HEALTH CARE PROBLEMS IN RURAL AND SMALL COMMUNITIES
(Macon, Ga., and Atlanta, Ga.)

JOINT HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

AND

COMMITTEE ON GOVERNMENTAL AFFAIRS
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CONTENTS

ADMINISTRATION WITNESS

Page

Reich, George, M.D., regional health administrator, U.S. Public Health Service, region IV 15

PUBLIC WITNESSES

Bacon, Ernest, administrator, Hamilton Memorial Hospital, Dalton, Ga 198
Blue Cross and Blue Shield, Atlanta, Ga., Fred R. Higginbotham, president 127
Busbee, Hon. George, Governor of the State of Georgia 95
Candler Memorial Hospital, Ed Tinnermon, administrator 70
Bryan, Morris, president, Jefferson Mills, Inc., Jefferson, Ga 109
Colvin, Hon. Curry, chairman, Lincoln County Commissioners 35
Davis, Dr., H. G., M.D., Sylvester, Ga 18
Dent, Otha, commissioner, Crawford County, Ga 37
Duttera, Dr. Maurice J., M.D., Sylvester, Ga 26
Georgia AFL-CIO, Herbert Maybry, president 116
Gillis, Hugh M., Soperton, Ga 76
Grady Memorial Hospital, Atlanta, Ga., J. W. Pinkston, Jr., administrator 211
Griffin-Spalding Memorial Hospital, Griffin, Ga., Carl Ridley, administrator 219
Hamilton Memorial Hospital, Dalton, Ga., Ernest Bacon, administrator 198
Hancock, Fred, president, National Bank of Fitzgerald, Ga 56
Harris, Dr. Rufus, president, Mercer University 17
Haskell, Susan, N rth Central Georgia Health Systems Agency 158
Haverty, Rawson, chairman, board of trustees, St. Joseph's Hospital, Atlanta, Ga 112
Higginbotham, Fred R., president, Blue Cross and Blue Shield, Atlanta, Ga. 127
Hodges, Grace, member, board of governors, Health Systems Agency of Central Georgia 54
Jackson, Hon. Maynard, mayor, Atlanta, Ga 104
Jefferson Mills, Inc., Morris Bryan, president 109
Jones, J. B., commissioner, Lumpkin County, Ga 48
Mavbry, Herbert, president, Georgia AFL-CIO 116
Medical Association of Atlanta, Ga., Dr. A. Cullen Richardson 185
Medical Association of Georgia, Dr. Harrison Rogers 162
Melton, Hon. Buckner F., mayor, Macon, Ga 11
National Bank of Fitzgerald, Ga., Fred Hancock, president 56
Neeley, Hon. John, mayor, Butler, Ga 52
Owens, Thomas J., administrator, Wheeler County Hospital, Glenwood, Ga 61
Pinkston, J. W., Jr., administrator, Grady Memorial Hospital, Atlanta, Ga 211
Rice, Dr. Walter, cooridnator of development, Mercer Medical School 79
Richardson, Dr. A. Cullen, Medical Association of Atlanta, Ga 185
Ridley, Carl, administrator, Griffin-Spalding Memorial Hospital, Griffin, Ga 219
Rockmart-Aragon Hospital, Rockmart, Ga., Donald Tate, administrator 67
Rogers, Dr. Harrison, Medical Association of Georgia 162
Shapard, Hon. Virginia, State senator from Griffin, Ga 142
Skelton, Hon. Douglas, commissioner of human resources of Georgia 4
Snow, Dr. James S., D.O., Darien, Ga 24

	Page
St. Joseph's Hospital, Atlanta, Ga., Rawson Haverty, chairman, board of trustees	112
Sullivan, Dr. Louis, dean and director, School of Medicine, Morehouse College	190
Tate, Donald, administrator, Rockmart-Aragon Hospital, Rockmart, Ga	67
Tinnermon, Ed, administrator, Candler Memorial Hospital, Savannah, Ga	70
Wheeler County Hospital, Glenwood, Ga., Thomas J. administrator	61

ADDITIONAL INFORMATION

Analysis: Community Hospitals in Georgia; Analysis of a Vital Georgia Industry	199
Article: Mercer Gets Millions From Estate Bequest, By Dewey Knudson	13
Folder: Crawford County—Rural Health	38
Pamphlet: Family Practitioners for Georgia: A Proposed Plan, By the Joint Advisory Board of Family Practice	21

HEALTH CARE PROBLEMS IN RURAL AND SMALL COMMUNITIES—MACON, GA.

TUESDAY, AUGUST 16, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON FINANCE AND THE
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Macon, Ga.

The committees met, pursuant to notice, at 10 a.m., in the Monument Room, Macon Coliseum, Senators Talmadge and Nunn presiding.

Present: Senators Talmadge and Nunn.

Senator TALMADGE. This hearing will come to order. It's a real pleasure for Mr. Nunn and I to be here in Macon with so many people who share our concern over the need to make available good health care to our citizens in rural and small communities. I suppose I have a somewhat unique interest in the problems we are taking up today. First, as chairman of the Agriculture Committee of the Senate, there is an obvious interest in helping meet the needs of rural Georgia and rural America. Then I wear another hat as chairman of the Subcommittee on Health of the Senate Finance Committee. There we deal with medicaid, medicare, and the maternal and child health care program. But in order to better understand the current health problems in rural areas, it is important to get out of Washington and to visit with and listen to those people who are trying to solve those problems. Senator Nunn and I will have a better view of what we can do in Washington if we have a better understanding of what is happening, and what is not happening, in terms of meeting the health care needs in the rural areas and small towns in Georgia.

In Washington, as you know, as well as elsewhere, there are people who want to save the world by passing every program and spending every dollar in sight. As a matter of fact, they are prepared to spend dollars which are out of sight. My own view is that we have real problems here and now at home which we ought to deal with before we go on to the "pie in the sky" bigger and better things which are proposed. But we are making progress. Just 2 weeks ago the Senate Finance Committee approved a bill to authorize medicare and medicaid payments in rural clinics. Mr. Nunn was a cosponsor of that measure and I'm pleased that I was able to help as the principal sponsor of the legislation in getting the program approved. It is a good example of things we can do to bring care to rural areas. But there are quite a few other things which need doing. Senator Nunn and I have been working closely together in an effort to cut redtape and bureaucracy in the Federal health care program as well as to put a stop to

the fraud and abuse in medicare and medicaid which are costing us billions of dollars each year. Money, at least, some of which could be better used to help meet the kind of unmet needs we are going to hear described this morning. Senator Nunn and I sponsored the original legislation last year which led to the establishment of the Inspector General for the Department of Health, Education, and Welfare. He is the head of the strengthened antifraud activities. We gave him a pick and shovel and now we'll wait to see whether he does the job. There is a good example of how hard it is to get the job done in Washington.

Senator Nunn and I sponsored legislation to consolidate the administration of the medicare and medicaid programs so as to cut out duplication, eliminate redtape and bureaucrats, and to provide a means to have uniform policymaking instead of conflicting policy in these areas. Well, the administration took our idea before it was enacted by Congress and set up this agency, the Health Care Financing Administration, through administrative order. Here's an example of how the Federal Government cuts out waste or duplication. There were 43 different units before the consolidation, at last count the new agency was going to have 75 units. There were 13 top level Government employees in the agencies being merged. They have now proposed to have something like 25 or 26 superbureaucrats. This is the agency which, by the way, is supposed to show hospitals how to become more efficient and cut out waste. I assure you that this kind of reorganization is not my idea of cutting out inefficiency or waste. Now I look forward to hearing from all of you who have kindly consented to spend time with us this morning. Senator Nunn.

