1968

TO: COTH Committee on Modernization and Construction Funds  
for Teaching Hospitals

Richard T. Viguers, Chairman  
Lewis H. Rohrbaugh, Ph.D., Vice-Chairman  
Robert C. Hardy  
John H. Knowles, M.D.  
David Littauer, M.D.  
Richard D. Vanderwarker  
John H. Westerman

COTH Members on AAMC Committee on Federal Health Programs

Charles H. Frenzel  
Harold H. Hixson  
James T. Howell, M.D.

We have been able to maintain close liaison with the staff of the National Advisory Commission on Health Facilities. Following several discussions with them, they suggest that we submit a more general statement of the role which teaching hospitals assume in the health care delivery system and the needs for financing. This we have done in the attached statement.

As you will recall, we had submitted a copy of the draft of the COTH position statement on modernization and construction funds, and we do not believe that this most recent request by the staff, negates this statement at all. Rather, we believe they are now searching a broader rationale to which they can later include specific proposals.

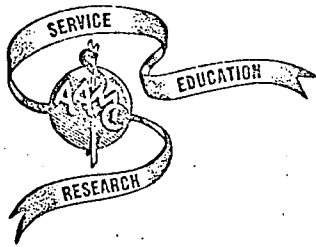
This item will be included in the agenda book for the June 28th meeting of the Committee.

Cordially,

*Mat*  
MATTHEW F. McNULTY, JR.  
Director, COTH  
Associate Director, AAMC

Enclosure: A General Statement of the Teaching Hospitals Contribution to  
the Ideal of Excellence in the Health Care of the Nation

cc: John W. Kauffman



*File*

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COUNCIL OF TEACHING HOSPITALS  
1346 CONNECTICUT AVENUE, N.W.  
WASHINGTON, D. C. 20036  
202/223-5364

MATTHEW F. McNULTY, JR.  
DIRECTOR

June 25, 1968

William L. Kissick, M.D.  
Executive Director  
National Advisory Commission  
on Health Facilities  
Room 6235, Federal Building  
726 Jackson Place, N.W.  
Washington, D.C. 20506

Dear Bill;

Since our most recent opportunity of meeting we here at the Council have been giving prolonged thought to the development of a general statement relating to the challenges and opportunities incumbent upon teaching hospitals, and how these component elements are interwoven into the entire health care system. We were also interested in developing a position that would satisfactorily indicate how these responsibilities have served to accentuate the need for modernization and construction funds for these several hundred hospitals. The attached statement is our modest attempt in this regard.

We had hoped for an opportunity of meeting with you to discuss several of the ideas contained within the document but like Kipling's East and West, translated into mutually heavy travel schedules, we were unfortunately unable to arrange for a convenient time. Miss Jane Katz did very thoughtfully call yesterday, and we discussed the Council's thinking to date on the prevailing issues. Assuming your concurrence, I am forwarding to her a carbon of the "General Statement".

Either Fletcher (Fletcher H. Bingham, Ph.D., Assistant Director, COTH) or I stand prepared to discuss any portion of the enclosed, at any time, with you or a member of your staff.

I do look forward to an early opportunity of visiting with you again. Until then, best regards.

Cordially,

MATTHEW F. McNULTY, JR.  
Director, COTH  
Associate Director, AAMC

Enclosure: A General Statement of the Teaching Hospital's Contribution to the Ideal of Excellence In Health Care of the Nation

cc: Miss Jane Katz

A GENERAL STATEMENT OF THE TEACHING HOSPITAL'S CONTRIBUTION  
TO THE IDEAL OF EXCELLENCE IN THE HEALTH CARE OF THE NATION

June 24, 1968

Prepared for:  
Staff, National Advisory Commission  
on Health Facilities

By:  
Matthew F. McNulty, Jr.  
Director, Council of Teaching Hospitals  
Associate Director, Association of  
American Medical Colleges

The health services of this nation are provided to the people through a distributive mechanism, that has most frequently been characterized as a "system". The various institutional components that combine to serve as the distributive points for health and medical services, although interdependent in nature, have a heritage of management autonomy or semi-autonomy, which can be translated into an operational pattern of fragmented, or non-comprehensive, patient care for the individual in need of such services.

A thread of continuity which gives persuasive identification of a "system" to the separately managed service activities in the existing social health service order is the teaching hospital. It is in these institutions that every physician and many practitioners of the allied health disciplines spend a period of their professional development. For this and other reasons mentioned hereafter, the teaching hospital is an existing, viable entity which represents a potential unifying force in the collection of health activities designated a "system".

From previous contribution, many teaching hospitals of the country have long been the only source of health care for the community and regional socially and medically indigent patients. In continuing this past and current vital capability, the teaching hospital has a further potential of providing a catalytic opportunity for effecting a "system". Of all present elements within the existing order, the teaching hospital is, for a variety of reasons, best qualified to directly and indirectly increase the accessibility and acceptability of health services to those who presently are unable to gain entry to them.

Yet, to make contributions of the proportions discussed, the teaching



hospitals of the country are poorly equipped with both quality and quantity of space. To understand the urgent need for modernization and expansion funds for teaching hospitals, it is necessary to look at the entire structure of health care delivery and delineate the unique social roles of these teaching institutions.

