RURAL HEALTH CARE DELIVERY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

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RURAL HEALTH CARE DELIVERY

SATURDAY, JANUARY 28, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Manhattan, Kans.

The subcommittee met, pursuant to notice, at the Student Union Building, Kansas State University, Hon. Robert Dole presiding.

Present: Senator Dole.

Senator DOLE. I first want to say that we are very pleased to be here, and certainly appreciate many of you coming rather long distances on a Saturday, which is not probably your best day, but it does give us an opportunity to discuss what I believe is a very important matter. It's well to point out, first of all, that this is an official hearing of the Subcommittee on Health of the Senate Finance Committee. I am the ranking Republican on that subcommittee, and the chairman is Senator Herman Talmadge of Georgia. I would hope today to obtain some information that might be helpful to all of my colleagues in the Senate, particularly those in the Senate Finance Committee, Health Subcommittee. And I think it might be helpful, just as a matter of information for some who may not be totally familiar with the committee to review the jurisdiction of our subcommittee. The Health Subcommittee of the Finance Committee deals with medicare, medicaid and the maternal and child health program, as well as the various national health insurance proposals. Medicare and medicaid are, of course, the committee's major health programs. While many of the health programs, such as the health manpower, planning and research, are not within the jurisdiction of the Finance Committee, I am nonethless involved and concerned with those areas.

After hearing from many of you concerning the proposed planning guidelines, I wrote Secretary Califano and indicated my concern about the guidelines and my belief in the need for an emphasis on local planning and decisionmaking. I think, as many of you know, that HEW has responded with revised planning guidelines, taking into account the needs of rural areas as well as providing for more local control over the planning process.

These revised guidelines were published in the Federal Register on Friday, January 20. I think we have a limited number of the revised guidelines which will be available to anybody who would like to look at them and hopefully to comment on them for our benefit.

Now, I certainly understand and agree with the need to avoid duplication of facilities and services, particularly in view of the tremendous increases in the costs of health care in this country. I think it's well to emphasize, as often as we can, the costs, because medicare and medicaid alone, for example, will cost more than $47 billion during this fiscal year, which is some $9 billion more than the last fiscal year; and I think we all agree that we have to find some way to reduce health care costs or to face having to reduce benefits but, in working on ways to control costs, I guess it's fair to say we don't want to throw the baby out with the bath water. During 1977 the Committee on Finance held hearings and discussed numerous legislative proposals to improve our medicare and medicaid programs.

Two such proposals were enacted into law, the Medicare and Medicaid Anti-Fraud and Abuse Amendments, and legislation designed to assist rural areas by reimbursing clinics staffed by nurse practitioners and physician assistants who worked under the general direction of a physician. A third proposal which has carried over into this session is the medicare and medicaid administrative and reimbursement reform bill, S. 1470.

Among other things, this bill would provide an opportunity for efficient hospitals to earn incentive payments above their costs. The bill seeks to encourage cost moderation and to encourage and reward efficiency in providing proper care. This is in contrast to the flat price controls or percentage limitations as is being proposed by President Carter and his administration.

There is also a provision in the bill which would encourage small rural hospitals which are located in areas where there is a shortage of long-term care beds to utilize their excess beds for long-term care services. In the past many of you have written me regarding your concern with the increasing number of rules and regulations governing health care. Because of these letters, this past week I joined with the chairman of the Health Subcommittee, and the vice-chairman of the permanent Subcommittee on Investigations in sending a letter to the General Accounting Office requesting a review and evaluation of all the requirements applicable in hospitals, Federal, State, local and voluntary, which deal with the licensure certification, data requests, nonstandard claims forms, health and safety requirements for patients and employees and related matters. And I think this may be very helpful. We would hope that the GAO report would give us some basis either for statutory revision or administrative changes, legislative changes, some way to consolidate the activities and maybe eliminate some of the requirements, and establish procedures that assure that requirements are essential and cost effective.

We specifically suggest that they solicit the views of State, local, and voluntary agencies concerned.

I guess that's enough comment from me. I didn't ask you here to listen to me this morning, because I want to hear about your problems and concerns regarding rural health care.

Now, with me today is my legislative assistant, Ms. Sheila Burke, a R.N. by training, and John Kern from the staff of the Finance Committee, who also happens to be a trained hospital administrator.

I have also invited representatives from the HEW regional office in Kansas City so that they may hear firsthand your concerns as well as be available to assist in any discussions concerning HEW programs affecting rural health care.

Is Barbara Bailey here?

Mrs. BAILEY. Yes.

Senator DOLE. This is Barbara Bailey. What is your title, Barbara?

Mrs. BAILEY. I am National Health Service Corps field representative working in Topeka.

Senator DOLE. Mr. John Morefield, John, what is your title?

Mr. MOREFIELD. I am acting director, division of management with the medicaid program.

Senator DOLE. We appreciate very much your coming today and being with us. In the interest of trying to maintain some sort of schedule and make certain everybody who wants to be heard will have an opportunity, we are going to try to limit testimony. We don't want to do that, but there is another activity going on here in Kansas today that I need to attend sometime. [Laughter.]

Our first two witnesses, I think are well known in Kansas by everyone. We'll start with Jim Wilson and Dwight Metzler. Mr. Metzler, as you probably know, is secretary of the Kansas Department of Health and Environment, and Dr. Wilson is director of health. I might say at the outset, if you have a prepared statement—you are not required to have one—if you should have a prepared statement, it will be made a part of the record in full. You can summarize it, you can depart from it, you can tear it up, you can do anything you want. I guess Dwight, you are the first witness.

STATEMENT OF DWIGHT METZLER, SECRETARY, KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Mr. METZLER. Senator, thank you very much. We are appreciative of the concern which you are showing for the health care status of Kansas citizens by holding the hearing here. We have appreciated particularly your concern about the health of mothers, infants, and children with your active participation in the WIC program.

Senator DOLE. The WIC program is coming up again this year for renewal. We may need your help.

Mr. METZLER. It's one which has already had a great benefit on Kansas citizens, the expenditure rate is somewhere around $2½ million for this year and it has a great impact in terms of preventing brain damage and other kinds of disabilities for young infants and small children.

Senator DOLE. I might add—I don't want to interrupt you—but it's one of the many programs that came from the very fertile mind of Senator Hubert Humphrey.

Mr. METZLER. Yes, that's a very good tribute, I think, Senator.

Senator DOLE. Yes.

Mr. METZLER. Today we do have a statement, we also have copies which are over on the end of the table, as many as you might care for, and I will not read the statement. We refer in the statement to

the first Kansas State health plan which we are just in the process of unveiling, and that plan has been participated in development by many of the people who are here today, are here in the Health Systems Agency panel.

But two of the four problems that we have dealt with in there, I would like to mention very briefly to you. First, is dealing with the availability of primary health care services; and second is the cost of State health care. Now, Dr. Jim Wilson, director of health, is with me, we did a national recruiting job after our last director of health left, and we are fortunate I think to conclude that, a Kansan, a man who had had a lot of experience in Kansas, both in the private practice of medicine and in the recruitment of persons into the primary health care field could be talked into coming in and leaving a lucrative private practice and coming to us in this public service position. He has a great deal of knowledge, he brings a lot of knowledge, and knowing how to not only cooperate with the medical health care system, but with the KU Medical Center and its important responsibilities.

Now, the plan that is attached to the statement [1] has 21 specific recommendations about what to do about health care costs. I will not try to review those at all, but I do want to emphasize that the true cost of health care in this country isn't known. The facts and the figures that we so often hear, but rarely question, are largely guesstimates. If I could draw on our experience with water pollution, Senator, you remember we started out to clean up water pollution, we thought it was going to cost $18 billion, and naturally no one had made a study of the cost and all of a sudden we are up in the hundreds of billions of dollars for that. I certainly hope—it seems to me that one of the things that the Federal Government can do is—and very few States are capable of producing the data—as to get an accurate data collection system which lets us know the costs that we are dealing with, and therefore gives us some idea what happens if certain cost control measures are not put in place. It seems to me that this kind of monitoring can only be done by the Federal Government, and I would hope that you and your associates in the Congress would give attention to this.

I would like to point out in the area of financing that we would not propose that a lot more money be appropriated at this point, or a lot of new programs developed. It does seem to me that there should be some change in the priorities which are given to where the money is spent. Way, way less than a cent on a dollar is spent, as you know, in the area of prevention. We simply have to develop a great deal more responsibility in the area of persons taking responsibility for their own health, and following good health practices, and then some of the preventive medicine, immunization, public health education, and things that underly that.

Now, in quick summary, we've watched the growth of the health care system, some of us, many of us here in Kansas, certainly since World War II, and we've seen the Government become more and more involved in the financing of health care, and in financing institutions. They finance the preparation of health care professionals,

[1] The plan was made a part of the Committee file.

and of course along with this has come a lot of increasing regulations of industry. The Government has been generous, I think, in returning our money to us through some of these programs, and I'm going to tell you something you probably won't hear from anyone else today. I feel that we have more programs, more money and more regulations than we know what to do with. We need to be able to digest some of that before we start out with more new imaginative programs or other massive financing. The area of—the special 314–D funds, which provide assistance for local health departments, it seems to me is an area that needs additional financing, particularly because it helps our counties with their development of county health departments, and we do have in Kansas 97 of our 105 counties now that have developed full-time staff in local health departments. So you are working with the county commissioners, county leaders, and with a local health department where many of these services, especially in the prevention area, can be delivered more effectively. The ball has been in the Federal court ever since Lyndon Johnson and Dr. Cohen got together and developed the health care part of the Great Society, and in many ways the Federal Government has done a great job; but it seems to me the ball is back in the court of the States now, and to digest some of that, we think working through the State health plans we have a good chance to do that in Kansas.

I would like Dr. Wilson to hit the topic of primary health care in some of the kinds of things that are being done in that area.

STATEMENT OF DR. JIM WILSON, DIRECTOR OF HEALTH, STATE OF KANSAS

Dr. Wilson. I just wanted to say this, that an example in which changes have occurred which have saved health costs, has been our TB program. Kansas for years had a TB hospital, and in its wisdom the Kansas Legislature said maybe there's a better way, and I might say in this room, of course, Dr. Taylor provides the care on an outpatient basis in the Salina area for TB patients, so we don't have TB hospitals, but in the local hospitals on a needed basis.

In this program which we have given to you here today, we have outlined some of the problems, for instance, let's take an acute care hospital of 50 beds, and let's assume that in many cases communities can only use say 25 beds. But the way things are so structured, those 25 beds can't be turned into acute skilled nursing care beds. There should be a simple way in which this can be done so we can get the best utilization of space, the beds, and the consumer dollar. I agree that we have a vast number of programs, it seems to me that the money best spent at this time is in the prevention areas, and this is out in the final end point of distribution for health education, that's the community health centers where we get the biggest services like family planning and other areas, and I think we need to emphasize that.

Last year, the Kansas Legislature appropriated $35,000 for a physician recruitment program. I won't get into that, Joe Meek is here and he can speak for himself, there's been organized a physician recruitment program, and I know we have several lists now of physi-

cians and they are actively placing physicians in areas of need in Kansas. The Wichita University branch is very active in this area and there will be regional centers, I think one in Hays and one at Chanute working on placing health care professionals. In that regard, we have had wonderful cooperation from Dr. Holman Wherritt at region 7 headquarters in Kansas City. As a matter of fact Barbara Clark Bailey, who's a Smith Center girl, I just put the Clark in because she was recently married, anyway her father farmed for years, and she's come to us on loan, we hope it's a permanent loan, from HEW. She is a specialist in locating and placing health care professionals throughout the State of Kansas. The way the system works, I think most of you know—may not know, but if these people have received a loan, then they are obligated to stay for 2 years in an area of need, whether it be a physician, nurse, nurse practitioner, or dentist, we have placed some of these in Kansas, particularly the physicians and dentists, and they are paid a certain salary, very low salary.

Now, many of these people opt to go into private practice, and this is what we want, and that's what the Federal Government wants, and they stay in the community, and as long as they stay in that area of need, then the forgiveness of the loan is carried out over a several year period of time. I was pleased a while back to sign a paper for Leon Boor over at Abilene, for instance, and I believe Lincoln is going to get two physicians this year; isn't that correct, Barbara?

Mrs. Bailey. Yes.

Dr. Wilson. They already have a dentist, the dentist found out he could do better in private practice, the idea is to get them in the communities where the great need is. We have 35 percent of the population, and only 12 percent of the physicians, and 18 percent of the nurses to get that ratio of health care professionals up to the level of the population, because I submit to you the most valuable resource that this country has, and this State has, is the small communities where people learn true principles of democracy and fairplay and interaction, and every kid can get a chance to develop his leadership potential. So we feel right now, that Congress, while it's been generous, it's almost been like the Boy Scout trying to do his first good deed after he became a Boy Scout, and the old lady said, but I didn't want to be helped across the street. We think we need to have time to digest and absorb some of these programs, with exception we do think the county health local units of government, through 314–D, in some areas we could place more and do more good. But I think, by and large, you have been most generous. I do have here a letter to you, Senator Dole, which I will take the privilege of reading. It's from the Governor's Advisory Commission on Health:

Agrees with the position of the Secretary of the Department of Health and environment that:

a. The problems of health care costs and delivery of health services are important to the Nation and Kansas;

b. The Federal Government has taken many major steps to resolve these issues;

c. Many steps taken by the Congress have not been fully implemented and their results, either positive or negative, have yet to be documented;

d. Governmental actions in the past have vastly increased the supply of facilities, manpower, and money for health services to the point that there may be no need for additional effort to increase resources.

e. There now is a clear need for the Government to rest while local leaders attempt to efficiently and effectively utilize the vast resources now available.

The Commission strongly supports the Department's position that the mantle of leadership in health affairs should be passed back to our communities and that Congress should defer any additional major health legislation until there is clear need to act in the future.

This was signed by Mary Jane Wiersma, vice chairman, who is here today with Kansas Farm Bureau; Betty Taliaferro, registered nurse, who is here today, by the way, John D. Atkin, M.D., from Yates Center; Diana Wise, LPN; Don Schmidt, nursing home administrator in Wichita; and Bill Tucker—William E. Tucker, who is president of the hospital board and leading community leader in Elkhart.

I don't have anything further, Senator, unless you have some questions.

Senator DOLE. Well, I was just interested in that one phrase in that letter, "for the Government to rest" I think a lot of people would probably apply that across the board. Maybe we ought to rest, in fact most taxpayers are more concerned when we are in session than when we are in adjournment. But it's a real problem, and I think that's what we are trying to find out at the grassroots level. I think sometimes we end up talking with each other in Washington, and I am certain that is true in any agency and it's not intended that way, but it happens that way, particularly those of us who are on the committee. We talk to our staff, and our staff talks to other staff, and we do talk to a lot of people from our States. I think we are hoping, and we certainly think this is the right way to approach it, that we can get the grassroots feeling about generally what the Government should do and then try to incorporate that into our thinking when we get down to issues—whether it's cost containment, or whether it's some health insurance bill that may be proposed this year. I assume some health insurance bill will be introduced whether it's on catastrophic illness coverage or whatever. It's going to be very difficult to find the right program, particularly when there's so much pressure from the standpoint of cost. I've, through the excellent work of staff, tried to get a fair picture. I note, Dwight, that there is a so-called rural initiative project in Louisburg. Do we have more than one now?

Dr. WILSON. We have one in Louisburg, the physician has left, we do have one in Oberlin and Decatur County, a rural health initiative —rather a health-unserved rural areas, and also one just starting up now in Garden City. I believe that rural health initiative person has left. Barabara, you might fill us in on that.

Mrs. BAILEY. There's a health for underserved rural areas project in Dodge City rather than Garden City.

Senator DOLE. The program in Louisburg then is——

Dr. WILSON. They are recruiting for another physician, I think they are going to get one, and this is what I'm pointing out, we have these many programs, and many people, many communities are not aware of the health-unserved rural areas, nor the rural health initi-

ative in which they can get dieticians; all these people who owe the Federal Government a debt for their education, who are available will come in and who will work either on a salary—and the idea is after they work for the period of time, then they will go ahead and establish practice in the areas and the idea of the Federal Government is, as soon as these people are in place and practicing, and served their obligation, they step out. And the salaries provided is only meant as pump priming until these individuals can see the advantages of going into the free enterprise system, one we want to push to provide health care, and this is somewhat different from some of the other people's philosophies, but it's one of—they pay their debts back, primarily by serving where they are needed.

Senator DOLE. Right. Now Mr. Metzler, you indicated in your statement, and of course I have known that you have seen the system expand and grow, and of course improve for the past 40 years. With all the pressures we have at the Federal level, and certainly you have at the State level for dollars, where do you think we can best direct our attention as far as the expenditures, if you had to pick out 1, 2 or 3 years. You mentioned prevention and that certainly is one.

Mr. METZLER. Well, it seems to me that in the general prevention—also, first in the general prevention area, I think that the administration's proposal for increased emphasis on health education and family planning—as I understand there is some emphasis—and the present budget is on a very sound basis, that's needed, and we need to encourage local health departments and many others in that area.

There's also an area that I don't really understand very well, I've never understood this medicaid, medicare financing bit, but do know that the State of Kansas is promoting home health care services and is paying for services subsidizing those new counties as an alternative to keeping people out of nursing homes and for getting adequate health care. Again, there's a need in that area.

Frankly, Senator, this program is too important for the bookkeepers to run, and I get the impression that the bookkeepers are running it rather than the people who are really concerned about health care. [Applause.]

So, I think those are two specifics and then I mentioned that of collection, the kind of—we simply have to have a better understanding of the financial base. It's my judgment, for whatever it's worth, that national health insurance now would not only be a disaster in the health industry, I think it would be a national disaster. Look at what happened to Federal expenditures after—with the open-ended medicare, medicaid programs.

Senator DOLE. Right.

Mr. METZLER. I think that's only the tip of the iceburg of what would happen if we go into a program of national health insurance, broad coverage, before we have a lot better feeling for data.

Senator DOLE. Well, in just one particular area, end-stage renal disease, the program is costing us almost $1 billion a year. How many people are participating? Thirty-six thousand people, a pro-

gram that cost nearly $1 billion a year, $900 million, so if we try to project that into some national health insurance program, we can see the enormous cost, and I guess cost has to be a factor. But we also have to find ways to contain it. We were in Kansas or had hearings in Kansas earlier last year, early last year on Federal food programs including WIC and others, and I think I cited then a rather interesting statistic that we spent, I don't know how much per child, $27 or $28; or $55 for driver's education, but at that time not 1 cent for nutrition education. Now, we finally, as of last year, have a formula. We hope to have 50 cents per child on a formula for nutrition education which does tie into prevention. Maybe it's not the only answer and once you start talking about nutrition, then you raise the hackles of some who raise certain products, so there are always a few minefields to go through.

Mr. METZLER. Certainly that's true, but basically you were so right and are so right, that nutrition is one—one of the building blocks of health, and it starts right out from conception on. That's why we are so enthused about those food programs, and about what they are really doing for Kansas mothers and children.

Dr. WILSON. It's been well established beyond the 28th week of pregnancy that lack of protein can result in brain damage. It's been documented, in fact there's even—it's irrefutable information now, and I think that this may explain why many of the—many of the poor score so low on test scores and are so poorly. This has been something that we have just been lacking in and we appreciate the leadership which you showed because you almost single-handedly put that through the U.S. Senate and it's really paying off I think in terms of improved capabilities of the people it's reaching, which are the poor and needy.

We have another serious health care problem in Kansas, and this is something we need to mention, that's in this immediate area, and that's the military's lack of physicians, they are down to barely able to provide health services to the people on active duty, not to mention the dependents without care and also the retirees who spent their many years in the service with the understanding that they would get health care with active military establishments. I am not pointing any fingers, but it is serious in again that it impacts on the department of health and environment in that we have this large number of people who going to require additional services as more young men and women leave the military service, and we—particularly the medical care.

Senator DOLE. With your military background, I think you will probably appreciate this: I will have to confess that I have tried to get early outs for military physicians to go to physician shortage areas in rural Kansas because we have had physicians tell us that they didn't do anything in the military. They wanted to practice medicine. I might add we didn't have much success, but we tried three or four times. I am told that there is a shortage in the military, so it doesn't seem that we can look to them for any help right now.

If you were going to try to pick out the most important health care problem in Kansas, Dr. Wilson, would you say it was the prevention area or where?

Dr. WILSON. Basically, yes, we—much of our disease is preventable if we start out early, and we—a lot of this has to do with constructive personal health habits, but we have in Kansas an excellent medicaid program. We have an excellent medicare program and an excellent health—private health insurance, so that we don't need health insurance, but we need health education, and I think this is an important area, and we need to get health providers out into the areas of greatest need. I think it's a matter of distribution and we are working on that. We have been given a lot of tools to get this accomplished and I think that given a couple of more years we can meet most of those needs. The rural health departments and counties do need help, they are suffering from anemia; much of the money which they get is passed-through money, the 314–D money which I am sure you are aware of, and this is an area of great need. We get more utilization for health care dollars in the local county health departments, the use of which is determined by the county commissioners and the county health physician and we think that more help for these people would be—is really the greatest area of need.

Senator DOLE. I think we all look to preventive health care, and I know Secretary Califano is having a little excitement now regarding his smoking crusade. I don't know who's smoking more, Califano or the people. [Laughter.] There are a lot of people smoking because they think that's another interference by the Government, that next it may be grape juice, and next it may be something else. But I think it's pretty well established that smoking is harmful to health, and I've quit twice. [Laughter.] Those are the worst kind of reformers.

Mr. METZLER. Well, Senator, incidentally the Kansas Legislature has dealt with this problem. We would say—we carry on active programs for our own employees statewide in withdrawal from smoking, and some of the other addictions. The Kansas Legislature has acted on this to the point that they made posting of public auditoriums, so forth, with no smoking as one of the requirements of the new law. Now it's not always observed, but the legislature did at least recognize it as a problem.

Senator DOLE. Well, I even saw a sign the other day, "Keep the Panama Canal and give Califano away." [Laughter.] These are being distributed by smokers. So it's a tough job he has.

Mr. METZLER. You could even get a few nonsmokers to agree with that.

Senator DOLE. I don't know if you have an opportunity to stay a while, if you have, you are welcome.

[The prepared statement of Mr. Metzler follows:]

TESTIMONY OF THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

(Prepared by Dwight F. Metzler, Secretary, Department of Health and Environment)

Senator Dole, Members of the Committee, thank you for the opportunity to speak with you about two major health related problems: (1) the availability of primary care services, and (2) the cost of health care. These two issues are center stage in the public affairs arena of this state as well as the nation.

Both of these problems are under intense scrutiny and the subject of many well intended, if sometimes misguided, proposed solutions. There are two points that are common to both issues and upon which there is general agreement. First, both are highly complex, and second, neither will be resolved with a single quick solution. During these times of intense political interest in these issues we must remain just as concerned about avoiding ill-advised attempted solutions as we are in developing thoughtful, positive efforts which over the long-term, will hopefully bring us to our desired goals of better access to quality care at a reasonable cost to the consumer and our governments.

During the last year our department, working in conjunction with the State Health Coordinating Council, has studied these two issues at length. We have included complete written statements on both problems with a copy of the brief statement that I will make before you today. These statements are found in the text of our State Health Plan which will be published within the next few months. The plan is much too lengthy to cover in detail here today, consequently I'd like to take this opportunity to highlight certain elements of it which we think should be of special interest to members of the United States Congress.

COSTS

Our state plan contains twenty-one (21) specific recommendations relating to the issue of health care costs. Many of these relate to the basic needs of keeping people healthier and encouraging them to assume more responsibility for their own health. Others relate to helping both providers and consumers to better understand the underlying causes of the high cost of health care through educational efforts. Others are regulatory in nature such as improving our certificate of need program; establishing a state rate regulation agency; and expanding coverage of the PSRO program to all patients in acute care facilities. Still others relate to the development of alternative competing forms of medical practice such as health maintenance organizations. While some of these objectives can be achieved sooner with federal cooperation and assistance. they remain primarily the responsibility of many individuals and organizations both public and private here in the state of Kansas.

There are some aspects of the problem which can be addressed primarily by the federal government. I would like to single these out today for specific emphasis;

1. The true cost of health care in this country is not known. The facts and figures we hear so often but rarely question are, in fact, largely estimates and guesstimates. There is a need to establish an accurate data collection system to monitor health costs on a state by state basis. Only a very few states are now capable of producing these data and their methods are not standardized. It is remarkable that such a system is not in place now but we will never be able to evaluate our efforts to control costs unless we can monitor trends. The federal government must assume the leadership in the establishment of a health care cost monitoring system.

2. There are more efficient ways of utilizing our present health care institutions. For example many of our smaller hospitals could easily offer both short-term and long-term care services in the same building. But these efficient operating arrangements are often thwarted because the Medicare bookkeepers are more interested in accounting techniques than they are in the purpose of the program. Relief from this problem can and should come in the form of revised Medicare and Medicaid regulations. They have been drafted but for some inexplicable reason they have not been implemented. Senator, this is an area that I know you are familiar with. We in the state appreciate the effort you have made in attempting to alleviate this problem yet the administration continues to drag its feet. Any effort you, or members of this committee, can make to dislodge these needed changes in federal regulations will be very much appreciated.

3. Recent Medicare amendments will facilitate the use of new health professionals in rural clinics. These changes will help but they don't go far enough. New health professionals are already practicing in many urban areas in both private physicians' offices and in clinics. Additional changes need to be made in Medicare and Medicaid programs to encourage, not prevent, the deployment of these new personal health providers.

We have a national health financing system in the form of Medicare and Medicaid. The shape of our health care system is being manipulated by decisions regarding what and who will be reimbursed under this system. Yet these decisions are being made not by people planning for effective and efficient health care. Rather the rules are being written by an army of accountants. The health care system of this country is too important to be run by bookkeepers.

PRIMARY CARE IN RURAL AREAS

The availability of primary care is a serious problem in our state. You are well acquainted with the slow decline in many services for residents in our smaller more rural communities. We have made fourteen (14) specific recommendations designed to alleviate this problem in our state plan. Some of these deal with the expansion of specific programs or services such as those for high-risk mothers and children and family planning centers. Others recognize the responsibility of health professionals to organize delivery systems such as group practices with satellite clinics to serve rural areas. Still others deal with the need to support the efforts of communities to compete effectively in nationwide recruitment of needed health professionals. And finally we suggest the enhancement of the professional environment by the decentralization of our state's health science education system. As in the area of cost, federal efforts can and are supporting many of these activities but the primary responsibility must be assumed by our communities, our health professionals, our health institutions, and state and local governments.

POLICY DIRECTIONS FOR THE FUTURE

There is general consensus that health costs and the availability of care are major problems in our state. But, we must look at these issues in perspective with our real objective—good *health*. More money for health care and additional health services are important means to this end but are not an end in themselves. There is, in fact, a point of diminishing returns that we certainly cannot afford to ignore. Many national health insurance proposals, for example, will be inflationary in nature, drawing resources from other areas that are critical to the health of our citizens. I speak specifically of the basic needs for food, shelter, education, and a safe environment. There is no apparent need to adopt a nationalized insurance scheme in this state which will surely divert limited resources from other areas while holding no promise whatsoever of improving health status.

There are important disease trends in this country which we must not overlook. Death rates for many diseases are on the decline with few startling exceptions. Lung cancer, for example is increasing while death rates for most other cancers are declining. Homicides are increasing; suicides are increasing; alcoholism is increasing. Much of this morbidity and mortality is preventable. Yet, one area that government at all levels has traditionally shortchanged is disease prevention and health promotion. If *any* major initiatives are taken by the federal government in the near future, I hope they are into the areas of prevention and health promotion instead of further expansion of the medical care delivery system.

SUMMARY

Senator, I have watched the growth and developmetn of the health care system in this state for over forty (40) years. During that time I have seen the government become more and more involved in financing care; in financing institutions; financing the preparation of health care professionals; and increasing its regulation of the industry at least commensurately with its financial involvement. Government has been generous returning our money to us through these programs. In fact, I must tell you we have more programs, more money, and more regulation than we know what to do with. We need time to sort things out—get good programs organized and running efficiently—and take the time to evaluate what we have put in place. We have the money and the manpower supply to make the goal of quality care accessible to all in the foreseeable future. More money; more legislation; more regulation now may well do more harm than good. Senator, the ball has been in the federal end of the court since 1966. You have done your job well. Now it's our turn. Let us have a shot.

Thank you.

STATE OF KANSAS,
DEPARTMENT OF HEALTH AND ENVIRONMENT.
Topeka, Kans., January 27, 1978.

Hon. Senator BOB DOLE,
U.S. Senator,
Washington, D.C.

DEAR SENATOR DOLE: The State's Advisory Commission on Health agrees with the position of the Secretary of the Department of Health and Environment that:

a. The problems of health care costs and delivery of health services are important to the Nation and Kansas;

b. The federal government has taken many major steps to resolve these issues;

c. Many steps taken by the Congress have not been fully implemented and their results, either positive or negative, have yet to be documented:

d. Governmental actions in the past have vastly increased the supply of facilities, manpower, and money for health services to the point that there may be no need for additional efforts to increase resources;

e. There now is a clear need for the government to rest while local leaders attempt to efficiently and effectively utilize the vast resources now available.

The Commission strongly supports the Department's position that the mantle of leadership in health affairs should be passed back to our communities and that Congress should defer any additional major health legislation until there is a clear need to act in the future.

Sincerely,

MARY JANE WIERSMA,
Vice Chairman.
BETTY TALIAFERRO, R.N.
JOHN D. ATKIN, M.D.
DIANNA R. WISE.
DONALD E. SCHMIDT.
WILLIAM E. TUCKER.

Senator DOLE. Our next panelists are Health System Agency representatives, Mr. Newman, Mr. Hempling, Mr. Brownrigg and Dr. Harris. Mr. Newman is the executive director of the Northeast Kansas Health System Agency. You can proceed any way you wish, and if you would like to discuss your responsibilities and your efforts in a general way, or separately that's fine. We can start with Bill or maybe you have a different order. You might have it all planned.

Mr. NEWMAN. Dr. Harris, why don't you go ahead and the two directors will cover everything else.

Dr. BROWNRIGG. We'll modify that a little bit.

STATEMENT OF DR. LARRY HARRIS, O.D.

Dr. HARRIS. First of all for the record I would like to correct a couple of things, I'm Larry Harris, not Lawrence Harris, and as an optometrist, I'm a O.D., not an M.D. I apologize for the mistake on that.

As president of the Health System Agency with experience in comprehensive health planning and a practicing optometrist, I am aware of many rural health problems. I practice in Topeka, I also have a satellite practice in Valley Falls, Kans., population 1,300. It gives a little more insight as to both ends of it. I recognize that my fellow witnesses will address the major problems in their professional areas, physician manpower, hopsital costs, et cetera. I have tried to identify issues that may not be covered because they are not the most paramount problem confronting a profession, but are of

importance as viewed from a Health System Agency's standpoint. These problems impact on cost and quality of health care, two of the areas which you are particularly concerned with.

The efforts of HEW and the Justice Department to supposedly restore the health care industry, the free enterprise system is somehow excessive and impacts adversely on the delivery of quality health care. This forced free market condition is not advantageous to either consumers of health care nor those providers of health care who are affected. When a health profession is forced into competitive advertising the provision of quality care ceases to be rewarding. Price becomes the dominant criteria upon which services are sought. In this situation the patient does not receive quality services. Incentives for the health provider are diminished and the profession draws fewer people into its ranks. Our experience has been that whenever there is a shortage of health care providers it is usually felt first in the rural areas of our country.

Another facet of this situation is the ill effect of diminishing the faith of patients in their health professionals. This is particularly so when the success of the treatment is greatly dependent upon the patient following the health professional's directions. These actions by Government in the long run hurt both the patient and the provider of health care.

Specific examples of this are the recent headlines in the paper of a pharmacist allegedly filing fraudulent claims with the Government. They neglected to state that approximately 1,200 pharmacists did not try to rip off the Government.

Senator DOLE. That's the same problem we have in politics. [Laughter.] A charge is made and then you have to run around everywhere proving you're not guilty of something.

Dr. HARRIS. True. Another flagrant example of this was the medicare list of practitioners who had expenditures—income of over a $100,000. They found that over 75 percent of that list was inaccurate.

Senator DOLE. We have taken that up with Secretary Califano and he promised to be more careful with the computer next year. [Laughter.] It's a computer error, but it's also very embarrassing and very damaging to the profession, and if they can't be accurate, if they can't check it by hand, then they shouldn't issue the list. This is the view I have expressed to Secretary Califano and I think he agrees.

Dr. HARRIS. This raises a question too, as to whether or not there is a concealed effort of destroying public confidence in our present health system, so that our saviours in Washington can rescue us with National Health Insurance. I am not sure I want to be rescued from this particular system that we have.

In another area, Health Systems Agencies are perplexed by the double messages that are received from Washington. Health Systems Agencies are charged with trying to slow down the upward momentum of health care costs. Yet minimum wage increases impact most heavily on the rural areas, such as Kansas, and particularly in the nursing home industry where many entry level health workers are employed. If the success of the Health Systems Agency concept is to be judged by its effect on health care costs then Washington will

have to recognize the roadblocks it has placed in the path of Health Systems Agencies and as another aside, I have been to the mountain top, and I spoke with the guru and I asked the guru, "What are the secrets of economic viability?" And the guru in his knowledge said:

No 1, buy low and sell high; two is don't spend more than you got, and three is make sure you utilize everything you got before you ask for some more.

And I look at a Government that is buying oil high and selling grain low, and I say we are in trouble. I look at a budget that is drenching with red ink and I say I think we are spending more than we got. The third area, of utilizing what we have before we go looking for more things, I would like to move to the third part.

As a Doctor of Optometry who is concern about health care costs, I am troubled by current medicare policies which reimburse physicians for certain services but will not reimburse optometrists who are qualified to provide the same service. Specifically, this is the monitoring and following of cataract patients. In Kansas there are 300 optometrists located in 85 of our 105 counties. Seventy percent of these providers practice outside of the Kansas City, Wichita, and Topeka metropolitan areas. Eighty of the optometrists who practice outside of the Kansas City, Wichita and Topeka areas practice in the 50 rural counties located on or west of Highway 81. This excludes Wichita. In the western portion of our State there is situated a good number of optometrists ready to provide services, yet medicare requires its beneficiaries to travel long distances at high cost and great inconvenience. It is not easy for the elderly to travel or obtain transportation. Many of these cataracts should not be driving anyhow. To cause them to travel unnecessarily at their own expense is a hardship on them and a costly mistake. If we are truly concerned about health care cost we should not condone rules which drive up the cost of health care or the cost of obtaining that care.

Now, as you are well aware and have sponsored lots of acts that have helped optometry, there is a report that was done by a board or a staff of consultants consisting of both optometrists and ophthalmologists, public members, and the director of the American Foundation of the Blind that was filed with Congress, a report to Congress on reimbursement under part B for medicare under certain services provided by optometrists. This is a half-inch thick. The recommendations were in stating that indeed optometrists should be reimbursed for providing these services to the elderly. Two things the elderly need under medicare, neither of which are covered, are teeth and glasses. The HEW massaged this so that it came out to recommend that they were—to say that the committee, although the committee recommended some definite basic changes, the staff massaged the report to say that they want the status quo. Nothing has been done of this report, it sits now for 8 months with both Houses, and as I said, nothing's been done.

Senator DOLE. We are working on legislation and I also understand there is a definitive study from HEW. I know that HEW can study some of these things forever, and they certainly have a lot of people there to study them.

Dr. HARRIS. Still another area of concern to me is the direction and the possible results which may accrue from expanded use of nurse

clinicians and physician assistants as supported by HEW. I believe that expanded use of these professionals is appropriate and I support this effort. There are definite benefits which can result from the infusion of these health professionals into the health care delivery system and particularly the rural area health care system. I can see significant benefits from the availability of a physician assistant in a rural community where there is a need for more than one physician, but not a great enough demand for two full-time physicians.

I am concerned, however, that physician assistants and nurse clinicans may end up in rural communities without appropriate physician supervision with the rural areas getting the lower quality of care provided by the lone rural physician assistant or nurse clinician and a higher quality of care provided in urban areas by physicians. If this were to happen our rural hospitals would be relegated to glorified first aid stations. HEW should be constantly made aware of this possibility and medicare and medicaid payment mechanisms should be so structured as to prevent such an occurrence.

The last issue I would like to address is medicare hospital cost accounting policy which penalizes hospitals who provide meals to such programs as "meals on wheels" for the elderly and adult day-care centers. HEW continually stresses cost of health care and alternatives to nursing home care as being more cost effective than institutionalization. In a rural setting the community hospital is the logical facility to provide this, these meals. It seems unreasonable that medicare would discourage, with its regulations, that which is supported by HEW.

Two hospitals in our area have indicated that they lose tens of thousands of dollars in medicare reimbursement because they provide from their hospital kitchens meals for programs for the elderly. It is recognized that medicare probably reduces its budget by this policy. However, the overall impact on Federal health care expenditures is probably more than offset by the medicaid payments made for elderly who are in nursing homes because "meals on wheels" type programs are not accessible. Coordination between agencies of the Federal Government is essential if we are going to impact on the cost of health care.

These are all issues which I feel either impact now or could impact on the quality and cost of rural health care. Thank you.

Senator DOLE. Thank you, Dr. Harris.

You may proceed in whatever order you gentlemen have decided.

STATEMENT OF RANDY HEMPLING, HEALTH PLANNING ASSOCIATION OF WESTERN KANSAS

Mr. HEMPLING. I'm Randy Hempling of the staff of the Health Planning Association of Western Kansas, as such I'm going to briefly paraphrase the prepared statement that I have, and I think Sheila has. I have got several other copies available. The Health Systems Agency in Western Kansas also has the acronym "HAWK" which has other meanings to other people, but the area itself is a 54 county area, by all definitions, whether Federal or State, it is a

rural area. There is no SMSA in the area. We have 430,000 people scattered throughout 46,000 square miles.

The board of directors of the Health Planning Asscciation is made up of 57 individuals, 51 percent of whom are consumers, the balance are providers, covering most of the major fields of emphasis in the provision of health care. We also have 210 members on the subarea council.

