METROPOLITAN HOSPITAL PLANNING

CONFERENCE REPORT

HAS the time come for the Hill-Burton hospital and medical facility construction program to place more emphasis on the needs of the Nation's metropolitan centers?

This question was given serious consideration at a Conference of the Surgeon General with State and Territorial Hospital and Medical Facilities Survey and Construction Authorities held in Washington, March 9–11, 1959.

Hill-Burton State agency chiefs agreed that more attention should be directed to the growing dilemma facing metropolitan areas. The degree of emphasis, however, remained unsettled. General concepts evolved from the discussion were:

1. Urban hospital and medical facilities should be expanded in an orderly and coordinated manner.
2. Rural areas are not without medical facility problems, therefore continued attention should be given to their needs.
3. Geographic regions should be examined in order to view the problems of both metropolitan and rural areas in their proper perspective.

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The conferees, in examining the problems of metropolitan hospitals, found that the chief complaint appeared to be insufficient funds for necessary construction. The complaint is chronic and widespread and extends even to hospitals in smaller communities. It is the result of many factors.

Many of our older hospitals were built without future needs in mind and grew as money became available to meet a recognized local need. Little or no thought was given to coordination of medical and hospital facilities to serve communities efficiently and economically. Many now obsolete hospitals, built 50 or more years ago, find that replacement would be more economical than modernization of the existing building.

Advances in medical science and technological progress have resulted in the need for new and costly equipment as well as changes in architectural design of facilities.

Socioeconomic, cultural, and demographic changes in our society have resulted in a shift of medical needs. The longer lifespan of the population and the growth of suburbs are among the many trends affecting medical needs unforeseen prior to the thirties when many metropolitan hospitals were built.

The conferees suggested that a major step toward aid to hospitals would be establishment of planning agencies on a permanent basis for each metropolitan area.

Remarks by George Bugbee, president of the Health Information Foundation of New York City, set the pattern for the panel discussion that followed. Other members of the panel, which was moderated by Dr. Robert N. Barr, secretary and executive officer of the Minnesota Department of Health, were: Gordon R. Cumming, chief of the bureau of hospitals, California State Department of Public Health; Dr. John R. McGibony, professor of hospital and medical administration, Graduate School of Public Health, University of Pittsburgh; Ralph Murphy, executive director of the Hospital Council of Baltimore, Md.; and Dr. Helen Knudsen, director of the hospital services division, Minnesota Department of Health.

Bugbee, who played an important role in the development of the Hill-Burton Hospital Survey and Construction Act, emphasized that the program provided an incentive for developing more adequate hospital and medical care in this country, adding:

"There has been general acknowledgment and approval of the act both in serving its purpose and in its administration. As with any national program, there is continued need for reevaluation of operating principles. Currently, there is considerable concern about whether the act and the priorities it established now permit the granting of funds for facilities where they are most needed in every State."

Referring to the need for replacement of older hospitals which have been leaders in quality in metropolitan centers, he said that several years ago the American Hospital Association estimated that such replacement would cost in excess of $1 billion.

"Our oldest, largest, and finest general hospitals are located in cities," he said. "Evidence of the quality of patient care, teaching responsibilities, both graduate and postgraduate, and research, shows that these hospitals are our most important resources in maintaining and raising the quality of hospital and medical care nationwide."

While emphasis under the Hill-Burton program has been directed to rural needs, a relatively large proportion of funds has gone to larger centers of population. This is supported by Bugbee's analysis of Hill-Burton grants from 1947 through the end of 1958. Grants during this period totaled $1,091,801,000. He said that 45.7 percent of these funds was expended for all types of hospital and medical facilities in standard metropolitan areas where 56 percent of the Nation's total population lives. Central cities in these standard metropolitan areas which have 33 percent of our total population received 32 percent of the allocations. General hospitals have received 82 percent of all Hill-Burton funds, or a total of $895 million since passage of the act; 43 percent of this amount was earmarked for standard metropolitan areas and 29 percent for central cities within these areas.

Explaining that he did not intend to evaluate urban needs with a view toward shifting priorities, Bugbee pointed out that only with adequate planning can priorities be applied intelligently. There is currently a great upsurge in demands for better metropolitan planning, he emphasized.

Suburban growth was cited by Bugbee as a big complication. He noted that population shifts to the suburbs have changed the texture of the central city population and its ability to finance hospital care, resources available for capital fund raising, and distribution of physicians.

A community planning agency should be independent of other community organizations, Bugbee suggested. He explained that "The agency must be representative of the community. Its active members, particularly, should be selected for their objectivity, community-mindedness, and, in the instances that apply, for their sense of responsibility in raising funds. It would be desirable if the agency would be designated by the State planning agency as its affiliate organization in the metropolitan center. Planning is not a temporary function—the agency must be set up on a relatively permanent basis."