Teaching hospitals have three functionally related health care goals. First in order of priority is the rendering of medical care to patients; next is the education of future health practitioners and the third is research in medicine and related biological, social and managerial sciences. If all hospitals are dedicated to the first goal, the community of teaching hospitals is unique in providing the setting for the truly complicated, extensive team-type diagnostic, therapeutic and rehabilitative care, while additionally being the primary locus in the nation for providing the clinical facilities for education and research.

Through its provision of essential facilities for the education and training of students of medicine and the allied health professions, the teaching hospital serves the entire nation and is a national resource. Aspiring health practitioners congregate in these large institutions and then, having received their training, disperse throughout the nation to serve the population's health care needs. Thus, the teaching hospital transcends its local environment by providing health manpower for the nation as a whole. In truth the alumni and alumnae of these institutions if assembled for "old school" reunions would represent almost exclusively the nations medical practitioners of today.

Although the teaching hospitals are a major national resource for

health manpower, they perform no less a significant role in harboring the research facilities so necessary in expanding the body of knowledge in the health sciences and in the social and management sciences related to the delivery of health services. Highly trained research scientists, utilizing specialized techniques and with the aid of constantly refined precision instruments, provide the foundation for the conquest of the nations diseases and ailments. The teaching hospital as the locus of specialized competencies enables the gains of one area of investigation to be quickly absorbed and thus become the source of other discoveries in medicine.

The research function of the teaching hospital does not stop at the cure of disease, however. Because it is the locus of the varied health professions, teaching hospitals in individual instances, have provided a vigorous community effort by experimenting with different systems to deliver primary, comprehensive, community based, patient care. One model that has been proven particularly useful in this regard is the concept of the "neighborhood health center". In a number of instances teaching hospitals located in the urban inner city, have exercised a leadership position in the development of these programs. Thus, many teaching hospitals have demonstrated the unique base of manpower, financial strength, management expertise and facility capability for providing primary care to its immediate community.

The role of the teaching hospital in the system of health care can be readily dichotimized into direct and indirect categories. The teaching hospital affects the system of health care delivery directly in its rendering of primary patient care to the community in which it is located.

Additionally, the teaching hospital is an indirect, but very real force on the system of health care in its educational and research capacities.

The last general role provided by the teaching hospital straddles the categories mentioned before but which should not be understated in an assessment of the socially unique function of these institutions. The teaching hospital renders to the national community the more advanced forms of patient care normally undertaken on a referral basis. Linked intimately with the advancement of medical research, the advanced care rendered within these institutions serves as models of excellence for the health industry.

#### THE NEED FOR FUNDS

Attendant to the unique social contributions provided by teaching hospitals are general program requirements for modern and expanded facilities. The inability of the teaching hospital to launch an immediate, frontal attack on many health problems of an urban and rural nature, is a result of the present total inadequacy of facilities, commensurate with the services which society is presently expecting it to provide.

In rendering direct patient service, the teaching hospital like hospitals nationwide, experiences problems in financing modernization and expansion proposals, primarily because hospitals are non-profit organizations and are reimbursed for their services, most frequently, on a cost basis. Explained another way, those elements of a cost reimbursement formulae which provide a "plus" factor to exact reimbursement - such as accelerated depreciation payments, developmental factors, and so forth - are seldom sufficient to enable the amortization of large-scale funds needed

for modernization and expansion. The economic impact of these arrangements effectively prevent the accumulation of a capital surplus. Moreover, depreciation charges when received, most often must be used for maintaining the existing facilities rather than for modernization purposes.

Coupled with the indirect but highly significant role played by teaching hospitals in the provision of health manpower and the housing of medical, social and management research, these financial needs become even more pressing. Educational programs require space to support teaching, laboratories, classrooms, seminar-conference rooms, house staff offices, and so forth. The research function makes heavy spatial demands on the teaching hospital, including the need for experimentation in different health delivery systems. The rendering of advanced medical care requires highly skilled health practitioners coupled with prodigious technical apparatus to aid in performing the many diagnostic, therapeutic and rehabilitative functions so unique to the teaching hospital.

If the teaching hospital is to continue to provide the health care system with the impetus for excellence, it must have the requisite financial support for modernization and expansion. In order for the teaching hospital to serve as a catalytic agent congealing many of the present disjointed elements of health care, then substantial assistance for a base physical facility capability needs to be established. Time and continued stability, through solid financial backing, will permit the nation's teaching hospitals to continue to effectively discharge their unique functions as an integral part of the health care system now and in the future.

MEETING SOCIETY'S EXPECTATIONS FOR EXCELLENCE  
IN SERVICE AND EDUCATION

*Closing date for  
comments - July 13*

*Go out next  
week*

A Statement of the Urgent Need for  
Modernization and Expansion Funds for  
Teaching Hospitals

and

Proposals for the Support of  
Teaching Hospitals Facilities by the Federal Government

DRAFT - Not for Publication or  
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May 22, 1968

INTRODUCTION

*Problems  
whole system*

The teaching hospitals of this country, many of them closely related physically to a medical school, constitute a significant core of hospital services to sick persons in the communities they serve. In addition, they provide essential facilities for education and training of students in medicine and the allied health professions, including extensive and varied graduate programs. They also offer opportunities for clinical research. This multiple role places upon teaching hospitals a heavy responsibility to establish and maintain standards of excellence in all three areas of endeavor. One result of these facts is that patient care in a teaching hospital tends to develop greater complexity and duration than is true in the average community hospital, which in turn generates relatively high operating costs and the need for special and usually costly facilities. Normal fees for hospital care have proven inadequate to carry this extra load. Existing hospitals need extensive modernization and replacement. Accordingly, a program of capital grants in aid is suggested, designed to upgrade the facilities for patient care, education and research, and to conserve and improve the invaluable assets represented by our teaching hospitals.