My prepared statement has attached to it several problem areas in the health systems program that we are working on, but for the purpose of emphasis I'm going to deal with four main areas.

The first concern, and this is not necessarily priority, but one of the main concerns in western Kansas is the distribution and supply of manpower, primarily physicians, and of physicians we are talking about primary care physicians, family practice, pediatricans, OB/GYN, and internists. At the present time, in seeking a ratio of 1 to 1,500, we will need 69 new physicians within the next 5 years. We also have a large number of physicians who are over age 60 and will be retiring, so we'll need a constant supply.

To support these physicians in their practice of medicine, we will also need additional nursing personnel, nurse's aides, physician assistants, whatever. So this is also a constant problem. Recently it's been noted in our area that we have a shortage of R.N.'s, and L.P.N.'s. We also have a shortage of public health personnel. We are trying to reach a level of 1 to 2,500 public health practitioners whether that be a nurse practitioner or public health nurse or whatever, and at least 1 per county; we do not have that at this time.

Second area I want to address is service distribution availability. We do not have comprehensive home health services in western Kansas. The State Department of Health and Environment has provided seed moneys to some counties for the provision of home health services. But in each case this amount of money has been too small and does not allow for comprehensive services. It's primarily tied in with the public health department or the public health nurse who is already loaded down with things to do. It certainly is not a comprehensive service so we do need that.

The problem with this is that we have an inappropriate utilization of other forms of service, nursing homes, the national average for utilization of nursing homes is 5.6 percent of the number of people over 65. In western Kansas it runs 10 to 11 percent who are in nursing homes, perhaps inappropriately, because of this absence of home health. The main reason we don't have home health is because we do not have an appropriate reimbursement system to cover it, particularly the particular problem areas of this are obviously medicare, medicaid and Blue Cross. There are very few other people that would get involved in this.

The third major area is once again financing, financing of all forms of services, third party payments whether governmental or private, impact a manner of utilization of health service, failure to reimburse logically, and this is a main problem in western Kansas. Failure to reimburse logically for services of home health agency nurse practitioners, physician assistants, a long-term care based in

hospitals, field nursing facilities; this caused once again an over-utilization of acute settings in nursing homes.

It is the intention of HAWK to analyze this further in the next year and come up with a position paper on it.

The final point, and I probably put this last for emphasis, is in the area of regulation. The problem of regulations often administered arbitrarily and designed to affect national standards in small areas is dramatic. Little thought is apparently given by State and Federal agencies to the overall cost implications of implementing ever-changing rules and regulations. There are numerous examples of hospitals, nursing homes and other service providers being inspected by several State and Federal agencies, all looking at exactly the same things. The cost in inspection services to the State and Federal Government are quite high, and the resulting costs of service providers in meeting these often arbitrary requirements further compound the rise in health cost.

It is the intention of HAWK to develop an analysis and position paper on the impact of these regulations. It is the full intention of HAWK to see that all regulations promulgated in the future have a cost analysis attached to them, and perhaps more importantly, a life-benefit analysis. Service providers should be allowed, based upon the determination of the local planning body, to seek and receive waivers to regulations which would have a detrimental cost effect upon their operation and thereby increase the overall cost of health care, and where no life threatening situation can be proven by the regulatory agency. Additionally, there should be a concerted effort on the part of all regulatory agencies to coordinate and combine inspections, regulations, and fees where possible. Thank you, sir.

Senator DOLE. Thank you. We might have some questions when we finish. I think we will hear from Dr. Brownrigg.

STATEMENT OF DR. RICHARD L. BROWNRIGG

Dr. BROWNRIGG. Senator Dole, I do have a short written statement and I will read this statement.

This testimony should not be regarded as primarily that from the perspective of a practicing physician from rural Kansas. However, it cannot be maintained that this perspective is typical of most rural practicing physicians. Experiences as a surgical specialist, experiences in a moderate-sized group practice, and most importantly those experiences gained in the formulative and subsequent years as chairman of a rural health systems agency have tended to influence that perspective considerably.

I will not reiterate the problems previously identified by Randall Hempling, the executive director of the Health Planning Association of Western Kansas in regards to the shortage and maldistribution of manpower, but will tend to focus on suggested solutions for that problem. Not to say that's the only solution, but it's a suggested solution. This problem is perceived by the residents of rural Kansas to be the most critical, or perhaps one should say most demonstrative of rural Kansas getting the "short end of the stick."

Health care problems in general and most assuredly those of manpower in rural Kansas would be greatly alleviated if rural Kansas

collectively was to receive an adequate return for its labors. To build upon the theme of a popular song after World War I, one cannot expect to keep the farmer back on the farm once he has seen the rewards of living in Paris, and likewise one cannot expect to attract and retain a physician in rural Kansas once he has seen the rewards of living in Kansas City.

The physician in rural Kansas in general, just as the farmer and laborer in rural Kansas, works harder, works longer, works with less, has less diversification, recreation, and educational opportunities than his big city brothers. Because there is strength in numbers, and one might add votes, somehow the marked contrast in adequate rewards received between rural and urban peoples has been allowed to continue.

The Federal Government could reverse this inequality. The Federal Government could institute a rural affirmative action program as it has in the area of civil rights to help rectify some of the historic injustice experienced by those who reside in rural areas.

Specifically in the area of health manpower, such Federal tools are preferential tax rates, investment tax credits, accelerated depreciation of facilities and equipment, low interest loans, grants, consultative assistance, and equitable reimbursement from Federal third-party insurance programs could be helpful in attracting physicians to rural areas.

Such a program would be far more productive in increasing the availability of stable, dependable, and high-quality physician services for rural areas, and involve far less costs, redtape, bureaucracy, and regulations than any of the current governmental HURA, AHEC, Health Services Corps, or similar programs. Those programs which do not address the basic need of an adequate return or reward for the labors that are performed by rural people.

I directed that primarily for physicians, but it includes all segments of rural population, laborers and farmers, as far as reward for their labors are concerned in reference to those that are available in the large cities. Thank you.

Senator DOLE. Thank you. We'll come back after we hear from Mr. Newman.

STATEMENT OF WM. A. NEWMAN

Mr. NEWMAN. Senator, my fellow panelists have covered the issues quite well. And perhaps we could use the remaining time for questions which might be more beneficial, so I will forego my remarks for now.

Senator DOLE. Well I think I can identify one need that certainly you are all aware of, and that's the primary-care physician in rural Kansas or rural America, or rural anywhere. You have just touched on some possible ways to attract physicians to rural areas. Are you saying in effect that since income is less for a physician in rural areas, that he therefore avoids those areas. Is it the income itself or a lack of other opportunities?

Dr. BROWNRIGG. Sir, I think it's primarily a combination, the lack of recreational facilities and educational facilities, those sort of things do tend to keep a rural area from being attractive and a prac-

tice setting, that he has to spend the long hours that he has to spend, tend to keep that rural setting less attractive. And many times we find, particularly with Federal reimbursement programs, medicare, for instance, that the reimbursement that is allowed for that person in that undesirable setting is not as much as that might be allowed, let us say, in a metropolitan area.

Senator DOLE. I have an example of that that I want to have in the record right now. In an earlier version of the medicare-medicaid administration reimbursement reform bill—always be careful of that word reform—we included a provision to pay physicians in rural areas not less than 80 percent of urban area rate. It seems to me that this provision would be helpful, but it was opposed by AMA and it was dropped from the current bill. However, the current bill retains a provision which would pay physicians coming into the rural areas at the 75th percentile of the prevailing charge in the area instead of the current 50th percentile. Obviously, payment at the 50th percentile is one of the examples that you are citing as discriminatory; right?

Dr. BROWNRIGG. That's correct. I think that physicians in rural areas——

Senator DOLE. You want 100 percent of parity; is that it? [Laughter.]

Dr. BROWNRIGG. That seems to be the general thing. I think they need—it needs to be recognized that if you want to solve the problem that you might have to reward those individuals that are willing to serve in that undesirable area.

Senator DOLE. Except I wouldn't want the record to think that rural areas are undesirable. You have all the advantages, all the pluses, you don't have the pollution, you don't have the traffic jams, you don't have all the urban problems, you have, in many cases, better opportunities for families, more recreational opportunities, and also, of course, in this day of access by plane or superhighway, all the cultural advantages are fairly nearby. The statistics show that more people are moving out of the urban areas into so-called rural areas. So I think there are some balances there.

Dr. BROWNRIGG. For you and I. I obviously wouldn't be practicing in that rural area if I did not—but I think the record shows that we have been unable to attract physicians, and we have also been unable to attract other skilled individuals into rural areas, so on the balance it must be at least—in the past at least been attractive. What I am suggesting, that I know that those rural areas cannot finance higher fees, higher returns for those practitioners, but I think because it is a relatively unrewarded area as far as all products are concerned, agricultural, and labor, I think if the Federal Government wants to recognize that as a problem, that some preferential tax credits, if you will, might be of benefit to not increasing the cost to the local individuals and I think would have very little impact on the Federal budget.

Dr. HARRIS. Another possibility that I think has been overlooked, at least is not emphasized all that much as far as providing physicians to the underserved areas, is the possibility of satellite practice

by existing physicians in larger towns. Do you still have some satellite practices running out of your group in Dodge City?

Dr. BROWNRIGG. We do maintain another clinic that's 20 miles away from Dodge City in Cimarron, where at one time we had covered that with nurse clinicians, but we ran into problems there, particularly as far as reimbursement is concerned, and there's some question as to the legality in the State of Kansas. We now have recruited a family practitioner to help cover that clinic.

Senator DOLE. We have tried to correct that in the rural clinics bill to the extent that the State law permits——

Dr. BROWNRIGG. I think if there could be some rapid acceleration of depreciation of the funds necessary to build a clinic in that town, that would offset some of the other income that is made in the clinic practice that might be a stimulus for us to get involved in supplying other areas that are unserved. That's what I had reference to as far as these tax tools.

Senator DOLE. [continuing]. That's an area that I hadn't been—well I hadn't thought of and it's an area that we could certainly focus some attention on. The Health Subcommittee is part of the Finance Committee which is a tax committee and we have a tax bill coming up this year. At least we can take a look at it. Are you suggesting that if physicians in Dodge City, or wherever in rural Kansas, were provided some tax incentive where they could depreciate equipment and other property at a faster rate, that this would be an added incentive income-wise.

Dr. BROWNRIGG. Rapid acceleration of depreciation has been allowed as far as historical restoration is concerned, and I can see something like a 5-year depreciation on a building that would be built in Cimarron, Kans., to help supply the medical services in that underserved area, that might be very advantageous for not only my group, but for a new physician graduating from the University of Kansas Medical Center to come out and stay in that area. He knows that his fees that he's going to receive from the patients are going to be lower, but with these tax advantages, there could be some offset.

Dr. HARRIS. We are talking here about the physicians living there from then on. What I had reference to is, for instance in Topeka, there are five optometrists that not only practice in Topeka, but either a half day or 1 day a week, one goes to Valley Falls, one to Onaga, one covers Eskridge, one covers Holton, these are all small towns around there. It would be possible for those smaller towns to perhaps contract with a doctor, or the other way around. They all seem to be more than willing to set up clinics any time they can get a live body from the National Health Services Corp. that would agree to come in. What I am saying, let's use what we've got. We do have some practicing physicians—it might be possible to draw some of the physicians that are in the larger towns out 1 day a week, which is better than no physician at all. The incentive, and the idea, and perhaps through our medical schools, the idea of implicating the idea of perhaps practicing in your main place most of the time, but maybe 1 day a week performing a little missionary work. It's another alternative.

Senator DOLE. There's obviously more of that going on than I recognized. I just had an example yesterday where doctors from Leewood were working in Lucas, Kans., It just alerted me to the fact of another example of missionary work, I guess you call it, to visit nursing homes in that area.

Dr. Brownrigg, in an article you've prepared for "Dialogue" you talked about the need to get health professionals involved in health planning. Have you been successful with that open letter?

Dr. BROWNRIGG. I don't know if the letter had anything to do with it, but I have seen physicians, particularly, showing more interest in getting involved, at least in their subarea council levels, which is about the only area open for them now, because of—you have to be known in the system, let us say, in order to get appointed to the board of these Health System Agencies. But I think in terms of time, we will see more physicians involved in it. My concern in that letter was that I feel that physicians have a lot to offer as far as health planning is concerned, and I was concerned that they were sitting back and letting others who have some things to offer also, carry the weight and carry the role rather than them offering their services.

I think it's understandable they are overworked in general, and perhaps don't have the time; but I think for their own future, plus the future of the health of Kansas, it is necessary for them to get involved.

Senator DOLE. Going back to one thing I referred to, and that's the provision that would pay physicians coming into rural areas at 75 percentile of the prevailing charge in the area, do you think that offers any incentive to physicians in rural areas.

Dr. BROWNRIGG. When you are talking about percentiles it's kind of difficult to say—that isn't obviously the same as 75 percent—it's difficult to say exactly what that is.

Senator DOLE. I don't know where that would fit.

Dr. BROWNRIGG. I think that returns in the rural area has to be at least as equitable as those in the metropolitan area because you do have some offsetting lower costs, too. But, to take advantage of those things that are available in America in general—you talked about travel and what have you, you have to have funds available in order to do that travel. You also have to have funds available to hire local physicians, if you are a sole practitioner, to cover your practice; and for a physician to get away a week, to take postgraduate education, he might spend $3,000 or $4,000 to do that, and with the expenses involved to get out of the office, there needs to be at least an equitable return.

The Blue Cross-Blue Shield in the State of Kansas uses a figure of the 19th percentile, and that seems to be a reasonable figure as far as most practitioners in the State of Kansas are concerned, except in a number of areas there's a high percentage of participation in that reimbursement program.

Mr. NEWMAN. Senator, I might add something to that. I was medicaid director for the State of Kansas for 4 years, the difference in the actual dollars between the 50th and the 75th percentile is

sometimes deceptive. It's not really that much money in expenses, and dealing with health providers during that time, the problems seem to be that they were disadvantaged by getting a lesser payment. It may not really cost much more money to do that kind of thing, pay it at the 75th, and then that feeling of being disadvantaged by being in the rural area might be eliminated and help considerably.

Dr. BROWNRIGG. The only difference is that the small dollars sometimes do make a difference because that difference between the 50th percentile and 75th percentile is coming out of your profits, it's not coming out of your cost, and the costs continue whether you are paid at the 50th or 75th.

Mr. NEWMAN. That's the point I've been making, it might not be that expensive to the Federal Government to make the change.

Senator DOLE. We don't have any cost estimate, but I understand that it would add little cost to the program. There's a lot of focus on home care—I think the thing that we concern ourselves about when we look at it from the standpoint of cost, is again, are we going to get the Federal Government involved in an area where a lot of it may be accomplished by friends and family. How do we separate all this? The Government just shouldn't become involved in everything, normal things that you do for your mother, brother, neighbor—how do you cut through the maze?

Mr. NEWMAN. Let me say something about that. Part of our analysis of long-term care facilities is beginning to indicate that in those areas where we have considerable numbers of long-term beds, we have more people utilizing those beds. In looking at our Topeka area, some initial data indicates that people are entering nursing homes at an average earlier age, and we have more nursing homes in the Topeka area than we do in other areas. That supports our idea that when facilities are available, that obligations of family and friends to take care of their loved ones is perhaps negated somewhat. If the facility is nearby, it's convenient, providing nursing care, and in Kansas there's an extra attraction, when a person enters a nursing home they can qualify more readily for medicaid programs, and then all the services. There's also a financial incentive to perhaps allow your mother, father, what have you, to go to a nursing home, especially if they are nearby.

We have some tradeoffs that we have to consider, decreasing the availability of facilities will force people to provide those kinds of things themselves. This may be a change in philosophy. We are paying high costs though for transferring that responsibility to the Government, and as Health Systems Agencies maybe we can in the long run affect that kind of situation.

Senator DOLE. That's going to be one of the problems, getting into costs again, it's going to be one of the real problems. I don't have to tell anybody in this group that there are great pressures now on the health dollar and the costs and how we are going to divide it. We start out this year with a budget presented to Congress which is to start with $61.4 billion in deficit. We always add on a few things, so we are looking at a deficit of maybe $70 billion or more. I have had people tell me it didn't make any difference because there would

be somebody else to come along later to pick up the deficit. But the deficit is a problem I'm certain everybody here understands.

The 69 number that was mentioned, something about 5 years from now we're going to have a shortage of 69 physicians.

Mr. HEMPLING. I was saying we would like to attract 69 to reach the level of today in 5 years. It's going to be compounded and we are shooting for at least 30 in the next 5 years.

Senator DOLE. Are there a number of foreign physicians in western Kansas now?

Mr. HEMPLING. Yes.

Senator DOLE. How many?

Mr. HEMPLING. I can't say offhand, but a good many of the communities have only foreign physicians.

Senator DOLE. Vietnamese?

Dr. BROWNRIGG. There are a few Vietnamese, there are also Indian extractions, and some from the Arab lands.

Mr. HEMPLING. Philippines.

Senator DOLE. This is a recent development though, isn't it?

Dr. BROWNRIGG. I have seen it primarily in the last 2 years. I think they are offering a definite service in those areas, but there are frequent problems with communications between them and their patients.

Senator DOLE The difference in languages could prove to be a real problem. You could treat a patient for the wrong symptoms.

Dr. HARRIS. At the risk of sounding like a heretic, I think perhaps when you look at the cost effective basis, perhaps not every town needs a doctor, when you look at it from a cost effective standpoint, because the truth of the matter is docs cost money. When you have a doc, he is going to write prescriptions, there's going to be more hospitalization and that sort of thing. The other alternative—and I go back to Jefferson County where Valley Falls is located—there are only three doctors in the whole county, two of them in Winchester, where there's a hospital in the middle of nowhere in McLouth. To fill that void, the Public Health Department has beefed up—they do a lot more physician calls. There are a lot more home health visits. I think the people realize there's not a doc available for every time they have a sore throat, and this is a little bit of a stimulus to look after yourself a little bit, where if there is one you can go to for every sore thoroat, something like that, that's going to drive the cost up, office calls, and sometimes hospitalization that may not be given. Yet I would throw out the possibility that perhaps the general health of Jefferson County is not that much lower than it would be in Topeka. So is a doctor in every town a necessity or even desirable?

Senator DOLE. Well, I don't have the answer.

Dr. HARRIS. I just thought I would throw it out.

Senator DOLE. Right, it's all right for you to throw it out. [Laughter.] We appreciate very much your being here. Is there anything else you would like to add? I don't want to cut anyone off, but we will have the statements and we will focus on some of the suggestions, and that's the purpose of the hearing. It's sort of free-wheeling and wide ranging, you don't have to stick to the topic. We

appreciate very much you coming the distances you have to be here. We will correct the record and make sure you are not accused of being an M.D. Thank you very much.

[The prepared statement of Mr. Hempling follows:]

STATEMENT OF RANDALL HEMPLING, EXECUTIVE DIRECTOR, THE HEALTH PLANNING ASSOCIATION OF WESTERN KANSAS, INC.

The Health Planning Association of Western Kansas, the conditionally designated Health Systems Agency in the area, has, for almost two years, been hard about the task of defining the health and health care needs in the 54 county area of Western Kansas. This area, by all definitions, is rural, with a population of 430,000 people scattered throughout 46,000 square miles.

The 57 members of the Board of The Health Planning Association and the 210 members of the six supporting Sub-Area Councils firmly believe their sole function is the definition and solving of health problems in terms of the needs of the population of Western Kansas. The attached Problem and Goal listing is only part of the Health Systems Plan of the area and is only a brief outline. Several areas of concern will be studied in future Health Systems Plans, but for purposes of emphasis, the following are considered to have a major detrimental impact upon the availability, quality, and certainly the cost of health care in Western Kansas.

PROBLEMS

I. Manpower (shortage and distribution)

(A) Best estimates show a need for 69 primary care physicians (Family Practice, Pediatricians, OB/GYN, and Internists) at the present time to achieve a ratio of 1:1,500 persons.

(B) Additional support personnel must also be available to support these physicians.

(C) Public Health Nurses are needed to maintain a level of 1:2,500, and one per county.

II. Service distribution and availability

(A) Comprehensive Home Health Services are lacking Western Kansas, causing to a great extent, inappropriate utilization of services, such as, nursing homes and in-patient acute facilities. The cause for this, and many other problems, is inefficient and inappropriate reimbursement by third party payers, particularly Medicare and Medicaid.

(B) The manpower situation again, compounds service availability.

III. Financing

Third-party payments, whether governmental or private, impact the manner and utilization of health services. Failure to reimburse logically for services of home health agencies, nurse practitioners, physicians' assistants, etc., has caused many people to be in nursing homes and acute settings inappropriately and at a much higher cost. It is the intention of HAWK to develop in the next year, a comprehensive analysis of this problem in Western Kansas.

IV. Regulations

The problem of regulations often administered arbitrarily and designed to affect national standards in small areas is dramatic. Little thought is apparently given by state and federal agencies to the overall cost implications of implementing everchanging rules and regulations. There are numerous examples of hospitals, nursing homes and other service providers being inspected by several state and federal agencies, all looking at exactly the same things. The cost in inspection services to the state and federal government are quite high, and the resulting costs of service providers in meeting these often arbitrary requirements further compound the rise in health costs.

It is the intention of HAWK to develop an analysis and position paper on the impact of these regulations. It is the full intention of HAWK to see that all regulations promulgated in the future have a cost analysis attached to them, and perhaps more importantly, a life-benefit analysis. Service providers should be allowed, based upon the determination of the local planning body, to seek and receive waivers to regulations which would have a detrimental cost effect

upon their operation and thereby increase the overall cost of health care, and where no life threatening situation can be proven by the regulatory agency. Additionally, there should be a concerted effort on the part of all regulatory agencies to coordinate and combine inspections, regulations, and fees where possible.

SELECTED PROBLEMS AND GOALS IDENTIFIED BY THE HEALTH PLANNING ASSOCIATION OF WESTERN KANSAS, INC.

Prevention and detection.—Manpower.

Problem: General lack of primary care services in Western Kansas. Lack of primary care physicians, especially in the South Central, Southwest Plains, and Far Southwest Sub-Areas.

Goal: To achieve a primary care physician to population ratio of 1:1,500. Increasing the utilization of physician extenders may increase the availability and accessibility of primary care services.

Habilitation/rehabilitation.—Reimbursement.

Problem: Poor reimbursement coverage for rehabilitation and habilitation services provided in an ambulatory setting.

Goal: By 1983, third-party coverage should be extended and procedures eased to adequately allow for home health services, skilled nursing services and adult day care services.

Long-term care.—Reimbursement.

Problem: Lack of alternatives to institutional care for long-term and home-bound patients in HSA 1.

Goal: By 1983, establish home health programs to serve those parts of HSA 1 that are not currently being served; establish adult day care services for at least 50% of the population needing this service; third-party coverage should be extended and procedures eased to adequately allow for alternatives to institutional long-term care.

Long-term care.—Reimbursement.

Problem: Poor reimbursement coverage for nursing homes.

Goal: By 1983, third-party coverage should adequately allow for services rendered in a nursing home.

Acute care services.—Excess Beds/Underutilization.

Problem: Lack of studies to indicate the correlation between excess beds, underutilization of beds, and lack of primary care providers. Possible over-abundance of acute care hospital beds. Lack of plans to coordinate and integrate counties having multiple hospital acute care services. Lack of plans to develop in hospitals with inefficient acute care delivery, the provision of needed alternative health services, such as home health and county health department programs.

Goal: By 1985, reduce unnecessary duplication of acute care inpatient services and simultaneously provide efficient, high-quality, and cost effective care by coordinating similar services delivered within a single county. Additionally, studies need to be conducted to indicate whether or not there is a correlation between excess beds, underutilization of beds, and lack of primary care providers.

Data.—Availability/Comparability.

Problem: Data availability and reliability are of particular concern as they relate to the incidence of disease, mental health, disability, substance abuse and the availability of acute care services.

Goal: By 1983, develop a data collection system that would yield reliable, comparative data throughout the State of Kansas.

Long-term care.—Provision of Services.

Problem: Maldistribution and inappropriate utilization of intermediate nursing care beds in specific areas of Western Kansas.

Goal: During the next five-year period, the Health Planning Association of Western Kansas, Inc., should maintain the current level of intermediate nursing care beds in the following sub-areas: Far Northwest, Northwest Central, South Central and the Southwest Plains.

Senator DOLE. Next we have Dr. Dean Kortge, Dr. Cramer Reed and Dr. Richard A. Walsh.

Ms. FRANCIS THOMAS. You know, Senator Dole, concerning about doctors being so high, if they didn't put that high malpractice insurance on them, I don't think they would be quite so high, I don't know, I am just guessing, because I read in the paper where the State was doing that.

Senator DOLE. The State was doing that. Is this your statement, Francis?

Ms. FRANCIS THOMAS. Yes.

Senator DOLE. Thank you, Francis, now don't leave, we have to go on.

Again, I might say to those in the audience who may not be familiar with the members of this panel, they are representatives of the Kansas University Medical School. You gentlemen may have some order you wish to proceed.

STATEMENT OF DEAN KORTGE, PH. D., UNIVERSITY OF KANSAS SCHOOL OF MEDICINE

Dr. KORTGE. We do have an order and we will try to present three different focuses on the problem of rural health care. Copies of my comments have been provided to Sheila, and I would hope to address five of the most important of what we call acute health care concerns in Kansas, virtually which has been covered by other people in previous testimony, so I would make these comments very short.

The first concern is that of physician manpower; allied health and nursing manpower; emergency medical systems; urban-rural reimbursement differentials; and fifth, what I'm going to talk about will be briefly community expectations, but I would like to provide some information and perhaps some data relative to the physician manpower shortage.

This is not a problem unique in Kansas, in 1947, for example, 56 counties out of 105 petitioned the Kansas Medical Society to help them obtain additional physicians for their counties. During the period 1959 to 1976, 82 Kansas communities lost their only physician.

There is a new program which was referred to earlier, opted by the medical school, the physician's recruitment and placement program which has been just set up to hopefully help to address this problem. Another problem relative to the physician manpower question is the definition of unserved areas, using ratios discussed earlier, one physician for "X" number of people. This is terribly difficult, although understandable as to why it came about, but perhaps an equally significant ratio would be the number of physicians for hospital beds. I think there's several problems relating to physicians per ratio and it makes several false premises which I will not elaborate on.

Another issue which you mentioned just briefly a second ago—concerning foreign doctors——

Senator DOLE. I wish I had that information on the foreign doctors.

Dr. KORTGE [continuing]. Yes; we did put some figures together and approximately 15 percent of all the physicians practicing in Kansas are foreign medical school graduates, and 35 percent of those

practice in rural counties, and in three Kansas counties foreign medical school graduates are the only physicians in the county, while in another six counties, those graduates constitute 50 percent or more of the total physicians. The recent visa qualifying exams required by the immigration officials only for physicians, was passed by only 25 percent of those individuals who took the exam. This is a problem if this ratio continues, and if this exam is continuously administered it certainly is going to have a tremendous impact on Kansas physician manpower. And I think we will be hurt very drastically.

Senator DOLE. What are we talking about in numbers, in percentages of physicians?

Dr. KORTGE. I don't have those immediately available with me, Senator, I believe the total number is somewhere in the neighborhood of 340 to 350 total physicians in Kansas practicing who are foreign medical school graduates in Kansas communities, rural Kansas communities, other than Sedgwick, Johnson, Wyandotte, and Shawnee Counties primarily.

Senator DOLE. Am I correct, is this a rather recent development, at least there's been more in the past 2 or 3 years?

Dr. KORTGE. I believe that's correct, yes, sir.

Senator DOLE. What about the other side of the coin, what are we doing to the countries where the needs may be greater, where the doctor may leave India, for example, I don't know what the ratio is over there, it must be up in the thousands per physician.

Dr. KORTGE. Certainly, it would be I believe a problem that would be better addressed to a State Department hearing rather than the hearing on rural Kansas affairs. Perhaps we can trade nuclear reactors for a couple of physicians.

Senator DOLE. How about some wheat, trade some wheat.

Dr. KORTGE. Trading some wheat would be a super idea. I think the University of Kansas School of Medicine as well as private community hospitals in Kansas have been among the Nation's leaders in establishing family practice residency programs, which is hopefully one of the ways in which to address this problem. The Kansas Legislature in 1977 provided additional funds to support the affiliated family practice programs and we have high hopes for those. However, only 86 family practice residents have completed training in Kansas since 1970, and you heard Mr. Hempling mention the numbers that was needed or desired only in western Kansas. Of those 86, 37 are now practicing in Kansas, but only one is in a community under 2,000 population. This is important given that 69 percent of all incorporated Kansas communities are less than 1,000 population, and only 8 percent of all incorporated Kansas communities are over 5,000. I think this is important information to look forward to in the future. What it means, we are not quite sure, but it is some data that might be of some help.

Another program which the University does opt which hopefully provides some short-term assistance is the locum tenens program where residents or house officers hopefully can be encouraged to go cover a physician's practice for a 1 or 2 week period of time to allow that vacation or continuing medical education time that Dr. Brownrigg so adequately covered.

The allied health and nursing manpower problem additionally, again this ties in closely with health manpower, and the nurse practitioner program from the medical center opted in Hays, hopefully will again address this problem.

Emergency medical care refers to, I will not elaborate on it. I would like to extend a couple of minutes to community expectation. I believe this is very important. A small town medical practice is no longer what it used to be. It used to consist of a doctor, that no longer is true, and often this expectation from the community becomes translated into legislative action under the guise of citizens rights to health care, in contrast to medical care. I think certainly this is a problem that we need to address and face. It is a problem of attractiveness of communities which is certainly not the responsibility of the medical school to correct. The medical school does require a preceptorship for all medical students as well as for many residents. A very structured complete interdisciplinary team program, referred to as the Harper project is another example of programs which hopefully will attract students, or at least will expose them to rural health weekends for medical students, supported by the medical school to encourage students to experience rural medicine.

However, again, those individuals who live in 92 percent of all of Kansas incorporated communities under 5,000 certainly have health care needs. But given the certainty in the past track record, it will be difficult to provide physicians for every one of those communities, as Dr. Harris has mentioned just a moment ago. Perhaps the community needs need to be itemized and a health care system designed for those needs. But that health care system must be controlled by the community. Thank you.

Senator DOLE. Thank you. Dr. Reed.

STATEMENT OF D. CRAMER REED, M.D., UNIVERSITY OF KANSAS SCHOOL OF MEDICINE

Dr. REED. Senator Dole, my name is Cramer Reed and I appreciate the opportunity of talking about the middle range set of problems that we've identified. We all know today it seems more popular, and that's because it's easier to identify problems rather than solutions, and in developing our tripartite remarks for this particular presentation, the three of us have attempted to identify only those concerns that have broadly been recognized as having a significant impact, and we are certainly not attempting to imply that these are all inclusive by any means.

We have also attempted to identify six issues and/or potential medium range problems which can have a dilatorious impact on the effectiveness of our rural health care system in Kansas.

These are job satisfaction, continuing medical education, transportation, communications, allied health manpower, and health planning. And for this particular part of our three presentations, the medium range factors that I will allude to, these are defined as those that will probably influence the system over a period of the next 3 to 5 years. I will attempt to focus only on three of these six that have been mentioned.

Certainly job satisfaction must be considered one of the most significant factors influencing the availability of the health manpower in the rural setting. The problem, of course, is not confined to the medical faction, and we think this is of some importance. It's long been recognized that those communities having a high turnover of physicians experienced difficulty in retaining nursing and allied health manpower. Probably, and in general for the same reasons, the physicians tend not to stay in the smaller communities. Some of the reasons often cited for failure to keep health professionals in the community are lack of recreational facilities, already been referred to, loss of privacy, professional isolation, lack of primary care facilities, family social dissatisfactions, perceived educational inadequacies for offspring, decreased income potential—already been so very well identified by Dr. Brownrigg—less than optimal working environment and unsatisfactory social opportunities. As we know, if you are in this business much, you find that disenchantments often do not begin when the young man first hits the community or the young woman physician, everything seems to be fine until they get caught up into the situation, then 2 or 3 years later—that's why we consider it a middle range problem—they begin to identify with other interests and feel that the community no longer addresses their professional and social needs. And about the same time the same thing is happening to the allied health persons, the nursing personnel, so consequently these communities are short on med-techs and physical therapists, even though the law mandates you must have these kind of people available to administer long-term health care facilites.

We feel that communities must assume certain responsibilities for rectifying many of these responsibilities. I don't think that any of us here today feels that we can count on Big Brother, or Washington, to do all of these things for us. On the other hand, as Dr. Brownrigg recommended in terms of professional manpower, health manpower, perhaps there could be some start-up incentives that would encourage communities to make some of the changes, in the geographic environment that might make them more attractive and if inducement could be provided by the Federal Government, it might get the system going a bit faster.

Senator DOLE. Any specific recommendations you might have in that area would be helpful to me, in addition to the specifics Dr. Brownrigg mentioned in the tax area.

Dr. REED. I could do that subsequently. The second item I would like to allude to has to do with CME, or in the medical profession known as the continuing medical education. This in recent times has become a very significant factor in nonurban or nonmetropolitan area physician retention. The problem is multifacet, it is related to cost, and I believe as Dr. Brownrigg, again, pointed out that it can be a costly experience for rural physicians to obtain a locum tenens, or some other kind of coverage when he or she goes to the city to become educated again, so there is a cost factor. This factor becomes especially acute in those areas where there's only one physician that feels that he or she, out of loyalty to the community, or out of loyalty to the patient, cannot leave to attend scientific or professional meetings, for which they must earn credits over a period of a 3 year period of time in order to be licensed.

So pretty soon you find they are caught up in a "catch-22" situation because they know they must comply with the requirements for accreditation for relicensure in Kansas, plus the recognition they know they must keep up because of the expansion of medical knowledge, this is difficult to do just with journals at home, and yet because of these other commitments, yet because of costs, and their failure to get the same kind of reimbursement, they really can't go to the city or wherever it may have to be conducted to get this kind of continuing education.

Certainly these are some of the real reasons why there are very few physicians today out of the medical school, because those who are involved in this kind of activity, know that young people are no longer going solo anymore. And that's another problem, because if the community cannot attract or support at least two physicians, almost, then they feel they can't support one, because they are not going solo for these and other similar related reasons.

We think that future developments perhaps in micro-relay television, closed circuit television, telecommunications and as our sophistication is enhanced in these areas that perhaps it won't be so expensive as it is today, that they will help in relieving the potential and do have the help of diffusing this dilemma.

The final area that I want to just briefly comment on has to do with health care planning and this will be discussed more in detail by Dr. Walsh, because it certainly is a long-range matter. However, it has some pertinent aspects that I think are worthy of including under the mid-range category to which I am speaking. Public Law 93-641, we are all familiar with, is certainly to ultimately have an impact, many of us are not sure what that impact is, it is certainly likely to do something. The question, I think most of us have about it, I think is when and how. The issue is whether national guidelines are merely to be that, or whether they are going to be interpreted as absolute, and that's where some of us get into trouble with those that have been evolved so far.

Fortunately, we believe that the new revised guidelines have some potential benefit that the others did not. It may make life more comfortable for those in the rural areas, but we are not certain of that, and certainly it makes a big difference as to how they are going to be interpreted. Hopefully, as a meaningful national health plan emerges, and the consumer representatives on the various agency boards become more knowledgeable, we can anticipate more useful interpretation of the guidelines; otherwise as the Senator has already spoken, we may throw the baby out with the bath water.

We believe that the inordinate cost of health care must be addressed and very soon, but health care should and can be improved through HFA planning, if it is managed constructively and in a reasonable way. Health care economic pressures are increasing to the point that certainly some form of Federal intervention appears inevitable. But we must strike a happy medium between the relevance of local decision and the local people that Dean, Dr. Kortge and others have pointed out, that are so important to this process versus those mandated by Washington. They must make some decision about this if we are going to avoid compounding the human problems while

we are attempting to solve all of our economic enigmas. Thank you, Senator.

Senator DOLE. Thank you. I just noted your comments on physician extenders. This another area that I have some questions about, and I am glad you have addressed the subject. You indicated some of the problems that maybe John and Sheila are aware of, but I guess we can get more information from you on that if we need it.

Dr. REED. I will be glad to speak to that. I have had some experience in that area, that certainly has a sensitivity for me as a physician, and also one who has been interested as an educator, and there are major problems that exist in this State as in most States, Senator Dole, in terms of their acceptance and usefulness in the rural communities, particularly, and it has a lot to do with job identification. The role of supervision, the status of acceptability by the medical profession, the relationship to increasing numbers of physicians that are being educated today. It is a complex situation that's difficult to——

Senator DOLE. Particularly the area of supervision, that would, I guess, relate directly to the confidence that someone might have in the extender depending on supervision. I don't know how you put it all together. I understand that it is a very sensitive issue but I think the extender program has some potential. I think the program has potential if we approach it properly.

Dr. REED. There are those of us that believe, and there are some of my very good friends in this room that have a different view. Maybe they will have the opportunity of—of Dr. Chaney speaking to that, since he is a good friend, and we know each other well. There's nothing wrong with that. I think there are two sides of the issue.

Senator DOLE. Being a politician, I think I had better change that recommendation to limited potential. [Laughter.]

Dr. REED. Thank you, Senator Dole.

Senator DOLE. Dr. Walsh?

STATEMENT OF DR. RICHARD WALSH, DEAN, KANSAS UNIVERSITY MEDICAL SCHOOL

Dr. WALSH. Senator Dole, my name is Richard Walsh, and I'm Dean of the Kansas University Medical School at Wichita.

My cohorts have addressed the short and intermediate term aspects of health problems in rural areas. I would like to take a few minutes to address the long-term problems which have been detected and the potential solutions to them. This area is of great significance, not only of the impact on morbidity, and mortality in the future, but also the severe escalating cost crisis of health care in America. If one looks at the leading causes of death, one finds the majority of those within the top 10 are related primarily to life style and environment. At the present time if one looks at the distribution of expenditures within the area of health care the majority of dollars are going into treatment of acute conditions. Since the epic report of René Lalond, Minister of Health in Canada in 1974, the widespread realization that the great causes of death in this country at present, and I need only mention a few, are related primarily to life style.