Senator NUNN. Thank you very much, Senator Talmadge. I'm delighted to be back in middle Georgia and I'm looking forward to hearing the distinguished panel of witnesses we have this morning. I understand that Dr. Harris is in the audience this morning, we've got as our last witnesses, the Mercer panel talking about the medical school and I know Dr. Harris may not be able to stay the whole time, so I want to welcome you, Dr. Harris, to be here as the president of Mercer. I welcome the opportunity to have a chance to discuss the health needs of citizens here in middle Georgia. This morning, we really are covering a great deal more than middle Georgia; we're covering south Georgia and other sections also. Access to health care and the ever-increasing cost of this care is of vital concern to all Georgians. Senator Talmadge and I hope that the citizens who will testify today can tell us of the specific health problems which they face in their own cities and counties and communities in Georgia. We are hopeful that the hearings in Macon today, and in Atlanta on Thursday, will be the first in a series of hearings in several States which will focus on health care problems. Our purpose in these hearings is to learn firsthand about the problems of health resources, manpower, and financing so that Senator Talmadge and I can feel confident that the legislation which we propose and on which we vote will be responsible and responsive to the needs that exist. Before we begin, I would like to share some particular concerns of mine. I believe that our great Nation has the very best medical technology and personnel in the world. Our physicians and our hospitals can perform, and do perform, daily, modern miracles. In order to gain this service, we spend, as a Nation,

about $160 billion a year on health care. That is about $600 for every man, woman, and child in our Nation. That is not just governmental expenditure, that's all expenditure.

Indeed, this is more than we, as a people, spend for our national defense. It is greater than the incomes of our giant industries. For, while our doctors and hospitals can work these lifesaving miracles, and do, there is an uneven, perhaps even unfair, distribution of manpower and resources in the health field. There are approximately 5,400 physicians in Georgia, but there are no doctors in 14 counties to serve the crucial health needs of 62,000 people. We spend $25 million on maternal and child health care in Georgia, and the State medicaid budget is $386 million. Yet, according to the information supplied by the Health Systems Agency of central Georgia, more infants per thousand die in the first year of their lives in Webster, Treutlen, Wheeler, Schley, and Hancock Counties than in the countries of Russia, Czeckoslovakia, Bulgaria, Jamaica, Singapore, and Italy—more infants per thousand. No one can convince me that babies born in even the most rural counties in Georgia should have a poorer chance for survival than the babies born in Russia or Bulgaria, but that is the case today. I feel that the problems which result in such shocking statistics are attributable primarily to the poor distribution and allocation of our resources. For the past 3 years, I have directed several Senate investigations of health programs. I've not been as involved as Senator Talmadge has in the legislative end of health care, but I've been very involved in the Governmental Affairs Committee in looking into the fraud and corruption that exists in the many programs that we already have on the books.

We've had many, many examples of problems in medicare and medicaid and out of many of these examples came the Inspector General bill which Senator Talmadge and I coauthored last year and which is now law and, hopefully, will be implemented in a very effective way. In one State, we found that physicians were charging to the medicaid program fancy penthouses, cabins, and boats. We found that the Federal Government picked up the tab for expensive gourmet meals and $80 bottles of wines, which were served daily to doctors in a hospital which had Federal health programs. Obviously, I realize that the large majority of health care professionals are conscientious and ethical; however, there is still a great deal of waste in our health delivery system which we must recognize and help to eliminate. I think the health care professionals who really are conscientious in this country completely share that sentiment. Senator Talmadge and I have worked on many different pieces of legislation, but the one we're most interested in seeing work effectively is the Inspector General bill, because in the health and welfare field, there is ample room for an internal organization within HEW to really crack down on fraud and abuse that makes our many good programs, which are served by conscientious people, look bad because of the abuses of a few. I believe we must eliminate waste in our present programs, identify the abuse, and develop legislative responses to it, and we must prosecute those who defraud these programs. I believe we must assure ourselves that we can manage effectively and efficiently the programs that are already on the

books before we go into any massive new national health insurance program.

It is essential that we bring effective and efficient management to Government programs and that we identify the changing needs of our people. We must do this if we are to appropriately address the urgent health care problems of rural Georgia, urban Georgia, and indeed our entire country. We face a great challenge to accomplish this goal, and the people here today play a vital role in this process. A lasting framework is only as strong as the underpinning or the foundation. An informed and concerned citizenry is the strong foundation from which Senator Talmadge and I and other Government officials can work to effect meaningful and realistic reform in our health care programs. I appreciate the people who are going to be testifying today; I look forward to the testimony, and I believe that this hearing will be beneficial to all of us.

Senator TALMADGE. I want to hasten to point out that the hospitals and health care facilities which Senator Nunn's committee and others found such massive fraud and abuse were not in Georgia. The first witness this morning is Hon. Douglas Skelton, Georgia's Commissioner of Human Resources. We're delighted to have you, Mr. Skelton. You may proceed as you see fit. If you like, you may insert your full statement in the record and summarize it. As you know, we have a multitude of witnesses and we want to hear them all if humanly possible.

STATEMENT OF HON. DOUGLAS SKELTON, COMMISSIONER OF HUMAN RESOURCES OF GEORGIA

Dr. SKELTON. Senator Talmadge, Senator Nunn, it is indeed a pleasure for me to address this joint hearing on rural health care. I would like to request that two documents which I have with me be made a part of the record.

Senator TALMADGE. Without objection, they will be inserted in full in the record.[1]

Dr. SKELTON. Thank you, sir. It will certainly come as no surprise to you, indeed, to any observer of modern medical trends, that that country doctor who traveled many miles, day and night over dirt roads to dispense medicine and kindly homilies to rural families, to deliver their babies, sit up with their elderly when they were passing—that doctor has virtually disappeared from the American scene. And with him has disappeared—if in fact it ever existed before for the rural population—a vital vehicle for rural health delivery. Let me illustrate, with slides, some trends in rural health care in Georgia. About 60 percent of Georgia's population live in the urban or suburban areas indicated in the orange-red on the map. These are areas of Georgia that are relatively affluent and better able to attract medical personnel. Doctors are attracted to urban areas, primarily because that is where the facilities and the patients are, at least those patients who form the basis for a successful private practice. Rural areas, on the other hand, have trouble keeping family doctors. If you will note the solid blue, those are the areas where there are more doctors per population. When

[1] The documents referred to were made a part of the committee files.

we get to the orange-red, the green and the white, we are indicating areas that the people that live there have a fewer number of physicians that they can turn to for care, primarily in the rural areas of our State. Since the early 1960's, over one-third of Georgia's 159 counties experienced a drop in patient-care physicians. The white counties would indicate those counties in Georgia that lost physicians in terms of the population of the county. The result of this medical migration to the cities, of course, is that rural doctors have more patients to treat; they have less time to treat them. The doctor or the patient, usually the latter, must travel longer distances for medical care and it's hard to convince young physicians or medical students to locate in these areas. But what is left behind when doctors move to the cities?