THE PROBLEMS FACING THE NATION'S TEACHING HOSPITALS

The communities of this nation must take action to provide personal health services to their residents. These services should promote good health through the application of established preventive measures, early

*Continuum  
of services*

detection of disease, prompt and effective treatment, and physical, social and vocational rehabilitation of those with residual disabilities. This broad range of personal health service has become patterned as a continuum ranging from the promotion of good health to rehabilitation after illness, and involving home care programs, nursing homes, community hospitals and the modern teaching hospital. Each component must have adequate support if the entire health care system is to operate in a comprehensive fashion.

Significant gains have recently been made in removing the economic, geographic and social barriers to the availability of health care. The pace of progress has accelerated in recent months and years. The people of this nation have made it abundantly clear that they demand adequate medical care which is readily available, freely accessible and individually acceptable. Recent social legislation reflects this national resolve. The possibility of progress toward achievement of these new national goals faces the dual obstacles of shortage of manpower and facilities capable of delivering the medical care which society will demand.

The teaching hospital will be the locus of the confrontation when the forces of rising expectations and effective demand meet head on with the hard facts of acute shortage of manpower and facilities. This nation, and its teaching hospitals, faces a major crisis.

The teaching hospital crisis is due to many factors:

1. The teaching hospital, by virtue of its size and location (usually 300 beds or more in an urban or metropolitan setting) cares for a high percentage of patients from the immediate

Washburn  
Lorne W.

Wood Dorky



locality and the surrounding regions, and maintains the resources of physical plant, skilled health personnel, complex equipment and a spectrum of services necessary for comprehensive health care of high quality.

2. The teaching hospital contributes significantly to the education and training of the nation's physicians.
3. The teaching hospital provides national norms and standards for patient care.
4. The teaching hospital is the locus of much of the scientific investigation that is done to advance the state of medical knowledge.
5. The teaching hospital develops, tests and makes operationally feasible "model systems" of rendering medical care.

A teaching hospital is one in which the education of physicians and other allied health personnel is continually taking place. The administration, library, <sup>equipment,</sup> laboratories, service programs, research activities and staff organization are <sup>necessarily designed for and</sup> centered on the student and the staff-student management of the patient. This complex of resources and activities must be so arranged and operated that good teaching, good research, <sup>as well as</sup> and good patient care are not compromised. ~~In contrast to all of this, In the non-teaching institution or service,~~ <sup>not founded on the education of physicians</sup> the organization of all resources and activities <sup>can be simplified to center</sup> is centered on the individual practicing physician and his <sup>premise of good care in the management</sup> management of the patient.

*See Bill Field*

*Do not copy on least*

The design and direction of this institutional commitment to medical education may take many forms. The hospital may provide, on the basis of a joint venture with a medical school, the clinical instruction of the

*McDuffy*  
*concerning*  
*costs - residency*  
*teaching*  
*Cost. Cost*  
*index*

medical student. The development of the internship and residency programs which have become such fundamental components of modern medical education has provided additional educational responsibilities. Finally, the teaching hospital may be involved in programs of continuing medical education, thereby insuring practicing physicians exposure to new diagnostic and therapeutic techniques.

The primary function of any hospital is the care of the sick and injured. Additional responsibilities of the teaching hospital are the expansion of medical knowledge through scientific research and, more recently, efforts related to prevention of disease. Thus the teaching hospital is that singular social instrument which encompasses the interface where medical knowledge is acquired, disseminated and utilized.

The program of needed education facilities begins with a definition of the educational activities to be housed within the hospital institution. This definition must include the types of teaching and training programs, the numbers and types of persons involved in each, the instructional methods to be involved in each, and the location and resources within the hospital that are involved. A teaching hospital requires additional space throughout. Enough space to house the additional functions, people and equipment of a teaching hospital is its problem, and may increase the total size by as much as 50 percent. (From 800 to 900 square feet per bed to 1200 square feet for teaching hospitals.) In terms of cost, this can reflect a variation in cost from \$30 to \$35 per square feet for non-teaching hospitals and \$65 to \$70 per square feet for teaching hospitals. These additional space needs on the patient floors alone take the form of examination-treatment rooms, designed to support teaching, clinical

*Under work*  
*\$4500*  
*Teaching*  
*has potential*  
*more elaborate*  
*features include*  
*increased costs*

*total  
w/ lab*  
laboratories [by service] classrooms, seminar-conference rooms, and residents' offices. They also tend to require larger patient rooms and a higher percentage of single rooms.