We realize a number of changes have occurred over the past 34 years, some we can explain and some we cannot, but they seemed to be related more to life style than any medical intervention. As an example of these, I would mention the fact that cancer of the stomach has decreased remarkably since 1930 and we do not know why this has occurred. This has been a long sustained decrease in incidents of this disease. A second occurrence which we have noted in the past 20 years has been a progressive decline in cardiac disease, for which we do not have an explanation; perhaps the implication of dietary fat or the need for increased exercise are important, but we have been unable to correlate any significant relationship in this area. However, the decrease in morbidity and mortality, particularly mortality, in this area is significant. Likewise we have seen, since 1930, an increasing incidence of deaths due to cancer of the lung. This is an entirely preventable condition caused by the pernicious habit of smoking. This is a factor which is increasing in women at the present time, as they have taken up this habit in the past 15 years. The direct relationship is indisputable. These conditions that I have given as examples of life style factors, some of which we understand and some of which we do not, are related to changes in long-term patterns of incidences of morbidity and mortality in the country. Complications of hypertension and diabetes directly related to obesity are subject to dietary control and exercise. The spending of hundreds of millions of dollars to treat hypertension, after the fact with drugs or its results, stroke and coronary disease, is really not a cost effective form of treatment nor is it anything but trying to salvage the devastating results of the illness.

Until such a time that we are able to influence people to make them responsible for their own health care and educate them to assume this responsibility as part of their public duty, we will be unable to contain the escalating costs of health care in America. This escalation is significant if one looks at the expenditures for health care in the United States; the minimal amount of money put into controllable preventive measures, life style, and environmental causes of cancer. Here we could truly develop cost effective systems if adequate financing and prolonged effort were made. However, this is a 10 to 20 year impact which we would hope to achieve, unfortunately, that period of time probably does not allow significant political payoffs.

The next most significant factor in long-term changes——

Senator DOLE. Could I just interrupt, I want to make reference to that first sentence.

Dr. WALSH. Right.

Senator DOLE. Are all of the Federal efforts now sort of counterproductive? Are we losing discipline? Are we doing less and less for ourselves because of the theory that once we contact the illness the Government is going to step in and take care of it?

Dr. WALSH. Rather, over the last 30 years, from about 1940 to the present, there was a gradual transition of decisionmaking from the family in certain types of illnesses, and responsibility for care to the physician, to the point where the average mother, who had a child, felt that she must take the child to the doctor, irregardless of whether

it was of any significance or not. It used to be that grandma, and various people in the family, would take care of the minor illnesses. But during this period of time, there was a complete loss of responsibility in all health care. Just the biggest single cause of visits to the physician office is upper respiratory illness. Ninety percent of these can be treated at home with aspirin and lemon juice. Yet the biggest single cause of going to a physician, tremendous cost in health care, but the loss of being able to assume that responsibility—one of the—the major thing we need to do is to try to transition people back to assuming more responsibility for their own care, better decisionmaking, and we will only do this through health education, public consumer health education. Those factors, we cannot decrease health care costs, after the patient has gotten to the physician, the cost is already there.

Senator DOLE. A great deal of the pressure in Washington is the other way, to make it easier, more money, total care. No doubt about it, some of it's extremely helpful, but it has just occurred to me, that somebody will be suggesting some day, rather than pay for illness, we pay for keeping fit. So you get $10 a month for not smoking in a Federal check, rather than $5,000 for whatever you do when your lungs are removed for smoking. I'm not going to introduce that program [laughter], but it seems to me, we may turn that corner some day. I mean all the emphasis is on curative. For example, we are spending, I think, in the Federal Government, about $3½ billion total for school lunch and other nutrition programs and about $50 billion on health care services. It seems to me we have got to turn it around somewhere.

Dr. WALSH. The other significant area, the next most significant area in long-term changes in the health field are in the area of manpower. Specifically in regard to physicians. As you are aware, it takes 7 years to produce a physician from the time of his entrance into medical school. Any change in number of distribution or types of physicians is a long-term solution to the health delivery problems in this country. Changes made today will not have an impact for 10 to 20 years. As one looks at the Federal policies in health manpower production, one sees this geographically displayed over a period of the last 40 years, since the first Federal interventions into the production of health manpower with the Mental Health Act of 1946. Since that time we have created a system which is doubling the output of physicians and has recently, in the Health Education Act of 1976, recognized the primary problem at this time is not production of increasing numbers of physicians, but rather the problem of maldistribution, both within specialties and subspecialties, but also of geographic maldistribution. Efforts to change the maldistribution are a long-term solution and we must realize that these efforts, while they must be undertaken and must be supported, will take 10 to 20 years to have significant impact.

Historically, one has to look at the impact of Federal funding in the area of health manpower to see the ability of funding to directly produce the types of physicians and meet the needs, as indicated by society and their priorities at any particular time. In the State of Kansas we have responded to the mandates of both the people of

the State and the Federal mandate to increase production of physicians. At the present time we are admitting 200 students per class, up from 125 students in 1970. This will have an impact on the numbers and distribution in the State of Kansas. This will, however, take 10 years for the impact to be noticeable, statewide.

Senator DOLE. Right. But it wouldn't be fair to assume from that, that in 10 years there would be no shortage, would it, because you're going to have——

Dr. WALSH. Nationally, at the present rate that we are producing physicians in the United States, by 1985 we will have 240 physicians for 100,000 population. The highest ratio of physicians to population in the world is Sweden at the present time which is approximately 170, so we will have much more, we have increased our output of physicians 150 percent in the United States since 1965. So the total numbers on our present production capacity is—does not need to be increased any more. People are talking now of excess physicians by 1985. We still have the problem of maldistribution. Maldistribution within specialties and areas of needs and geographic maldistribution.

Senator DOLE [continuing]. What about the—I am certain the figures are available—the percentage who stay in Kansas who go to our medical school. Is it——

Dr. WALSH. At the present time, or in the last survey that we did, over a 10-year period, there were 36 percent remained in Kansas. This varies in the physicians who are west of Highway 81. At the present time I believe that 58 percent of them are Kansas KU graduates.

Senator DOLE. Is there any effort underway to recruit students from rural areas on the theory, that having been born there, they will return?

Dr. KORTGE. Yes, sir; for the last 2 years the school has had what we call a rural advocacy committee that advocates on behalf of rural student applicants to the admissions committee, and we were to take students who had less than the usual high grade point average and med-cat score who were from rural counties, and faculty from the school would go interview these students, I personally served on one of these committees and went around several towns across the State; as to whether that was successful, that was initiated for the first time—this is the second year, but that will be a 10-year payoff as well of that particular program.

Senator DOLE. Has this gotten you into any of the Bakke type problems.

Dr. KORTGE. Haven't yet.

Senator DOLE. You don't have any quota or anything?

Dr. WALSH. No quota involved in it. Essentially one might say that students who go to school in very small communities and community colleges, essentially tend to be somewhat educationally underprivileged because they don't have the competition and levels of pressure on them to perform that students who come from your urban areas do. On that basis we have treated it as a special category. But there are no quotas involved in this. The students still have to be qualified, we have to be sure they are going to be competent enough to graduate.

Dr. PAIGE. What about the Farm Bureau—the mediserve——
Dr. WALSH. The mediserve program is going——
Dr. PAIGE. Is going what, 2 years, or is this the first year for it?
Dr. WALSH. The first year.
Senator DOLE. Please identify yourself.
Dr. PAIGE. I am Dale Paige from Plainville.

Dr. WALSH. To proceed with this, the next subarea is in the consideration of manpower production, is the development of residency training programs which specifically address the problem of the types of health manpower which are produced. A graduate of medical school is no longer competent to practice medicine because of the complex medical growth in the past 20 years, they now require a minimum of 3 years of post-graduate training to produce a competent physician. Some specialties require longer periods of training. The decrease of family practitioners, general practitioners, general internists, and pediatricians over the past 30 years from 60-odd percent to less than 20 percent is now being reversed by a redistribution of primary care residency care training. Experience in the State of Indiana shows the impact of a sustained increase of residency training programs scattered throughout the State. But these programs over a period of 8 years have significantly increased the number of physicians in all areas of the State of Indiana. That plan has proven to be an extremely effective one and is being continued: It is based on the acknowledged fact that physicians tend to stay in the geographic area where they have completed their residency training. Not statistically as much as where they came from, or where they went to school, but rather where they complete their graduate training has the highest correlation.

The next area that contributes to long-term consideration in health care, I guess health planning, there is a great deal of concern amongst all people in the area of health regarding the potential and future impact of health planning in this country. The experience with CHP's was disastrous and the impact was essentially nil. The question of the ability to understand a system as complex as the health delivery system is questionable. The fact that it does not respond to ordinary economic principles of elasticity of demand and saturation of markets, cost benefit ratios, et cetera, leads one to believe that we have not, in the past, been able to effectively direct the health care delivery system in this country. The very fact there are a number of efforts being made to subvert the health planning law and to exempt large groups of people from the law because of the awareness of the fact that one cannot apply uniform standards, particularly those generated in Washington, to urban and rural areas indiscriminately. The problems of developing standards for rural areas by people who have never been in a rural area is being attempted, at the present time, by the Secretary of Health. This makes one extremely fearful of a worsening situation through Federal intervention in the future. Health planning would support regionalization of health services in rural areas. This is a difficult program to sell to those who need it most. The AHEC concept being promoted by the Kansas University Medical School will help to facilitate the regional approach to planning and implementation of health education and services.

In summary, for 10 to 20 years we need to take a look at the development of large health education programs to teach people to care for themselves.

Two: To shift emphasis to those areas of life style that are responsible for the bulk of the major causes of morbidity and mortality at the present time. Prevention is the only cost-effective treatment.

Three: Shift emphasis and support in health manpower training programs to produce the type of physicians we need and have incentive programs to encourage them to distribute to areas where they are needed.

Four: Promote area health education centers to: (a) Recognize health services; (b) Provide support to those working in health rural areas; and (c) To relate the training and education programs to the real world.

Thank you, Senator.

Senator DOLE. With reference to health education centers, it's my understanding that there was an application submitted to HEW that was denied.

Dr. WALSH. Not funded.

Senator DOLE. Not funded. What are your plans, do you have any?

Dr. WALSH. Dr. Meek is here in the audience, Senator, Dr. Meek.

Dr. MEEK. Thank you, sir. Senator, we were denied funding for that. There's another cycle that begins this spring and we still haven't made the commitment to apply for that. We are incorporating many of the features of the area health education center concept into our own Kansas plan. There may be a decision to enter into the next cycle of funding which will be made available this spring.

Senator DOLE. I only mentioned that, because if we can help we want to be helpful. What about legislation that I think is even now being discussed in Kansas that provides for tuition forgiveness, does that have any real impact? In other words, you forgive tuition, if they go into underserved or rural areas. Do you think it would provide any incentive?

Dr. REED. I might say something about that. Obviously there are various aspects to this one too, and unfortunately the experience of other States would tend to indicate that the concept is not totally valid. I think that's regrettable because we are relying on past procedures and I don't think you can always transmit those to today's.

There is a proposal in Kansas for this present legislature, legislative session, that several of us think has considerable merit and has in our opinions an opportunity of being successful, whereas some of these other plans have not been. I, for one, feel that it's worthy of a trial for the same reasons that Dr. Brownrigg mentioned. If you're going to try and make incentives for the physician once he or she is out there, then perhaps it makes as much sense to try to attract them into that area at the front end and the only real question I have is whether we pay enough attention to the general idea at the right time. I have a bias that says that I think a number of high school students that have a potential of going back but don't because they are awed by the cost, awed by the academic process that Dr. Walsh has alluded to, so maybe we ought to begin to look at them, to keep them encouraged in a scientific way to start earlier on, be-

cause by the time you get into medical school, ready for that, you have the armed forces that I think are going to begin to bid more highly for these services. We have already heard they are underserved. I think they are going to become competitive with the people keeping them in our own State. I think it's an enigma. I think there is some merit in plans such as have been proposed, particularly by the regions in the State of Kansas that has concepts that are improved over those employed in previous States where they failed.

Dr. KORTGE. If I may, Senator, I think there is a possible danger that's inherent in those kinds of programs. Hopefully this particular one in Kansas can address it. That is if not done carefully I would guess the community might sit back and expect the State to provide this and the key still is the community has to want that physician and know what is needed by that physician. I don't think every community can, nor do they expect to be a Topeka or Kansas City, but they need to sell their highlights and if they sit back and wait for the State legislature or the political process to either make the determination of being an underserved area, and therefore at some future time, 1, 5 years, that the system will be frustrated. I think the two have to definitely go hand in hand and perhaps one of the obligations of the university is to assist the community in knowing realistically what their expectations are and could be, and what those expectations of health care providers are.

Dr. WALSH. Another factor, if this bill is passed this year, the people of the State must understand that none of those physicians will be available for 7 to 8 years, so that all manpower solutions to problems are 10 to 20, really year solutions to the problems, it's not going to help the community for 7 to 10 years. The distribution problem——

Senator DOLE. I am just curious, and should know this. Is there a lot of activity, where a community in effect adopts a student, pays the cost of the education for some commitment? Is that rather widespread?

Dr. KORTGE. I think it's a growing trend, I think it's a very recent one to my knowledge in Kansas, but certainly has grown in the last 4 years at the time I have been involved with the school, and one of those things that we have encouraged communities to do. Not only that, if indeed they don't even pay or provide some stipend tuition reimbursement directly to that student, certainly to maintain close contact with that student. One of the things that was rather surprising to me personally, in talking with community leaders, in the last 5 years they would not know students from their own home town, say Russell, who went to medical school, or osteopathic school, or dental school.

Senator DOLE. There are some in Washington who think the best way to make certain we have enough primary care physicians is to mandate by law, that is, through grants and other Federal programs force medical schools to train primary care physicians. How do you view this type of Government activity or Government threat, or Government help, I don't know how you look at it?

Dr. REED. A recent study was recorded in the New England Jour-

nal of Medicine out of Maryland in which they found where these efforts were made in the population that they reported on that there's 40-percent change from the primary care disciplines, maybe from one to another. They didn't all leave the primary care concept, I'm not implying that, but there was about a 40-percent change because of some disenchantment for various reasons, a lot of different reasons, moving from one to the other. I think there could be some correlation between that. I think it's very difficult to expect somebody else to mandate these and have people always be perfectly happy. I think the men that are represented here in this room and others that are stalwart in their practice patterns in nonmetropolitan areas of Kansas are there because they want to be there, because they see it as a good thing, the right thing. I doubt, knowing these people as I think I do, that very many that I do know would stay if they were just forced into that. If they were just to be forced into it, I don't think they would be the top performers that they are. So, I think that there's a problem about that manipulating whether Washington does it or specialty boards or whatever. Maybe others don't share that opinion, sir.

Dr. WALSH. Since, as I said, the Mental Health Act in 1946, when the Government first determined that there were needs for a specific type of health provider, and went ahead and subsidized psychiatric residency programs under that act, the Government has intervened and changed the flow of health manpower, first, during the 1950's to develop research personnel in the subspecialty programs; then finally came to the realization that by doing this they were creating significant deficiencies in rural areas and urban ghetto areas. It's entirely possible, at least I believe on the basis of a 30-year history it has shown that the Government by directing dollars can correct manpower flow. I think you would have a hard time arguing about it, even though people do tend to switch as Dr. Reed said from primary internal medicine to family practice, to pediatrics, but still the majority would stay in that area. I think it is possible, and we are in the process of seeing a significant increase in the number of primary care physicians. This I think we need to get away from the—what to me was the artificial development of subspecialties, many of which fields became very badly overcrowded. Those fields existed because of Federal dollars that were creating them.

Dr. KORTGE. Perhaps your question, Senator, has a two-fold philosophical-political overtone to it; one is mandate schools to have 51-percent capacity or something like that; another way to skin the cat might be to provide funds that would make it attractive for family practice or general internal medicine, but would not carry with it the stick, but certainly would provide the carrot.

Senator DOLE. I think as everyone has said, you can provide certain incentives, but there's always a resistance on the part of some. But I guess if the incentives don't work then there would be more pressure for mandates, and if we run out of carrots, you know, I don't know what happens. In some instances we have already run out of carrots.

[The prepared statements and attachments of the preceding panel follow:]

STATEMENT OF RICHARD L. BROWNRIGG, M.D., DODGE CITY, KANS.

This testimony should be regarded as primarily that from the perspective of a practicing physician from rural Kansas. However, it cannot be maintained that this perspective is typical of most rural practicing physicians. Experiences as a surgical specialist, experiences in a moderate sized group practice, and most importantly those experiences gained in the formulative and subsequent years as chairman of a rural health systems agency have tended to influence that perspective.

I will not reiterate the problem previously identified by Randall Hempling, the Executive Director of the Health Planning Association of Western Kansas, in regards to the shortage and maldistribution of manpower, but will tend to focus on suggested solutions for that problem. This problem is perceived by the residents of rural Kansas to be the most critical, or perhaps one should say most demonstrative of rural Kansas getting the "short end of the stick."

Health care problems in general and most assuredly those of manpower in rural Kansas, works harder, works longer, works with less, has less diversifi- receive an adequate return for its labors. To build upon the theme of a popular song after World War I, one cannot expect to keep the farmer back on the farm once he has seen the rewards of living in Paris, and likewise one cannot expect to attract and retain a physician in rural Kansas once he has seen the rewards of living in K.C.

The physician in rural Kansas in general, just as the farmer and laborer in rural Kansas, workers harder, works longer, works with less, has less diversification, recreation, and educational opportunities than his big city brothers. Because there is strength in numbers, and one might add votes, somehow the marked contrast in adequate rewards received between rural and urban peoples is justified.

The federal government could reverse this inequality. The federal government could institute a rural affirmative action program as it has in the area of civil rights to help rectify some of the historic injustice experienced by those who reside in rural areas.

Specifically, in the area of health manpower, such federal tools as preferential tax rates, investment tax credits, accelerated depreciation of facilities and equipment, low interest loans, grants, consultative assistance, and equitable reimbursement from federal third party insurance programs could be helpful in attracting physicians to rural areas.

Such a program would be far more productive in increasing the availability of stable, dependable, and high-quality physician services for rural areas, and involve far less costs, red tape, bureaucracy, and regulations than any of the current governmental HURA, AHEC, Health Service Corp., or similar programs. Programs which do not address the basic need of an adequate reward for the labors performed by rural people.

ACUTE RURAL HEALTH CARE CONCERNS IN KANSAS

(By Dean Kortge, Ph.D., University of Kansas School of Medicine)

The problems of rural health, which affect all of rural America, are intensified in Kansas. Indeed, Kansas is a rural state. Fortunately, some of those problems are not as severe in Kansas as they are in other rural states; nonetheless, they are real. This presentation will attempt to highlight some of the more acute needs and concerns as seen by the University of Kansas School of Medicine. It will also, at times, highlight briefly some of those university programs that attempt to address those needs and concerns. The concerns that will be highlighted will be:

(1) Physician manpower;
(2) Allied health and nursing manpower;
(3) Emergency medical systems;
(4) Urban-rural reimbursement differentials; and
(5) Community expectations.

The acuteness of physician manpower in Kansas is one which definitely receives the most attention. One of the most serious issues facing the medical school is knowing where these shortages are the most acute. This problem is not a new one for Kansas. In 1947, 56 Kansas counties petitioned the Kansas Medical Society to help them obtain a physician. During the period 1959–1976, 82 Kansas communities lost their only physician. It is only this year through the

physician recruitment and placement office, operated by the medical school, that this problem can be attacked more directly.

At the same time, however, it is virtually impossible to accurately determine a statistical number of physicians needed. Using a ratio of one physician per a set population amount is nothing more than a rule of thumb. Perhaps as equally significant would be to use a ratio of one physician per a set number of hospital beds. It is, however, the physician/population ratio that sets Federal planning guidelines which constitute eligibility for Federal grants. The school of medicine tries to assist communities, who are eligible for various Federal grants, apply for them.

Another issue relating to the supply of doctors for rural Kansas is that of the foreign medical school graduate. Approximately 15% of all physicians practicing in Kansas are foreign medical school graduates and about 35% of those practice in rural counties. In 3 Kansas counties, foreign medical school graduates are the only physicians while in another 6 Kansas counties, those graduates constitute 50% or more of the total physicians. The recent visa qualifying examination, required by the immigration officials only for physicians, was passed by only 25% of those individuals taking the exam. If this rate continues, Kansas physician manpower will be hurt drastically.

The University of Kansas School of Medicine, as well as private community hospitals in Kansas, have been among the nation's leaders in establishing family practice residency programs. The Kansas legislature in 1977 provided funds to support additional residency positions in affiliated family practice programs across the state, where they could be accredited. However, only 86 family practice residents have completed training in Kansas since 1970, the first year anyone could complete training. Of those 86, 37 are now practicing in Kansas but only 1 of those 37 is in a community under 2,000 population. This is important since 69% of all incorporate Kansas communities are less than 1,000 popuulation and only 8% of all incorporated Kansas communities are over 5,000 population.

A part of the problem of physician manpower relates to the overworked physician for whom it is difficult to obtain any free time, either for continuing medical education activities or for private vacation time. The university has a *locum tenens* program through which all house officers are encouraged to provide one week of coverage per year. This program is coordinated through the Kansas Medical Society and hopefully provides a modicum of assistance for an acute problem.

Another acute rural health care need is in the area of allied health and nursing manpower. Again, like physician manpower, this is an area which is very difficult to become very knowledgeable. The university has initiated various programs, such as the nurse practitioner program in Hays, which is an attempt to address this problem.

Emergency medical care is another acute problem facing rural Kansans. There has been a lot of activity in this area recently and many gains have been made. The University of Kansas School of Medicine had been involved in training emergency medical technicians for some time and, hopefully, the available manpower for these systems is improving.

The final two areas of concern need to be listed more as umbrella problems. The differential between urban and rural reimbursement rates, particularly through medicine and medicaid, place all health care manpower in rural areas in a disadvantaged state. Working within a free economic system, this differential discriminates against the rural provider and poses an initial and essential hardship for rural providers to overcome. It is not an area that can be addressed by the University of Kansas School of Medicine but certainly is one which frustrates any university programs designed to assist in attracting health care providers to rural areas.

The last, but probably most important area of concern, is that of the community expectation. A small town medical practice used to be a simple matter. It consisted of a doctor. No longer is this true. However, many communities expectations are the same—all that is needed is a physician, and perhaps a nurse. Often, this expectation becomes translated into legislative action under the guise of the citizens rights to health care. School systems, transportation, shopping facilities, and many other similar community problems all constitute the attractiveness of a community, and are concerns out of the areas of responsibility of the school of medicine.

The medical school does require a preceptorship program for all medical students as well as for many house officers. While these two programs are designed for their educational contact, they do also serve to provide those

students with rural experiences and exposures. A very structured, complete, inter-disciplinary team program, referred to as the Harper Project, also provides the same exposure. Additionally, the school supports rural health weekends for medical students to provide yet additional experiences for students in rural medicine.

Still, the community expectations probably cannot be met simply through those programs. Those individuals who live in 92% of all Kansas incorporated communities under 5,000 population have health care needs. The role of the university in addressing this problem and its responsibility is somewhat uncertain. However, it is most likely this problem cannot be solved simply by the addition of another physician. Rather, the community needs must be itemized and a health system designed for those needs. This system must be controlled by the community.

Those problems of rural health in Kansas are listed as the most acute. They are not meant to be listed as the *only* problems. They will be itemized by the following two presentations.

Middle-Range Rural Health Care Issues

(By D. Cramer Reed, M.D., University of Kansas School of Medicine)

Today it is more popular, (probably because it is easier), to identify problems rather than solutions. This is particularly true when rural health is the topic of discussion. Regrettably, our perceptions aren't always correct, and we devote an inordinate amount of energy and dollars for solutions to problems that don't exist or are not of significant magnitude to warrant the attention they generate. In developing our remarks for this presentation, we have attempted to identify only those concerns which have a broadly recognized impact.

While there are obviously others, we have identified six issues and/or potential meadium-range problems which can have a deleterious effect on the effectiveness of our rural health care delivery system. For this presentation, "medium-range" factors are defined as those influencing the system over a period of the next 3–5 years.

1. Certainly *job-satisfaction* must be considered one of the most significant factors influencing the availability of health manpower in the rural setting. The problem, of course, is not confined to the medical profession. It has long been recognized that those communities having a high "turn-over" of physicians often experience difficulty in retaining nursing and allied health personnel, generally for related reasons such as: lack of recreational facilities, loss of privacy, professional isolation, lack of primary care facilities, family social dissatisfactions, perceived educational inadequacies for offspring, decreased income potential, less than optimal working environment, and unsatisfactory social opportunities.

2. *CME* or *Continuing Medical Education* in recent times has become a very significant factor in physician retention. The problem is especially acute in areas where there is only one physician who feels he/she cannot leave to attend scientific-professional meetings for which credits toward the required 150 hours of Postgraduate education could be earned every three years. This problem resembles "Catch 22" because he must comply to be relicensed in Kansas and of equal importance is the recognition that he/she must keep abreast of new medical developments. Yet, due to community-patient commitments, it is not possible to comply with the law. These are some of the reasons why there are few young M.D.'s willing to do solo practice. Future developments in micro-relay, cable television, and tele-communications have the potential of defusing this dilemma.

3. *Transportation* problems are not unique to the mid-range group; difficulties posed due to long distances between rural communities, from the physician and/or hospital, are serious concerns of today. The real problem, however, as previously cited, is not so much miles but rather time; "How *long* does it take to get to the hospital or physician?" This is especially true with emergency medical problems.

4. Inter-related with transportation issues is the problem of *communications*; linkages between the physician and the hospital, his/her office, the highway patrol, etc., are not adequate. When the doctor must travel more than 15 miles from his base, conventional "beeper" systems are not adequate.

Often mobil phones are not available or, if so, are technically inadequate to meet the needs of a specific isolated area.

Ultimately, the state-wide Emergency Communications System when completed should prove invaluable with its patch-in capabilities to link patients with health facilities for acute medical care and emergencies.

5. In the early 1960's, the health care team consisted of the physician, a nurse and possibly a third health professional such as a medical technologist or physical therapist. Today, there are over fifty different academic allied health disciplines many with their own national organizations, accreditation procedures, graduate education programs, etc. Physicians and hospitals have become quite dependent upon such ancillary personnel to provide health care in a variety of settings.

The issue today is not "whether" but rather "how many" or "are allied health professionals simply maldistributed?" In any event, *physician extenders* such as physician's assistants, nurse practitioners, etc., are performing invaluable patient care services relieving physician shortages and making it possible for their supervising physicians to devote time to more serious medical problems.

There are, however, problems such as licensure, certification, supervision standards of such personnel, etc. The one major problem that links the allied health professionals and nurses with medicine is the fact cited in numbered paragraph one above—where there is a physician shortage, generally, support professionals are also in short supply for similar reasons.

Hopefully, when the fog clears with respect to this nation's future involvement in comprehensive health care, our nursing, allied health, and physician extender requirements will be in sharper focus. It follows that we should also also develop insight to deal more effectively with accreditation, supervision, and acceptability issues; all of these influence their availability in rural areas.

6. *Health care planning* will be discussed under the heading of long range problems. It is, however, equally pertinent under the "mid-range" category. P.L. 93–641 is certain to ultimately have an impact. The question is "when" and "how"? The issue is whether national planning guidelines are merely that or whether they will be interpreted as absolutes. If the latter, there are bound to be major shake-ups even though the recently published HEW revised guidelines are less punitive with respect to the rural health care system.

Hopefully, as a meaningful national health plan emerges and the consumer representatives on the various agency boards become more knowledgeable, we can anticipate more useful interpretations of the guidelines—otherwise, we may "throw the baby out with the bath water." Of course, the inordinate cost of health care must be addressed, but care should and can be improved through HSA planning if managed constructively and in a reasonable way. Health care economic pressures are increasing to the point that some form of federal intervention is inevitable. We must strike a happy medium between the relevance of local decisions vs. those mandated by Washington to avoid compounding human problems while trying to solve our economic enigmas.

STATEMENT OF DR. RICHARD WALSH, DEAN, KANSAS UNIVERSITY MEDICAL SCHOOL

Ladies and gentlemen: My cohorts have addressed the short and intermediate term aspects of health problems in the rural areas. I would like to take a few minutes to address the long term problems which have been detected and the potential solutions to them. This area is of great significance, not only because of the impact on morbidity and mortality in the future, but also the severely escalating cost crisis of health care in America. If one looks at the leading causes of death, one find the majority of those within the top 10 are related primarily to lifestyle and environment. At the present time if one looks at the distribution of expenditures within the area of health care the majority of dollars are going into treatment of acute conditions. Since the epic report of Renee Lalond, Minister of Health in Canada in 1974, the wide spread realization that the great causes of death in this country at present, and I need only mention a few, are related, primarily, to lifestyle.

We realize a number of changes have occurred over the past 30–40 years, some we can explain and some we cannot, but they seem to be related more to lifestyle than any medical intervention. As an example of these, I would

mention the fact that cancer of the stomach has decreased remarkably since 1930 and we do not know why this has occurred. There has been a long sustained decrease in incidence of this disease. A second occurrence which we have noted in the past 20 years has been a progressive decrease in cardiac disease, for which we do not have any explanation; perhaps the implication of dietary fat or the need for increased exercise are important, but we have been unable to correlate any significant relationship in this area. However, the decrease in morbidity and mortality, particularly mortality, in this area is significant. Likewise, we have seen, since 1930, an increasing incidence of deaths due to cancer of the lung. This is an entirely preventable condition caused by the pernicious habit of smoking. This is a factor which is increasing in women at the present time, as they have taken up this habit in the past 15 years. The direct relationship is indisputable. These conditions that I have given as examples of lifestyle factors, some of which we understand and some of which we do not, are related to changes in long term patterns of incidences of morbidity and mortality in the country. Complications of hypertension and diabetes directly related to obesity are subject to dietary control and exercise. The spending of hundred of millions of dollars to treat hypertension, after the fact with drugs, or its results, stroke and coronary disease, is really not a cost effective form of treatment nor is it anything but trying to salvage the devastating results of the illness.

Until such a time that we are able to influence people to make them responsible for their own health care and educate them to assume this responsibility as part of their public duty, we will be unable to contain the escalating costs of health care in America. This escalation is significant, if one looks at the expenditures for health care in the United States; the minimal amount of money put into controllable preventative measures, lifestyle, and environmental causes of cancer. Here we could truly develop cost effective systems if adequate financing and prolonged effort were made. However, this is a 10–20 year impact which we would hope to achieve, unfortunately, that period of time probably does not allow significant political pay offs.

The next most significant factor in long term changes in the health field has been manpower in the area of health manpower, specifically in physician production. As you are aware, it takes a minimum of seven years to produce a physician from the time of his entrance into medical school. Any change in numbers of distribution or types of physicians is a long term solution to the health delivery problems in this country. Changes made today will not have an impact for 10–20 years. As one looks at the Federal policies in health manpower production, one sees this graphically displayed over a period of the last 40 years, since the first Federal interventions into the production of health manpower with the Mental Health Act of 1946. Since that time we have created a system which is doubling the output of physicians and has recently, in the Health Education Act of 1976, recognized that the primary problem at this time is not production of increasing numbers of physicians, but rather, the problem of maldistribution, both within specialities and sub-specialities but also of geographic maldistribution. Efforts to change the maldistribution is a long term solution and we must realize that these efforts, while they must be undertaken and must be supported, will take 10–20 years to have significant impact. Historically one has only to look at the impact of Federal funding in the area of health manpower to see the ability of funding to directly produce the types of physicians and meet the needs, as indicated by society and their priorities at any particular time. In the state of Kansas we have responded to the mandates of both the people of the state and the Federal mandate to increase production of physicians. At the present time we are admitting 200 students per class, up from 125 student in 1970. This will have an impact on the numbers and distribution in the state of Kansas. This will, however, take 10 years for the impact to be noticeable.

The next sub-area in the consideration of manpower production, is the development of residency training programs which specifically address the problem of the types of health manpower which are produced. A graduate of medical school is no longer competent to practice medicine because of the complex medical growth in the past 20 years, they now require a minimum of three years of postgraduate training to produce a competent physician. Some specialities require longer periods of training. The decrease of family practitioners, general practitioners, general internists, and pediatricians over the

past 30 years from 60 odd percent to less than 20%, is now being reversed by a redistribution of primary care residency care training. Experience in the state of Indiana shows the impact of a sustained increase of residency training programs scattered through the state. These programs over a period of 8 years have significantly increased the number of physicians in all areas of the state. This plan has proven to be a very effective one. It is based on the acknowledged fact that physicians tend to stay in the geographic area where they have completed their residency training.

The next area that should contribute in the long term consideration of health care problems in this country is health planning. There is a great deal of concern amongst all people in the area of health regarding the potential and future impact of health planning in this country. The experience with CHP's was disastrous and the impact was essentially nil. The question of the ability to understand a system as complex as the health delivery system is questionable. The fact that it does not respond to ordinary economic principles of elasticity of demand and saturation of markets; cost benefit rations, etc. leads one to believe that we have not, in the past, been able to effectively direct the health care delivery system in this country. The very fact there are a number of efforts being made to subvert the health planning law and to exempt large groups of people from the law because of the awareness of the fact that one cannot apply uniform standards, particularly those generated in Washington, to urban and rural areas indiscriminately. The problems of developing standards for rural areas by people who have never been in a rural area is being attempted, at the present time, by the Secretary of Health. This makes one extremely fearful of a worsening situation through Federal intervention in the future. Health planning would support regionalization of health services in rural areas, this is a difficult program to sell to those who need it most.

The AHEC concept being promoted by the Kansas University Medical School will help to facilitate the regional approach to planning and implementation of health education and services.

SUMMARY

Long term—10-20 years—we must look to:

1. Development of large health education programs to teach people to care for themselves.
2. Shift emphasis to those areas of lifestyle that are responsible for the bulk of the major causes of morbidity and mortality at the present time. Prevention is the only cost effective treatment.
3. Shift emphasis and support in health manpower training programs to produce the type of physicians we need and have incentive programs to encourage them to distribute to areas where they are needed.
4. Promote area health education centers to:

A. Regionalize health services.
B. Provide support to those working in health in rural areas.
C. To relate the training and education programs to the real world.

THE UNIVERSITY OF KANSAS,
OFFICE OF THE CHANCELLOR,
Lawrence, Kans., January 4, 1977.

[Memorandum]

To: Members of the Kansas Legislature.
From: Archie R. Dykes, Chancellor.

From time to time, I have written to provide you with a progress report on University of Kansas programs and activities which are designed to help address some of the health care problems of our state. I write again at this time to review further for you the status of our efforts.

You know, of course, that we have expanded significantly the enrollment in all of our health sciences programs—medicine, nursing, and allied health professions. The increase in the School of Medicine is especially important, because the size of the entering class was expanded 60 percent—from 125 to 200—between 1970 and 1975. This spring we will graduate our first 200-member class. When these students complete their residency training, we can

look forward to having additional physicians establish their practices in Kansas.

As we plan for the graduation of increased numbers of medical students, I thought you should be informed about some of the special efforts we are making to encourage them and other health care providers to establish practices in areas where their services are most needed—and to support them in their work. Consequently, this report will focus primarily on our outreach efforts. A number of our programs are summarized under separate headings below.

AFFILIATED FAMILY PRACTICE RESIDENCY PROGRAM

In earlier reports, I have referred to the affiliated family practice residency program as an ambitious effort to provide more doctors for the smaller communities of our state. As you know, the program provides for training family practice residents for the first year at Kansas City or Wichita, then at a smaller city for the second and third years of training. While in the smaller city, residents will rotate for short periods of time to even smaller communities, thereby gaining exposure to the possibilities and benefits of practice in those communities.

We have worked this year to develop affiliated family practice programs in three locations, Garden City, Salina, and Pittsburg. Affiliation agreements have been signed with groups in Garden City and Salina, and discussions are going forward in Pittsburg.

Our efforts at Garden City have not been as successful as we had hoped they would be. While interest, support, and enthusiasm remain high there, accreditation has been withheld by the national accrediting agency until certain deficiencies can be corrected. We are now working to correct those deficiencies and we plan to submit a new application for accreditation later this year. The application for the program in Salina will be submitted to the accrediting body in a few weeks.

We intend to press ahead with discussions in Pittsburg about an affiliated program there, and we have opened discussions with physicians and community leaders in Hays about the possibility of developing one of the programs in that city. We intend to pursue as vigorously as possible the development of the affiliated family practice residency programs, because we are convinced that these programs can help in important ways to meet our state's need for more general practitioners for smaller communities.

NURSE PRACTITIONER PROGRAM

The 1977 Legislature provided funding for the University of Kansas to begin and operate a Nurse Practitioner Program in Hays. The goal of the program is to provide additional training for practicing nurses from western Kansas communities to that they will be capable of providing expanded health care services. The program has accepted its first class of students who will begin their training in January, and ultimately it will provide this expanded training for 25 nurses per year.

The program has been located in Hays for convenience to students from Western Kansas who come to classes for a few days each week then return to their homes and professions. We are exploring the possibility of establishing a similar program in Southeast Kansas to meet needs there.

PHYSICIAN PLACEMENT AND RECRUITMENT

With funding provided by the 1977 Legislature, augmented by a grant from the Ozarks Regional Commission, we have established this year the new Office of Physician Placement and Recruitment. Since his appointment in September, the director of the program has assisted 96 Kansas communities and will be working with many more in the weeks just ahead. Additionally, he has advertised nationwide for physicians who might be interested in moving to Kansas. In response to these ads, we have received more than 220 inquiries or expressions of interest and we are following up on these contacts in appropriate ways that will assist communities in their efforts to recruit physicians.

In addition to these efforts, the Physician Placement and Recruitment Program is also encouraging Kansas medical students and residents to establish

practices in Kansas in communitites where their services are most needed. We believe these efforts will also be productive and that this initiative will result in an increase in the number of doctors locating in our state.

SUBSTITUTE DOCTORS

As you know, last year was the first full year of operation for our substitute doctor program—known as the *locum tenens* service. Primarily utilizing medical residents who serve during their vacation periods, the *locum tenens* service provided last year nearly 500 days of service in cities and towns across the state, assisting practicing physicians who needed time away from their practices.

