HEALTH CARE COSTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

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PUBLIC WITNESSES

HEALTH CARE COSTS

MONDAY, FEBRUARY 13, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
St. Louis, Mo.

The subcommittee met, pursuant to notice, at the U.S. Federal Building, Hon. John C. Danforth, presiding.

Present: Senators Danforth and Dole.

Senator DANFORTH. Good morning, ladies and gentlemen.

I would like to welcome everyone to this field hearing of the Finance Committee on the rising cost of hospital care and possible solutions to contain that cost.

The Finance Committee has jurisdiction to deal with health care legislation and particularly health care cost legislation.

We would have liked to have had about a week of hearings here in St. Louis on the question of health care cost containment, but unfortunately, we are limited to just this morning. And as a result we have to be a little bit abbreviated in hearing from the witnesses.

However, we do believe that it's crucial that all views are represented and therefore, we plan to keep the record open until February 27 for additional comments. We encourage all those who have a view to submit a statement to my St. Louis office and the statement can be included in the printed record.

For those who are testifying orally, we have asked you to limit your formal statements to 5 minutes, which sounds ridiculous. If we can't get to Kansas City, it might be a little more leisurely, but Senator Dole and I are planning to leave at 11:30 to catch a plane for Kansas City.

The rising cost of health care is a concern to all of us. For the 20 percent not covered by any insurance, the cost is direct and the concern is particularly acute. Those of us who have insurance coverage have experienced the costs indirectly.

We have all seen taxes increased to finance the rising cost of government health care programs. We have seen insurance premiums increased without additional benefits provided. We have forgone wage increases and paid more for goods and services as a result of the increasing cost of health care fringe benefits.

I'm told that health insurance is a larger cost component of building a General Motors car than steel.

The dollar figures on health care costs are staggering. In 1970, total U.S. payments for hospital care were $26 billion. In 1977, 7 years later, the payments were $65 billion—a 150-percent increase.

Each year a higher percentage of the Federal budget is taken up by health care expenditures, from 9.2 percent of the budget in 1970, to an estimated 13 percent in fiscal year 1979.

Translated into more personal terms, if you become sick today, you can expect to spend well over $150 a day in a hospital. For an average hospital stay, you can expect to receive a bill for over $1,000.

These figures are dramatic but they don't answer the hard questions. No one would say that the American people should have second-class medical care. We are entitled to the highest quality medical care available. But what can we do without sacrificing quality?

Are the costs high because of administrative waste? Because of overstaffing? Overbuilding? Excessive laboratory tests? Unnecessary surgery?

What incentives can we introduce to keep the costs down? Should we impose a ceiling or some other inflexible device on the system as a whole, as the administration has suggested? What will that do to quality? Senator Dole has proposed a solution which introduces competition and takes into account differences among hospitals. Is that workable?

Will its implementation present excessive administrative cost? Excessive redtape?

Ultimately, we must face the most difficult question of all—what is the appropriate standard of care? Are we going to spend millions of dollars on the care of one person? How much of our Nation's resources can we commit to health care? This question requires Solomon-like judgment to resolve. But we must face it in formulating policy.

Senator Dole and I hope that we can begin here to get some answers to these questions. There are many people here today who have dedicated their lives to the health care area. We believe that listening to you and reading your statements will help us develop appropriate proposals.

We deeply appreciate those who have agreed to come here today. We hope to learn today and to carry a message back to Washington in the form of information to our colleagues and perhaps in the form of new legislative initiatives.

Senator Dole has a statement which we'll insert into the record at this point.

[The prepared statement of Senator Dole follows:]

STATEMENT OF SENATOR BOB DOLE

It is a great pleasure for me to be here in St. Louis today with those of you who share our concern over the high cost of hospitals and health care.

This is the second hearing on health care in which I have participated in the last few weeks. As many of you may be aware, I held a hearing on rural health care problems in Manhattan, Kansas on January 28, which I felt was very helpful.

I am hopeful that these hearings will also provide us with information on what you feel to be the critical issues facing us, and how we can be of help as members of the Senate.

The increasing expenditures, and costs of health care have become a major issue facing the Congress for a number of reasons. The increases have had a significant impact on: Public Expenditures by Federal, State and local governments, industry expenditures for employee benefit plans, and ultimately, consumer expenditures, through direct payments for health services, insurance premiums, taxes, foregone wage increases in favor of increased health insurance benefits, and an increased cost of living due to the impact of health spending on the rest of the economy.

Additionally, the increases remain an issue because we are unclear at this time exactly what the expenditures are buying as far as health care quality is concerned.

An increasing portion of the Federal budget has been given to health over the past decade. The total percent of total Federal outlays for health care has gone from 2 percent in 1966 to 9.7 percent under the Carter Administration's budget proposal.

Constant trade-offs must be made between health care, social welfare, defense, and spending for other government programs. Increased spending for any one of these areas decreases the money available for the others. Health has been focused upon as a problem primarily because the spending has risen much more quickly and dramatically than the spending for some of the other programs.

We are now faced with the choice of either gaining control of these costs, decreasing spending in other areas, or reducing benefits.

As the ranking republican member of the Finance Health Subcommittee, I have a very special interest in these problems. As you know, the health subcommittee deals with Medicare, Medicaid and the maternal and child health program, as well as various national health insurance proposals. Additionally, while many other health programs are not within the jurisdiction of the subcommittee, such as health manpower, planning and research, their influence on medicare, medicaid, and maternal and child health makes them equally important and thus, of interest to us.

We are with you today, so we can hear from you directly how you believe we can best address the issues, and, as I mentioned earlier, what you believe the issues to be.

I am particularly pleased that both Senator Danforth and I will have an opportunity to hear from those of you here in Missouri, as I believe we have a great deal in common, and can only gain by working together.

With me today is my legislative assistant, Sheila Burke, a nurse by education, and Jay Constantine, the chief health staff member for the Senate Finance Committee.

I again want to thank you for being here and apologize for my tardiness. I look forward to hearing from each of you.

Senator DANFORTH. Mayor Conway, I'm told, was here and had other things to do such as get the snow off the streets. We'll insert his prepared statement at this point.

[The prepared statement of Mayor Conway follows:]

STATEMENT OF MAYOR JAMES F. CONWAY

INTRODUCTION

Express thanks for coming to Saint Louis.

Thanks for allowing Mayor to express the unique situations of public and municipal health.

As an older city, Saint Louis has something few other places do—a lot of rich history, and a lot of fascinating medical history—even history about medical costs.

HISTORICAL ANECDOTE

In the early years of this city we had the steamboats. It seems exciting now, but then it was infested with disease and more specifically, cholera. The boats brought the first cholera epidemic in 1832. It came from down river and it killed 5 percent of the village population.

Cholera came again in 1849—and this time it was really a plague. During the summer of 1849, when the city had less than 50,000 people, there were 4,500 deaths caused directly by cholera, and another 4,000 deaths from other causes.

In the early summer people tried to ignore the disease problem. But finally, when citizens started to literally die in the streets, there was a mass meeting. They gathered down at the Old Courthouse, just down the street on June 25 and formed a Committee on Public Health.

My predecessor, Mayor James G. Barry, called an emergency meeting of the City Council that next day, June 26. The Mayor and the Council—who were literally frightened to death of the plague—appropriated $50,000 to this committee to fight the cholera epidemic.

This committee:

Established not one but *six* emergency hospitals, one for each ward in the city.

Appointed teams of inspectors to comb every nook and filthy cranny of the city and clean it out, block by block, house by house, room by room.

Set up squads of "fumigators." These squads gathered coal, tar and sulphur, and at 8 o'clock on the night of Saturday, June 30, 1849, they ignited bonfires on every intersection of the City. Their hope was to somehow sterilize the air from the cholera disease.

They even proclaimed Monday, July 2, as a citywide day of prayer and fasting.

What happened?

History tells us that on August 1, the emergency committee declared the epidemic at an end.

More to our point. The Committee on Public Health gave back $16,000 from the original $50,000 they were given.

They must have known something about cost containment!

COST CONTAINMENT

We are strongly in agreement with the President and with others.

We have a City budget of some $214 million. Health and Hospital Division alone consumes some $60 million annually. This is a staggering burden.

I, as Mayor, just recently moved to get some control over health and hospital costs. An 18-member citizens task force studied every hospital, every facility, every service and even studied every study that went beforehand.

Less than a month ago I directed Dr. Wochner, our Director of Health and Hospitals, to start consolidation of the overlapping services at our two general acute care hospitals.

For historical and political reasons, this will be tough. But we'll cut out the waste.

IMPROVED COLLECTIONS

Since 1971, we have been aggressive in trying to recover costs from patients and from third parties—from Medicare, from Medicaid, and from private insurance firms.

We've been very successful. In 1971, we recovered a total of $11 million. This year, we are recovering a total of $33 million. Thus, we have *tripled* our collections in 7 years.

And yet, costs have soared. They've soared so much that last year we spent about $21 million in tax revenue for hospitals. That's just about the same as 1971. We have run hard and fast, and are barely staying even.

OTHER COST-SAVING MEASURES

We've kept costs from soaring even more by completely eliminating any capital improvements. We've built very little. We've purchased virtually no new equipment. (Dr. Wochner will provide details of this situation).

URGENT SUGGESTIONS

In this urban area we believe costs can be kept under control—and even lowered by providing health care *outside* of hospitals.

By expanding clinics, and making them much better used:

We can *postpone* hospitalization for non-emergency causes.

We can *prevent* hospitalization in many cases.

We can *shorten* hospital stays for those who absolutely must go to hospitals.

Thus, shifting much health care from the expensive bed-and-board hospital to the ambulatory clinic, we can definitely cut a lot of unnecessary costs that are now tied up with hospital treatment.

Our problem: how do we shift a lot of this treatment? We have applied for a grant of $3 million from the Robert Wood Johnson Foundation. So have 25 other U.S. cities. They all need and want to do this kind of transfer. If federal help were available, they all could shift from costly general hospital to more direct, economic, clinic treatment for a sizeable majority of patients.

A further suggestion.

This transfer could be made more quickly and more effectively if Medicaid programs would pay for out-patient services, which it presently does not, and for nurse practitioners, and for physicians assistants, which it presently does not. (Again, Dr. Wochner will explain more detail).

UNIQUE SITUATION OF PUBLIC HOSPITALS

Municipal hospitals and public health institutions are going to be hit hard by any plan to reduce hospital costs by applying a rigid "cap" on cost increases.

Why? Because private hospitals will quickly discharge their highest-cost, longest-staying patients. They will also refuse completely to take patients in dubious financial circumstances.

What happens then?

The long-term patient comes to the city or county hospital, and will be taken in. The poor and the financially questionable will do the same.

This, of course, is the responsibility and, in a way, the privilege, of city and county governments.

At the same time, we hope that these public institutions have a priority on federal help, on subsidy, on any measure of relief that will be offered to all health care institutions.

FINAL POINT

Back in 1849, we were able to organize, to halt a dreaded cholera epidemic. The entire city joined together—doctors, officials, religious organizations and citizens—and when it was done, they returned $16,000 out of $50,000. They refundcd 32 per cent of the money they were given.

I seriously wonder if that would happen today—anywhere in the U.S. We know a lot more about public disease, and we stop epidemics before they become plagues. But we seem to have lost the knowledge of balancing costs and services the way those Saint Louisans did in the summer of 1849. For the sake of our social as well as our physical health, I hope we rediscover that knowledge.

Thank you very much.

Senator DANFORTH. I know Supervisor McNary was heading here when last seen—he's here. Good. How long have you been here?

Mr. MCNARY. I got here about 5 minutes before you did.

Senator DANFORTH. Are you ready?

Mr. MCNARY. Ready.

STATEMENT OF GENE McNARY, ST. LOUIS COUNTY SUPERVISOR

Mr. MCNARY. Senator, I have submitted a prepared statement and I know what your time constraints are, so I would summarize my statement by saying that our problem in St. Louis County is not like hospital problems and health care problems throughout the United States.

We had a greater problem some 3 years ago. Ours is approximately a $20 billion health and hospital budget. We found that while our health care was considered excellent, the costs were rising. By and large the costs were beyond our control—outside external forces.

To the extent that we could do something about our problem—we, first of all, reaffirmed our commitment to provide health care for our citizens. I say that because we considered various alternatives. Indeed, the first question, whose responsibility is it.

And this takes into account private hospitals, the obligation of public hospitals, whether or not our responsibilities extend beyond the indigent, whether we could contract with private hospitals, which as you know, in St. Louis County, we're blessed with many.

And we probably have more private hospitals—fine new private hospitals—per capita than any other place in the Nation. So we did an in-depth study to find out if because of our peculiar blessings, we might be able to cut back or rearrange through private contracts, some better way of rendering health service.

We found that we could not. We did have an obligation in our ordinance to cover indigent care and that the better form of rendering that service, to stay in the public hospital business.

We at that time determined that while our health care—our secondary health care—was excellent, the business operations—much of

that is because of rules and regulations that are set down by the Federal Government and third party payments, much of our business operations was not as efficient as it should be.

We reviewed experience in various areas, public and private, with hospital management firms. And starting January 1, 1977, we contracted with Hospital Affiliates—they're national—for professional hospital managements.

In 1977, we increased in revenues, most of which was on third party payment, $1,380,000, which in St. Louis County was a real savings of approximately 4 cents on the property tax rate.

We feel as though the experience with hospital management in 1 years' time has been excellent. The savings in efficiency have been a further savings to our taxpayers. At the same time, we think the quality of care has been improved. It's not just a matter of business concern; it's a matter of efficiency which carries over into the rendering of health care service.

My recommendation is that as the Federal Government considers this very important service and considers the cost of it—not only to the taxpayers but cost to the individual who uses hospitals, and it may cover not only public but private hospitals—it has to be such that every human being can afford hospital services.

Our concern is that there not be a level of cuts that will force the local hospitals into drastic changes that cannot be followed. Changes that will force cutbacks in certain areas that will severely hinder the quality that's afforded.

We feel as though gradual cutbacks, gradual levels of cost, maximum costs, we can live with. And there should not be a penalty on those hospitals who have already gone into the cost control area.

That's our main concern. I'd like to point out——

Senator DANFORTH. You think a 9-percent cap would be a negative——

Mr. MCNARY. Yes; I do. And I think that it would be a short time before there would be a hue and a cry go up throughout the country that hardships were created. And very real hardships to the point that people will suffer from the decrease in health care in particular areas. You just can't cut 9 percent without having drastic repercussions. A smaller cut——

Senator DANFORTH. Well, it wouldn't be a cut, it would be a lid on increase.

Mr. MCNARY. All right. A lid, except that's the other side of the same coin. As we inflate, a lid on your increases, it means a cut.

Let me suggest to you that in another area—this may not be directly related to your subject, but I'm not satisfied with the structure that Congress has given us in regulating health care services on a regional basis—or a metropolitan basis.

We have health services agency in this area, and I'm sure there are similar regional agencies in other places—unlike East-West Gateway Coordinating Council which is made up of the elected officials.

HSA is a conglomerate of providers, users, and elected officials by statute restricted to 20 percent. It concerns me that there's not accountability. I see another level of government there, a very powerful level of government that is not accountable to anyone.

And it concerns me that if we're going to solve a problem, or if we're going to work as a unit or even have some kind of coordinated

effort, that that needs to be restructured. It's bad enough to have the Federal bureaucracy much less one further extension that's not even accountable to HEW or to the Congress.

Senator DANFORTH. Do you object to the certificate of need concept? Do you object to the makeup? I know that this is in litigation in the Attorney General's office. It's in litigation on the question of the makeup of the HSA's. Do you have a feeling on the certificate of need concept?

Mr. MCNARY. I really do not have a position on that.

Senator DANFORTH. You're just concerned with the governmental role?

Mr. MCNARY. Yes. It seems to me, if we're going to address this problem of hospital costs, we need to have the structure mechanism to work with. And I don't see it there. I think the entire structure needs to be rethought in Congress.

Second, and this is very general, it seems to me in St. Louis County we're taking the approach that we might save cost in the long run, if we concentrate more on primary health—not the extensive secondary health, but that if we can treat and somehow reduce the problems at the earlier stage, that that has long-term benefits in reducing costs in the secondary.

Those are my comments.

Senator DANFORTH. Thank you very much. I appreciate your struggling down here.

Mr. MCNARY. And I tried a different route which turned out to be a better one really.

[The prepared statement of Mr. McNary follows:]

STATEMENT OF ST. LOUIS COUNTY SUPERVISOR GENE MCNARY

As Supervisor of St. Louis County with the responsibility of administrating a public hospital, I have first-hand knowledge of the complex problems relating to the escalating costs of providing health care and the impact health care benefits have on an employee's paycheck.

By ordinance St. Louis County Government has a responsibility for the care of indigent patients. In addition, we have an obligation to be fiscally responsible to the taxpayer—trying to lessen the cost-burden of services wherever possible—and, our employees expect us to provide adequate health insurance benefit for them.

Nearly three years ago our Department of Community Health and Medical Care was suffering for a financial crisis so severe as to threaten the extinction of hospital services. County Government grappled with the problem for some time and undertook studies to determine alternate means of providing hospital services elsewhere in the area. Cost estimates for such alternative measures revealed no gain for the citizen, the patient or County Government. It is my belief that though external forces drive hospital costs ever upward, a hospital—private or pbulic—should itself trigger an in-house mechanism to control real and inflationary costs

To that extent we in County Government began to do something about our problem: First, we reaffirmed our commitment to provide health care for our citizens; second, we felt that since 40 percent of this nation's medical expenses are attributed directly to hospital costs, our first line of attack should be hospital management, the day-to-day financial operations of the hospital.

There was no disputing our hospital offered excellent patient care, but we felt a need for financial expertise—someone knowledgeable of the latest trends in good hospital management, especially someone with a track record of recouping losses from third party payors, someone who could effect cost saving through efficiencies in management or functions.

We subsequently contracted for the services of a professional hospital management firm to assume total responsibility for County Hospital's day-to-day management. In just one year the firm achieved an increase in revenues totaling $1,380,000. That is a very real savings of approximately 4 cents on the property tax rate.

In addition, all management procedures including billing and collection were streamlined—losses were reduced in many areas of the hospital. Many departments were reorganized to achieve efficiencies in patient-centered care. These changes fostered a greater degree of accountability in each level of nursing supervision and improved the utilization of available resources.

Patients, our citizens, received more individualized care because of management decisions, making financial improvements, decreasing expenses, increasing revenues. Our TOTAL hospital vastly improved.

Now, if we in St. Louis County can, on our own, effect such improvements in costs, other private and public hospitals across the nation could do the same. At least, it should be considered as a starting point. I contend such hospitals *must* initiate their own cost controls, or the federal government may be forced to exercise controls. I, personally, hope this never happens. But if it must, I caution you to carefully consider the method and extent of intervention. Federal intervention should never penalize those hopsitals which have exerted their own controls and through self-motivation have produced cost efficiencies.

Let us not forget, it is the citizen who pays hospital costs. As congressman responsible for health care legislation, I urge you to remember hospital care must not only be available and accessible, but also it must be affordable.

Senator DANFORTH. Can everybody hear? OK. The next part of the program is a panel of two people from the medical schools; Dr. Virginia Weldon and I don't know if it's Mister or Doctor——

Mr. STENSRUD. Mister.

Senator DANFORTH. Mr. Richard Stensrud. Thank you very much for being with us.

STATEMENT OF VIRGINIA V. WELDON, M.D., ASSOCIATE PROFESSOR OF PEDIATRICS

Dr. WELDON. Senator Danforth, we have submitted a written testimony for the record and I'll just summarize from that testimony.

Senator DANFORTH. Just for the record, you are assistant to the vice chancellor for medical affairs at Washington University.

Dr. WELDON. That's right.

Senator DANFORTH. And Mr. Stensrud, you are the director of the——

Mr. STENSRUD. St. Louis University Hospital, yes.

Dr. WELDON. I'm also a pediatrician and have some experience as a provider of health care, not as an administrator, in the medical school. I'm representing Dr. Samuel B. Guze, the vice chancellor for medical affairs.

Both he and I are deeply concerned about what we all perceive to be an excessive rise in the cost of medical care over and above the inflation rate for the rest of the economy.

We are all aware that expenditures for health care are rapidly approaching 10 percent of the gross national product. And we're concerned about the stressful effects on the economy which this disproportionate share for health care may have.

In addition, since we are very much involved in biomedical and behavioral research in order to find the causes of and cures for and especially ways to prevent diseases, we are concerned about the disproportionate share of the HEW budget which the so-called uncontrollables are consuming, leaving less and less available for allocations for biomedical research.

Finally, and perhaps most importantly, we are concerned as to whether increasing expenditures for health care are actually resulting in improved health. Added expenditures may only improve health

marginally. Many who are concerned about this area have suggested that changes in personal behavior may have a greater beneficial effect on the Nation's health than delivery of more personal health services.

Much has been written during the last 5 years regarding the economic factors which are peculiar to the health care industry. Some of these are detailed in our written testimony. And I'm sure everyone in this room is familiar with these, so I won't go into them in detail.

I think the question I'm perhaps supposed to try to answer this morning is what role can the academic medical centers play in controlling and moderating both demand for health services and the cost of such services.

I have no simple solution to this question. Traditionally, medical schools and their affiliated teaching hospitals have been at the cutting edge of the delivery of tertiary care. Most of the technological advances in medicine have been tested and made available initially in these centers.

And we're all familiar with the implications of the so-called half-way technology. Unfortunately, no one has been really able to assess the true value of this technology. In addition, many technologic advances in medicine become additive rather than supplantive. That is, we put in a new piece of technology but we don't throw out any of the old.

I think this may be because all physicians are constantly striving for perfection, with their highest goal being the preservation of human life. And they are unwilling to take, perhaps, what may be needed risks.

But when the chips are down, I seriously doubt that anyone in this room would be willing to put a dollar value on his neighbor's life. And I think that's where part of our dilemma lies.

Until all of us are willing to make compromises—and these compromises may be fairly simple, such as the willingness to drive 30 miles in the snow, to gain access to a CAT scanner—it will be really very difficult to control medical care costs.

However, I believe there are a number of steps that medical centers such as ours can begin to take to hold these costs in line.

First, I think we can study the effects of our own employees' health benefit packages and perhaps begin to evaluate the impact of say, first dollar coverage versus coinsurance, deductibles, and ambulatory care coverage. All of these factors can be evaluated on the demand for health care, utilization, and cost.

In some large and complex centers, such as the Washington University Medical Center, more than one type of plan exists. And there would be a possibility there for comparative studies. Now I'm aware there are a number of comparative studies already.

But we don't seem to have reached any compromises or any significant achievements in those areas, so perhaps there's room for more study.

Second, academic medical centers should study the effects of licensure and accreditation of paramedical professionals on health care costs. According to Prof. Uwe Reinhardt, the operation of the nonphysician health manpower market is virtually unknown. The pace at which new health professionals arise, carve out new disciplines, develop national associations, and encourage State and Federal Government to incorporate them into accreditation procedures for hospitals has been explosive over the past decade.

I think this is an opportunity, perhaps, for our academic medical centers to study the effect of these paraprofessionals in medicine on health care costs.

Third, the medical schools and their teaching hospitals must make a conscious effort to incorporate an awareness of medical care costs in their teaching programs for medical students and resident physicians, because all of us are aware of that the doctors control the entrance into the health care system and further control by the tests they order, so that they have been implicated as one of the key factors in the whole problem.

I believe that we are beginning to do this in our day-to-day interactions between faculty and students, but I think there's room for much more improvement in that area.

Finally, I believe it is important to note that the Federal Government has played a major role in increasing health care costs by its direct policy of increasing the number of professionals and paraprofessionals in the health care system, thereby increasing the demand for health care incomes.

Initially, the reason for this policy was a perceived shortage of health manpower and subsequently a perceived specialty and geographic maldistribution of health manpower. The projected figures suggest, however, that we will have an oversupply of health workers in almost every area by 1990.

I believe that we must all recognize that continuous and frequent perturbations of the system by the Federal Government may only lead to further dislocations.

I should like to conclude with a note of caution and echo Reinhardt's——

Senator DANFORTH. What's that last sentence?

Dr. WELDON. I believe we must all recognize that continuous and frequent perturbations of the system by the Federal Government may only lead to further dislocations.

I should like to conclude with a note of caution and echo Reinhardt's concern regarding a national policy to control health care costs. He warns us that such a policy can be translated into a policy to control health care incomes—and I'm not speaking of positions now, or reduce the number of health care workers in the system.

It's estimated that approximately 6½ million persons are involved directly and indirectly in health care. A substantial percentage of these workers are estimated to be women and minorities, so I'd like to emphasize again I'm not concerned about physician income, but incomes of other workers in health care.

That's the conclusion of our formal statement.

Senator DANFORTH. Thank you.

STATEMENT OF RICHARD L. STENSRUD, DIRECTOR OF ST. LOUIS UNIVERSITY HOSPITALS

Mr. STENSRUD. Senator, thank you for allowing us to present our position to you. I have submitted a formal statement in writing and I would like to now share some verbal remarks in summarizing them.

I too represent an academic health center where we are engaged in research—social research, medical research, and service—health service and health education. And the service part is particularly different,

I think, then you might find in a community hospital along the lines Dr. Weldon mentioned.

In other words, we're doing tertiary care. We're bringing together the leading edge of technical technology, applying it in a tertiary setting—in a very disciplined setting, to avoid a radical use of one technology. In other words, a collaborative approach.

And as a representative of an academic health center, I think we see the problems more acutely and the cost, the applied technology, the intensity of services occurring in our setting is as much or more than maybe in the community hospital.

So, St. Louis University invited a number of people to participate in a voluntary conference—a paper—a study of the causes of increasing health care costs. And people from around the country participated, a number of them came from St. Louis and we talked about it. And we are in the process of preparing a more formal and lengthy document.

I think I can summarize by saying there are two major causes of what we now call health care cost problems. The first is a financing mechanism. The financing mechanism was started in Dallas and during the depression, so that hospitals and people could get together, and it was clearly the hospital costs that were bothering the people in Dallas.

And that system of concentrating on inpatient services was built and expanded and we have now a system of financing that clearly addresses inpatient care. And it builds big hospitals and big medical centers to deal with whatever problems occur. Maybe they're small problems maybe they're big problems.

And we've ignored some of the behavioral and the health promotion things, so that I think the financing mechanism has dragged us into a situation where we're going and it's causing a problem.

The second thing, there have been 12 major laws—Federal laws, that it concerned only the health industry, in the past 12 years—12 laws. If you owned a company in St. Louis and you had the president in Washington and every year he passed a great big mammoth policy that says we're going to tool up and train emergency doctors, then we're going to tool up and get health care out to everybody in the world, then we're going to tool up and undo that and then we're going to do something else.

Twelve major policy decisions for a corporation in 12 years, the corporation would be going bankrupt. It's very fortuitous that the Government allowed us to have a cost base system because there wouldn't have been any other way to exist, if there had not been a cost for all this.

It was 12 major laws that just discombobulate, and I don't remember that word but I think that means the same thing.

So, I think that one more law and one more regulation won't solve the problem satisfactorily. I looked at the proposals of the Senate and the House and they were just one more control. And if you look at this one more control and you think, well, now, I suppose we could work our way around that and the next thing that's going to happen is somebody is going to put another control and it's going to be a contest from now on. There's just no way out the way we're going.

Senator DANFORTH. What do you think we should do? Nothing?

Mr. STENSRUD. Well, yes, in summary—well, I tell you what, that the people in Missouri have 411 people per 100,000 population in

Missouri who die of heart problems; 88 in Alaska die of heart problems. Now is there a need for one central government that proposed one solution for those two States, when the problems are completely different?

I'm not so sure nothing is the answer. I think that we have to look at what we've got. The same thing is true of accidents. There are some States that have a high accident rate and some a low accident, some high cirrhosis of the liver rate and some a low cirrhosis of the liver.

And I think we must look at what is needed instead of just passing one solution for everybody. The same thing is true with the financing mechanism. The old people probably need a health insurance. That's probably the best thing for old people. But for students in high school and college a health insurance is probably not the right thing. It probably would be better served by health service.

And so, I think if you look at the matter of difference in needs—a stop sign might serve more benefits in one area than something else, in terms of getting the most cost-effective benefits for the morbidity and mortality rates of the population served. I think a fourth point—or a third point, one point is to look at the differences in health need throughout the city, within the city, within the State, within the country. Look at the difference in financing that might be an approach—that must service, for instance, care.

Third, I think the planning process that has been started, the health planning process, is very effective. I think it's becoming more effective. It's brand new——

Senator DANFORTH. Ineffective?

Mr. STENSRUD. It's very effective. I think it's becoming more effective. It's brand new——

Senator DANFORTH. Ineffective?

Mr. STENSRUD. Effective, it works.

Senator DANFORTH. It is effective.

Mr. STENSRUD. I think it's working. It's working better and better. And I think supporting that process is worthwhile.

Finally, I think the use of the corporate structure of hospitals, and whatever exists, to get into other kinds of services—like promotion, health maintenance, that sort of thing, the existing institution you might do more.

Right now we are constrained from really going into those because our charter says we take care of the medicine and surgical hospital in the corporate charter. And we are limited in our scope and I think, you know, partly because of our own lack of wisdom—foresight.

That's a foruth recommendation. I think that existing services can be expanded into health promotion along the line Dr. Weldon mentioned there. We can prove it ourselves. We can use our own employees and look at financing mechanisms, health promotion mechanisms.

And just one other point. I think that many conflicting regulations that we have to contend with might be examined and see if we can get a consistently applied program that doesn't change from year to year.

Thank you very much.

Senator DANFORTH. Thank you very much.

Do you have some comments?

Senator DOLE. I apologize for being late but I understand we're not going to Kansas City today. We may have more time in St. Louis.

Senator DANFORTH. For that reason, you don't all have to feel that your 33 revolutions per minute record is being played at 78 speed.

Senator DOLE. Have you both testified?

Dr. WELDON. Yes.

Senator DOLE. I don't want to go back over the testimony. I think Jack may have covered the questions.

As he probably indicated, we're concerned about a number of things in the Finance Committee and in the Health Subcommittee including how do we get ahold of hospital costs.

Is there a bed surplus in the St. Louis area?

Mr. STENSRUD. What's a bed surplus?

Senator DOLE. I don't know; defining it is one of the problems——

Mr. STENSRUD. Most of the hospitals are full, I think, right now. I think the occupancy of most hospitals is very high at this time.

Dr. WELDON. If you use the Institute of Medicine survey of recommended number of beds, we would have to agree that according to those standards there is a surplus. However, I think that—speaking from a point of view of a medical center such as ours or St. Louis University Hospital—that we draw patients from a much wider area than our own HSA's or our own even bistate area.

We all have patients who come to us from neighboring States and even further away than that. So that it's very difficult, at least from our point of view, to use those bed statistics from Iowan study as a basis for our beds. So local HSA has estimated an oversupply based on those figures and I'm sure people who are later scheduled will address that problem also.

Senator DOLE. Have you discussed the—cost containment proposal—the flat 9 percent or how that might affect——

Mr. STENSRUD. Not specifically. I guess we would be opposed to that. We think it's an arbitrary number, it is not dealing with the health issue. It's dealing with the problem that the Federal Government doesn't have enough money to pay for the hospital cost.

It doesn't deal with the health issue which I think is much larger. And if you look at your objectives as reducing the morbidity and mortality and allowing people to have more days work because they are not ill, then I don't think we are dealing with that at all.

I think that is what our objective is and I think our objective is to do that at a reasonable percentage of the gross national product—8.6–9 percent. But not necessarily—in other words, to reduce the demand for services makes more sense than the reducing the supply of services.

Senator DANFORTH. How do you do that? How would you do that?

Mr. STENSRUD. Well, I think along the lines that we're tried to outline in terms of health promotion, in terms of looking for alternate strategies to take care of patients. Right now, for example, the end-stage kidney disease program makes it very difficult for a physician to convince a patient that they ought to stay at home and have home dialysis.

One reason is the spouse has to clean up the machine in addition to anxiety and all that. And it's an out-of pocket cost to them to be cared for in the home. Whereas, they come into the center there is an incentive in the financing mechanism for the people to feel that they've done everything for their loved ones by having the last illness taken care of in the hospital with all of the technology as opposed to whether

or not all the applied technology is prolonging life or prolonging anything, except incurring cost.

So I think health promotion, alternate theory sources of care are very viable. The HMO has reduced the number of inpatient beds required per thousand population for example.

Dr. WELDON. I don't think we really know what the demand is and I think we need to distinguish between need and demand. And I think it's one of our basic problems in accepting what percentage of the gross national product we're going to spend for health. Nobody has really come to grips with a health policy and if we are going for the limit on the percentage of the Federal budget or the percentage of the GNP that we spend on health, then as I said, we're going to have to make some choices. Because I think there is almost at this point an unlimited demand out there for health care services.

Senator DANFORTH. It's just a matter of national philosophy though, isn't it? It's a matter of values.

Dr. WELDON. That's right. And I think that's why it's so difficult. I think that with regard to the bills themselves, one of our major concerns is that that 9 percent cap will have some adverse effects for those hospitals that have already made major attempts to economize.

Senator DANFORTH. How do you feel about Senator Dole's bill?

Dr. WELDON. I'm not familiar enough with it, Senator Danforth, to be able to comment on it specifically. I know that Mr. G is in the audience, and I'm sure he'll be able to.

Senator DOLE. I think the problem with the administration's 9-percent cap is that it doesn't make any effort to sort out the efficient and inefficient hospitals, and it just seems to Senator Talmadge and myself and others that it's not going to work. It's easy to be against the proposal if you don't like the 9-percent cap, but what do we do to provide the incentive? We think S. 1470 does that.

But there's always the suggestion that maybe beds are filled because of the temptation to fill the beds for prolonged stays that may not be necessary. Plus the story we get from time to time, that it's just as easy to dump everybody in the hospital then taking care of them in the office. You sent them to the hospital because they're right there and the doctor can see 10, 20, 30 patients.

Those unnecessary admissions add to the cost. When there's an oversupply of wheat or anything else, prices go down. But with an oversupply of hospital beds, the cost is the same.

Dr. WELDON. I think that the PSRO and utilization review has helped somewhat. I know, for example, that at the Barnes Hospital, the length of stay has been cut by a quarter of a day in the last year.

Now, that doesn't sound like much, but if you multiply all the days—patient-days—that begins to be a substantial figure, and I think that the PSRO and utilization review has yet to be proved to be fully effective. And I think it's beginning to help shorten length of stay.