While these are the more evident needs of teaching hospitals, there are other features of the teaching hospital contributing directly to increased space needs. Patients generally are tested more extensively with a wider range of results in teaching hospitals. This is because the teaching hospital attracts the sicker patients, there are more difficult diagnostic problems and there is a greater variety of available tests. The ultimate result of this is the need for larger clinical laboratories and for diagnostic radiology. The teaching hospital must allow for research and experimentation in operational methods and patient care in addition to the rapidly expanding programs in clinical research. Occasionally particular research facilities are needed to attract a particular type of staff. Commitments of this nature can, and do, require 1000 square feet of research space per investigator. As the hospital assumes more care and teaching roles, the full-time staff becomes larger, which requires offices, research and out-patient facilities for them within the hospital.

The teaching hospital has been assigned other particular responsibilities by society, best characterized by the phrase, "center of medical excellence." The community of teaching hospitals has responded by encouraging the development of such "centers" whose excellence can be related to both the science and technology of medicine. Teaching hospitals have been characterized as the summit of the health care pyramid, the cap-

stone of the nation's hospital system. High standards of clinical practice necessitate accepting referrals from physicians in other hospitals involving patients who present difficult problems of diagnosis or require treatment available solely in the teaching hospital.

More recently, teaching hospitals have accepted society's additional charge that they become positive "health centers", serving all social and economic classes. This potential development takes on added significance when it is noted that a large portion of the teaching hospitals are located in city centers with all of the accompanying problems. The teaching hospital, as a health center, is becoming the single most effective social and technical instrument available to both the medical educator and practitioner for the solution of medical problems.

The functional demands that are placed on the scarcity of resources of the nation's teaching hospitals promote a certain measure of constant internal stress. The demands for classroom facilities and equipment compete with simultaneous demands for laboratories for scientific investigation and even further with demands for the development of specialized patient care units. Decisions relating to the conflicting demands for such facilities, equipment and manpower are resolved in an economic calculus, the overriding determinant of which is a shortage of the major resources including significantly the institutional facilities.

Our nation relies on its teaching hospitals for the graduate education of physicians and other health manpower, the establishment of standards for the promotion of better health, the best care of the sick and injured, the continued advancement of medical knowledge and the transfer of new technology to the patient's bedside. It is imperative that these facilities

recieve more adequate capital financing support, as a matter of national policy, if they are to remain the social instruments best serving the overarching interests of the community in matters of health and disease.

#### THE NEED FOR SOLUTIONS TO THE STATED PROBLEM

Because the problem of facility need for teaching hospitals can only be resolved through a prompt and comprehensive national effort, it is essential that representatives of the teaching hospital community outline the basic capital requirements to accomplish preservation of excellence in these multi-purpose institutions. To this end, the Council of Teaching Hospitals of the Association of American Medical Colleges is suggesting Federal assistance programs for modernization and expansion of teaching institutions. The need for such financing is urgent. The many inter-related facilities for patient care, education, research and community service are continually affected by advances in both clinical medicine and the basic sciences. Correspondingly, there is constant demand on these institutions for personnel, equipment and adequate, modern, up-to-date buildings.

The problems in financing hospital construction arise mainly from the fact that hospitals are non-profit organizations, being reimbursed for their services most frequently on a cost basis. The economics of such a situation prevent the accumulation of a surplus. Depreciation charges, when received, most often must be used for renovation or for maintenance of existing plant and equipment rather than for modernization or expansion of plant facilities.

In 1967 the Council of Teaching Hospitals of the Association of American Medical Colleges sampled its membership to determine the extent of need for modernization and expansion among 250 of its members. Federal and Canadian hospitals were not included. Replies were received from 214 hospitals, providing an 85% return.

Of the approximately 115,000 beds represented in the survey, 35% were over 35 years old and an additional 16% were between 21 and 35 years old. Of the 85% responding hospitals, 120 planned to replace 27,500 beds over the next ten years, and 142 planned to add 24,000 beds during the same period of time. For all forms of construction, including replacement, renovation and expansion, the estimated attendant cost for the ten year period is \$4 billion.

The reliability and validity of this study have recently been verified by a series of circumstances and events. Governor Rockefeller of New York has estimated that \$1 billion is needed for the construction and modernization of all hospitals in the State of New York alone, and is working toward the development of legislation that will accomplish this purpose.

A study completed by the Hospital Planning Council for Metropolitan Chicago resulted in the determination that \$370 million are needed for modernization and \$720 million are needed for facility replacement of the 69 hospitals totalling approximately 6,000 beds in that city. This same Council determined that the costs of modernization would approximate \$156 million and the cost of replacement, \$300 million. Additionally, in Philadelphia the capital needs for modernization, replacement, and expansion of the hospitals either operated by or affiliated with the areas

5 medical schools would total \$278 million as determined by the Philadelphia Hospital Survey Committee in 1967.

Because the teaching hospitals serve a combination of community, regional and national purposes and because their strength is divided through a diversity of forms of ownership and control, the Council of Teaching Hospitals, Association of American Medical Colleges, favors both Federal and local participation, as well as the use of borrowed capital, in the construction of teaching hospitals.

Federal funds should be provided under conditions that will:

1. be sufficient to encourage action that is both prompt and adequate;
2. encourage the facility modernization and expansion of existing teaching hospitals;
3. encourage an institution's continuing effectiveness in maintaining diversity in its sources of financial support;
4. Recognize the indispensibility of the multiple purposes of the teaching hospital, i.e., patient care, education, research and service to the community and the beneficial influences which these multiple functions have in the standards of excellence maintained by the teaching hospital.