NURSING OUTREACH PROGRAM

The State of Kansas requires all nursing instructors to have or be enrolled in a program leading to a master's degree. To meet this increased need in nursing graduate studies, the University of Kansas School of Nursing has greatly expanded its off-campus course offerings and is providing classes for 60 graduate nursing students in Hays, Garden City, Pittsburg, and Topeka.

REGIONAL HEALTH EDUCATION CENTERS

Using as models successful efforts in other states, we are exploring development of regional (or area) health education centers in Kansas. With funding provided by the 1977 Legislature, we have begun developing one such center in Chanute. Using the state's former tuberculosis hospital as the base facility, a variety of programs—physician placement and recruitment efforts; continuing education programs for doctors, nurses, and allied health professionals; nursing outreach; medical preceptorships, and medical residency outreach, among others—will be organized and administered for southeast Kansas by this regional health education center. We are also exploring the possibility of developing a similar center for the northwestern part of our state. After these two centers are operational, we hope to develop centers to serve other parts of the state.

Development of these regional centers is important for several reasons, but especially because they will help attract physicians to practice in medically underserved areas by providing a source of regional identification along with assistance and support for physicians in their practices. We believe it is important to pursue development of the centers and will be giving increasing attention to this effort in the months ahead.

INCREASED NUMBERS OF RESIDENCIES

As I mentioned, we will graduate this spring our first 200-member class. There are not at present, however, sufficient first-year residencies in Kansas to keep all of our graduates here for their residency training. Consequently, we are requesting a number of additional residency position for FY 1979 so that there will be a residency available for each of our graduates. The preponderance of the positions we are requesting are in primary care, and since the location of residency training is a very significant factor in determining location of practice, we believe these additional positions are essential.

MEDICAL RESIDENCY OUTREACH

Because the location where medical residencies are served is so important in determining where physicians establish their practices, we are expanding the number of residents who take a portion of their training in locations other than Kansas City and Wichita. Many of our residents in Family Practice, Pediatrics, Internal Medicine, General Surgery, and Obstetrics-Gynecology are serving residency rotations in Garden City, Halstead, Hays, Kingman, Norton, Minneola, Belleville, Phillipsburg, Topeka, and other locations, and we are next year increasing significantly the number of residents who do so. We believe it is important to continue and expand this practice because it broadens our residents' education, it exposes them to the advantages of practice in various communities over the state, and it provides additional medical service to the communities to which they are assigned.

MEDICAL PRECEPTORSHIPS

We have also expanded our medical preceptorship program, and each medical student now spends a minimum of two months working with a practicing physician. The preceptorship program previously was a one-month elective for medical students. It is now a two-month minimum requirement, and students can choose to spend additional time with preceptors if they wish. As with residency rotations, we believe this program provides an important opportunity for our medical students to learn about the practice of medicine in smaller communities.

* * * * * * *

Although I know you are familiar with most of the programs described above, I thought you might like to have this progress report. If you should have questions or want additional information about any of these programs, or about other efforts we are making, please let me know.

We in the University of Kansas have no higher priority than improving the availability and quality of health care in our state, and we will continue to do all we can to educate more doctors, nurses, and allied health professionals and encourage them to establish practice in Kansas where their services are most needed. We know your goal is the same as ours—to assure that all the citizens of our state have good health care available to them, regardless of whether they live in large or small communities.

PROPOSALS OF THE STATE BOARD OF REGENTS FOR ATTRACTING AND RETAINING PHYSICIANS FOR KANSAS

The Board of Regents has for some time recognized the need to initiate and implement programs to increase the number of physicians for Kansas. Toward this end, the Board has supported and encouraged the University of Kansas in the efforts it has been making to educate more doctors, nurses, and allied health professionals; to encourage them to practice in Kansas; to attract physicians to Kansas from other states; and to support these health care providers in their professional activities.

Among the efforts which the University has been making are the following:

1. *Increased number of students in health sciences programs.*—The University of Kansas College of Health Sciences has increased enrollment significantly in the Schools of Medicine, Nursing, and Allied Health in recent years. The increase in the School of Medicine is especially important, because the size of the entering class was expanded by 60 percent—from 125 to 200—between 1970 and 1975. This spring, the University will graduate its first 200-member class and when these students complete residency training, there will be additional physicians establishing their practices in Kansas.

2. *Medical preceptorship programs.*—As one means of exposing undergraduate medical students to opportunities for practice in Kansas communities, medical students at the University of Kansas are required to work for a period of time with a practicing physician in a community setting. The preceptorshop program in Kansas has served as a model for other states, and the time which medical students spend in the program has been expanded from one month to two months.

3. *Medical residency outreach.*—Because the place where medical residencies are served is so important in determining where physicians establish practices, the University of Kansas has for years had a program of rotating residents to communities over the state. Residents in family practice, pediatrics, internal medicine, general surgery, and obstetrics-gynecology spend a portion of their residency training in such communities as Garden City, Halstead, Hays, Kingman, Norton, Minneola, Belleville, Phillipsburg, Topeka, and other locations. Because of the value of this program, the University plans in the coming year to increase the number of residents serving such rotations each year. Not only does this program of rotating residents provide additional medical service to these communities, it also broadens the residents' education and exposes them to opportunities for practices in the areas in which they are serving.

4. *Physician placement and recruitment program.*—The Board endorsed last year a new proposal from the University of Kansas—and it was subsequently

approved by the Legislature and the Governor—to initiate a program of physician placement and recruitment. Although the program has only been in operation for a few months, it is already beginning to produce results. The director of the program has been in touch with more than 100 Kansas communities seeking assistance in the recruitment of physicians. Additionally, more than 220 inquiries or expressions of interest have been received from physicians in other states in response to nationwide advertising. In addition to these recruiting efforts, the program seeks to place University of Kansas graduates in touch with Kansas communities which need physicians.

5. *Affiliated family practice residency programs.*—The University of Kansas has embarked on the development of affiliated family practice residency programs as an additional way of attracting physicians to practices in smaller communities over the state. The Board endorses these efforts and encourages support for them by state officials and members of the medical community of Kansas.

6. *Nurse practitioner program.*—The University of Kansas has this year begun a nurse practitioner training program, and the first class of students is now enrolled. The program will provide additional training for nurses so that they will be capable of providing expanded health care services, thereby freeing physicians to concentrate on medical problems which require their special attention.

7. *Continuing education programs.*—The University of Kansas has for many years had one of the premier programs in the country for providing continuing education for physicians, nurses, and allied health professionals. These and other services—such as the provisions of library materials and consultation services—are provided to support physicians in their practices and to keep them on the cutting edge of new developments in health care.

The Board of Regents strongly endorses all of these efforts. It recognizes, however, as does the University of Kansas, that additional steps might be taken to help meet the health care needs of Kansas.

The education of physicians is an important responsibility of society, and the Board of Regents believes that public medical education should be provided at a cost which would not prevent anyone qualified to enter such a program from doing so for financial reasons. The Board also recognizes, however, that medical students receive an education of extraordinary value, both to themselves and the society which provides it for them. In recognition of the value of this education to medical students and the State of Kansas, the Board of Regents will increase tuition at the University of Kansas School of Medicine—effective July 1, 1978—to $3000 per year for a Kansas resident in the four-year medical curriculum. Tuition for a Kansas resident in the three-year curriculum will be increased at the same time to $4000 per year, while tuition for out-of-state students will be increased to $6,000 and $8,000 for the students in, respectively, the four- and three-year curricula. Moreover, the Board will continue its practice of reviewing at regular intervals tuition rates for medical education (as for other academic programs) to be sure that the rates are appropriate for a public medical school. When the Board deems it appropriate to do so, those rates may be increased.

As the Board of Regents takes this step, it calls upon the Kansas Legislature to support a number of programs for attracting and retaining physicians for Kansas. These include:

1. *Providing financial support for medical students.*—The Board of Regents believes that no one should be denied access to public education because of financial limitations. Consequently, the Board supports those provisions of Senate Bill 528, now pending in the Legislature, which would provide financial assistance for medical students. Specifically, the Board endorses the following:

a. Waiving annual tuition costs for a medical student in return for an agreement by the student to practice medicine or surgery for one year anywhere in the State of Kansas, such agreements to be avaiable for the student each year he or she is enrolled in the University of Kansas School of Medicine.

b. Waiving annual tuition costs for a medical student and paying the student a stipend of $500 per month for each month he or she is enrolled in medical school in return for an agreement by the student to practice medicine or surgery for one year in a state institution or a location designated, by specialty, as being medically underserved, such agreements to be available for the student each year he or she is enrolled in the University of Kansas School of Medicine.

The Board also supports the provision in Senate Bill 528 for postponing fulfillment of such service obligations for specified periods of time for the purposes described in the legislation.

The Board also proposes that Senate Bill 528 be further amended to provide that a person may select the medically underserved area in which he or she will fulfill service commitment from any list prepared by the Secretary of the Department of Health and Environment between the date the student enters medical school and the date he or she completes residency training.

2. *Providing additional residency training opportunities in Kansas.*—There is convincing evidence that the place where a physician takes residency training has a significant influence on where he or she establishes medical practice. In fact, several studies indicate this is the most important factor in such determinations.

There are at present 153 first-year training slots in graduate medical education in Kansas (166 if one counts first-year students in programs such as neurology, opthalmology, and otorhinolaryngology, which require one year of internship before students enter the programs). Since the University of Kansas will graduate its first 200-member class this year, additional residency positions are needed for FY 1979 if we hope to retain this number of physicians in Kansas for residency training.

The Board of Regents and the Governor have recommended 29 new first-year residency positions for FY 1979. These additional positions will be needed to help accommodate this year's graduates, and the Board encourages the Legislature to approve this request. Additional positions will be requested for FY 1980 to meet additional needs and to secure a net gain for our state through in-migration of physicians.

3. *Incentive residency programs.*—The proposed financial assistance in Senate Bill 528 applies only to undergraduate medical students. Since it would be several years before students who take advantage of this program would begin fulfilling their medical service commitments, the Board of Regents believes efforts might be made to produce earlier results by providing more attractive residency opportunities in return for service commitments. Specifically, the Board encourages the Legislature to appropriate funding sufficient to provide annually a stipend at 175 percent of the state's usual base stipend for each resident who agrees to serve for a year in a medically-underserved location.

4. *Special residency programs for foreign medical graduates.*—For the same reasons cited in proposal 3 above, the Board of Regents encourages the Legislature to consider funding a number of special one-year residency positions which would be used to provide required residency training for graduates of foreign medical schools who agree to practice in medically-underserved areas. For licensure in the State of Kansas, a physician must have a minimum of one year of residency training, and there are a number of graduates of foreign medical school who are willing to commit themselves to service in medically-underserved communities in return for this required residency training and licensure. In a limited way, the University of Kansas is providing such opportunities at present, with five persons in training, and the program could be expanded to produce an additional twelve practitioners per year if necessary funding were to be provided.

5. *Community incentive programs.*—The Board of Regents recognizes there are steps which communities might take to attract physicians to practice there. These might include using industrial revenue bonds to build and equip medical offices (and perhaps providing as part of the physicians' equipment an airplane to facilitate travel to other locations in the geographical area which they may be serving), and providing office administrative support and other assistance. Provision could also be made for the physicians to form a limited partnership to lease such facilities and equipment at very low cost during the life of the revenue bonds and to purchase such facilities and equipment for minimal cost after the bonds have been retired. To the extent that legislation may be required to assist communities in this way, the Board of Regents encourages the Legislature to enact appropriate legislation.

6. *Regional health education centers.*—After physicians locate in small communities and medically underserved areas away from large medical centers, appropriate professional support needs to be provided for them. A regional health education center can provide such medical support, and the State of

North Carolina has through an exemplary network of such centers virtually eliminated its physician distribution problem.

The University of Kansas, with endorsement by the Board of Regents and funding approved by the Legislature and the Governor, has begun to develop the regional health education center concept in Kansas. The first such center is now being developed in Chanute to serve southeast Kansas, and funding has been requested for FY 1979 to continue and expand that center and to begin developing a similar center in Hays to serve northwest Kansas. Other centers would subsequently be developed to serve other regions of Kansas.

Regional health education centers serve in several important ways in attracting and retaining physicians in locations over the state. Not only do they serve as a central point of reference for all physicians in a region, they also serve as headquarters for a variety of medical support programs which help practicing physicians in their work, as the area center for continuing education programs for doctors, nurses, and allied health professionals, and as a place through which communication can be regularly maintained with other physicians in the area and with faculty clinicians in the University of Kansas School of Medicne, thereby eliminating possible isolation of physicians who practice in small communities.

The Board of Regents endorses the development of regional health education centers as an important effort to attract and retain physicians in areas that may currently be medically underserved, and the Board urges the Legislature to provide necessary funding to continue developing these centers and to operate them.

The Board of Regents believes there is no single program which can effectively address the health care needs of Kansas over the long term. Existing programs must be strengthened, and new efforts must be made. There must be necessary support for the affiliated family practice programs, for residency training in all medical fields, for physician placement and recruitment, for continuing education and other outreach programs, for regional health education centers, and for programs, such as the locum tenens service, which support practicing physicians in their work. Efforts should be made to make the practice of medicine in Kansas attractive, whether it be through programs of financal assistance to medical students, through increased remuneration (or the provision of fringe benefits such as malpractice insurance or health insurance) for residents, through community assistance for physicians, or through laws (such as those defining malpractice) which make attractive the professional practice environment in Kansas.

Individually, none of these programs can solve our state's need for more and better distribution of physicians and other health care providers. Taken together, however, these programs which the University of Kansas has underway, plus additional efforts which the University and the Board are proposing, can and will produce significant results. The Board of Regents believes all of these programs and proposals to be inextricably intertwined and the Board endorses them as a comprehensive plan which, if appropriately supported, will help meet the health care needs of Kansas.

Mr. STONE. May I interject a comment, Senator Dole?

Senator DOLE. Sure.

STATEMENT OF DAVE STONE, UNIVERSITY OF KANSAS

Mr. STONE. I am a freshman medical student at the University of Kansas and I think there's a difference between positive and negative incentives. I think what's happening in the State now is we have the development of what we call the indentured servitude bill where we are going to be enticed to go out to rural areas; along with that, the legislature, to my understanding, is trying to, or has thought about raising tuition to the point where we are to be coerced into accepting this type of position, and to accepting the types of scholarships there are and I know last year they wanted to raise the tuition to $20,000 or so, something that nobody could pay. Then with

the other hand give the freedom to not pay this tuition if you were to serve in the State. I think if we can stick with positive incentives as opposed to these negative incentives, which really, among the people I know in the medical center, is breeding a lot of bitterness as far as people being used like cattle, being told where they are to go, being enticed with very negative coercive measures. I think this would be very important to make the distinction.

Senator DOLE. Thank you. I think you're going to be on the panel later.

Well, I appreciate very much your taking the time to be with us, and if we can maybe ask for additional information on the nurse practitioner and physician assistant program, and anything else that you think of, we would appreciate the resource. We want to use it.

We now have a panel of community hospital administrators, Mr. Boor, Mr. Erickson and Mr. Ewert. Do you have an order as to who wants to go first? I might suggest again that in view of the time problem, that you present your statement and summarize it. We still have seven witnesses and it's now a quarter of one and the hearings were going to end at 12:30. I will allow time for discussion at the end of your testimony. I need to be back in Topeka by three and we don't have immunities on the highways. [Laughter.]

STATEMENT OF MARVIN H. EWERT, ADMINISTRATOR, BETHEL DEACONESS HOSPITAL

Mr. EWERT. Senator, seeing the time pass, I was reminded that congregations love the ministers who leave off the third point in their sermon as the clock approaches 12, and you can be advised by that. I do have a written statement that I have prepared and a number of issues that I have addressed have been addressed by other speakers. I do not think it would be necessary to elaborate, but I would like to at least call attention to the issues we see as an administrator.

I would like to again, by saying first of all, I am a hospital administrator and I don't know whether you knew it or not, but I am also a licensed nursing home administrator, and also operate a 74-bed nursing home in connection with the hospital, so perhaps I can also bring something from that perspective here today.

Senator DOLE. Do I have a copy of your statement?

Mr. EWERT. Yes, I gave you two copies. Yesterday morning the chief of police of Newton, Kans., was admitted to our hospital and at 5:30 the chief of police died. This morning when I left for Manhattan, his condition was stable but serious. That's an indication I think of where we have come in the delivery health care in the United States today, through defibrillation——

Senator DOLE. Oh, I see. I was going to have you go over that again. [Laughter.]

Mr. EWERT. I would like to suggest to you that there are people in this room who 20 years ago would not be living, and I think perhaps the excellence that we have developed in the American health care system is something that often goes unheralded. I think we ought to take out the time once in awhile to say what we have really

done. We concentrate so much on the problems that we have, and the things we should be doing to correct problems, and I think we overlook the excellent system that we really have. Sometimes in trying to improve it, why, I think we actually do damage to it. I think that sometimes the excellence that we have achieved has actually risen up to be the thing that accuses us, and as you know, the one area that we are being much assailed on today is the matter of cost.

There is one issue that I think has been skirting around us here today, and I would like to point straight at it, it's not an issue of nuts and bolts or adjusting the system here or there, but its a philosophical issue, and I think it's the issue of how much care is enough? What level of excellence is good enough, and what is too much? I don't know how we're going to really answer that question because I think it's a very difficult one, and yet we work at the question of costs and we work at the question of distribution of services, we work at the question of developing alternative services and so on, but nobody has yet said, you know, what is the right level of care. I think the medicare and medicaid programs, implicit in them we said we need more care, we need to make it more available, we need to make it a right of every citizen, not only a privilege. And I think this is one issue that we're going to need to be working at, and I think because of its difficulty, I think we often skirt around it and work on other things instead.

One of the biggest problems that we have to deal with, of course, is the problem of regulations, and it often seems to me that the approach seems to be that if a regulation is good, two regulations are better, and certainly a dozen would thoroughly solve all the problems that we have. But oftentimes the regulations actually compound problems through their regimentation, through stiffling local ingenuity and creativity to solve the problems. What we see is regulations are written by people who are far away from the scene of care, far away from Kansas and oftentimes create an impediment rather than be helpful.

Just to show the effect of regulations, I would like to point to a study taken by the American Hospital Association in which it was found from the period from 1969 to 1976 there were marked productivity gains in the areas of care deliverance such as in laboratory, and housekeeping and so on, but when you took the number of man hours which were used by physical services, and administrative services and by medical records and compared them, for instance to discharge days, one found a great increase. We have found that the regulations have simply compounded our cost problem by increasing the number of regulations that need to be read, the bits of paper that need to be shuffled, the reports that need to be filed, and records that need to be kept. So regulation is certainly not an unequivocal solution to the problem that we have in the health care situation. Sometimes, as I have already suggested, we find great unrealism in the regulations, to be sure there are regulations and requirements that are helpful, and I point to those that came out with the desire to improve nursing home care in the United States. They certainly do have a salutary effect. But sometimes, the regulations are actually impediments rather than help.

Another issue is the issue of planning. Surely the day is gone when everyone can do that which is right in his own eyes and the days of regional and area wide planning is here. We only wish it were more sophisticated to do a better job. Many of us had high hopes when Public Law 93–641 came down the line. Many of us have been devoting many hours in involvement in this process, both providers and also the consumers in our community. But this is certainly a growing dissolution when we see from not only a national level, but also the State level, even before the local processes had an opportunity to try to do its job, we began to see plans and guidelines and regulations coming, not only from the State, but also from Washington, telling us what we ought to be doing. There's no way in the rural areas of our Nation that we can require 80 percent occupancy, that we can require 500 births per year in an obstetrical unit and still in any way try to serve our people. It doesn't make any sense. Somehow it must become the responsibility of our legislative representatives to turn back the dictations of bureaucrats whose dictums would work harm and not good in that area.

Senator DOLE. The modified guidelines, of course, take care of two things you mentioned, and there may be others we haven't discovered, but there is a 30-day comment period from January 20.

Mr. EWERT. Could I respond to that and say I think the issue is more fundamental though than of simply the nuts and bolts of whether it's 80 percent or 50 percent. I think there's a basic philosophy involved here that in the United States we have been able to, on the legal level, address issues and find creative—and I would say cost effective solutions to problems—but we are in a situation where everything seems to need to be dictated from somewhere on high, whether it's Topeka or Washington, or Baltimore. That's what I am taking issue with, as well as the specific numbers.

Senator DOLE. I agree, and I think the other side of the coin is, of course, the increased costs and much of this cost is in Federal tax dollars. We don't know how to contain the increase, it's just out of hand in many cases, it just goes up and up and up, so people start looking for ways to contain the cost. One way to contain cost is to regionalize standards, have different standards; but you are right, I think fundamentally it's broader than whether it's 500 or 400, maybe we could find a balance.

Mr. EWERT. Another area that I would like to address is the area of reimbursement. Here I would say that it often has seemed, both from the national level as well as the State level, that the Government has put its hand to the plow and then turned back. To us in the administration it seems as though often we have been long on requirements, long on quality assurance, but short to put the dollars back of those requirements. Here I think perhaps the best illustration can come from the long-term care field where there has been, as I said earlier, many fine improvements made in the long-term care homes and so on, I think oftentimes in response to regulations that have come. But we are still being asked in Kansas to provide not only housing, not only food, but nursing care, personal care, activities, social work services, and all the rest of it for $17.60 a day.

Now anybody who gets all of the care that I have mentioned for $17.60 a day is getting a bargain. In fact they are getting something

that isn't being fully reimbursed, even though there was Federal legislation to push the States in the direction of giving us cost based reimbursement, you know, there's been one moratorium after the other of putting that section of the law into effect. Yet, there was no similar moratorium on asking nursing homes to live up to the life safety standards, to live up to introducing social workers into the scene, getting activity directors on board and all the rest of it, you know, this is an area where we say it looks as though government put its hand to the plow and then turned back and has not lived up to the physical requirements of care that they would have liked to have seen implemented.

Sometimes there also seems to be a good deal of what I call bureaucratic schizophrenia both at the State level and also at the national level. Here I would point to the reimbursement problem that we have when we operate a long-term care unit in connection with the hospital. I think earlier "Meals on Wheels" was mentioned. Our institution is also involved in that. When we come to setting down with the medicare auditors for our hospital, then we get into a great big hassle, what is acceptable cost to the hospital, and what is acceptable cost to "Meals on Wheels", and how do you divide the meal costs between the hospital and the long-term care unit. Yet, at the same time, we have been told that we should look for alternative methods of care in order to cut down the total health care expenditure. Yet we are encouraged to get out of these kinds of things because they simply create administrative problems with us.

Senator DOLE. I'm going to have to speed you up, I think you have given me the third verse already, we only have an hour for nine more witnesses.

Mr. EWERT. I simply say that I have attached a copy of the full statement on financial requirements of the American Hospital Association, I think that's a good one to look to. The other area, of course, is the cost control thing, and we would only plead that the voluntary effort which has now been launched by the American Hospital Association, American Medical Association, Federation of American Hospitals, be given a chance to really do its thing, not only as mandated through Federal legislation from a Federal level, but to work at the State level as our Kansas Hospital Association has encouraged; and finally I would like to say a word about the prospect of national health insurance. We already do have national health insurance programs, medicare and medicaid, and it would seem that this would not be the time to try to move ahead and try to take over other areas of the health care systems through a national health insurance system when we still have some unresolved questions with the medicare and medicaid program. It seems to be a most inauspicious time to move ahead in that direction, if indeed we really do need this. At this point I will rest and if you have questions I will be glad to try to respond to them.

[The prepared statement of Mr. Ewert follows:]

STATEMENT OF MARVIN H. EWERT

I am Marvin H. Ewert, administrator of Bethel Deaconess Hospital, Newton, Kansas. The hospital has 86 adult and pediatric beds and 12 bassinets.

I am also the administrator of the Bethel Home for Aged, Newton, Kansas, which has 74 beds licensed for intermediate nursing home care, of which 67

are certified for intermediate care for participation in the medicaid program.

There are thousands of people alive, well, active, enjoying life, and making a contribution to society in Kansas and all over the United States who 20 years ago would have been dead. The difference between their being alive or dead is the availability and accessibility to high quality health care services. And yet today, in spite of the tremendous contribution that health care services are making to society and to individual persons, there is scarcely any segment in our society that is undergoing as much scrutiny as our health care system. Surely there will always remain room in most anything, including the delivery of health care that can be improved in organization, quality, and economics. However, the situation as it has developed at the present time, is one in which the pressures and other actions being taken to re-design, improve and make more efficient and effective the health care system has reached the point of diminishing returns.

I am happy for the opportunity to appear before this subcommittee to share with you about what is going on and how this whole matter of health care delivery looks from down on the scene where hands are actually being laid on patients and residents and where the need for health care services is confronted face to face in encounters by those who provide care.

First of all, I share the observation that the tremendous effort that has been put forth and the tremendous achievements that have been attained in the provision of health care, as good and desirable as these might be, both in the eyes of providers and consumers, have given rise to criticism of health care providers with regard both to cost and quality. The American public has been quite ready to seek, if not actually demand all the benefits that advancing medical science and technology have had to offer. And providers have put together the resources necessary to satisfy the public's expectations and requirements. But the public and the reimbursers for miracles of modern health care have not been nearly as ready to accept the economic consequences as the services they so freely take and demand. Any inclination that the consuming public might have had for modern health care services was certainly abetted by the enactment of the Medicare and Medicaid programs, in which the government said the availability of and access to health care services is the right of every citizen, and no longer merely a privilege for those who can afford them and somehow arrange to receive them. There is no question about the fact that these programs increased the public's demand for health care services. Providers scrambled to meet the demand. Today we have the anguish and outcry and the attempt to place at the door of the providers the responsibility for the economic consequences of the resulting health care system.

The approach of government to resolve the problems of the health care delivery system seems to be that if one regulation is good, two of them would be better, and a dozen would certainly finaly solve the problem. The truth of the matter is, at least insofar as rural health care is concerned, that the regulations are only compounding the problem by regimenting the providers, stifling local ingenuity and creativity to solve problems, and add the ever-increasing expense of more bureaucracy, not only in the growth of the regulatory agency but to the providers too in attempting to cooperate with and to satisfy them. The walls of the business offices and the medical records departments in every hospital and home for aged have been moved out at least once and sometimes twice in the last 12 years since the initiation of the Medicare and Medicaid programs. They simply required more people to sit and more desks to read more regulations to develop more audit and reporting programs to shuffle more paper to satisfy the requirements of more and more regulations. A review of hospital productivity data tabulated by the American Hospital Association Hospital Administrative Services Program shows that in the period 1969 to 1976, less man-hours were devoted in 1976 to such things as x-ray procedures, housekeeping, the preparation of meals, plant maintenance, clinical laboratory, and the number of pounds of laundry processed. In these areas there were productivity gains of 6.2%, 9.8%, 13.7%, and in clinical laboratory, a whopping 45.3%. In medical records, the number of man-hours required per discharge unit grew from 2.3 to 5.9, a 27.6% increase. In administrative and physical services, man-hours increased from 32.67 to 41.76 per bed, an increase of 27.8%. The approach of developing more regulations in an attempt to bring about desired changes in the health care delivery system

is certainly not unequivocal. In some cases, more harm than good can be the result.

One of the serious limitations of the proliferation of regulations to try to deal with problems and concerns in the health care system is the degree of realism or unrealism of a given regulation in various situations across the country. There are times when regulations are so unreal that one is caused to wonder whether those developing the regulations really understand what it means at the local level to develop and provide services. Perhaps, there is not escaping all of the requirements and regulations that we now have and of which we seem to be getting ever more. But please hear the plea for flexibility and the realistic application of these regulations in any given local situation without the need to go through hearings and appeals that may drag on for years and which in themselves escalate the cost of health care, about which there is so much criticism today.

We do not take issue with the position that regional or area wide planning for health care facilities and services is a necessity today. On the other hand, to remove the planning process away from the local situations where local and regional needs can be identified and in which there can be the possibility of responding creatively to unique local situations, is surely as much in error as the day when nearly every health care provider did that which seemed right in his own eyes. Many of us had high hopes for what could be developed as a result of the provisions of Public Law 93-641. We saw the development of the health service areas and the health systems agencies as the opportunity and the mechanisms for doing responsible planning on a regional level. There is growing disillusionment at this time, however, in view of the aggressive action being taken on the national level in the development of planning guidelines. Somehow, we cannot at the same time affirm the importance and rightness of making health care services available and accessible to people in the rural areas of our nation and at the same time require that every hospital have at least 80% occupancy and that no obstetrical unit should be permitted to operate that has less than 500 births per year. This is so unrealistic that it is ludicrous. Again, it seems that not only does big government not have faith in the ability and the desire of people to solve problems and see to their welfare on a local level, nor does big government in far away Washington understand what the situation really is in many areas of the nation. Somehow, it must become the responsibility of our elected representatives to turn back the dictation of bureaucrats whose dictums would work harm and not good, in the efforts to meet the health care needs of people in Kansas and many other areas of our country. Somehow, we must maintain regional and local autonomy in the planning and provision of health care services. We must not so easily nor so soon forget that in a large measure it has been the ingenuity, initiative, and action of people acting in freedom in local situations, and not people proceeding in measured step regimented by some remote authority that has made our nation unique and great. And let us never forget that the great health care delivery system we have today, even with all of its faults, became what it is in an atmosphere of freedom and as the result of voluntary ingenuity, initiative, and action. This should be instructive to us as we face the future.

It seems to us down on the health care provider scene, that in its health care provider programs, the government, both at the national and state level, has put its hand to the plow and then turned back. The states, through licensure requirements and the federal government, through its' conditions of participation in the Medicare program, both in hospitals and in long term care units, such as homes for the aging and nursing homes, have established standards for care, including staffing, safety in the care environment, utilization review and care audits, etc. Adding social workers and activity directors in long term care units, improvements in both homes and hospitals, even those recently constructed, to meet the Life Safety Code requirements, are just an indication of things that providers have needed to do to meet standards set through regulation by the government. Some of these requirements are ridiculous when it comes to finally doing what needs to be done to meet them in the care situation; but in the main, particularly the upgrading of care in long term care units where mostly older people are cared for and where adequate financing is hard to come by, the government standards have

had a salutary effect. A problem of no small proportions, however, has been the fact that government dollars have not always matched government requirements. There has been delay after delay at the federal level in requiring that the states reimburse long term care units at full reasonable cost. There is no way to finance fully adequate care in a nursing home without finding a way to subsidize the reimbursement under the Medicaid program. Currently in Kansas, the maximum allowed reimbursement for intermediate care is $17.60 per day. How inadequate this reimbursement is is quite apparent when compared to the cost of a room in even a low-priced motel and what it would cost to eat three meals a day in a restaurant. And of course, that would not take into consideration nursing care, personal care, social service care, sponsored activities, and all of the other services that are rendered by nursing homes today. The cost of caring for a Medicaid patient, provided they are really given an adequate level of care, must be subsidized by other revenues which must come either from contributions or from charges in excess of the cost of caring for them to the private pay residents. This is not right. The government should assume its full financial obligations in reimbursing for services to those to whom it has been established its responsibility.

The Medicare reimbursement program, too, is so designed and so administered that the cost of serving Medicare patients in hospitals is not covered in full by the reimbursement that is received. And so again, the cost of caring for these patients for whom the government has assumed responsibility, must be met from other sources of revenue. And those other sources, in the main, constitute the third party payer and the private pay patient.

At the state level we have the situation where the state Department of Health and Environment is responsible for licensure and Medicaid and certification for long term care units and the Department of Social and Rehabilitation Services has the responsibility for reimbursing the homes. This seems to leave the Department of Health and Environment free to promulgate regulations without any necessity to consider the financial ramifications of those regulations. On the other hand, it seems that the Department of Social and Rehabilitation Services does not have the sense of responsibility it should have for providing increased reimbursement when requirements are made on the homes which cause the cost to increase.

At times it seems that there is the same bifurcation at the national level. The suggestions has been made that when possible, alternates to expensive hospital care be utilized. It has also been urged that there be continuity of care, and yet hospitals such as ours that also operate long term care units in conjunction with the hospital, are not satisfied with the treatment received from Medicare in the allocation of costs between the acute hospital and long term care unit. Medicare auditors steadfastly maintain that the cost of a meal in the long term care unit is the same as that in the hospital. This simply is not true. The serving portions for the long term care unit are smaller; the level of diet therapy required in a long term care unit is less than that required in a hospital. In a long term care unit there are not the stand-by costs which there are in a hospital because of the full census in a long term care unit compared to the fluctuating and uncertain census in a hospital.

The government has a responsibility to meet the full financial needs of health care providers. It should not be expected and not be necessary that the government pay part of the cost of those patients and residents who are not beneficiaries of the government sponsored programs, neither should it be necessary for those patients and residents who are not covered by the government programs such as Medicare and Medicaid to make up the deficits in reimbursement from government programs. Attached is a statement issued by the American Hospital Association on the financial requirements of health care institutions and services. This summary statement on the topic makes reference to a more comprehensive publication of the American Hospital Association, which discusses financial requirements and reimbursement for health care institutions in a way that we support and commend for being followed.

The proposals that have been advanced during the past year for the government to develop programs to control the cost of health care are viewed with great concern and much anxiety. Again, we would not for a moment say that there is not room for improvements in the financial operation of hospitals and

nursing homes. On the other hand, one fears greatly unrealistic restrictions that might be developed and imposed on health care institutions. It is possible that restricting the cost and restricting the revenues available to health care providers would lead to the curtailment of services and in some cases, also to comprising the quality of these services.

In connection with the discussion on the proposals to control hospital costs, one cannot help but recall the unsatisfactory experience there was with the wage and price control program of some years ago. It probably is not realistic to think that one can control the financial operation of one segment in our society without also controlling others. There has been much discussion about the problems that could be anticipated in trying to control hospital costs and one does not need to repeat what has been said elsewhere on this topic and at this time.

In relationship to the continuing increase in hospital costs, there are a few things that do need to be said, however. It must be realized that the increase in hospital costs are, to a large extent, simply the result of other forces that are at work in society. The increase in hospital costs simply reflects the unrelenting inflation in our society. The increase in hospital costs simply reflects the constant increases in the cost of goods and services that hospitals purchase, including the sizeable increases that have come in the energy bill in recent years. The increase in hospital costs have come as a result of scientific and technological advances. Just one example is the need in the hospital that I represent to expend nearly $5,000 for a cardiac monitor and defibrillator in the emergency room. There is no way that the charges for the use of this instrument to the patients who will be served by it can ever pay for this piece of equipment. Also, it must be realized that up until this time, the hospital functioned without this instrument in the emergency room, but at this time the hospital's liability insurance carrier and also the Joint Commission on Accreditation of Hospitals are making the recommendation that the monitor-defibrillator be purchased. Up until this time, the hospital has operated and served in the delivery of thousands of babies without the benefit of fetal monitoring equipment. In recent weeks, the hospital placed an order for two fetal monitors which will entail an expenditure of about $12,000. These equipment purchases have been made necessary, not only by technological advances in medicine, but also as a result of the demand for higher quality in the level of services rendered to patients.

Hospital costs increase because, with technological advances and more sophisticated equipment, more highly trained personnel, which have a higher price tag in terms of wages and salaries, must be employed. And then there is also the additional expense of continuing education to maintain the proficiency of this personnel. Hospital costs continue to increase because of government madatory increases in the minimum wage, which even though they apply directly only to the lower paid categories of personnel, raises to these employees affect other employees by the "ripple" effect that is created. And we have pointed out earlier how hospital costs increase as a result of the mounting paperwork required of hospitals by the federal government and other agencies with whom hospitals must deal.

Health care providers accept the request for greater fiscal responsibility and accountability. We strongly urge, however that hospitals and other health care providers be permitted to follow through on the commitment to do this through voluntary means rather than a program designed by the government. Already last summer, the Kansas Hospital Association Board of Directors went on record recommending a voluntary prospective rate review program to be operated in conjunction with Kansas Blue Cross. We are pleased to see that the American Hospital Association has adopted a similar position in responding to the concerns for greater fiscal responsibility and accountability for hospitals. We plead that the government now permit the voluntary cost containment program being developed by the American Hospital Association, the American Medical Association and the Federation of American Hospitals, to carry through its plans to develop cost containment activities and programs on a voluntary basis. We think this would be much preferred because it would provide the possibility of building in the necessary flexibility to be responsive to regional and local situations in ways that would not compromise the quality, the availability, acceptibility, and continuity of health care and still

provide assurance that the services were being provided in a cost effective manner. We hope the government will not soon become impatient with regard to these efforts. As is said, "Rome was not built in a day," and it may not be possible to do all that needs to be done in containing the cost of health care overnight. Some of the other things that will no doubt need to be done cannot be effected by revolution but rather by evolution.

We sincerely hope that the government will not rush forward in the proposals to enact a national health care system. The problems, limitations, and frustrations that there are with current Medicare and Medicaid programs should be an adequate warning to us to proceed with great caution in enacting national health insurance. The fear of providers is that the government will hold out to people the prospect of more and better services and that the providers, in some way, will need to respond to those promises and then receive criticism if the utilization of services increases and the costs continue to skyrocket. At a time when much effort and attention is being given to improving the operation of health care institutions and the health care system, through the cost containment program and through other programs, the situation should not be further complicated by the cataclysmic enactment of a national health care program. Perhaps in the long run, such a program is not needed, given the proper amount of time and the proper incentives, those deficiencies in the health care delivery system which a national health insurance program would be designed to correct, can be addressed and resolved on a voluntary basis. Let's first resolve the tensions and problems we have in the present partnership between the voluntary health care system and the government in the Medicare and Medicaid programs before we plunge forward to enact a national health insurance program in which the present problems would surely only be multiplied and magnified. In fact, it could strain the present relationship between voluntary health providers and the government, which we will refer to as a partnership, even though it often seems that the government is the senior partner, to the point that the partnership would be destroyed. Then, heaven forbid, we would have a government operated health care system. It is inconceivable that public benefit could be enhanced by such a development.

In summary and recapitulation, then, we have the following observations and concerns about health care delivery.

1. The American public has never had it so good and never have they received so much of such great benefit from the health care delivery system as they do today.

2. Health care providers today seemingly find themselves in the peculiar situation that the excellence with which they have performed and the progress that they have made, rather than resulting in support and commendations, have become the source of concern, criticisms, and castigation.