Senator DOLE. There was one report about the unconscious automobile victim who was taken to Barnes Hospital, he had to wait several hours because nobody could establish his ability to pay. Has that been resolved?

Dr. WELDON. I presume you're asking me that question.

Senator DOLE. Anyone.

Dr. WELDON. Like I said at the beginning, I'm a pediatrician, and I work at the St. Louis Children's Hospital. But I don't know a lot of the details.

Senator DOLE. I didn't mean to put you on the spot. You mentioned Barnes Hospital, I guess that triggered a computer up there.

Senator DANFORTH. How do the doctors at Barnes or Furman-DeLoudge react to PSRO's? Do they think—does it appear to them to be an attack on their professional responsibilities?

Dr. WELDON. Well, I think basically they've accepted it fairly well. Anytime you put in a new system, people are going to gripe about it. And I think there was a certain amount of anxiety and how is this going to work, who's going to come along and tell me that my patient shouldn't be here for this number of days, and how I see a note stamped in my chart that it's time for you to justify why this patient is here. And my temper flares every once in a while, and I justify it.

But also, I think, It certainly heightens my consciousness about the fact that we've got to get patients moving. Certain things have to be prepared in advance for discharge. For example, we sent home a lot of children on intramuscular medication, so their parents have to be taught to give it to them.

We can't wait until the day of discharge to do that. So you have to think about it the day the patient's admitted and start the nurses teaching that patient.

And I think this really has changed things. I think we all are much more aware that we have to take steps early in the hospitalization rather than waiting until the day of discharge.

Mr. STENSRUD. I think our doctors have accepted it very well, and I think it has some salutary effect.

Senator DOLE. I'm also on the nutrition committee and we keep talking about the need for more of a focus on better nutrition with it might save billions of dollars down the road. Now we wait until the illness strikes while it may have been prevented by a number of reasons. And there's certainly always that exploration going on.

But is there an effort in the medical schools and the teaching hospitals to increase nutrition education and the physicians learning more about nutrition?

Mr. STENSRUD. Well, the health benefits that we're going to give to our employees starting tomorrow on Valentine's Day, is a nutrition program. And 1 evening a week for 14 weeks, we're going to have a nutrition diet program. And for employees who are interested in putting the two together it's not a bad diet kind of thing but a basic nutrition program.

I think we believe that has some merit and——

Senator DOLE. I remember in the nutrition hearing we had witnesses testify that many physicians left school without much knowledge of nutrition because it wasn't being taught. So it's pretty hard for them to advise someone else on nutrition if they——

Mr. STENSRUD. I think there's a heightened awareness at this point and I think that's changing.

Senator DOLE. We're finally getting it into the schools. We have a nutrition education program authorizing us to spend 50 cents per child. We spend $30 or $40 on drivers education per child, but we had trouble getting 50 cents per child for nutrition education. This appears to be vital to us.

Senator DANFORTH. You were the one who mentioned about the possibility of personal behavior being effective. Do you agree with Secretary Califano wanting to educate us on not to smoke?

Dr. WELDON. I think that's going to be very difficult and I have thought in my mind about how to get people to change their behavior. I wonder how to get my kids to change their behavior and not to buy junk food at the grocery store. I'm appalled at what they come home with. And I'm a physician and a pediatrician and I can't change their behavior.

I sometimes think maybe we need to build in some incentives into the system. For example, perhaps a reduction in insurance premiums if you don't smoke, or some kind of lever. There are people who would argue very strongly against that, especially smokers in the room, but there are those who would say that smoking is something you can't help, or obesity is something that you can't help. You're made up that way and it's easy to gain weight, but I think that's true to a limited extent and I think that if there were incentives in the system for people who made an effort to keep themselves healthy, that we might achieve more behavior modification that way.

Senator DOLE. But that's the problem. The Government takes a certain direction as we have in nutrition, and then runs into opposition.

We suggested—though probably didn't word our report correctly, that people eat less meat. That brought every cattleman in Kansas up in arms. So we changed the report—eat more lean meat. You know, if you say it in a positive way, it's all right.

Senator DANFORTH. Thank you both very much.

[The prepared statements of the preceding panel follow:]

STATEMENT OF WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

I am Virginia V. Weldon, M.D., Associate Professor of Pediatrics and Assistant to the Vice Chancellor for Medical Affairs at the Washington University School of Medicine. I am representing Dr. Samuel B. Guze, the Vice Chancellor for Medical Affairs and President of the Washington University Medical Center. Dr. Guze regrets that he is unable to attend these hearings. He is deeply concerned about what we all perceive to be an excessive rise in the cost of medical care over and above the inflation rate for the rest of the economy. Washington University is pleased to have been invited to participate in these hearings.

We are all aware that expenditures for health care are rapidly approaching 10 percent of the Gross National Product. Although national policy has not yet set a limit on health care expenditures as a percentage of the Gross National Product, we are aware that economists become concerned about artificial distortions in the economy when any sector consumes such a large segment of all goods and services produced.

We at Washington University are also concerned about the stressful effects on the economy which this disproportionate share for health care may have. In addition, since we are very much involved in biomedical and behavioral research in order to find the causes of and cures for diseases, we are concerned about the disproportionate share of the HEW budget which the so-called "uncontrollables" are consuming, leaving less and less available for allocations for biomedical research. Finally, and perhaps most importantly, we are concerned as to whether increasing expenditures for health care are actually resulting in improved health for the nation. Added expenditures may only improve health marginally. Many have suggested that changes in personal behavior may have a greater beneficial effect on the nation's health than delivery of more personal health services.

Much has been written during the last five years regarding the economic factors which are peculiar to the health care industry. These include: physician induced demand, technologic advances, and societal demands, which taken together have resulted in changes in the types and level of services provided. The absence of direct payments by consumers with most payments made by third parties

has been implicated as a major factor contributing to increased societal demand for more technologically spohisticated services. Further, the fact that a majority of insurance premiums are hidden from consumers by virtue of the fact that they are included in employment-related benefits has been implicated. Other factors Include rising malpractice premiums coupled with unrealistic consumer expectations, the labor intensity of the health care industry, and a lack of incentives in the system for providers to reduce utilization of health services.

What role can the academic medical centers play in controlling and moderating both demand for health services and the cost of such services? I have no simple solutions to offer you. Traditionally, medical schools and their affiliated teaching hospitals have been at the cutting edge of the delivery of tertiary care. Most of the technological advances in medicine have been tested and made available initially in these centers. You are all familiar with these examples: coronary intensive care units, renal dialysis units, transplantation surgery, and more recently computerized axial tomography and the artificial pancreas. Unfortunately, no one has been able to determine a way to assess the true value of this technology. In addition, many technologic advances in medicine become additive rather than supplantive. I think this is because all physicians are constantly striving for perfection with their highest goal being the preservation of human life. When the chips are down, I seriously doubt that anyone in this room would be willing to put a dollar value on his neighbor's life. And that is our dilemma. Until all of us are willing to make compromises—and these compromises may be fairly simple, such as a willingness to drive thirty miles to gain access to a CAT scanner—it will be very very difficult to control medical care costs.

However, I believe that there are a number of steps that medical centers such as ours can begin to take to help hold these costs in line. First, we can study carefully the effects of our own employees' health benefit packages and evaluate the impact of first dollar coverage, co-insurance, and ambulatory care coverage on demand, utilization and cost. In some large and complex centers more than one type of plan may exist, resulting in the possibility of comparative studies within the same setting. The entire medical staff should be encouraged to take a hard look at costs and the necessity of services as they relate to members of the medical school-teaching hospital group.

Second, academic medical centers should study the effects of licensure and accreditation of paramedical professionals on health care costs. According to Professor Uwe Reinhardt, the operation of the nonphysician health manpower market is virtually unknown. The pace at which new health professionals arise, carve out new disciplines, develop national associations, and encourage state and federal governments to incorporate them into accreditation procedures for hospitals has been explosive over the past decade. It is my impression that the universities and medical schools must share in the responsibility for this burgeoning number of paramedical professionals. We must also study their effect on the cost of medical care.

Third, the medical schools and their teaching hospitals must make a conscious effort to incorporate an awareness of medical care costs into their teaching programs for medical students and resident physicians. I believe that we are beginning to do this in our day to day interactions between faculty and students in patient care settings but I also believe there is room for a much better and more organized effort in this area. Alternative ways of providing care must be explored and pointed out to all physicians—both students and teachers.

Finally, I believe it is important to note that the federal government has played played a major role in increasing health care costs by its direct policy of increasing the number of professionals and paraprofessionals in the health care system, thereby increasing the demand for health care incomes. Initially, the reason for this policy was a perceived shortage of health manpower an subsequently a perceived specialty and geographic maldistribution of health manpower. The projected figures for 1990 and beyond estimate an oversupply of health workers in almost every area of the industry as compared to other industrialized countries. I believe we must all recognize that continuous and frequent perturbations of the system by the federal government will only lead to further distortions and dislocations.

I should like to conclude with a note of caution and echo Reinhardt's concern regarding a national policy to control health care costs. He warns us that a policy to control costs can be translated into a policy to contain or reduce health care incomes or to reduce the number of health care workers in the system. Such a policy will have a very real effect on the approximately 6.5 million persons involved directly and indirectly in the health care system.

TESTIMONY OF RICHARD L. STENSRUD, DIRECTOR, ST. LOUIS UNIVERSITY MEDICAL CENTER

Senator Danforth, my name is Richard L. Stensrud and I am the Director of St. Louis University Hospitals and I am here representing the entire Medical Center which we wish to call an Academic Health Center.

It is my pleasure to have this opportunity to present the views of our academic health center on the topic of hospital and health care cost increases. I should like to add that these views are shared by other academic health centers across the country who worked with us in St. Louis to voluntarily examine the health care cost issue and attempt to reduce the increase. The participants in this voluntary effort are listed in Appendix A.

CHARACTERISTICS OF THE ACADEMIC HEALTH CENTER

My first point is to try to acquaint you with the unique characteristics and mission of the academic health centers across the country of which this State has several.

Academic health centers have the mission of educating health professionals, providing health services and advancing the state of the art of the health disciplines. Because of the synergistic nature of their mission, academic health centers as institutions utilize resources to deal with health problems that have not yielded to routine and widespread resolution. The term tertiary care is used to describe the association of sophisticated medical skills with new technology to treat unyielding health problems.

Tertiary care is exemplified by the collaborative treatment of cancer by a medical oncologist who treats with chemotherapy, a surgial oncologist treating with surgical intervention and a radiation oncologist utilitizing sophisticated radiation therapy equipment, tumor localization equipment and treatment planning computers. By using all three modalities, the treatment by any one may be less radical thus increasing the possibility of salvaging proximate vital organs.

Commitment to service, research and education frequently increases the cost of a day of care in an academic health center. For these as well as other reasons academic health centers administrators encourage the delivery of services unavailable in community hospitals. Frequently the health problems cared for at the academic health centers are those which would require sophisticated resources typically not available in community hospitals.

A. Medical research

As institutions with clear academic goals, teaching hospitals have a responsibility to provide the environment for creating new knowledge through supervised research. Because teaching hospitals are referral centers for the most complex and least understood disorders, the first insights into the fundamental nature of a biological abnormality frequently occur in these institutions. By identifying and communicating these findings, physicians in teaching hospitals bring the abnormality to the attention of the biomedical research community for further investigation.

Clinical trials are a highly formalized procedure for comparing a new drug, device, or procedure with either a placebo or "standard" therapy using protocols designed to protect the patient in order to obtain statistically valid results and to avoid erroneous conclusions. Clinical trials help determine whether a theoretical concept and laboratory experiment will, in fact, make a useful contribution to diagnosis and treatment.

New surgical procedures, drugs, and therapies make their transition from the laboratory to patient care primarily in teaching hospitals. This transition of treatment and technology is further extended when the medical student completes his training and carries the knowledge and skills to his practice.

B. Social research

Academic health centers have long been in the forefront of identifying health problems and seeking solutions. Examples include rat control, hypertension, lead poisoning and illness behavior. During the 1960's, academic health centers provided the manpower and technological resources for dealing with the major killers—heart disease, cancer and stroke. Major improvements in mortality due to these diseases have since been made.

Currently academic health centers are leading the way in identifying benefits of health promotion, studying the cost and benefits of annual physical examinations, the efficiency of various types of expensive hardware and advantages and disadvantages of alternate health delivery systems.

Other characteristics of the academic health centers are:

1. University owned or strong affiliations with a university and hospital that virtually and extricably ties the destiny of one with the other.

2. Educational programs usually include:

(a) Medical schools with graduate, post graduates and continuing education programs.

(b) Nursing schools with baccalaureate and master's degrees including major in subspecialities of nursing for careers in hospitals, physicians' offices and home health agencies.

(c) Dietetics with baccalaureate and master's degrees in dietetics and nutrition.

(d) Physical therapy with baccalaureate degrees in physical therapy.

(e) Medical technology with baccalaureate and graduate degrees in medical technology leading to certification by the American Society of Clinical Pathologists, including specialties in blood bank technology, clinical chemistry, microbiology and serology.

(f) Radiologic technologists with baccalaureate degrees.

(g) Hospital and health care administration with graduate degree programs.

3. Research Programs:

(a) Sponsored research from government, foundations, and industry.

(b) Non-sponsored research.

(c) Institutes.

(d) Basic research.

(e) Clinical research.

(f) Social systems research.

4. Health Services:

(a) Community medicine deals with such problems as rat control, lead poisoning, water and air pollution, other environmental problems, and community outreach programs designed to educate health care consumers.

(b) Operate hospitals. Provide tertiary care services under rather rigid institutional controls.

(c) Provide ambulatory care to geographical areas often including social-economic disadvantaged neighborhoods. Specialists in most areas of medicine are usually available to large geographic areas surrounding the immediate neighborhood.

(d) Provide primary care.

(e) Provide unreimbursed services in amounts usually far in excess of community hospitals.

(f) Provide new forms of therapy under controlled conditions.

(g) Provide a multidisciplinary approach to diseases that have not responded to other therapies and for which routine therapy has not been developed.

(h) Provide the following share of the nation's health care:

Teaching hospitals: Volume of services

Item:	*Percent of nationwide services provided by teaching hospitals*
Hospitals	5.1
Total beds	18.3
Total admissions	16.0
Inpatient days	19.2
Emergency room visits	16.0
Non-emergency-room visits	23.3
Total outpatient visits	21.0

5. Typical organizational differences between university and non-university hospitals include:

(a) High percentage of salaried physicians with offices on campus.

(b) Faculties available in most health disciplines.

(c) Written affiliation agreements with other hospitals in the area where the academic health center provides house officers and faculty.

(d) Often assists in staffing municipal hospitals at less than cost

(e) Medical staff has responsibility for service, education and research at far greater levels than in community hospitals.

(f) Salaries of faculty are based upon academic achievement and therefore do not provide incentives to provide direct patient care.

(g) Teaching hospitals belonging to the Council of Teaching Hospitals, have 18.3 percent of the nation's non-federal short term beds and provide 45.6 percent of the hospital based allied health education positions. Other distinguishing characteristics are shown in the following table.

COMPARING TEACHING AND NONTEACHING HOSPITALS: PROVISIONS OF SERVICES

	Percent of—	
	Coth hospitals [1]	All hospitals [2]
Item:		
EEG	98	40
Physical therapy	98	68
Inhalation therapy	97	70
Social work department	97	46
Intensive care unit	96	60
Diagnostic radioisotope facility	96	46
Histology lab	95	47
Blood bank	95	59
Emergency department	95	81
Organized outpatient department	94	24
X-ray therapy	88	30
Radiation therapy	85	24
Therapeutic radioisotope facility	84	22
Intensive cardiac care unit	81	32
Premature surery	81	35
Inpatient renal dialysis	73	12
Open heart surgical facilities	72	8
Occupational therapy	71	18
Cobalt therapy	66	13
Psychiatric emergency services	65	17
Psychiatric outpatient unit	65	11
Psychiatric inpatient unit	63	16
Outpatient renal dialysis	59	10
Inpatient abortion service	43	18
Family practice	43	6
Rehabilitation outpatient unit	42	7
Psychiatric partial hospitalization	37	8
Rehabilitation inpatient unit	30	5
Outpatient abortion service	24	8
Home care	24	6
Burn care unit	23	3
Organ bank	22	3
Self care unit	17	3

[1] Non-Federal, short-term members only.
[2] Non-Federal, short-term hospitals only.

Source: American Hospital Association's Annual Survey of Hospitals, 1974.

HEALTH CARE COST INCREASES—CAUSES

Senator Danforth, utilizing the U.S. Department of Labor's Consumer Price Index for 1976 and the baseline year of 1967 equaling 100 the following items are compared:

Item:	*Consumer Price Index, December 1976*
Heating oil	250.8
Coffee	243.6
Sausage	226.6
Postal charges	201.3
Gas	200.9
Lawyer's charges	199.9
Insurance and finance charges	196.6
Water and sewer charges	188.7
Medical care	184.7

The increase in medical care cost has resulted in some improvements although my source, the statistical abstract of the United States, compares in like terms 1965 and 1974.

Death rate, all causes per 100,000 population: 1974, 915.1; 1965, 943.2.

Death rates have decreased for such causes as:

	1974	1965
Major cardiovascular disease	478.2	510.9
Accidents	55.7	49.5
Influenza and pneumonia	25.9	31.9

Interestingly, those diseases that are regarded as largely self-induced compare as follows:

	1974	1965
Malignancies	170.5	153.5
Cirrhosis of liver	15.8	12.8
Suicide	12.1	11.1
Homicide	10.2	5.5

The above is positive evidence that the health care dollar has produced more benefits over the years compared. It also clearly demonstrates one major cause of health care cost increases is Inappropriate Health Behavior.

Controlling hospital costs will not deal with the problem, it will only take curative dollars away from those who need care.

A second cause of cost increase according to the representatives of academic health centers attending the conference at St. Louis University Medical Center is the matter of medical technology. On the one hand the federal government supports the American expectation to discover new, better, bigger and faster technological solutions to health problems. But on the other hand, technological changes further increase public expectation, cause competition among organizations to make the technology available and may cause the misuse of that very same technology. Health care costs increase as a result of the reliance on new technology as opposed to reliance on proper behavior, costs increase still further when it is used where it is unnecessary.

We can witness technology being applied to patients where prolongation of life is the goal without regard to the quality of the life we are prolonging.

The technological applications for terminal illness has become society's way to assuage the feeling of relatives who can proclaim that nothing was spared to save the life of a loved one.

The third cause of health care costs increases, in our opinion Senator, is the issue of the reimbursement mechanisms and national entitlement. Because people pay for and are entitled to health care, few believe that health care solutions are sought to problems that may more properly be the province of other disciplines. Chemical dependency, for example, was a social problem in the criminal justice sector of society until a few years ago when it became a reimbursable health care problem.

Further, it is estimated that 80 percent of the visits to a physician's office are for people termed the "worried well".

The entitlement/reimbursment issue further exacerbates health care costs by encouraging the use of hospitals for diagnosing and treating rather than the less expensive ambulatory care settings. There are actually disincentives for people to care for one another in the home or outside of the health system. Home renal dialysis, a treatment for people with end stage kidney failure, could be performed in the home in many cases. The problems of caring for the equipment and the relief from anxiety are, in many instances, the only advantages of treating the patient in a dialysis center. Out-of-pocket cost to the patient however, is substantially less for in-center treatment than it would be for the treatment rendered in the home by trained family members. Many other examples exist that are less dramatic but together account for a substantial amount of health care dollars.

It has been common, our group concluded, for politicians to promise great health benefits, like Medicare and care for patients with end stage renal disease and then attack the health professions for abusing the system that was a compromise perfectly suited to no one but the people who make the promises.

Another major cause for health care cost increases is regulatory compliance There has been one new law per year during the past twelve years that has resulted in continuous alteration and realteration of the health care system. If a large corporation was bombarded with major policy changes like the health care system has been bombarded by laws and their attendant regulations, I believe they would go bankrupt from the cost of "retooling". It is very fortuitous that the federal government put hospitals on a "cost reimbursement" system because there is no other way the system could have financially withstood such massive and far reaching policy changes that have occurred since the enactment of Medicare.

We would point to other factors that have caused health care costs to increase, such as, inflation and the tort system but these have been pandemic in the country causing costs to rise in all sectors.

RECOMMENDATIONS TO CONTROL HEALTH CARE COSTS

Senator, with all of the laws that have been passed over the past twelve years that dealt with nearly every aspect of health care, it is impossible for me to believe that another law will satisfactorily serve the American people. Perhaps we should permit the many policies, laws, regulations and guidelines to remain in place for a few years and see if our tinkering is, in fact, the cause of the problem. I am reminded of what Eric Severied said: "Most problems are caused by solutions". Mr. Elliot Richardson, soon after leaving the post of Secretary of the Department of Health, Education, and Welfare, warned of the ills of increased federal involvement in the health system. He stated:

"We must first set reasonable limits on further governmental involvement" and "secondly, so far as there is governmental involvement, we must strive to keep it simple."

The honor of this occasion prompts me to subordinate my strong feeling to leave things alone and offer suggestions that are directed at improving the quality of health of the people of this country. Recommendations which, we believe, will serve to stem and in some cases even lower health care costs. If this is our objective, let me share my thoughts and those of my colleagues from academic health centers across the country.

1. Morbidity and mortality rates are substantially different in each of the 50 states and even within a state or a city. One health care option, that is, the traditional hospital, may be the least cost/effective way to deal with human health problems. One could consider incentives, from government, to mobilize new and different resources under the corporate structure of existing hospitals to offer other needed health services besides direct health care. I suggest that health education in nutrition and self care may reduce costs along with programs to curtail smoking, chemical dependency, accidents and other causes of illness and death.

2. Just as the health problems of Missouri are different from those of Alaska (411 people per 100,000 population died from diseases of the heart in Missouri in 1974 compared to about 88 in Alaska) so too are the financing problems. One financing system imposed by one central force ignores the behavior of individuals of different social situations, e.g., the employed versus the unemployed, the old versus the young, the affluent versus the poor. Not only do persons of differing geographical regions and backgrounds seek care differently but they need different kinds of programs to improve their health (e.g., the poor may need money).

Students may require a health service rather than a health insurance to encourage early detection, education and proper behavior. The elderly, however, may best be served by benefits such as Medicare with options such as in the home and in the office care being encouraged.

This leads me to the recommendations that we should utilize the existing financing mechanisms where they are acceptable such as employer paid health insurance which may be restructured to reduce inpatient care as the best solutions evolve.

3. While everyone wants the latest medical advances made available in times of need there is evidence of technological overkill in the health field. The Health Systems Agency (HSA) is addressing this matter and offers local control and local administration. Further effort should be made to strengthen the HSAs across the country so that the technology is available in the most appropriate quantity and in the most appropriate setting. For example, limiting kidney transplant centers has been an acceptable decision.

4. The federal government should undertake a major study of all laws, regulations and authorities that deal with health in such a way that there is a consistently applied, coordinated approach that does not contradict and conflict.

While I have been rather general in my recommendations in this message, my colleagues in the academic health centers who share these views will pledge to work with you to detail the plans, assist in demonstrating their feasibility and provide the talent to evaluate the results.

APPENDIX A

ACADEMIC HEALTH CENTER'S FORUM FOR CONTAINING HEALTH CARE COSTS

A forum of hospital administrators from academic health centers was held on January 10 and 11, 1978, at the St. Louis University Medical Center, St. Louis, Mo., to discuss and formulate realistic means for containing hospital costs.

Chaired by Richard L. Stensrud, Director, St. Louis University Hospitals, the group included administrators representing a number of the leading academic health centers, including the following:

Dr. Richard T. Fox, Acting Chairman, Hospital and Health Care Administration, St. Louis University.

Mr. Robert Frank, President, Barnes Hospital, Barnes Hospital Plaza, St. Louis, Mo. 63110.

Mr. David A. Gee, President, Jewish Hospital of St. Louis, 216 So. Kingshighway, St. Louis, Mo. 63110.

Rev. J. Barry McGannon, S.J., St. Louis University.

Mr. James E. Moon, Administrator, University of Alabama Hospital, 619 South 19th Street, Birmingham, Ala. 35233.

Mr. Charles O'Brien, Jr., Administrator, Georgetown University Hospital, 3800 Reservoir Road N.W., Washington, D.C. 20007.

Mr. Bruce M. Perry, Executive Director, University Hospital and Clinics, 800 N.E. 13th Street, Oklahoma City, Okla. 73104.

Mr. Richard L. Stensrud, Director, St. Louis University Hospitals.

Mr. Linn B. Perkins, Executive Director, St. Louis Children's Hospital, 500 South Kingshighway, St. Louis, Mo. 63110.

Mr. J. Paul Poretta, Assistant Vice President for Health Services, University of Texas Medical Branch at Galveston, Eighth and Mechanic Street, Galveston, Tex. 77550.

Those from whom we received valuable input but were unable to attend are:

Dr. Paul R. Donnelly, Vice President, Catholic Hospital Association, 1438 South Grand Boulevard, St. Louis, Mo. 63104.

Mr. Paul Gazzerro, Jr., Assistant Director of Medical Affairs for Operations and Fiscal Planning, Vanderbilt University, Room CCC, 3312 Medical Center, Nashville, Tenn. 37203.

Mr. Ronald W. Green. Executive Director, Tulane University Hospital, 1415 Tulane Avenue, New Orleans. La. 70112.

Dr. Richard M. Knapp, Council of Teaching Hospitals, 1 Dupont Circle, N.W., Washington, D.C. 20036.

Mr. James Leming, University of Connecticut Health Center, Farmington, Conn. 06032.

Mr. William McLees, Administrator, Medical University Hospital of the Medical University of South Carolina, 80 Barre Street, Charleston, S.C. 29401.

Mr. William T. Newell, Director, University Hospital, 2500 North State Street, Jackson, Miss. 39216.

Mr. Merlin L. Olson, Executive Director, Uuiversity of Colorado Medical Center, 4200 East Ninth Street, Denver, Colo. 80262.

Max P. Pepper, M.D., Chairman, Department of Community Medicine, St. Louis University.

Mr. Charles Steib, Assistant Director of Government Legal Services, Catholic Hospital Association, 1438 South Grand Boulevard, St. Louis, Mo. 6314.

The conference staff included:

Kristine Gebbie, Assistant Director, St. Louis University Hospitals.

Vincent E. Jordan, Assistant Director, St. Louis University Hospitals.

Chris Messina, Director of Community Relations, St. Louis University Hospitals.

Herbert Schneiderman, Assistant Director, St. Louis University Hsopitals.

Robert M. Swanson, Ph.D., Assistant Director, St. Louis University Hospitals.

APPENDIX B

[From the Wall Street Journal, Feb. 10, 1978]

HEALTH AND HAPPINESS

We were struck by the central finding of a recent University of Chicago survey on health care: 61 percent of the respondents think there is a "crisis in health care" in the U.S., but an even higher proportion, 88 percent, are satisfied with the health care they themselves receive.

It is interesting to ask how a "crisis" can exist when only 12 percent of the people are unhappy. The survey, carried out by Chicago's Center for Health Administration Studies with the help of the university's National Opinion Research Center, found other substantive evidence that a lot of things are right with U.S. health care.

For example: Infant mortality has dropped 19 percent in the last five years; 76 percent of the population and 87 percent of infants and small children had at least one visit to a doctor in 1976; blacks and low-income Americans have obtained sharply improved access to medical care; 52 percent of the population had a physical examination in 1976; 64 percent can obtain a doctor's appointment within two days; the ratio of doctors to population has increased to 162 per 100,000 in 1976 from 139 in 1960; 63 percent of people who visit doctors are satisfied with the out-of-pocket cost of care and 87 percent are satisfied with the quality of care they receive.

These numbers hardly paint a picture of health care "crisis." Rather they suggest that the nation's doctors, nurses and other medical personnel are doing a commendable job. The performance is particularly impressive when you look abroad. One of our readers recently sent us a horror story about the handling of an emergency case by a hospital in Kiev, U.S.S.R., during his visit with a party of American tourists. The patient, a woman who had suffered a miscarriage, incurred a serious infection because of a lack of the simplest precautions by the hospital staff.

The answer to the health care riddle is not complex, however. The "crisis" that is so often cited by political leaders is not a medical crisis but a budget crisis. Government, mainly through Medicare and Medicaid, now pays a major share of hospital costs in the U.S. and it has been unable to control the rise in the budget amounts it must allot. The federal government's total health care outlays are budgeted at $47 billion in fiscal 1979, up sharply from $36 billion in fiscal 1977, even assuming President Carter gets new legislation to try to control those costs.

Government's cost control difficulty is, of course, an embarrassment to people who want to nationalize the entire health care industry. So are the evidences that Americans, by and large, are not unhappy with the quality of health care they now receive. It is not surprising that a lot of people think there is a "crisis;" they are being told that constantly by politicians. But it is useful to try to get a better understanding of what the "crisis" really is all about.

Senator DANFORTH. The next group here are representatives of Blue Cross and Blue Shield, Robert E. Shelton is the president of the Blue Cross Plan of St. Louis, and James B. Hughes, the president of the St. Louis Blue Shield Plan.

STATEMENT OF ROBERT E. SHELTON, PRESIDENT, ST. LOUIS BLUE CROSS PLAN

Mr. SHELTON. Thank you, Senator Danforth and Senator Dole, and members of your staff.

I hope I don't get into having to rate some of the things that previous speakers talked about. I am Robert Shelton, president of the St. Louis Blue Cross; and with me is James Hughes, president of the St. Louis Blue Shield.

As requested, we have previously submitted our formal testimony to you in reports, and we will be very brief today.

There are many strategies which can be effective in containing the rising cost of care, and we are working on a lot of them in Blue Cross

and Blue Shield—the use of less expensive alternatives to inpatient hospital care, encouraging the public to use the health care system more wisely and being more responsible for their health care. Thereby, reducing the need for inpatient care or care at all.

Continuing improvement of our participating agreements with providers to encourage the most effective efforts to jointly hold down costs. In addition, we do support the national voluntary effort of providers to voluntarily contain health care costs.

In the interest of time, however, rather than to try to draw on all of these, we have picked just one that we think is especially promising and concern, where we think there's a lot of dollars involved and that we have spent more time on than any other cost containment effort. And that is areawide planning.

I personally, as I said, have spent more time and probably been more frustrated by this aspect of cost containment than any other strategies that we have been involved in in trying to adopt.

Nevertheless, we are convinced that it holds potential for saving millions in unnecessary capital investments and resulting operating expenditures.

This is why our Blue Cross Board of Trustees has been a long-standing—in the very beginning—and a consistent supporter of area-wide health planning. And they've been willing to take the considerable heat that this policy has generated. I think that everyone agrees that intelligent areawide planning for health facilities and equipment is a good thing.

But when it comes to the application of the principle, support tends to fade very quickly. What community wants to give up plans for a new hospital or new equipment just because the planning agency says it may be unnecessary. Anyone who suggests that it should is suddenly in a most unpopular position.

We do feel that the voluntary efforts have been productive, and are improving. We think progress has been slow, and we welcome support from the public sector. Such support continues to be lacking in the State of Missouri.

State laws backing the decisions of local area health planning agencies through empowering these agencies to issue certificates of need for new facilities are still to be enacted in Missouri. As a result, in Missouri, medicare and medicaid payments are not affected by the planning agency decisions.

This, I think, is the substance of our comment, Senators, and we welcome any questions you may have.

Senator DANFORTH. Would you like to add something, Mr. Hughes?

Mr. HUGHES. All right, sir.

STATEMENT OF JAMES B. HUGHES, PRESIDENT, ST. LOUIS BLUE SHIELD PLAN

Mr. HUGHES. I am James Hughes, president of the Missouri Medical Service, the St. Louis Blue Shield plan.

And St. Louis Blue Shield is a nonprofit, commun ty service, health-oriented organization, represents some 950,000 members. And we have long been concerned about the costs of health care. Although our activities are largely confined to those services involving the professional providers of care, because much of that care is provided in the hospital, we are vitally interested in the associated hospital costs.

One of the most effective measures that we feel can be taken to control hospital costs is community planning for health care facilities. Through community planning and cooperation, we feel any unnecessary and costly duplication of equipment and services can be avoided.

Perhaps more importantly from the standpoint of the overall savings, the overbuilding of hospital beds can be prevented through planning. The methods and cost effectiveness of community health care facility planning are well known to you gentlemen and well documented. And St. Louis Blue Shield supports and participates in the local planning efforts.

Another tool for hospital cost containment—one which can and does actively employ—is supervision for various medical services when rendered outside of the hospital setting.

By making these benefits available for care in the physician's office, for example, we encourage the patient to avoid the use of costly hospital facilities, and in particular, to avoid inpatient admissions and a day or more stay as a patient.

Among the services for which we provide on an out-of-hospital basis are diagnostic laboratory services, diagnostic X-ray radiation therapy, endoscopy, emergency first aid provided by a physicain, surgery—minor surgery and fracture care.

Another program in which St. Louis Blue Shield is actively engaged is utilization review. The most common and most utilized procedures, as reported to us through members' claims, are continually monitored to determine cost trends. At the same time, the physician's patterns of practice are under constant study to ascertain both trends and inconsistencies.

Utilization review, of course, in itself simply provides information, which in turn, gives us the ability to establish parameters for physician care as practiced in the St. Louis Blue Shield service area.

Necessary followup is supplied through educational programs for practitioners and their employees in which a variety of cost effective suggestions are emphasized. And these range from opportunities for selection of alternative settings for care to the efficiencies in the filing of claims that result in savings of time and money. St. Louis Blue Shield currently maintains a staff of 19 people to carry on these review and educational program for providers.

We believe that educational programs for St. Louis Blue Shield members and the general public can do much to encourage cost containment. Although the results of these programs may be longterm in nature, furnishing information on health care topics and illness. promotion of fitness programs, and more specifically how to use and not abuse health care protection plans, we believe, will prove cost effective in the long run by improving the general health of the people, as well as making them more knowledgeable about the proper use of health care facilities.

One of the most successful health information programs we have used in the St. Louis area, and I'm sure you'll hear more about that, is the Tel-Med project, through which callers receive recorded messages about specific health topics by telephone.

This project, which is delivering some 800 to 900 messages every day, is jointly sponsored by St. Louis Blue Shield, St. Louis Blue Cross and the St. Louis area medical profession, with the assistance of a number of other health care and health associations.

We are engaged in a number of other programs designed to contain costs. Some examples are worth mentioning, even though they may not directly impinge on hospital charges, because of the broader necessity to control the increases in all health care costs.