#### PROPOSALS

1. The Council of Teaching Hospitals, Association of American Medical Colleges, recommends that the Congress provide

*Introduce  
Grant + loan  
combination  
as fiscal might  
do not  
Five years  
one period  
exchange  
might be  
Two send  
One  
(1) go to program that  
loan (4%)  
(2) below*

assistance in the form of a combination grant and loan.

such program might be:

- a. The teaching hospital, in applying under the provision of this program, must assure Federal authorities that it has 10% of the proposed construction monies.
  - b. The Federal government would grant the application 20% of the total estimated cost at the time construction begins.
  - c. The Federal government assures the applicant 35% of the construction monies from government borrowing. The principle and interest would be paid by the government over a period not to exceed 10 years.
  - d. The Federal government would authorize the applicant to borrow 35% on a straight loan or bank issue basis, payable over a period not to exceed 25 years. The government would insure both interest and principle.
2. Because of the severity of the problem and the immediate need for modernization in teaching hospitals, it is further recommended that the Congress appropriate \$220 million per year over a 10 year period to provide the necessary financial support for such a program.

*Hardy*



*Changes  
Smythe*

January 29, 1968

A PROPOSAL TO INITIATE A STUDY OF FACILITIES FOR HEALTH EDUCATION

The next few years present a splendid opportunity for the Association of American Medical Colleges to initiate a study of facilities for health education. The objectives of such a study should include:

Objectives

1. Describe significant programmatic, that is conceptual, developments in buildings for health educational purposes during the past five years.
2. Extrapolate from such descriptions meaningful lessons for future construction.
3. Project statements of some of the characteristics that health educational facilities should possess in future years if they are to be adaptable to changes which are now so confidently expected.
4. Encourage innovation in building and escape pat solutions.
5. Examine experiences in other countries for any relevant developments.

Background Considerations

Both the nature and provision of facilities in which to train the manpower, new directions in health care will call for are natural concerns of the AAMC. The pace of development and the breadth of interest in bringing about changes in facilities are no less intense than in other aspects of the health care field. Evidences of such activities are:

1. The National Academy of Engineering held a conference on costs of health facilities on December 5-6, 1967.
2. The National Advisory Commission on Health Facilities, chaired by Mr. Boisfeuillet Jones, is expected to bring in its report in the next four months.
3. Public Law 90-174 provides funds for "(A) projects for the construction of units of hospitals, facilities for long-term care, or other medical facilities which involve experimental architectural designs or functional layout or use of new materials or new methods of construction, etc., etc."
4. The Commonwealth Fund has shown much interest in optimal hospital design as evidenced by a major grant to Stanford University.
5. The Educational Facilities Laboratory, Inc., of the Ford Foundation has indicated its interest in working with health facilities.

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Relevant Factors

There are a number of factors relevant to the assumption of a more active role by the AAMC in this area at this time. Among these are:

1. During the past 15 years approximately \$2 billion has been expended for construction of facilities for health education. Of this about 60% has gone for hospitals and other clinical facilities and 40% for research laboratories and other medical school buildings.
2. It has been estimated that an equivalent sum will be needed in the next 15 years if the medical centers are to keep up with demands now being made upon them. Estimates of projected construction expenditures submitted to the AAMC by the medical centers at various times are of a similar order of magnitude.
3. ~~The current freeze on funding of new construction from federal sources can be expected to continue for at least ten months and possibly longer.~~ When it is relaxed, it will take some time to activate and implement dormant plans. The long lead times characteristic of major construction funded from many public sources will impose a further delay on the construction of new buildings. These considerations suggest that the next two years are an excellent time in which to study recent advances and current thinking in the construction of facilities for health education.
4. The needs of the cities, schools, air and water pollution programs, to cite but a few, can be expected to compete with medicine actively and effectively for funds for social development. Analytical questions will be directed to the cost and size of buildings and to the nature of activities carried out in them. The benefits to be expected will be equated against those of other discriminatory investments.
5. The undoubted benefits and excitement involved in the building of new centers for health education will come increasingly into competition with the realities of renovating the old. If for no other reason than limitations on the potential number of solutions available, this often proves to be a more difficult problem than new construction. Careful study of best methods of remodeling and expansion of the old are as much in order as planning the new.
6. The U.S. Public Health Service Publication -- Medical Education Facilities - Planning Considerations - Architectural Guide -- is now out of print. This text has served its purpose admirably. Despite the clear intent of its authors that it not become a manual, the needs of any public agency for uniformity, fairness, and objectively verifiable processes in the administration of its responsibilities inevitably creates pressures for specific interpretations. At a time when great changes in the health care systems are in the offing, greater flexibility in buildings

6. (continued)

should be encouraged. The appearance of another federally sponsored "guide" would be accompanied by the hazard that its suggestions will harden into yardsticks against which all construction requests are to be judged. The Public Health Service is aware of this possibility, and the Bureau of Health Manpower does not intend to reissue this guide at this time. However, some satisfactory substitute must be found. There is little prospect of any decrease in demand from many sources for the valuable help such texts can provide, especially for the many who are new to the complexities of major medical center planning.

7. New patterns of health care will call for new patterns of health education. Such programs will encompass different functions and will call for facilities adapted to their most prominent features.