Generally the so-called high risk medical population is left behind, those people who because of their age, their social and economic circumstances, are more likely to need medical care than the rest of us. The areas indicated in dark blue on the map would indicate the high risk, generally rural population areas in Georgia. Medical areas of need are determined by the U.S. Public Health Service using most of the factors that I have just mentioned. The Public Health Service says that the rural areas are generally underserved, in many cases critically underserved, 117 Georgia counties, and parts of 30 more, are medically underserved according to the Federal criteria. Some people in Georgia literally have no access to health care. Only 12 counties in Georgia do not have some portion designated as medically underserved. All the counties that are shown in color on the slide are medically underserved and portions of all the counties in white except 12 have some areas that are medically underserved. What's to be done? Are we to bring back the country doctor in his model "T"? I don't think so. Doctors have good reasons for moving to or locating in the cities, and those reasons aren't likely to change rapidly enough to meet the pressing health needs of our rural areas. It appears to me that new directions in public health programs will have to take up the slack, programs like Georgia's primary health care centers, or health access stations. These centers were started under the Georgia regional medical program in cooperation with the Medical Association of Georgia. We have these primary health care programs in 12 areas of the State.

Another is being developed in connection with a private practice and funding is being sought for several others. These centers have shown a steady increase in patient use. The orange-red indicating the growth of one year, 1975 to 1976, in the patients that they serve. What this graph does not show that is most important is the community support that these programs have received, from the citizens and from the city hall people in the area. I visited one of these programs in Madison County and had the mayor of Carlton, Ga., tell me what a contribution that this program is making for health needs of the citizens of that small community. The success of these primary health access stations contains a number of ingredients that I would urge the Congress to consider when it undertakes to remedy the shortage of medical availability to rural citizens. There would, for example, have been more counties served by health access stations under the Federal rural health initiative if it were not for regulations that are sometimes unrealistic. Community involvement in our health programs is im-

portant, but to require that boards of directors come from communities in which populations are widely scattered, in which the people are poor and often without transportation, defeats the entire program. It fails, in my judgment, to recognize the authority and responsibility of local and State governmental entities to implement services to the citizens they represent. We noted favorably the concern of Congress about such regulations in the recent report of the conference committee on H.R. 4975. Public entities like county boards of health or the Georgia Department of Human Resources should be eligible to receive grants for such projects as our primary health care centers. I would urge your continuing effort in correcting this problem.

Senator NUNN. May I ask a question here, Mr. Chairman?

Senator TALMADGE. Senator Nunn.

Senator NUNN. What causes this requirement of community involvement—you're not saying that the community shouldn't be involved, you're saying it's an unrealistic regulation; is that right? Or are you saying it's something in the law that requires that?

Dr. SKELTON. We would be most supportive of community involvement. The concern is that where the regulations require that there be a community board that acts as a policy board for that program before it can be funded, then that bypasses the opportunity of the county boards of health acting for their citizens to be the agents. This is something that I discussed just last evening with Dr. Reich and I hope to discuss further and try to work out the problems we have.

Senator NUNN. Is it a regulation or is it something in the law that requires it?

Dr. SKELTON. To my knowledge it is a regulation.

Senator TALMADGE. Dr. Skelton, when I was Governor the general assembly submitted and the people ratified the constitutional amendment granting forgiveness of tuition and fees to the M.D.'s that practiced in underserved areas. To what extent has that been effective in motivating doctors to go into these areas?

Dr. SKELTON. Senator Talmadge, my knowledge of that would indicate that it has not been that effective. The concern would be how long they stay or the pay-back opportunities they have. There are considerable attractions that the urban areas hold in terms of the kind of life that you can live there——

Senator TALMADGE. Equipment, social life, and so on.

Dr. SKELTON. The kind of training that they have and the many places that might give them the great hospital base, they are looking for facilities that can support their specialty, so the things that we do as part of our kind of unwritten national health policy that make it more likely that physicians will locate in urban suburban areas. I would like you to note the staff makeup of the primary health care center and its relationship to what I believe are necessary new directions in our health system as a whole. It is time to recognize the essential wisdom of the old bromide, "an ounce of prevention is worth a pound of cure." Put another way, I believe that the operation of our health system should be governed by as strong an emphasis on the maintenance of health as the treatment of illness. I recognize that life style changes and environmental improvements are long-term and are difficult goals. I urge the Congress, nevertheless, to keep in mind

that the major improvement in this Nation's health depends more on prevention services, more early detection of illness and more available and accessible basic health care—depends more on those factors than on increasingly sophisticated and increasingly costly technology for the treatment of the severely ill. In many cases the patient-care physician, with his sophisticated education and highly developed skills is not participating in a health care system which utilizes his skills and training to the optimum. Physician extenders or health care practitioners, on the other hand, can provide much of the basic expertise needed in a community health access station. At Georgia's primary health care centers, nurse practitioners provide the appropriate services in many cases and refer others where further treatment is required to local physicians who have agreed to accept referrals.

In Georgia, 95 percent of the patients are served by nurse practitioners, including treatment under medical protocols, medical guidelines, that have been developed in conjunction with the nurse practitioner and the physician. This, obviously, is a more appropriate use of medical manpower. It is an arrangement that is feasible both financially and staffwise. Because of the success we have seen in these programs, I support current proposals to allow direct payment of medicare and medicaid to qualified extender personnel. It is a first step that could offer a major incentive to the development and career satisfaction of this type of health manpower. It has major potential for expanding access to primary care in urban as well as rural communities. I believe that it's clear from the trends indicated earlier in the slide presentation that access to private doctors for primary care cannot be guaranteed in many rural areas. Thus, the burden falls on public health delivery systems to extend their services into primary care delivery in areas which cannot sustain private medical care. Whether such services should be totally public or a combination of the public and private should be determined by the needs of circumstances in that local community. To obtain that flexibility and the opportunity to tailor programs more directly to local needs, I would urge more latitude in the use of Federal funds, to permit the use of those funds in ways deemed most appropriate by the State or local government without a loss of accountability. The program of the Appalachian Commission, for example, contains such latitude, and the northern areas of Georgia have benefited substantially from the availability of such funding. Federal recognition of some of the problems we are discussing has helped, and we have tried to take advantage of Federal programs. But again, the mechanics have been such as to make our efforts less than successful.

Here is an example: Over 100 Georgia counties are designated by the National Health Service Corps as medical and/or dental manpower shortage areas. Unfortunately, that designation raises community expectations to the possibility of physicians and dentists being placed in their area. Eleven projects have been approved for assignment. But some areas have been waiting for several years, and so far only a handful of sites have been able to attract these National Health Service Corps personnel. The free choice by Corps personnel of their location and the length of time of the assignment does not help the program attain its goals. It appears that we must recognize the fact that there are some areas which will never attract physicians or den-

tists, or have the economic base to sustain them. Voluntary assignment of National Health Service Corps personnel plus the expectation that they will develop self-sustaining private practices and therefore remain in the area permanently are concepts which warrant reexamination. Let me cover briefly some other recommendations that I believe will enhance the quality of rural health care, and reemphasize some important points. We have found that in the absence of other primary care facilities, rural families often use the emergency rooms of our public community hospitals as a health access point, or entry point for the care they need. We would recommend that support be continued to these hospitals for the development of ambulatory services, and that development of primary care or basic medical care services in affiliation with hospitals be encouraged. This recommendation is made more feasible by the fact that 90 percent of Georgia's hospitals are public community hospitals, and thus Georgia would be able to develop a strong health care strategy along these lines.