Among these are the program for coordination of benefits of Blue Cross and Blue Shield with other coverages the patient may have, to assure that the duplicate programs combined will not pay more than the actual charges involved. This, of course, helps hold down the cost of the protection itself.

In connection with our full payment usual, customary, and reasonable program, benefits are limited to the 90th percentile of the total range of charges of physicians, which effectively puts a cap on benefit levels and prevents payment of runaway fees.

St. Louis Blue Shield is experimenting with prepaid group medical practice, attempting to determine whether such alternate care deliver systems are, indeed, effective in reducing costs.

And as we continue to attempt to search out and develop other methods, both limited and extensive in nature, to help in this task of containing health care costs of all kinds. Assistance in this direction is supplied to all Blue Shield plans from their national organization, the Blue Shield Association, and, in fact, cost containment programs are required of local plans as a standard of membership in the Blue Shield Association.

In summary, gentlemen, St Louis Blue Shield has in place a number of continuing programs aimed at helping to contain health care costs, including hospital costs.

We agree with and we support the need to combat rapid and unbridled increases in the cost of health care. At the same time, we must be careful and we sound a note of caution because of our national concern in cost, that we do not impose restrictions which will interfere with the quality of care we have available, which will limit the access to care, or which will stifle the medical advances of the future.

It's a pleasure to be here with you, gentlemen.

Senator DANFORTH. Let me ask you each a question. Since about 1970 or so, what has happened to premiums for Blue Cross and Blue Shield?

Mr. SHELTON. As far as generally speaking, Senator Danforth, the Blue Cross premiums have fairly well tracked the hospital costs increases. Now it gets a little bit complex because we have really three factors involved in what happens to our dues, as we choose to call them—or premiums. First, of course, is the rise in hospital costs which we being a service benefit-type program must absorb into our dues structure.

The second is the intensity of services which has increased substantially in the last 7 or 8 years. And of course, then the fact that people are buying better benefit programs being negotiated through labor contracts et cetera.

So those three factors tend to cause the increase in our dues rates. But generally speaking, the cost portion of it has tracked the recent hospital cost in the 12, 15 percent.

Senator DANFORTH. So what's happened, let's say—let's take 5 years ago, what percentage increase has there been in premiums?

Mr. SHELTON. I'd have to get the data and furnish it to you, sir. I would say it's been in the neighborhood of 45 percent.

Seantor DANFORTH. And what about Blue Shield, about the same?

Mr. HUGHES. Can I just preface that a minute with a statement? Not to avoid the percentage increase but really Blue Shield, over the last 5 years, has experience in putting into their contracts, new technology and new services, that to try to compare a contract today with a contract 5 years ago, Senator, is almost an impossibility.

However, we do have two contracts—types of contracts and would be an indemnity kind of contract where the services affect and the technological changes affect that kind of contract. And the percentage of increase under the indemnity type of contract, has not been as much as our usual and customary, where we automatically have a built in escalation of services, physicians fees increase. So do the cost of these contracts.

I would say that probably like the last dues increase that we had for the UCR that I met with the board of trustees just a week ago, we have about a 5-percent increase of our UCR contract this coming year over last year.

So that's the kind—in the UCR program, that's the kind of——

Senator DANFORTH. What's it been over the last 5 years?

Mr. HUGHES. I'd say it would probably be in the range of 25 to 35 percent.

Senator DANFORTH. It is 25 to 35 percent for Blue Shield?

Mr. HUGHES. Yes.

Senator DANFORTH. Now, supposing I get sick today, supposing I'm a member of Blue Shield-Blue Cross, I get sick this afternoon and I'm taken to a hospital. I'm treated and get my bill from the hospital and I get my bill from the doctor. What percentage of that is paid by Blue Cross and Blue Shield?

Mr. SHELTON. It depends—it depends upon which of the 700, our plans we have in the market now that you have. For example, the Federal employee program has been——

Senator DANFORTH. Let me then withdraw the question, and give you a concept and ask you to comment. One thought is that the reason for the increased cost of health care is that somebody else is paying for it, and that you pay your premium or negotiate it as a part of a labor contract. Somebody else pays the premium or you pay the premium. Then you get sick, you go to the hospital and you're there for a week or 10 days or 2 weeks, or however long you're there, and you receive medical attention, and somebody else pays your bill for you; namely, Blue Cross and Blue Shield.

So the argument goes that as far as the actual consumer of health care is concerned, there is no actual disincentive for use. You know, I went to a doctor a year or so ago to have a wart removed from my thumb, and I did not care what he charged me. If I had to pay for it, I think I would have kept the wart on my thumb.

But the fact of the matter is, if somebody else pays the bill, there is no particular disincentive not to overutilize and there is no disincentive to the hospital or the physician not to charge whatever the noncaring writer of the check will pay.

That, as you know—that's kind of a caricature of a physician, but as you know, that is the theory that's been advanced. So that's why I asked you what portion of the bill you pay.

Should coinsurance and should deductible be as a matter of course, or are they now the rule?

Mr. SHELTON. We have all kind among our many programs—types of deductible programs that can reduce the cost to the Blue Cross-Blue Shield members. We have 1-, 2-, 3-, up to 7-day room-and-board deductibles which the patient is required to pay that part himself. We have one insurance, of course, on all our major medical programs.

The fact is, they have not been acceptable to the marketplace. The last change we made in our direct pay, which is our nongroup-type program at home. We put in a new low level program which pays a set number of dollars per day as a supplemental program for those who might need that type of care and at no increase in cost to them. We just converted benefit levels to what the present day cost was.

And there was no acceptance of it of any great consequence at all. So as far as we could see, now we're looking at the so-called major medical-type deductible programs, comprehensive—there is no great demand for them, at least as we could see it in the marketplace.

Senator DANFORTH. Do you agree with the theory?

Mr. SHELTON. I don't disagree that the patient ought to be responsible——

Senator DANFORTH. Let me ask, Do you agree with the analysis that says that part of the reason for the rapid increase in the cost of health care is that somebody else is paying the bill? We talked with the last panel about demand and about the fact that people want the best, and the kind of social value that goes into that kind of question, How much do you pay? I mean, how much is the human life worth? How much is good health worth? Is the sky the limit? Do we spend the most amount of money we can possibly spend to keep a person alive for another day? I mean, it's the Karen Quinlen type of argument all over again, I guess. But one of the points that's been made is that most decisions that people make on what kind of house they buy and what kind of automobile they buy, and where they buy their clothes, and what kind of food they eat, and most decisions that people make, are made on the basis of weighing on the one hand the product, whatever it is they're going to purchase, the worth of that product to him, and then on the other hand, the dollar outlay that they are asked to pay.

And therefore, if you don't really have to shell out the money out of your own pocket, if you don't have coinsurance or deductible feature, then why not believe nothing's too good for me? I'll get my wart taken off at any possible cost.

Mr. SHELTON. I think that's true to a degree that you don't shop at the hospital you want to go to, where your physician puts you, he may give you one or two alternates. But I don't believe that there's widespread misuse of hospitals in terms of people wanting to go in or wanting to stay. I certainly don't feel—I've been in and out of hospitals enough visiting to know that I don't want to be in there unless I absolutely need the care.

Now perhaps they're kept a day or two longer than they should, maybe some could have been done on an outpatient basis which is why we have tried hard to expand out outpatient benefits, so they don't have to do it in the hospital starting with 1-day surgery type care and things like that.

Senator DANFORTH. Is that a good analysis or not?

Mr. SHELTON. If I understand—I'm not trying to evade it but I think that because the patient maybe had full coverage is not the reason the hospital costs have gone up.

Senator DANFORTH. Meaning it's not a good analysis?

Mr. SHELTON. No; I don't agree with it.

Senator DANFORTH. How about you? What do you think, Mr. Hughes?

Mr. HUGHES. I think we have to remember that even though there are some major accounts where the employer is footing the entire bill, the biggest majority of our people are paying some part of their health care prepayment Blue Cross and Blue Shield. And it is coming out of their pocket and I think this is probably a misconception and a lot of education has to be given. We have experience rated groups. For instance, all of our accounts, over a certain number, actually are based on the experience—how many dollars actually are utilized by the members of that group.

So the employer and the employees are becoming more knowledgeable, that every time they go to the doctor and every time they go to the hospital, that it is coming out of their pocket.

Getting back to your former question that you withdrew, under the Blue Shield plan we do have only, say about 28 percent of our people who have opted to take the full payment type of contract. The rest of them do have to pay out of pocket because they have a limited amount, even though we have say a $250,000 major medical contract on top of indemnity.

They are paying out of their pocket. So the assessment is solid to a degree. However, much is being done in the way of education of proper use of health care facilities on a local basis.

Senator DOLE. You have talked about how you've been able to help contain costs through voluntary programs—I think you said at the end of your statement, that in focusing on cost we don't want to, of course, submerge the need for access and the quality of care that we receive and also future successes in medical research and so forth. But what recourse do you have if you want to move into an area and suggest some change? What can you do? Can you impose any sanctions? How do you deal with resistance? Surely you have resistance if you start some cost cutting efforts. What do you do, if you want to reduce the cost and somebody says no—the doctors say no—the hospitals?

Mr. SHELTON. Speaking for the Blue Cross side, Senator Dole——

Senator DOLE. Or do you do anything?

Mr. SHELTON. Are provided contracts with the institutions, they have sanctions built into it, if the facilities are added that are not approved by the areawide planning agency which, of course, is voluntary just for them to submit it. And that's where the heat gets generated.

Mr. HUGHES. Senator, on the Blue Shield side, I mentioned the staff of utilization and review people that we have. Also, we do have built in the actual charges the physician makes for all of his services so that we know what he's charging specifically for a particular service.

And we do consult and we do work with the physician community, if there are charges that are out of line, in our opinion. If we see a

particular service that needs review with peer review groups of the medical profession, we do meet with them and we give them statistical information and they in turn—to their peer group activities, do monitor——

Senator DOLE. Is that a frequent occurrence?

Mr. HUGHES. Yes, sir. Yes, sir. That is on a very frequent observation on our part and meetings with some, probably 15 peer groups of various specialities, with the 80 specialities that we have. You can imagine the number of reviews that we have.

Senator DOLE. Getting into specifics, what about CAT scanners? I don't know how many there are in St. Louis, but I assume there are probably a good many. I understand they cost approximately one-half million. The cost increases because not only do you have that first expenditure, you also need personnel and everything else that goes with it.

There may be either overutilization or underutilization. What do you do about that? How are you able to detect if there are too many CAT scanners in the St. Louis area? You don't have to point out where the excess may be.

Mr. SHELTON. Again, I think the jury is still out on how many is too many. As I understand it, from the health system there is approximately 25 in or about to be in the St. Louis area. And again, we are in the position of still voluntary planning, they could put a CAT scanner in and the medicare and medicaid program will have to pay their portion of it.

As I say, our contract with them, if it does not get approved by the health systems agency, is that we will not pay the interest and depreciation on that piece of equipment.

Senator DOLE. Are there any that have not been approved by the HSA?

Mr. SHELTON. They're still in the process of being submitted, as I understand. They declared a moratorium, I think, for 90 days while we study their policy on it. But I prefer that question be addressed to the HSA people.

Senator DOLE. I think you touched on another matter that you are providing at least some incentives to doctor's offices and so forth that result in less expensive care as compared to hospitals, admission costs, the routine costs. Has that been successful?

Mr. HUGHES. Yes, sir. We have seen that the outpatient, as far as Blue Shield, we see the biggest number of our cases—the majority of our cases, X-ray, lab and the services that I men ioned, are done on an outpatient setting basis. And this does cut down on the costs.

Senator DOLE. This is acceptable then? You offer that to all your subscribers?

Mr. HUGHES. Yes, sir.

Senator DOLE. It's available to everyone?

Mr. HUGHES. Yes.

Mr. SHELTON. We also found that the 1-day surgical centers that are hospital based here, we have contracts with hospitals established, and have saved considerable amount of money from the data we have.

Now, it's only been in effect about 2 years, but there are four, I think, now operating in the St. Louis area. And the best we can tell, and the hospital is convinced, it is saving at least 2 days of stay on every one of those surgical cases they do from what it would have been 2 years ago.

Senator DOLE. It's difficult to judge because in the final analysis, I guess, the doctor determines whether you go to the hospital and how long you stay and what may be done while you're there. Do you deal with that directly?

Mr. HUGHES. No, sir, we do not. We do not interfere with the direction that the patient would take or the—really the length of time that they stay in.

Mr. SHELTON. Only to what the utilization review committees would recommend—education processes would be attached there, too.

Mr. HUGHES. Some work has been done nationally in experimental programs on monitoring lengths of stay, of course, by diagnostics.

Senator DOLE. That's the problem we're facing—not suggesting anything, except that costs are just getting totally out of hand and everybody says we don't want cost containment, we want to continue to buy expensive equipment if the Government's going to pay for it—or most of it. And I think the very people who are threatened by national health insurance may be helping bring it about. Because of the cost.

Senator DANFORTH. What would you do if you were in our shoes?

Mr. SHELTON. Regarding legislation?

Senator DANFORTH. Yes.

Mr. SHELTON. Well, I'm perhaps a little bit prejudiced, Senator, but I would suggest that we let the voluntary effort have a good shot at it. I think the AHA, the AMA—those groups have put forth a program, that—and I would like to think in our area here working with the hospital field, medical field, jointly—Blue Cross and Blue Shield and these groups, that we can do something to resist the rise in health care costs.

Turn it down—I don't think anyone thinks that's going to happen. I'd like to see it have a good chance before we impose that cap or something across the board which would have—I mean, wage-price freeze a few years ago, I went through all kinds of gymnastics with that trying to understand it, to begin with.

Senator DANFORTH. You know, I'm delighted that efforts have been made and you've explained the efforts. Supervisor McNary began the morning explaining what had been done at various levels to try to reduce the cost of health care.

On the other hand, the cost of health care has gone up very, very dramatically and all of the figures point to that. And anytime you have something like this occurring, there is always a demand that the Government do something.

And oftentimes somebody's put forward an idea with no real thought about whether it will work or not. If it sounds good in theory, we get bills we consider and eventually do something with.

But I think there's one thing that's really certain. That is, the Government will not, for very long, do nothing.

Mr. SHELTON. I think that's true. There are areas that need to be—I think the fraud and abuse bill has a lot of good things in it.

Senator DANFORTH. And given the increased cost of health care, Government is not for long going to say, well, let's use a Band-Aid here or there.

So I hope that it's done voluntarily. I hope that this voluntary effort is going to work, because I've never been one who believes that yet more Federal programs and yet more Federal control are

the solution to very many problems. Much less something as complicated as health care.

But I do think that it's something that you, who are in this field, are going to have to take very, very seriously. If part of the reason for the increased cost of health care is that somebody else pays all or most of the bill, if deductibles and coinsurance for hospital insurance is not popular, and if that unpopularity is because of the increase, I don't know what to suggest to you.

But if I were in the private sector addressing this, I think that I would try to figure out how we can maybe market deductibles and coinsurance and make them more attractive and try to build in the kind of marketplace consideration in buying health care that you have in buying automobiles and houses.

Mr. SHELTON. As long as we don't deter them from getting the care they need. I think we have to get the right balance.

Senator DANFORTH. Sure. There's always the question of the care you need versus the absolute extreme.

Senator DOLE. I don't have any other questions, I just think that the problem is maybe the voluntary program doesn't go far enough and the Government program goes too far. And somewhere in there we have to find some way to put a break on costs. I oppose the cap. I think it's a mistake.

But having done that then we ought to be able to come forth with something else and say well, I'm for that. That may satisfy constituents but it doesn't address the problem. So we're looking at that issue through S. 1470.

Thank you.

[The prepared statements of the preceding panel follow:]

STATEMENT OF ROBERT E. SHELTON, PRESIDENT, ST. LOUIS BLUE CROSS PLAN

Senator Danforth, Senator Dole, and members of the Committee Staff, I am Robert Shelton, president of the St. Louis Blue Cross Plan. With me this morning is James Hughes, president of the St. Louis Blue Shield Plan.

There are many strategies which can be effective in containing the rising cost of health care. For example, we are working on stimulating the use of less expensive alternatives to inpatient hospital care. The public should be encouraged to use the health care system more wisely and to take more responsibility for their own health, thereby reducing the need for care. And we need continuing improvement of participating agreements with the providers of health care to encourage the most effective efforts to jointly hold down costs. In addition, we support national and local efforts of providers to voluntarily contain health care costs.

In the interest of time, however, I have picked just one aspect of cost containment that I think is especially promising. This is the need to achieve the most cost effective distribution of health facilities and equipment through community planning.

Personally, I have spent more time on and been more frustrated by this aspect of cost containment than any of the other strategies with which we've been involved. Nevertheless, I'm convinced that it holds the potential for saving millions in unnecessary capital investments and resulting operating expenditures.

That is why our Blue Cross Board of Trustees has been a long-standing and consistent supporter of area-wide health planning. And they've been willing to take the considerable heat this policy has generated.

Almost everyone agrees in theory that intelligent area-wide planning for health facilities and equipment is a good thing. But when it comes down to the application of the principle, support fades fast. What community wants to give up plans for a new hospital or new equipment that the planning agency says is unnecessary? Anyone who suggests that it should is suddenly in a most unpopular position.

Those who've put Blue Cross in this position from time to time have varied greatly. So have their accusations. The wide range of accusations is of some

comfort to us because it indicates that we've been even-handed in implementing our policy in support of planning.

We feel voluntary efforts have been productive, and are improving. But progress has been slow, and we would welcome support from the public sector. Such support continues to be lacking in Missouri.

State laws backing the decisions of local area health planning agencies through empowering these agencies to issue certificates of need for new facilities are still to be enacted in Missouri. As a result, in Missouri, Medicare and Medicaid payments to providers are not affected by planning agency decisions.

Thank you for the opportunity to comment.

I'll be happy to entertain any questions you may have.

TO THE MEMBERS OF THE HEALTH SUBCOMMITTEE OF THE SENATE COMMITTEE ON FINANCE

Gentlemen: Missouri Medical Service, the St. Louis Blue Shield Plan, is pleased to submit this statement in connection with the Subcommittee hearing on hospital cost containment held in St. Louis on February 13, 1978.

St. Louis Blue Shied, as a non-profit, community service, health oriented organization representing some 950,000 members, has long been concerned about the costs of health care. Although our activities are largely confined to those services involving the professional providers of care, because much of that care is provided in the hospital we are vitally interested in the associated hospital costs.

One of the most effective measures that can be taken to control hospital costs, we feel, is community planning for health care facilities. Through community-wide study and cooperation, any unnecessary and costly duplication of equipment and services can be avoided. Perhaps more importantly from the standpoint of over-all savings, the over-building of hospital beds can be prevented through planning. The methods and cost effectiveness of community health care facility planning are well known and well documented and St. Louis Blue Shield both supports and participates in local planning efforts.

Another tool for hospital cost containment—one which St. Louis Blue Shield can and does actively employ—is the provision of benefits for various medical services when rendered outside the hospital setting. By making these benefits available for care in the physician's office, for example, we encourage the patient to avoid use of more costly hospital facilities, and particularly, to avoid in-patient admissions and a day or more stay as a bed-patient. Among the services for which we provide benefits on an out-of-hospital basis are: diagnostic laboratory services, diagnostic X-ray, radiation therapy, endoscopy, emergency first-aid provided by a physician, surgery and fracture care.

Another program in which St. Louis Blue Shield is actively engaged is utilization review. The most common and most utilized procedures, as reported to us through member's claims, are continually monitored to determine cost trends. At the same time, physicains' patterns of practice are under constant study to ascertain both trends and inconsistencies.

Utilization review, of course, in itself simply provides information, which in turn, gives us the ability to establish parameters for physician care as practiced in the St. Louis Blue Shield service area. Necessary follow-up is supplied through educational programs for practitioners and their employees in which a variety of cost effective suggestions are emphasized, ranging from opportunities for selection of alternative settings for care to efficiencies in the filing of claims that result in savings of time and money. St. Louis Blue Shield currently maintains a staff of 19 people to carry on these review and educational programs for providers.

Similarly, we believe educational programs for Blue Shield members and the general public can do much to enhance our cost containment efforts—although the results of such programs may be long-term in nature. Furnishing information on health care topics and illness, promotion of fitness programs, and more specifically how to use and not abuse health care protection plans, we believe, will prove cost effective in the long run by improving the general health of the people, as well as making them more knowledgeable about the proper use of health care facilities.

One of the most successful health informational programs we have used in the St. Louis area is the Tel-Med project, through which callers receive recorded messages about specific health topics by telphone. This project, which is delivering some 800 to 900 messages every day, is jointly sponsored by St. Louis Blue Shield, St. Louis Blue Cross and the St. Louis area medical profession, with the assistance of a number of other local health associations.

We are engaged in a number of other programs designed to contain costs. Some examples are worth mention, even though they may not directly impinge on hospital charges, because of the broader necessity to control the increases in all health care costs.

Among these are the program for coordination of Blue Shield benefits with those of other coverages the patient may have, to assure that the duplicate programs combined will not pay more than the actual charges incurred. This, of course, helps hold down the cost of the protection itself.

In connection with our full Payment Usual, Customary and Reasonable Fee program, benefits are limited to the 90th percentile of the total range of charges, which effectively puts a cap on benefit levels and prevents payment of run-away fees.

St. Louis Blue Shield is experimenting with pre-paid group medical practice, attempting to determine whether such alternate care delivery systems are, indeed, effective in reducing costs.

And we continue to attempt to search out and develop other measures, both limited and extensive in nature, to help in the task of containing health care costs of all kinds. Assistance in this direction is supplied to all Blue Shield Plans from their national organization, the Blue Shield Association, and, in fact, cost containment programs are required of local Plans as a standared of membership in BSA.

In summary, St. Louis Blue Shield has in place a number of continuing programs aimed at helping to contain health care costs, including hospital costs. We agree with and support the need to combat rapid and unbridled increases in the cost of health care. At the same time, we would sound a note of caution in that, in our national concern over costs, we must be careful that we do not impose restrictions which will interfere with the quality of care we have availabe, which will limit access to care, or which will stifle the medical advances of the future.

JAMES B. HUGHES *President.*

Senator DANFORTH. We now have two or three people in the next group. Three. Mr. David Gee and you are the president of Jewish Hospital.

Mr. GEE. Correct.

Senator DANFORTH. And Dr. R. Dean Wochner, the commissioner of department of health and hospitals, city of St. Louis, and Mr. William D. Blair, the administrator of the Farmington Community Hospital in Farmington, Mo.

Thank you all for being with us. Who would like to start?

STATEMENT OF DAVID A. GEE, CHAIRMAN, MISSOURI HOSPITAL ASSOCIATION BOARD OF TRUSTEES

Mr. GEE. Senator Danforth and Senator Dole, I'm David Gee, I'm ch airman of the Missouri Hospital Association and I'm also a member of the board of trustees of the Hospital Association, Metropolitan St. Louis, in addition to being the president of the Jewish Hospital of St. Louis.

We appreciate the opportunity of being able to attend this hearing and to share our thoughts with you regarding the problem of cost containment in hospitals.

Mr. Rostenkowski issued a challenge to hospitals earlier this year in regard to cost containment and I'm happy to report that the hospitals of the State of Missouri have already organized in collaboration with the various position groups within the State in a voluntary cost containment program. And we hope that that will be an effective program.

I might add that the hospitals in the State of Missouri have costs which are below those of the Nation as a whole. And the rate of increase in cost in this State had been below the national average. So

we think there is a proper groundwork for the voluntary program. And we hope that that will be further successful in solving this problem.

We also have noted that there has been a change in attitudes over the last year. A year ago there was a somewhat simplistic approach by Government toward hospitals regarding them as being the sole reason why there has been an escalation in health care costs.

And we have heard some of the comments about the inefficient systems within the hospitals and have noted that there have been some charges of fraud and abuse and things of that nature.

Over the past year, I think that as hospitals have attempted to acquaint government with the complexity of the health care system, there has been an acceptance of this complexity factor. And there has been the realization that it is a multifaceted problem which affects, not only hospitals, but also the physician, the consumer, government, third-party payers, and others.

And all of these are going to have to work in concert if there's to be any solution to the problem. We're also very much familiar with the fact Americans expect and demand good health services. Americans have grown accustomed to the fact that they have the best health service in the world.

And they know the fruits of good health and they want to maintain those benefits. Your committee is also very familar with the kinds of cost impacts that hospitals have had in terms of energy costs and the problems of the minimum wage increases and the matters of new technology and new equipment, the effect of governmental regulations, professional liability insurance, and so on.

All of those things have had their own kind of impact. And we think that those matters are the ones of concern which when looked at in terms of an overall cap on hospital revenues become very difficult to handle unless there are certain other parameters that are taken into consideration.

You asked an earlier panelist what would we do if we were in your shoes. I think that we already have a number of pieces of health legislation that have been enacted in this country, which are rather long term in nature and that have not really had the opportunity of taking effect yet.

Planning has been in place for the last 9 years. Part of it on a voluntary basis. Part of it with sanction. But it really has not had a chance to make full impact and I think planning a legislation needs to be able to go its full course before we can see the effects of that.

We need intelligent planning. We need appropriate planning. At times the planning process is more form rather than substance. But over time, we may expect some improvements.

The professional standards review organizations and the utilization review activity have only just begun to make their impact on changing the physicians' behavior patterns and I think these should be given their opportunity to proceed.

We also have seen the long range kind of approach, as outlined in Mr. Talmadge's legislation—proposed legislation, that would address the long-range solution to some rational classification of hospitals and we think that has some merits that ought to be taken into consideration.

We have outlined the various elements that go into increased hospital costs. We have outlined what we are doing in the State of

Missouri. And we have also outlined certain specific recommendations to the committee which are contained in a statement for your use.

And we appreciate the opportunity of being able to make this presentation to you today.

Senator DANFORTH. Thank you.

[The prepared statements of the preceding panel follow:]

STATEMENT OF DAVID A. GEE, CHAIRMAN, MISSOURI HOSPITAL ASSOCIATION BOARD OF TRUSTEES

Senator Danforth and Senator Dole, I am David A. Gee, Chairman, Missouri Hospital Association Board of Trustees and a member of the Board of Directors of the Hospital Association of Metropolitan St. Louis. I am employed as president of The Jewish Hospital of St. Louis.

We are pleased that you have chosen to hold special hearings on cost containment in the State of Missouri. The cost of health care is a real concern of health care providers today. Hospitals are particularly aware of the rising costs of institutional services; the successful efforts of hospitals and the hospital associations in Missouri are being expanded to include a new voluntary cost containment program in cooperation with the physicians' associations in the State.

Congressman Dan Rostenkowski, in a statement to the American Hospital Association on February 1, 1978, stated that he supports the national and state voluntary cost containment program which is underway. He indicated that he plans to give the voluntary effort a chance to moderate the rate of increases in costs. The Congressman will seek standby authority for cost or revenue controls in the event governmental intervention appears necessary.

The hospitals in Missouri are involved in many cost-saving programs and activities, individually and collectively. However, it is recognized that the rate of increase in expenditures for health care must be reduced further, to a level which is closer to the rise in expenditures for other services.

Hospitals are part of a complex, interrelated system of health care services. The acute, episodic nature of demand for hospital services, coupled with the factors listed below, makes it difficult to achieve the moderations in expenditures which are desired.

Patient demand for more and better services, and increased utilization of services;

Minimum wage increases and total remuneration expenses;

Advances in technology and equipment;

Improved quality and diversity of services;

New services and equipment, resulting in new diagnostic and therapeutic services, additional cost and improved quality of care;

Governmental regulations and programs;

Energy;

Petroleum-based products;

Professional liability insurance;

Research and educational programs;

Dietary products;

Social Security tax increase in a labor-intensive industry; and

Construction costs.

External factors already are forcing hospital costs upward; more external controls through governmental enforcement will not solve the problem. A monolithic system based upon governmental intervention, authority and control will evolve, and with it, we fear, the delays in delivery of services, stagnation of quality advances and governmental cost problems which plague socialized medicine programs in other countries will result. Missouri hospitals oppose a governmental takeover of the health care system; we urge that control of hospitals be retained in the local community.

The multi-faceted problem requires a coordinated solution which addresses the major forces which influence expenditures for health care. These range from behavior modification of the public to alternative delivery and financing systems.

Attached is a statement of the Missouri Hospital Association, Hospital Association of Metropolitan St. Louis and Kansas City Area Hospital Association. It contains a number of recommendations which we believe will reduce the rate of increase in expenditures for health care. To be effective, all dimensions of the problem must be dealt with, a outlined in the attachment.

We appreciate the opportunity to present our observations about cost containment and to offer our recommendations.

Thank you.

STATEMENT OF MISSOURI HOSPITAL ASSOCIATION, KANSAS CITY AREA HOSPITAL ASSOCIATION, HOSPITAL ASSOCIATION OF METROPOLITAN ST. LOUIS ON COST CONTAINMENT

Cost of health care is a concern of hospital trustees and management; during the past several years, hospitals have heightened their sensitivity to the total cost of health care. Their concern is reflected in many individual and group activities which have proven to be cost effective.

ROLE OF THE FEDERAL GOVERNMENT

National health insurance has been a topic of debate in the United States for more than five decades. During the past three decades, the government's role has changed from promoting more and better health care services to constraining utilization and cost through regulatory controls. According to the August, 1977 1977 Congressional Budget Office report, Expenditures for Health: Federal Programs and Their Effects, "From the end of World War II until the early 1970's, federal policy on health-related matters concentrated on increased equality in access to care and encouraging the use of services. Demand for health care was boosted by the enactment of health financing programs for the aged and poor and by tax subsidies for the purchase of private health insurance. . . . After the early 1970's, the emphasis of new federal programs shifted to reallocating resources and containing costs."

During this shift in federal emphasis, national health insurance has emerged as a major objective, and now is a top priority of the current Administration. The federal government proposes to reach its objective by imposing so-called "cost containment" measures in the form of revenue caps. There are many inequities in the Administration's Hospital Cost Containment Act of 1977. These five provisions of the legislation present major problems for hospitals:

1. The arbitrary lid on hospital revenues has no relation to individual hospital differences and reduces allowable revenue increases irrespective of costs being incurred; other segments of the economy which affect hospitals' costs are left uncontrolled.

2. Class of purchaser controls will further limit hospital revenues, without consideration of changes in enrollees among third party payors or Medicare and Medicaid limits.

3. Exceptions are highly restricted and force hospitals to reach bankruptcy before qualifying.

4. Emphasis on federal controls and authority leaves little authority for states and does not deal with the causes of rising hospital expenditures.

5. Capital controls are arbitrary and not linked to local differences and needs, nor is there a provision to adjust revenues when approved capital expenditures are made.

With the enactment of Public Law 92-603 in 1972, Congress placed several controls upon hospitals, most of which are just being implemented. The law created professional standards review organizations (PSROs), planning approval of capital expenditures, limitations on coverage of costs under Medicare, health maintenance organizations, utilization review controls and Medicare-Medicaid payments based upon the lesser of reasonable cost or customary charges rather than reasonable costs.

In 1974, Public Law 93-641 was passed by Congress. The law establishes a health planning system, including health systems agencies (HSAs), state health planning and development agencies (SHPDAs), statewide health coordinating councils (SHCCs) and a National Council on Health Planning and Development. The SHCC in Missouri has been appointed, and the Department of Social Services has been designated as the SHPDA. There are five HSAs in the state, all of which are functioning.

Public Law 93-641 further requires that states must enact a certificate of need law by 1980 or lose Medicare and Medicaid funds. If Missouri has not enacted such a law by September 30, 1979, the SHPDA will lose its federal operating funds. The Missouri SHPDA is in the second year of a two-year conditional designation, but such designation may not exceed 36 months. The SHPDA must be in substantial compliance with Public Law 93-641 to receive permanent designation and continue its functious.

Stringent federal requirements for utilization review and medical audit activities are being enforced on an expanded scale through the five PSROs in the state. Additionally, hospitals have been subjected to a myriad of federal Medicare regulations which have been adopted since the inception of that program in

1966. These regulations exert control over almost every aspect of hospital operations.

Recently, the Department of Health, Education and Welfare has promulgated regulations which require hospitals to make specific accommodations for the handicapped. We estimate that these regulations alone will cost Missouri hospitals over $20 million in construction and renovation costs initially.

The opposing forces within the federal government have created a continual dilemma for hospitals. As one arm of the government attempts to reduce reimbursement at every turn, another arm imposes more regulations which dramatically increase costs, and yet another acts almost annually to expand the benefits of health care to a growing number of recipients.

MISSOURI HOSPITALS

There are 160 general community hospitals in Missouri, with a new hospital facility under construction in Reynolds County. The existing hospitals provide 28,800 beds. During 1976, Missouri hospitals treated more than 900,000 inpatients and rendered over 4.5 million units of outpatient and emergency service.

Missouri's hospital system is one of the finest in the nation, providing Missourians with several outstanding secondary and tertiary care centers and many excellent general community hospitals. The September, 1977 report from the Joint Commission on Accreditation of Hospitals shows that nearly 100 percent of the Missouri hospitals surveyed this year have received a two-year accreditation. Nationwide, only 58 percent of all hospitals surveyed this year received such approval.

Hospitals in Missouri—public, not-for-profit, private and investor-owned institutions—represent a composite of interests and offer a wide range of medical and social services. Our state is fortunate to have several schools to train medical doctors and osteopathic physicians, most of whom practice in Missouri after graduation. Exclusive of federal and state institutions, Missouri hospitals provided in 1975 essential community service jobs to more than 100,000 people, with an annual payroll exceeding $700 million. In addition, the economy of the state was strengthened by many other Missouri businesses and industries which provide hospitals with goods, services and supplies.

HOSPITAL COSTS

In 1976, inpatient costs averaged $145.84 per day in Missouri community hospitals, compared to the national average of $167.67 for all community hospitals. These figures are approximately 70 percent higher than the average inpatient daily costs in 1970. Two-thirds of the increase in hospital costs is due to inflation, and one-third is the result of new services and technology, intensity of services and increased patient demand.

A comparison of community, state and federal hospitals for 1976 shows the following:

	Cost per inpatient day
United States community hospitals	$167.67
Federal hospitals in Missouri	187.26
Missouri State-owned hospitals	155.97
General community hospitals in Missouri	145.84

Source: American Hospital Association.

Hospitals have responded to the demands of both the public and national policymakers for high quality health care. Now, they are being blamed for successfully meeting these very same expectations of government and the public.