The Proposal

These are among the factors which lead to the suggestion that the AAMC undertake a review of the planning for and construction of facilities for health education and the preparation of a suitable report at the end of such a review. The major emphasis of the proposed study will be on the needs of the "client" rather than of the architect or engineer. The functional aspects of programming and planning and operational aspects of buildings rather than description of a series of blueprints is envisaged. Many of the difficulties involved in publishing a book (especially the time) could be obviated by issuing a series of technical reports. Steps in the study suggested might include:

1. Identification of major new construction whether medical school, research laboratory, library, hospital or clinic in the country's medical centers. This could be done in part by study of the Association's records and verified by appropriate questionnaires.
2. Identification of remodeling or renovation involving new adaptations or new uses of old space. The means suggested above could be used.
3. On a very limited scale inquiries of the same nature should be made abroad.
4. Selection of a series of buildings or centers for more detailed study based on such factors as:
  - a) Scope of project.
  - b) New approaches, materials or methods.
  - c) Success of the building.
  - d) Conspicuous problems with the building.
  - e) Specialized features.

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5. Analysis of such facilities in sufficient depth to allow description of their features.
6. From such studies preparation of a series of reports describing:
  - a) The planning and programming process.
  - b) Significant factors, both advantages and disadvantages, in location of medical centers both new and old.
  - c) A variety of features of unique importance to facilities for health education.
  - d) Alternate solutions to specific problems.

#### Preliminary Steps

Preliminary inquiries into the feasibility of this project have included:

1. A visit to the Commonwealth Fund. From unexpended balances in grants made over the past many years to the Association, the Fund has authorized an expenditure of up to \$9889 to:
  - a) Ascertain the demand for the output from such a study by those responsible for development of medical centers.
  - b) Ascertain the availability of individuals with the necessary interest, competence, energy, and experience to implement and complete such a study.
  - c) Explore the potential benefits of organizing a small conference designed to acquaint those to be involved in any study with each other.
2. Discussion with the Commonwealth Fund of potentials for funding a major study. All estimates suggest \$250,000 to \$300,000 expended over 24 to 36 months will be necessary. The Fund has indicated its interest in the project but has in no way committed or obligated itself. Other possibilities for support include the Educational Facilities Laboratory of the Ford Foundation, the Bureau of Health Manpower, and the Bureau of Health Services.
3. Discussion with senior partners of two major architectural firms, representatives of two programming groups, one medical school "resident architect", and a variety of medical educators. It is evident that competent architects can be identified in the commercial architectural world for assignment to such a study by their parent firms for appropriate periods.
4. No approach has been made to HEW.
5. Discussion of staffing and organization. Envisaged thus far are a full-time staff of five at full strength for a period of about 18 months. Two co-directors, one an architect and one medically oriented, one staff writer, one draftsman, and one secretary would be needed. They in turn would report to a Steering Committee made up of about seven men. The potential scope of the undertaking is so large that the task group pattern of organization seems

5. (continued)

mandatory. Four or five such groups are suggested. The possibility of many alternates is recognized.

- a) Task group on locational factors: site, site improvement, traffic patterns, water, utilities, population density, urban problems, and all factors affecting location of a medical center. These are as important for established as for new medical centers.
- b) Task group on programs, for what functions are the buildings designed: who is to be taught, and what, and how, and in what settings, and what exposure to what sorts of experiences?
- c) Task group on mechanical equipment: elevators, heating and air conditioning, laboratory equipment, automation, computer uses, audiovisual aids, communication techniques, etc.
- d) Task group on clinical facilities: the hospital, clinics, and all their attendant complex problems.
- e) Task group on programming: how one goes about planning, the identification of significant information and methods for its manipulation.

Executive Council Action

The desirability, feasibility, and order of priority for further development of these ideas into a full project of the AAMC should be discussed by the Executive Council. A very large assignment has been outlined. It encompasses many areas susceptible to major study within themselves. However, the primary objective of the study suggested is to be on physical facilities. No effort will be made to study or criticize every building which has been constructed, but only those from which significant lessons are to be learned.

Further expression of intent to carry out such a study without doing so is not to the advantage of the AAMC. Inhibition of potential similar efforts by other groups by premature discussion is also to be avoided.

RECOMMENDATION:

It is recommended that the Executive Council authorize the staff of the AAMC to:

1. Continue to explore the feasibility of a major study of health educational facilities with the objective of preparing a series of reports or other documents of value to those planning medical center development.
2. Identify and begin negotiations with groups prepared to finance such a study.
3. Identify a Steering Committee to provide leadership for the study.
4. Identify individuals equipped to staff it.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

December 11, 1967

Dr. Colin Macleod  
Commonwealth Fund  
1 East 75th Street  
New York, N.Y. 10021

Dear Dr. Macleod:

The Association of American Medical Colleges wishes to request that \$9,889.18 be transferred over from a grant made by the Commonwealth Fund to support three administrative institutes in the amount of \$50,000 be assigned to a project entitled: A Study of Recent Health Facilities Construction.

In the past 15 years approximately \$2 billion in health education facilities construction has been expended. Of this sum approximately 60% has gone for hospital and other clinical facilities, and 40% for research laboratories and what might be called loosely, medical schools.