Redirection of Federal support toward education in general and family medicine would tend to reduce the attraction of urban areas and their sophisticated technology geared toward specialized medical practice. The development of a number of family practice residency programs in Georgia shows an awareness of the lack of physicians to provide general primary care. The Federal Government should certainly expand and continue support of these efforts. I believe there should be a higher priority placed on public health funding to insure integration with community health systems such as outpatient hospital care and the primary health care delivery systems. I will call attention to the efforts which I believe have been more successful in Georgia to bring together community mental health programs and mental hospital programs into a single system of health care delivery for the mentally ill. We do not have that kind of training in our physical health care systems at the present time. National Health Service Corps personnel should, in their training, be oriented toward working with public health care practitioners in providing community health services and medical care. I would urge and would welcome more support and funding for the training and the development of training facilities for physician extenders in medical schools, nursing schools, and medical centers, and training for physicians of the future so that they are able to work with extender personnel. As you know, I am a physician, and some of my colleagues, perhaps me also, have not been properly trained in working as a member of a team in delivering health care. Recognizing the need for additional services for those cases that cannot be served locally, I recommend a referral system that provides comprehensive health care. Such systems should be the goal of Georgia's health planning and development efforts.

And finally, I would suggest that differences between medicaid and medicare reimbursement rates in urban and rural areas be reduced to eliminate at least one of the disincentives for physician location in rural settings. I appreciate the opportunity to discuss these items with you and am open to any questions.

Senator TALMADGE. Dr. Skelton, I notice in your statement that you urge that physician assistants and nurse practitioners in rural areas be reimbursed under medicare and medicaid. I think you will be

pleased to know that the Senate Finance Committee has just approved an amendment which I sponsored and Senator Nunn cosponsored, which will do exactly what you want. That is, reimburse under medicare and medicaid the services of the physician assistants and nurse practitioners in rural clinics. You think that would be a great benefit, do you?

Dr. SKELTON. I certainly do.

Senator TALMADGE. In your statement you stressed the need for preventive health efforts in rural areas. You indicate a need for more health workers, such as nutritionists and home health aids. Why can't we use the WIN program to take people off the welfare rolls by training them as preventive health workers so as to meet the needs you described in rural areas and in our cities as well?

Dr. SKELTON. Senator, that's an idea that I like. We've talked about similar ideas with some of our Asian population and we could perhaps provide them with some employment opportunities so they can feel better about their contribution to society and also have them helping other people who have health needs that are unmet.

Senator. TALMADGE. Mexico has done that, I understand with quite effective results. On page 2 of your statement, you refer to health access stations. It's my understanding that you have established one of these in Plains, Ga. I've also been told that you had to go all the way out to Albuquerque, N. Mex. to find a nurse to staff it. Is that true, and if so, how come you can't find any home grown nurses?

Dr. SKELTON. Senator, if I could, I would like to ask one of my staff in the audience to answer that question. I do not have the details concerning the Plains center.

Senator. TALMADGE. Can someone answer that question in the audience?

Dr. SKELTON. Mr. Tom Gibson is in the audience and I believe can address that question.

Senator TALMADGE. Identify yourself for the record and respond to that, too, will you?

Mr. GIBSON. Tom Gibson, of the Division of Physical Health. We made a commitment to the people of Plains, Senator, that we would try to open up the primary health care center there by June 1. We did, unofficially, but about the only way we could recruit someone in time was to work with our friends in the regional office to recruit someone through the National Health Service Corps. This is the nurse that we got from New Mexico and she's there on temporary assignment.

Senator TALMADGE. Is that one of the WIN trainees from New Mexico?

Mr. GIBSON. No, sir, I think she's been practicing there for several years in the National Health Service Corps.

Senator TALMADGE. Senator Nunn.

Senator NUNN. Thank you. I have a good many questions that I could ask, but in light of the many panels of witnesses, I'm going to make mine brief. Have you talked with Dr. Reich about the problem you identified with Federal regulations on the community participation?

Dr. SKELETON. Yes, sir, I have, only last evening. We need some further time to explore that.

Senator NUNN. He's going to be here with us this morning and I think it would be a good opportunity for all of us to discuss that. What about the reimbursement? I hear a good many complaints from doctors about reimbursement under medicaid being inadequate and I also hear that that causes many doctors not to really participate, at least with any enthusiasm, in the medicaid program. Do you think this is a valid complaint about medicaid reimbursement?

Dr. SKELTON. Well, I think certain aspects of it are a valid complaint. I would indicate to you that one of the selling points of my returning to State government and to be Georgia's commissioner was the fact that Mr. Faulkner set the medicaid program of the State, but I do know that there is concern about the differential in medicaid-medicare payments to rural and urban areas. That seems to me to be inconsistent with what should be a national concern about health care in rural areas. If anything, we ought to be trying to provide incentives. There are also, in my view, discriminatory practices in terms of psychiatric physicians, in terms of what their reimbursement under medicaid is limited to, no more than $250 a year, which almost excludes them from medicaid type practice by the type of patients that they would see.

Senator NUNN. Do you believe you can set up standards for them to be eligible on the same basis as general practitioners without getting into possible abuse?

Dr. SKELTON. I believe the standards can be set if a professional would sit down and do it.

Senator TALMADGE. Will my colleague yield at that point?

Senator NUNN. Certainly.

Senator TALMADGE. In the medicare and medicaid reform bill which we drafted and which you are a cosponsor, we provided that practitioners in rural areas could not be paid less than 80 percent of practitioners in urban areas. I think the overwhelming majority of the doctors in Georgia supported it. Strangely enough, the American Medical Association opposed it.

Senator NUNN. On page 6, Dr. Skelton, you say in the first sentence, "Redirection of Federal support toward education in general and family medicine would tend to reduce the attraction of urban areas and their sophisticated technology geared toward specialized medical practice." You give the examples of family practice residency programs in Georgia beginning now. Could you give us a little bit more detail about what you mean by redirection of Federal support toward education in general and family medicine; and then, I'd like a little bit of information about the Georgia family residency programs.

Dr. SKELTON. Senator, what I was addressing there is a concern that I have that at times the physicians are scapegoating the family health care problems in this country. We need specialized physicians. We have people who have illnesses that require specialized care, but we also must begin to develop that balance between specialized-care physicians and the high-cost facilities and hospitals, and the need for the basic medical services in the communities where families can for that, and it essentially is a specialty because these people must have aches and headaches, diabetes, lung problems, that require continuing medical care and maintenance of a physician that they can see as their family doctor. I think we need to provide much more support

for that, and it essentially is a specialty because these people must have not only high-level medical knowledge but knowledge of family life and social life, and I think we need to look at the funding factors of our Federal programs that would tend to lead people toward specialized practice and see if we can redirect them toward family practice programs. There are a number of family practice programs in Georgia. I'm not sure if I can list all of them; I've only been with the family practice residency program in Augusta, involved in Columbus. There may be a number of others in the State——

Senator NUNN. Are they working? Have they been underway long enough to tell whether they really are working or if the people who are in them are going back to the underdeveloped, more rural areas?