3. Government involvement in health care delivery has solved some problems, has created others, and unfortunately, to some degree at least, has depreciated something as sacred as health care to the status of a political pawn.

(a) Government involvement has brought an avalanche of regulations and paperwork which has added not only to cost for health care providers, but also to the cost of government.

(b) Government involvement and its attending regulations has not always provided creative solutions and realistic answers to local health care needs, particularly for rural areas.

(c) Government involvement and the inflexibility of controls and requirements that have come with it, has often created unnecessary problems and obstacles in efficiently providing health care services.

(d) Government involvement in some situations, particularly with respect to long term care in nursing homes have provided the stimulus for upgrading and improving the quality of services provided.

4. Area wide planning for health care facilities is a necessity, but it must be done on a regional basis, taking into consideration regional and local health care needs, and not on the basis of prescriptions set forth by some central government ageney.

5. Reimbursement through the government health care programs, have not and are not at the present time meeting the full financial requirements of health care providers.

6. Health provider cost containment efforts must be carried out on a voluntary basis and not imposed through legislation. Any cost containment pro-

gram should not be carried out at the expense of compromising the quality, availability, accessibility, and continuity of services. A comprehensive national health care and insurance program should not be enacted at this time, nor perhaps at any time in the future. Government efforts should be devoted to the improvement of the current national health care insurance programs, the Medicare and Medicaid programs.

We are appreciative and express thanks for the opportunity to present this testimony.

CURRICULUM VITAE—MARVIN H. EWERT, ADMINISTRATOR, BETHEL DEACONESS HOSPITAL AND BETHEL HOME FOR AGED, NEWTON, KANSAS

Birthdate—March 16, 1925, at Dolton, South Dakota.

Education—A.B., Bethel College, North Newton, Kansas; B.D., Bethany Biblical Seminary, Chicago, Illinois; Postgraduate study in religion and personality, two years, University of Chicago, Chicago, Illinois; Course in principles of management, University of Wichita, Wichita, Kansas; and Hospital Administrators Development Program, 4-week summer course, Cornell University, Ithaca, New York.

Experience—Administrator, Bethel Deaconess Hospital and Bethel Home for Aged, Newton, Kansas, January, 1957 to present.

Member—American College of Hospital Administrators.

Past president—Kansas Hospital Association.

Past delegate—American Hospital Association House of Delegates.

Past president—American Protestant Hospital Association.

Past chairman—Protestant Health and Welfare Assembly.

Past director—Kansas Blue Cross.

Past director—Prairie View Mental Health Center, Newton, Kansas.

Member—Master Planning Committee for Nursing and Nursing Education in Kansas.

Member—Kansas Hospital Association Council on Fiscal Affairs.

Delegate—American Association of Homes for the Aging House of Delegates.

Member—Kansas Association of Homes for the Aging Board of Directors.

Member—Sand Hills Associate Health Systems Council, Kansas HSA III.

AMERICAN HOSPITAL ASSOCIATION

FINANCIAL REQUIREMENTS OF HEALTH CARE INSTITUTIONS AND SERVICES

Financial requirements, as differentiated from accounting costs, are defined as those resources that are not only necessary to meet current operating needs, but also sufficient to permit replacement of the physical plant when appropriate and to allow for changing community health and patient needs, education and research needs, and all other needs necessary to the institutional provision of health care services that must be recognized and supported by all purchasers of care.

If an institution ensures that its role and mission is consonant with community needs, there is a corollary that the institution be assured that its financial requirements are met. In essence, the community must provide the proper financing of its health care delivery system, and the components within the health care system must accept the responsibility for proper planning and management of that system. Philanthropy should be encouraged as an important source of funding. To provide this encouragement, it should not be used as reimbursement for services that could otherwise be paid by the patient or a third party.

This revision of the 1969 Statement on the Financial Requirements of Health Care Institutions and Services *reaffirms and updates the position taken in that document by emphasizing that all purchasers of health care must recognize and share fully in the total financial requirements of institutions providing care. It further recognizes the established concept of the need for adequate reserves as a capital requirement. This statement was approved by the House of Delegates of the American Hospital Association in August 1977.*

Introduction

The delivery of health services requires a vast array of professional services, institutions, allied health organizations and educational programs, research activities, and community health projects. A high-quality health care delivery system is dependent upon the commitment of sufficient resources and their effective management. The system must ensure that necessary services are provided to the public in an effective, efficient, and economic manner. Coordination of the components of the health care delivery system and self-discipline of all participants within the system are necessary to meet this end. Three interrelated functions whereby such coordination and self-discipline can be achieved are effective planning, effective utilization, and effective management. These functions share the ultimate purpose of maintaining the highest standards of quality in the delivery of health care.

The health care delivery system has and should continue to have multiple sources of financing that must meet total financial requirements. These sources of financing should recognize that health care institutions must be financed at a level that supports the health objectives of the community, including uncompensated care costs as defined herein. The health care delivery system and its financing should be sufficiently flexible to change as the needs of the community change and as new and effective technologies are developed so that the total financial requirements can continue to be met.

Elements of financial requirements

Institutional financial stability requires that there be a realistic appraisal of the two major financial components: (1) current operating requirements and (2) operating margin.

Meeting these financial requirements will enable the institutions to maintain and improve current programs and facilities and to initiate new programs and facilities consistent with community needs and advances in medical science.

Health care institutions differ in size, scope, and types of ownership and services, and therefore their operating and capital requirements differ. However, all elements of financial requirements must be reflected in the payments to health care institutions to provide adequately for demonstrated financial needs. The elements of financial requirements are described below.

Current operating requirements

Current operating requirements include the following costs:

1. Patient care

   These costs include, but are not limited to, salaries and wages, employee benefits, purchased services, interest expense, supplies, insurance, maintenance, minor building modification, leases, applicable taxes, depreciation, and the monetary value assigned to services provided by members of religious orders and other organized religious groups.

2. Patients who do not pay

   It must be recognized that a portion of the total financial requirements will not be met by certain patients who:

   a. Fail to fully meet their incurred obligation for services rendered,

   b. Are relieved wholly or in part of their responsibilities because of their inability to pay for services rendered.

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Therefore, these unrecovered financial requirements must be included as a current operating requirement for those who pay.

3. Education

Where financial needs for educational programs having appropriate approval have not been met through tuition, scholarships, grants, or other sources, all purchasers of care must assume their appropriate share of the financial requirements to meet these needs.

4. Research

Appropriate health care services and patient-related clinical research programs are an element of the total financial requirements of an institution. The cost of these programs should be met primarily from endowment income, gifts, grants, or other sources.

Operating margin

In order to meet the total financial requirements of an institution, a margin of net patient care revenues in excess of current operating requirements must be maintained. This difference will provide necessary funds for working capital requirements, capital requirements, and return on equity.

1. Working capital requirements

Financial stability is dependent on having sufficient cash to meet current fiscal obligations as they come due.

2. Capital requirements

Health care institutions are expected to meet demands resulting from such factors as population shifts, discontinuance of other existing services, and changes in the public's demand for types of services delivered. In order to be in a position to respond to such changing community needs, health care institutions must anticipate and include such capital needs in their financial requirements. There must be assurances that adequate resources will be available to finance recognized necessary changes.

The capital requirements of a health care institution must be evaluated and approved by its governing authority in the context of the institution's role and mission in the community's health care delivery system. Coordination among the health care institution's governing authority, administration, and medical staff and the cooperation among health organizations and the appropriate areawide health planning agency are essential to this evaluation.

a. Major renovations and repairs

Funds must be provided for necessary major repairs of plant and equipment to ensure compliance with changing regulatory standards and codes and to finance planned and approved renovation projects.

b. Replacement of plant and equipment

Because of deterioration and obsolescence, assets must be replaced and modernized based on community needs for health care services. Funds that reflect the changes in general price levels must be available for the replacement and modernization of plant and equipment.

c. Expansion

Sufficient funds must be available for the acquisition of additional property, plant, and equipment when consonant with community needs.

d. New technology

Advances in medical science and advances in the technology of delivering health services often require additional expenditures. Sufficient financial resources must be available for continued additional investment in the improvement of plant and equipment, consonant with community needs, so that health care institutions can keep pace with changes in the health care delivery system.

3. Return on equity

Investor-owned institutions should receive a reasonable return on their owners' equity.

Responsibilities of purchasers for meeting financial requirements

Each institution's total financial requirements should be apportioned among all purchasers of care in accordance with each purchaser's use of the institution and measurable impact on the operations of the institution. Any apportionment that permits a purchaser to assume a lesser responsibility is not appropriate and does not alter the total financial requirements of the health care institution. Rather, it requires other purchasers to make up the deficiency.

Responsibilities of providers

Health care institutions have an obligation to disclose to the public evidence that their funds are being effectively utilized in accordance with their stated purpose of operation. Institutions also have a responsibility not only to purchasers of care but also to their community to provide effective management. An institution's goals and the methods that it uses to achieve those goals should be consonant with community planning and the resources in that community.

Senator DOLE. I don't know that I have a question. As you know, cost containment is on the front burner right now in our committee, and there seems to be a move to compromise the administration's view and the committee's view. There's some indication that there may be some movement. As far as national health insurance is concerned, there may be bills introduced this year and discussed, but I don't see any legislation being enacted this year. There's too much before the committees that have jurisdiction now. We still have the energy bill, we have welfare reform, we have tax reform. I don't think anyone, even the most optimistic proponent of national health insurance feels there's going to be any bill this year, though there's still hope there will be.

STATEMENT OF LEON BOOR, ADMINISTRATOR, MEMORIAL HOSPITAL, ABILENE, KANS.

Mr. BOOR. Senator Dole, I am Leon Boor, administrator of the Memorial Hospital, Abilene, Kans., a 69-bed rural hospital. I am sure it was not by design that you chose our town to remind yourself and ourselves of the time.

I appreciate the opportunity to present some personal views regarding problems in rural health care delivery in the context of the four areas which we are addressing today. I'm going to read from a prepared text which was summarized, so I think we can get through it pretty quickly. The first of these areas is manpower distribution. Prominent in the discussion of health manpower has to be the physician component because it has such a bearing on the size, profile and makeup of the balance of the health care delivery team, particularly in the more remote areas of our country. Serious consideration must be given to ways to increase the supply of primary care physicians in this country and in the State of Kansas. Preoccupation with specialization must somehow be curtailed as well as the influencing factors in our medical education system that tend to encourage among students the emulation of specialists. This has a limiting effect on the number of new primary care physicians available to rural areas where they are so acutely needed. The 1978 State Health Plan for Kansas cites a recent statewide public opinion poll as listing the lack of primary care physicians as the number one health problem in the State. The rate of increase in the physician population nationally was almost twice the rate of increase in total population between 1950 and 1973. The physician to population ratio has improved also in Kansas, but the increase has been primarily in specialists at the expense of the primary care physicians and particularly in the rural areas. Between 1963 and 1973 the State has experienced an overall decrease of 12 percent in primary care physicians and more particularly a 29-percent decrease in physicians in the rural areas. Efforts on the part of the legislature and the University of Kansas and its medical school has recently effected an apparent halt in this downward trend.

The expansion of enrollments as well as the family practice program and residencies has been a very positive influence. Kansas ranks among the top five in medical graduates-to-population, yet its

practicing physicians-to-population ranks 28th. Recognizably, the University of Kansas Medical School should not be made into a primary care training center for many good reasons; however, even more emphasis on family practice would seem desirable as well as more deliberate considerations in the selection process at time of admission. Concurrently, rural communities must adopt a much more aggressive posture regarding physician recruitment as opposed to expecting the medical schools to "place" physicians in their areas.

I am happy to report in our little town we have recruited five physicians in the last 2 years and we think we have a very aggressive program, and I just wanted to report we have some new physicians.

Mandatory allocation or coercion of medical school graduates to practice in an area, tuition disincentives, and these types of mechanisms do not appear to be viable, long-term solutions to the rural practitioner problem. Also in reference to "primary care" physicians in rural areas it seems more appropriate to refer to the family or general practitioner. We see very few internists, pediatricians, and obstetricians in the small towns of Kansas.

On the topic of distribution of services in rural areas, it appears that the resolving of the problem of physician distribution will go far in resolving the services problem. This is predicated on the assumption that HEW regulations will not, for example, close down obstetrics and nursery services in almost all rural areas of our country as was recently proposed. Also, that overzealous and misdirected health planning efforts do not close rural hospital that fail to maintain some predetermined occupancy level that is deemed appropriate for large urban and small rural hospitals alike. Another observation I would make is that we see very few physicians locating or practicing in a rural area that does not have some semblance of a small but adequate general acute hospital with the basic acute services.

On financing health care, the problems are intricate, with many interrelationships and actors, and are not amenable to easy, simplistic solutions. Among the chief causes are the reimbursement and financing patterns presently in use to finance health care which serve to contribute to rather than moderate health care costs. These mechanisms serve as fueling factors to both the supply and demand sides of health care services. Reform efforts dealing with reimbursement methodologies of the title XVII and title XIX programs are needed that will recognize the full financial requirements of health care providers and which will not work at cross purposes with excellent programs and services such as "Meals on Wheels", long-term care services and others that are so beneficial to residents in the rural areas.

The blizzard of governmental regulations is another prime contributor to financial problems for rural hospitals. One, among many examples is life safety code regulations. Within the last 3 weeks my institution was inspected and received a report listing approximately $35,000 worth of deficiencies which must be corrected. That same facility had previously been in compliance with all inspections prior to that time. This amount represents $2.50 per patient day increase in our daily service charge alone.

Mandated governmental regulations including increase in the minimum wage, increased Social Security taxes, newly added unemployment compensation taxes and life safety code expenditures have provided the bulk of the increases in our budgets this year. The direct and indirect cost of these regulations are becoming of insurmountable proportions both in terms of dollars and time.

Regarding the health care planning I would merely state that having served on the board for the past 2 years of our local subarea planning council, Health Systems Agency No. 2, and our Statewide Health Coordinating Council, it is apparent that we have much work ahead of us before substantial interpretation and implementation of that law will be effective.

In short, I believe the best service you could perform for both rural and urban health care would be to withhold your support of any new health planning legislation until we can better digest the legislation we have now. Thank you.

Senator DOLE. Thank you. Curtis?

STATEMENT OF CURTIS C. ERICKSON, EXECUTIVE DIRECTOR, GREAT PLAINS LUTHERAN HOSPITALS, INC., PHILLIPSBURG, KANS.

Mr. ERICKSON. I am Curtis E. Erickson, executive director of the Great Plains Lutheran Hospital at Phillipsburg, Kans. I appreciate the opportunity to present some concerns, and I want you to know that it would seem as though we have all gotten together and written our remarks and that's not true, and it's amazing of the similarity in some of the areas that we have concern, which I guess indicates the importance of them.

I have been in the operation of small hospitals for some 20 years, our organization operates 19 hospitals in Kansas and 1 in Nebraska having from 13 beds to 100. I won't speak any further about the physician situation because it's been well covered and there are a panel of physicians yet to come. I do want to discuss one thing, and we are seeing as the young physicians come out with their training, we are seeing a great deal of pressure on the allied health personnel. We are concerned about the fact that nurses, other technical professionals, respiratory professionals, physical therapists, and so on, the whole gamut, being watched very closely because I think there's no question, without the allied personnel, the increase in the number of physicians will be of little value in the long run. I believe the current health manpower legislation does address this, but the thing that concerns me, that facilities will always be available to let these people do the professional services they are trained for.

One area a little bit further in regard to the reimbursement area I want to touch on and that's this area again of medicare and its relationship to sharing services in an acute hospital, other than providing acute care. Our organization has been instrumental in the area of long-term care in conjunction with hospitals since 1964, and I jokingly say sometimes we did it before medicare went into effect, which we had never thought of it at that time, but the only thing that I think that we need to be concerned about is that the

reimbursement formula mandatorily calls for these allocation of costs. I won't belabor the point, except to say that out of the—in the 30 institutions in Kansas that have acute care and long-term care in the same facility, they are all having this problem. One institution in Kansas closed their long-term care because of the extreme loss ratio. The requirement of having these institutions use the combination method of cost funding is unfair and impractical, and some months ago the Health Care Financing Agency, and I think this has already been testified to before your committee, they indicated they would let us go to some flexibility, at least, to the departmental cost funding method. This has not happened, and I think it still needs to be done.

Someone mentioned earlier on a number of occasions there's a shortage of home health activities in rural areas, and all areas really, but it's difficult with the reimbursement formula we are faced with to see this kind of thing happen, it's practically impossible to develop programs that would be implemented in this manner because of financing practices. But it just seems to me in all the years I have been around it's difficult to say why the small hospital can't really be used to meet the community health needs. We like to even say the community health center because I see no other way out in the rural area other than to do so. We know when we devaluate the rural hospital in the statistical sense, which was really what was done when we got to talking about the 80-percent occupancy thing, and I will venture to say that we will have another percentage come back, Senator; I always like to relate this back to the fact that most of our rural hospitals were planned and many in this room have heard me call it by one of the greatest Federal planning efforts we have ever seen, the Hill-Burton program. They didn't just bring it up from topsy, they were promoted by our Government, and all at once now we see a great deal of abuse, but I think we go back and analyze, most of those were made up statistically on the basis of population in 1940 and 1950, and they maintained a licensed bed capacity, and in these intervening years the population has gone down in some counties as much as 25 percent. But now the population has stabilized and it does cause the rural hospital to show a low occupancy. After all, all we are doing in that thing called occupancy is measuring the number of people in the hospital based on the number of licensed beds. But by merely reducing the number of beds, the percent of occupancy would be raised, but we are just playing a game and I think that's something that needs to be understood. The variable costs in a small hospital is determined by the number of beds used, not by the number licensed. And if some reasonable flexible formula could be developed, I think we could use the unused space in the rural hospital, not necessarily for beds, but for services.

Talk about Public Law 93–641, very quickly I just urge your committee to evaluate very carefully any recommended changes that will come before your committee in this session, I know they will. In my judgment, just to be sure that—in my judgment, I would like to see the 93–641 continue on without significant changes. I don't believe we have had an opportunity yet to even see the Health

Planning Act to even function, more particularly when most of us even in Kansas have yet to see the finalized health service plan that we are operating under, it seems—it's something that I would like to see the Congress hold back and let the program work for a few years to see whether it has any legitimate way of helping us out.

One last point, and I have other things in the document, but the thing we need to always keep in mind, and I am one of the few that talk about it, I think we need to understand that rural Kansas, and certainly the Midwest is different than any other section of the United States. We have in many of our counties over 20 percent of our population over 65. For some reason even people in the Federal HEW don't realize that other sections of the United States don't have that, in the southeast portion of the United States, counties have as low as 5 percent of the population over 60, so we do have a different set of circumstances and needs, yet we are trying to operate and function under the same rules of the game.

So, I think, Senator, those are the things—the regulations, certainly, I think is one that has been brought up and I want to add one further little thought that we have come up with. We think maybe that when regulations and new legislation is developed, it ought to be studied as maybe an impact on the rural health delivery, and this impact statement might well be made a part of the legislation or the regulations. Let's look at it ahead of time rather than what we are doing now, after the fact, then go back and try to react to it. We want to thank you for this opportunity and certainly for holding the hearings——

Senator DOLE [interrupting]. Excuse me, Curt, is that in your statement?

Mr. ERICKSON. In the last page on page 5.

Senator DOLE. Thank you.

Mr. ERICKSON. We appreciate your taking your time to come out and listen to problems, probably in some cases our frustrations, but we think also we would certainly be willing to help in any manner we can to get additional information for you.

Senator DOLE. That would be helpful, especially the rural health impact of various proposals. Well, as you probably all know we have added a provision in S. 1470, which would encourage small rural hospitals located in areas where there is a shortage of long-term care beds to utilize their excess beds for that purpose. We think that's a possibility.

Mr. ERICKSON. As long as the reimbursement formula correlates to that process so we can at least live with it. No question it's very good.

Senator DOLE. I am reminded by John that there's a new reimbursement formula which would avoid the current requirement for separate placement of long-term care patients within a hospital and separate cost findings. That might help.

Mr. ERICKSON. If we can get to the department—they promised even early last year, and they didn't come through.

Mr. MOREFIELD. Medicare is doing reimbursement experiments in a number of States with small hospitals, converting a portion of

their beds into the long-term care. This has been going on about 2 years and they have to have it finalized within the next year.

Mr. ERICKSON. Utah experiment, yes. Senator, it's kind of interesting on two types of programs, real quickly and I'll close, on medicare on one side, for example, they may—they made a determination on the cost that Marvin mentioned might add up to $28 per patient a day that's allocated from the acute side of the building, over on the other side, long-term care side of the building, and yet when reimbursement comes around, from the standpoint of a medicaid program, which in our eyes is not too much different than a Federal program, they reimburse at even a skilled rate of let's say $22 or $23. This float in the middle, let's say is just wiped out and not recoverable in any manner by anybody except local taxation or local donations of some kind. It's a tough situation.

Senator DOLE. Well, I think as I have indicated, the one area that I am certain concerns the three of you and others is the cost containment proposal. It's one that we still haven't resolved in Congress, and we would keep looking to you for some suggestions and advice on that.

[The prepared statement of Mr. Erickson follows:]

STATEMENT OF CURTIS C. ERICKSON

I appreciate the opportunity to present some concerns and ideas which I have regarding rural health care and its delivery.

The organization of which I am Executive Director operates 19 hospitals in Kansas and 1 in Nebraska varying in size from 13 beds to almost 100 beds.

The major problem in recent years in the rural areas has been that of a significant shortage of physicians. This problem has by no means been solved, but I believe it is definitely on the way to being remedied by the significant increase in the number of students in training programs at the University of Kansas. I must emphasize that the "distribution" of physicians is still leaving the rural areas in very short supply. Other manpower requirements in the health field in my judgment will need to be watched carefully in the years to come. As young physicians locate in the rural areas, we feel immediately the need for additional allied health personnel such as registered nurses, physical therapists, respiratory therapists, laboratory and x-ray personnel. As the physician's training causes the increased use of these professional and technical persons, we must be sure that the rural areas have such persons available. Without allied personnel, the increased number of physicians will be of little value. I believe that the current health manpower legislation will be a help in meeting many of our needs in future years. The major concern, however, is that facilities will always be available to allow the health manpower to perform their function.

The types of services which are provided in the rural areas have been restricted to primarily those covered by third party reimbursement and this, because of the reimbursement formula, has not allowed for any flexibility in provisions of services. For example, the reimbursement formula of Medicare makes it practically impossible to provide services other than acute hospital care as part of the total hospital's operation. Our organization has since 1964 operated long term care units in conjunction with acute hospitals; and we currently have eight in operation. The reimbursement formula mandatorily requires the allocation of costs to long term care in a manner which unfairly loads the long term care, and therefore, makes it completely impractical for the shared services to be provided. There are 30 of such institutions in Kansas and at least one has recently closed the long term care unit because of this cost allocation problem. The reimbursement formula of requiring these institutions to use the combination methods of cost finding is very unfair and impractical. Some months ago, it was indicated by the Health Care Financing Agency that departmental cost finding would replace the combination method

for these institutions. This has still not been finalized and even though this would be an improvement it would still not allow the necessary flexibility for all hospitals to share the services that the community needs. There is a severe lack of home health services, and one of the primary reasons is because of the reimbursement formula. It is very difficult for innovative programs to be implemented because the finance practices do not correlate to the need for the program. It is just so impractical for small community hospitals to provide only acute care and not be able to use the skilled personnel and physician coverage for many of the community's health needs. I believe that the rural hospital has a most important function in the future to be the "community health center" for all health persons as they provide the services to their community. We know that as one evaluates the rural hospitals in a statistical sense they show very low occupancy, and yet without these rural hospitals it seems that most rural health care would suffer significantly. The recent planning guidelines point up the lack of understanding in regard to the small rural hospital when the guidelines called for 80% occupancy. Many of our rural hospitals were planned and established by the federal Hill-Burton program in which census figures of either 1940 or 1950 were used to determine the number of licensed beds needed. This number of licensed beds has not changed in most hospitals in the intervening years and yet the population in these rural counties has decreased in some cases as much as 25%. This population has now stabilized but it does cause the rural hospital to show a low occupancy rate. By merely reducing the number of licensed beds, the percent of occupancy would be raised which is merely playing a game. The variable costs in a small rural hospital are determined by the number of beds used and not beds licensed. If some reasonable and flexible reimbursement formula could be developed then certainly the unused space in many rural hospitals could be used for the other services listed above.

When and if revisions to the Health Planning and Resource Development Act, P.L. 93-641 are presented in this session of Congress, I urge the committee to carefully consider any recommended changes to insure that they do not dictate the closure of rural hospitals by arbitrary guidelines which have not been studied at the local level.

I believe that the present Health Services Areas have not had sufficient time to function and therefore, 93-641 should be allowed to continue without significant change. We in this area are just completing the writing of the Health Services Plan and have not been able to function within its recommendations. The Health Planning Act has as one of its primary recommendations one of determining the health needs of the area on a regional basis and I believe that this process should be allowed to function for a reasonable period of time before any major changes are made.

Access to health care has always been and will continue to be a problem for the rural areas, but we do not believe that all citizens can be transported to a regional center for all their services. The vast majority of the health needs of people can be taken care of very adequately and economically in the rural areas if only the multi-services system which we have discussed can be developed by allowing the reimbursement formula to be compatible with the provision of services.

In many Kansas communities, the percent of people over age 65 is almost 20% which is different from any other area of the United States. The midwest, therefore, has needs for health care that are not found in any other area of the country even in a rural setting.

There are numerous health care needs to be met in the rural areas and there are also many federal programs attempting to solve or meet these needs. We feel that because of the large number of different programs there have been times when they have actually opposed each other when they were implemented. Regulations have many times seemed to change the intent of the law. It would be very beneficial to rural areas if it were required that new legislation and regulations be studied to determine their impact on rural health delivery. This impact statement might well be made a part of the legislation and regulations.

Thank you for giving me this opportunity to testify about such an important subject as rural health care and its delivery. If I can be of any other assistance in providing information to the committee, I would be happy to do so.

Senator DOLE. Thank you very much. Next we have a panel of physicians, Dr. Neuenschwander from Hoxie, Dr. Chaney from Belleville and Dr. Taylor from Salina. Then our final panel will be a panel of community representatives.

Dr. PAIGE. Senator Dole, I would like to know what this group of people, or what you think about amending the medical care law——

Senator DOLE. [Interrupting]. Let me finish this panel of witnesses first and then we'll ask if anyone has anything to say. Dr. Neuenschwander?

STATEMENT OF DR. JOHN R. NEUENSCHWANDER, HOXIE, KANS.

Dr. NEUENSCHWANDER. I appreciate the opportunity to speak here today, I am John Neuenschwander and I grew up in Hoxie, population 1,400, completed medical school in family practice residency and returned to Hoxie to enter practice with my father. We are the only two M.D.'s in the Hoxie and Shearton County, population 4,000. I will summarize my remarks quite a bit. I believe you do have a written statement and I will address myself to the problem of physician shortages and the factors that determine a physician's choice of practice location.

First, let me state that the physician shortage in rural Kansas is exaggerated and is rapidly improving. Shortages are usually based on the figure of one family physician for every 700 or 1,000 population. The family physicians I know feel that one per 2,000 population may be more reasonable. However, no ratio is appropriate for all areas due to variations in age distribution, socioeconomic factors, transportation, et cetera.

There is also now a marked trend towards general practice and family practice. Less than 10 percent of my class at graduation sought a family practice specialty, now the figure is closer to 50 percent in graduating classes from Kansas University. Still, many communities in rural Kansas and rural America do need more physicians.

I think medical schools should be encouraged to develop quality rotations in family practice, out-patient medicine and rural medicine to expose the student to family practice. But the solutions to the rural health manpower shortage at this time is family practice residency. The physician planning a rural practice requires superior, not minimal training, and family practice residency ideally addresses this need. In a poll of the Northwest Kansas Medical Society, 80 percent of the members felt any physician planning a rural practice should complete a primary care residency program, and they are speaking predominantly, of course, of a family practice program in this group. I might mention that I am the only family practice resident currently in the Kansas Northwest Medical Society.

Senator DOLE. How many counties in the Northwest Medical Society?

Dr. TAYLOR. About 16.

Dr. NEUENSCHWANDER. In a study of Iowa family practice residents done by a colleague of mine, Dr. Ken Olson, 54 percent sought

communities of less than 10,000 population. Rural America can have adequate physicians if family practice residencies and residents have adequate support.

There are several factors which determine a physician's choice or practice location. One is community size. Though small towns present the advantages of delightful people, low crime and relaxed existence, a town can be too small. Physicians require sufficient time off for continuing education and leisure, so the day of the solo practitioner is over. Any community unable to support two or three physicians is unlikely to obtain any.

There are financial factors, physicians in group practices seeking new members have found that potential members inquire about facilities, call, free time, educational opportunities and then salary. Yet in America, status seems to increase with wages. Though medicare and medicaid do not particularly fix rural physicians' fees below those of urban physicians, the policy of denying, delaying and limiting fee increases tends to make traditional fee disparities permanent and inflexible. This tends to penalize most of the physicians with low fees, usually rural. Ever since I began practicing medicaid has frozen my office call fee at $5.

I know of no family practice resident willing to begin practice without local hospital facilities. Yet, survival for the rural hospitals seems to be a game of fitting the expense of quality patient care between sudden costly Government requirements and meager delayed Government payments. The guidelines developed for 50-bed institutions are vigorously applied to 20-bed hospitals. OSHA has recently been criticized in the press for its irrational treatment of small businesses and farms; small hospitals have suffered in silence through years of even more unreasonable regulations.

These rules affect me too. I drive 100 miles each month to obtain utilization and peer review from a physician not associated with my hospital practice.

Most threatening are the multitude of proposed guidelines which simply close some facilities. Predictable utilization is impossible in our hospital, but our average length of stay for most disease states is well below urban averages. If our community appears to overutilize, it is because a disproportionate number of elderly, 49 percent in Kansas, live in the rural areas and require more care. They have mentioned guidelines for obstetrical units that average less than 500 deliveries or 200 a year. In October 1977, 55 of the 57 family practice residents in Wichita stated they would not practice where they had no local obstetrical privileges, that's 96 percent, so merely by enforcing the governmental guidelines on OB clinics, you could virtually keep physicians out of small communities.

Hoxie has a 19-bed hospital with attached 38-bed long-term care unit. It has had full Joint Commission on Accreditation of Hospitals approval yearly since 1968, the smallest hospital in Kansas possibly the United States to be so honored. Our citizens support it vigorously with their time and money—and they must, for medicare reimburses it only 50 cents on the dollar. These people do not deserve to have this fine facility closed.

In summary, recent changes in physician attitudes and physician training seem to have properly and adequately increased physician

interest in primary and rural care. The factor most likely to minimize this encouraging trend is lack of the facilities necessary for the physician to effectively use this training in rural areas. The most certain way to keep physicians out of rural America is to continue the pressure and restrictions on rural hospitals. As a final comment, let me relate events in a neighboring town in Oberlin, Kans. I am not sure how familiar you are with this situation, Senator, but anyone interested in health care I think should be fairly familiar with it.

Dr. Ren Whitaker, the town's only physician, was the enthusiasm and expertise which led to the county obtaining a Federal health underserved rural areas grant in 1976. The grant's specified purposes were to improve organization and communication, and decrease duplication of records and services, among the local hospital, nursing home, physician, and public health services, all of which were to remain autonomous.

After the first year, HEW in Kansas City withheld funding and personally told Dr. Whitaker that funds would return only if all services and earnings, including his own, came under direct HEW control. Dr. Whitaker has notified his community that, rather than practice as a salaried employee of HEW, he would leave the community.

Northwest Kansas has watched with interest this experiment in local-Federal cooperation.

Senator DOLE. I am aware of that, I don't know who's working on that, maybe Mary Wheat in our office.

Dr. NEUENSCHWANDER. I thought perhaps you were but that's bothered a lot of people in western Kansas, and we are becoming leery of Federal help in our health care problems after that.

Senator DOLE. Well sometimes you are never certain whether you are getting assistance or not.

Mr. THOMAS. There was a piece, I guess this one girl said it came out in the news, she said there was a doctor in Great Bend and he was, you know—they tried to force him out with the high prices on the malpractice insurance and he refused to take it and Governor Bennett sent the State attorney general to force him by trying to threaten to sue him, that's what she got over the news, it didn't come out in the papers, because they knew I would report it. I don't approve of that malpractice insurance because it's against the Federal law. They said in the paper they wanted it out in the States, that malpractice insurance.

Senator DOLE. It's a good thing they don't have that for politicians. [Laughter.] I appreciate that, Francis, thank you very much.

[The prepared statement of Dr. Neuenschwander follows:]

STATEMENT OF DR. JOHN R. NEUENSCHWANDER

I will address the problem of physician shortage in rural areas, tracing the factors that determine a physician's choice of practice location.

First, let me state that the physician shortage in rural Kansas is exaggerated and is rapidly improving. Shortages are usually based on the figure of one family physician for every 700 or 1000 population the family physicians I know feel that one per 2000 population may be more reasonable. However, no one ratio is appropriate for all areas due to variations in age distribution, socio-economic factors, transportation, environment, and neighboring health facilities.

There is now a marked trend toward general practice. In Kansas and the Midwest, medical school classes that saw 5% or 10% of their graduates seek

general practices in the late 1960's have 40% or 50% interested today. Most of my neighboring communities in Northwest Kansas have added a new physician in the last few years or have one coming in the next year.

Still many communities in rural Kansas, and rural America, do need more physicians.

MEDICAL SCHOOL APPLICANTS

The first factor involved in preparing a physician for rural America is entering someone in medical school. There is indication that students from rural areas are most likely to return to rural areas, though the statistics are skewed by the past trent to specialization and should improve with the current return to family practice. Most medical schools, states, and localities are now encouraging rural applicants, the further federal involvement probably is not needed.

It should be noted that in past years federal guidelines have required medical schools to favor minority applicants primarily found in urban areas.

MEDICAL EDUCATION

When I was in medical school the concept of exposing students to family practice and family physicians was new. Now the University of Kansas has an active department of Family Practice and excellent out-patient rotations. The Preceptership rotation is considered by students to be the best primary care rotation and among the best of all rotations; K.U. is once again stressing this rotation, though I believe federal support for it is being withdrawn.

Medical schools should be encouraged to develop quality rotations in family practice, out-patient medicine, and rural medicine.

FAMILY PRACTICE RESIDENCIES

The solution to the rural health manpower shortage is the Family Practice residency. The physician planning a rural practice requires superior, not minimal, training. The Family Practice residency ideally addresses this need. Though Pediatric and Internal Medicine specialties serve primary care functions, they are not as likely to provide rural primary care. In a poll of the NorthWest Kansas Medical Society, 80% of the members felt any physician planning a rural practice should complete a primary care residency program.

An American Academy of Family Physicians study shows 16% of 1976 U.S. Family Practice graduates seek to practice in communities of less than 5000 population, 37% in less than 15,000. In a similar study of Iowa Family Practice residents done by my colleague Dr. Ken Olson, 54% sought communities of less than 10,000 population. Rural America can have adequate physicians if Family Practice residencies and residents have adequate support.

Recently it was proposed that all residencies be university affiliated to receive federal support. Many Family Practice residencies developed excellent programs because of, not in spite of, their lack of university affiliation. With affiliation come residents in surgery, obstetrics, cardiology, etc. who tend to take control of "complex" patients leaving the family practice resident with experience in "routine" cases only. Similarly, the family practice resident is unlikely to have good educational experiences in a large institution with other specialty programs; K.U. understands this and sends its family practice residents to work individually with some of Bethany hospital's excellent physicians. It should be understood that Family Practice presents quite unique educational requirements and may not thrive in an atmosphere of massive facilities and esoteric research. Attempts are now being made to develop a Family Practice residency in Western Kansas, and rural physicians support this.

There are several factors which determine a physician's choice of practice location:

COMMUNITY SIZE

Though small towns present the advantages of delightful people, low crime, and relaxed existence, a town can be too small. Physicians require sufficient time off for continuing education and leisure, so the day of the solo practitioner is over. Any community unable to support two or three physicians is unlikely to obtain any. If a physician plans to do no surgery or obstetrics, he may seek a community large enough to have appropriate specialists.

FINANCIAL FACTORS

Physicians in group practices seeking new members have found that potential members inquire about facilities, call, free time, educational opportunities, and then salary. *If* income were to become an important factor, rural areas would have great difficulty attracting a physician. My fellow residents who began urban practices triple my income. Still Kansas and other states have been naively developing programs hoping to financially reward or penalize new physicians into practicing in state-designed areas.

Yet in America, status seems to increase with wages. Though Medicare and Medicaid do not particularly fix rural physicians' fees below those of urban physicians, the policy of denying, delaying, and limiting fee increases tends to make traditional fee disparities permanent and inflexible. For example, Medicaid denies one physician a fee increase from $5.00 to $7.00 while paying $8.00 to another. This tends to penalize most the physician with low fees—usually rural—and the young physician who may wish to join his practice. When I joined my father's practice, Medicaid fixed my office call fee at $5.00, and I am still frozen there over 2 years later. I have written the Topeka Medicaid office about this matter, and they only reply "We cannot bring about the changes suggested in . . . your letter."

LOCAL HOSPITAL FACILITIES

I know of no family practice resident willing to begin practice without local hospital facilities. The practice of modern medicine requires these facilities. I use our hospital as my source of lab, X-ray, and EKG facilities as a well-equipped site to treat emergencies and injuries; as a stimulus and source for continuing education. There I find facilities and time to confirm or refute clinical impressions and manage complex cases. If Hoxie loses its hospital, it will lose its physicians.

Yet survival for the rural hospital seems to be a game of fitting the expenses of quality patient care between sudden costly government requirements and meager delayed government payments. Guidelines developed for 500 bed institutions are vigorously applied to 20 bed hospitals. OSHA has recently been criticized in the press for its irrational treatment of small businesses and farms; smal hospitals have suffered in silence through years of even more unreasonable regulations. Allow me a few examples:

Federal authorities demanded our one-story brick hospital install an automatic fire sprinkler system, to be contracted within 90 days—cost $35,521.03—though the greatest distance from a patient room to a building exit is 50 feet and the fire department is five blocks away. In another small hospital a steel doorframe had to be chiseled from a brick wall and reversed so that the door could not strike a surgery cart; a surgery cart was in the area less than once a week. Though patient risk was theoretically lowered in these instances, the communities' priorities for best patient care were clearly ignored.