The current freeze on construction can be expected to continue for at least a year and probably somewhat longer. Subsequent to the release of funds it will take some time for institutions to be in a position to complete the plans, estimates, drawings, etc., to spend such funds wisely. Furthermore, it is abundantly apparent that the medical centers and their attendant hospitals, laboratories, and schools will be competing for development funds with other portions of our society whose social needs are now seen to be on an equal or even more urgent plane than those of health education.

The 1964 monograph of the Public Health Service "Health Education Facilities, an Architectural Guide" is now out of print. Many who must plan such facilities have found this a useful document despite its limitations which are recognized by many including its authors. Furthermore, its increasing obsolescence is also acknowledged. There is considerable interest in finding some satisfactory substitute.

The Association proposes to explore the feasibility of preparing a series of technical reports describing certain aspects of medical construction. Currently our thinking indicates the organization of four task forces to deal with various facets of this problem. These task forces are: 1) site improvement, location, traffic, population density, etc.; 2) mechanical equipment: elevators, heating, air conditioning, laboratory equipment, audiovisual aids, computer uses, communication techniques, etc.; 3) the educational program: where medical students, nursing students, dental students, etc., are to be educated, in what sorts of facilities, and to what types of experience should they be exposed and should this program be related to facilities; 4) the hospital and all attendant complex problems.

This is a large order. Since it encompasses many areas susceptible to major studies within themselves, it must be clearly understood that with the exception of committee number three which must deal with content, interest will be

based on a study of facilities. Furthermore, it is not our intention to study or look at every building that has been constructed, but only those which are seen as significant or worthwhile advances. Some poor examples might be included for the sake of contrast.

The major problems concerning the feasibility of such a study lie in the acceptance of those administering medical centers for its usefulness and, most importantly, in the ability to procure people of the necessary interest, energy and background to complete a significant study. The Association is fully aware that the declared intent to carry out such a study without doing so is not to its advantage nor to the advantage of any group underwriting its efforts. Furthermore the Association recognizes that such a declaration without delivery of a final product would be inhibitory of a parallel effort by other groups.

It is for these reasons that we request the authorization to expend the above money to explore the feasibility of this study, spend the necessary time with significant individuals in this field to test their reactions, and to identify appropriate individuals to carry out the study.

At this time a formal conference seems premature, but dependent upon the information collected in the next few months such a conference on a limited scale might further the project.

I trust these notes are self-explanatory and if further information is desired, please do not hesitate to call upon me.

Sincerely yours,

Cheves McC. Smythe, M.D.  
Associate Director

CMS:es

cc: Doctors Berson, Powers

THE COMMONWEALTH FUND

December 26, 1967

Cheves McC. Smythe, M.D.  
Associate Director  
Association of American Medical Colleges  
1100 Ridge Avenue  
Evanston, Illinois 60201

Dear Cheves:

This is to let you know that the Commonwealth Fund is glad to authorize the use of the balance of \$9,889.18 remaining in the grant to the Association of American Medical Colleges. This will be for the purpose of exploring the feasibility of a study leading to a series of technical reports on health facilities construction.

We believe that your approach to this question is very intelligent; also such a study is of considerable importance and most timely.

Of course I'm sure you realize that permission to use the balance of this grant in no way commits the Commonwealth Fund to further support of this program.

Sincerely yours,

(Signed) Colin  
Colin M. MacLeod, M.D.

CC:yd



ASSOCIATION OF AMERICAN MEDICAL  
COLLEGES

January 5, 1968

Dr. MacLeod, M.D.  
President for Medical Affairs  
Commonwealth Fund  
Business House  
1 East 75th Street  
New York, New York 10021

Dear Dr. MacLeod:

This is to acknowledge your letter of December 26. The Association quite understands that the permission to use the balance of the grant does not in any way commit the Commonwealth Fund to further support of this program.

Since my visit to your offices early in December not much concrete has been established except that there is a talent available in the "commercial" world which would be more than interested in joining the Association in an effort of this sort. These people also seem to agree with the broad implications of the approach toward the problem which we discussed.

This process of approaching people one at a time is reassuring in a way, but it has the drawback that it does not bring out much hard or critical thinking from the men to whom one talks, especially if they are strangers.

We shall keep you informed. Thank you for your help.

Sincerely,

Cheves McC. Smythe, M.D.  
Associate Director

Sn

R. C. Berson, M.D.

6330-10

*Ford  
Educational  
Facilities  
Laboratory Inc.*

A PROPOSAL FOR A HEALTH FACILITIES LABORATORY

Hospitals and Health Committee  
New York Chapter  
American Institute of Architects

I. SUMMARY

Health care is a primary concern of society, and a major consumer of funds. The efficiency of the health care plant is being questioned on several counts; both quality and cost are under scrutiny. Planners and architects are unable to cope with the ever-increasing complexity of facility planning and design because of a lack of data on objectives, requirements, and methodology. The need for an independent research agency, soundly financed to make possible a long range program of study and education, is becoming critical at this time. This proposal calls for the establishment of such an agency, utilizing foundation funds in part or in entirety. The purpose of this agency, tentatively named, The Health Facilities Laboratory, would be to help health institutions and their communities by encouraging research and experimentation in planning and design, and by disseminating knowledge of such developments in the health field. The investment in the work of this agency would pay handsome dividends in improving the health care system in the United States.