Dr. SKELTON. I don't have the data in mind to give the answer to that question. I know they are going to rural and urban areas. There is no similar health problems in our urban areas that we can cite in the rural areas.

Senator NUNN. But there are a good many parts of the urban areas that are understaffed and do not have medical care, I understand, now.

Dr. SKELTON. I think the problem is unless we have more of these kind of physicians that participate in a health care system as opposed to a health care nonsystem which we have now, then we can't get that balance of care between the basic medical care, adequate assessment, think about physician, physician extender, working in a health access station or private clinic, for example, and the referral to a specialty center, the tertiary care center, like some of the fine ones we have, one here in Macon, one in Savannah, and in other areas of the State. We've got to get these services there so that there's a comprehensive system instead of certain parts of it being overfunded, perhaps overdeveloped; other parts of it being totally, almost totally, understaffed.

Senator NUNN. Thank you very much.

Senator TALMADGE. The next witness is the distinguished mayor of Macon, the Honorable Buckner F. Melton; and I see in the audience the distinguished president of Mercer University, Dr. Rufus Harris. I would imagine, Buck, that your comments would address themselves in part to the same subject. I would suggest that you share some time with him if you will.

STATEMENT OF HON. BUCKNER F. MELTON, MAYOR, MACON, GA.

Mayor MELTON. It would be my pleasure, Senator.

Senator TALMADGE. Dr. Harris, would you come to the witness stand.

Mayor MELTON. I'd be somewhat embarrassed to try to take time away from Dr. Harris, because——

Senator TALMADGE. Take time away from each other.

Mayor MELTON. But I shall try to make mine very brief. First, Senator Talmadge, Senator Nunn, I want to welcome you to Macon and thank you for coming here for these hearings. Your interest in the health care needs of this country makes me feel a lot more comfortable. I know we call on you so often and you always respond so well, and I sort of hate to pose, continually, problems concerning efforts that we are making here, but I think it's necessary this morning, and I'll try to run through this as quickly as possible and give Dr. Harris some time to talk. Of course, I'm honored to appear before you as mayor of Ma-

con, a city of approximately 125,000 people located in the heart of Georgia, but more importantly I come before you as a fellow Georgian deeply concerned about our medical care shortage that affects not only this community, but, indeed——

Senator TALMADGE. Would you yield at that point, Mayor? If you would pull that mike a little closer to your voice, I believe you can be heard better. The accoustics are not too good.

Mayor MELTON. We are concerned, of course, about the medical care shortage in the State which has been amply demonstrated by the previous witness. Macon is the health care center for the middle and south Georgia area. Its doctors and facilities provide medical services for more than 40 surrounding counties. Approximately 1 million Georgians live in this area. These people look to Macon for their secondary and tertiary care—specialty care and sometimes hospitalization. But because of the storage in these mostly rural counties of general practitioners, internists, pediatricians, and obstetricians, many of these citizens also seek the services of Macon doctors for their primary care. For example, three of our county's—three of Bibb County's six neighboring counties have only one physician each. Citizens of these counties are almost forced to come to Macon for help. But Bibb County, like the surrounding rural counties, also suffers from a lack of primary care physicians. If you use the yellow pages of the Macon telephone directory as a source, only 72 out of the 177 Macon doctors listed, much less than a half, practice the primary care fields of pediatrics, internal medicine, obstetrics, and family practice. These are the kinds of physicians who will see a patient without a referral. What we have is best described as specialty maldistribution. In this area, there is only 1 primary care physician to every 3,600 people. The national ratio, at 1 to 1200, is three times bettter. Although more than 40 percent of the people who live in the area are black, fewer than 10 black physicians practice in the area. Senators, the startling fact is in Macon we have only two black physicians. Physicians assistants, nurse pracitioners, and physicians trained in foreign medical schools were once considered as possible solutions to this problem.

However, the supply of these health professionals has not materialized to meet our current crisis, much less our pressing future needs. With Georgia's population expected to grow by 1.5 million by the year 2000, the situation can only get worse unless we do something immediately. My fellow citizens decided last summer to do something significant, something that no other community in this country has done in recent times. A bond referendum was handily passed which commits this community to provide up to $7 million in construction funds for this new medical school. Our city council and the Bibb County Board of Commissioners also committed a total of $500,000 for this school. The business community has raised nearly $2 million towards the school's establishment under the leadership of Senator Nunn. Mercer University continues to give support as a vital partner in this community-based project, and I assume that you have probably heard the news in the last day or so of the very splendid bequest that was made available.

Senator TALMADGE. Is this the headline I hold in my hand now?

Mayor MELTON. Yes, sir. I might add, I had nothing to do with the timing of that headline, but there are some pretty smart people who obviously did. I'm glad you're looking at the Telegraph this morning.

Senator TALMADGE. "Mercer gets millions from estate bequest. Mercer University has received landlocked multimillion dollar gift for its proposed medical school, University officials announced Monday. Mercer President, Rufus C. Harris, announced the bequest from the estate of Mrs. Mary Johnston Ray of Twiggs County who died June 6th." Without objection, I'll ask that this article from the Macon Telegraph dated Tuesday morning, August 16 be made a part of the record at this point.

[The article referred to follows:]

[From the Macon Telegraph, Macon, Ga., Tuesday, Aug. 16, 1977]

MERCER GETS MILLIONS FROM ESTATE BEQUEST

(By Dewey Knudson)

Mercer University has received a "landmark multi million dollar gift for its proposed medical school," university officials announced Monday.

Mercer President Rufus C. Harris announced the bequest from the estate of Mrs. Mary Johnston Ray of Twiggs County, who died June 6.

The first major bequest in support of the planned Middle Georgia Medical School at Mercer University, the gift was an endowment in memory of Mrs. Ray's deceased son, Joseph Hamilton Ray.

Mrs. Ray, the widow of banker George E. Ray, left 40 percent of her gross estate, before estate taxes, to the medical school.

The value of the endowment is conservatively estimated at some $4 million. Mrs. Ray's estate consisted of 5,000 acres of property in the Macon area and other assets.

Experts say the property, which has not yet been appraised, could be valued at $1,000-$5,000 per acre. Using a low figure of $2,000 per acre as an average value, the value of Mercer's share of the estate comes to $4 million.

"Mrs. Ray's bequest we look upon as a noble gesture of recognition of the school," said Dr. George Bernard, dean of the proposed school. "It is indeed a landmark."

Harris expressed the university's great appreciation to Mrs. Ray and her family on behalf of Mercer's board of trustees.

In her will, Mrs. Ray paid tribute to her late son and hinted at the reason for the donation. "By an accident at birth, or some other human failure, which modern medicine might have prevented, our son was never able to take his wanted place in life, and upon his death I inherited his one-half interest in all the property," she wrote.

Bernard pointed to three areas in which the bequest will strengthen plans to get the medical school off the ground. Civic leaders have been working on plans since 1971.

It is an indication of a broadened base of support for the school, coming in combination with other varied sources of funding. Other funds will come from smaller gifts, a local bond issue and the State and Federal governments.

The gift will help convince outsiders, and particularly those who will have to decide on medical accreditation for the school, that progress is being made.

The donation will serve as seed money to encourage other contributions and possible grants from foundations.