The environment of hospitals makes them atypical of most businesses and industries. Some of the more notable differences are listed below:

1. *Labor.*—Hospitals are labor intensive, with over 55 percent of their expenses allocated to personnel. The federal minimum wage bill, which raised the minimum wage from $2.30 to $2.65 on January 1, 1978, will increase hospital costs in many Missouri hospitals by more than $10 per patient day. This external force, beyong the influence of hospitals, will increase hospital costs by more than $50 million in 1978.

2. *Regulations.*—The cost of complying with federal regulations is staggering. Nevertheless, the red tape and paperwork continue to increase with almost every new regulation and interpretation issued by HEW and others. It is estimated that $22 was added to each patient's bill in 1977 to comply with eight recently

imposed and expanded federal regulations. This does not include previous costs or new costs in 1978 which are attributable to regulations.

3. *Malpractice Insurance.*—Malpractice insurance rates for Missouri hospitals skyrocketed between 1973 and 1976. The Missouri General Assembly has enacted eight measures in the past three years to alleviate the problem, and Missouri hospitals have responded by forming the Missouri Professional Liability Insurance Association (MPLIA) to provide professional and general liability coverage at a stabilized, reasonable rate. MPLIA is successfully fulfilling the intent of the state law enacted in 1975, but the cost of such coverage remains relatively high because of the frequency and severity of claims.

4. *Energy and Petroleum-Based Products.*—Hospitals are dependent upon energy 24 hours each day to maintain patient services. The cost of primary and standby fuels in hospitals has increased markedly since the energy crisis began. Despite considerable savings being realized through in-house energy management programs, hospitals still are faced with a mounting energy bill.

Hospitals use many petroleum-based products, including pharmaceuticals, plastics and disposables. This dependency on rapidly escalating items further increases hospital costs.

5. *Education and Training.*—Many Missouri hospitals are involved in the training of physicians and other health care personnel. The cost of preparatory as well as continuing education adds to the cost of hospital care, yet it is essential if health care services are to be provided throughout the state.

6. *Technology.*—Space age technology in health care is commonplace, with breakthroughs in the diagnosis and treatment of patients' illnesses occurring almost weekly. This development, much of it supported by federal grants, creates new services and increases patient demand. An often-publicized diagnostic machine of today is the computerized axial tomography (CAT) scanner. This rather expensive equipment represents the greatest breakthrough in diagnostic radiology since the discovery of X-rays in 1895. While it is impractical to have a CAT scanner in every hospital in Missouri, most large institutions have sufficient base utilization to support such a unit. The initial cost, while significant, is justified by the long-term benefits of more efficient and effective diagnosis of many conditions. Ultrasound and other equally sophisticated diagnostic tools are essential to modern-day treatment.

7. *Public Demand.*—Public demand and governmentally-created expectations have caused an increase in expenditures for hospital care, particularly since the enactment of Public Law 89–97 (Medicare and Medicaid) in 1966. We have observed that whenever the government promises services or provides free coverage, public demand for an use of those services increases. In 1972, for example, Medicare coverage was extended to end-stage renal disease and care for the blind and disabled. The demand, and cost, for these services has risen sharply, far beyond HEW's estimates.

People create and live in an environment which is increasingly detrimental to their health. The lifestyles of many people, with little emphasis placed on health maintenance, only add to the problem. A staggering number of health care dollars could be saved if we would accept individual responsibility for modifying personal habits such as smoking, drinking, drug abuse, stress, overeating and lack of exercise. We continue to place greater demands upon the curative and more expensive modalities of treatment, however, rather than adopt proper health care habits and preventive practices.

8. *Utilization Changes.*—Advancements in the diagnosis and treatment of petients have resulted in better care, shorter lengths of stay in hospitals and increased utilization of outpatient and ambulatory services. Which such improvements cause an increase in the cost of care on the inpatient unit, they produce a net savings to the entire population. Early diagnosis allows treatment at an earlier stage in the disease; individuals are able to return to productive lives sooner; and the period of stress and interruption experienced by the family during an illness or accident is significantly reduced.

9. *Unemployment Compensation.*—In 1976, Congress enacted a law which requires public employers to provide unemployment compensation protection for their employees, effective January 1, 1978. We estimate that the unemployment compensation cost to Missouri's public hospitals in 1978 alone will exceed $1 million.

10. *Doctrine of Sovereign Immunity.*—The Missouri Surpeme Court abrogated the doctrine of sovereign immunity in Missouri in a landmark decision handed down September 12, 1977. The state's 67 public-general hospitals will be required to purchase professional and general liability insurance in 1978, a requirement

which will add another $6 per patient day ($14.5 million) cost to externally generated cost increases imposed upon hospitals.

11. *Social Security.*—Congress increased the tax rate and base of txation for Social Security prior to adjournment. While such a law will affect all employers, the impact is particularly severe for hospitals because of their labor intensive characteristics. This additional expense will be translated into higher hospital costs during the next ten years.

There has been considerable publicity about empty beds and unused facilities during the past two or three years. Recently, HEW alleged that there are 100,000 excess hospital beds in the country. The Missouri State Health Planning and Development Agency applied a figure of 4.77 beds per thousand population and concluded that there are 2,609 excess beds in the state. The agency then assumed that it costs $20,390 annually to maintain an empty bed, thus yielding an excess annual expense of $53,197,510.

The Missouri hospital associations challenge the methodologies for calculating the number of excess beds and cost of their maintenance. An arbitrary bed-population ratio ignores age distribution differences among communities, seasonal and weekly population and patient fluctuations, travel time requirements in rural areas, accessibility of essential life support services, special requirements of referral and teaching hospitals, patient differences and operational problems of smaller rural hospitals.

In estimating the cost of "excess beds," it is impossible to arrive at a fixed figure. The cost of "empty beds" is, in almost every case, limited to its maintenance (housekeeping and climate control requirements, etc.). Extra staffing, in terms of nurses, is not retained for empty beds, nor are other technical personnel maintained for unoccupied beds.

As the size of a hospital decreases, the occupancy rate must also decrease. To maintain quality of care and meet patient fluctuations, the patient census for a single hospital service can rarely exceed the general trends given below:

Hospital beds	Reasonable daily census [1]	Average occupancy (percent)
15	7	47
20	11	55
50	35	70
80	60	75
100	79	79
200	168	84

[1] Based on Poisson distribution.

Source: Modern Hospital, vol. 97, No. 6.

Even these target rates cannot be maintained when the hospital offers a variety of different services and has separate nursing units to properly care for the patients. For example, a 200-bed hospital may have 160 medical-surgical beds, 15 obstetrical-gynecological beds, 15 pediatric beds and 10 intensive and coronary care beds. In this typical situation the various units preclude the attainment of an overall 84 percent occupancy because of the necessary separateness of the patient services.

In the average Missouri hospital, most rooms are semiprivate. This fact, in consideration of the patient differences listed below, makes it impossible to operate at the occupancy levels advocated by certain public officials:

Levels of patient illness;
Isolation patients;
Smoking and non-smoking patients; and
Male and female patients.

If a typical rural Missouri hospital has an average annual occupancy of less than 60–70 percent, the institution will be overflowing during much of January, February and March as well as several other mid-weeks during the year. The fixed cost of having the services available during the reminder of the year is minimal, and the variable cost is eliminated during such periods of time.

The very nature of life-preserving hospital services on a 24-hour-per-day basis creates some unavoidable standby expense. Emergency and critical care medical capabilities must be available to the public whenever needed, and they are best provided in the hospital setting.

Discussions of hospital costs usually are narrowly focused and fail to recognize the rate of cost increases for other items and services. To help keep hospital costs in perspective, the following summary of the cost of selected items as measured by the U.S. Department of Labor's Consumer Price Index at the end of 1977 is presented. The baseline year of 1967=100.

Item:	*CPI, December 1977*
Heating oil	288.7
Coffee	457.5
Postal charges	225.6
Sugar	180.5
Natural gas	249.2
Insurance and financing	220.1
Medical care	209.3

If an index for Social Security taxes was published, the figure for the maximum would have been well above 300 in December 1977.

ACTIONS TO CONTAIN COSTS

Missouri hospitals, the Missouri Hospital Association and the metropolitan associations in Kansas City and St. Louis have been working aggressively to contain costs and become more cost effective. One or more of the three associations operate the following programs to improve hospitals and help contain costs:

Group purchasing;
Shared laundry;
Shared data processing;
Management engineering;
Peer review program;
Educational programs;
Group employee benefit programs;
Creation of the Missouri Professional Liability Insurance Association to stabilize the cost of professional and general liability insurance; and
Establishment of the Missouri Health Data Corporation to consolidate data collection and reduce duplication among state and voluntary agencies.

In cooperation with the Blue Cross plans which are based in Kansas City and St. Louis, agreements have been developed to support areawide health planning. According to the agreements, hospitals participate in health planning and seek HSA approval for projects exceeding specified dollar limits.

The three associations, in support of health planning, have adopted statements which recommend that their member hospitals submit their capital projects to the appropriate planning agency on a voluntary basis.

Individual hospitals and groups of hospitals have embarked on many cost savings programs, ranging from shared clinical services, equipment and personnel to shared facilities. Cost containment programs have been implemented by many Missouri hospitals covering, for example, staffing, energy conservation, and the purchase of goods, services, equipment and facilities. In addition, a large number of hospitals have minimized operational expenses through the formation of multi-disciplinary cost containment committees and implementation of cost containment programs.

Many Missouri hospitals share facilities, services and equipment, including computerized axial tomography scanners and other radiological services, laboratory equipment, and services, obstetrical facilities, pediatric services, psychiatric services, and others too numerous to mention. Even though such cooperation is in evidence in every area of the state, duplication of certain services and facilities will continue. It should be pointed out that duplication is not bad; only unnecessary duplication adds unjustifiable increases to the cost of health care.

Hospitals are forming consortia and other organizations to meet the demands of today's environment. Multi-institutional systems are being developed through which single hospitals may attain a level of quality and economy otherwise unachievable. It appears that the pooling of hospital resources will be the wave of the future in the innovative developments among Missouri hospitals.

Local community needs, institutional differences, patient requirements, time and travel distances, physician distribution and many other factors determine whether a particular facility, service or piece of equipment is needed. Because there is no magic formula to quantify all of the variables which are important in finding the best course of action for a particular community, local and regional

input is needed to assist health care providers plan for the current and future needs of our state. This process can best be carried out with positive, constructive leadership of health care providers. Missouri's hospitals, physicians and other health professionals have been active participants in the health planning process. They have played a major role in its success and will continue to contribute their talents to this effort.

Although effective management within hospitals and greater cooperation among them have saved millions of dollars, costs have continued to rise. As long as inflation, public demand, the hospital's atypical marketbasket, advances in medical science and external cost-increasing forces continue, hospital costs will increase. Hospitals are one part of a complex and changing health care system, which is, in turn, part of a broad interdependent socio-economic system. Until the entire economy is balanced with our economic structure and social climate, hospital costs, just as other services and products, must continue to increase.

RECOMMENDATIONS

Missouri hospitals believe that both sides of the supply-demand equation of health care costs must be addressed. Federal attempts at legislation have skirted the demand aspect of health care economics. We believe emphasis must be placed on the demand side—not through direct controls on who may receive which services but, rather, through the provision of incentives for consumers of health care to encourage their thoughtful utilization of health care resources. Features of the "free market" should be introduced into health care delivery so that some element of consumer incentives can be achieved. Specifically, the associations recommend:

Deductibles on health insurance policies so that the health resource user will participate financially in each use of the health care system;

Co-payment by health care users of a certain percentage of all health care costs up to a defined limit;

Incentive system which provides for a refund to individuals of a portion of health insurance premiums, if utilization of health care resources is less than predetermined levels;

Incentive for exercise of individual responsibility for personal health through lower health insurance premiums for those whose personal health habits are indicative of lower risks;

Imposition of higher taxes on alcohol, tobacco and other health endangering products with the proceeds devoted to related health education and rehabilitation;

Incentives for health insurance companies to pay for necessary care based on the least costly level where comparable quality can be assured; and

Incentives to encourage providers to become more efficient and participate in joint activities and shared programs.

Further, the associations believe that other steps can be taken, and recommend:

Educational programs beginning at the elementary school level, emphasizing individual responsibility for health;

Initiation of an aggressive public information campaign by HEW regarding good health practices and health care;

Tax advantages for employers who conduct health education programs for their employees and adopt measures to control utilization of health services; and

Health insurance premium refunds to employers who demonstrate successful health education efforts among their employees.

Finally, the associations conclude that more governmental intervention into the health care delivery and financing systems will prove to be ineffective, and increase costs without corresponding improvements in the quality or accessibility of health care services. We recommend:

Responsible health planning through a network of local and state planning bodies, coordinated to promote the development of an optimal health care delivery system while maintaining responsiveness to the needs and differences among individual hospitals and communities;

A system of accountability which requires governmental agencies to promulgate only regulations which are proven to be cost effective, which promote high quality of care or which establish only essential safety standards;

Governmental responsibility for paying the actual cost of health services for their program recipients; and

State and local control and administration of cost containment programs, licensure of health care personnel and facility licensure.

If Congress enacts cost containment legislation, we recommend that the principles and concepts embodied in the Medicare-Medicaid reform act authored

by Senator Talmadge in 1977 be used as a base. Senator Talmadge is attempting to recognize the differences among hospitals in a constructive way rather than force all institutions to fall under the knife of a single arbitrary cap.

The voluntary cost effectiveness efforts of Missouri hospitals and the associations in Missouri have been, and will continue to be, an effective tool to promoting high quality care at the lowest reasonable cost. Hospitals are forging ahead in a new voluntary initiative to contain the rise in hospital costs, and we urge the Congress to support these voluntary efforts.

STATEMENT OF WILLIAM D. BLAIR, MEMBER, MISSOURI HOSPITAL ASSOCIATION

Senator Danforth and Senator Dole, I am William D. Blair, member of the Missouri Hospital Association and administrator of Farmington Community Hospital in Farmington, Missouri.

We appreciate the opportunity to appear before you on the issue of cost containment. I would like to address the subject from the point of view of rural hospitals, and to present several recommendations which are particularly applicable in the non-urban setting.

MANPOWER

While hospital cost containment is a concern of all Missourians, the greater concern among people in the rural areas of the State is a shortage or maldistribution of health manpower. The cost of health care in rural communities is substantially less than the cost in urban centers, primarily because the large hospitals have more sophisticated services, technology and equipment. In addition, higher wages, construction and land costs, educational programs and research activities add to the expense of urban health care. It should be emphasized that these expenses are essential to providing a comprehensive network of health care services to the State and preparing manpower for all areas of Missouri.

The most critical shortage is in the physician category, in the specialty of family practice. However, many rural communities also experience periodic shortages of nurses, laboratory and X-ray technicians and other personnel. In some instances, the unavailability of nurses has threatened the continued operation of rural hospitals.

UTILIZATION

Use of hospitals differs in the rural and urban areas of the State. Over 80 percent of the acute hospital treatment required by rural citizens is provided in local community hospitals, with the remainder being referred to the secondary and tertiary centers.

The aging population in many rural areas has produced a heavy concentration of Medicare patients whose utilization rate is higher than younger populations. National studies have shown that use of of hospital services rises significantly with age, particularly after 65. We feel that these patients can best be treated, and that they and their families respond best to the treatment, in their local environment.

Physicians in rural communities are faced with a wide range of geographical distances which may mandate a treatment program, including hospitalization, which may be somewhat different from care rendered in situations where the patient is in close proximity to a physician and hospital. Such care is tailored to meet the needs of individual patients and is necessary to maintain high quality service.

In sparsely populated rural areas, the need for different levels of service varies from the need in urban centers. While the proportionate need for skilled nursing care, intermediate care or domicillary care may be higher in rural communities, the bed need is smaller because of the total number of people involved.

The responsibility for providing the proper levels of skilled, recuperative care and intermediate care needed by an aging population has fallen on the rural hospital in most instances. Restrictive and even discriminatory Medicare reimbursement policies make it extremely difficult for smaller hospitals to provide long term care facilities and services, however. The cost allocation rules of the Medicare program have the effect of reducing federal payments for acute care in hospitals which also operate long term care units or other community health programs such as school health, public health, mental health and meals on wheels.

In many rural communities, the hospital is the most economical and logical organization to provide selected nonacute services. We believe that changes in

Medicare reimbursement policies are necessary to permit rural institutions to provide the range of health services needed in their communities.

Fluctuations in utilization of acute services in many hospitals create the need for "swing beds." Medicare policies should allow hospitals to meet patient demands for varying levels of service without being penalized financially. It seems reasonable that hospitals which are given the flexibility to adjust facilities and services, will be able to use more effectively their limited resources.

PLANNING

Much publicity has been given to the National Health Planning Guidelines which were published in the Federal Register last fall and again in January. The guidelines portray a "top down" approach to planning rather than a "grass roots" effort among consumers, providers and local government.

Even in revised form, the guidelines still require less than four non-Federal, short-stay hospital beds for each 1,000 persons and an average annual occupancy rate of at least 80 percent. Although vague references are made to rural areas in both instances, HEW has made it clear that exceptions are not compatible with its philosophy of rigid quantitative standards.

Most of the rural hospitals in Missouri were fostered through the Hill-Burton program between 1947 and 1960. These institutions provide a vital community service, and the original intent of Congress to have local hospital services available in rural areas should not be thwarted by the Department of HEW's emotional cost containment campaign.

We recommend that Public Law 93-641 be amended in the extension legislation to insure the continued availability of hospital services to rural communities.

COST CONTAINMENT

Mr. David A. Gee, Chairman of the MHA Board of Trustees, has explained already the complexity of the health care system and those factors which influence hospital costs. Those forces are at work in both rural and urban hospitals. Many of them are beyoud the control of hospitals, and a majority of them are due, either directly or indirectly, to governmental action.

In 1978, the minimum wage will have a greater effect upon rural hospital costs than any other single item. Many smaller institutions will experience cost increases of $10 or more per patient day because of the minimum wage adjustment alone.

Even though rural hospitals are faced with substantial cost increases in 1978, they are committed to an intensified voluntary effort to control rising expenditures. The Missouri Hospital Association is developing a voluntary cost containment program in concert with other states, and individual hospitals are searching for every conceivable way to save money and still provide the basic inpatient and outpatient services which are required in their communities.

The concept of hospital costs in rural areas has been oversimplified by many critics. The wide geographical distribution of rural people creates several unique problems, including the cost of travel, time away from work, family expense and inconvience. The cost of these problems does not appear on a person's hospital bill, but the expense incurred is an indirect health care cost. These expenses will be multiplied if rural hospitals are forced to close.

The characteristics of rural America must be taken into consideration when governmental intervention in the health delivery system is contemplated. Caution should be exercised to insure that rural citizens will not be deprived of the essential health care services which have been provided through the initiative of local communities.

SUMMARY

When people are injured or ill, they seek and demand the highest quality of health care available. This fact, coupled with an increasing demand for therapeutic treatment to correct personal health problems, places providers in a difficult position. We are making strides to improve quality within strict cost constraints, but must have the cooperation of all sectors of society—the public, suppliers of hospital goods and services, and government.

In addition to the efforts which are already underway or being initiated by providers, we recommend the following steps to address other parts of the supply-demand equation for health care:

Deductibles on health insurance policies so that the health resource user will participate financially in each use of the health care system;

Co-payment by health care users of a certain percentage of all health care costs up to a defined limit;

Incentive system which provides for a refund to individuals of a portion of health insurance premiums, if utilization of health care resources if less than predetermined levels;

Incentive for exercise of individual responsibility for personal health through lower health insurance premiums for those whose personal health habits are indicative of lower risks;

Imposition of higher taxes on alcohol, tobacco and other health endangering products with the proceeds devoted to related health education and rehabilitation;

Incentives for health insurance companies to pay for necessary care based on the least costly level where comparable quality can be assured;

Incentives to encourage providers to become more efficient and participate in joint activities and share programs;

Educational programs beginning at the elementary school level, emphasizing individual responsibility for health;

Initiation of an aggressive public information campaign by HEW regarding good health practices and health care;

Tax advantages for employers who conduct health education programs for their employees and adopt measures to control utilization of health services;

Health insurance premium refunds to employers who demonstrate successful health education efforts among their employees;

Responsible health planning through a network of local and state planning bodies, coordinated to promote the development of an optimal health care delivery system while maintaining responsiveness to the needs and differences among individual hospitals and communities;

A system of accountability which requires governmental agencies to promulgate only regulations which are proven to be cost effective, which promote high quality of care or which establish only essential safety standards;

Governmental responsibility for paying the actual cost of health services for their program recipients; and

State and local control and administration of cost containment programs, licensure of health care personnel and facility licensure.

Thank you for the opportunity to present our views on this important subject.

STATEMENT OF DR. R. DEAN WOCHNER, COMMISSIONER, DEPARTMENT OF HEALTH AND HOSPITALS

Dr. WOCHNER. I'm Dr. Dean Wochner, director of health and hospitals for the city of St. Louis.

And I also appreciate the opportunity to be here. When the President proposed his program for the containment of health care cost, one of my staff commented that we have our own cost containment program. He's known as the city's budget director.

This simply serves to illustrate the fact that the St. Louis public health and hospital services, like most of the public programs across the country, have been confronted with an extremely difficult situation in the past 10 to 20 years.

We've been caught in a big squeeze between two familar forces; one of these is the rapid escalation of medical costs, which is the topic of this hearing. The other is the financial crisis of the cities, our funding authority, who have been required to perform ever-increasing services to their communities, while the tax base to support these services, have failed to grow or has even declined.

During this period of inflation in medical costs, the private sector managed to keep pace with these demands through reimbursement of full costs by Blue Cross, medicare, and other third-party sources.

However, for public hospitals, with their large volume of patients who lack this coverage, such an increase in budget simply was not possible. It would have to come from tax revenues that did not exist.

The result has been that we failed to keep pace with the many technological improvements, capital improvements, and equipment purchases which have characterized the rest of the industry.

There are other unique features to the public health and hospital systems which should be considered in any cost control program, even though we are also affected by the same factors which apply to the private sector and are summarized by Mr. Gee's statement.

Some of these additional features are the fact that the patients with the most expensive illnesses or the least financial resources are the ones most often referred to the public hospitals.

The medical problems faced by our patients are frequently complicated or even caused by severe social and other economic problems. Our antiquated physical plants are inefficient and do not always meet modern safety standards.

We are obligated to provide all types of care, including not only hospital care, but long-term care, emergency services, public health programs, and in particular, large outpatient departments.

Therefore, I'd like to urge that the health and hospitals systems operated by local governments should be given special considerations in any cost containment legislation, as perhaps was suggested for the VA and other Federal hospitals.

Naturally, we all favor containment of cost. But we feel very strongly that any cost containment program should address the root causes of inflation and medical services, and not merely clamp an arbitrary lid on allowable costs. The plain truth is, the hospitals must go into the marketplace like everyone else; and if the costs they experience are increasing, there is no way to avoid passing these increases along in charges to consumers, unless the programs themselves are curtailed.

I'd like to offer several suggestions. The Federal Government could, through its medicare program and through the requirements it sets for medicaid programs, provide some incentive to offering care in ways that may be less expensive and more efficient, particularly in ambulatory care settings.

At present, these programs pay so poorly for outpatient care, that the incentives actually point toward admission of patients. Further, because ambulatory care payments are so poor, we and others have been unable to finance improvements in our ambulatory care program to make them more effective in serving the community.

Specifically, then, I'd like to recommend that Federal regulations require the full cost of outpatient care services be reimbursed by both medicare and medicaid. This cost reimbursement should be available for programs using nurse practitioners or physicians assistants or other physician extenders rather than limiting payment to services of physicians only.

Prescription drugs and medicines prescribed for outpatients should be paid for under the medicaid-medicare program. And there should be improved payment for home care services.

With particular emphasis on public health and hospital systems, I'd like to suggest that Federal grants be made available to assist cities through a transition period to reallocate some of their resources from hospital care to expanded ambulatory care programs. The Robert Wood Johnson Foundation has recently offered such a program in co-

operation with the U.S. Conference of Mayors and the American Medical Association.

However, only five cities will be funded through this program, while another 25 have developed plans that would allow them to implement this program if funding were available.

I believe this idea deserves careful consideration by the Congress, because a dramatic improvement in urban health care could be brought about by prompt and judicious action.

A special note should be made of the costs of regulation itself, particularly that imposed by the Government. Frankly, its cost us a great deal in recent years just to follow, comply with, and report on all of the Federal, State, and accreditation requirements which now direct the activities of hospitals.

The costs of this paperwork have recently been estimated to be as high as $30 per patient day for some hospitals. We realize that such regulations are here to stay and we're not requesting that it be removed. However, we would like to request that it be kept in reasonable bounds and further suggest that Federal grants might be made available for the design and implementation of medical information systems to improve the efficiency of maintaining the required medical and statistical records, as well as——

Senator DOLE. If I could interrupt right there, sir.

Dr. WOCHNER. That was the end of my statement anyway, sir.

Senator DOLE. Because you were touching on a matter that we have begun to address. On January 24, I joined Senator Talmadge who is the chairman of our Subcommittee on Health, and also Senator Nunn who is the vice chairman of the Permanent Subcommittee on Investigation, and sent a letter to the Honorable Elmer Staats, who's the Comptroller General, specifically asking for a review of regulatory activity.

We have asked for review of Federal, State, local, and voluntary requirements covering licensure, certification, data request, nonstandard claim forms, health and safety requirements for patients and employees, associated matters with a view toward legislative or administrative recommendations to eliminate or consolidate activities and requirements.

I assume we'll have a rather exhaustive report and hopefully some recommendations from the GAO.

Dr. WOCHNER. We certainly appreciate that. It has been a major problem for us because in the health care today, we are attempting to deal with all of these escalations and bureaucracies, as well as the increases in technology that must be employed in services and at the same time doing what we're talking about—trying to control cost.

It's extremely difficult. We do have—not only the Federal Government with its various programs, the State government, the various health planning agencies, in our setting, we also have the city bureaucracy to deal with, which has its own requirements, it simply is an expensive addon.

Senator DANFORTH. It's not just the regulations either, it's the actual—for example, in social security we just got through increasing the social security tax burden for State and local government and for nonprofit organizations, such as hospitals, by $15 billion a year between 1987 and what it was last year.

And we fought this battle in the Finance Committee and again on the floor of the Senate and again in the conference on the social security bill. We tried to provide some small cushion for State and local governments and for the nonprofit employers by reducing their social security tax burden 10 percent.

And we, namely my staff and I, and others who were interested, worked very carefully and very hard particularly with those of you in Missouri who are interested in this area, and got excellent support, excellent support from your national organizations and the various lobbying groups in Washington who were interested in the economic health of the hospitals and schools and colleges and universities, to provide some cushion.

Now there are a couple of ideas floating around—just to take a second look at the whole social security financing question, because of the tremendous effect it's going to have on the economy and particularly on you. You can't pass this on to Uncle Sam in the form of deducting it from your income tax next year.

A private employer can. So Uncle Sam picks up about 48 percent of the increased burden for a private employer. But not so for city hospitals. So it's just one area in which the Government says it is concerned about the increased cost of health care, but is actually making things worse rather than better.

I think that's a very useful comment.

Dr. WOCHNER. Thank you.

Senator DANFORTH. Yes, sir.

STATEMENT OF WILLIAM D. BLAIR, ADMINISTRATOR, FARMINGTON COMMUNITY HOSPITAL

Mr. BLAIR. Senator Danforth, Senator Dole, I'm William Blair, member of the Missouri Hospital Association and administrator of Farmington Community Hospital.

I represent the out-State hospitals, the rural hospitals, and small hospitals. But our problems really aren't all that different from the city hospitals or the larger ones.

We do have a number of problems which I would like to maybe just briefly touch on and hopefully any questions that you might have relevant to our particular situation, and maybe we can get those answered well.

In the area of manpower, I think we have a peculiar problem. We don't have too many people to pick from, so to speak. We always have to go by what we have locally. We can advertise and so on and we may draw from a small area, but manpower shortage is a little bit bad. Position shortage is one area where we really have a peculiar problem.

Our hospital is blessed by a number of excellent physicians and we'd like to have more. But we have one problem in that the physician may like Farmington, may like our hopsital, but the other half of the marriage doesn't always like the smaller community, the social structure and so on.

So we have kind of an offshoot kind of a problem that maybe other areas don't have. Nurses—we have a nursing school in our area and they produce an excellent nurse.

We also have—well, we've got several schools in our area producing 2-, 3-, and 4-year nurses. We don't necessarily go along completely with the idea of eliminating all the nursing programs and making them all one particular level. We find that the 2-year nurse is doing an excellent job.

We have some difficulty in finding some technicians—X-ray, laboratory, respiratory therapist. We just don't have the charismatic quality that draws these people to us. We have to go out and recruit and occasionally we're successful—more often, we're not.

In the area of utilization, we have, I think, a reasonably active PSRO utilization review type activity going on in our hospital. It has not been completely effective, but has been reasonably so. We shortened the length of stay. We've done all the right kinds of things.

And I think our doctors really have responded fairly well to them, but it does take an attitude on the part of the medical staff—the medical community to accept the PSRO and those activities and do something with them.

In planning, I have my own set of thoughts on planning. I think that a 9-percent cap on hospitals is not only arbitrary and unwise, but could be just disastrous for us. We don't have a strong financial base. We've been in operation 9 years and we are financially sound, but we are not able to cope with an arbitrary, unimaginative 9-percent cap and then have it ratcheted down from—over a period of time to where it is below the cost of living and some of these other points.

It is awkward and cumbersome for me to determine how our hospital will function much beyond 4 or 5 years with that kind of a prospect ahead of us.

We have the effect of increased cost on supplies and equipment, and we have the influence of the salaries paid to professionals and hospital personnel in other areas, we have—things we have no control over and some things we do have a considerable amount of control over. All of which go into an increase in our costs that we have not been able to really hold at 9 percent and then expect to go down from there.

But we do have a cost-containment committee. And I think we've done a pretty good job—as I'm sure all hospitals feel they've done a good job—in doing what we can do to contain costs. But it isn't something that we can have that much impact on when a lot of the things we buy—goods and services that we buy—do not appear to be that influenced or that controlled.

You have the written statement of mine, and I really appreciate being here and presenting the testimony before you. And I would end with saying I would be glad to answer any questions that you might have.

Senator DOLE. There is always that feeling that hospitals are crowded in the wintertime and empty in the summertime. A letter was called to our attention, not from this part of the country, but I'd like to quote:

> Patient census, help, help, help. As most of you know, we've always had our summer slumps, but during the July 4 weekend, we dropped to a lower patient census than we've had at any holiday during the past several years.
>
> Our census dropped to 120 patients and hasn't improved too much as of 4 p.m. today. We've had 30 admissions and 20 discharges, so it looks like we've had a net increase of 10 patients. Personnelwise, we're staffed for an estimated average census of 195 patients, so it's quite obvious the financial strain we have when our patient census dropped below that.

If you have any patients out there in the bushes, nursing homes, extended care facilities, or whatever, we could certainly use them during this period of low census.

We would appreciate any assistance you can give us. Personal regards to each of you.

Now, I don't know if you have any solicitations like that going on in this area, but it does seem that there's sort of a pattern across the country that in the summertime, the census is low; and in the wintertime, the census is high.

Maybe that's not bad, but you have that cost in the summertime. It's still pretty much the same, isn't it? How do you treat that? Is your census pretty much the same year round?

Mr. BLAIR. It fluctuates some. We have small fluctuations immediately before or immediately after vacationtime and national holidays like Christmas, New Year's.

Senator DOLE. And it's a very understandable thing, why you wouldn't want to be hospitalized.

Mr. BLAIR. If it's vacationtime for schools—elective type work, it does take a downturn. If we have a problem, like the flu this past winter, we ran on a reasonable census for a long time—7, 8, 9 months, and all of a sudden with the flu we just really—our census really jumped. And I think everybody experiences about the same problem.

But I don't know any way to work on the peaks and valleys, since we have so little impact on admissions.

Senator DOLE. But is there any pressure to fill the empty beds?

Mr. BLAIR. No, sir. No. We have all of our activities that go on, as far as the medical staff and their review of records and admissions and stays, that goes on continuously and has absolutely no bearing on what our census is.

Senator DOLE. Have you tried to compare the cost, say, of treating some emergency or nonemergency care in a hospital as compared to a doctor's office? Is a hospital cost that much greater?

Mr. BLAIR. Well, in our case—and speaking only in our case, it is greater in the hospital because of what we have to do in order to be available and ready to provide that service. A doctor's office may be, for all practical purposes, closed at 5 o'clock or 6. And we're faced with the 24-hour staffing problem and certain other things.

Senator DOLE. It might be even higher in urban areas, I assume, isn't it?

Mr. GEE. The problem, of course, in urban areas is that the people living in inner city ghettos don't have physicians. The only place that they can get medical care, whether it's during the day or the middle of the night, is from our hospital emergency room.

And hospital emergency rooms have to be staffed 24 hours a day, 365 days of the year, in order to meet that need which may not always be equal and which has its own kinds of peaks and valleys. There's a built-in inefficiency there.

Nevertheless, this is the only way in which many of these people can find their care. Either through the city hospital system or through an emergency room that is maintained by one of the inner city hospitals.

Senator DOLE. It's been suggested that maybe we could reinforce the availibility of less costly care by establishing so-called freestanding clinics out in the community which would feed into those hospitals,

rather then building new hospitals or swamping outpatient departments.

Maybe financial support in areas like Kansas-Missouri, might be a step in the right direction.

Mr. GEE. Neighborhood health centers have been tried and were financed through Federal dollars. The problem is, where do you get the health care professionals to work in those kinds of settings. If you could somehow solve the problem of medical care and physician availability, to get a population to provide primary care at that level, then the hospital emergency room or a hospital could become the recipient on a referral basis——

Senator DOLE. They were independent, I think. They weren't tied to the hospital. I was talking about some tie to the hospital where you'd rotate——

Mr. GEE. There are affiliations between neighborhood health centers and hospitals, some of which are affected, many of which are not.

Dr. WOCHNER. This is essentially what I was suggesting awhile ago when I suggested that programs be brought into place that would help ambulatory care services be expanded. Particularly those offered by local government. It would, in fact, meet a need that is not going unmet and many of the patients are just not being seen.

I think a word of caution needs to be tossed in here, however, that there is some data to indicate when this does take place, in fact, the hospital census does not go down, but it goes up.

Because one is finding more cases that should have been in the hospital previously for treatment, particularly at first when this happens.

But nevertheless, the community is being better served.