Another point emphasized is the need for further research to aid in establishing more definitive goals. This, Bugbee said, is essential

if urban hospitals are to maintain leadership in providing quality medical care, teaching, and research.

Gordon R. Cumming, of Berkeley, Calif., told the group that there is nothing "special" about metropolitan area planning. He suggested that "we must concentrate on the cities or the sub-orbits within them rather than plan grossly for a big group of 10 million people." He added that there is a surprising amount of useful information available about population trends, highway programs, and other such data needed in planning for the future. Referring to a study of the Los Angeles area, Cumming stated that "in tackling its planning, Los Angeles pegged the date 1975 toward which to build."

"As a second principle used in this study," Cumming stated, "we considered people and geography and distance and relationships, and evolved a concept of a central hospital service area and suburban areas, taking into account several characteristics. In each of the 14 hospital service areas, we defined the metropolitan community and where there should be a center with a community identity. Each of these areas have or will attain a population of at least 250,000 people by 1975.

"Third, we assumed the proposed traffic patterns for the future would persist. We'll still have traffic congestion in 1975, and we should plan for hospital services within about one-half hour's travel time. You can't travel very far even on a super-freeway in half an hour, if you count the time on a portal-to-portal basis.

"Finally, we asked what kind of institutions should serve these people and this geography? At first we thought of 200 beds as a minimum for a hospital, but upon the advice of people in the hospital field, this figure was reduced to 150."

The question of priorities (rural vs. metropolitan areas) was discussed by Dr. John R. McGibony, of Pittsburgh, Pa.

McGibony recalled that in the early days of the Hill-Burton program, considerable emphasis was placed on the needs of rural areas. He added that the time has now come "for us to direct more of our efforts toward meeting the needs of the urban, metropolitan areas."

In reviewing the approach taken in the theoretical blueprint of a coordinated system of hospitals, McGibony indicated there might have been more strength in such a system if the hub had been stronger. "The satellite facilities might have been stronger with a stronger central tie," he said.

McGibony noted that not enough emphasis has been placed on some factors in rising hospital costs. Referring to a recent article by Pat Groner, of Pensacola, Fla., he pointed out that the increase in use of existing X-ray facilities and laboratory services account for probably one-third of the increasing cost of hospital care, and that another one-third could be accounted for by other adjunct facilities and services.

"In meeting the demand," McGibony observed, "we tend to lose sight of the quality of care. If this is not a major item in planning, then most of the planning will go for naught, whether for diagnosis and therapy, prevention in both its primary and secondary aspects, or restoration or rehabilitation."

McGibony added that despite the fact that perhaps one-third of the internships and residencies in this country are served in non-primary university-connected hospitals, the urban metropolitan hospital complex is the seed of education for the health profession. Certainly a majority of the clinical and related research is in that setting, he said, and such education leads directly to the supply of personnel for satellite facilities.

On fund raising, McGibony said that industry will contribute as a general rule about 50 percent of the total capital outlay for an institution. He added that metropolitan, urban, and rural planning has to be a combined responsibility of all voluntary and governmental agencies.

"Hospital councils are meeting this need," he continued. "In Pittsburgh we have more than 60 hospitals working together closely in the improvement of care, services, and planning."

Ralph Murphy, of Baltimore, Md., placed special emphasis on the problem of obsolescence in metropolitan area hospitals. However, he said that there is much more to a

hospital than the excellence of its physical facilities. "While physical facilities are important in a very real sense," he said, "the excellence of a hospital depends upon the people and staff." As an example, he stated that patients in pre-1900 beds do not necessarily receive poorer care than those in newer beds.

Murphy added that one of the major needs in metropolitan planning is to deal realistically with the problem of obsolescence. Furthermore, it is necessary to face up to the economics of the problem—especially as it relates to replacement versus modernization. This requires the development of measures of obsolescence which are realistic and meaningful to both the community and the hospital involved. Murphy explained that the position taken by the individual hospital regarding obsolescence is usually based upon its own situation and does not always correspond to the community viewpoint.

Murphy said it is agreed that the ring of very small hospitals in the suburbs is to be avoided. However, people are not reassured by statistics indicating that less than 1 percent requires a hospital within the first 10 minutes after an emergency. Therefore, suburban hospitals which are desirably sized and staffed are a vital component of the overall plan for adequate hospital service in a metropolitan area.

Agreeing with the need for additional research, Murphy pointed out that current planning must be based on the knowledge we have. He observed that frequently maximum use is not made of the vast amount of data already gathered.

Added to the obstacles facing hospital planners are the unpredictable and intangible factors which should be considered. An example is estimates of population growth. The erroneous predictions made by the demographers in the thirties could easily be repeated.

Two conclusions, based on the fact that hospital planning still is an inexact science, were drawn by Murphy. First, he said, planning must be flexible. Second, plans should be based on the needs and past experience of an individual community. He warned against the inadvisability of one community adopting plans which were devised to meet the needs of a different type of community.