As endowment money, the contribution can be invested to provide a steady flow of income in future years, Bernard said.

"All schools need sources of money we can count on year after year—that's what an endowment is," Bernard said.

Mrs. Ray directed in her will that the income from the gift can be used for scholarships and tuition grants for medical students and, in some cases, for pre-medical students.

Her will called for setting up a committee of three persons to award the scholarship funds.

Bernard said the gift will not affect the present timetable for opening the school, which now calls for the first students to be enrolled in the fall of 1978.

Other major commitments to finance the planned medical facility include $5 million in the State budget, a local bond issue of $7 million and a fund-raising campaign sponsored by the Greater Macon Chamber of Commerce that is nearing its goal of $2 million.

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In addition, the 1977 Federal budget includes $250,000 earmarked for the Macon medical school.

Macon Mayor Buckner Melton said the endowment will not affect sale of the local bonds.

"The timing on sale of the bonds is not going to create a problem for the medical school," he said. "The council and I are committed to issue the bonds at a time we're reasonably assured the school will move forward and at the time the funds are actually needed."

Melton said he has always been optimistic the medical school would become a reality, even before the endowment was granted.

"The need was so obvious, and the plans so practical, that people were going to develop ways and means to get it done," he said.

Senator NUNN. Mayor, if you can assure us that you can get $4 million every time you have a hearing, we'll have one——

Mayor MELTON. Well, we will assure you that there will be at least something happening, Senator. In 1973, then Governor, Jimmy Carter, included in his appropriation bill $5 million for a medical school at Mercer University and the general assembly passed the appropriation. Under the leadership of Gov. George Busbee, Lt. Gov. Zell Miller and the Speaker of the House, Tom Murphy, the general assembly has maintained these funds in its yearly appropriations because of the vital role this school will play in meeting the health care needs of the citizens of the State. I must point out that these funds were maintained during a period of economic crisis for this State, and if the general assembly had not believed in this school's potential value to the citizens, the funds surely would have been deleted. I would like to present copies of letters of support that have been received from members of the Georgia General Assembly representing all districts of our State and ask that they become part of this committee's records.[1] Thanks to the continuing support of our two distinguished U.S. Senators and the Georgia congressional delegation, and I would like to submit copies of their support for the record,[1] a bill was passed by the Congress and signed by the President that will allocate up to $250,000 for planning the medical school at Mercer University, but more important, the legislation under the Health Manpower Act would trigger the State's $5 million and the city of Macon's $7 million bond money.

But this morning I address you as a frustrated elected official. We have competently staffed the medical school project and I believe we have intelligently and properly sought to comply with the many guidelines and directives that have been placed on the project by the Department of Health, Education, and Welfare. But sadly we continue to experience a passive, even negative attitude. We are not receiving the reasonable and impartial response from HEW which this great effort deserves. We again turn to you and our other elected officials for help. The dreams and efforts to establish this needed medical school has spanned many years, committed much in terms of human and fiscal resources, united institutions, governmental bodies at all levels, but more importantly brought citizens from all walks of life together for the common purpose of providing adequate health care to our area. This type of effort deserves the support, encouragement, and positive suggestions from HEW and the Liaison Committee for Medical Education, and I want to emphasize, Senators, that

[1] The letters were made a part of the committee file.

it seems to me that if this is the problem of establishing the medical school that we have here in middle Georgia, that it indicates to me on a national basis that the real problem there in getting the medical community and the American Association—colleges, medical colleges, and the American Medical Association, to provide the kind of cooperation and support that is needed to solve the medical school's problems and the health care problems of this country.

Senator NUNN. Mr. Mayor, I might say that I've just been brought up to date on some of the frustrations you have had in trying to obtain this grant of up to $250,000, and I'm really amazed. I want to hear from HEW on that point because the law was as specific as Congress can write a law. The report language was specific in that Mercer was intended as the beneficiary of this appropriation up to $250,000. I had a dialog on the floor of the Senate with the chairman of the Appropriations Subcommittee, Senator McClellan and Congressmen Evans and Brinkley had similar dialogs on the House floor. I'm literally amazed that it hasn't been carried out. The only thing else we could have done was to have written the check, and Congress does not have the constitutional power to do that, so I really want to hear from HEW on that point.

Senator TALMADGE. Will you yield at that point, Senator Nunn? Dr. Reich is here from the Department of HEW. Doctor, I've been following this testimony of the mayor, and the way I summarize it, there has been some $250,000 authorized of the Government's planning money, the General Assembly of Georgia has provided what, Mr. Mayor, $5 million?

Mayor MELTON. Yes.

Senator TALMADGE. $5 million. Also, the citizens of Macon have voted a bond issue of $7 million. And the citizens of the community have raised an additional $2 million. Now you have an estate grant of how much, $4 million or $5 million?

Mayor MELTON. We don't know exactly, sir, it will obviously be multimillions of dollars. There's a great deal of money involved.

Senator TALMADGE. It seems to me to be close to $20 million effort from the community the State, the business community, and charitable contributions. What's the response of the Department of HEW? Why can't they go forward and help finance the Mercer Medical School? State your name and title for the record, please.

STATEMENT OF GEORGE REICH, M.D., REGIONAL HEALTH ADMINISTRATOR, U.S. PUBLIC HEALTH SERVICE, REGION IV

Dr. REICH. Dr. Reich, I represent the Public Health Service in the South. As I recall, I don't have the facts in front of me, but last year Mercer had not gotten its medical school accredited and it must be accredited by law before any Federal money can go to it.

Senator NUNN. Dr. Reich, we had a specific revision of the law under section 788–G that was put in the law specifically so that this requirement would not be applicable to a school that was caught in a position of having to be accredited before it could get Federal funds and having to get Federal funds before it could be accredited, I mean, this is a joke. It really is a joke. It's just incredible. You've got to get the funds in order to be accredited, but you've got to be accredited to get the

Federal funds. Now, how can you do both? One of them has got to come first, so we put a provision in the law that said you didn't have to be accredited to get the Federal funds. That provision hadn't been funded until this last year and we specifically designated $250,000 to fund that section. We specified that Mercer University was an intended beneficiary, not exclusively, but one of them, and we specifically provided in a report that HEW, within 60 days, make this grant, and I don't know what else we can do but write the check, so this business of accreditation does not apply to this section, does not apply to the $250,000, does not apply to what we are talking about. There's got to be a different explanation.

Dr. REICH. Well, I mentioned that last year——

Senator TALMADGE. Maybe you ought to come up here by the mayor, take that seat by his right side where you can be heard.

Dr. REICH. What I was saying to Senator Nunn, I don't have the——

Senator TALMADGE. Now you are the Regional Health Administrator?

Dr. REICH. Yes, sir. I don't have the file in front of me. I'm trying to recollect from my memory, but last year there was an accreditation problem. Now you indicate that that has been corrected by Congress. I don't know what the situation is now, but you remember another thing that Congress did, you took the whole program and you took it back to Washington. I don't have it anymore, so I'm just going to have to, when I get back to my office, call up there and find out——

Senator NUNN. What do you mean, took it back to Washington?

Dr. REICH. The whole manpower legislation was taken and put back to the headquarters in Washington.