I must drive 100 miles each month to obtain utilization and peer review from a physician not associated with my hospital practice.

It appears that the next regulations will require construction of special facilities for handicapped. Specifically, the hospital must facilitate wheelchairs with special ramps, doors, rails, pay telephones, restrooms, tables, fountains, etc. When we in clear conscience assess our communities needs, in the last 15 year we can think of no person who could have benefitted by these special facilities.

Most threatening are the multitude of proposed guidelines which would simply close some small facilities. Varying occupancy rates and "overutilization" for population are cited as condemning evidence. Predictable utilization is impossible in our hospital, but our average length of stay for most disease states is well below urban averages. If our community appears to overutilize, it is because a disproportionate number of elderly, 40% in Kansas, live in rural areas and require more care. Regardless of statistics, I cannot see how care or efficiency will improve by denying patients local care at $60,000 a day and sending them to distant hospitals charging $100.00 a day.

One proposed guideline would close obstetrical units that average less than 500 deliveries per year. In October 1977, 55 of the 57 family practice residents in Wichita stated they would not practice where they had no local obstetrical privileges.

Hoxie has a 19 bed hospital with attached 38 bed Long Term Care unit. It has had full Joint Commission on Accreditation of Hospitals approval yearly since 1968—the smallest hospital in Kansas, possibly the U.S., to be so honored. Our citizens support it vigorously with their time and money—and they must, for Medicare reimburses it only fifty cents on the dollar. These people do not deserve to have this fine facility closed.

ALLIED HEALTH PERSONNEL

Educational requirements for dieticians, lab technicians, etc, are the same for all size hospitals. Attracting these personnel and sufficient nurses is difficult for financially strapped small hospitals. Physicians Assistants and Nurse Clinicians are of immense value to the physician but cannot legally assist with the care of government-pay patients.

In summary, recent changes in physician attitudes and physician training seem to have properly and adequately increased physician interest in primary and rural care. The factor most likely to minimize this encouraging trend is lack of the facilities necessary for the physician to effectively use this training in rural areas. The most certain way to keep physicians out of rural America is to continue the pressure and restrictions on rural hospitals.

As a final comment, let me relate events in a neighboring town, Oberlin, Kansas:

Dr. Ren Whitaker, the town's only physician, was the enthusiasm and expertise which led to the county obtaining a federal Health Underserved Rural Areas grant in 1976. The grant's specified purposes were to improve organization and communication, and decrease duplication of records and services, among the local hospital, nursing home, physician, and public health services, all of which were to remain autonomous. After the first year, HEW in Kansas City withheld funding and personally told Dr. Whitaker that funds would return only if all services and earnings, including his own, came under direct HEW control. Dr. Whitaker has notified his community that, rather than practice as a salaried employee of HEW, he would leave the community.

Northwest Kansas has watched with interest this experiment in local/federal cooperation.

PHYSICIAN MANPOWER IN KANSAS

(By John Rand Neuenschwander, M.D.)

I am the son of a physician who has practiced for 20 of the last 25 years as the only M.D. in Hoxie, Kansas population 1500 and Sheridan County, population 4,000. As a child I saw rural physicians on call 24 hours a day for five years without vacation I saw some die at age 40 from the stresses of practice.

I attended the University of Kansas Medical School graduating in 1972, took an internship at Bethany Hospital in Kansas City, and completed a Family Practice Residency in Cedar Rapids, Iowa. All family practice residents were acutely aware of the medical needs of rural areas and our potential roles in meeting them. I have returned to Kansas and have for the last 2½ years been in practice with my father in Hoxie.

I have seen the medical manpower problems of rural Kansas as physician's son, patient, medical student, resident, and family physician. I am before you today to speak from this background regarding the physician manpower shortage in Kansas.

THE PROBLEM

What is the medical manpower problem in Kansas? Simply, it is that there are insufficient physicians to care for the population, and that they are distributed such that some areas are comfortable and others are desperate for care.

However, the situation is badly exaggerated. A newspaper article on the physician shortage, which boasted accurate and current data, listed my county as desperately underserved with one physician, when we have 2 M.D.s and one D.O.; I could detect similar errors in surrounding counties. Rural citizens are constantly told they are underserved, and most would be amazed to find that they spend less time obtaining medical care than their urban counterparts. If I should suffer severe injury or illness I would prefer to do it in

Western Kansas. None the less, many areas do need more medical manpower, and we are addressing this problem today. What factors are involved?

MEDICAL EDUCATION

There has recently been concern over medical school admissions policy. An often quoted study indicated that physicians rarely settle in a community smaller than their home town. This statistic is distorted because it was gathered at a time when nearly all physicians were specializing and could not possibly settle in a rural area. In my experience, many young family doctors are now seeking smaller communities, for reasons I will give later. Still, I'm sure origin is a factor. Though the number of rural applicants accepted to medical school appears small, the percentage accepted, rural versus urban, is comparable. Added to this are those rural products who are accepted with current addresses of Lawrence or Manhattan. The *need* is to *increase* the number of qualified persons *applying* from rural areas. I know of no easy way to do this, but I suspect that the recent expression of interest from K.U., in rural students and publicity regarding rural health care, will help.

The student's best exposure to primary care is the precepteeship, where he spends a month sharing the professional and social life of a rural physician. My father has been a preceptor in this program for 20 years. His experience, as well as K.U.'s surveys, show that students consider this rotation among the best, and nearly all are favorably impressed with family practice, regardless of their field of interest. About 1971, K.U. allowed the precepteeship to be in specialties and cities, such as Dermatology in Wichita. As a result, more graduates maintained erroneous concepts of rural life and practice. I will refer several times today to a poll of members of the NorthWest Kansas Medical Society, of which I am a member. 85% of the membership felt that it would be helpful for K.U. to return their precepteeship to a rural primary care experience.

The greatest factor in a physician's choice of career is societal attitudes. Ten years ago the family physician was universally accepted to be a second-class doctor. It was a status symbol to have all your care provided by "specialists." Family doctors were considered by many to be those who lacked the abilities or determination to further their education. Such attitudes were and are wrong, but we should not be surprised to learn that medical students of those times shunned family practice. Now the family physician is esteemed—every family is proud to have "their doctor" provide or guide their health care—and now, so many young doctors want family practice training that residencies are overfilled; the only residencies in the U.S. with more demand than supply. This has all happened without legislative intervention. I vividly remember my first day of medical school; my class was asked how many wanted to be family doctors, and less than 15% raised their hands; at graduation under 10% responded. That question, asked to today's classes, would see half the students reply. Some critics curse the medical school for not producing 50% family physicians from my class, conveniently ignoring the fact that 85% of the students had no interest in family practice when they entered. A state representative, in his column in my hometown paper, said "We are serving notice to the medical center that the legislature expects them to train doctors for rural Kansas, or future state support will be reduced or terminated." Such an attitude is not only naive, but counterproductive, and should be condemned.

FAMILY PRACTICE RESIDENCIES

The main component in the solution to the rural physician shortage is the family practice residency. It was born of the desire of physicians to enter a general practice with education, experience, and skills suitable to the needs of their patients. The residency helps create a physician ideally prepared for a rural practice. Though 90% of the members of NWKMS completed no residency, 80% feel that any physician seeking a rural practice should complete a primary care residency. It is ironic that this affirmation of the need for *superior* knowledge and skill in a *rural* practice should come at a time when physicians assistants are being considered to replace physicians in some communities, and many legislators are voicing more support for physicians who do not complete residencies. These residencies help prevent the sense of insecurity which drives physicians to urban practices surrounded by specialists, and provide competence in skills which the physician can ideally use in

a rural practice. Family physicians are finding city hospitals deny them the privileges of doing tonsillectomies, delivering babies, and caring for heart attacks, even if they can document training and skills in these areas. They find that their skills best correspond with the needs of a rural practice. One of my fellow residents, Dr. Ken Olson, surveyed family practice residents in the midwest U.S. and found that 16% sought to practice in communities of less than 5000 population, and 54% in less than 10,000. The American Academy of Family Physicians made a similar study of all U.S. 1976 graduates and found that 16% sought populations 5000 and less, 37% chose 15,000 or less. This trend evolves without coercion or penalties; it is a simple result of society recognizing needs and encouraging solutions. Physicians and educators feel that this trend toward rural medicine will provide adequate manpower over the next several years. Predictions of massive shortages are based on the nebulous figure of one family doctor for every 700 to 1000 population, and all family doctors I know consider that figure ridiculous, a rate of one per 2,000 or 2,500 population being more reasonable. A physician must be busy to maintain low fees and adequate knowledge. The federal government recognizes the importance of primary care residencies, and was planning on mandating quotas to attain 35% primary care residencies. That figure has already been met.

RURAL KANSAS

Small towns have much to offer the family physician: They possess the world's nicest people, and serving them is much more rewarding and less difficult. The environment is nearly free of crime, pollution, and the ratrace. Here is the last frontier, where physician is friend rather than adversary, and people ae proud and supportive of their health care facilities.

Many areas have excellent small hospitals. Hoxie has a 19 bed hospital and 38 bed long term care unit. We have physical therapy, cardiac monitors, and lab facilities including telemetry EKG, blood gasses, and Hycel profile; we are obtaining fetal monitor capabilities. Our hospital has had Joint Commission approval yearly since 1968—the smallest hospital in Kansas, possibly the U.S., to be so honored. Yet the government seems determined to destroy this facility. Standards designed and appropriate for 500 bed institutions are applied more vigorously and punitively to small hospitals. Payments are insulting: through our hospital's charges are below city levels, it receives only half payment from Medicare. The average length of stay for most disease states is well below the big hospital average, testifying to our hospital's efficiency. It's services are indispensible, to the elderly, half of which live in rural areas in Kansas.

As a final comment on hospitals, let me state that any community without good hospital facilities is very unlikely to attract or keep a physician. I can promise that if Hoxie loses its hospital, it will lose its physicians, and most physicians in my area feel similarly. This is not a threat, it is a statement of fact. It is not negotiable. The hospital provides the environment for the physician to handle complex cases, obtain special lab work, care for emergency patients, and generally keep current in medicine. It is very difficult to provide good medical care without a hospital if a community does not allow me to provide quality care, I will leave.

SCHOLARSHIPS

In Northwest Kansas, the Dane Hansen Memorial Fund provides scholarships to students in health fields who promise to return to Northwest Kansas. The legislature tried a similar program one year, had little student acceptance, and abandoned it. That year many Hansen scholarships went unaccepted also, and the selection committee and I agreed that though this gesture of good will and support for rural health practitioners was worthwhile, one cannot *buy* physicians or dentists for rural Kansas. Recently, as I predicted 2 years ago, the Hansen Fund has had more applicants than it can handle. Perhaps the legislature will wish to try again, though they can only reward, not coerce, a students decision toward rural practice.

ADMISSIONS QUOTAS

Since rural students are thought more likely to return to rural areas, a medical school admissions quota has been suggested. The most frightening

proposal would allow appointment of students from senatorial districts. Obviously, any admissions based on criteria other than ability and merit will adversely affect the excellent quality of graduates for which K.U. med school is justifiably famous. Furthermore, the graduating family physician does not need the stigma of being selected and trained for political expedience rather than accomplishments. 80% of the membership of NWKMS opposed any concept of area quotas, but 100% felt it would be helpful for K.U. to increase its recruitment activities in rural areas. Thankfully, the recent surge of interest in family practice makes any quota unlikely.

CONSCRIPTION

One of the more controversial suggestions has been a financial penalty for medical students. Most recently this has been described as increasing K.U.'s tuition from among the lowest to among the highest in the U.S., and then "forgiving" part of the tuition for graduates who practice in "deprived" areas. Described in this manner, the proposal will sound reasonable to many. Unfortunately the damage has been done—the proponents of this measure made it quite clear during its formation that it was intended to be punitive. One representative stated on television, "It is time that medical students started paying back the state for their education, either in money or in services." This is a grim precedent in Kansas education. Original estimates set the graduating student's debt at $80,000 to $100,000, more if he took a residency in Kansas. This has led many students to believe that rural Kansas is so dismal that only through conscription can necessary services be obtained; and since proponent of this measure claim massive public support, students begin to see the people of rural Kansas with alarm and contempt rather than sympathy and concern. In my experience, no such public support exists, and the concept of governmental coercion in one's occupation is incompatible with the principles of rural people. If this program were adopted now, it could not possibly produce results for 5 to 7 years, and is certain to be inappropriate by that time. 90% of the physicians in NWKMS strongly oppose this bill, many flatly stating that they want no help that is sent under duress or temporarily. Medical educators universally agree that this measure would adversely affect the quality student our schools now produce: many plan to resign if this bill passes. This concept of conscription has caused enough ill will already. It should be abandoned.

EQUAL PAY FOR EQUAL SERVICES

When I entered practice, I could set my own fees, but Medicare, Medicaid and Blue Shield *told* me what I would be paid. As I did not wish to set fees that would penalize the patients who pay their own way, my fees were in essence set by these groups. They will pay my city colleagues twice as much. Let me state that the wolf is not at my door—I am not concerned over my ability to make a living. We should all be concerned, however, that our government would state that when one serves a rural population, his services are only worth half as much. Although my county has little welfare population, I have spoken with physicians whose practices are mostly Medicare or Medicaid. Some collect only 10¢ on the dollar charges, and the state's policy of partial, delayed, and refused payment does them serious hardship and injustice. It is ironic that with all the imaginative plans to penalize or reward or manipulate physicians, the legislature has ignored the simple tradition of equal pay for equal service. 85% of NWKMS supports this concept.

RECOMMENDATIONS

Rural Communities

(1) The small community and the economy car both existed ten years ago and were largely ignored, but times have changed. At this time, unprecedented numbers of physicians in training are planning rural family practices. Communities can make their opportunities known to residencies and medical schools, and through organized meetings of students and community representatives such as Kansas Health Day.

(2) Promises of loans, guaranteed incomes, or low cost facilities are useful primarily as gestures of good will. Rural physicians are aware that they could double their incomes in urban practices.

(3) A physician is unlikely to settle in a community which cannot offer the support of a local hospital, proper lab facilities, adequate nursing and paramedical personnel, and other physicians to share responsibilities and problems. The day of the solo physician in an isolated office is past.

(4) Rural youths should be encouraged to seek careers in medicine. At this time, their background will be a favorable influence on admissions committees.

Medical Schools

(1) Consider an applicant's background, origin, and practice intentions when selecting students. Strict quotas should not be used.

(2) Provide students with exposure to family practice and primary care physicians during their education. Preceptorship.

(3) Support and encourage family practice residencies. Assure that residents have productive experiences on Surgery, OB/GYN, Pediatrics, and other rotations. If the resident is continuously a low teaching priority at large institutions, better educational opportunities should be found elsewhere.

Kansas Legislature

With the resurgence of interest in Family Practice and the recent increase in physicians seeking rural practice, little legislation is needed, and radical legislation is likely to be counterproductive.

(1) Scholarships to physicians seeking practices in deprived areas may help, but will tend to reward rather than influence their decisions.

(2) As Family Practice residencies are the key to solving the Kansas physician shortage, they must be adequately supported. Residencies based in smaller institutions, with rural exposure and few competing specialty programs, have better reputations for quality primary care education than do programs in large urban teaching institutions. There are indications that residents are likely to practice near their training programs. A Family Practice residency in Western Kansas should be ideal.

(3) Encourage Medicare, Medicaid, and insurance companies to cease payment practices that punish physicians who serve rural or deprived areas, and needy or elderly populations.

(4) The plan to make medical education expensive to those who resist legislative dicta has already driven wedges between medical students and medically underserved communities. It should be abandoned. Conscientious, concerned health care cannot be obtained through coercion.

(5) The heated political rhetoric surrounding Kansas health care has had many unfortunate consequences. We are told through the press than K.U. is insensitive and self-serving, and requires legislative control. That medical students are lazy, ungrateful, and respond best to threats or bribery. That physicians consider profit more important than facilities, community, or practice opportunities. The traditional warm doctor/patient relationship is suffering under this barrage. The health needs of Kansas will be better met through a spirit of cooperation and understanding than through animosity and mudslinging. The legislature's success in improving health care in Kansas will not be measured by the number of radical bills hastily passed.

Let me close with a medical metaphor:

There is no cancer of our health care status. It has a flu--possibly a swine flu—and shows all indications of gradual recovery through its own natural defenses. Physicians, relatives, and friends have all expressed concern; their gentle support is appreciated. The learned physician knows that some illnesses cannot be boldly cured, and that radical therapy is of greater risk than careful observation and supportive measures.

There are those among us, however, who insist that a swift and glamorous cure must be found that the patient cannot improve without their grand intervention. These are the quacks. Their desire to gain profit or fame at the patient's expense is contemptible. Had their suggestions been accepted two years ago, they would now be claiming credit for the patient's improved condition.

In seeking solutions to our health care problems, let us be guided by the traditional principle of medicine: Primum Non Nocere; First Do No Harm.

Preference Of Community Size And Location Of Iowa Family Practice Residents[1]

(By Kenneth R. Olson, M.D., Third Year Resident, Cedar Rapids Family Practice Residency Program)

RESEARCH PROJECT BY
DR. KENNETH OLSON, RIII

# of Residents Responding		% of Residents Responding Totally of 76
1st Yr.	27	
2nd Yr.	19	68%
3rd Yr.	5	

Home State		% of Residents Residing in Each State	
Iowa	25	Iowa	48%
Illinois	5	Illinois	9%
Kansas	6	Kansas	11%
Virginia	1	Virginia	1.9%
Nebraska	2	Nebraska	3.8%
Wisconsin	2	Wisconsin	3.8%
Texas	1	Texas	1.9%
Minnesota	1	Minnesota	1.9%
Michigan	1	Michigan	1.9%
Ohio	2	Ohio	3.8%
Mississippi	1	Mississippi	1.9%
South Dakota	1	South Dakota	1.9%
Florida	1	Florida	1.9%
Connecticut	1	Connecticut	1.9%
California	1	California	1.9%

Preferred Size of Community		Yr. of Training			Native	% of Preferred Size of Community				Native
First Choice	All	1st	2nd	3rd	Ia.	All	1st	2nd	3rd	Ia.
< 5,000	8	5	1	2	3	16%	19%	5%	40%	12%
5-10,000	19	8	9	1	10	38.5%	30%	50%	20%	41%
10-20,000	10	3	6	1	4	20.2%	11%	33%	20%	16%
20-50,000	9	8	1	0	5	18.3%	30%	5%		20%
> 50,000	4	2	1	1	2	8.6%	7%	5%	20%	8%
TOTAL	50	26	18	5	24					
Second Choice	All	1st	2nd	3rd	Ia.	All	1st	2nd	3rd	Ia.
< 5,000	10	5	5	0	7	24%	26%	31%		36%
5-10,000	12	3	6	3	5	29%	15%	37%	60%	26%
10-20,000	9	4	3	1	3	21%	21%	18%	20%	15%
20-50,000	4	2	1	1	1	9%	10%	6%	20%	5%
> 50,000	6	5	1	0	3	14%	26%	6%		15%
TOTAL	41	19	16	5	19					
Third Choice	All	1st	2nd	3rd	Ia.	All	1st	2nd	3rd	Ia.
< 5,000	7	2	4	1	2	17%	10%	22%	20%	10%
5-10,000	1	1	0	0	0	2%	5%			
10-20,000	24	13	8	3	12	58%	68%	44%	60%	63%
20-50,000	7	1	6	1	4	17%	5%	33%	20%	21%
> 50,000	2	2	0	0	1	4%	10%			5%
TOTAL	41	19	18	5	19					

[1] For use in academic year 1974 75.

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Preferred Size of Community Cont'd	Yr. of Training				Native	% of Preferred Size of Community				Native
Fourth Choice	All	1st	2nd	3rd	Ia.	All	1st	2nd	3rd	Ia.
< 5,000	4	0	2	1	3	10%		16%	20%	15%
5-10,000	10	7	2	1	4	27%	38%	16%	20%	21%
10-20,000	1	1	0	0	1	2%	5%			5%
20-50,000	21	9	7	3	11	56%	50%	58%	60%	57%
> 50,000	2	1	1	0	0	5%	5%	8%		
TOTAL	37	18	12	5	19					
Fifth Choice	All	1st	2nd	3rd	Ia.	All	1st	2nd	3rd	Ia.
< 5,000	11	7	3	1	4	28%	38%	21%	20%	21%
5-10,000	1	1	0	0	1	2%	5%			5%
10-20,000	0	0	0	0	0					
20-50,000	0	0	0	0	0					
> 50,000	26	10	11	4	14	68%	55%	78%	80%	73%
TOTAL	38	18	14	5	19					
Undetermined	2	1	1	0	1					

Geographic Area of Preference	All	Yr. of Training 1st	2nd	3rd	Native Ia.	All	Yr. of Training 1st	2nd	3rd	Native Ia.
Iowa	21	13	5	1	17	40%	48%	29%	20%	68%
Midwest	20	8	9	4	4	38%	29%	47%	80%	16%
Other	4	2	2	0	2	7%	7%	10%		8%
Undetermined	7	4	3	0	2	13%	14%	15%		8%
TOTAL	52	27	19	5	25					

Preference of Residents From Other States	All	%
Iowa	3	11%
Midwest	17	62%
Other	2	7%
Undertermined	5	18%
TOTAL	27	

ABSTRACT

A survey of all Family Practice residents in the State of Iowa during the 1974–1975 academic year was undertaken to determine their practice preference as to community size and state.

The results indicate 74% of those responding desire communities of less than 20,000 population, 78% prefer the Midwest as a place to practice and 40% prefer Iowa specifically.

Materials and methods

A questionnaire was sent to all Family Practice residents in the State of Iowa (totalling 76), asking for the following information:

(1) Current year of residency.
(2) Home state.
(3) Community size of practice intention (Rank 1-5) 5,000, 5-10,000, 10-20,000, 20-50,000, and 50,000.
(4) Areas in which you will settle: (a) Iowa, (b) Midwest, and (c) other.

The replies were tabulated as follows:

1 Numbers and percent of total from each training year were calculated,
2 The percent reply from the named, home states of residence was tabulated,
3 Preference of community size with choices ranked 1-5 was counted initially with all resident groups lumped together. This was then further divided to delineate resident training year and finally, included just those who listed their home state as Iowa.
4 Figures from the geographic area of preference were calculated all together and then divided as to year of training and also those residents from the State of Iowa.

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5 Finally, the area preference from those residents who listed their home state as other than Iowa was figured.

Results

Seventy-six questionnaires were mailed out and 52 replies were received for a return of 68%.

The largest single home state represented was Iowa at 48% and not surprisingly, 85.1% of the replies received came from Midwest-raised physicians including Iowa.

Size preference

Respondents were asked to rank their preference of community size from a 1-5 choice. All indicated a first choice (52), however, only 41 respondents actually ranked 1-5. First choice by far was population between 5-10,000 (38%); second choice was a tie between less than 5,000 and 5-10,000 (24 & 29%); third preference was towns of between 10,000 and 20,000 (58%); fourth choice was 20,000-50,000 (56%), and fifth choice were towns greater than 5,000 (68%).

Geographic area of preference

Of the 52 respondents, 40% chose Iowa as an intended state of practice. Thirty-eight percent preferred the Midwest category excluding Iowa. Residents whose home states were other than Iowa, preferred the Midwest (52%) choice rather than Iowa specifically.

Conclusions

State—Most of the residents taking Family Practice residencies in Iowa were from Iowa (48%). Including Iowa, 85% were from the Midwest.

Size—Towns with less than 10,000 population appeared to have more appeal for most residents (54%), while larger communities especially those greater than 50,000 had the least attraction (8%). Third year residents (60%) seemed to favor small communities more than those in their first year of residency (40%).

Area—A majority of those responding (78%) wish to stay in Iowa and the neighboring Midwest.

Summary

There seems to be a definite preference for smaller, rural communities in Iowa and the Midwest by physicians in Family Practice training programs.

The information obtained from this survey is a hopeful sign to the many towns who are sorely in need of medical manpower.

Addendum

As of December, 1975, there will be nine graduated of three year Iowa Family Practice training programs. Of these two, one is serving his obligated military time and another has elected one year of further surgical training. (These two graduates were excluded from the following statistics).

	Number	Percent
Size preference:		
Less than 5,000	2	29
5,000 to 10,000	1	14
10,000 to 20,000	2	29
20,000 to 50,000	0	0
Greater than 50,000	2	29
Geographic area of preference:		
Iowa	3	43
Midwest	3	43
Other	1	14

Conclusions

Overall, 72% chose to practice in towns of 20,000 or less. Eighty-six percent decided to remain in the Midwest including Iowa, while 43% specifically chose Iowa.

These final statistics correlate well with the initial survey.

HOXIE, KANS., *December 3, 1977*

BOB FITCH, M.D.,
Medical Director
Medical Services Section, SRS, State Office Bldg., Topeka, Kans.

Dear Dr. Fitch: We met at the Physician Manpower symposium in Topeka one month ago. At that time, I made a statement in my presentation that Medicare and Medicaid had a policy of paying rural physicians less than urban physicians, and you asked me to draft a written explanation of that statement. I have delayed this response in order to better assess the feelings of my peers in this matter.

As nearly as I can determine, I owe you an apology. I am now convinced that there is no official or statutory policy to discriminate against rural physicians. Many rural physicians feel there is such policy, however, and perhaps that merits your attention. From my inquiries, I estimate that one third of rural physicians at least believe there is no *practical* way for rural M.D.'s to be reimbursed at the level of urban M.D.'s.

I have spoken with physicians who state that, when a new doctor joined their practices, he was reimbursed by Medicaid fully for his charges, and above their current reimbursement. However, when I joined my father's practice in July 1975, we were told in a phone call to the Topeka Medicare/Medicaid office that under no circumstances could I be reimbursed above my father's current level; and furthermore, we could have no increase allowed until after a full "fiscal" period. Therefore, our fees did not change immediately and now, 2½ years later. I am still reimbursed only $5.00 for an office call. Thus my original statement at the symposium was based on other physicians' opinions and supported by my personal experience.

Because I may be called to explain my position to legislators, I would appreciate some information on Medicaid reimbursement policies. Could you permit me answers to the following?:

(1) What is the highest office call fee paid for a northwest Kansas family physician? What is the highest for a similar Kansas City physician? If there is a difference, why?

(2) What is the maximum office fee I could have been paid in July 1975 in Hoxie, Kansas? In Kansas City? If different, why? Had I set an $8.00 fee in either location, would I have been paid the same?

(3) Why, after 2½ years in practice, am I reimbursed only $5.00 for an office call?

Anticipating some of your answers, please allow me this opportunity to make suggestions.

It is a frequent observation that, where physicians are plentiful and underworked, fees tend to be higher. A less appreciated corollary is that where physicians are overworked, fees are lower. A harried rural physician is the most likely to have low fees. When his community adds a physician, it is likely that all local fees will need to increase. That is unfortunate, but is the price a community pays for better availability and quality of care.

I stated previously that there is no practical way for a rural physician to be reimbursed as well as his urban counterpart. When he begins practice, he cannot set fees far above other area doctors or to "city" levels. When in future years he requests higher fees, though still below urban reimbursement levels, Medicaid refuses an increase for several years. Thus the rural physician's reimbursement is constantly held below urban levels merely because he previously charged less. I am not convinced that the legislature intended Medicare policy to make traditional fee disparities permanent and inflexible.

I suggest that physicians' fee increases be honored immediately, at least up to any fiscally necessary maximum. Many rural physicians are currently "frozen" at $5.00 at the time some urban physicians, I suspect, are receiving twice that. At least, when a new physician enters a rural area, I request that you allow his fees and increases, and those of his partners or local colleagues, to be honored more expeditiously for the first several years.

I hope we can agree on the impropriety of paying an $8.00 fee with one hand while denying an increase from $5.00 to $7.00 with the other.

Sincerely,

JOHN RAND NEUENSCHWANDER, M.D.

STATE OF KANSAS,
STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES,
TOPEKA, KANS., *December 21, 1977.*

Re: Reimbursement by Medicaid for Medical Services Delivered.
JOHN R. NEUENSCHWANDER, M.D.,
Hoxie, Kans.

DEAR DR. NEUENSCHWANDER: I am writing this letter in response to your letter of December 3, 1977, after having studied and thought a great deal about your letter and after considerable reinvestigation of the regulations and policies and procedures involved in the State Medical Assistance Plan.

There is no statutory or either official or unofficial policy in the Medical Services Section of Social Services of the Kansas State Department of Social and Rehabilitation Services or Medicaid offices at any level to pay urban doctors higher fees than rural doctors. Reimbursement to urban doctors is probably higher at times because, having been one myself almost 15 years and thus having real empathy with the feelings you are expressing, the general practitioner, family, small town physician, in general seems to give more services for less money.

The enclosure, "Medicare", explains the procedures for determining fees paid under that program. Fees paid under the Medicaid Program are determined in the same way. Even working within the "system" I do not feel that the enclosure explains the method too well. I will try to explain more clearly. If there were 101 doctors in the state doing appendectomies and they all used as their "customary and usual charges" fees somewhere between $200 and $300, with 50 of the doctors charging anything between $200 and $274, and 50 doctors remaining charging $276 and $300, and one doctor charging $275, the 50th percentile of all these charges would be the charge of $275. Then for the 101 doctors the fee paid by Medicaid for the appendectomy would be at the 50th percentile (not average or mean) or $275 or their "customary and usual charge", whichever is the lesser.

When you arrived at your father's office you were "stuck" with the "usual and customary" in that office. I do not know who advised you how you could go about increasing the Medicaid rates at which you could be reimbursed, but they apparently did not give you the complete story. It is true you must, over the course of the year, use a higher charge ($8, $10, $15) for office calls and other services furnished before you can have established a "new customary and usual charge" history. In addition, if your year with new "customary and usual charges" is completed for 4, 5, and 6 months, etc., prior to July 1, you will not immediately have any increase in fees paid to you under Medicaid. The higher fee you will be paid will begin on July 1 which is the beginning of the state fiscal year. Your new higher charge will be compared with the charges of *all* physicians, northwest, southwest, Johnson County, et al in the whole state. Then you will be eligible to be paid a fee at the 50th percentile of all charges throughout the state (for the same service) or your "usual and customary charge"' whichever is lesser. To repeat, fees you are paid according to this system will begin on the July 1 following the year that you have been using higher charges for your services. I am sorry any previous information furnished you was incorrect and/or incomplete, but we can do nothing about it according to the federal regulations with which we must comply to assure the state's continued receiving of federal funds essential to the continuity and scope of the state Medical Assistance Program. This letter so far has been an attempt to answer the third of your specifically numbered three questions.

Answers to your first two questions are also contained in the information furnished in this letter above. A northwest Kansas physician and a Kansas City, Kansas, physician will be paid the same fee, at the 50th percentile or his "customary and usual fee", whichever is lesser; the maximum office fee which you can establish in Hoxie and/or anywhere else in Kansas is no difference again, the 50th percentile or your customary and usual fee, whichever is lesser.

Examples of maximum fees you can be reimbursed by Medicaid through the Blue Cross-Blue Shield fiscal agent are given below with amounts, code numbers, and descriptions of variations in services furnished; this informa-

tion may also help you understand, not necessarily like or agree with, when you may hear about someone being paid $8 for a service and another being denied an increase from $5 to $7 for the same service (if one can be certain the services are the same). Examples are as follows:

Amount	Code	Service furnished
$10.00	0001	Initial office visit, new patient, or new illness.
3.00	0002	Brief office visit (blood pressure, ear wash, pulse check, etc.)
8.00	0004	Standard office visit.
10.00	0005	Intermediate office visit (more than 15 min and up to 30 min of direct professional attendance. Length of time with patient must be shown on claim.)
10.00	0006	Extended office visit (more than 30 min of direct professional attendance. Length of time with patient must be shown on claim.)
10.00	0007	In office reexamination or reevaluation (established patient) or routine physician—(new or established patient).
20.00	0008	Complete diagnostic history and physical exam.
10.50	0010	Initial home visit, new patient, or new illness.
7.00	0013	Home visit each additional member of same household.
10.00	0014	Standard home visit (follow up).
15.00	0015	Intermediate home visit (more than 15 min and up to 30 min of direct professional attendance. Length of time with patient must be shown on claim.)
10.00	0016	Extended home visit (more than 30 min of direct professional attendance. Length of time with patient must be shown on claim.)
12.00	0073	Night home visit.

These examples may give you some assistance in constructing a new schedule of charges for your services.

We cannot bring about the changes suggested in the last paragraph of your letter. We can only add your complaints and concerns to those of many others and use them collectively to negotiate with state legislators and representatives of the Department of HEW to try to affect changes in the regulations so that medical providers can be satisfied as much as possible and the patients/recipients be furnished with as many needed services as possible considering the skyrocketing costs of the Medical Assistance Plan and resultant cost containment demands and legislative budgetary limitations at the same time.

I am certain I have not given you completely satisfactory or acceptable answers but I am certain my remarks are accurate. I sincerely hope the information has been helpful to you and will be helpful to you in the future. If any of the information or the examples I have given need further clarification, please feel free to communicate with me further or to call me at 913-296-3981.

Sincerely yours,

ROBERT E. FITCH, M.D.,
Coordinator of Hospital and Related Medical Services,
Medical Services Section.

MEDICARE,
Topeka, Kans., July 1, 1977

To: Kansas Medicare Part B Professional Providers.
From: Professional Records and Review Department.
Subject: Changes in Medicare Part B Payments.

The 1978 Medicare Part B Fee Screen Year recomputation of charges to be used for payment guidelines has just been completed.

WHEN EFFECTIVE

Medicare claims *received* and processed July 1, 1977 or later will be processed under the new payment guidelines.

HOW CUSTOMARY CHARGES WERE COMPUTED

Individual customary charges were computed as follows—

Medians (midpoints) of your professional charges for given procedures performed during 1976 were used to establish "customary charges" for each service performed a minimum of 8 times if 2 charges were the same or 4 times if none of the charges were the same.

For example, if Provider X developed a "customary" charge for "code XXXX" of $6.00, this is how that "customary" charge was determined—

Provider X performed "Procedure XXXX" ten times during 1976 with charges as follows: $5.00 was billed 4 times; 6.00 was billed 3 times; and 7.00 was billed 3 times.

When the above charges are arrayed, they look like this:

	$5.00
(One half of the services at *or below*)	5.00
	5.00
	5.00
	6.00
	Median (midpoint) of charges for "code XXXX" in 1976
	6.00
(One half of the services at *or above*)	6.00
	7.00
	7.00
	7.00

The Medicare "customary" charge is, therefore, computed to be $6.00.

HOW MEDICARE PART B MAXIMUM ALLOWANCES WERE THEN DETERMINED

1. Each provider's 1976 "customary" charge *and* the number of times he performed that procedure were used to develop the prevailing range of actual professional charges for each professional service. The *75th Percentile* of all these charges was then identified.

2. An "Economic *Index* Factor" of 1.357 was then added to each procedure's 75th Percentile of prevailing charges which were in effect beginning July 1, 1972, through June 30, 1973 (Fiscal Year 1973). 1.357 appears to be the *general* national increase in medical charges for the period 1971 through 1976.

3. The lesser amount of #1 or #2, above, or the actual charge made is the new Medicare Part B maximum allowance for claims received on and after July 1, 1977. An exception to using #1 or #2 would be the application of the no-rollback provision which provides that no prevailing charges for fee screen 1977 and subsequent years can be reduced below fiscal year 1975 prevailing charges by application of the economic index.

EXAMPLES OF HOW THIS WORKS

	1	2	3	4	5
Procedure code	Medicare's fiscal year 1975 75th percentile	New 75th percentile based on 1976 charges	Base year 75th percentile in effect fiscal year 1973 (1971 charges)	Economic index column No. 3 plus 1.357	New fiscal year 1978 medicare maximum
XXXX	$12.00	$15.00	$12.00	$16.30	$15.00
ZZZZ	5.75	7.50	5.00	6.80	6.80
YYYY	15.00	16.00	10.00	13.60	15.00

For Procedure XXXX the new actual 75th Percentile (Column 2) is the Medicare maximum because it is less than 1.357 of the 1973 Fiscal Year Prevailing 75th Percentile (Column 4).

For Procedure ZZZZ the Medicare maximum is 1.357 of the 1973 Fiscal Year 75th Percentile (Column 4) because that figure is below the amount in Column 2.

For Procedure YYYY the 1978 FSY—maximum is the FY 1975 prevailing because of the application of the no-rollback provision (Column 1).

STATEMENT OF DR. TOM TAYLOR, SALINAS, KANS.

Dr. TAYLOR. Senator Dole, I have one comment I would like to make. It seems to me if we are really interested in cost containment in the health care field, that one of the things we must do is to put

a cost of implementation by the provider, whether that be in the private sector or in the public sector as part of the rule or regulations handed down. For example, if the Department of HEW says that this hospital or this unit must provide this service, then it's going to cost you so many dollars to do it, you see. I understand that there's been two studies done during the past 2 or 3 years which indicate that somewhere between $36 and $40 a day of each hospital bed pertains to some regulation provided by some unit of government, whether that be the local or State or Federal. And if they are really going to control costs, you have got to control the thing that produces the cost.

Senator DOLE. That's sort of like one of the other witnesses called it a blizzard of regulations I guess.

Dr. TAYLOR. I pursued this about a year ago and I found out that Congress is doing this through the Office of Management and Budget, but it's only being done for the agency they are putting a cost for the department for implementation, but they didn't put down the cost for particular providers.

For example, and I am not sure you are even aware of this, IRS came out with a new regulation effective the first of January 1978, which basically states that a person who builds a new home is not allowed to write off interim financing. That's effectively raised the cost of that house somewhere in the neighborhood of 9 percent after the first of the year. We see this all the time in the health care field.

Senator DOLE. That was a regulation or a law?

Dr. TAYLOR. They passed a regulation effective the first of January of this year.

Senator DOLE. I am not aware of that at all.