Senator DOLE. I think it's back to the same question. Senator Danforth posed earlier—what do you recommend—I mean we've got the problem and it's not going to go away, it's going to be worsened. I agree with Jack, if there's no other solution—I'm certain the Government is willing to step in, and—of course, in some areas we have it was very beneficial.

So the Government has a role to play in health care. But in addition, to the role of shelling out money, there has to be some way to restrain costs. We're talking about a budget this next year that's already $61 billion in the red before we start to add on in the Congress.

The budget comes to Congress $61 billion in deficit. And maybe it's not alarming but as a member of the Budget Committee, we don't know where to go. Where do you make the cut? Everybody believes we ought to have more grants for cities and more this, say for prescription drugs, but how do we get a handle on it?

Mr. GEE. One of the difficulties in making cuts in anything, especially at the Federal level, is that it has such far-reaching consequences that what you set in motion today you either reap benefits or disaster from somewhere down the line.

A point I had made earlier was that you already have in place a number of pieces of legislation that could have some very significant effect in regard to utilization review and planning, which really have not blossomed into their full effect at this point.

I think this is a long-range problem rather than a short-range one of merely applying an arbitrary cap which could cause some very significant detriment to the system.

Senator DOLE. Yes, I'm not talking about cutting back—about moderating, I guess, is a better word. You've got to slow the increase and I agree with you on the cap. We don't like it, we're now searching around for something that will work and will not be a disaster to your hospital and others.

Mr. GEE. Well, part of the problem of course is that arbitrary approaches tend to penalize the good and promote the bad. And I think that's something that all of us want to avoid.

Senator DANFORTH. But, Mr. Gee, when you said that some of the planning ideas have not really come to fruition yet, are you talking specifically about the HSA program?

Mr. GEE. Well, the HSA is good in concept but as I mentioned it sometimes hangs more at form rather than substance. The HSA also tends to be reactive to what hospitals and health care providers want to do rather than creating some kind of a goal toward which everybody can work in concert.

And I think that we already have in St. Louis a problem right now where we have overbedding, and the question was asked earlier, how much overbedding, and it depends on how you measure that because the HSA's measure it on the Sunday before Christmas and the hospitals measure it on a Wednesday in February.

So somewhere in between is the correct figure. But until there's some rational approach on determining how many beds a community needs and then there is some sanctions imposed to make sure that those things are accomplished, we have in this community—already we've all been through when you read the newspapers, the fiasco of the north St. Louis Hospital, with an attempt to add that many more beds unnecessarily in the community. We have an eye hospital that's going to be constructed. And we have a psychiatric hospital that's going to be constructed in a community that is already overbedded.

There's something wrong with a system which has had planning in place for 9 years and is still unable to cope with this kind of problem.

Senator DANFORTH. Now, just explain to me how that affects the cost of health care?

Mr. GEE. Because when you build new facilities, those facilities generally are located in areas where they are attractive primarily to the white surburban consumer and these then tend to be fully utilized, thus making the older facilities that may be located in the inner city, underutilized.

So that the capital investment and the manpower investment has been made in the already existing facility, then becomes diminished as new facilities go up.

Senator DANFORTH. And the effect of that on the patient's bill is what?

Mr. GEE. Well, the effect is that Government, Blue Cross and other third parties pay for both new facilities and the less utilitized old facilities. And that's where the cost comes.

Senator DANFORTH. So the patient's bill isn't just for paying for the cost of food and the hospital and the cost of a nurse being at the station? It also pays for the debt service on the construction and it pays for certain overhead expenses?

Mr. GEE. That's correct.

Senator DANFORTH. Therefore, if you have too much overhead, if you have too many debts, then when you're a patient, you're paying for the overhead you don't need?

Mr. GEE. That's correct.

Senator DANFORTH. Is that the concept?

Mr. GEE. That's correct.

Senator DANFORTH. How big a problem is that? How much of the health care cost problem is this over capital expenditure?

Mr. GEE. Well, it's just a broad generality and it's difficult to apply any set figures. In general 30 percent of hospital expenditures are the controllable and variable expenditures which are related to whether a patient is in a hospital bed or not.

Seventy percent of the costs go on regardless whether they are occupied or not occupied.

Senator DANFORTH. So, what does that mean?

Mr. GEE. That means that the costs will be maintained at the 70-percent level whether they are used or not used.

Senator DANFORTH. I see.

Now, when Senator Dole read the health letter, it has been said that in order to finance the structure, the number of beds that are in existence, there is pressure on physicians to admit people to hospitals in order to fill the beds in order to produce the revenue from patients bills which are necessary to finance the structure in the first place.

It's kind of like somebody who builds an office building, an apartment bulding, and if he doesn't have enough tenants in the building, he's not going to be able to meet his debt service.

Is that, in fact, a problem with hospitals? Is that done?

Mr. GEE. There are two elements to the "Help, help, help" letter. One is—is it aimed at causing unnecessary and illegal admissions and utilizations or is it aimed at getting the legitimate admissions away from other hospitals?

One is a marketing approach aimed at improving one's own parochial interest. The other is, of course, a direct violation. And a hospital that has a good utilization review program and rigidly adheres to the PSRO concept, is not going to be violating the utilization concepts.

That doesn't mean that the administrator of X hospital that you read about may not want to be able to attract some patients from his neighboring hospital, if he can do it better, why, that's part of the free enterprise system.

Senator DANFORTH. Anyone else have a comment on that?

Dr. WOCHNER. The only thing I can say is that—well, I don't know of any such evidence of "help, help, help" letters here. That doesn't mean that it hasn't happened. But in our setting, at least, we are staffed really to deal with the lowest level of census, not by intent, but that's the way our budget works out.

And so the pressure by and large from the—from within and particularly from the physicians, is to avoid admissions and we more often than not have people who object to being turned away, when they felt they should have been admitted. In many instances, perhaps they should.

Mr. BLAIR. We don't have, as I mentioned earlier, we don't have that kind of an activity going on or at least like Dr. Wochner was saying, I'm not aware of it.

But the PSRO in our hospital has been fairly effective and we have noted a shortening of the length of stay, yet the doctors in their own clinic practice have been just as active as before.

So we are feeling, right now, the effect of the PSRO, the person looking over their shoulder and their level of activity has remained the same. So we're on the short end of that so to speak.

Senator DANFORTH. Is it working, in your opinion?

Mr. BLAIR. I feel it is, yes.

But I would like to back up what Mr. Gee said. I think there are so many things in place, that I guess it's probably difficult to remember last year and the year before and the year before that, what was put in place to make some—have some impact or have some effect on the system. But I think there are a number of programs that can work, can do some good and can be maybe developed further, if they're given a chance to.

We, in a small hospital in a rural setting, kind of—we just kind of follow everybody else's lead. And we're not going to have any kind of an impact on legislation anywhere. Because we're so small. So we wind up getting the tail end of the whip and at times it gets kind of cracked by the time it gets to us. So we try and do as much as we can, but I think if we just didn't have the propensity to regulate, and let us do our jobs, there probably could be some benefits.

Senator DANFORTH. Now one proposal has been made for decertification of hospitals. What's your view on that?

Mr. BLAIR. Well, in a rural setting again, you know where we can't raise or lower and change bed complements and shut off and start up very easily, we have to kind of keep beds available—those beds that may not be in use today may be needed tomorrow. We can't start it up and shut it down quite as—I won't say easily, but the same way somebody else could.

And we have, say, a county bed complement, and on regulation I think our cake, really, personally to set so many beds per thousand and say that's the national quota, because how does my bed needs relate to Mr. Gee at Jewish.

Senator DOLE. We try to make that distinction in our bill, S. 1470, if you're the only hospital in town you have a little more leeway. But if you've got several, as you have in any urban area, then it's pretty difficult to have that tolerance sometimes.

Mr. BLAIR. Right. And the utilization of services is not always the same. We may have a more active OB service for local reasons and somebody else—we don't happen to want a cat scanner right now, but there are several around.

Mr. GEE. One of the problems with decertification is that it tends to take a broad brush and take some arbitrary statistical figures and apply them to the entire Nation.

We've already noted that we have established at rather great expense, health systems agencies within our community, and theoretically they're suppose to make the judgments as to what the health care needs of the community are.

It seems to me that rather than having a Federal mandate about decertification, that the health systems agencies ought to make some kind of a rational plan that ought to arrive at what the correct number of beds are.

And I suspect that through some peer pressures and through the application process, that eventually beds will indeed be decertified voluntarily rather than by mandate.

Senator DANFORTH. Can I just hit on your previous question on the illegal versus the competition. Is it fair to say that your view is that people are not being put in the hospital for the sake of paying off the debt?

Mr. GEE. I wouldn't say that that does not exist in some institutions, but I'm not aware of any practices of that nature in the city of St. Louis or the surrounding area. We hear about them in other parts of the country but I think in Missouri we tend to be somewhat conservative and I think that the facts pretty well measure that out.

Dr. WOCHNER. I'd like to add a couple of comments to this general business on the beds because, first of all, it's a very complex thing and a partial answer to what was asked a while back, it seems to me that only a part of the cost escalation a relatively small part is because of the, quote, excess of beds.

The other factors are much more prominent. The fact that we are labor intensive and our people must be paid a wage that will allow them to have at least equal purchasing power as inflation goes on. The fact that our supplies and so forth are among the most inflated in the industry.

But in addition to that, if one could, in fact, get some of the patients out of beds, that could perhaps be handled in the doctor's office, one whole separate question is how much money will it take to take care of them in a doctor's office, as you asked, and it certainly will cost a certain amount.

But in the hospital itself it may not save that much money either because that means that the built in cost that Mr. Gee was speaking of and a lot of others, then must be spread across a smaller number of patients.

Second, many of the controllable costs are the ones that—the testing and so forth, must be performed on the patients that are the sickest and are still there.

What I'm getting at is, therefore, that the cost per day—per patient day would actually rise considerably by that kind of a process, even if one were to close out these beds from a given hospital.

So in other words, it's not—one has to avoid simplistic answers. This an area where it is so complex that there is a great temptation to set upon simplistic answers like the beds, the expensive equipment like cat scanners, but it is not that simple and has to be analyzed very carefully.

Senator DANFORTH. How about malpractice insurance? How much of the increased cost has been the explosion in malpractice insurance costs?

Mr. WOCHNER. I can't give you any figures but I'm told by my financial people and by others in town that that's been a major factor in some of the—major factor—it's certainly one of the factors that's been added in and it's major in the sense that it has doubled, quadrupled or gone up tenfold depending on what period of time you want to talk about it.

It is now a substantial portion of our costs.

Mr. BLAIR. I'd like to just briefly comment——

Senator DANFORTH. Too many lawyers around?

Dr. WOCHNER. I'm afraid so, yes.

Senator DANFORTH. Elect them all to the Senate.

Mr. BLAIR. Just to comment briefly on that. Our liability insurance, the whole package cost in 1970, $1,100. In 1971, it was $11,000. And it's gone up now to where for our hospital which is 108 beds, we're paying about $82,000 a year.

Now, I would ask you a question. Why should there be that kind of—not only an attitude but seemingly almost an unnecessary view of build up of reserves without some kind of controls and regulations? Now why should there be only two or three companies in the State of Missouri who are threatening—literally threatening with the loss of insurance in order to get you to pay the premium. Now we have a company that was sponsored and literally started by the State association, a separate firm, but the idea and the concept was promoted by the State association, and that has done a lot to put in a 1 or maybe 2 years time, the liability premiums a little bit more in perspective.

The fact that they were able to offer insurance the first year caused a drop in a number of areas where the company who was offering literally cut their premium notice just to keep the business.

Now if it's all that much necessary to offer the insurance, how then, can they afford to cut the premium that much and still provide the insurance?

It looks to me like from our standpoint, $82,000 to somebody who's paying $1 million, that's a drop in the bucket. But to a person that really would prefer not to spend $82,000 on it, that's a heck of a lot of money.

Senator DANFORTH. Thank you all very much for being with us.

Mr. GEE. Thank you for allowing us to be here.

Senator DANFORTH. Mr. Alphonse Lynch. Are you Mr. Lynch or Dr. Lynch?

Mr. LYNCH. Mr. Lynch.

Senator DANFORTH. I don't want to bump any of these titles. You're the president of the governing board of the St. Louis HSA, is that right?

Mr. LYNCH. That's right. I've been president for the past 3 or 4 months. I was vice-president prior to that time.

STATEMENT OF ALPHONSE J. LYNCH, PRESIDENT, GOVERNING BOARD OF THE ST. LOUIS HSA

Mr. LYNCH. I'm also speaking in that position and probably in my individual capacity at this time. I'm the executive director of the Gatwin District Community Corporation and we operate two neighborhood health centers, funded by HEW and the city of St. Louis, which serves something like 1,500 to 2,000 persons from up around there ambulatory care.

I have submitted a statement which supports certain items and which makes certain ascertions. I will speak from it in part except that I will note in the first paragraph where we do refer to in conformance with your seekings about support for the cap legislation.

We do support that legislation, at least I do. I'm not suggesting that 9 percent is a right figure. Maybe it's 8, 7, 5, or 6, we don't know. But the skyrocketing of costs in the last 5 years of all health costs

with the hospital issue being the majority or greater portion of that cost, tells us that something has to be done.

I think, though, at this hearing—you can tell from this hearing today, that we spend an inordinate amount of time with health facilities, hospitals, things which put people and keep people in hospitals as a result, rather than devoting a lot of our time to what probably in the long range, will reduce that cost.

That's the education, illness prevention, and also the promotion of health. It is our understanding and belief that a route in which we should be heading, is the one which involves planning, and planning not only on a short-range basis but on a long-range basis. I think that's probably the problem with things we try to do in the inner city and across the country now, is that we try to do things on a short-range basis.

For instance, more Federal fund programs are for 1 year, we set 1 year goals. Most things are done in a short-range basis, we set things on a short-range basis as far as the goals are concerned.

Our health problems, our housing problems, our crime problems, our education problems, our employment problems, are problems which did not originate last year. They started to come into being 5 to 10 years ago, and form a basis for what we're trying to do now.

And we cannot separate health from the other components from which the Federal Government—disaster, environment, housing, employment—as it involves in this city a big problem with lead poisoning which the city and community health people and the planners are trying to combat.

Just as an example, in the second paragraph of my statement, we refer to the costs of cat scanners. You can see that it is a very costly kind of approach to something. Now, we're not saying there shouldn't be any cat scanners. We're not saying there should not be cat scanners given to those who have needed them. But I think the role of the Health Planning Agency has been, and will be in the future, is to see that there is a sharing, to see that there is not the overpurchasing and to see that they're justified and there's some criteria, for the issuance of that.

And some of the problems which are being addressed are stated in the statement that has been given. I'd like to also state that as far as planning is concerned, I agree with Mr. Gee that planning should be on a basis on which it is creative. We're attempting here to see if we can't get all the health program people to start developing their own plans within their own systems, which would relate to an overall system of health planning and a goal from which we could work.

One of the things, I think, in the cap legislation which you've looked at very closely, and some improvement should be done in the whole cost basis as far as health is concerned, is the accounting system. We've often argued that the accounting systems with which costs and other things are based, is something with which we, sort of, get amazed.

For instance, people who are using cat scanners, are paying for them whether they use them or not. Now we're not saying that the total operation should be based upon costs that's expended to all the users. But there should be some thought given to how the cost structure is affecting—the accounting system is affecting health costs.

There should be that uniformity in the accounting system which will probably be of some benefit to a health cost patient. It also, in the legislation, with reference to the exemption and the exclusion of the salaries of employees, we think that should be retained in the concept. The increase or if there's going to be an increased cost, we don't think that hospitals should be penalized for its increasing its salaries of its employees.

I think the labor-management relationship, and the labor-management picture should not be affected in that way. One of the main problems, though, we'd like to see the legislation applied to and to remedy against, would be that of dumping. We would not want to see any hospital in order to conform to what would be done, and to conform with its mission policies as so to come within the compliance of the law, just dump patients into the public sector where they feel they ought to be taken care of, as was related a minute ago, that's the problem we have.

As the city, as I am sure Dr. Wochner here will attest to, one of the biggest populations is medically needed persons and all citizens, surely this one.

Is that person who's caught in the gap a medically indigent person? He does not have enough money to go to a hospital—private hospitals, he has no insurance or not enough. He doesn't feel that he wants to go to the public hospitals or maybe he can't get in because he's making too much money.

We think that that population should be one in which the city plans, of which we surely are going to direct our attention.

In closing, and the rest of the matters which I refer to, can be shown in the statement. But in closing, I'd like to sort of summarize and give some focus as to how I feel individually and how maybe the Agency feels with reference to this health picture.

Health is not an isolated kind of thing that sits off by itself, waiting to be solved. Without solving the problems of environment, housing, employment and lead poisoning and other things, we kid ourselves if we think that.

Another kind of point I'd like to leave with you is that the health problems we have now, can they be solved overnight? We cannot solve everything that's being talked about between now and year after next.

We are going to have to have probably a long-range program with segments each year. And the achievements and objectives that we're going to get at, being done partially each year.

Another kind of thing, I think emphasis should be on health planning. I think health planning should be encouraged, go into long-range planning. By long-range planning, we're not talking about 5 years. We're talking about a plan which is based upon a real terrific education system, in which reading, writing, arithmetic, and health are taught in schools.

It'd cause a lot of change of attitudes toward health, styles of living, and there are going to be byproducts of that. Now unless we focus, say, in 1999 to 2000, where we want to be, we probably will be staggering with these same problems 5 years from now.

Also with reference to the medically indigent, the others, we'd like to say those are the persons we'd like to shoot for.

Now, in closing also, the health systems agency here has not been fully designated yet. It's still conditionally designated. But we're hopeful that we will be designated fully soon. At that time, I hope there will be more realizations of the health planning focuses year to year on a long-range basis, than there have been in the past.

And we do feel also that there's going to have to be a complete cooperation between government, providers, consumers, all users, and all deliverers of health care on a real crytallized basis to determine where we are.

One thing that the health systems agency has done, is provide a planning input. Persons who have never had it before. I heard Supervisor McNary relate to the structure. I think the structure is ideal. It's ideal in that it does not have too much of any one sector in it. We feel it would be wrong to put public officials completely in charge of health planning. Those are the guys who have been in charge all the time.

And we feel there should be more or less a input from everyday citizens, businessmen and everyone else.

And that's my conclusion. Thank you very much.

Senator DANFORTH. Thank you. You, I guess, obviously support the certificate of need legislation in the State legislature.

Mr. LYNCH. Sure would. We have also done—I believe we are concerned too about the kinds of legislation. We've been a little disappointed in Missouri because of the 1122 not being in operation. We feel that that has disappointed us. But we are much in favor of certificate of need, in fact, we are encouraging the legislature to so act favorably in that direction.

Senator DANFORTH. In planning, Mr. Gee raised the question how do you know how many beds there should be. Are you confident that the kind of statistical information that is necessary to do good planning is available? And that the right criteria for determining what statistics are relevant? Do you measure occupancy on the Fourth of July or the middle of February?

Mr. LYNCH. I'll say this, maybe there are some misgivings certain times about it, but I feel that basically, we are sure. It leaves a groundway too, that if you do have some maladjustments, you can correct them. And that's what a planning base can do.

If we haven't counted the beds correctly a good planning system will let you make those corrections. So I believe we're in the right ball park.

Senator DOLE. I'm just getting a little review on how many different kinds of beds there are. I mean, is there more than just beds. there's surgical, medical, pediatrics, long-term care, intensive, coronary, empty——

When you start breaking those down into all those categories. there's still unnecessary beds in St. Louis.

Mr. LYNCH. I'd go along with the figures that have been given and I think there is—now, I don't say those figures couldn't be corrected. And I have another—with beds, I'm interested too, whether we're talking licensed beds, beds that are provided, beds that are—there are a lot of kinds of bed definitions.

But I think the answer to your question is the same as Mr. Danforth's. The planning process—if you're set up properly, and if you've made a misconception somewhere down the line, it can correct itself

to adjust to the misconceptions, whether it be definitions of beds, numbers of beds, or anything else.

So I'm confident we're on the right track.

Senator DOLE. He also talked about equipment and I raised that question earlier, not directing it at St. Louis, I guess it was NBC that had a 3-hour documentary on medical care—health care in America. It focused on Denver and other areas. As you state in addition to the cost—the initial cost, is the upkeep of maybe $300,000 a year.

The operating cost of the CAT scanner, for example, and there were what, 26 in St. Louis?

Mr. LYNCH. In that area. There's some still being applied for, some that were denied, not refused but withdrew after questioning about them. But they're up to 20 or more, and we're not sure we've used the right criteria for passing favorably on CAT scanners.

Senator DOLE. You mean you have turned down applications? There have been some——

Mr. LYNCH. There sure have. We not only have turned some down, we have discouraged those who would apply. We're not saying we wouldn't have approved some sooner or later, but it depends upon the circumstances in each instance.

I don't think——

Senator DOLE. You don't think there's an excess now in this area.

Mr. LYNCH. I do not know. There's been some indication and justification of the ones we've issued that CAT scanners have acted favorably toward discovering things which would not have been discovered in an adequate manner without them.

So we have to wade into that problem.

Senator DOLE. It's such a massive problem, you know, when you get into the Federal costs of any program, I don't know of any one more complicated than health care.

You try to sort it out for any community, whether it's Farmington or an area like Russel, Kans., or an urban are alike St. Louis. It's a very difficult problem.

Mr. LYNCH. I think national planning guidelines, if we get the focus from the Federal level as to national planning and directions, I think it would be a big help to all of the 200 HSA's across the country we're trying to help struggle with that problem, and I'm sure we are.

Senator DOLE. I appreciate your input and I think you indicated the cap shouldn't be 9 percent, maybe it should be 8, 7, 5, or 6. Maybe it could be 10, 11, or 12. You didn't mean to——

Mr. LYNCH. I think something should be done because we do have a tremendous short year of people and the cost in that area, and it has to be stabilized if we're going to really provide planning and adequate care for the rest of the system.

Senator DOLE. Thank you.

Senator DANFORTH. Mr. Lynch, just one final question. I've been doing a lot of reading in this area and one thing that I read—it has nothing to do with St. Louis, it was just a national conclusion, was that HSA's in practical terms tend to approve of everything. And that you've indicated in answer to Senator Dole that that is not the case in St. Louis.

Mr. LYNCH. It's not. We've turned down hospital applications, in fact, the old planning group, I was with them too, has been sued once or twice for turning down hospital applications. I think under

the CHP, the 314—under the planning, we didn't have the teeth that we probably have here. But it has not been looked upon as an application which would be approved just because it was filed.

There was an editorial some years ago, in citing St. Louis as one of the cities as trying to really struggle with that problem realistically.

Senator DANFORTH. If that's so, do you have some lesson for the rest of the country? Maybe it isn't a fair commentary for the rest of the country, but if it is, do you have any words of advice or any strategy that can be adopted? Or is it simply just a matter of attitude?

Mr. LYNCH. It's an attitudinal thing. I notice and I think in talking to other HSA's that if their boards are properly, and the persons who are handling reviews are properly oriented and trained as to what's really going on here, and what it is you're trying to achieve, then you will get out of the rubberstamp area.

If they have some standard or criteria by which—very definitely set, by which approvals are going to be made based upon your own goals or objectives, then you will have something objective by which to prove something.

That seems to be, from talking to other HSA directors and board members, seems to be the little laxity so as to ease their way out to prove something, rather than sit down and do the groundwork and create some standards and criteria for its approval.

Senator DANFORTH. We do the same in politics, it's called the politics of joy.

Senator DOLE. If you look at it realistically, if you start to try to rationalize services, then you're running into the status of the hospital and the scope of the services, and you have resistance from trustees and administrators—everybody wants the best hospital in St. Louis or Kansas City or Topeka or Los Angeles. How are you ever going to rationalize all these things, if everybody wants to be best.

Mr. LYNCH. Actually, Senator, I think the solution to it is investry preplanning. In other words, the decision as to whether there is to be an addition to a hospital, hospital beds, cat scanner, that decision should not be made at the time of the review.

That decision should be a part of a planning process by which all the producers, all the suppliers, participated in. And then it becomes a joint thing, as to an approach. It's very bad for HSC to pass on something and say no all the time, when way down the line 90 days or 1 year ago that same applicant should have been planning with the HSA and would have known early.

But this is something that they cannot have, then that justifies the whole decision.

Senator DOLE. Thank you.

Senator DANFORTH. Thank you very much.

[The prepared statement of Mr. Lynch follows:]

STATEMENT OF ALPHONSE J. LYNCH

Two thousand unnecessary licensed hospital beds in metropolitan St. Louis! Two thousand licensed hospital beds which stand idle each day! Two thousand licensed hospital beds which provide absolutely no service yet, cost citizens of this area in excess of $36,000,000 a year. One hundred thousand dollars a day for nothing!

If the concept of "empty beds" is too abstract, let's discuss poorly utilized equipment. A single unneeded CT Scanner, a sophisticated diagnostic instrument, costs in excess of half a million dollars—plus an additional $250,000–$300,000 in annual operating costs—a luxury which must be supported by consumers of

health care services who previously have had little voice in decisions to purchase and operate such equipment.

In a community with the highest reported incidence of childhood lead poisoning in the country, it is unacceptable that resources should be squandered needlessly. In a city where almost half of all live births are illegitimate and family planning resources are scarce, waste and inefficiency cannot be condoned. How long are the pains of children and mothers to be sold for equipment that isn't used? How long are we to support a system of inpatient care to the neglect of programs for the prevention and early identification of disease?

It was precisely these concerns which led to the incorporation of the Greater St. Louis Health Systems Agency, under the provisions of the National Health Planning and Resources Development Act of 1974. In the first year-and-a-half of its operation, the Agency has directed its efforts toward identifying the ways in which a variety of health care services are currently being delivered and exploring alternatives which may more effectively address the actual health problems of area residents. The approval of the community's first comprehensive Health Systems Plan by the Agency's Board of Directors in January denotes a significant point for local health planning. Where before we had opinion, we now have fact. Where before we had hope, we now have strategy. Where before we had division, we now approach consensus.

The single goal of the Health Systems Plan component which examines hospital services is to improve the cost-effectiveness of inpatient care. The conclusions of the analysis are inescapably clear:

1. Many of the hospital services in metropolitan St. Louis are poorly utilized;
2. Enormous pressures are exerted on institutions to purchase equipment duplicated elsewhere in the region; and finally
3. The support of such poorly utilized and unnecessary care precludes the funding of alternative services which benefit the health status of large numbers of area residents.

Although the goal of improved cost-effectiveness is difficult to achieve, the community through the Greater St. Louis Health Systems Agency is not without its successes. In early 1977, it became apparent that the region had a significant surplus of hemodialysis facilities for the treatment of patients with chronic kidney failure. Equipment and personnel were idle; while the Agency became aware of plans to build two additional facilities in St. Louis County. The cost for no improvement in care would have been staggering. However, with the broad support of area physicians, hospital administrators, and consumers, this potential situation has been avoided. A moritorium on the addition or expansion of such institutional capacity has been in effect since April, with the full support of the appropriate Federal regulatory agency.

A second illustration is even more recent. There has been a growing concern among all sectors of our community concerning the costs and benefits of expensive pieces of new technology. Institutions and individuals have often purchased such equipment, at the expense of those they serve, with little evidence to suggest that such technology actually improves the health of patients. In response, the Agency has developed and implemented a comprehensive process for evaluation the utilization, distribution, and quality of technologically innovative equipment.

In summary, it is clear that the health care system, nationally, lacks systematic direction and equilibrium. Scarce financial and manpower resources are allocated in a manner which all too frequencly ignores the pain of the community as a whole. Unlike the retail market place, the health care arena functions without competitive pricing and freedom of choice. Yet, hospital costs cannot be examined in isolation. Any proposal for the control of institutional costs must be sensitive to the multitude of factors which contribute to such costs and over which individual facilities have little control.

To paraphrase the Nobel scientist, Albert Einstein: answers are easy—it's the questions that are difficult. As President of the Board of Directors of the Greater St. Louis Health Systems Agency, I want to assure you that we will continue to ask the difficult question. We will continue our stewardship of community resources. We will continue to provide an open forum for the expression of community needs and the implementation of broad community values. We ask that you join with us in a partnership that recognizes the need to contain unnecessary expenditures so that all might receive the health care they so rightly deserve.

Senator DANFORTH. Claire Rodriguez is—is Mr. Rodriguez here? Mr.—Ms. or Dr. Rodriguez?

Mrs. RODRIGUEZ. Mrs.

Senator DANFORTH. Mrs., OK.

STATEMENT OF CLAIRE RODRIGUEZ, MEMBER, GREATER ST. LOUIS HEALTH SYSTEMS AGENCY GOVERNING BOARD, REPRESENTING CONSUMER INTERESTS

Mrs. RODRIGUEZ. I have a prepared statement that I would like to read, but before I do, could I just add a word or two to Senator Dole's question on cat scanners and the discussion that followed?

One of our problems, as far as cat scanners goes, is that we do not provide an opportunity for private individuals, physicians in their offices, to approach us for approval. In other words, our program, as most programs are set up to review, institutional applications so that we do know there's a few scanners sitting out there in doctor's offices that are not institutionalized. And so, we could not have been responsible for those.

Senator DOLE. Is that part of the total?

Mrs. RODRIGUEZ. They are. They are figured in part of the total and it does dismay us. It's one of the reasons why the Greater St. Louis Health Systems Agency has gone on record in support of the certificate-of-need law that includes private purchasers, because it's really not fair to the hospitals to let this happen. That's really not fair in our opinion.

Another thing is, we have the unique distinction in Missouri of being without either a certificate of need or 1122 for, oh, approximately a year and a half. And that has not allowed us to impact in the way in which we would like to on health care costs.

In Missouri, it has just about nothing in the way of an approach from a long-term care facility. They're going on their way. And, although, a few care facilities have been cooperating to a great degree. But there have been loopholes by not having any real control.

I would then like to say the few words I have prepared. Numerous National, State and local health policy discussions in the last year, including what I've heard this morning, on upward spiralling health care costs, tends to indicate how everyone is caught in the middle.

Doctors, hospitals, hospital administrators, accountants and insurers. But I would suggest the group caught the hardest is the public who must pay for it all. People are angry, bewildered and even feel cheated by unresponsiveness and costliness of the present health care system.

Strong national legislation is needed to deal sensibly with the issue of costs. I would now like to speak to the range of health care issues. You, as our legislators, must address in order to develop national legislation capable of dealing with America's complex health care system.

Where should shrinking dollars be utilized? Hospitals seek construction of more beds than the offering of specialized services as profitable and more appropriate to consumers demands for better services, than the provision of ambulatory services.

More fundamentally, physicians and their patients, disagree over the type and manner in which care should be offered. An example, one example of consumer impact on the method in which physicians rendered care was dealt with in a study last year by the Federal Trade Commission which indicated that health maintenance organizations are providing competition for fee-for-service providers.

Moreover, these prepaid plans are competing with each other. This report also said, the results provide evidence that significant HMO presence may help lower costs, not only to HMO subscribers but to others in the area as well. There are presently inadequate incentives for the use of appropriate alternate levels of health care and for the substitution of amublatory and intermediate care for impatient hospital care.

Now, how many hospitals and inpatients beds do we need? The National Institute of Medicine found significant surpluses of short term general hospital beds exist or are developing in many areas of the United States and as has been discussed earlier, we know that these are contributing significantly to rising hospital care costs.

Concern about the cost of excess hospital beds, the report states, arises not only because of the expense of maintaining unused hospital facilities but also because empty beds encourage their unnecessary and inappropriate use for medical care situations that could be effectively handled in less expensive surroundings.

This was referenced earlier, and I did appreciate it. Now, our responsibility on a local level is to stand firm where powerful community interests favor building or expanding hospitals and oppose cutting hospital services regardless of dwindling occupancy or other signs of reduced needs and efficiency.

Now to this end the Greater St. Louis Health Systems Agency has, and recently, November 30, adopted a plan which provides for the construction of no—no net new hospital beds.

In our area, 2,000 unnessesary hospital beds exist, yet as people migrate from our urban areas so do hospitals. And the city of St. Louis could see an experience of shortage of needed hospital services.

Senator DOLE. Do you have those broken down by hospitals? Could you supply for the record how you get the 2,000?

Mrs. RODRIGUEZ. Yes, may I—I would like to include our plans and point specifically to that point, Senator Dole.

Senator DOLE. And what kind of beds are they?

Mrs. RODRIGUEZ. Yes, and I thank you for that opportunity.

Our plan urges consolidation of services and where appropriate and the provision of alternatives to institutionalizing services where community needs are identified.

Another point is, what role do the providers play in the reshaping of our health care system. Well, recently I read an advertisement by the Aetna Insurance Co. which suggested the establishment of State commissions to set limits on hospital expenditures. They referenced Maryland, I believe.

Aetna also encouraged local medical societies to monitor doctors' use of hospitals, a PSRO has been dealt with this morning. What is the impact of rising health care cost on industry and the wage earner. Business is concerned because the level of medical charges affects health insurance premiums which companies commonly pay part or even all of for employees.

Increased health costs limits industry's ability to pay increased wages. So both management and labor leaders are concerned over the impact on prices, wages, and profits.

A classic example of the role health care costs play in industry employer and employee relations is our Nation's current pole study. Here management dropped health care coverage for the workers

because it's too costly. Yet, employees strike and refuse to ratify contracts because health benefits are seen as nonnegotiable from their point of view.

So I've raised a number of serious questions which any national attempt to modify the existing health care system must address. Really, most of us are realizing these are complex issues, and yet we're learning they affect us all.

I cannot make more specific directions for Congress at this time, except to say, something must be done and soon. And I really heard that echoed by the points you two Senators have addressed to us this morning.

And lastly, Americans desire for rapid control of the rise in health care costs is shown in last years Harris poll which indicated nearly two-thirds of the people supported President Carter's 9-percent limitation on hospital cost increase. And sad enough to say, the majority, 54 percent, favored it even if it meant reduction in services.

I'm most appreciative for the chance to present my comments. And it's commendable that the broad spectrum of those providing acute care in our community be offered this opportunity to give testimony.

In my opinion, it would be equally advantageous for the Senate subcommittee to hear the comments of the broad spectrum of health care consumers, who are concerned about health care costs, and I would hope that subsequent hearings would provide this.

And I assume that the Greater St. Louis Health Systems Agency being a majority, the consumer dominates; I mean, we have a majority mandated by Federal law, and we would be glad to help in any contracts you might wish to make, so there is more consumer representation.

Senator DANFORTH. Thank you very much. Were you here when the representatives of Blue Cross and Blue Shield were here?