Senator NUNN. Of course, the regional aspect of that legislation, I understand that's——

Dr. REICH. No, sir, the way the law was rewritten, we were told to keep our nose and our hands out of that entirely. We were directed to—anymore—to provide only technical assistance and compensation to people—we're not even looking at applications or——

Senator NUNN. Maybe someone from Mercer could tell us who's looking at these applications now, who handles the section 288–G application? Is it at the regional level or the Federal level?

Mr. HALL. Senator, I'm Floyd Hall of the medical school. We were told by telephone it would be handled on the Washington level by Dr. Bennett, but we received a visit from the regional level, which, in turn, he told us that he was going to be the project director for us out of the regional Atlanta office.

Senator NUNN. Who was that?

Mr. HALL. Dr. Gerhardt. So, we don't know.

Dr. REICH. I'll find out for you.

Senator TALMADGE. Before the hearing is over, would you please call Washington and give us a report on the exact status?

Dr. REICH. Yes, sir, I'll call right now.

Mayor MELTON. Senator, if I may, I'd like to give Dr.—let me give you a summary, which we will also introduce into the record, with your permission, two letters which pretty well summarize the problems that we've encountered, one from Dr. Harris, and one from the dean of the

medical school, and we will furnish you copies so that you'll have copies for the record.

Senator TALMADGE. You have extra copies for the record?

Mayor MELTON. Yes, sir.

Senator TALMADGE. It will be inserted into the record and if you will, please, give Dr. Reich copies.

Mayor MELTON. In closing, I want to reemphasize that this medical school at Mercer University will have an impact that extends far beyond Macon and this surrounding area. The doctors we educate will serve citizens who currently do not have access to doctors or any other health care. We need a medical school in middle Georgia to do that which has not been done, that is, to produce more primary care physicians to serve the people of this community and other Georgia communities, who, by American standards, are underserved. As you both know, everyone turns to Washington for help, and we believe that our request is unique. While we need Federal help, we have made our commitment. The citizens and governmental units of this city and county and all of middle and south Georgia, also Mercer University, are fully prepared to share the responsibility of this endeavor. I am very pleased to have had this opportunity to tell this distinguished panel about our needs and hopes and we pledge our continued cooperation and we know that we have yours. Thank you.

Senator TALMADGE. Dr. Harris, do you have anything to add to what the mayor has so ably stated?

STATEMENT OF DR. RUFUS HARRIS, PRESIDENT, MERCER UNIVERSITY

Dr. HARRIS. I would have very little to add, Senator. I thank you for the privilege of adding to it, but there's nothing much than I can say. I can only assert that the need of the school is established in the minds of all the people of this community. It is not a project that is adventurous in nature. This is a sound project and it ought to be employed. I resent some of the implications that come from different sources that this is not a well thought out proposition. This is one of the best thought out medical propositions that this country has ever known.

Senator TALMADGE. This is a matter that Senator Nunn's and my respected colleagues in the Congress have been working on now for about for about 4 years of my certain knowledge. It gives you a typical example of the government bureaucracy that you have to deal with. I remember when I was a very young man my father used to say that government was mostly bluff and redtape. I've come to realize that much of what he said was true.

Dr. HARRIS. We are sometimes given the impression that there are bureaucrats who think that they can thwart the will of Congress by their own power. I believe some think that.

Senator TALMADGE. Any further questions, Senator Nunn? Thank you very much Dr. Harris and Mayor Melton for the splendid testimony. Next we have a panel of physicians, Dr. H. G. Davis, Jr., M.D., from Sylvester, Ga., Dr. Maurice J. Duttera, M.D., of LaGrange, Ga., Dr. James S. Snow, D.O., from Darien, Ga. Most of these are from small towns. LaGrange does have a very well equipped hospital which

serves as a regional hospital in that area, so I think y'all can give us some idea of what's going on there. I would suggest, if you like, that you insert your full statement into the record. And proceed any way that you see fit, gentlemen. What we would like to know is the frustrations that you experience as doctors, largely in rural areas, trying to serve the needs of your patients and our constitutents.

STATEMENT OF DR. H. G. DAVIS, M.D., SYLVESTER, GA.

Dr. DAVIS. I'm Gordon Davis, Senator Talmadge, Senator Nunn, from Sylvester, Ga., and I'm a family physician. I——

Senator TALMADGE. I'm well acquainted with you. I might say, you managed my campaign when I ran for the Senate many years ago.

Dr. DAVIS. Thank you, Senator. I am president of the Georgia Academy of Family Physicians representing 540 physicians. I am also a member of the Advisory Board of the Family Practice in the State of Georgia. I was asked to discuss the manpower resource and finances relating to the health care problems of rural and small urban communities. It has been alluded to the fact that there is a wide fee differential made between different parts of the State and between different States on medicare and medicaid programs. Because of this many physicians are reluctant to locate in these rural areas. Physicians are sometimes reluctant to locate—to treat these patients because of the publicity given to those physicians with the high patient loads of medicare and medicaid patients. The physician that treats this patient should be commended rather than condemned. These physicians are providing care which was promised to this type patient when the medicare and medicaid program was first conceived, yet their names are publicized in glaring headlines and the public is led to believe that they are defrauding the public trust. When fraud does exist, gentlemen, the names should be publicized and the guilty party tried by the proper court, but until the charge is proven, these names should not be released to the press.

Senator NUNN. You've had a good many cases, haven't you, Dr. Davis, that the names have been released and then they would find they were in error?

Dr. DAVIS. Absolutely, and something should be done to correct this. Such bad publicity has caused numerous physicians to stop treating patients under these Government sponsored programs.

Senator TALMADGE. Would you yield at that point? You will recall that in the original medicare-medicaid reform bill that I authored, I prohibited the Secretary from releasing names due to the high error rate. There was the great human cry that we were keeping Government information confidential and that we were keeping expenditure tax funds confidential to the Government. We think we'll have to amend that provision, but I do have an oral commitment from Secretary Califano that in the future he will go to every length possible to see that no inaccurate statements will be released.

Dr. DAVIS. That's fine, Senator. Inequitable payments by insurance companies to surgeons and other specialists encourage students to specialize. Insurance company payments favor specialists. One cannot blame medical students for seeking higher paying positions. Supply and demand—it has been alluded to the fact that there's the need of

500 additional physicians in the State of Georgia to bring it up to the national average of physicians practicing. The current need of primary care physicians aggravated by the large number of physicians who are 70 years of age or older, an additional 200 physicians will be needed by 1980 to replace these aging physicians. Georgia remains in a critical situation regarding medical care 16 Georgia counties are without family physicians and 117 have insufficient numbers of family physicians. These figures may increase by 1980. Family physicians treat 90 percent of the patients that consult them. They are trained to manage physicial and emotional problems in patients from birth to death. They function as the advocate of the patient sending him to the various specialists when their problem is beyond his training. With the specialization of physicians and the inability of the rural areas to furnish expensive specialty equipment then these specially trained physicians gravitate to large urban areas.

