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

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

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

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

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

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

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

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

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

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

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