Mrs. RODRIGUEZ. Yes, sir.

Senator DANFORTH. Well, I asked Mr. Shelton about deductible and coinsurance features, and he said they're just not very popular. Let me ask you, have you given thought to one, whether an increased reliance on deductibles and coinsurance would help get at the problem of the increased cost of health care? And two; what, if anything, could be done to increase acceptability of them?

Mrs. RODRIGUEZ. Well, I guess we're talking about an educational effort. I don't know—in answer to your first question, I don't know if it would make a difference. I do know what you're getting at in the idea there really is no free lunch—to use the overworked cliche. And more of us are beginning to realize that we pay in many ways. Not just by insurance costs but our personal income tax, corporation taxes, in many ways we pay for all this.

And whether our awareness would be heightened and that we would give reconsideration to needs if we had to pay more, I'd have to say I don't know. It's an interesting theory. I do know the distinction between Blue Cross and Blue Shield. Blue Shield indicated that only 24 percent of their clients opted for a full range of coverage. So that left 70-some percent of Blue Shield people—if I understood correctly this morning—do pay some out-of-pocket costs.

But again, that's not the same as Blue Cross, and I really don't know.

Senator DOLE. It doesn't really get at the problem; it shifts the cost around. We're trying to see how we can moderate the increases. That might have some effect; if the consumer pays more, maybe there would be more pressure to moderate increases.

Mrs. RODRIGUEZ. I appreciate that and I think—I really don't know that I agree with that but I understand from where you're coming and it's hard to refute in some ways, but the education of consumers is certainly part of what this has to be about.

Some of the comments that you both made, I know that you're aware of everything that I presented, and you, you know, you really are trying to get hold of the problem. And the education of the consumer to some of the things you pointed out, is part of it.

So I don't know whether their having to pay more would moderate the use of not. I really don't know.

Senator DANFORTH. How about the malpractice question, the explosion of malpractice suits? Every time you get a malpractice suit, you have a plaintiff, and the plaintiff is somebody who has been treated by a physician, and the person is treated as the consumer.

Mrs. RODRIGUEZ. I'd have to say I don't know there either. I don't know if the explosion is because there's more malpractice or lawyers are finding a new thing. I really don't know how—what percentages of escalating costs malpractice figures, and I think that the physicians—and you're going to have some eminent physicians who will be before you and they're the ones—I've never been involved in lawsuit. I really can't speak to that.

Senator DANFORTH. Senator Dole just said it's a lawyer's Panama Canal.

Thank you very much.

Mrs. RODRIGUEZ. You're welcome. Thank you for the opportunity.

Senator DANFORTH. Dr. Lieb and Dr. Boles.

Well, I think I can tell these two doctors apart. Dr. Lieb is on my right and he is the past president of the St. Louis Medical Society, and Dr. Boles is on my left and he is the past president of the St. Louis County Medical Society.

Thank you both very much, and I'm sorry you had to cool your heels for so very long.

STATEMENT OF FRANCIS X. LIEB, PAST PRESIDENT, ST. LOUIS MEDICAL SOCIETY

Dr. LIEB. It's been an educational experience. I appreciate it.

Senator Danforth and Senator Dole, my name if Francis X. Lieb. I am a practicing physician in St. Louis and I am the immediate past president of the St. Louis Medical Society, but I am appearing before the committee to present my own personal views. And I deeply appreciate the opportunity to be here.

As a physician in the solo practice of pediatrics, I am well aware of the need for control of our runaway costs. Unfortunately, there are no simple methods of controlling this problem, no simple legislative procedure that will provide a remedy, no unilateral action that will produce a lasting cure.

Any actions that are planned or proposed must include not only those who provide health care, but also those who utilize the services of those providers as well as those who finance the system. It is further

necessary to control the economic environment in which these services are provided. It is naive to believe that health care cost can be controlled without, in some way, providing a stable economy in which the system can function.

This, of course, implies that Government must come up with a reasonable fiscal policy. Imposition of controls on hospital costs in a milieu of constantly rising expenses appears to me to be unrealistic.

The proposed imposition of these controls correlates well with the present practice of Government insisting upon full service from the hospitals and yet reimbursing them at less than their proper share of the costs of that service. Recognition of the fallacy of this type of reasoning is provided by the exception from the cost control legislation of Federal hospitals and certain HMO-supported institutions.

This, to my way of thinking, tells the people, we'll tell you how to control your costs, but don't expect us to control ours. Certain Federal guidelines may well be appropriate, but the volunteerism that characterizes our country should be given an opportunity to function before the inappropriate and unrealistic provisions of the Cost Containment Act are imposed.

It has been said that the physician determines how many health care dollars are going to be spent. And this is to some extent true. We can and must provide service in the most economic setting and manner that is consistent with good patient care. Our relationship with our patient must be such that the practice of defensive medicine can be virtually eliminated.

We must educate our patients as to what they can expect from us and from the rest of the health care system. In other words, they must have realistic expectations.

While this sounds commendable, it will be impossible to accomplish this without the cooperation of the patient. There are may aspects of our daily lives that must be scrutinized and changed to affect our general well-being: appropriate diet, judicious use of tobacco and alcohol, control of potentially hazardous conditions in the home and automobile, good personal habits of hygiene—just to name a few.

It must also be emphasized to the patient that prevention is more economic than crisis care or illness care.

Finally, those who finance the system must begin to realize that the role of their programs, whether insurance or self-provided, must shift emphasis from hospital or in-patient orientation to ambulatory or out-patient orientation. I think of this as providing coverage for the way medicine is practiced rather than forcing the physician and patient to behave in a manner dictated by the way in which coverage is provided.

A realistic program of prepaid medical care that will not interrupt the physician-patient relationship; that will continue to provide freedom of choice for both physician and patient, and that will include incentives for the patient, physician, and the financer, will go a long way toward achieving the goal of good health care for our people at reasonable costs.

How do I perceive Government's role in this scheme of things? I believe that Government has the right or possibly the obligation to see that health care programs offered to the people are realistic in what they provide.

Optimal standards should be established by which all health care programs can be evaluated. No programs should be allowed that do not provide ambulatory benefits, and at the same time, reasonable inpatient and catastrophic coverage. Those who provide the benefits should also expect that the physician and patient be subjected to peer review to assure appropriate utilization of facilities and service.

These remarks are necessarily brief and sketchy, but I cannot close without at least mentioning the importance of educational efforts. These efforts should be directed not only toward the physician and the patient but also toward the legislator so that he may have a more complete and workable knowledge of the medical care system.

It is important to point out that medical care is not a matter of statistics and numbers and costs, but a very personal and intimate relationship between a person on the one hand, with a need, and a person on the other hand, equipped to help him meet that need.

From my position of involvement with physicians over recent years, I have already begun to sense a rebirth, if you wish, of the personal relationship between patient and physician I believe communication has improved so that each of us, patient and physician, is getting a better view of our own individual needs. Where we can establish good communication, whether between physician and patient, or physician and legislator, or patient and legislator, a good relationship must necessarily follow.

Thank you for the opportunity to present these remarks.

STATEMENT OF C. READ BOLES, PAST PRESIDENT, ST. LOUIS COUNTY MEDICAL SOCIETY

Dr. BOLES. I am Dr. Read Boles, private practice and past president of the County Medical Society. And my comments reflect my own opinions rather than those of the past president.

I will back very much what Dr. Lieb said and choose from my written statement just certain comments. One; when the American people assumed the right of health care as an inalienable right, leaving education, et cetera only as a privilege, this put a priority on health care. This created also excessive expectations and demands on the health care system with resultant escalation of costs. This is a real factor.

Therefore, the public must be educated as well as the doctors, including ourselves, of the costs of this—of various unrealistic expectations, facilities, et cetera. Also, we must meet some recognition of their role, the public, and the many social economic problems which create health and health care problems and escalate cost, such as nutrition, housing, accidents, and environmental hazards, and individual health habits, like tobacco, alcohol, lack of exercise, various things which are contributory to morbidity and also to mortality.

The Government does relate to increased costs with minimum wage, social security, and—all of this has been reviewed for you this morning. But I might point out that we are dependent upon the charitable contributions of many volunteers and also upon gifts, and I would hope that there would be full tax credit for charitable deductions. This contributes certainly to our children's hospitals.

Technology has increased our costs, of course, and the unique role of our tertiary hospitals—and our children's hospitals, by the way, some 20 percent of the children we admit at Children's and I am sure at Glennon, come from HSA's beyond age as a planning area, so there should be some concept of reasonable planning.

We also have the additional responsibility of very ill patients requiring consultative care, more ancillary groups. We do save some by having lack of duplication of services.

Other things which enter into it, the peer review organizations, HSA, may help but they can't be hampered by conflicting and constantly changing policy statements and directives by HEW or other governmental agencies.

Hospital cost effectiveness will be stimulated if the consumer is more directly involved in payment of the hospital bill, and also if our hospital personnel is dedicated to cost effectiveness.

We don't need more regulations, but creation of an atmosphere where trained and inspired personnel will, by their dedication and expertise, materially contribute to the reduction of hospital costs. We, as physicians, are dedicated to the well-being and care of our patients.

This dedication must not be buried by well-meaning but poorly conceived, costly and time-consuming unnecessary and inflexible regulations with multiple layers of administrative costs. We have to be left free for whatever innovative techniques and procedures no matter what the cost.

Thank you.

Senator DANFORTH. I believe medicare has, at least in some cases, required second opinions for surgery. Is that right?

Dr. BOLES. They have been discussing it, but I don't think——

Senator DANFORTH. It is encouraged but not required. Well, what do you think about that, is that a good idea or a bad idea? What about a second surgical opinion?

Dr. BOLES. It is an idea that has never been proven, to the best of my knowledge, those programs that have been instituted, and I am thinking of one particularly in Washington, D.C., in the FEP program, the utilization of this as of several months ago was very poor, and they really had no figures to support the wisdom of it.

We are working on second surgical programs with several insurance companies trying to implement one on a pilot basis in St. Louis but we haven't gotten things ironed out as yet.

Senator DANFORTH. Do you think it could be workable or is it——

Dr. BOLES. I guess the best person to ask that question would be a surgeon. I am a pediatrician and we are second-guessed all the time. It depends upon how much unnecessary surgery you believe is going on and I personally believe it is minimal in our own community but we may live in a rather sheltered community and not be aware of what goes on in other areas.

I personally don't have any hesitation at all about someone giving a second opinion on a patient that I have seen. I welcome it, I don't pretend that I am going to do the right thing all the time. In the vast majority of instances, I feel that surgeons would feel the same way.

Now would it be economically—would the cost effectiveness be good? I would have to question that personally. I think we have to speak in terms of cost effectiveness there. There's the cost of second

opinion, there is the inconvenience of second opinion, there is the time-consuming aspect in terms of degree of emergency of whether or not that procedure is one which can be deferred.

I am speaking in terms of the patient's well-being. We are patient-oriented people, how it affects them. I think it is terribly important. If such a delay of procedure is endangering to the patient, I—because it is a flatout regulation, I——

Senator DANFORTH. It must be done carefully and judiciously applied. As I understand the medicare provision, it has to do purely with elective surgery. I don't know what elective means, I mean, I guess a nose job would be elective surgery, is that right?

Dr. BOLES. I would assume so.

Senator DANFORTH. And then you would go to the doctor and say—I mean, does a second opinion make any sense for elective surgery? If I were to go—if you two were surgeons, and I would go to you, Dr. Boles, and say, well, what do you think of my nose? And you would say, it is the worst looking nose I've ever seen. And then I would go to Dr. Lieb, and I would say what do you think of my nose? And he would say, well, I like it. I mean isn't elective surgery this kind of thing where it is just anybody's guess or not?

Dr. BOLES. This is my concern that there is a wide range of opinions in this and among the same specialities varying both regionally and where you were trained, and in terms of the total patients. So if you isolate all these——

Senator DANFORTH. Well, this is the real concern on surgery. If I were to go to the doctor and say, I've got a pain in my stomach or something. He might say well we have got to get you to the hospital and operate. That is not elective surgery, as I understand it. It is the doctor's opinion of what is necessary for my health.

On the other hand, I could go to another doctor and he could say you don't need any operation at all, all you take is a Tums or something. But I wonder if you are going to have a second opinion. What I am saying is, if you are going to have a second opinion, it would seem to me to make more sense in a nonelective setting than in an elective setting.

Dr. BOLES. That's right.

Dr. LIEB. Most of the studies that have been done, at least of what I have seen, and that Metropolitan and Aetna have produced for our study, have been confined to a few procedures, tonsillectomies, hernias, such things as this. Of course, those are in the vast majority of instances, pure and simple electives. And that are not something—a mother does not usually want their child to have a tonsillectomy unless they really need it. You don't usually want to have your hernia repaired unless it is really bothering you. But you can live with large tonsils and you can function well with large tonsils and breathe through your mouth instead of your nose. And you can wear a truss and such things as that.

But now when you get into areas where you have expressed concern, that's one of the big problems in making the thing function properly. And I really don't know what the answer is to that. That is why we are kind of soft pedaling it on a local basis.

Senator DANFORTH. But what you are saying is that it certainly has not been proven to be a big cost saver, that the facts are not in as yet. And, therefore, until there is some sort of track record for it, it would be a mistake as a matter of course to require it?

Dr. LIEB. In my opinion, yes.

Dr. BOLES. A second factor that enters into it, with adequate peer review within the hospitals as necessity procedures, this would in essence by education of the doctor by being a continuous offender by the peer group within his own hospital, certainly, we have that.

Senator DANFORTH. What do you have peer review for?

Dr. BOLES. Peer review will extend through the superior organization for almost all procedures, and through that the hospital will have its standards, while the region is based on multiple standards, and I plead that those be allowed as things change. But peer review has not been in operation long enough to do this, we think we need more physical evidence, we do have inhouse things, certainly in a teaching hospital where you have review by your peers.

Senator DANFORTH. Well, let me—just so I can understand what peer review is. Supposing that Dr. Jones would admit somebody to the hospital for a bad back. That person is lying there in the hospital and nothing much has happened. Now the peer review would be just a matter of course, the other doctors on the staff of that hospital would look through the files and they would say to Dr. Jones, what is this patient doing in the hospital?

Dr. BOLES. At the present time, the peer review is set up in terms of defining the necessity of the patient's admission, duration of stay, and getting gradually into the quality of care, and defining what the standard care is for that particular disease. That is down the line, it is down the pipeline still.

Senator DANFORTH. Well, what does the peer review—what do they say? Do they say you must release this person from the hospital or do they just kibitz, or what?

Dr. BOLES. At the present time, there is enough pressure on those that are federally paid patients, or State paid, to where it is a monetary thing. This admission will not be authorized for payment. And that is a monetary thing, this is more of the administrative office type of thing.

Senator DANFORTH. And again, on peer review, its——

Dr. BOLES. Yes, but on down the line——

Senator DANFORTH. There is not enough information to make a good judgment on it?

Dr. BOLES. I don't think at the present time.

Dr. LIEB. If Dr. Jones admits patients with bad backs frequently, and by review of his activities prove that he really isn't doing much for these bad backs or evaluating them properly, in the long run you can use this type of information that you obtain in peer review to see that Dr. Jones—Dr. Jones, we reviewed your charts and this is what we have found over a period of time, and effective as of January 1, your admitting privileges are limited, as far as bad backs are concerned. We are going to take your privileges away for admitting bad backs.

Another problem of delineation of privileges, not all doctors should be able to do all things. Those of us who specialize, of course, have already cut our field down quite a bit. And even within those fields we have very little expertise, and we don't attempt to do other things.

So I think the peer reviews, the audit committees, the utilization review committees, et cetera, will help us to identify those physicians who should have their privileges limited.

Senator DANFORTH. Now just for a matter of information, or for any other instructive comments you have, how much defensive medicine is practiced? Just in your judgment, in order to avoid lawsuits——

Dr. LIEB. There have been all sorts of things printed about this, and there have been estimates from anywhere from 20 percent to 50 percent or more costs are accrued because of defensive medicine. And I think it really depends upon the individual physician and his approach to the problems. Most of us as pediatricians have a fairly good relationship established with most of our patients.

I would say our defensive medicine costs about, probably minimal. But on the other hand, there are those situations in which you can foresee the problem and then you really do practice defensive medicine.

And you mentioned Dr. Jones, I'll mention Dr. Lieb. In a recent instance in which I was personally convinced that this child had no particular problem but I couldn't convince the parents of this. The child was ill but I couldn't convince the parents that this was not a physical problem but a psychological problem and I practiced very defensive medicine, and in doing so, managed to increase the hospital bill considerably.

I finally convinced them that the child needed care other than surgical care. So what does happen, I don't think it is a common occurrence but it does happen.

Senator DANFORTH. You say some studies say 20 percent to 50 percent of the costs?

Dr. LIEB. Right, the laboratory costs.

Senator DANFORTH. Oh, laboratory costs.

Dr. BOLES. I will speak to that in terms of the doctor-patient relationship. We have an ongoing relationship in your private practice, you know, you know the family, you know their reaction, you know how able they are to cover this child who has possibly been injured and report to you.

It is different in an emergency room situation when they come in, so to speak, cold, in terms of the doctor who is seeing them. You have to go out and outline more tests. For example, if a child has fallen, a skull film and cervical spine which is a low product activity in terms of the number of kids today having a fracture of the spine associated with it. But it is almost a routine procedure in many different places now.

Some of us will—knowing we can follow the child carefully, not obtain that. It depends upon the degree of follow-up, your relationship to this patient, I think, has a bearing on it.

In terms of malpractice, the flu vaccine—I understand the Federal Government is being sued now for almost a billion point two-five million, which must put a terrible load on the Federal court.

Senator DANFORTH. Well, I'll tell you, this field of product liability, the courts are being overloaded, the cost of living in this country is being escalated, and lawyers are being kept in their livelihood, I guess, but I don't know what to do about it. And frankly, I haven't heard any good ideas, I don't know what Congress is supposed to do about it. You hate to get into the torts field that has traditionally been a matter for State courts, not at the Federal level. But if it is 20 percent to 50 percent of the laboratory services——

Dr. LIEB. That is off-the-cuff.

Senator DANFORTH. Would that be a large portion of the total cost, or are laboratory costs just a small fraction?

Dr. LIEB. I would think it would amount to quite a sum.

Senator DANFORTH. Significant?

Dr. LIEB. Yes.

Senator DANFORTH. And also the time of the doctor?

Dr. LIEB. It would be more than likely that you would have repeated visits to the physician's office, if you are defending yourself.

Senator DANFORTH. OK.

Senator DOLE. I guess Jack covered everything quite well. As far as I know, I think you have both pointed up the problems and, of course, I don't know what would happen if we had a peer review in the U.S. Senate, we would probably all be ousted after a year or two, but it is a very difficult thing, and I think we are just searching for ways to somehow moderate costs. It is like the second opinion, maybe we ought to try to find out where the second opinion is needed, rather than try to apply it across the board. That is always the Government's answer, just make it straight out.

Every community wants a hospital, it is like the corner drugstore, everybody wants a hospital they can walk to. There have been some, statements here that there are 2,000 excess beds available in St. Louis, would you agree that there is an excess in the area?

Dr. BOLES. Having also sat on the arch board, which is the health care planning board, I've been through years of this, there are an excessive number of beds but in my mind it is a matter of distribution.

We also have to accept the fact that we think only in terms of new facilities, expanding facilities. You have to, somehwere along the line, think in terms of closing obsolete, or inadequate, or poorly located facilities. It is a great desire, of course, to have a hospital around the corner. I would love to have a drug strong around the corner, et cetera, et cetera, but that's like all these things, in passing, by the boards for various reasons we cannot control. As we have sophistication of hospitals, we can't—especially the teritary hospitals made into secondary hospitals, and most all the hospitals in St. Louis fall into line in one or two categories, in my mind.

These hospitals have increased cost. We also have within a hospital structure the crash concept, mainly, like me, if we have to have beds, say, for me, a kid with meningitis being terribly ill and not being able to get a bed, in this sophisticated place where you have adequate personnel and equipment to backstop and take care of the child.

That's an additional cost factor, it is the same concept you have in the military hospital concept, which I don't know how to predict. Certainly the health care agency has to be given the responsibility. Also it has to have some autonomy when the problems that exist in St. Louis are different, in part, from Kansas City. Regulations emanating from Washington from HEW, making a flat regulatory concept of number of beds and so forth, doesn't take into a lot of local transportation funding where your population is, you're into the population. There has to be some autonomy of the planning groups and they still have to have a fair providing of representation to give the expertise as well as the consumer input.

Senator DOLE. Is there any exodus to the suburbs, or if that happens, are the doctors leaving the city too, are they following their patients to the suburbs?

Dr. BOLES. Yes.

Dr. LIEB. There is no question about that, there has been a marked exodus to the suburbs by both.

Senator DOLE. What impact does that have on the hospitals that are still here?

Dr. LIEB. Hospitals have moved to the suburbs as well, leaving some problems in the inner city, such as Dr. Wochner referred to this morning. I would guess that 50 percent of the hospitals in the county—I don't know those figures, don't quote me.

Senator DOLE. That is probably where the problem is, if there is a problem, let's put it that way. If there are empty beds——

Dr. LIEB. They are in the city.

Senator DOLE. They are in the city, they are not in the suburbs.

Dr. LIEB. Well, there are some empty beds in the suburbs. There are hospitals that have been established in the suburbs in areas where other hospitals have been established previously, and their occupancy rates are very low. But I would guess that that would be remedied with the natural growth population in those areas in the next 5 years.

Senator DOLE. I know out in rural areas, I am certain this is true in Kansas, you drive 30, 40, 50 miles just to go to the hospital, I assume that there is a difference in urban areas. Of course, there is a more dense population, and maybe it has to be that way, but how many hospitals are there in Greater St. Louis?

Dr. BOLES. I think there are 37; how many hospitals are there?

Dr. LIEB. There are 47.

Senator DOLE. How many beds?

Dr. GEE. There are 13,000.

Senator DOLE. That is a pretty good number. What is the population? I'm just trying to find out—is it pretty much the national average?

Dr. GEE. It is 2.4 million. It is 5.9 beds per 1,000 population.

Senator DOLE. That's high. Thank you.

Senator DANFORTH. Thank you very much.

[The prepared statement of Dr. Boles follows:]

STATEMENT OF C. READ BOLES, M.D.

We, as providers of care, welcome your interest and concern in this complex area of Health Care costs and join you in your concerns. You, as the government, have by policy statement, legislation and regulation, and at times promises, successfully conveyed to the American people their inalienable right rather than just privilege to accessible quality health care at affordable cost.

Today the escalating health care costs are being addressed. The questions are multiple. Fiscally viable answers which would satisfy these multifaceted needs within the framework of our democratic society are even more obscure. The December 1977 report of the National Commission on the Cost of Medical Care addresses itself well to these problems and offers some possible solutions. I concur with many, but in no way with all of their recommendations.

We must consider the term "Cost Effectiveness" rather than "Cost Containment". If the public through their government sincerely want to control costs, responsibility must be assumed. There must be general recognition and acceptance of the great costs of the many social economic problems that relate to health and health care costs—such as nutrition, housing and environmental hazards.

To attain this goal there must be:

(1) Education of the public as to the role played by excessive expectations and demands upon the health care system with resultant escalation of cost. There must be education of both physicians and patients as to what costs really are and of their validity.

(2) There must be governmental and legislative recognition of the immense costs many well-intended, many uncoordinated, inadequately planned and funded programs doomed to ultimate failure because of such fundamental defects. If the government has the courage and vision to institute health care programs, the same conviction and vision is required to terminate without delay impractical or unsuccessful programs.

(3) The government has contributed to the escalation of hospital costs by:

(*a*) Increased minimum wages with the resultant increase of labor costs which constitute approximately 45 percent of Hospital costs.

(*b*) Increased social security benefits for Hospital personnel.

(*c*) Uncontrolled energy costs.

(*d*) Administrative costs of mandated regulatory reporting, etc.

(*e*) Failure to control inflation with exorbitant increased costs of (1) labor constituting approximately 45 percent of hospital expenditures, (2) essential supplies and equipment and services. These have both risen far more rapidly than the general rate of inflation.

(*f*) The national malpractice crisis with its enormous additional costs of premiums, defensive procedures, documentation and peer review. The threat of unreasonable malpractice liability hangs like an ever present cloud over every practitioner and institution.

(*g*) Reduced charitable gifts due to: (1) increased regulation and taxation of charitable trusts, (2) increased personal and corporate levels of taxation by all governmental levels, (3) decreased availability of charitable endowments and funding.

There must be full tax credit for charitable deductions. This is partially made up by the generous contribution of the many volunteers time and services of which our society is deeply indebted.

In consideration of other major cost escalation it must be emphasized that:

(1) Constantly advancing technology, while markedly improving the quality of care and extension of life, contributes through the cost of sophisticated equipment and the training of sophisticated personnel for the use and maintenance of such equipment. The high costs of depreciation of such equipment and training is further accentuated by a rapidly advancing technology which may make such equipment or techniques obsolete within a short period of time.

(2) Nationally adopted requirements for admission routines, some mandated by Joint Hospital Commissions and review organizations, and other administrative requirements.

(3) The unique role of tertiary care hospitals, particularly teaching hospitals with their additional but also costly and effective role of time-consuming levels of care and consultation, require expensive equipment and highly-trained personnel. More critically ill patients require more personnel for each patient and more equipment. The responsibility of training of physicians, nurses and the multiple ancillary groups, now deemed essential for the total patient care, also increases costs. There is some saving by reducing the need for duplication of equipment and services in other hospitals providing less intense levels of care.

(4) Failure of third party insurors, etc. and the Federal and State programs to cover adequately outpatients costs and preadmission tests and examination.

(5) Discrepancy in reimbursement between various State and Federal programs gives rise to futher significant deficits, particularly within certain hospitals—the difference of reimbursement between Missouri and Illinois Medicaid is locally illustrative of this problem.

(6) Effectiveness of federally mandated programs, such as the Health Care Planning Act and the Peer Review Organization Act, has not as yet been determined because of insufficient duration of operation.

The PSRO's with a major concern for quality of care appears to be defining standards of care with identification of unnecessary or outdated procedures or care, providing resulting cost benefits.

The HSA's with their long and short-range projected planning may decrease duplication of facilities and services and more clearly define needs and programs.

These agents to be effective must have a great degree of local autonomy as needs, problems and solutions vary immensely from region to region. The HSA must improve their provider reputation and input vs consumer ratio if they are to be more effective in viable planning and community acceptance of such planning. The HSA's must recognize that certain health facilities are regional—at least 20% of the care rendered by our two major children hospitals is provided for children who live beyond the local HSA planning area. These programs must not be continually hampered by conflicting and constantly changing policy statements and

directives by HEW or other governmental agencies. Hospital cost effectiveness will be greatly stimulated if the consumer is more directly involved in payment of the hospital bill and all levels of hospital personnel are dedicated to such effectiveness.

We don't need more regulations, but creation of an atmosphere where trained and inspired personnel will, by their dedication and expertise, materially contribute to the reduction of hospital costs. We, as physicians, are dedicated to the well being care of our patients. This dedication must not be buried by well meaning but poorly conceived, costly and time-consuming unnecessary and inflexible regulations with multiple layers of administrative costs. The limitation of well conceived and supported innovation concepts can only hasten the demise of the quality and distribution of Health Care.

Senator DOLE. Who is your last speaker?

Senator DANFORTH. The final speaker is Dr. Perkoff.

Dr. Perkoff.

Senator DANFORTH. The last speaker is Mr. Perkoff. You are the director of——

STATEMENT OF DR. GERALD PERKOFF, DIRECTOR, HEALTH CARE RESEARCH, WASHINGTON UNIVERSITY

Dr. PERKOFF. I'm director of the division of health care research and professor of medicine at Washington University, and our group has administrative responsibility for the medical care group. The director of the medical care group is Dr. Lawrence Kohn.

The medical care group is a prepaid group practice.

My testimony deals with alternative health care delivery systems, especially prepaid group practice as exemplified by the medical care group of Washington University. Prepaid group practices are thought to offer opportunities for cost control because it is believed that if one reduces financial barriers to the appropriate delivery of medical services in ambulatory settings, and provides an organized system for the delivery of those services, decreased hospital utilization and increased use of ambulatory services will result.

This is thought to control costs by substituting less expensive ambulatory care for more expensive hospital care. Over the years, data has accumulated from a variety of prepaid group practices which tend to support these ideas, but the results have varied greatly from plan to plan. And many questions remain.

When medical care group was first developed in an experimental program to try to answer some of these questions by means of a control study, beginning in 1969 families were enrolled in the medical care group and then were randomized into two groups, one cared for by their own physicians in the traditional private system and one cared for in the medical care group under a comprehensive prepaid plan. At the end of 3 years of study, the following results were observed: The study group cared for in the medical care group used 23 percent fewer hospital days then did the control group.

As predicted the medical care group used significantly more ambulatory care services than the control group. Medical care group hospital services did cost less money than the control group's hospital services.

This savings was not large enough to pay for the increased costs of providing the additional ambulatory services. However, several other areas for cost controls, besides savings in hospital days, were identified in the medical care group experiment.

These were: First, physician services costs. Counting professionally rendered technological services, such as radiology and clinical laboratory services, physician services accounted for almost three-fourths of MCG's expenditures, besides the hospital costs themselves.

Second, unnecessary specialists services. Many services presently performed by specialists, physicians, and service consultants could be performed at less cost by primary care physicians and other primary care providers, if the training of the primary care professionals was expanded to include simpler specialty tasks.

Three, elimination of useless practices. Without the fee for service incentive, the physicians in the medical care group were able to look at some of their habitual day-to-day patient care practices and to decide whether or not each procedure was of use to their patients.

Sometimes they were able to discontinue less useful or useless ones, especially some laboratory tests, X-rays and parts of detailed annual physicial examinations.

Since its initial experimental period, the medical care group has grown rapidly. There are now 21,000 individual enrollees using over 75,000 ambulatory visits per year. The medical care group markets its plan at a modest cost advantage over traditional health insurance coverage with comparable benefits.

But, despite these sucesses, the medical care group still experiences difficulty in controlling physician generated health care costs, and almost certainly will loose some of this cost advantage over traditional plans in the next few years.

Nevertheless, its major initial objectives have been achieved. In my opinion, however, prepaid group practice is not likely to become the domiante method of medical care in our country for a wide variety of reasons.

But many of the leasons of prepaid group practice are applicable to cost containment in other settings. Among these are the importance of emphasis on ambulatory care. There is little doubt that some significant portion of today's hospital use is fostered by current forms of health insurance which emphasis hospital over ambulatory care.

Incentives for office care should be provided for both physicians and patients. Studies in Montreal, Canada, for example, show that care can be shifted from the hospital to the office in a fever service system by appropriate economic incentive.

Likewise, the control of hospital use that is characteristic of prepaid group practice and also be obtained in other ways. In organization for medical care is important here, but availability of payment for services and alternative sites would help a great deal.

Emphasis on procedures known to be effective, also can be obtained outside prepaid group practices by physician review within their own practices, by peer review or both, encouraged by financial incentives, structured toward those procedures which good research shows to be effective, and against those shown to be ineffective.

And the tonsillectomy is a classic long standing example. There's still almost a million unnecessary tonsillectomies done in our country paid for by private and public health insurance.

Finally, physicians services costs must be ameliorate also. Physicians are not only higher earners in our society, but their services are highly valued in the abstract as well. Despite the difficulty of approaching this volatile subject, it must be recognized that any effort at cost

containment in medical care must affect at least the two major sources of cost, the hospitals and the physicians. Not just one or the other.

I might also interject there, that the suppliers of hospitals make unusually large profits for items sold to hospitals, when they don't make them when they're sold to other areas even though they might be comparable.

Some combination of the organization of medical care, negitoiaton of fees and/or salaries of physicians, and a levying of physician income so that the generalist specialist radient is not so steep, will be essential before cost containment can be a reality.

Thank you very much for the opportunity to testify.

Senator DANFORTH. Very good and concise. You said that you also had some comments on what you heard while you——

Dr. PERKOFF. Well, there were three areas of particular importance, because I believe in response to these three areas you were told there wasn't difinitive information and I would dispute that. I wouldn't say what's right or wrong.

For example, with regard to second opinion, the main study upon which the concept of second surgical opinions its base was done by Dr. McCarthy and others in New York. Whenever someone says New York and St. Louis, of course, we all say it's different. And it is different.

But it was done in the context of a prepaid insurance plan where every surgical opinion, not just elective plastic surgery, for example, had to be gotten a second opinion before the plan was paid for. The doctor could go ahead and do it if the patient agreed to pay without a second opinion.

Now I haven't read those papers in awhile, but some specialities are as much as 35 percent of the surgery was disapproved without loss of health to the patient.

In other specialities it was as low as 6 or 7 or 8 percent, clearly there were differences. But even paying full fees to the surgeons for the second consultation, the program clearly saved money. And it did not clearly result in detrimental health care.

Now that's only one study. But the fact is there will never be a track record. If physicians find it difficult to implement such files elsewhere and that will become a self-fulfilling process that they are on no data.

On a second point, there's considerable data about coinsurance and deductibles. Tekowski and others studying people enrolled in prepaid and fee for service plans in California, there's a national health insurance study under Joe Newman of the Rand Corp. and a variety of others and a medical study which showed what the addition of even $1 as a coinsurance or deductible rather, people covered who were poor, resulted—sure it resulted in decreased utilization. And what did the women fail to get? They failed to get prenatal care.

They failed to get precriptions because they couldn't afford to buy the drugs. And they failed to go to the dentist and other preventive things which weren't acute urgent care.

When you are a faculty member at Stanford, it takes about 25 per cent coinsurance or deductibles result in reduction in medical care use. But it isn't clear that's appropriate reduction in medical care use even yet.

And of course, if the patient pays for it out of his pocket, it doesn't reduce costs at all, just moves it from one place to another.

So there are data and people can make choices as to how they would prefer to pay for it. But none of those things, in fact, control the overall cost. They only control what the premium on the insurance plan is, and the rest of the cost comes from someplace else.

Now with regard to defensive medicine, the Robert Wood Johnson Foundation just published a fascinating study that doesn't have directly to do with defensive medicine but tells us something about it.

The study conducted by Ronald Anderson at the Center for Health Administration Studies at the University of Chicago using the national survey, some 40,000 household interviews as part of a continuing study that's gone on there for years. And it shows that despite the fact that people believe there's a crisis in health care, they are satisfied in the great majority with their medical care. They're satisfied in the great majority with their hospital care.