Dr. TAYLOR. We see it all the time in the health care field and we are being blamed for the high cost of health care, and we have to meet the standards of somebody else. I happen to be building and found this out—[laughter.]

Senator DOLE. Excuse me, what did you say?

Dr. TAYLOR. I happen to be building and found this out accidentally from my CPA.

Senator DOLE. I think the GOA study may address the very thing you mentioned—we have asked for that specifically in the letter that I signed with Senator Talmadge and Senator Nunn. I will send you a copy of that letter.

Dr. TAYLOR. I appreciate it.

Senator DOLE. Dr. Chaney?

STATEMENET OF DR. E. J. CHANEY, BELLEVILLE, KANS.

Dr. CHANEY. Senator Dole, I am Ernie Chaney from Belleville, Kans., and I appreciate the opportunity to visit with you. I would have a couple of suggestion since we're pressed with time, I'm going to summarize this four and a half pages that you already have.

Senator DOLE. I read it on the way over and I think it's very good.

Dr. CHANEY. Secondly if you're really pressed for time and don't mind getting in a small Kansas made aircraft, I'll fly you to Topeka. [Laughter.]

Senator DOLE. Well it's so far from the airport to where I'm going that——

Dr. CHANEY [interrupting]. There's no bears in the air. I do appreciate the opportunity to be with you, there seems to have been a lot of publications made about rural health problems, but most of the people that published these things either live in Kansas City, New York City, or Washington, D.C. It's interesting and enlightening that you bring your committee's actual investigation to where rural health care is actually delivered. That's refreshing.

I'm going to summarize this as most of it has really been said in bits and pieces by everybody here but I would make a comment that I happen to practice in a 46-bed hospital with a 49-bed long-term care attached, and I'm on the board of trustees of that hospital, and it cost us $60,000 a month because of medicare's inability to cost equate and cost account. For 20 years I worked with Curt Erickson and this is probably the first time we have agreed on anything. So that's quite something.

I would suggest to you as legislator the thing that you could most singularly do that would help us in rural America deliver heath care is repeal Pub. L. 93-641. I don't believe it is helpful at all, I worked on voluntary health planning, I worked for bureaucrats in new health planning system agency and I find it cost us nothing but money. Our health system agency is run by dedicated people but it still has a cost of a $130,000 budget and I haven't seen anything come of it at all, except in building our new addition of about 6 or 8 months which has cost us several hundred thousand dollars in costs of waiting.

I do have some things that I think that are of some concern to me. I didn't mention in my printed material anything about PA's and I have had a friend say that I probably have some concern about that.

Senator DOLE. I was going to ask you about that.

Dr. CHANEY. I do have great concerns about it, and I think my concerns are the quality of care should be the first thing we are concerned about. I'm sure a Senator doesn't want to wait to drive 45 minutes or an hour if his wife is going to have a baby, and I don't think they want to go that far to a coronary care unit. I was a corpsman in the Navy for 2 years and I don't want my family taken care of by corpsmen. I think it's perfectly okay if you have direct visualization. I have physician's assistants in my office, they are called nurses, and they give shots and they take out stitches, and I am there. And I see people come to my office and they want to see the doctor. I have to spend a little extra time to see them, but I at least see them a little bit at a time. So I think we have to be very careful that we don't relegate the care of people in the rural America to people who are poorly trained. If you're going to train people for 2 years to do semigood medicine, why not train them another 3 or 4 years and make them physicians. That would save you money in the long run I believe. No one's addressed the

problem of medical malpractice insurance rates, which has increased about 500 percent of my practice. I do the whole concept of family practice, the skin and its contents, surgery and everything, and our cost rates have gone up tremendously. The only thing I ask you as a legislator is don't mess with it. I think we will solve it, but if the Government gets into it we will never solve it. [Laughter.]

I think the student problem is important. I don't want to say that you haven't done anything as a legislator, because you have done a great deal, the Hill-Burton Act was a great thing. Many communities have rural hospitals because of Hill-Burton and without rural hospitals we won't have physicians practicing in rural areas, so I think that's very important. The law that funded money directly into family practice was a good law, I don't know the Senate name for it, but it was an educational law that funded money into family practice. I suggest to you that you continue with that, and that you be more specific and say, "family practice." I have some problems with primary care in my area. Primary care physicians according to some definitions is an obstetrician. An obstetrician in my town, when a farmer puts his foot into a tractor, is not going to be worth a darn. So I think in rural areas you need to concentrate on family practice and I would suggest that those residencies be funded and that you should try to train family practice in the community hospitals as we are trying to do in Kansas and many other States have done.

That's briefly what I have to say, thank you, Senator, for listening.

[The prepared statement of Dr. Chaney follows:]

STATEMENT OF DR. E. J. CHANEY

Senator Dole, and members of the Senate Finance Health Subcommittee, I want to express my appreciation for the opportunity to present some of my views on the subject of Rural Health Care Delivery.

A great deal has been written in both the public press and in professional publications regarding problems in Rural Health Care. However, it seems that the vast majority of those individuals writing about this subject reside in either Chicago, New York City, or Washington, D.C. It is extremely refreshing and very encouraging to have this committee seek views and comments by individuals who reside where the Rural Health Care is actually delivered. I've had the honor, responsibility and privilege of delivering health care as a Family Physician in a town of 3,300, in a county of approximately 9,000 with a drawing area of some 12,000 to 15,000 for the past twenty (20) years. I have practiced in a Community Hospital of 46 beds, with a Nursing Home attached with an additional 49 beds. My practice includes the broad concept of Family Practice, including Orthopedics, Geriatrics, Obstetrics, Pediatrics, Internal Medicine, Surgery, and Anesthesiology. I also have the responsibility of being on the Board of Trustees of our Community Hospital. I have had the opportunity and responsibility for the training of Family Practice Residents from the Wesley Family Practice Program in Wichita for the past seven (7) years.

A great deal has been written, read and said about the crisis in health care. A recent study by the University of Chicago, indicates that, although 60% of the people believe that there may be some crisis in health care, 80% of those have no problems themselves.

I don't mean to imply that there are not some problems in rural medicine and delivery of health care, or that we in rural areas do not have some difficulties. However, if I were asked to name the single, most important problem that we in rural medicine encounter, the answer would be, without a shadow of a doubt, that our biggest problem is the Federal Government. I would like to give you some examples of the difficulties that we encounter because of the

Federal Government's rules, regulations and bureaucratic misconceptions. I'd like to preface these examples by noting that the rural hospital is the basis center from which rural health care is delivered and that without rural hospitals, the delivery of health care can scarcely be considered.

A recent survey done on Family Practice Residents would indicate that 96% of those individuals trained in Family Practice would not practice in an area unless facilities for delivery of babies is available to them, and unless hospital privileges are available. Rural hospitals have had a great deal of difficulty existing because of Government rules, regulations, requirements, and red tape that are primarily designed for large metropolitan hospitals.

As an example in 1974 The Congress enacted the National Health Planning & Resources Development Act, Public Law 93-641. Obstensibly, this was a bill which was designed to try to hold down the cost of health care by avoiding duplications of services. Prior to this time, it was my responsibility to serve on a voluntary Health Planning Committee, which cost the Federal Government almost nothing. Our meetings ran efficiently and at no time during that period did we have any meetings called because of a lack of a quorum. However, at the advent of Public Law 93-641, the Bureaucratic Management moved in. We have established Health System Agencies and in the last year and since the Health System Agency has been in full affect, we have had two meetings cancelled because of a lack of a quorum, both of which were a direct result of bureaucratic mismanagement. The funding for that one health system agency is some $180,000.00, and in the opinion of most of us serving in that agency, we have seen no advantage, help or aid from such an organization.

I am sure that you are all aware that the Secretary of Health Education and Welfare has issued certain guidelines for hospitals to abide by under Public Law 93-641. Included in this ridiculous document were guidelines for the number of beds, occupancy, number of deliveries, etc. These particular guidelines, if fulfilled, would close 90% of the hospitals in Kansas. The guidelines, as far as deliveries of babies, would leave only two hospitals in the State of Kansas open. The guidelines for percentage of occupancy would probably close all but one or two of the rural hospitals.

These guidelines, in addition to showing a shocking lack of knowledge concerning rural hospital and rural health care delivery, also show a basic lack of concern for the health care of people outside the Metropolitan areas. I would suggest to you as legislators that the prompt repeal of Public Law 93-641, could possibly be the single, most important thing that you can do to improve the quality and delivery of rural health care.

A second example that I wish to bring to your attention is a problem regarding the Nursing Home or Long Term Care facilities which are built in association with acute hospitals. This idea was originally conceived in order to utilize the facilities in both the hospital and Nursing Home more economically and efficiently. However, the government accounting offices have interpreted certain rules and regulations regarding cost accounting, that results in a tremendous burden on rural hospitals and rural taxpayers. There is at least one rural hospital which has been forced to close their Nursing Home, in order to keep their attached acute hospital fiscally sound. It has been estimated that the average cost of this type of inequitable cost accounting amouns to $60,000.00 annually to each of these institutions.

I would suggest to you legislators a very prompt, thorough, and extensive study of this situation, because if this type of inequity is allowed to exist, many rural hospitals will no longer be able to continue to survive.

The rising cost of health care is of concern to you, and of course, concern to medicine also. However, I don't believe that hospitals and medicine in general can be blamed for the active amount of rising health care cost, as some people would suggest. Our economy with its tremendous inflationary cost has raised the cost of hospital care. Technology which has produced marvelous instruments for the diagnosis and treatment of human disease has raised the cost of medicine. Just recently the Federal Government in its compulsory minimum wage law has raised the cost of medicine considerably. As an example, our small hospital employees around 140 people, and the 35 cent an hour raise that went into affect in January, which of course, must be reflected in all wage earners salaries, has cost our hospital around $6,000.00 monthly. This cost has to be recouped someplace, and will be reflected in increasing room charges.

I would not want to leave you with the impression that the Government has not done some things which have been helpful and of assistance to rural health

care. The Hill Burton Act allowed many rural communities to acquire hospitals which have enticed physicians to practice in that area and increased the overall health care in rural areas.

The Health Professions Education-Assistant Act, which has funnelled federal monies into training programs for Family Practice Residency, has been a great and useful tool in attempting to educate and train medical students in the specialty of Family Practice. I would encourage and suggest that this be explicitly designated for Family Practice Residency Training Programs.

Rather than be all negative and put forth no solutions, I would have a few suggestions that might be applicable to improving rural health care.

I would suggest that perhaps some type of *rural* renewal program, akin to the urban renewal program be considered. It has been done somewhat in recreational grants and loans and I believe that other types or development for rural communities would be most helpful in enticing physicians and other personnel to rural areas. The possibility of some type of tax advantage for those individuals who practice in underserved rural areas would, I believe, be of enticement to Physicians to practice in these areas. Federally funded student loans, either foreign or paid back at minimum rates by individuals who practice in rural areas, is another area that should be investigated. The use of better education in rural areas by a closed circuit TV to Medical Centers, the availability of transportation suc has the Military Aid to Safety and Traffic, are areas which should be expanded, and this may help in recruitment of physicians to rural and underserved areas.

I once again want to take this opportunity to thank your committee for the privilege of expressing some thoughts gleaned from 20 years of delivery of medicine in the rural area.

Senator DOLE. I was going to ask a question about how do you view the use of nurse practitioners and physician assistants in rural areas. Is that pretty much the view of the whole panel, or is that just Dr. Chaney's view?

Dr. TAYLOR. I agree with that 100 percent that they have to have, well, direct supervision—well I'm not gong to use the word "direct" because that connotation means you have to be in there when they're doing whatever they are doing, but requires real close supervision.

Dr. CHANEY. I think you will find out. I think if you don't you will find out what we also have with nurse anesthetists. I also give anesthesia. I have no quarrel with nurse anesthetists, some of them are very good, but they should be supervised because that's the practice of medicine. Right now nurse anesthetists are beginning to say, you know, I really know as much as doctors about putting people to sleep, so I want to be licensed, so I can carry my practice out independently. I think physician assistants, physician extenders, whatever you want to call them soon are going to say I want to be licensed so I can practice medicine. I think that's very important that we do not allow licensry but keep them certified and keep them observed. I think they are fine if they are observed carefully. I don't think they should be paid directly, I think they should be salaried by the physician that employs them.

Senator DOLE. Is there any direct interest or any grassroots interest in health planning?

Dr. CHANEY. I think there was some involuntary health planning, we have had voluntary health planning in our area for the past 7 years. We had meetings all the time, everything went smooth; since the bureaucrats came in, we have had three or four meetings that were called because of a lack of quorum. The voting has been messed up, voluntary health planning I think is good. Whenever you start from the top and filter down it loses its effectiveness.

Senator DOLE. That's about the same reaction, John——

Dr. NEUENSCHWANDER [interrupting]. I think you should be aware of some of the things we see coming in health planning are causing a lot of competition and animosity among hospitals that used to communicate very well and cooperate very well. We now see, oh, publicity fights and such as this because the hospitals are getting the idea that the one that appears in the paper the most has the most nice things said about it, or can suddenly get the most facilities is going to be the only one allowed to stay in western Kansas. I think this may be escalating the problem. I don't see much hope for this type of planning in rural areas. I think pretty much the situation is probably about as good as it's going to get, if you start putting specific limits on hospital beds or on OB departments and such, I think you're going to end up with physicians leaving thea area.

Senator DOLE. You also indicated you're not as concerned about the physician shortage now as you were, you think there's improvement all over. Salina doesn't have the problem?

Dr. NEUENSCHWANDER. Most of the eight communities surrounding Sheraton County either have gotten new physicians in the last few years or have one coming within the next year. The main thing has been that, first of all, there are so many more people going into family practice, like I said, it went from about 5 to 10 percent of my graduating class to 40 to 50 percent, and the next thing, the American Academy of Family Practice did a study which I mentioned that showed a significant percentage of their graduates in the entire United States planning on going to communities of less than 10,000 or 15,000. But I think my friend's study in Iowa is more representative of the Midwest. There I think it was what, 50-some percent were planning on practicing in communities of less than 10,000. That's pretty small, our community technically, as far as the people that we serve is 4,000, the county, because we're the only MD's in the county. I really feel the trend is going to take care of itself for the reasons that you mentioned earlier. Western Kansas is a delightful place to live and they are delightful people to serve, and I'm sure you wouldn't oppose that going into the record.

Senator DOLE. No. [Laughter.]

Dr. NEUENSCHWANDER. And there are people and physicians who would realize this also, they are looking for a life style, not money. I mentioned in my written testimony that finances can be a problem. I certainly don't consider myself poor. The two residents that graduated with me and did go to a city to practice will triple my income in 1977, each of them will. They are the only two I know about, I haven't asked the others. So I am not out in western Kansas for the money, I'm there for the people. I don't think any particular program to reward or penalize physicians or medical students is going to drive them out there. If someone had given me a bill of $50,000 to pay the State for my education, if I did not practice where they wanted, the obvious thing for me to do was to go to the city, make that $50,000 extra within the first few years and then practice anywhere I darn pleased. This would have only kept me from where I wanted to be for an extra 2 years, it wouldn't have driven me to any particular area.

Dr. CHANEY. It may have driven you to a new medical school though.

Dr. NEUENSCHWANDER. That it's tending to do.

Senator DOLE. Can you tell just for the record a little bit about the program of this young man who is with you from KU. Is this a weekend program?

Dr. TAYLOR. That's right, there's 40 or 50 students out of first year medical school that filter out into the State for 2 or 3 days. This young man has been with me since night before last, to find out actually how you practice medicine way out away from medical school.

Senator DOLE. So it's sort of an observer program; right?

Dr. NEUENSCHWANDER. There's one in with my father and I also.

Dr. TAYLOR. They do this again sometime in April. I would like to get back just a minute to health planning. I think there are certain positive aspects of health planning and I think number one, when we first started health planning in Kansas in 1968 we had a multitude of communities who would not even talk to each other and they might be 30 miles apart. Now, I am sure we are all familiar with this, we did accomplish certain things over about a 5- or 6-year period. We did get this community talking with each other where they never did before.

The second positive thing that I see coming out of this thing is the people who provide services in the health field have become involved with people who buy the services, the so-called consumers, and for the most part it seems to me like the consumers have been educated as to some of the many problems that we do have in the health care field, and a lot of these people have become advocates for us. As a result of this kind of movement, I grant you it's taken a long period of time, but it has been pretty effective.

Senator DOLE. Thank you very much. I'm sorry we don't have more time, but I may be asking for some more information. Next we have Ernest Davidson, Judith Schrock, and Mary Wiersma, a panel of community representatives, and I will say to this group as I have said to the others, your entire statement is made a part of the record. We have about 15 minutes. Do you have any order you want to proceed in, ladies first?

STATEMENT OF MARY J. WIERSMA, DIRECTOR, RURAL HEALTH CARE DEPARTMENT, KANSAS FARM BUREAU

Mrs. WIERSMA. Senator Dole, on behalf of the Kansas Farm Bureau, first I thank you for the opportunity to be a community representative. I am not yet certain what that really was to have meant in this forum situation. I think maybe because of a couple of questions that came up earlier this morning that I would like to tell you about one particular program initiated this past year in April of 1977 by Kansas Farm Bureau, and the Kansas Medical Society cooperatively, to address the question of an optional program to try and attract young people, young practitioners interested in primary care medicine to the underserved areas of the State. We had known for some time that in Illinois a program had functioned

since 1948, with the goal of being placed in the State medical school annually a given number of students whose qualifications were equal or above those of other students seated in the class, but who had made a commitment upon completion of a residency program to return to an underserved area of the State.

So in April, our program was announced to the public and our program begins at the county level where a young person seeks, first of all, the recommendation of the local medical society and the local farm bureau, and in making that recommendation those two local organizations are not really reviewing the academic credentials of the individual as much as they are, has this young person always honored a commitment in the community, what has their work record been, is this an overnight enthusiasm for rural Kansas or is it basic character motivation. Then the students are directed to the State organization, called mediserve. They were reviewed a month before they went to the University of Kansas School of Medicine for their interviews by the mediserve board, three physicians, three farm bureau representatives had prioritized these candidates according to suitability for return to underserved areas. Our definition of an underserved area is a county with a population of less than 12,000. Our definition, with primary care is broader than some would like to see. It begins with family practice and after that we do include general surgery, general internal medicine, pediatrics, OB/GYN and there are given areas in the State we feel the addition of OB/GYN would be a great value to the service and residents of that county and for that reason our definition is broader than the Federal definition. It's strictly an optional program.

We have intended to look upon the indentured servitude concept with a little fear, we found the young people approached our program because they were interested, we felt in starting in the home community and following through with them in their program with home community eyes, not ropes, but just eyes, and hopes, knowing they are committed to the State of Kansas and they make the choice as to which community of 12,000 they want. That is the best way to proceed and was one way where we could put a legislative policy to work with some of our own funding and some of our own personal resources.

We had 16 students admitted or received notification last Friday of admittance of 16 students. We have five on the alternate list. We are looking 7 years down the road of this first class, though we would like the privilege of keeping you informed of this program.

I would like to say just one last thing about the health care planning. Part of my job involves trying to implement existing organizational policies and the American Farm Bureau has an interesting policy. They called for repeal of Pub. L. 93–641 in the middle of their resolution text, at the beginning, and then at the end, they encouraged organizations to work with all existing local health agencies, knowing if we all don't pull together in the rural communities we are going to go under. So, I have stressed as a staff person, as much as I could with a weak voice this week, the importance of the involvement in this activity. It's extremely frustrating and a most frustrating element of the whole thing when

you work on this blessed thing called HSP, House Systems Plan, you have a draft and a million chapters of that plan to the regional office and they come back with the comment, it wasn't that we are looking for, that's a discouraging element of health care planning. If you read the law to its word, local planning is still encouraged in Pub. L. 93-641, and the local plan should be reflective of the needs of that community in an attempt to develop a plan and hopefully live long enough to implement that plan. We thank you for letting us come and would respond to any questions that you might have.

[The prepared statement of Ms. Wiersma follows:]

STATEMENT OF MARY J. WIERSMA

Senator Dole, members of the Health Subcommittee and interested participants: It's a pleasure to share these brief comments with you. Since I am employed to represent an organization with a distinct "rural bias," I think it might be appropriate to explain the scope of Rural Health Care Department activities at Kansas Farm Bureau.

Until last April, the concerns of our members relative to health care delivery, medical education, health manpower distribution, etc. had been expressed in legislative policies of the state and national organization. Those policies still remain the backbone for our public activities. Because of a growing concern expressed by county Farm Bureaus across the state, the Kansas Farm Bureau Board in 1976 directed a Special Health Insurance Study Committee within our organization to study the health insurance problems facing the membership and make positive recommendations for solution no later than November, 1976. When this study committee completed it's work, the Board accepted all recommendations presented. Thus, in Aprfl a staff support was created to work with a State Rural Health Care Committee and now developing county committees. These Farm Bureau committees are monitoring three particular areas: (1) Group health insurance programs offered to the membership at the most cost-efficient level; (2) Implementation of the Mediserve program— a cooperative program of Kansas Farm Bureau and the Kansas Medical Society aimed at seeking University of Kansas School of Medicine admission for the talented and committed young people who are willing to practice primary care medicine upon completion of a residency program; and (3) Development of the health education and awareness program within the organization.

We, hopefully, have just begun to accomplish some self-assumed tasks that will be successful only if meshed with now existing programs of other private and public agencies.

In response to your invitation to specifically address four specific topics— distribution of services, financing health care, manpower distribution, and health care planning, we'll turn to the policies adopted at our state meeting in December and our national meeting just two weeks ago.

We have tried to encourage Farm Bureau members to become involved in the third generation of health planning. We have seen a number of good community leaders try their hand in implementing P.L. 93-641—since we've always been a rugged people, some have stayed active in HSA development and planning. Many have become frustrated when plan drafts were turned back to the Agency for revision because "it wasn't what the regional office was looking for." Our national policy stresses, "Government participation in the area of health care management, where necessary, should be at the most local level practical." It is possible to kill local planning efforts if too much regulatory authority has been extended. As the HSA's across the nation struggle to do what many consider to be a "last-ditch" planning job (featuring that if they fail, we will see National Health Insurance implemented from the Potomac), we would hope that the local flavor which must be evidenced in any planning effort will be allowed to stand the test of at least three Annual Implementation Plans.

We can testify without reservation that there is an evident maldistribution of primary care health manpower in Kansas. We would like to suggest that there are a number of programs now developing in Kansas which—given some

time for demonstration after development—can make the greatest impact on this situation. There is no single program which can meet the maldistribution crisis head on. After a first-year attempt, we can report that 16 Mediserve applicants will enter UKSM next fall—all with a five-year service commitment in Kansas in a community with a population under 12,000. We're beginning now to recruit applicants for the 1978 admission process. The Outreach Program of the University is catching the eyes and ears of many Kansas community leaders. The State Department of Health and the University are developing, cooperatively, a recruitment program which will be close enough to the people to make meaningful and positive progress. To suggest, at this time, that *additional* federal participation might further impact this area of need is questionable.

Communities may be given new medical support—on a short-term basis—through the programs now being coordinated with an HEW representative working out of the State Department of Health. These programs often leave a community with more needs than answers—the placement of a state liaison person in the State Department should alleviate some previous program blunders.

We would respectfully suggest, Senator, that both consumers and providers have a lot to live with—health may well be endangered if other federal programs are created and set in our midst. Would it be out of order to suggest that the federal government grant us a moratorium on *new* health programming—could we use a year of reflection, development and implementation of the many responsibilities yet incomplete? We thank you for listening. We attach a copy of our policy positions and would certainly answer any questions appropriate at this time.

Kansas Farm Bureau Resolutions—1978

EMERGENCY MEDICAL SERVICES

"We urge county Farm Bureaus to participate in the development of an effective EMS program. Such programs should be locally financed, preferably through utilization of revenue sharing funds that may become available to local units of government.

GOOD SAMARITAN LAW

More and more state legislatures have come to realize that original intent of such laws has been clouded as additional health professionals sought exemption from such statutes. We would encourage the Kansas Legislature to remove the specific language exempting various health professionals and laymen now found in Kansas Statutes and substitute a general statement exempting from civil damages any person acting in good faith to render emergency aid without compensation.

HEALTH CARE PROFESSIONALS IN KANSAS

We favor development of additional residency programs to provide in-state programs for those University of Kansas School of Medicine graduates interested in primary care medical practice.

In the development of additional primary care residency positions, we urge particular emphasis be given to on-site—community based—residency training. We urge the legislature to finance such residency programs. Such funding could come from the state share of General Revenue Sharing monies.

As a practical inducement to qualified youth interested in a medical career, we will support reinstatement of a state loan forgiveness program. We suggest that such a loan program be based on need and require a year's service in a rural Kansas community or a Kansas inner-city area for each year of schooling funded by a state medical loan.

Nurses compose the largest group of health care professionals in Kansas. We believe that many registered professional nurses are qualified, by education and experience, to meet some of the primarily health care needs of Kansans. We will support legislation to allow an expanded role for properly trained, certificated professional nurses in providing primary health care services.

We continue to support the training program for the physician's assistant as operated by the Wichita Branch of University of Kansas College of Health

Sciences. We encourage Kansas communities to utilize the services of these medical "extenders" whenever qualified personnel can be recruited. We will continue to work for established legal guidelines for the practice of paraprofessionals in our state.

HEALTH INSURANCE POLICY COVERAGE

Individuals or groups seeking to purchase health insurance policies should have the freedom, flexibility and opportunity to purchase coverage for those items, diseases, conditions, or procedures desired by the individual or group to be covered.

We will oppose legislation which seeks to mandate the terms, types, conditions and coverages of health insurance policies.

Health

Government participation in the area of health care management, where necessary, should be at the most local level practical.

We will support government program funding of health care education, training, and research, while asking for careful scrutiny of these areas to avoid the waste of funds or human resources, and to assure the best possible return on the investment.

Greater use of medical aides and assistants would help to relieve personnel shortages in the medical profession. However, we support expansion of medical school facilities to train a larger number of qualified family physicians. We also support economic inducements by states and local people to encourage doctors to practice in rural areas. We encourage the development of residency programs sufficient to provide postgraduate primary care training away from the major metropolitan-based medical training center. Such decentralized residency programs should be designed to allow maximum exposure of residents to the progressive medical centers across our respective states.

We strongly resist the enactment of stringent, inflexible standards by the Department of Health, Education and Welfare which have already and will continue to, without positive modification, result in the closing of rural hospitals and nursing homes throughout the country. National life-safety codes and professional standards now required for institutions participating in the Medicare or Medicaid reimbursement programs have failed to recognize the practical limitations of the institutions now struggling to survive in the medically underserved areas of the country.

The most recent intrusion of HEW into the area of national certification of facilities and/or federal credentialing of health care personnel appears to pose a definite threat to the survival of small health care institutions. While we believe in maintaining quality health care for all citizens, we cannot support legislation or regulations which will impose mandatory credentialing, certification, or licensure standards on participating personnel and facilities. Any unnecessary and unreasonable requirements on health manpower will not only further reduce health care services in the rural areas but can lead to an increase in health care costs.

We oppose federal guidelines that would close the obstetric wards in hospitals that do not meet annual requirements for number of births.

We recommend that the Health Care Act (P.L. 93-641) regulating hospital, medical, and physician services be repealed, thereby giving control of our local hospitals back to local citizens.

We support efforts to reduce medical malpractice insurance costs.

We support local, state, and national programs, including education, for the eradication of venereal disease.

Special emphasis should be placed on disease prevention, immunization, sanitation, and better nutrition as means of minimizing our health problems. We support legislation to require the use of the generic as well as the trade name on prescription drugs.

We urge State and County Farm Bureaus to establish rural health committees and to promote a closer working relationship with acadamies of family physicians, medical societies, and health agencies at all levels. State Farm Bureaus should establish rural health departments.

Senator DOLE. Thank you. Judy?

STATEMENT OF JUDITH SCHROCK, PUBLIC HEALTH NURSE, MANHATTAN, KANS.

Ms. SCHROCK. I am Judy Schrock and I am a public health nurse at the Manhattan-Riley County Health Department in Manhattan, Kans. In speaking to the issue of using nurses in the expanding role for providing primary health care in medically underserved rural areas, I would like to clarify that nursing care in these situations does not take the place of physician care. That it augments the care that is provided by the physician and also provides care that physicians do not supply.

Curriculum in nursing school are changing now so that nurses are being educated to provide the expanded role of nursing and the definition of the expanded role of nursing varies from place to place, so I don't think we need to get into that right now.

Earlier in the session today one gentleman spoke of the health implications of using nurses in this role and in Kansas. In this legislative session, again the nurse—a revision in the nurse's practice act is going to be debated and if it is revised it will allow more legal—broader legal limits for nurses to practice in their capacity. So it is a good possibility that in the rural areas nurses will be better able to provide this primary health care. In the written report that I have submitted to you, I have listed a successful project we have used here in Manhattan through the local health department, using a public health nurse who's been educated as a family nurse practitioner in a rural area, and if you have questions of that I will be glad to answer them.

Senator DOLE. Is this on page 2?

Ms. SCHROCK. Yes, this is a clinic that we have weekly in one of our smaller communities, the Leonardville community, about 25 miles from town. There's no physician present at the clinic, it is staffed by the nurse only to—well, a list of services provided are children's vaccinations, check-up for the breasts, cervical conditions, VD exams, blood pressure tests, urine tests for diabetes, blood tests for anemia, nutrition counseling, family planning counseling, health education, home health services, and facility referrals. I would like to point out that the only services that require physician's orders are children's vaccinations and some of the home health services. So there's a large amount of health care that can be provided by nurses without physician's orders. I think the directions that's been indicated by the Federal Government that they are willing to consider reimbursing for these nursing care services in rural areas is a step in the right direction in terms of providing health care to people in the absence of physician care or in addition to physician care.

Senator DOLE. The one area of some concern is supervision, but I think Dr. Taylor indicated that it wouldn't necessarily be on-site supervision.

Dr. TAYLOR. No, it should be, it should be.

Senator DOLE. It should be on-site, in your view?

Ms. SCHROCK. I might add in Riley County, when you are considering what is a medical unserved area, it depends on what kind

of definition of health care you are using, whether you are using the traditional definitions of providing hospital care and physician care to sick people or whether you are considering the preventive aspects of care and promotion of self-care. Nurses seem to be working in the direction of developing skills and helping to promote these extended or broader definitions of health care.

[The prepared statement of Ms. Schrock follows:]

STATEMENT OF JUDITH SCHROCK

I am Judy Schrock—Public Health Nurse at the Manhattan-Riley County Health Department in Manhattan, Kansas. Health care is important to me as a private consumer and as a nurse provider.

At one time, the definition of health care was care provided in hospitals by doctors and nurses to patients when they were ill. Today, that definition has changed to also include a wide range of persons educated in different skills who participate with people wherever they live and work. The goals of health care have also expanded. We now work to prevent illness and promote the concept of strengthening self-care skills.

In Riley County there are 37 private doctors to provide medical care. This number does not include physicians working at LaFene Health Center at Kansas State University or North Central Kansas Guidance Center. All these Physicians, except one, have located their offices in Manhattan. The one exception is a general practitioner who is semi-retired and maintains a part-time office practice in Riley.

We also have in our county two hospital (both located in Manhattan) which have been in the process of consolidating services for a number of years, a city-county health department, an ambulance service, three nursing care centers (two located in Manhattan and one in Leonardville), two apartment complexes for older and disabled persons located in Manhattan, and federally funded low-income housing projects in Manhattan.

Compared to health care problems occurring in other places, this data could persuade us to believe the area is not medically underserved and the health care needs of the residents of Riley County are being satisfied. In most cases, illness care is sufficient and available as supplied by a variety of physicians in their offices and in the hospitals; however, these physicians are expected to provide services for persons who come from a geographic area that extends beyond the county lines and includes many Ft. Riley residents. Also, many of the physicians are specialists.

Health manpower for providing preventive health care is minimal. For some people, difficulty in entering this available health care system is an obstacle to obtaining preventive health care. One solution to this problem has been a nurse operated clinic in several different locations in the county. The most successful clinic is held one-half day per week in the Leonardville Fire Station. Leonardville is located twenty-five miles northwest of Manhattan.

A public health nurse, educated as a family nurse practitioner, is available to provide children's vaccinations, checkups for breast and cervical cancer, VD exams, blood pressure tests, urine tests for diabetes, blood tests for anemia, height and weight checkups, nursing assessment of children, nutrition counseling, family planning counseling, health education, home health services, and facilities referrals. The only services that require physician's orders are children's vaccinations and some home health services. Fifteen to thirty-five people are seen per week.

Community persons feel responsible for the clinic. They provided the space and most of the equipment and a play area for children in the waiting room. This cooperative effort began in 1973 and has become a vital source of primary health care.

P.L. 95–210, which authorizes Medicare and Medicaid payments for the services of nurses practitioners and physician's assistants in rural health clinics without a requirement for on-site supervision by a physician, will help make more comprehensive health care available. Nurses are being educated to provide broader services and accept more responsibility for their actions. According to Donna Diers, Dean of the Yale School of Nursing, "It has been estimated that nurses with this new training can quite capably handle 60 to 70 percent of the patient's health care problems".

No one group of persons can be totally responsible for the nation's health care. Each of us has to participate, and nurses working in expanded roles have been shown effective in promoting this participation. Recognition of this fact by the federal government is a step toward a more realistic method of making available a wider range of health care services in medically underserved rural and urban areas.

Senator DOLE. Thank you very much. Mr. Davidson?

STATEMENT OF ERNEST DAVIDSON, PUBLIC HEALTH, IOLA, KANS.

Mr. DAVIDSON. I'm Ernie Davidson, I do work for the Public Health in southeast Kansas. But I am here more global, I think, than promoting my own profession or my own organization. I like to think that I am representing my family and my neighbors. In my written text I talked about the fact that we are voluntarily living out here in rural Kansas and we don't expect to have everything available to us that we have available at Kansas University, at Topeka and Wichita. But we do expect that we should have the same kind of primary care services and we think we have some kind of a right to have those primary care services. What is primary care? I have to disagree with—not disagree, I have to add a little bit to what Dr. Chaney said. I certainly think we need family practitioners, but I think we have some rights to some other primary practitioners such as the obstetricians, gynecologists, and pediatricians, and the opthalmologists. Where I live we don't have an opthalmologist within 100 miles. We don't have a pediatrician within 100 miles. We don't have an obstetrician within 100 miles. I think we ought to have that somewhere at least in southeast Kansas, and western Kansas, and wherever else.

Senator DOLE. Where do you live?

Mr. DAVISON. I live in Iola. It's 100 miles to anywhere. It's 100 miles to Joplin, it's 100 miles to Wichita, it's 100 miles to Topeka, it's 100 miles to Bartlesville. We expect that when we have a tonsillectomy, or hysterectomy, or gall bladder surgery, or prostrate surgery, or even when our children are born, they ought to be born in our local hospital and we ought to have the same quality care they have in Topeka. I don't think that's asking too much. We don't expect to have a catscanner, or open heart surgery, heart catheterization, all that fancy stuff, we don't expect to have that in rural Kansas. Where we do have services available are not necessarily available to people out there, especially in rural Kansas in our part of the country. I think southeast Kansas probably has the lowest per capita income anywhere in Kansas. We have a lot of young people. They are staying there now because we have some small industry but the wages are low. These people can't afford the high price of health insurance and the elderly people on medicare, they have pretty good coverage or insurance, and the poor ones that—they have medicaid, but the working poor don't have anything. They can't afford $85 a month for Blue Cross. I'm asking for some help for the working poor. Some of these people don't have Blue Cross, some of them don't have the $300 it takes to get them prenatal care. Their babies get born because the on-call doctor has to deliver

it, the hospital doctor has to provide the care. They don't necessarily get paid for it and they don't have to provide prenatal care. They don't do it either. Children are being born without prenatal service. Not a great number, even one is dangerous.

I got off the subject a little bit. Talking about the farmer who needed some help, I have known people who have lost their farms because their wife or maybe the farmer has died and the wife is the survivor and she gets critically ill and they have to sell the farm in order to keep her in a nursing home for 8 or 10 years. I think there needs to be help there because these people can't help themselves. We can't buy any catastrophic type health insurance to hedge against 10 years in a nursing home, no matter how much you are worth, you can't buy that kind of insurance. It's just not available. I still think we need to look at some type of catastrophic care because this farmer spends his life out here buying a farm and that is his retirement. It's not my retirement, I'm paying into a retirement system and regardless of what happens when I retire, that retirement money is going to come in monthly. That farmer doesn't have that. When he retires he is depending on that farm, whether he rents it out or somebody else farms it, that is his retirement. If he has to sell his retirement in order to keep his wife in a nursing home, he has got nothing.

Senator DOLE. I might add that that's one area that this year that the Congress may address, and that's coverage for catastrophic illnesses.

Mr. DAVIDSON. That's commendable.

Senator DOLE. I think there's some staff working on that right now in the Senate Finance Committee. In fact I know there's staff working on it, in this area, and I'm not certain just what form it will take, but it's an area that must be addressed.

Mr. DAVIDSON. I talked a little bit about health planning, I am very active in health planning. I am on a dozen different committees, a half a dozen, it seems like a dozen sometimes, all the way from the local area—I am active in the county, I am active in the subarea council of nine counties, I am active in a 22-county area in southeast Kansas, and I am also on the State Health Coordinating Committee. I am very active in health. I might add in 1972, in reaction to Dr. Chaney, again, I went to southeast Kansas and there wasn't any health planning going on at all. The only thing that they ever did was something the State did under the Hill-Burton, the locals didn't have any control over Hill-Burton, the State ran the organization and the State decided where all the hospitals were to be and that's what they are reacting to today.