II. BACKGROUND

- A. Every citizen in the United States is affected by the availability and quality of health care facilities. Hospitals, which form only part of these facilities, annually care for 28 million inpatients and 125 million outpatients. Every year, about two billion dollars are spent in hospital construction, continually adding to plant assets now worth some \$23 billion. Hospital operating expenses are rapidly rising; in 1964 they stood at \$12 billion per year, more than tripling the 1950 figure. At the present rate of increase, expenditures on health care will grow from 6% of the gross national product to 10% by the year 2000.
- B. As the mainstay of health care facilities, the hospital is under close scrutiny due to concern over the doubling of the daily cost of patient care every seven years since 1945, and the accelerating rate of obsolescence of hospital facilities which is causing a crisis in financing of new hospital construction.
- C. The Health Facilities system is under unprecedented pressure to meet new demands and to adjust to fundamental changes:

1. Demands for more care of higher quality are inherent in the growing realization that good health is the fundamental right of every citizen. The role of the federal, state and local government in health care and controlling legislation has ever-increasing impact on planning. The urbanization of our population alters the pattern of the health care system.
2. Specialization and teamwork are becoming more important. The behavioral and social sciences, as well as biological and physical sciences, are more strongly represented on the health team. These changes are turning medicine away from the disease-oriented care toward emphasis on health and the life process. The coordinated comprehensive health care system that would provide the essential continuity of care has not yet been created.
3. New technology is providing better tools for health care, for planning facilities, programs and construction. Technological change is occurring faster than can be absorbed by present health care organizations.

### III. OBSTACLES

- A. The design of health care facilities and the design of the health care system as a whole should be studied together, but generally are not. As long as facilities are planned with little relation to an overall system of care, and systems of care are devised without regard to the available or planned facilities, progress will continue to be slow.
- B. The fragmented health care system prevailing in most of our communities makes coordinated planning difficult, if not impossible. While regional planning agencies have some effect, they are hampered in their activity by the diversity of the typical community health services, which may include municipal, county, state, federal, V.A., non-profit voluntary, non-profit religious, and private-for-profit agencies. Overlapping methods of financing construction and conflicting regulations on planning and operation of new facilities create further problems.

- C. The process of change is held back by the huge investment in existing durable facilities which are expensive to modify and to enlarge. In New York City alone, some \$1.2 billion would be required to bring existing hospital facilities up to acceptable standards for their current use. ~~These obsolete facilities, old organizational patterns, and personnel trained in outdated methods tend to hold back needed changes.~~
- D. Guidance of the process of change is inadequate. A fragmented research effort is under way, using both government and private funds, carried out in government offices and universities here and abroad. These efforts are limited in scope, and lack overall coordination. The total amount of money spent on planning research is, without doubt, seriously deficient in view of the enormity of the problem.

#### IV. NEEDS

There is a growing awareness in the health facility planning field of the need for a catalytic agency which could initiate an attack on the basic planning problems. Such an agency would stimulate, organize, and coordinate efforts to bring about:

- A. Planning approaches that recognize the feedback relationship between facilities and health care systems.
- B. Methods for dealing with the perplexing fragmentation of the health care services.
- C. Planning techniques that will permit the facility system to change and grow in an orderly way as new demands arise.
- D. Coordination of diverse research efforts and methods of financing research.

To establish such an agency, we propose the formation of a Health Facilities Laboratory.

#### V. PURPOSES OF THE HEALTH FACILITIES LABORATORY (HFL)

- A. To encourage the study and development of new ways to manage the planning process.

1. Methods for interrelated study of systems and facilities.
2. Methods for dealing with redundant community health services, with conflicting legislation and codes, and with overlapping methods of financing.

B. To encourage the study of elements of the health care system and the distribution of these elements within the community:

1. The relationship between health facilities and urban development.
2. The integration of health facility planning within the overall urban planning process.

C. To encourage the study of the process of growth and change, with a view toward developing principles and methods of planning that will help avoid obsolescence.

1. Methods for designing facilities flexible enough to accept changes in operational methods and scope.
2. Methods to achieve a proper balance between capital cost and operational cost in order to reduce the total cost of health care in the effective manner.

D. To act as an agent of change by:

1. Lending financial assistance for the design, construction and evaluation of facilities suggested by HFL studies and for experimental approaches to planning and design.
2. Encouraging manufacture of pertinent products and assemblies not now available.
3. Publishing and disseminating the results of studies conducted under HFL auspices.
4. Publishing and disseminating educational material on significant developments in health facility planning.
5. Encouraging the development of information centers for health facilities planning and research.

VI. METHOD OF OPERATION, HFL

- A. To assure a broad approach, HFL activities should be directed by a group which has available the specialized skills of architecture, engineering and planning, as well as the medical, behavioral and social sciences. The officers of HFL should be sympathetic and capable generalists who will see the planning process in the widest context. Specialized skills may be available either on a full-time staff basis or through outside consultants.
- B. HFL leadership would be responsible for determining coordinated programs of study, not subject to the whim of individual enthusiasm. These programs should be flexible enough to permit adjustment, but sufficiently firm to avoid fragmented studies that do not contribute to the total effort.
- C. HFL would ideally be an independent agency, not associated with a university or government agency. With a relatively small full-time staff, it would make grants for research projects to qualified individuals or groups in universities, health care facilities, or private practice.