Dr. Helen Knudsen, of Minneapolis, Minn., told of problems encountered in two metropolitan areas, Minneapolis and St. Paul, existing side by side, but operating independently. She said that assistance had been given Minneapolis in surveying needs as preparation for a united hospital fund raising drive. On the other hand, St. Paul does not have a planning group, each hospital raising its own funds.

"We're very concerned in our office," Knudsen said. "We have attempted for some time to persuade St. Paul authorities to organize an overall planning group."

The difficulties of hospital planners are not confined to metropolitan areas, Knudsen said, citing the real problem in rural development. She noted that at one time or another, practically every town in Minnesota has discussed construction of a community hospital, whether it needed a hospital or not. "I'm sure we can say that we spend as much time trying to discourage some of these smaller communities from building as we do trying to encourage others to plan and raise funds," she said.

However, after the would-be sponsors of a community hospital are convinced that it is not justified, they become very realistic and grateful for the advice, she added. Instead of building a hospital, the sponsors may build a clinic more suited to their needs.

"The Minnesota State Board of Health has now adopted a policy requiring every applicant to submit a realistic plan for staffing before Hill-Burton money will be allocated," Knudsen said.

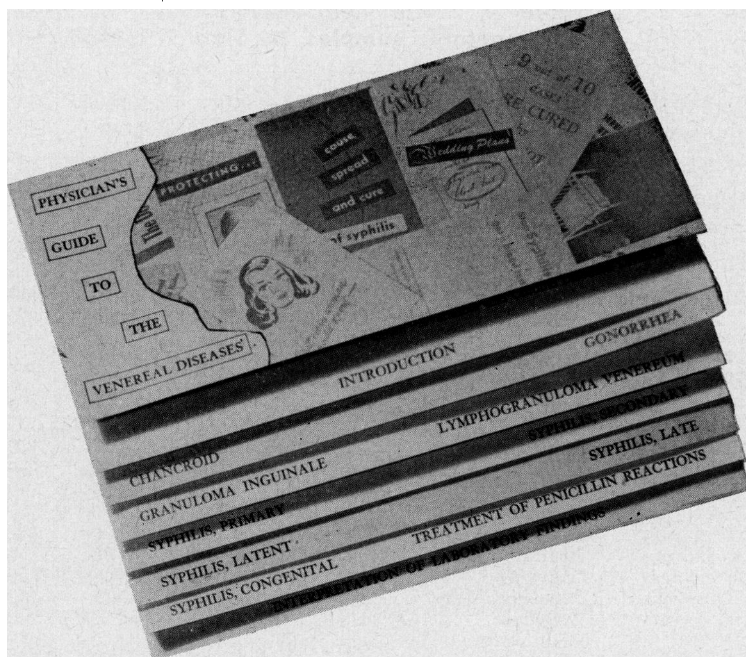
During the general discussion, attention was again given to the question of emphasis in the Hill-Burton program. Reference was made to the statistics cited by Bugbee that since 29 percent of Hill-Burton funds were allocated to central cities where 33 percent of the population lives, the needs of our large areas have not been disregarded "by any manner of means."

It was emphasized that much credit is due to State agencies for planning their programs in such a way that, while taking care of the peripheral needs, and the needs of rural areas, a good job has been done in the central cities.

While they cautioned that attention should not be directed to the needs of urban areas to

the detriment of rural areas, the conferees agreed that planning is just as important in the large communities as it is in the smaller communities and the problems are just as great in one area as in the other. It was emphasized that one of the greatest strengths of the Hill-Burton program has been central planning for the whole State. Further, that, while the needs of metropolitan areas could be emphasized more and more in future planning, this need probably should be developed jointly by local planning groups with participation and direction on the part of the State Hill-Burton agency. Experience indicates that no one area of a State can and should plan independently of other areas. The conferees agreed that the success of the Hill-Burton program justified the role of a statewide planning agency in any future efforts to meet the hospital and medical facility needs of all segments of the population.

HEALTH EDUCATION CASE HISTORY



Guide to Venereal Diseases

An unusually well-designed information piece, A Physician's Guide to the Venereal Diseases, has been printed by the preventable and chronic diseases division of the District of Columbia Department of Public Health, which gives its address and telephone number, with the date of publication on the back. The pages are folded horizontally so that each one successively projects enough to provide a ready index to the subjects treated: chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, syphilis (primary, secondary, latent, late, congenital), treatment of penicillin reactions, and interpretation of laboratory findings. The subjects are printed on the projecting margin of the page (see illustration).

The brochure, in addition to explaining diagnostic and therapeutic processes, points out the necessity of joint responsibility of the private physician and the public health department in the control of these diseases and discusses the services and facilities of the department that are available to the private practitioner. The pamphlet was presented in connection with a seminar held in Washington in October 1959 in cooperation with the Public Health Service. It is being distributed on a continuing basis to all physicians in private practice in the District.