Poor people have increased access to medical care since medicare and medicaid, even though those programs have many deficiencies and are highly unsatisfactory in many ways. But people are regularly dissatisfied with the cost of their medical care, even though all these other things have improved.

Which tells us the subject we're talking about today, is the one which is bothering the American people more, whether or not it is the correct one to bother them is a separate issue. It's my belief—now not based at all on fact, that given the malpractice problem and given the fact that we find the people under other circumstances say they are satisfied with almost everything but cost, until cost is ameliorated the malpractice problem is not going to go away.

If somethings done that a patient doesn't like, and it doesn't cost them very much money, my guess is they won't get nearly so upset about it as if something is done and they don't like it and it costs them a great deal, that they have to take out of some other pocket to pay for it.

So I think there are—there is information about all of these things. And I don't believe that it's quite as empty a field as you might have been lead to believe.

Senator DANFORTH. In the question of the tradeoffs between costs and quality, how is that resolved? Or should it be resolved? If it was a dollar deductible, then the result of that would be, to reduce costs and to reduce overutilization but it might lead to underutilization.

Dr. PERKOFF. Correct, correct. My suggestion would be to pick the areas of our population that needs the services most, namely the underserved, and shift that so they don't pay any deductible at all. And I would charge enough deductible to the people who could afford so that they became a little bit less satisfied with their health care.

In other words, if you are going to control health costs, you can't do more for people who haven't done—had anything done for them or much done for them, and still control costs, unless you take it away from somebody else.

And the fact is, that unpopular though it may be, I believe that it needs to be taken away from other people to some slight extent. If you take away a small amount of the health care that 80 percent of the population gets, you may come up with quite enough money, to take care for that 20 percent that gets very little.

But I wouldn't do it by adding a dollar to a medical deductible unmarried mother who is pregnant and needs prenatal care.

Senator DANFORTH. You would have a very selective deductible——

Dr. PERKOFF. Yes, and I would have it income related. And I would have it be steep for well to do people.

Senator DOLE. Well, I appreciate very much your statement. What about all the money we spend now? Do you think we're making progress?

Dr. PERKOFF. I agree with the people who have told you we have the best health care system in the world. I don't believe there's any question about that. And I think we're buying a highly satisfactory level of health care for those people who get it. There are many difficulties with that system and much of it costs more than it needs to because of the factors I've alluded to and others that have been discussed by other people.

But I don't believe that just cost containment per se is going to resolve what I consider to be the major need in health care and that is, like other major social problems attention to the people who do not have. It doesn't do us much good to talk about having the best health care system if that health care system isn't good enough to take care of the underpriviledged people in our society.

Senator DOLE. How are they taken care of in your plan?

Dr. PERKOFF. My plan isn't any better than any of the others the way it's set up and especially under Missouri law we're not allowed to have prepaid capitations for medicaid and enrollees, it's against the law.

As a consequence we don't have poor people enrolled in our plan and I'm ashamed of it.

Senator DOLE. Your plan does not address——

Dr. PERKOFF. Does not address the issue at all.

Senator DOLE. The very thing you indicate——

Dr. PERKOFF. We do not do it.

Senator DOLE. And how would you do that?

Dr. PERKOFF. I would do it by providing—if prepayment was one of the options, I would provide an option for people who didn't have their own money to enroll in a plan like ours or others which are gradually beginning in this community and elsewhere, so that they have the same choice that people who have money and employment have.

And then they would receive the kind of care they choose to receive under these circumstances. So that I would like to see, for example, if medicaid were to continue, and I'm sure that in time that will be changed, that it be made mandatory that public programs would pay for the care of poor people in any one of the prepaid programs which might exist in an area. Not just ours, which is one kind, there are other kinds.

Or in the private setting. It doesn't pay adequately. Now versus control cost, we're going to have control costs of those private settings. You can't have them pay full fees, for example.

Senator DOLE. In a program like yours, would the costs be less if they were permitted, to care for poor people?

Dr. PERKOFF. It wouldn't be less unless we're able to moderate physician generated costs. Because our program is rapidly approaching the cost of comparable programs with comparable benefits. I think

it's important to point out that we have an extremely rich benefit package. Our people get complete 24-hour-a-day, 7 days-a-week coverage of all ambulatory and hospital costs with a savings of a limitation on psychiatric admissions of 120 days. Otherwise, everything is paid for but there is no copayment or deductible.

Some of our enrollees have a drug plan, others do not. So we don't market this plan for a cheap price. It's an expensive plan. But comparable benefits under traditional plans cost more.

Right now our most expensive plan runs around $110 a month per family. And individual, I believe is in the $30 range, but the exact figure I don't know.

Senator DOLE. What do you pay the physicians?

Dr. PERKOFF. Too much.

Senator DOLE. How much is that. We're paid to much according to people who write to us.

Dr. PERKOFF. We pay some of them more than you make.

Senator DOLE. That wouldn't be too much, then. But you indicated that physicians earned too much.

Dr. PERKOFF. Again, there are some that don't depend on the medical care group and there's a continuing study going on—the research health and statistics publication at the National Center for Health statistics came out several months ageo, with a study of a thousand physicans, it's going to 7,000 in the last year, for incomes of 1976.

So this is not data which is terribly out of keeping and the average take home pay, after office, overhead and before taxes for phusicians in the country was around $58,000 in 1976.

Now that excludes from that income those things which physicans which can properly charge off to the business of their office operations but which other people might have to pay for out of personal income such as business automobiles and entertainment, expenses and things of this variety about which you know more than I.

Now the average reported in that survey varied from about 35 for family physicians up to as high as 78 for certain nonsurgical specialties. And some of the highest earning specialities weren't included in that survey. It would be very simple to sit down with today's medicare usual customer and reasonable fees for certain procedures in this area and be able to project it with an avearge load some specialty physicians in St. Louis have to make—say, your incomes well into the six figures, and I'm sure that they do.

Many people believe that's too high.

Senator DOLE. We had some figures, in radiology and pathology where they were flying around different hospitals——

Dr. PERKOFF. There are other specialties also. I wouldn't for a moment try to estimate what individual doctors make.

Senator DOLE. But in your plan, does the doctor have a 40-hour week or do they——

Dr. PERKOFF. On the average, our physicians spend 80 percent—and this is kind of complicated—they spend about nine office sessions a week, to simplify it, from 3 to 4 hours apiece in the office, they make hospital rounds, more in medicine, of course, than in pediatrics, but that's the way those specialties work.

They take night calls, but there are enough of them so that it isn't often. They take weekend calls and again it isn't often.

Their office load is somewhat less than the average throughout the country. That's one of the reasons some physicians like prepaid group practice. It's also one of the reasons group practices have trouble controlling their costs because they have to hire somewhat more people to accomplish the same load. There's a tradeoff there as to whether that's good or bad. And how do you make that work.

But our physicians are paid somewhat less than the average for their specialty in the community despite the fact that I think they're paid well.

Senator DOLE. Thank you.

Senator DANFORTH. One broad question. We're here because we're on the Finance Committee. The Finance Committee has these bills in front of us, cap proposal and so on. What would you do? I mean, if you had the majority of the Members of the House of Representatives and the Senate in the palm of your hand and also the President, what would the Perkoff program be?

Dr. PERKOFF. Well, if I didn't die of fright, I think it would be considerably more socialistic than most people would like. I believe that it's wrong—maybe not wrong, certainly will be ineffective to only apply controls to hospitals.

The hospital administrators who sat before you this morning are quite correct. When they go to buy something on the outside it costs them more and they have to get it from some place.

I think that at least the three components of hospitals, physicians services, and major suppliers of equipment and supplies for hospitals and physicians offices need to have some sort of moderation in their costs.

Now people don't appear to do that voluntarily. So I really think the voluntary system has unfortunately flunked its test. I happen to believe the governmental system so far has flunked its test. And I think that regulation is kind of going to be a mess, but the public is going to insist that there be regulation and therefore, I think it ought to be broader than just one segment which would sort of like make it punching a balloon and it'll just pop out some place else.

And either Congress ought to look at this and realize that it's not just hospitals and it's not just doctors and not just suppliers, neither is it just patients over using doctors, because we're the ones who taught them to use them.

At least you have to deal with the business side of this and that gets into the problem of how you regulate further free enterprise business system which already believes it's overregulated. And Dr. Weedonbalm, of Washington University, of course, believes it far too much regulated. It may well be.

But if I were to try to develop a plan, it would certainly include those three components and to what extent I couldn't say at this particular time. It would not just include one component. And if I understand the major forms of legislation that are before you at the present time, no one of them deals with more than one component.

Senator DANFORTH. Thank you very much. Thanks to everybody for coming.

[The prepared statement of Dr. Perkoff follows:]

STATEMENT OF GERALD T. PERKOFF, M.D.

Senator Danforth, Senator Dole, my testimony deals with alternative health care delivery systems, especially prepaid group practice as exemplified by the

Medical Care Group of Washington University, or MCG. The idea of using alternatives to typical private, fee-for-service medical practice to attempt control of medical care costs is not a new one. Proposals for the prepayment for medical care were made even within the American Medical Association in the early 1900's. The landmark studies of the Committee on the Cost of Medical Care, completed in 1932, laid out various aspects of this problem and suggested group practice as one possibly effective approach. Prepaid group practice itself, in the form in which we know it today, has a history which goes back at least forty years. All these suggestions are based mainly on the belief that if one reduces the financial barriers to the appropriate delivery of medical services in ambulatory care settings and provides an organized system for delivery of these services, decreased hospital utilization and increased use of ambulatory services will result. This is thought to control medical care costs by substituting less expensive ambulatory care services for more expensive hospital services.

Over the years, data have been accumulated from a variety of prepaid group practices which tend to support these ideas, although the results have varied from plan to plan. In general, however, it is thought that at least one fourth—and some believe as much as one half—of the hospital days used in the traditional medical care system might be saved by prepaid group practices. If this could be done without additional costs for the increased numbers of ambulatory services the groups should provide, then one could project huge dollar savings. However, one cannot provide more services in the office any more than anywhere else without cost, so the actual dollar savings, if any, lie somewhere between the proposed extremes. Some plans show major savings in hospital use, some little or none. Some plans show major increases in ambulatory services and their attendant costs, some show little or none.

The Medical Care Group of Washington University, MCG, was first developed as an experimental program to try to answer some of these questions by means of a controlled study. Beginning in 1969, families were enrolled in MCG knowing they might or might not be accepted into the program, and then were randomized into two groups. One was cared for by their own physicians in the traditional private system, and one was cared for in MCG under a comprehensive prepaid plan. The medical care utilization and costs of medical care then were compared in the two groups. At the end of three years of study the following results were observed:

(1) The study group cared for in MCG used 23 percent fewer hospital days than did the control group.

(2) As predicted, the MCG group used significantly more ambulatory care services than did the control group.

(3) MCG hospital services did cost less money than the control group's hospital services, but this saving was not large enough to pay for the increased cost of providing the additional ambulatory care services, especially the preventive services which were emphasized in MCG. Several other areas for cost control besides savings in hospital days were identified in the MCG experiment.

These were:

(1) Physician Services Costs.—Counting professionally rendered technological services such as Radiology and Clinical Laboratory Services, physicians' services accounted for almost three fourths of MCG's expenditures besides the hospital costs themselves. Even without these two technologically oriented services, physicians' services accounted for almost half the expenditures. All physicians earn high incomes. While specialist costs are higher than primary care physician costs, both are high, and all such direct physician costs must be subjected to some scrutiny and limitation if medical care costs are to be controlled.

(2) Unnecessary Specialist Services—Many services presently performed by specialist physicians who serve as consultants could be performed at less cost by primary care physicians and other primary care providers if the training of primary care professionals was expanded to include simpler specialty tasks. We and others are attempting to do this in general internal medicine and pediatrics as well as by training non-physician primary care professionals. And the entire Family Practice movement represents a good start in this direction. However, much more needs to be done.

(3) Elimination of Useless Practices.—Without the fee-for-service incentive, physicians in MCG were able to look at some of their habitual day-to-day patient care practices and decide whether or not each procedure was of use to their patients. Sometimes they were able to discontinue less useful or useless ones, especially some laboratory tests, x-rays, and parts of detailed annual physician examinations. We had then and have now no information as to whether fee-for-service physicians are as able to carry out this same kink of decision making.

Since its initial experimental period, MCG has grown rapidly. There now are 21,000 individual patients enrolled. Six internists, three pediatricians, five nurse

practitioners and physician's assistants, three psychiatric social workers, two optometrists, one nutritionist, and an array of medical school specialists provide 24 hour a day, 7 day a week, comprehensive care, MCG patients continue to use fewer hospital days than the general population, although this is true to a lesser extent in some groups than it was for those studied during the experimental period. MCG provides over 75,000 ambulatory care visits per year.

By making efforts to control costs in all the areas mentioned, MCG markets its plan at a modest cost advantage over traditional health insurance coverage with comparable benefits, but because of the richness of its benefit package is not an inexpensive form of health care. Despite these successes, MCG still experiences difficulty controlling physician generated health care costs, and may well lose some of this cost advantage over traditional plans in the next few years. Nevertheless, the major objectives have been achieved. Comprehensive services are provided a defined population. There is an emphasis on primary and preventive care and there has been reduction of unnecessary hospital use.

In my opinion, however, prepaid group practice is not likely to become the dominant method of medical care in our country for a wide variety of reasons, not the least of which is the large start-up costs necessary to get such a plan under way. Not all physicians and patients will be comfortable in a highly structured form of medical practice. Nor will they accede readily to control of their incomes under a salaried system. But many of the lessons of prepaid group practice are applicable to cost containment in other settings. Among these are the importance of an emphasis on ambulatory care. There is little doubt that some singificant portion of today's hospital use is fostered by current forms of health insurance which emphasize hospital over ambulatory care. Very few people want to pay for procedures done in an office which would be covered under their insurance if they are in the hospital. In addition, physicians find it convenient to work in hospitals where many of their patients can be cared for in a single place. Today's hospital insurance makes this easy and profitable at the same time it makes office care less attractive. Incentives toward office care should be provided both for physicians and patients.

Studies of the national health plan as it operates in Montreal, Canada, are the most recent and pertinent in this area. These studies show that care can be shifted from the hospital to the office by appropriate economic incentives. Access of care for those who have few resources improved measureably. Data on cost are less easy to obtain but some progress may also have been made in this area. The control of hospital use characteristic of prepaid group practice also can be obtained in other ways. Various techniques which involve review of hosptial admissions by peers of physicians themselves can be initiated so that unnecessary admissions can be brought to the attention of the responsible physician in a way which is conducive to modified physician behavior. An organization for medical care is important here, but the availability of payment for services in alternate sites would help a great deal.

Emphasis on procedures known to be effective also can be obtained outside prepaid group practice. One of the characteristics of today's medical practice is continued use by physicians of methods to which they are accustomed but which may have been found less ineffective in diagnosis, treatment, or prevention than they were thought to be earlier. This problem, albeit a difficult one, can be resolved by local groups if they wish to do so, either by practicing together or by peer review, or both, encouraged by financial incentives structured toward those procedures which good research shows to be effective and against those shown ineffective. Much more support is needed for research in preventive medicine, quality assessment and the influence of organizations for medical care on physician behavior than now is available. Such research could be expected to five results which would be of direct use in cost containment. Finally, physician generated costs must be ameliorated. Physicians not only are high earners in our society but their services are highly valued in the abstract as well. Despite the difficulty of approaching this volatile subject, it must be recognized that any effort at cost containment in medical care must affect at least the two major sources of cost, the hospitals and the physicians, not just one or the other. Some combination of organization of medical care, negotiations of fees and/or salaries of physicians and a leavening of physicians' incomes so that the generalist/specialist gradient is not so steep will be essential before cost containment can be a reality.

I thank you very much for this opportunity to testify before this committee.

Senator DANFORTH. The record will be open until February 27 for any other statements that anyone would like to submit.

[Whereupon, at 12:55 p.m., February 13, 1978, the hearing in the above-entitled matter was closed.]

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[HEARING INSERT]

(Note: These communications were inadvertently omitted from the Committee on Finance printed hearing entitled "Health Care Costs". Please insert these pages following page 85.)

S361-116

DOWNTOWN HOSPITAL FOUNDATION,
Kansas City, Mo., February 10, 1978.

Senator JOHN C. DANFORTH,
U.S. Senate,
Committee on Finance,
Washington, D.C.

DEAR SENATOR DANFORTH: The question on hospital costs creates a dilemma for everyone and I am sure that there is no solution which will answer everyone's questions, at least on a voluntary basis.

I have, through the years, accumulated some ideas that I believe would be a sound solution to reducing hospital costs, however, I am also sure that there are too many people involved in the hospital field to accomplish this on a voluntary basis, and also enough opposition to government interference that it would be next to impossible to establish this through legislation.

A summary to my plan, which is attached, would be as follows:

1. Large hospitals would be forced either through voluntary cooperation or legislation to specialize and physicians would be required to establish themselves in their specialty either within the confines of the hospital or into a medical building adjacent to the hospital.

2. Small neighborhood hospitals would be established to take care of the majority of the cases, medical and surgical, within a person's own neighborhood.

3. A land and air transportation system would be established to either bring the patient to the specialty hospital from the neighborhood or small town hospital or to take a specialist to the patient should they be unable to move him.

The ideas that I have accumulated within this paper are not new, and basically it is a battlefield approach to medicine, but I sincerely believe that efficiencies could be established so the patient would get much better care, wastes could be cut to a minimum, and consequently costs would be reduced.

Our current system of medicine promotes spending rather than efficiency. We cannot control the spiralling inflation of labor nor products and I do not believe the shared services of purchasing, laundry, computers, and other services have produced the economies expected, therefore, I am presenting this program with the idea that the only way to contain costs is to change our method of treating the patients.

Thank you for any consideration you might give my thoughts.

Respectfully,

JOHN L. PHINNEY,
Administrator.

Enclosure.

A CANADIAN HOSPITAL DOES BRISK BUSINESS IN RUPTURE REPAIRS

HERNIA IS ONLY SURGERY DONE AT THE 88-BED SHOULDICE; IN AND OUT IN 72 HOURS

(By Stephanie Oliver)

THORNHILL, ONTARIO.—On a Thursday morning last year, Arthur J. Remillard Jr. strolled into an operating room at a small hospital here to undergo major surgery to repair a hernia. After the operation, he gingerly walked back to his room. Later that day he got up for a game of billiards with fellow patients. The following Monday he was back at work.

That case history is typical of the 6,000 hernias that are repaired every year by the eight surgeons at the 88-bed Shouldice Hospital, which could be the only institution in the world that does nothing else but treat the common ailment of the hernia.

Because of its unusual specialty, Shouldice has been able to develop techniques that have made it the fast-service expert of the hospital business. It routinely discharges its patients only 72 hours after surgery, compared with the seven-day stay that is normal at other hospitals. And the cost of a routine hernia operation and stay at Shouldice is less than $500, only a third of the cost at a large Toronto hospital.

TAKING A LOCAL

Mr. Remillard, 46, who is the president of Commerce Insurance Co., in Webster, Mass., says he went to Shouldice on the advice of a friend because "I couldn't see why I had to be off work so long to get a hernia fixed." Nor could Mr. Remillard "see any reason for a general anesthetic." Instead, like nearly all the patients at

Shouldice, he had a local anesthetic. This not only shortens recovery time and reduces the risks of post-operative complications, but also makes it possible for patients to get in and out of the operating room under their own steam.

Shouldice is able to survive on such a narrow speciality because hernia repair is the most frequently performed major surgery, and it ranks second behind tonsillectomy in all surgery. In the U.S. alone, there are about 500,000 hernia operations a year. The affliction also is painful economically. According to a U.S. government survey, in 1975 Americans spent 18.3 million days in bed and missed 7.4 million days of work because of hernias.

A hernia can be a relatively minor ailment, sometimes requiring the wearing of a truss, or a serious condition, accompanied by excruciating pain; according to its location in the body. Most hernias occur in the abdomen when internal organs, such as the small and large intestines, push their way through a weak area in the abdominal wall. There can be many causes, from obesity to heavy lifting. Sometimes a fit of coughing is enough to rupture the abdominal wall.

The most common of all hernias, the inguinal, occurs in the groin area. Protrusions elsewhere on the abdominal wall are called femoral and umbilical hernias. Highest up of all is the hiatus hernia, which occurs when part of the stomach pushes through the diaphragm separating the chest and the abdomen. The condition only rarely requires surgery, but Shouldice won't handle such cases because the operation is too complex, involving the opening of the chest and the abdomen.

WEIGHT IS A PROBLEM

Nor will Shouldice accept patients in poor physical condition or who are considerably overweight. "Overweight people heal much more slowly and much less effectively," says a Shouldice surgeon.

Fast healing is basic to the hospital's philosophy of "early ambulation," which means getting the patient back on his feet and out of the hospital as soon as possible. A few surgeons elsewhere also use these methods, but according to Dr. Blaise Alfano, executive director of the American Society of Abdominal Surgery, they aren't widely practiced. Large hospitals, he says, find it more convenient to wheel patients in and out of operating rooms and to confine them to bed for several days.

Shouldice "doesn't give you a chance to lie in bed," says insurance executive Mr. Remillard. Patients' functional, motel-like rooms are without telephones and television sets, and all meals are served in the communal dining room. "Even the phones are put at a height where you have to stretch to use them," says Mr. Remillard. This doesn't harm the incision because Shouldice surgeons repair hernias by overlapping the three layers of muscle in the abdominal wall with continuous stitches of stainless-steel wire.

Not that the hospital is Spartan. Nestled in a 32-acre estate in this small Canadian community five miles north of Toronto, it has such unlikely hospital amenities as shuffleboard, a tennis court and a putting green. "It feels like you're in a country club," says John Tsimis, a hair stylist from New Jersey. Jack Title, a Montreal fashion designer, declares, "Shouldice has no hospital atmosphere, no hospital smell."

This unusual hospital was founded by the late Dr. E. Earle Shouldice, who as a doctor with the Canadian army had been alarmed by the number of World War II recruits who were turned away because of hernias. In 1945, Dr. Shouldice opened a small hospital in a house in Toronto and began performing two hernia operations a day. In 1953, the fast-growing hospital bought the Thornhill estate. Last year, almost half of the hospital's patients were from the U.S., and nearly all the rest were Canadians. But Shouldice has treated patients from France, Germany and South America.

Former patients are full of praise for the relaxed surroundings at Shouldice. "The atmosphere puts you at ease with everyone. You meet people who have had the same operation, and you see how well they're doing and you're encouraged," says Mr. Title, the fashion designer. The "group spirit" that Shouldice promotes among its patients is "terrific," says Dr. William R. Drucker, chairman of the department of surgery at the University of Rochester.

Indeed, the hospital keeps in touch with former patients through an annual questionnaire, and every year it hosts a reunion at a Toronto hotel at which ex-patients can be examined by Shouldice doctors. They rarely find any cause for concern because Shouldice says that its annual rate of hernia recurrence is a scant 1%, compared with the average recurrence rate for the condition of 10%.

Even doctors like to have their hernias repaired at Shouldice. The hospital's administrator, John MacKay, recalls that a touring group of doctors from the Soviet Union was so impressed with the hospital's techniques that one member of the party asked to have his recurrent hernia repaired. He walked into the operating room the same afternoon and was able to rejoin his group a few days later.

Operations at such short notice, however, are a rarity. Right now Shouldice has a waiting list of 800 hernia sufferers.

Cost Containment In Hospitals

(By John L. Phinney, Sr., Administrator, Downtown Hospital Foundation)

Cost containment is going to be difficult to obtain in the short run. However, I feel that a long-range practical plan can be developed through changing our health delivery system as we know it in the Kansas City area today. The concepts that I will present are not new, however, I feel that they are combined in a manner that would not only improve health services to the patient, but in the long run would improve cost containment.

COOPERATION AMONG HOSPITALS

Presently hospitals are competing for patients, doctors, services, and last but not least, dollars. If the planning agency, in their long term planning, would look at the total picture of health care and rearrange existing facilities into primary and secondary care units, an atmosphere of cooperation rather than competition would result and health costs could be contained.

SPECIALIZED HOSPITALS

Hospital specialization and concentration on certain areas of the health picture' such as Obstetrics, Pediatrics, Specialty Surgery, Cancer Care, Cardiac Cases, etc., would allow specialists to pool their vast knowledge and research to support the patient. Through a communications media, the advice and skill of the specialists would be available to the family practitioner in the smaller hospitals, thus reducing travel time, health costs, and the duplications of services.

SMALLER HOSPITALS AS SATELLITES

Smaller hospitals, distributed on a basis of population, could serve as satellites to the specialty hospitals. By being able to handle 90 percent of the patients, that is, those with pneumonia, appendicitis, gall bladder disease, diabetes, cirrhosis, etc., the specialty hospitals would be better equipped and able to handle those 10 percent of the patients requiring special care and special equipment.

IN-HOSPITAL PHYSICIANS' OFFICES

In no way am I suggesting that physicians abandon private practice. I am suggesting that physicians' offices be located within a hospital setting to give the patients a centralized location to see the physicians.

Some of the advantages of in-hospital offices would be the shared use of:

1. Ancillary services:
   a. X-Ray;
   b. Laboratory;
   c. Physical therapy;
   d. Exam rooms;
   e. Inhalation therapy;
   f. Pharmacy.
2. Hospital personnel:
   a. Insurance billing;
   b. Statements;
   c. Accounting;
   d. Nursing service;
   e. Housekeeping;
   f. Dietitian.

We have talked about shared services for years, but the talk has been weak. In my opinion, it has been insincere because little has developed from this talk. With the need for cost containment, the time to act is now.

COMMUNICATIONS

A communications network through radio and telephone for specialized assistance between satellites and specialized centers could save many lives. A specialist's knowledge and skill would be available to the family practitioner in the small hospital at the dial of the telephone.

We also need communications between hospitals regarding services available and the cooperation of the hospitals in sharing these services.

TRANSPORTATION

Air and land ambulances should be used to transport patients and specialists to and from satellites and specialty hospitals.

RESULTS OF THIS PLAN

Ninety percent of the patients hospitalized today could be cared for in primary care units close to the patient's home. Through a communications or transportation network, the specialists would be on call. This could be of service not only to the physicians, but to the patients in saving money, and to the hospitals in sharing their knowledge, skills, and equipment.

By utilizing this communications network, physician's travel time could be cut and more patients could be seen, cost to the patient could be lowered because small hospitals operate less expensively without specialized people and equipment, and duplication of services and equipment would be reduced. By specializing, hospitals could create brain trusts to benefit all patients and physicians.

SUMMARY

While I realize that the subjects discussed here are idealistic and very socialistic in nature, I feel that the prima donna attitudes of hospital directors, administrators, and physicians toward empire building should bow to the physical needs of the patient. These groups of people should take it upon themselves to develop a plan that would best satisfy the needs of the community and cut costs to a bare minimum without governmental intervention.

As a footnote, we should adequately staff and equip a hospital, either large or small, to support the necessary treatments for cure. Many of the expensive amenities in some of our hospitals today are not necessary, and they are a source of added expense to the patient.

Specialists should develop in both primary and secondary care. They should concentrate on giving personalized care to relieve the anxieties and tensions developed in the patient by the "unknown" of hospitalization. We in the health care field must cooperate and communicate on behalf of the patient.

Hospitals cannot cut those major cost areas to the patient which are supplies and salaries to any great degree. We can, however, reorganize our Health Delivery System for greater efficiency and save the patient money by cutting travel time, equipment and facility duplication.

CHARLES MILLER, M.D.,
Kirkwood, Mo., February 10, 1978.

Hon. JOHN DANFORTH,
Senate Office Building,
Washington, D.C.

DEAR SIR: I was requested by the St. Louis County Medical Society to provide testimony for your hearings in St. Louis on the cost of medical care. Because I am deeply interested in this subject I am most unhappy that my activities will keep me out of the city of St. Louis at the time of your local hearings. I am none the less anxious that you should hear my thoughts on this subject because I believe that they represent a unique approach which better explains the reasons why certain cost cutting techniques fail to work and why other approaches might be highly successful in reducing the overall expenditure to obtain good medical care.

In the status of a professional, the health care provider is constantly dealing with unknown factors and unproven factors in making decisions that affect the outcome of illness and the lives of our citizens. There are risks of misinterpretation and misapplication involved in every decision that the practicing physician must

make. The physician takes multiple steps to reduce this risk to a minimum but never actually reduces it to the level of no risk at all. The use of expensive diagnostic procedures, hospitalization and multiple consultations very often make only a minimum impact on the reduction of this risk.

Since the risk of having to pay for these multiple tests, consultations and hospitalizations, no longer falls in a very direct way upon our citizenry, the typical patient and his family often press the physician for services far beyond the reasonable amount required to bring the risk to an acceptable level. If our insurance companies and our government try to curtail the use of facilities by putting themselves in opposition to the physician, they will surely lose the battle for expense control.

The enclosed material describes my approach to a plan in which our insurors and our government can enlist the support of one physician to supervise the financial outlay for one patient and simultaneously prod the medical profession into the use of the most efficient means of solving the riddle of cost efficient care. A plan such as this will automatically draw the criticism of hospital authorities and some super specialist oriented organizations. May I hear from you if I can be of further help in shaping the thoughts of those who are wrestling with this problem?

Sincerely yours,

CHARLES MILLER, M.D.

If your accountant came to you next week and told you that there was a potential saving of $5,000 on your income tax for the year but that the cost on accounting fees to accomplish this would be $2,000 it would take you no time to make the decision for your accountant to proceed with the service. The story that I am about to tell you is the story of American medicine today and the problems that beset bringing this behemoth into fiscal responsibility. It is the story of the need to utilize appropriate amounts of professional service to regulate runaway costs of ancillary services. Professional services account for only approximately 20 percent of the total medical bill in this country. The ancillaryservices including hospitalization, laboratory testing, drugs, supplies, appliances and associated technical and social services represent the 80 percent. To expect the professionals who represent only one-fifth of the economic pressure to regulate the ancillary services in this circumstance is like asking the tail to wag the dog. Accomplishing such an action represents the real secret to cost effective medical services. Not only is it possible, that in my opinion highly practical to replace large amounts of the 80 percent ancillary costs with additional 20 percent professional services.

Professional services of all types have developed because the concentrated knowledge which they represent in a particular endeavor makes it possible for the professional to save the economy far more than the cost of his services. In medicine, this basic economic truth of professionalism has been forgotten. The aim of most health plans seems to be to lower the fees of physicians or to extract more work from the physician for the same fee. The most obvious way to reduce the overall cost of medical care is to hire the professional who is on the job to accomplish such a task, that is to treat the patient's illness for the lowest overall cost regardless of the source of the service. I like to call the physician who is doing this job of expediting services, selecting options and managing the complete medical care of his patient, the designated primary physician.

The designated primary physician is a doctor selected by his patient to manage the patient's medical affairs. The relationship in no way implies that the physician is a primary care physician. On the contrary, the doctor who gives the patient the largest portion of his medical care would make an ideal designated primary physician whether he is a dermatologist, an internist, a gynecologist, an allergist or any other type of medical specialist. Many pateints will choose internists or family practitioners. The physician agrees to keep records on his patients which include not only his services but also all types of medical services which may be covered by the patient's insurance. It is his responsibility to approve all necessary expenditures and to guide the patient to the efficient use of medical facilities and services. A designated primary phyrician may hire office personnel to carry on a large share of the work involved in these duties. A substantial portion of his income may be obtained by capitation fees which are paid for this service. This capitation fee is only for the service involved in managing the patient's accounts and services. Any medical care administered by his physician may be billed in the usual manner and the designated primary physician will have some latitude in approving expenditures for additional professional services where he feels these will expedite the care of a patient and substantially reduce the use of ancillary

services. If three or four hospital visits are required in a single day to save the relatively larger expenditures for added hospitalization he may authorize or perform these services.

Most practicing physicians have experienced the situation created by the patient who arrives at an emergency room on a Saturday evening with a condition that might or might not call for hospitalization. Let us say for example, a patient with chest pain. If the physician is attempting to practice cost effective medicine, he knows that it is probably necessary for him to personally visit the patient and examine him in order to be absolutely certain that hospitalization is necessary or not necessary. The risk entailed in sending the patient home without personally examining him, is far too great and the easiest approach to the problem is to direct hospital personnel to admit the patient to the hospital so that he may be observed overnight or even longer. Consider what happens to the physician who actually goes to the emergency room to visit the patient after leaving his Saturday evening activities. Proceeding to the hospital, he usually finds that some laboratory testing might be needed in order to determine whether it is absolutely necessary for the patient to be in the hospital or if he could be treated just as safely at home. By the time the laboratory work is ordered, performed by hospital personnel, and reported back to the physician, perhaps an hour or even two or three hours have passed. This often necessitates a second visit to reexamine, reevaluate and prescribe. If the physician has applied two to three times the amount of time he would ordinarily give to an emergency room visit or to a hospital visit but has saved the patient from 3 to 5 days in the hospital at an average daily cost of $150 more or less, he has performed a very good deed. But for whom? Ironically, the patient came to the emergency room with the idea of being hospitalized and he is seldom overjoyed that the physician decides to send him home. Secondly, the hospital is not particularly pleased that the patient is departing to be cared for on the outside especially if they have facilities available and would rather the patient be evaluated within the hospital where they receive full remuneration. Finally, to add insult to injury, the physician's bill for the equivalent of 2 or 3 visits is submitted to Medicare or to an insurance company and in most cases, the patient will be remunerated for a percentage of the usual daytime emergency room visit by this physician and often sent a rather vilifying letter indicating that the physician has overcharged them for the service. Where then, is the motivation for economy which our government and our insurance companies feel should be exerted? If the physician had simply admitted the patient to the hospital and spread his professional fees out over the four or five days everyone would have been happy except the insuror and the physician would have had his bill paid in full without question.