When I went down there in 1972 I structured a five county health department and we had to—CHP was coming into effect, nobody in southeast Kansas was starting a CHP organization. When I got there, I told them if you want a grant, you have to have the CHP, you have to apply for CHP to apply for a grant. So the only thing I could do was start to organize one and I started to organize the CHP. Well the grassroots, three hospital administrators and four nursing home administrators didn't want me to do it, so they did it. We got it done. The CHP didn't last very long, 2 years, and

Public Law 93–641 came in. I believe Public Law 93–641 legislation was necessary to get local initiative planning going. It wouldn't have got done otherwise. We are very effective with dragging our feet when we need to drag our feet, and that's what was being done with health planning. I don't believe it's all the answer, and we are still trying to figure out what's going on, but I believe the process is correct, and that nothing would have got done in the planning area had not it been mandated. I do believe that now that we are mandated we are organized across the Nation in HSA and SHICK and whatever. We ought to at least now be given a little breather, time to work out our problems and see if we can't solve these things now that we know we have to do it. So the local determination issue comes up, so I'm not supporting the local determination issue at this point since we are organized and functioning. I don't believe we would have ever done it without being mandated, however. The home care issue is very important and it needs to be stressed, that medicare will only pay for nursing home care up to 100 days and that medicaid pays for most of the nursing home care for those people getting assistance, at least about 50 percent of the nursing home care in Kansas has been paid for by medicaid.

We need to look at an alternative, that's home care. There's a misnomer going around that home care is an alternative to hospital care and that's not so. Mostly home care is an alternative to nursing home care, and we need to look at using that a little more effectively. We haven't been able to produce enough physicians to cover services in Kansas, and I hear people from KU Med Center saying by 1985 we are going to have too many. In the meantime we need to do something to get back the 7 or 8 years. I think we need to look at the available alternatives. I think we need to expand the role and scope of some of these physician extenders. I don't know much about physician's assistants, it's a new program to me. I do know about nurse practitioners and nurses, and I might add that it was mentioned about the nurse anesthetist. I might say we wouldn't ever have any surgery in Iola or Fort Scott if we didn't have nurse anesthetists, because there aren't any anesthesiologists there in that part of the country. Nurse anesthetists do all the surgery and I think nurse anesthetists are an example of what nurses can do, how they can extend their services.

I think what we need in rural Kansas is a basic minimal primary care service. I don't say every town and cranny should have it, but I think every trade center, those places where you do the bulk of your shopping should have basic minimal primary care services there, at the places where you do your grocery shopping, you trade for your essentials, clothing and banking, et cetera.

Senator DOLE. I'm going to have to leave in about 1 minute. I don't want to cut you off.

Mr. DAVIDSON. That was pretty much the last of it other than to summarize it——

Senator DOLE [interrupting]. I think this panel and other panels have been helpful to me. I have to leave. Both Sheila and John will be here if there's any additional information that anybody wants to submit for the record, or if there's any clarification that

might be made for the record. I certainly want to thank the representatives from HEW for coming today and perhaps you will have some observations, based on the testimony you have heard that might be helpful as we make the record. Again I would thank the witnesses who have come great distances, and I apologize for your having to wait so long, but I think it's good to make as complete at record as we can. I think we have had a fairly good hearing from the standpoint of covering a lot of basic areas that directly concern our committee. We have certain jurisdiction that I spelled out in my opening statement and I have a responsibility as a member of that committee. Certainly Senator Talmadge will be interested and other members of the committee will be interested in knowing how we look at it from the standpoint of how it affects rural areas in the State of Kansas. In February—I think February 13, we will be looking at health care from an urban standpoint with a hearing in the morning in St. Louis and one in the afternoon in Kansas City.

I think one of the witnesses pointed up, Mr. Ewert I think, that we talk about the problems and we shouldn't forget about all the positive areas that we have in this country and in medicine and all the related areas. We sometimes dwell on negatives, but that isn't the purpose of this hearing. We tried to focus on areas that cause you problems because of what we do on the Federal level. We understand, at least I understand the great advances that are being made, and improvements that are being made and the fact that we have the best system on Earth, and that improvements are being made on a daily basis. So I appreciate very much your coming. Now I did indicate to some of you that if you have a statement, that you would like to make for the record that John Kern and Sheila Burke will be here.

Dr. HARRIS. One statement that I would like to take issue with that Ernie brought up, you do have three opthalmologists in a 100-mile area of Iola, you have one in Coffeyville, one in Parsons and——

Mr. DAVIDSON. I think Coffeyville is more than 100 miles away.

Dr. HARRIS. Isn't it 55 miles from Chanute and 19 to 20 from there.

Mr. DAVIDSON. Well I stand corrected.

[The prepared statement of Mr. Davidson follows:]

STATEMENT OF ERNEST DAVIDSON

The people of rural Kansas are an understanding, hard working people. We understand that we can't have everything immediately available to us like the metropolitan areas have available to them. We have voluntarily traded some of those conveniences for the open air and comfort of our rural homes.

We do think, however, that we should have exactly the same primary Health Care immediately available to us that is available anywhere else in the entire country. Primary care is where the action is. Without a very good primary Health Care System then we don't have a health care system at all.

Secondary care and tertiary care centers should be dependent and referral sources for the primary health care delivers. We don't expect CAT scanners, open Heart Surgery, Heart Catheterization in every rural county hospital.

We do expect and have every right to expect that our tonsillectomy, hysterotomy, gallbladder, prostate surgeries, or child births, etc. should be as good in rural Kansas as it is anywhere else.

In rural Kansas even where adequate services are available they are some times not also accessible to those needing care. Just because there are physi-

cians that doesn't mean that people are getting the service. In rural Kansas many industries are small and wages are at the minimum—Health Care Insurance is not offered as a benefit.

Many young couples are not getting prenatal care in rural Kansas because they don't have the 300 or so it takes up front, or they don't have health insurance. They just go along the best they can until delivery time and then they take the "on-call physician" at the hospital for delivery.

These people need some government assistance with their Medical coverage. The working poor can't seem to get any financial help. The physicians and hospitals are in essence giving free delivery services, they can't be expected to also give all the pre-natal service free.

We need some Congressional help for the farmer who has spent his lifetime working and buying a farm. This land, this farm, is his retirement. Currently hundreds of farms have been and are being sold prematurely by a farmer or his wife because their spouse has become chronically ill and is receiving nearly total care in a nursing home. There is not any insurance that this farmer could have bought to help avoid this catastrophe.

Medicare will not pay for Nursing Home Care. Medicaid won't pay until the survivor is totally penniless. Health Insurance Companies will not pay for Nursing Home Care either. At $7000 to $9000 per year for Nursing Home Care it doesn't take very long to totally break the farmer or his spouse whichever is the survivor.

Once the farm is gone to pay for the Nursing Home Care, the Home is gone, the retirement income is also gone. The survivor is penniless and on Welfare, lives in some rented room in town, or if lucky has a son or daughter to go live with.

We need some type catastrophic Federal help to help these people.

Why should a person, who has worked hard all his life and paid taxes, have to be totally penniless before he can get some medical assistance with nursing home care? There is no physical way for him to plan for or purchase insurance to protect him from this situation.

We either have not been able to produce enough physicians to cover rural Kansas or we have just not been able to make it attractive enough for them to settle in rural Kansas. Either way, rural Kansas isn't getting the physicians it needs to provide the needed and necessary primary care. We then need to look at available alternatives. We need to expand the role, scope, and availability of the physician extenders—the urse practitioners and physician assistants. We need the authority for Medicare, Medicaid and private Health Insurance to reimburse for these services rendered by these same extenders. These extenders could and do work effectively either through local physicians offices or organized health organizations like Public Health Departments.

A basic minimal level of primary health services should be available at the local trade area,—Local area of trade for essentials, i.e. food, clothing, banking services.

In the smaller communities these services will have to get some financial support from the State and Federal Levels.

In Summary: We need good primary care; health Coverage working poor; help for chronically ill nursing homes (catastrophic); physician extenders; and basic minimal primary services.

Senator DOLE. Do you have a comment you want to make or a statement?

Dr. PAIGE. I would like to know how all these people—how you feel—we are talking about cost containment. I propose somebody amend medicare-medicaid to remove health providers from the public trough. I think if we are really true physicians we should sink or swim on our own. I will relinquish my seat at the public trough any time for my freedom. I would like to know how people feel about this, if we are contributing to a half trillion dollar budget, I don't want to be a part of that. I will sink or swim with my own ability.

Dr. HOSTETTER. We have two secondary medical students here and I think they are the ones we have been talking about. They would like to make a statement, a brief statement, if you care to hear it. This is Alfred Davis.

STATEMENT OF ALFRED DAVIS, STUDENT, UNIVERSITY OF KANSAS

Mr. DAVIS. My name is Alfred Davis and like Dr. Hostetter said I am a first-year student from the University of Kansas. I'm down here for the rural health weekend. Being here has been very hospitable. I guess being here in this forum, I have got a lot of information and I kind of appreciate the complexity, and some of the problems that face Kansas and I guess other communities. I guess about the only thing that probably wasn't addressed, and maybe I might—I have a personal opinion, possibly, that I would like to present. When I first got in the University of Kansas, I guess I looked around and was wondering if I was a typical medical student, and I was kind of—I was wondering about the process of the educational system in which the physicians are developed, and my feeling was that possibly there was some problems. I guess my feeling was that the trend, as far as the type of students that are selected, is going more and more toward people that are in the natural sciences, and I believe, you know, that's probably very important, but I have a feeling, or suspicion that possibly it doesn't go hand in hand or is synonymous, natural science, possibly, with what a physician really is all about. The person who elected the sciences, that person possibly wouldn't be interested in the less glamorous and less prestigous position as a family practitioner, or any of the other persons involved in family health. I was just wondering that possibly there might be someone to possibly look, possibly there might be other criteria for physicians, other than persons that are in natural sciences.

Senator DOLE. I have got to go. I've already overstayed and that may be something that someone could address other than the Federal Government, I hope. I don't want to cut you off. I don't think that would have any bearing on the purpose of this hearing, but it certainly is information that I think we are happy to have. Do you want to introduce another student there?

Dr. HOSTETTER. This is Mark Epstein, a second-year student.

Senator DOLE. If you have a statement to make, Mark, I would be happy to have it if you would submit it in writing. If you do not we appreciate again very much your coming. Thank you all very much. [Applause.]

[The hearing was concluded.]

[By direction of the chairman the following was made a part of the record:]

FORT HAYS STATE UNIVERSITY,
SCHOOL OF NURSING,
Hays, Kans., January 25, 1978.

Hon. BOB DOLE,
U.S. Senator,
% Kansas State University, Student Union,
Manhattan, Kans.

DEAR SENATOR DOLE: Since at this time it is unclear as to whether I shall be able to attend the public hearing on January 28 regarding rural health care delivery, I wish to respond both as a tax paying citizen and as a health care provider. My concerns are congruent with both roles.

It is crucial that qualified health care providers be available to under served rural areas both in Kansas and elsewhere in the United States. It is also

known that persons tend to remain in areas where they are educated. This leads to the first priority I would respectfully advance to a person in your position, e.g. appropriations for approved grants for schools of nursing in rural areas. Funding should be made available, and states encouraged to allocate monies, for programs in rural areas rather than clustering the programs around the larger Medical Centers. While those centers have numerous and valuable experiences, they are not necessarily the experiences which best prepare all levels of care givers to function in rural areas. Some programs such as graduate nursing and practitioner (nurse) programs could be delivered quite well in rural areas by personnel in that area if resources were available. Also, the outreach residency programs which the University of Kansas has proposed should also be valuable in introducing persons to the rural areas and possibly result in their practicing in the training area.

Supporting evidence for utilization of health care providers, in addition to the high cost physicians, is contained in the attached copy of a letter submitted to the President of this University, Dr. Gerald Tomanek, when I was asked to respond to the proposed *Health Care Plan for Kansas*. I do hope that you will be able to allocate sufficient time to consider that rather long letter.

Whether or not I am able to attend and speak at the hearing, please allow me to express to you my appreciation for your efforts to listen to the people.

Your truly,

ELAINE B. HARVEY, R.N., ED.D.,
Dean, School of Nursing.

Enclosure.

FEBRUARY 24, 1978.

DR. GERALD TOMANEK,
President,
Fort Hays State University,
Hays, Kans.

DEAR DR. TOMANEK: After careful review of the draft of *The 1978 Plan for the Health of Kansas*, there appears to be at least two glaring areas of omission.

First, education and utilization of Advanced Nurse Practitioners are not mentioned. On page 4, #12, nurse practitioners are listed among those who should be able to receive third party payments. It appears to me, both from the document and from visiting with legislators and physicians at the recent "Human Values" conference, that research and studies conducted regarding function, utilization and acceptance of nurse practitioners is either unfamiliar to those people or are being ignored and emphasis placed on preparation and retention of greater numbers of physicians.

The second omission regards schools of nursing. One specific area where experiences for students and utilization of the expertise of faculty members would be available to the public is in the Maternal and Infant Care Centers as are proposed on page 42. The centers could have the expertise of faculty at no charge and they could conceivably be Nursing Centers or clinics operating under protocols.

The prevailing attitude that quality health care is possible only when delivered by high cost physicians is in direct opposition to the research findings listed below.

Spitzer, W.O., et als, "Nurse Practitioners in Primare Care III: The Southern Ontario Trial," *Canadian Medical Association Journal*, Vol. 108, April 21, 1973, pp. 1005–1016.

Spitzer, W. O. et als, "The Burlington Randomized Trial of the Nurse Practitioner," *The New England Journal of Medicine*, Vol. 290, No. 5, January 13, 1974, pp. 251–256.

Sackett, D. L., et als, "The Burlington Randomized Trial of the Nurse Practitioner: Health Outcomes of Patients," *Annals of Internal Medicine*, Vol. 80, No. 2, February 1974, pp. 137–142.

Attached is a page from the *Health Manpower Report* of January 19, 1977 which further sheds light on more recent information in this regard.

It seems regretable to me that only the more expensive resources are considered when the topic of Primary Health Care delivery is addressed.

There also should be concern for the proposal for the establishment of Health Science Education Centers (AHEC's) in rural Kansas if the pattern is followed here that prevails in states (Illinois, for example) with these

centers, and as proposed in the grant proposal submitted by Dr. Meek of the KU Medical Center. Decision-making and reporting of site directors is to the Medical Center with little or no autonomy for the rural areas.

In summary, I do feel that the document as constituted is quite comprehensive but concerns do exist as indicated above.

Yours truly,

ELAINE B. HARVEY, R.N., ED.D.,
Dean, School of Nursing.

Enclosure.

NURSE PRACTITIONERS CAN FILL PHYSICIAN'S ROLE IN OUTPATIENT CLINICS, SAYS VA/HEW STUDY

Using nurse practitioners in adult ambulatory care facilities increases the quality and volume of care to patients at a fraction of the cost for physicians to perform the same functions, says a government study.

These findings, some of the first concerning NPs in adult outpatient clinics, came from a recently released report on a model NP program begun in 1971 at the Veterans Administration outpatient clinics in Los Angeles. The study, conducted jointly by the VA and HEW's Division of Nursing, examined the educational background necessary for the NP to take over primary responsibility for the ambulatory chronically ill, how the treatment prescribed by the NP differed from that prescribed by a physician, and the acceptance of the NP by patients and physicians over a three-year period.

EDUCATIONAL BACKGROUND

Two registered nurses were chosen for the model NP program at the clinic. Each had a master's degree in nursing and some public health nursing experience. The NPs took medical and health care courses presented by surrounding universities and by organization such as the American Heart Association and the California Nurses Association for advanced training in such skills as how to read an EKG printout. Educational programs were also conducted by physicians of the various services of the clinic. Twenty-nine of the 34 doctors participated, usually by having an NP sit in on a particularly interesting case and later comparing his diagnosis and recommended treatment with the NP's conclusions.

THE PATIENT POPULATION

Patients whose main diagnoses were internal medicine problems, who had been followed in the clinic for at least a year and who had not been hospitalized within that time were candidates for the study. About 1,100 patients met these requirements, but only 750 were available for assessment by both the NPs and physicians as suitable for placement under the care of an NP. Asked if they would agree to be care for primarily by an NP, about 200 assented and were selected to participate in the project.

The patients were divided evenly with 100 under the direct care of the NPs and the other 100 under the physicians, which served as a control group. Each nurse practitioner was given an office in the clinic, and each had three options when she saw a patient: (1) the NP could assume full responsibility for the patient's care; (2) the NP could choose to be responsible for only part of the care or (3) the NP could refuse any responsibility for the care of the patient, in which case, the patient would then be seen by one of the clinic physicians.

Direct comparisons between physician-prescribed treatments and those the NPs choose provide impossible because the nurses used a problem-oriented patient progress chart unlike the doctor's charts. An outside consulting team reviewed the NPs work midway through the program, however, and their observations were favorable.

ACCEPTANCE BY PATIENTS AND PHYSICIANS

The study found that the patients under the care of the NP came to prefer an NP to a doctor for such tasks as explaning tests and treatments and how to take prescribed medicine correctly. Of the 23 physicians responding to questions about the project, 16 reported their contact with NPs was favorable, four had mixed feelings and three reported having no contact with them. None responded unfavorably to working with the NPs. Ten of the physicians re-

ported their patients had commented on the NPs, and all ten said the comments were in praise of the NPs' work.

Copies of *The Nurse Practitioner in an Adult Outpatient Clinic* are available by requesting HEW pub. no. (HRA) 76-29 from the *Health Resources Administration, Division of Nursing, Room 508 Federal Building, 9000 Rockville Pike. Bethesda, Md. 20014.*

MORRIS COUNTY HOSPITAL,
Council Grove, Kans., January 27, 1978.

Senator BOB DOLE,
U.S. Senate,
Washington, D.C.

DEAR SENATOR DOLE: Thank you for the opportunity to record my comments and suggestions concerning the problems relating to rural health care delivery.

The practice of medicine is an art aided by science. The physician must make decisions based on his judgment and supported by as much scientific data as possible. The scientific data may be very similar for two patients but the physician must have the freedom to make his decision based on all the circumstances. For example, the scientific data may indicate the need for renal dialysis, but other circumstances may cause the physician to reject the procedure. Some regulations proposed and already enacted are taking away the physician's right to practice the art of medicine.

Rural Kansas cannot provide a health care delivery system unless physicians continue to elect to practice in the small communities. In a recent survey of family practice residents at the University of Kansas School of Medicine, over 90% of the residents stated they must have the use of a hospital to practice medicine in a rural community. Forcing the closure of the small community hospital will create more problems than it will solve.

When illness disrupts the everyday life of an individual, often the result is a major crisis for the patient and his family. If the physician can prescribe treatment that is within the capabilities of the community hospital, the patient's response to treatment is often greater because he is in familiar surroundings and often he is personally acquainted with the staff caring for him. We cannot scientifically measure the significance of friends caring for sick friends, but we cannot discount its importance.

Mr. Califono and others have placed much emphasis on the cost of empty beds. Many of the "empty" beds are, in fact, occupied. Traditionally, hospitals do not charge for the last day of stay in the hospital. Our hospital is licensed for 28 beds. If we were to establish the suggested 80% occupancy, we would have to have 92% of the beds filled each day since we do not count the last day of stay. The only way to avoid this discrepancy is to have a newly admitted patient waiting for the bed of a dismissed patient.

The workload in a hospital varies. We have had patients in the hallways during a winter month, and 70% of the beds empty later the same year. If we averaged 80% occupancy, we would not have facilities for all the admissions during the peak load.

The average charge for each patient day in our hospital in 1977 was $101.77, as compared to the U.S. average of $144.00 in 1976. This variance is typical for the small hospital. The facts do not justify the position of some that closing the small hospital will save money.

We staff our hospital for 60% occupancy. If we have a heavy workload, nearly the same number of staff will care for the increased number of patients. 70% of our costs are fixed, but it is misleading to say that it costs us about $70.00 to maintain an empty bed. If the empty bed were somehow changed to be always occupied, we would have to add more staff and probably more facilities, including beds.

Much of the increase in the cost of hospital stay has resulted from government regulations. In 1970, there were only 11 members of our staff earning more than $2.00/hour. Today, no one earns less than $2.65/hour. Our payroll has doubled in less than 10 years.

Our country cannot afford to provide all the health care services to all the people. The mere development of a medical procedure does not justify its use use regardless of cost or other circumstances. We must not try to develop a "total health care plan."

Sincerely,

RON THOMPSON,
Administrator.

HEALTH SYSTEMS AGENCY OF SOUTHEAST KANSAS,
Wichita, Kans., January 27, 1978

HON. ROBERT J. DOLE,
U.S. Senator,
Dirksen Office Building,
Washington, D.C.

DEAR SENATOR DOLE: Thank you for the opportunity to comment on rural health care delivery problems in Kansas. A large number of volunteers of the Health Systems Agency of Southeast Kansas have spent the past year and a half working to identify health care delivery problems for this area. In HSASEK's recently adopted Health Systems Plans, various goals and objectives for improvement of rural health problems are spelled out.

One of the major issues in southeast Kansas is the shortage of primary care personnel. This includes physicians, dentists and optometrists. The physicians needed in rural Kansas are the generalists: the family practitioners and general internists. Since it is difficult to place physicians in a rural area, alternatives such as physician-extenders need to be further developed. In order to accomplish this, third party reimbursement restrictions on the payment for care rendered by physicians-extenders need to be corrected. Also the ole of the physician-extenders needs to be further examined in terms of the individual's ability to work in areas which are remote from the supervising physician.

Additional services needed in rural Kansas are home health and emergency medical services. Home health is an important alternative to hospitalization and nursing home care. For those people who need only periodic nursing care, home health care can be a very successful and less expensive alternative to institutionalization. Other types of support offered through home health care can also prevent deterioration of the individual or provide the simple assistance with daily activities that allows a person to remain in their own home. Such services could be physical therapy or homemaker services. A major barrier to development of home health resources is the current reimbursement practices of the third party carrier and Medicare/Medicaid. Consideration should be given to modifying regulations and statutes controlling the health care insurance and the governmental programs to allow payment for home health services where institutionalization would otherwise be required.

Emergency medical systems need to be drastically improved in rural areas. The shortage of primary care manpower necessitates an advanced life-support system to insure that emergency patients can be maintained until transported to the appropriate site for care. Systems involving emergency care centers, trained personnel, transportation systems (both ground and air), communication systems, referral patterns, etc., need to be developed in the rural areas. However for rural areas, initial investments in emergency medical care systems and continued operational costs serve as a severe obstacle to establishment of such systems.

An important factor in rural health care needs is the current emphasis from the Department of Health Education Welfare on cost-containment to the apparent exclusion of other factors. Under P. L. 93-641, Section 1513 A (2) notes that the purpose of the Health Systems Agency is: "Increasing the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of the health services provided them".

While reduction in overall cost is necessary to provide the funds for development of alternatives, an important aspect of any health systems agency's activity has to be the development of these alternative systems. It would seem appropriate that Congress give leadership in encouraging the development of rural health systems in conjunction with the necessary endeavors in cost-containment.

Lastly, decisions regarding the distribution of health services must be locally determined. This was emphasized in the recent nationwide discussion of the initial draft of the national health planning guidelines. The most recent draft is a considerable improvement over the previous document. However, care must be continually exercised to insure that the Health Care System of local areas shall be locally determined. It is quite appropriate for Federal agencies to take positions, issue guidelines and try to give goals and directions to the nation's health care systems. However, it is not advisable to issue inflexible

standards and impose them on all areas of the country, regardless of local characteristics. In addition, local input fosters much more informed and intelligent decisions about health care services and, through the involvement of local people in the decision process, local change can be accomplished in the Health Care System.

Again, thank you for the opportunity to comment on these issues.

Sincerely,

DEAN SIMONICH,
Executive Director.

KANSAS HOSPITAL ASSOCIATION,
Topeka, Kans., January 26, 1978.

Hon. ROBERT J. DOLE,
U.S. Senator,
Dirksen State Office Building,
Washington, D.C.

DEAR BOB: On behalf of all the hospitals in Kansas, I would like to thank you for the opportunity to submit these written comments of the Kansas Hospital Association for entry into the formal record of the meeting of the Health Subcommittee of the Senate Finance Committee held January 28, 1978, in Manhattan, Kansas.

The problems associated with the delivery of hospital services to citizens in the rural environment have become quite increasingly more complex and frustrating. I sincerely appreciate the sensitivity of not only yourself, but the other members of the Health Subcommittee of the Senate Finance Committee, to this fact. That a hearing of the Subcommittee will be held in Manhattan gives us hope that the many problems of small rural hospitals are going to be realistically addressed by the Subcommittee.

You will hear testimony from three of our state's many excellent administrators. We, therefore, will not attempt to duplicate in our statements the comments these gentlemen will be making in their testimony. We have included, and hope it will be made a part of the record of the hearings, copies of the statements adopted by the Kansas Hospital Association on these issues: 1) National Health Insurance 2) The National Health Planning and Resources Development Act of 1974, P. L. 93-641; 3) Health Care Costs; 4) Revised Specifications of the Talmadge and Dole Medicare/Medicaid Reform Act; and 5) Mandatory Uniform Accounting. These statements were originally prepared for the Kansas Congressional delegation at the Annual Meeting of the American Hospital Association, Washington, D.C. However, they are also applicable to the purpose of this hearing as many of the problems addressed in these statements are particularly troublesome for small and rural hospitals. Several of the recent proposed actions on the part of the Administration concerning health planning and cost containment would especially be damaging to the rural hospitals that are so necessary to the health care of our state.

We trust that the testimony you receive through the entire session will indeed help you assist all of us who are vitally interested in maintaining an adequate health care system in rural Kansas.

I will be unable to attend the hearing on the 28th, but James L. Scott, Director of Fiscal Affairs of KHA will be in attendance. I am looking forward to seeing you in Washington at the conclusion of our Annual Meeting.

Sincerely yours,

FRANK L. GENTRY,
President.

Enclosures.

NATIONAL HEALTH INSURANCE—A STATEMENT BY THE KANSAS HOSPITAL ASSOCIATION, JANUARY 16, 1978

Although national health insurance will apparently not be one of the Administration's top priorities during 1978, the Administration continues to say that it is one of the corner stones of its domestic policy. We have provided to you in the past copies of our position, with respect to the essential ingredients of a national health insurance program. We did so in the belief that these principles should be included in any legislative program that is enacted. You will not find in our position, however, a statement of support for the concept of

national health insurance. We feel that the vast majority of Americans now have insurance of one type or another, and the imposition of national health insurance to cover not more than 10% of the entire population would be a costly layer added on top of an already complex insurance system. Evidence to date suggests that each new insurance program creates more demand for health services, and short of new programs to control demand, we believe that any national health insurance program envisioned at this point would add to the demand, and thereby to the cost of health care in this country.

If and when the congressional debate heightens on the subject of national health insurance, the Kansas Hospital Association would appreciate an opportunity to discuss not only our own principles, which we would hope to have included in a national health insurance program, but also a new document being created by the American Hospital Association, which discusses not only the traditional insurance aspects of national health insurance, but a regulatory process which would help deal with the demand problem.

Enclosed is another copy of the KHA position paper on national health insurance. We would be pleased to discuss this subject with you or your staff at any time.

AMENDMENTS TO PUBLIC LAW 93-641—A STATEMENT BY THE KANSAS HOSPITAL ASSOCIATION, JANUARY 16, 1978

Kansas hospitals and the Kansas Hospital Association have been in historic support of health planning and supported the enactment of Public Law 93-641. We did so because the law represented a balance between health planning, resource development and regulation, and because the congressional intent was in support of a local and state decision-making process, with a maximum opportunity for local input into the creation of health systems plans, annual implementation plans, and into the review of certificate of need projects.

Since the enactment of Public Law 93-641, we have heard many direct statements from HEW that their intent in implementing the law is to maximize the use of the regulatory processes to the virtual exclusion of the planning and resource development functions. We understand that HEW will propose in the 1978 amendments to the law a further movement towards making P.L. 93-641 exclusively a cost containment tool.

It is our strong belief that a planning mechanism, such as was envisioned by congress in the enactment of P.L. 93-641, is needed and will continue to be needed. We believe that turning P.L. 93-641 into a federally controlled regulatory system will destroy the valid health planning and resource allocation aspects of the law, and will thereby have long-term adverse effects on the health care system.

You will recall that our recent objections to the national guidelines centered around the desire of HEW to require that local health systems plans conform closely to rigid national planning guidelines. We believe that flexibility must remain in P.L. 93-641 in order to have local decision-making opportunities remain. If all aspects of health systems plans must conform to national guidelines, then there is essentially no role for local decision-making.

We would support an amendment to apply planning reviews to all health care providers, regardless of ownership and setting, so that all institutional-type facilities and services are included in the planning process. We would also support an amendment which would provide a broader source of funding for HSA's than the current law permits, in order to insure the planning agencies have sufficient resources to accomplish their functions.

In summary, our position is that P.L. 93-641 should be maintained as a planning and resource development tool and should not be permitted to be turned into a program of federally imposed regulation at the expense of local planning.

During the course of congressional debate we would be happy to provide detailed information on the impact of various amendments which are proposed on the delivery of hospital care in Kansas.

HEALTH CARE COSTS—A STATEMENT BY THE KANSAS HOSPITAL ASSOCIATION, JANUARY 28, 1978

The issue of rising health care costs and the determination of the appropriate governmental response to this dilemma will no doubt receive a great deal of attention in the Second Session of the 95th Congress. In recent months a variety

of proposals from the private sector, from members of Congress, and from the Administration have been developed in an effort to deal with this highly complex issue.

The Kansas Hospital Association would like to take this time to briefly restate our position on the subject of hospital cost containment. The Kansas Hospital Association has, in the past, developed extensive documentation concerning the reasons for the rate of increase of hospital costs. We will not repeat at this time all of this detail but simply reiterate two major points: 1) That 44% of the rate of increase in health care costs is caused by inflation in the economy in general; 2) that costs continue to increase, particularly as a result of recent regulation or legislation. Examples of this are the increase in the minimum wage, increase in employer payments under the social security amendments, and the requirements of Section 504 of the Rehabilitation Act of 1973.

Because of the influence of inflation and governmental action on hospital costs, the Kansas Hospital Association feels that any federally mandated hospital revenue control bill cannot deal realistically with the true causes of rising hospital expenditures. Such a solution would also not take into account the very serious questions of public demand for services and the impact on the medical care system of self-destructive lifestyles.

The Kansas Hospital Association feels that the imposition of an arbitrary, across-the-board ceiling on hospital inpatient revenues, while other components of the health care system and the overall economy remained uncontrolled, would not only be unequitable but could lead to undesirable distortions in the delivery of essential health care services and could impair the ability of hospitals to continue to provide the present scope and quality of institutional health care services. The record so clearly demonstrated during the Economic Stabilization Program has shown that such price controls are unworkable and, in the long run, not capable of addressing the true reasons for the problems of rising health care costs.

Hospitals in Kansas are not opposed to cost containment efforts. Our record indicates the commitment to the goal of cost-effective operations. The Kansas Hospital Association feels that the best strategies for achieving realistic, long-range hospital cost containment are the continuation of established programs such as health planning, utilization review, and patient education. Kansas hospitals have been active and early supporters of the development and implementation of projects designed to fully develop these systems.

In addition, Kansas hospitals, working with Kansas Blue Cross, have voluntarily entered into a program that will require hospital rates and budgets to be prospectively reviewed by a committee of health care consumers. The Prospective Rate Review Program in Kansas has just completed its first full year of operation. A total of 51 Kansas hospitals have signed a contract with Kansas Blue Cross, who administer this program, to have their rates reviewed. The results of this initial year are encouraging.

We feel the cost containment efforts of Kansas hospitals when combined with similar efforts by hospitals in other states, as a part of the voluntary cost containment effort being spearheaded by the American Hospital Association; the Federation of American Hospitals and the American Medical Association, offers a more realistic opportunity for true cost containment than does a revenue control measure. We urge that no action be taken by the Congress until such time as the cost containment mechanisms already in place, or currently being developed, have been allowed sufficient time to demonstrate their effectiveness.

REVISED SPECIFICATIONS OF S. 1470, THE MEDICARE AND MEDICAID REFORM ACT PROPOSED BY SENATOR HERMAN TALMADGE (D-GA.)—A STATEMENT BY THE KANSAS HOSPITAL ASSOCIATION, JANUARY 26, 1978

Although specific legislative language is not available at this time concerning the proposed specifications for the Medicare and Medicaid Reform Act, S. 1470, the Kansas Hospital Association feels certain points need to be made concerning potential reforms of the Medicare and Medicaid reform system.

The alternative approach for establishing limits on total routine service revenues in the revised specifications expands upon the original proposal for the comparison of routine service costs by essentially similar hospitals. The classification methodology embodied in S. 1470 appears to be an improvement over the existing methodology for classification of hospitals to determine essen-

tially similar institutions, as has been employed in the administration of Section 223, P. L. 92–603. The Kansas Hospital Association, however, feels that any system designed to classify institutions for the purposes of determining reimbursement due to institutional comparisons has certain inherent difficulties. A classification system must be sufficiently sophisticated so as to realistically separate efficient from inefficient institutions. The system should be designed so that efficient hospital operations do not find themselves penalized because of inappropriate classification determinations. We, therefore, are concerned about the proposed speed up in implementation of the reimbursement reform program. Such an acceleration might preclude the opportunity for the collection and evaluation of the data important to the development of an appropriate classification system. Therefore, the Kansas Hospital Association hopes that such a control program will include sufficient flexibility to permit the timely consideration of exceptions and corrections of erroneous forecasting or classifications. The Kansas Hospital Association also feels that the system should be one that can be easily modified if serious problems do arise.

It is the opinion of the Kansas Hospital Association that the best vehicle for long-range reimbursement reform is through budget and rate review of individual hospitals. We support the provision in the revised specifications that allows for the exemption from federal limitations to state hospital regulatory activities. We do believe, however, that some existing voluntary programs, such as the one we have developed in the State of Kansas, operating under state sanction, could effectively carry out the rate control function. The Kansas Hospital Association therefore recommends that states should have the authority to utilize such heretofore voluntary programs. A state program can provide for individualized hospital budget and rate review, consideration of community characteristics, and handle the necessary coordination with local planning decisions. Further, any such state-based review program should permit the development and testing of alternative payment methods and their evaluation.

Finally, the Kansas Hospital Association supports the development of a uniform reporting mechanism for the federal entitlement programs. We do urge that such a program be viewed as a reporting system and that a uniform chart of accounts for all hospitals not be required.

These comments are a brief highlight of the major thoughts of the Kansas Hospital Association on the revised specifications of S. 1470. At such time as specific legislative language has been developed, a detailed analysis will be conducted and formal comments provided.

MANDATORY UNIFORM ACCOUNTING—A STATEMENT BY THE KANSAS HOSPITAL ASSOCIATION, JANUARY 26, 1978

There has been recently much discussion by governmental officials concerning the feasibility of mandating a uniform accounting system for hospitals. Several of the recent hospital cost containment legislative proposals called for the establishment of a uniform accounting system, and the Talmadge Medicare and Medicaid reform proposal calls for the establishment of a uniform cost accounting system. In addition to these proposals, the Medicare/Medicaid Anti-Fraud & Abuse amendments, P.L. 95–142, contained a requirement for uniform reporting systems for those hospitals participating in Medicare and Medicaid. In light of this recent activity, the Kansas Hospital Association feels it is imperative that our position on this highly technical, but nevertheless crucial, issue be fully explained. The attached statement details the position of the Kansas Hospital Association on a mandatory universal functional accounting system.

The Kansas Hospital Association does recognize the needs of the federal government for uniform data, and we fully support the development and implementation of a nationwide uniform reporting system. We are unalterably opposed to a mandated uniform functional accounting system that would govern the day-to-day decisions made in individual hospitals. The Kansas Hospital Association believes the needs of hospital management for information are more important than the data requirements of the federal programs, and further feels that such a uniform accounting system could frustrate the efforts of the individual hospital administrators to achieve cost-effective operations.

Position of the Kansas Hospital Association on the Mandating of a Uniform Accounting System for Hospitals

The Kansas Hospital Association, speaking on behalf of its member hospitals, is opposed to the mandating of any uniform functional accounting system on hospitals. The Kansas Hospital Association recognizes the need of the federal entitlement programs for certain kinds of financial data from hospitals that are necessary to enable governmental officials to attempt to solve the problems of health care cost increases, to achieve equity under current payment formulas, to develop alternative payment mechanisms, and especially, to control fraud and abuse.

However, it is important that it be understood that the mandating of a uniform accounting system will not assure the information necessary to achieve these worthwhile objectives. What is desired is a uniformity in the reporting of this necessary data, and uniform functional accounting is not in and of itself a better guarantee of uniform reporting than would be a specially designed uniform reporting system.

The Kansas Hospital Association therefore urges that no universal functional accounting system be mandated for the following specific reasons:

1. Although there is a need for accurate and comparable data with which the government can make health policy decisions, we feel hospital management information needs are primary, not secondary, to the provisions of such information for external purposes. The needs of hospital administration are best met by an accounting system based upon responsibility accounting. Responsibility accounting is essential for management to have the financial information necessary to maintain an efficient and effective operation. Such a responsibility accounting system requires sufficient flexibility in order to adapt to changing circumstances. The flexibility thus required is inherently impossible to achieve under a mandated functional accounting system.

2. The external requirements of the federal government for uniform data from hospitals can be met by developing a uniform reporting mechanism complete with uniform definitions. If such a system were developed, any existing responsibility accounting system could provide the data requested on any specific report.

3. The mandating of a uniform accounting system would be extremely costly. It is estimated it would require approximately $20,000 per institution to change current accounting systems to a functional accounting system. This would be a one time expense that would involve the retraining of personnel, the changing of accounting procedures, and, in some instances, the modifying of existing computer programs. In Kansas this expense would amount to approximately $3.3 million in the first year such a system would be in operation. In addition, there would be ongoing expenses incurred, as each individual hospital would be required to develop alternative accounting requirements that it needs to insure a cost-effective operation. These responsibility oriented reports would have to be developed outside the functional system. Even if these additional management reports, which are now being generated naturally through existing accounting systems, could be developed at an expense of only $10,000 per institution, it would still raise the total health care cost in Kansas hospitals by $1.65 million per year.

In summary, the Kansas Hospital Association recognizes the need of the federal government for uniform data and supports the development and implementations of a uniform reporting system. We are opposed to a mandated uniform functional accounting system. We believe the needs of hospital management for information are more important than the data requirements of the federal government, and such a uniform accounting system could frustrate the efforts of hospital administrators to achieve cost-effective operations. We are also concerned that the cost of implementation of such a system would be greater than its imagined benefits.

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