Nearly every country in the world has wrestled with the problem of producing more and better medical services without expending giant sums of money which threaten to bankrupt the economy. Nowhere have medical planners found a means to provide good services which will satisfy the patient and also satisfy the physicians who produce the services. Nowhere is there a comprehensive plan which is not deemed excessively expensive by those who pay for it. Medical knowledge has probably doubled in the past ten years and promises to redouble in the next ten years. Unfortunately, the solutions to illness become increasingly expensive as technical equipment and even more technical training of personnel produce these costly solutions. This makes it imperative that we learn to use the simple and inexpensive methods to diagnose and treat illness at the same time we must learn how to apply the new, effective and expensive solutions to solving those problems where simple and less expensive methods do not exist. Because there are risks in making decisions for ill patients, it is imperative that our solutions be acceptable to the physician so that we may increase his motivation to learn and apply new methods in the appropriate cases. Since there is no way to eliminate the risks of being occasionally wrong, we must educate both the physician and the patient to accept reasonable risks. To use an expensive laboratory procedure to verify the presence of an ailment when the chances of such verification are 1 to 100 may be acceptable but in most cases where such a test has only one chance in one thousand or one chance in ten thousand of verification of an ailment, it is seldom acceptable. The elimination of the use of chest x-rays for mass screening for pulmonary tuberculosis is such an example. An inexpensive tuberculin test will produce as much or more information on pulmonary tuberculosis than a chest x-ray but under rare circumstances the tuberculin like the chest x-ray may be negative during an active case of tuberculosis. The examining physician needs to apply his knowledge of active tuberculosis to determine the limited numbers of patients who should have chest X-rays done for this purpose.

In some respects medicine follows the law of supply and demand. When the government established Medicare without a plan to produce the necessary added services required, the price of services tended to rise. When Medicare was debated by the Congress of the United States it was often said that none wanted to be sick and the entire idea of overutilization was thus considered to be preposterous. Where would the doctor find a patient who would rather be in the hospital than at home? He has since been found in every doctor's waiting room and the government has been busy passing regulations by which committees would attempt to identify him in the hospital and force his dismissal. It is quite clear to most doctors that no committee is capable of identifying the need or lack of need as early as can the patient's own physician. Because the committee cannot assume responsibility for the care of the patient or for errors of judgment of the committee, the judgments which it passes are necessarily very conservative. It is very apparent that the patient's doctor is the most effective individual in preventing overutilization. Unfortunately, the health plans submitted to this date, place the doctor in opposition to the committees who are working for cost effective medical care. The patient's doctor simply works for his patient. He does not consider himself to be an employee of the government or the insurance company. He is his patient's protagonist. Furthermore, he is paid for what he does for his patient, not for what he does not do. In the patient's eyes, the doctor should be rewarded for healing illness. If he fails to run tests and to write prescriptions, the patient will be at least dubious that his physician has done a satisfactory job. The physician who chooses to take the simpler and less expensive approach to treatment must also take a considerable amount of time to explain in great detail to his patient about his plan of action to control the patient's problem so that he does not have an unhappy patient. Prior to the advent of health insurance, the patient was truly the consumer of health care and he controlled the health budget by limiting the doctor and by questioning each move that cost additional dollars. Today, the doctor has become the consumer by proxy for his patient and there is no longer control over the budget. The person who is ill is most interested that he has the best doctor and the finest facilities for recovery regardless of cost. The doctor wants to please his patient and reduce risks of error to lowest level possible with the facilities available.

How would the designated primary physician system actually save money? According to Dr. Perkhoff at Washington University four major precepts underly all the approaches to primary care. Nearly 85 percent of all visits to the medical care group of Washington University are attended to by primary care providers. About 9 percent of visits result in medical and surgical subspecialty consultations and another 5.9 percent are seen by optometrists, psychiatric social workers and other ancillary providers. Dr. Perkhoff feels that primary care must be first contact and also continuing care. While it is predominantly ambulatory, the primary care provider must function within the hospital as well as the ambulatory setting. There must be access to consultative specialty care when the need arises and it must be able to handle common human problems. The average hospital census in this country has increased from 2.5 per thousand in 1965 to 3.2 per thousand in 1976. In 1965 hospital insurance was less common and fewer hospital procedures were available for diagnosis and treatment. With current costs in excess of $150 per day for an average hospital stay and an average duration of stay in excess of 7 days, the shortening of each hospital stay by one day or a plan which reduces the average hospital census by as much as one-tenth of one case per thousand could produce a rather massive economic improvement. In December 1976, an article appeared in the Medical Tribune which quoted a study from West Germany showing that only 50 percent of those patients usually hospitalized would need inpatient care if careful and accurate diagnosis were established before hospitalization. This, of course, presumed that the extra hours of physician services necessary to establish such diagnoses would be recognized and the physician remunerated for the additional time required to handle some of these cases under more awkward conditions. In our community, we average approximately 1,100 hospital bed days for each thousand insured population. It is generally agreed that with adequate outpatient services including increased out-patient professional services, this number might be reduced to a level as low as 650 or 700 hospitaljbed days for each thousand insured population. Large numbers of hospital bed days could be saved by preadmission laboratory testing, by completion of history and physical examination and patient orders before the patient is admitted to the hospital. In addition, the doctor who is being remunerated for regulating the overall cost of treatment of his patient would become conscious of economic problems within the hospital. On Sundays and holidays limited diagnostic procedures may be available to the patient. Hospital delays are caused by scheduling procedures only during limited hours and making extra days necessary in order to accomplish these testing procedures. Further delays are caused by insufficient hours of availability of surgical

suites requiring days of delay before a patient may go to surgery. Some delays are caused by specialist consultants who do not perform their work promptly after being called or those who tend to observe the patient in the hospital when outpatient observation could be carried out with the addition of some extra time for professional services.

Patients are often allowed to refill medications for excessive periods of time and the problem of directing the patient to use lower cost generic drugs and to purchase drugs from low cost retailers has the potential for additional savings. To affect these savings the designated primary physician will keep a complete record on each patient. All bills to be covered by insurance will pass through the designated primary physician for his approval. This includes hospital bills, bills for laboratory services and pharmaceuticals, for consultation fees and for appliances. If the physician is financially involved in producing efficient care, he will soon be counted among those who demand a reform in inefficient or costly hospital policies such as repetition of laboratory tests done outside of the hospital. Repetition of electrocardiograms, chest x-rays and blood chemistry procedures has become routine in recent years.

Will such a system be acceptable to the patient? There are many reasons why the patient may actually prefer this system. First, it will probably make it possible for him to have complete medical coverage which many of our American workers have sought over a period of years for a reasonable cost. Complete coverage is nothing but a dream unless we are able to regulate utilization. If a major part of a physician's income is derived from keeping his patients out of the hospital rather than keeping them in the hospital, we will probably see a return of some house calls, we will find the average practitioner taking care of fewer patients but spending more time so that he can properly explain his position in handling the case. We will see a rather marked drop in the use of hospitalization for diagnostic purposes. In many communities, the house call may return. The role of the emergency room in handling routine care will diminish. If the patient is not pleased with the performance of his physician, he is free to go to another physician and to make his new physician his primary designated physician. If his primary designated physician denies him access to specialty consultation or laboratory tests it would only be denied on the basis of it being covered by his insurance. Therefore the patient would still be free to consult any physician of his choice at his own expense and to subsequently decide whether he wished to continue with his original physician.

Would this plan be acceptable to physicians? There is no question that many physicians would prefer to limit their work to diagnosis and treatment of disease with complete disregard for the economic consequences. It is likely that there would be adequate amounts of work to keep such physicians busy especially in certain fields of medicine. Many of the more exotic specialities might have a somewhat diminished demand because it is well known that large amounts of the work done by these specialists is relatively routine while a small amount is of a more technical nature actually requiring their high levels of training and skill. It should be noted that if a patient goes to his family physician for an examination and this physician incidentally performs a procedure such as a pelvic examination, large numbers of insurors would refuse to pay the additional fee for this examination. However, if the patient were referred by his primary physician to an obstetrician who performed the same examination, the same insurance company will often pay a substantially larger fee. This type of insurance activities has often encouraged unnecessary referrals. It is common practice to see patients being cared for by four or five different physicians particularly in our urban area where one physician could probably perform the entire job. If the status of the primary physician is improved sufficiently by this type of program, the numbers of specialists will necessarily decrease and the number of primary providers will necessarily increase. If the primary physicians are properly remunerated for the added services which they perform it would seem that primary care would become a more satisfactory specialty for physicians than it has been in recent years.

It would appear highly beneficial if a bonus were established for superior performance in the practice of this type of medicine. If an occasional physician failed to perform satisfactorily by using excessive amounts of hospitalization and using procedures which were unusually expensive, the obvious solution to the problem would be to drop him from availability to perform as a designated primary physician for some period of time, probably until he had completed instructional work which would allow him to do a better job in the future.

Professional review of this type of activity would be considerably eased by the accumulation of all records pertinent to this patient in one location. If a need for quality and control appeared to be necessary, it should be carried out through a

multidiscipline physician's organization such as The Medical Society, the Staff Organization in the case of larger hospitals, or other physician's professional groups.

How would such a system actually be marketed? Because this system blends perfectly with our current system of medical services, it could be promoted as a totally voluntary system. Industrial organizations which sponsor health insurance for their employees would give their employees the alternate opportunity of complete coverage for medical service provided they designated a primary physician and provided that physician agreed to serve as their designated primary physician. All costs of medical care which are to be borne by the insurance would then require the approval of the patient's designated primary physician and all bills for such services would be forwarded to his office for approval before action by the insurance company. The physician would receive a capitation fee for management of the records and he would receive an additional bonus for good performance in economically managing the affairs of these patients. This would not prevent the physician from taking on other patients in the customary manner and it would not prevent the patient from seeing other physicians at his own expense if he did not agree with his designated primary physician. Doctors would find themselves in a position to demand new efficiency from hospitals, laboratories, pharmacies, ambulances and appliance dealers. Out patient evaluations would become much more common and doctors would soon insist that the results of their out patient laboratory studies be acceptable in hospital charts and not be repeated on admission. A physician would not be satisfied to wait two or three days for the result of a hospital test or to obtain evaluation by a specialty consultant. Thus less frequent admissions and shorter hospital stays should be the result. The medical staff themselves would eventually put pressure on institutions to discontinue the practice of reduplication of expensive and unprofitable services. The pursuit of these goals would result in physician's striving to learn new techniques and procedures which would allow them to avoid unnecessary tests and consultations. The only person who is capable of rationing services to a patient is that patient's own physician who is thoroughly familiar with the patient's problems and who takes personal responsibility for the propriety of his decisions. If we can hire him to carry out the job of keeping his patient out of the hospital and in good health at the same time, we will have accomplished the real goals sought in cost effective medical practice.

SUTTER CLINIC, INC.,
St. Louis, Mo., February 13, 1978.

Hon. JOHN C. DANFORTH,
U.S. Senator,
St. Louis, Mo.

DEAR SENATOR DANFORTH: I was unable to be present at this morning's hearing but would like to submit the enclosed statement.

Sincerely,

VERNON H. BALSTER, M.D.,
Associate Physician.

I am Vernon Balster, immediate Past President of the County Medical Society, engaged in Occupational Medicine Practice, encompassing over 500 companies and corporations of varying size. I am speaking as an individual, not as spokesman for the County Medical Society.

It has been my experience when medical care and time loss benefits are paid or by the employer, the individual loses incentive for cost control. It seems to be a fact of human nature that the decision to return to work is influenced by whether it will be to the employee's advantage financially to return to work or not. I have seen people stay off on sick leave for as long as their benefits would allow them. If an individual is working for himself and is paying the full cost of the medical expense, he would not utilize the services unless they were needed. Any method of cost control must have participation by the individual built into it to avoid overuse. Thank you.

SAINT LUKE'S HOSPITALS,
Chesterfield, Mo., February 13, 1978.

Hon. JOHN C. DANFORTH,
U.S. *Senate, Senate Office Building,*
Washington, D.C.

DEAR SENATOR DANFORTH: The hearings you and Senator Dole held in St. Louis and Kansas City on February 13th provided the opportunity for you to hear from some of the most knowledgeable leaders of the health care industry in Missouri and Kansas. Their testimony was, I'm sure, comprehensive and factual. In response to your invitation for other written statements, I want to share with you my analysis of the difficult decisions you are being called on to make—factors I would want to consider if I was in your position.

In the broadest sense, your mission is to establish equilibrium between the health care of Americans and their economy. In view of the complexity of these two elements of our society, I fear there is no single correct solution.

In spite of the criticisms leveled against it, our present system of health care has been shaped by public policy decisions reached through the democratic process. Our national goal has been to provide the best health care for the largest number of citizens possible. Evidence of this public policy includes passage of the Medicare and Medicaid laws, maternal and child health financing programs, the tremendous investment our country makes in the fields of medical and technological research designed to improve health, and the growth of government financing programs for the education of students in health care fields. The problem your committee is now addressing—the rising cost of hospital care—is largely the result of having accomplished much of the goal described above.

There are many ways, and I am sure you have heard most of them, to level off, and even decrease the cost of health care in America. In selecting any of these options, however, our nation's leaders must be aware that they are also electing to modify the national policy that led us to the health care cost crisis. In spite of many protest to the contrary, health care managers can cope with governmentally imposed restrictions on financing mechanisms. I am just as confident, however, that the methods that will be necessary to adjust to these pressures will result in a shocked and dismayed citizenry that was not prepared for the alterations in traditional patterns of health care. The exact nature of the cost control measures will determine the elements of our system that will have to change which, of course, will dictate the members of our country that will be effected.

If, for example, we decide to further reduce the utilization of our general hospitals, patients who in the past have been cared for as hospital inpatients, will receive their care from an alternate source. It is predictable that the alternate source will be less attractive to the patient and his family than the security of the modern general acute hospital.

You, as one of the decision makers, are no doubt besieged by stack upon stack of reports from health planners, statisticians, and other bureaucrats not directly involved in delivering health care services to patients. The further away from the patient one gets in the health care industry, the easier it is to focus attention on numbers, dollars, budgets, trendlines, and other desk top matters dealing with patient care. At the same time, it becomes more and more difficult to remember that those numbers represent people with personal problems of the highest magnitude in American life—their health and the health of their loved ones.

The questions you must answer are among the most difficult I can imagine. You are equipped with reports, statistics, opinions, and analyses of all the options. Health care managers can live with the results of whatever decision is reached on the question of health care cost but the changes in public policy that may be necessitated will demand accountability. My intent has been to assist you, in some small way, to understand the eventual impact of the possibilities you and your colleagues have been asked to consider. Put whimsically, the devil we know may be better than the devil we don't know.

My best wishes for you are for clairvoyance and wisdom as you approach these and the many other difficult decisions you must make.

I would be proud to be of assistance to you or your staff with further information on the opinions I have expressed.

Sincerely yours,

RICHARD W. BROWN,
Senior Associate Administrator.

ST. LOUIS CHILDREN'S HOSPITAL,
St. Louis, Mo., February 13 1978.

Hon. JOHN C. DANFORTH,
Russell Senate Office Building,
Washington, D.C.

DEAR JACK: As a businessman and as President of St. Louis Children's Hospital, I am very concerned about what the government does on cost containment. It could be a disastrous limitation on a hospital like ours in a medical center where we serve an increasing number of patients each year at an added dollar cost. Also, we do research work and we offer services to patients that weren't possible a few years ago and we have found answers we didn't know before. This represents added costs but much improved health.

Touche Ross has issued a book on hospital costs covering the last 11 years. In this period, the biggest single reason for increased hospital costs are new services offered for treatment and cure that were not available 10 years ago. Also, the hospitals serve as a neighborhood physician through their outpatient departments and are performing a service for the public at a new volume level.

The latest information on health costs indicates that between 1960 and 1976, health costs went up $113 billion, from $26 billion to $139 billion. Hospital costs only went up $46 billion, from $10 billion to $56 billion. Hospital costs are $56 billion of the $139 billion health costs which is only 40%. We think it is unfair to blame the hospitals for the increase in health costs. The big change is that between 1960 and 1976, the public money that went into health costs increased from $6 billion to $59 billion while private money in health costs only went from $20 billion to $80 billion. In fact, per capita health costs are only up 400% which is exactly the percentage that personal income is up for the same period. So our big problem seems to be that the government is putting $53 billion into health costs and enabling a large group to be given health care through Medicaid and Medicare that was not true before. Also, with better coverage through third party payors (insurance companies and Blue Cross) the public has a right to demand more needed hospital care because they and their employers have paid for it. Why should hospitals be blamed for this and be referred to as having run away costs?

We believe that control of beds may be effective as a control, but we believe not allowing any new beds at any hospital will hurt the health industry. In the St. Louis area we have licensed pediatric beds at general hospitals that are twice the number of beds justified by the patients that are using the pediatric sections of general hospitals. On the other hand, the only two speciality children's hospitals in the St Louis area, Cardinal Glennon and St. Louis Children's frequently have over 100% occupancy and we really need additional bed approval. The big difference is that we do research and we have a full-time doctor staff, speciality trained nursing staff and speciality support facilities serving really sick kids 24 hours a day. Pediatric sections in general hospitals are not staffed with pediatric doctors around the clock, nor do they have our other speciality facilities and staff. Consequently, their service capabilities to children are more limited. This is appropriate though and reflects the national trend to regionalize speciality pediatric diagnostics and care at a few centers with the interest and capabilities.

The Local Health Systems Agency gave the citizens of our community the opportunity to participate in open public meetings to get the public's feeling about the government containing hospital costs. If you judge the public's interest by the response to these meetings, then the government is more interested in cost containment than the public has demonstrated in this area.

If the government had some way to eliminate duplicate services in a metropolitan area where one service is unprofitable and another hospital could take care of the total service, it is likely that savings could be made in hospital costs. However, to restrict all hospitals to a percent of increase in costs should be carefully studied unless the government wants us to reduce our service to the public. It is doubtful that 9% would be enough to take care of the cost of increased services which the public continues to expect and all the other increased costs resulting from inflation and labor increases. For example, in the year ahead, our budget is going to be up 9% in pricing for our services. The total dollars spent will probably be up 20% because we are going to serve more people if we continue to grow as we have ~~in the~~ last five years.

Thank you for an opportunity to give our viewpoint. Good luck in your effort. However, it is unfortunate that so many people in government are going to spend so much time on an item like controlling hospital costs when we are facing really big issues such as adequate defense and a serious energy shortage that needed to be faced in the near future. A lot of health problems can be improved through public school contacts and through general information by TV and radio, teaching people to take better care of themselves.

Sincerely,

C. ALVIN TOLIN
President.

HEDRICK MEDICAL CENTER,
Chillicothe, Mo., February 14, 1978.

Re: Field hearing on cost of health care.

Hon. JOHN C. DANFORTH,
U.S. Senator, Washington, D.C.

DEAR JACK: Health care costs have risen at our institutio primarily because of the federal minimum wage bills. Its been my experience that the more federal gets into our lives, the higher the cost.

Our semi-private room rate is $52.00 per day which I feel is very reasonable and if we had not been regulated from a $1.00 minimum to $2.65 minimum, our room charge would still be $20.00 a day so for my money federal brought all the health care problem on by its pay scales.

Sincerely,

PAUL SHELTON,
Administrator.

MISSOURI AREA V H.S.A., COUNCIL INC.,
Poplar Bluff, Mo., February 15, 1978.

Hon. JOHN C. DANFORTH,
U.S. Senator, Washington, D.C.

DEAR SENATOR DANFORTH: Thanks very much for informing us of the field hearings held in both St. Louis and Kansas City on February 13.

According to the news broadcasts, the idea apparently was well received by the members of the community, and I regret not being able to be in attendance.

It is, however, our feeling that the Health Systems Agency network which is now established across the country is the long-range answer to containing the rapidly rising health care costs situation. In the H.S.A. organization, we have the distinct advantage of providing "grassroots" participation in decisions regarding the health care system. For example, here in Area V we have not only a 30-member Governing Body but also 28-member coucils in each of our four planning commission areas.

Area V H.S.A. has just completed its first Health Systems Plan and the Agency for these 24-counties (which are primarily rural) is drastically underfunded, we feel the Plan is well-thought-out and definitely represents the feelings of the some 500,000 people in our area.

The thing that has been one of the H.S.A.'s outstanding selling points is the fact that who better should make decisions regarding the health care system than the persons who are footing the bill to a great extent, namely, the average American citizen, with his tax dollar.

Again, our thanks for your kind invitation to both the hearings and to submit remarks to your office regarding rising health care costs and possible solutions.

Yours truly.

WILLIAM D. BECKER,
Executive Director.

CHARLES J. JANNINGS, M.D.,
Fairfield, Ill., February 20, 1978.

Re: Health care costs.

The Honorable SENATOR DANFORTH,
St. Louis, Mo.

DEAR SENATOR DANFORTH: It was with great interest that I read the article in the St. Louis Globe Democrat last week in which you discussed the problem of health care costs. In response to your request for written comments on the problem, I have penned these thoughts.

Individuals should be encouraged to be responsible for their own health care. The roll of the Federal Government should be to assist health education at all levels, pre-school, primary and secondary schools, and by public service announcements in the media.

Positive and negative incentives for individual responsibility should be encouraged. Positive incentives—to encourage good health practices, and negative incentives—to discourage poor health practices. Individuals should be encouraged to monitor their risk factors and money expended in preventive health care and risk assessment programs should be reimbursed as a tax credit on the IR8 return. All insurance companies should be required to include deductibles and co-insurance in their policies to discourage abuse and to encourage conservation of health resources. There should be effective peer review of all health care provided by Federal, State, or group insurance programs, and the State provider organizations should be given responsibility for the conduct of such peer review, the cost to be defrayed by the Federal or State governments or the insurance program involved. Federal subsidy of medical high technology should be reduced, since the effect of such programs has been counter-productive to providing continuous and comprehensive primary medical care, and instead has encouraged the over utilization of expensive, tertiary, and sub-specialty care. Hospital personnel should be cross trained so that they may be used with greater efficiency. This is especially necessary in the small hospital.

Some basic ground rules should be obvious and agreed upon by the American people—and that is that health is affected by human biology, lifestyle, and the medical care system. That stress, diet, exercise, smoking, driving, drug use, and other modalities influence morbidity and mortality, and modification of these lifestyle factors offers, to effect, immediate and significant improvement in morbidity and mortality. That behavior modification techniques can effect changes in lifestyle, and positive directions can be given without absolute scientific proof of efficacy. For instance, we believe it is better to be relaxed that tense, better to be thin than fat, better not to smoke than to smoke, better to have normal blood pressure than to have high blood pressure, better to drink pure water rather than polluted water, etc. Health insurance companies should be encouraged to write preferred risk policies for those who take care and pooled risk insurance be available to those who don't. Negative incentives should be provided, such as:

1. An extra $1 per pack tax on all cigarettes such revenue to be remitted to Social Security for parts A and B Medicare payments to help defray the cost of bronchitis, emphysema, pneumonia, lung cancer, heart disease and stroke, primarily precipitated by excessive cigarette smoking.

Promotion of preventive medicine, prospective risk assessment, positive screening programs, and health education can result in happier, healthier people, and reduce expenditure for acute care salvage operations.

There is a need for improvement in the present health care delivery system, which often merely patches up the victims of heart attacks, auto accidents, and attempted murder at high cost, usually without affecting the underlying problems of poor diet, poor driving, pent up emotions, and other behavioral and environmental threats.

The demand for medical care is unlimited and although our resources are finite, there is no limit to the amount of money that could be spent on medical care; thus throwing more dollars at medical care will have little effect on morbidity and mortality.

There is not now, nor will there ever be, a medical Utopia, there will always be sickness, accidents, disease, and the cost of sophisticated systems of care will be high.

Paradoxical as it may seem, payment by State Medicaid programs of usual customary, prompt, and reasonable fees to health care providers would actually provide better medical care at a lower cost, since this would put the Medicaid mills out of business. Medicaid mills exist only because the honest, conscientious, practicing physician is unable to provide quality care at the price the State is

willing to pay. To prevent abuse, it is essential that the appropriate provider group State organization be given authority for peer review, thus enabling each provider group to discipline its own menbers.

Usual, prompt, reasonable, and customary reimbursement to health care providers is essential to attracting and keeping the numbers and kinds of caring, competent health personnel, and facilities to satisfy the medical needs of the people. At the same time, economic barriers to needed medical care must be moderated for the poor, minorities, mentally ill, elderly, and the rural individual. Deductibles are necessary to prevent abuse of the medical care system for routine problems, and co-insurance is necessary to prevent abuse in major or catastrophic situations.

Regarding reducing the Federal subsidy of high technology (not that we should withdraw support of appropriate research and development activities) we would look at what happens to the 2 billion dollars appropriated each year by HEW for the National Institutes for Health and follow this money through the research pipeline. These billions are distributed to the 120 research institutions in the U.S., known as "Medical Schools" where grantsmanship is the road to promotion, peer acclaim, and Nobel prizes. These "grants" are used to subsidize the education of "fellows." these "fellows" are sub-specialists in a tiny corner of medicine, who spend more time putting medicine into mice than they do into people. This has had some interesting spin-offs. For instance: it is easier to find an Orthopedic surgeon in Southern Illinois than it is a Family Physician. It is less expensive to take your child to a certified Family Physician. Fully trained surgeons are now in such a surplus, that they are trying to elbow the G.P. surgeon completely out of the operating room. Immediate access to sub-specialists who can work on one part of your body is almost universal, whereas access to physicians capable of assessing the whole person is extremely constricted. Forty years ago 80 percent of medical graduates set up a general practice. In 1977, less than 20 percent did.

There is no question but what the myriad rules and regulations of State Health Departments, the Joint Commission on Accreditation of Hospitals, Medicaid. Medicare, professional associations, etc, result in much inefficiency in hospitals, Much of the inefficiency is involved in the hiring of high technology people who are not fully employed to capacity. For instance, a general hospital with 80 percent occupancy has a full complement of personnel, the great bulk of whom supply personal nursing services, nurses, aides, LPNs or RN's. The paper work load on the RN's is such that perhaps 50 percent or more of their time is involved filling out reports. The other high technology departments of the hospital, such as x-ray technicians, respiratory therapy technicians, physiotherapists, etc. are called in for special situations. There is no reason on God's earth why an appropriate RN, LPN, or nurse's aide, depending on the level of experience, could not be cross trained in these other disciplines to avoid the necessity of hiring a covey of technologists who sit around 6 out of an 8 hour day doing nothing because of the lack of demand for his particular service at that time. Cross-training of hospital personnel by technical training of nurses' aides, LPN's, RN's, etc. would be a tremendous cost saver.

I am enclosing a copy of a contemporary fable by Donald B. Ardell, Executive Director of the American Association of Health Planning Agencies. Please advise if I can offer any additional explanation on the statements contained in this document.

Best wishes.

Sincerely,

CHARLES J. JANNINGS, M.D.

Enclosures.

A CONTEMPORARY FABLE UPSTREAM/DOWNSTREAM

It was many years ago that villagers in Downstream recall spotting the first body in the river. Some old timers remember how spartan were the facilities and procedures for managing that sort of thing. Sometimes, they say, it would take hours to pull 10 people from the river, and even then only a few would survive.

Though the number of victims in the river has increased greatly in recent years, the good folks of Downstream have responded admirably to the challenge. Their rescue system is clearly second to none: most people discovered in the swirling waters are reached within 20 minutes—many in less than 10. Only a small number drown each day before help arrives—a big improvement from the way it used to be.

Talk to the people of Downstream and they'll speak with pride about the new hospital by the edge of the waters, the flotilla of rescue boats ready for service at a moment's notice, the comprehensive health plans for coordinating all the manpower involved, and the large number of highly trained and dedicated swimmers always ready to risk their lives to save victims from the raging currents. Sure it costs a lot but, say the Downstreamers, what else can decent people do except to provide whatever is necessary when human lives are at stake.

Oh, a few people in Downstream have raised the question now and again, but most folks show little interest in what's happening Upstream. It seems there's so much to do to help those in the river that nobody's got time to check how all those bodies are getting there in the first place. That's the way things are, sometimes.

DONALD B. ARDELL.

CHARLES J. JANNINGS, M.D.

Born: June 7, 1927.

Medical education: S.M.U., Dallas, Texas, Navy V-12 Unit. Cadet Battalion Commander, Certificate with Honors; Washington University, St. Louis, Mo. A.B. 1947.

Medical school: Washington University, St. Louis, Mo. M.D. 1951.

Internship: St. Louis City Hospital 1951–1952.

Hospital affiliation: Fairfield Memorial Hospital, All offices and committees 1954 to present.

Positions held in National Chapter, Illinois Academy of Family Physicians: Secretary of Little Wabash Chapter, 1967 to present.

Positions held in Illinois Academy of Family Physicians: Delegate from Little Wabash Regional Chapter 1963, 1966, 1967, 1968; Speaker, Congress of Delegates 1969, 1970, and 1971; Commission on Legislation, 1968–69, Chairman 1976–77; State Legislative Committee, Chairman 1967–68, 1968–69; Member 1970–71, 1971–72; Rural Health Committee, 1964, Chairman 1965–66, 1966–67; Ad Hoc Committee to Study Committees, 1970–71; Registrar, 1962–63—Vice-President 1971–72; President 1973–74; Charter Fellow A.A.F.P.

Positions held in Illinois State Medical Society: I.S.M.S. Trustee-at-Large 1972–73; I.S.M.S. President Jan.–March 1972; 1st V.P. I.S.M.S. 1971–72—2nd V.P. I.S.M.S. 1970–71; Delegate from Wayne County to I.S.M.S. 1957 to present; Member Legislative Council I.S.M.S. 1966–69; Member of School Health Exam Committee 1974–75; Chairman 9th District I.S.M.S. Grievance & Peer Review Committee 1967 to present; HASP Advisor 1971–74; Region V HASP Advisory Committee 1974; Chairman Region V HASP 1975; Member 9th District I.S.M.S. Grievance and Peer Review Committee 1964 to present; Member I.S.M.S. Ad Hoc Committee to study formation of a Physician's Guild 1970; Member I.S.M.S. Ad Hoc Committee of Physicians' Assistants 1972 and Liaison Committee 1966; "Key Man" Governmental Affairs Council I.S.M.S.; Chairman of I.S.M.S. Ad Hoc Committee on Medicheck 1972; Member Reference Committees and Special Committees of I.S.M.S., House of Delegates; Member of Committee on Comprehensive Health Planning 1974.

Member Organizations (membership and positions): Wayne County Medical Society, all offices and committees; President Southern Illinois Medical Association 1976; Past President Lions Club; Past President Fairfield High School Board; Past President Fairfield Chamber of Commerce; President, Wayne Co. Chapter of the American Cancer Society; Vice-President of SIMRO; Christ Lutheran Church, all offices; Lay Delegate Detroit Convention 1965; alternate delegate to Dallas; Member Lutheran Academy for Scholarship; Former Member St. Louis Lutheran Hour Chorus; Charter Diplomate American Board of Family Practice; Member of American Association of Physicians and Surgeons; Member Society of Teachers of Family Medicine; Teacher Eastern Illinois Community College, Instructor teaching Physical Diagnosis to R.N.'s; Chairman of Region V Comprehensive Health Planning Council St. of Ill. 1973–74; Professional Rep. Greater Wasbash C.H.P.—A.H.A.; Member of Gov. Kerner's Commission to study Education of Gifted Youth; MECO Project Director Fairfield Memorial Hospital 1970–72; Radiological Defence Officer of Wayne County, Illinois 1955–56; Charter Fellow, American Academy of Family Physicians; Clinical Associate Professor of Family Practice SIU Medical School 1976; Nominee from Southern Illinois for National Advisory Council H.E.W. Health Systems Agencies.

Military service: Lt. M.C. USNR, Retired—Medical Officer U.S.S. Lattimer 1952.
Family: Married: Wife, Doris Mae (Nee Homan) 5 children, 6 grandchildren.
Medical experience: Assistant to G.P. Fairfield 1954–58; Partner Fairfield Med. Center Mixed specialty group 1958–73; Solo practice 1973 to present.

PEMISCOT COUNTY MEDICAL CENTER,
HAYTI, MO. *February 23, 1978.*

Senator JOHN C. DANFORTH,
United States Senate,
Washington, D.C.

DEAR SIR: Because we were unable to attend the field heraing for the Finance Committee, we respectfully submit our reasons for increased hospital costs. As all business men can understand that increased overhead causes increased prices, it is mundane to elaborate on this economic concept. In rural areas such as ours we find many hardships which reflect on our financial status.

1. Low occupancy due to lack of physicians to admit.
2. High percentage of Medicare/Medicaid patients where less than cost is reimbursed.
3. Federal and State regulations on environmental, social and patient care which have little to do with quality patient care.
4. Increased costs due to Federal directives such as minimum wage, social security, etc.
5. Increased costs due to State directives such as malpractice, unemployment, etc.
6. Inconsistencies in payment and administration of both Medicare and Medicaid Program.
7. Increased energy costs and petroleum based products.

This is a brief simple description on our problems of which many other factors affect.

Sincerely,

LARRY BAKER,
Administrator.

MID-MISSOURI PROFESSIONAL STANDARDS
REVIEW ORGANIZATION FOUNDATION,
February 24, 1978.

Senator JOHN C. DANFORTH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR: This is in response to your letter of February 7, 1978 requesting submission of a written statement regarding rising hospital cost and proposed solutions. We fully realize we all have identified the problems. We however, do not have all the answers or solutions.

It is the intent of the Mid-Missouri PSRO Foundation to bring about changes for improving health care and cost containment through various avenues:

Focused review of acute hospital care by reviewing the most frequent and costly admissions;

Focused review on the most prevalent surgical procedures to alleviate unnecessary surgery;

Focused ancillary review of the most frequent and costly services, i.e., X-ray, lab, diagnostic testing. These review efforts will be created through accepted medical norms, standards and criteria developed by physicians.

Physician education through peer review—feed-back mechanism through the PSRO review data collection system to bring about or affect change in physicians' practice habits where needed, thereby improving the quality of health care and hopefully lowering cost; and

Cooperation with HSAs and other health related education programs for better patient education towards preventive medicine.

Other areas that could ultimately affect the health care delivery system might be:

Effect the redirection of services rendered on an inpatient basis that could be performed on an outpatient basis thereby lowering medical costs.

In regards to this area of outpatient-emergency room services there needs to be an expansion of coverages by Medicare and Medicaid with reasonable reimbursement to the provider. This would lower the higher costs of inpatient care

There needs to be studies performed investigating alternative reimbursement mechanisms to hospitals, i.e., creation of several levels of care within an acute-facility thereby forming several levels of payment based upon the level of care. and ancillary services required; and

We do not feel, however, these goals can be accomplished without national changes affecting the rise of inflation, or of inflationary elements which have a direct cost effect on health care.

Although our PSRO has been performing review in our area's thirty-two hospitals for a short period of time, we have indeed realized some effective changes in shorter lengths of stay and improved medical care. We feel with additional time we can affect the changes we have mentioned.

We hope these procedures or suggestions will be helpful in your hearings of the Committee on Finance of rising hospital costs.

Sincerely,

THOMAS E. MANGUS,
Executive Director.