With the present health system plans currently being developed, the Government will cause an increase in the consumption of health care. The greater the consumption, the greater utilization and also greater expenditures. As this proceeds there continues to be an ever increasing demand on the short supply of physicians. This is especially true in the rural areas where there is a large percentage of the medicare-medicaid patients. The overworked rural physician often returns to the medical center for specialization in order to escape the rat race. Cultural and recreational opportunities are often concentrated around urban areas. In an effort to provide these advantages to his family, a physician may choose to live and work in areas where there is increased opportunities. During the years of college and medical training, many students develop tastes in entertainment that cannot be satisfied in rural areas. But, with proper family physician training programs, many rural students will return to rural areas. The desire of young physicians to devote more time to their families, the desire to have some free time, uninterrupted by medical emergencies, leads more and more young physicians into group practice or partnerships. Naturally, communities that can support only one physician have trouble competing for the limited supply of physicians willing to consider sole practice. The number of medical school graduates tripled over the past 25 years, yet there tends to be a geographic maldistribution of physicians that continues to perpetuate the shortage of primary care physicians in rural areas. Today's family physician is trained in the hospital and laboratory environment, but he also has a great deal of experience and training in an ambulatory setting. We feel that he is equipped to treat 90 percent of the patients he receives. He is more likely to locate in rural areas having a community hospital containing the necessary equipment which he needs in the everyday care of his patients. I do not feel that the young physicians will locate in an area without these facilities because of their training.

For a young physician to locate in an area without proper equipment for which he has trained, can be correlated to the fisherman getting into a boat with only a paddle without the motor to which he is accustomed to using. He may think the fishing trip successful, but he'll probably give up fishing after this experience. In 1930, 71 percent of the physicians were general practitioners. Today the percentage is 17 percent. This lack of family physicians has contributed to the rising

health care costs. Specialists charge more and see fewer patients per day than the family physician. The Government passed the medicare and medicaid laws proclaiming that the poor, as well as the rich, would now be able to receive proper care, both in the rural and urban areas. Since then Public Law 93–641 was passed directing that health system agencies be formed. These agencies were required to develop a health system plan. These plans have been developed. There is glaring evidence in these health system plans along with other plans and requirements from other agencies that small rural hospitals be closed. When this is done, those now deprived of enough medical care will receive even less health care. When this is done one will be able to point an accusing finger at the Federal Government. In malpractice, much has been said, much has been done, but this continues to be a serious problem in the practice of medicine but I do not feel that it is any different in the rural areas than in the cities. Overutilization—demands on physicians. Many patients make calls to the physician's office when the health care is free. Under normal circumstances, they would have used home remedies and cured many illnesses.

Demands are made on insurance carriers without any consideration as to the effect it has on insurance rates. This is influenced by the fact that the employee insurance is deductible as an expense by businesses. These demands are increased because the policyholder wants the best in health care and at the same time he is experiencing no out-of-pocket expense. He feels that he can demand the best and get the best. It may not be better, but it certainly is more expensive, and when a patient states that he wants what is best for himself, the physician that takes any shortcut is opening himself to hospital malpractice charges. I have mentioned briefly 6 factors that affect the economic practice of medicine in rural areas. I now state in abbreviated form some methods of correcting these factors. Fee differential—adjust those fees applicably for all physicians in all areas in all States. Supply and demand—provide funds to those hospitals with family practice departments. Local communities are unable to train family physicians and then to have them leave. You have, now five family practice departments in the State. You have Macon, Columbus, Augusta, Rome, and Savannah. At present there is talk of developing family practice departments in Albany, Marietta, Dalton, DeKalb General, and Georgia Baptist, and possibly Waycross and Valdosta. It has been shown that 80 percent of those in family practice training enter practice within a 100 mile radius of the city in which they train. By providing funds for this the rural areas would then be able to draw from new departments of family practice over the State. The Advisory Board of Family Physicians of the State of Georgia has programed two new programs a year for the next 5 years. Today funding is the major problem. Funding these programs would increase the supply of doctors and then the demand would be met.

Hospital and related health care facility availability—Develop formulas that will allow the small rural hospitals to survive. Develop a formula that contains a minimum of population for a minimum size. These small rural hospitals do not want the highly specialized technical equipment found in large urban hospitals and used only by highly specialized physicians. Overutilization—I feel that if the patients were

required to make some payment on his office visit as well as the cost of his hospitalization, overutilization would be reduced. In defense of medicine, I think that there's something that the Federal Government, some program, should undertake to train the public to understand that medicine is not a definite science and they should not expect perfect every time. Gentlemen, I thank you.

[The following was submitted for the record:]

Family Practitioners for Georgia: A Proposed Plan

By the Joint Advisory Board of Family Practice, October, 1976

WHAT IS A FAMILY PRACTITIONER?

A Family Practitioner or Family Doctor is a special kind of doctor. Like a pediatrician, an internist, or a radiologist, he is a specialist. Unlike these doctors, however, he is a specialist because of what his training and practice include rather than what they exclude.

The Family Doctor's training includes many specialties giving him the knowledge necessary to handle 90–95 percent of all human illnesses encountered in his office. Just as important, this educational background and his practice orientation enable him to offer continuing and comprehensive care to all his patients, regardless of the sex or age of his patients in the environment provided to him by the family and the community.

A most important part of the Family Doctor is continuity of care. This means that he is always your doctor even when he prescribes consultation with another specialist. He never relinquishes full responsibility for the supervision of your health. The Family Practitioner or Family Doctor is deeply interested in preventive medicine, which means that he is just as interested in keeping you healthy as in getting you well. In other words, the Family Practitioner is the only doctor who specializes in you, the patient.

HOW IS A FAMILY PRACTIONER TRAINED?

Family Practitioner training is completed in a three year residency training program. This residency training program begins immediately after graduation from medical school. The Family Practice Residency Training Programs accomplish the following:

They emphasize the need to have a strong but broad basic fund of medical knowledge (community medicine, dermatology, internal medicine. obstetrics and gynecology, pediatrics, psychiatry, surgery, etc.) and to excel in diagnostic skills in both the physical and behavioral areas.

They emphasize the need to excel in the treatment (management) of common medical problems in both the physical and behavioral areas.

They emphasize human behavior and an understanding of the ways in which the individual patient relates to the community of relatives, friends, job, school and church in which he lives.

They emphasize the need to involve the patient and the patient's family in the health care decision making process.

They emphasize the need to humanize medical education, to work with and assist the residents in building strong, healthy family relationships, to share their medical responsibilities with other physicians, to utilize sound office management techniques, and to allow time within their busy professional lives for rest and recreation as well as continued medical study.

They emphasize the need for patient education and application of preventive medicine techniques.

They emphasize the need to maintain good health through patient education programs and application of preventive medicine techniques.

They emphasize the involvement of other health professionals in meeting the health needs of the patient, to share the health care responsibility with appropriate health professionals to the end that health care services might be more accessible and available to the patient.

Last, and perhaps most important, they emphasize the need for the family physician to listen to and hear what the patient and the patient's family are

saying, to respond in a caring manner to the patient's emotional and physical needs, to be aware that the patient's trust and respect is not automatic but rather a precious relationship to be earned by the physician as he provides continuous comprehensive, general medical care to patients of all ages.

CAN FAMILY PRACTICE RESIDENCY PROGRAMS PRODUCE FAMILY PRACTITIONERS FOR THE STATE OF GEORGIA?

Created in 1969, Family Practice is a new specialty with a good track record. Beginning with 16 residency training programs, there are now 280 programs training 4,700 residents.

As many as 70–85 percent of residents graduating from a Family Practice Residency Training Program practice in the state in which they were trained.

Nationally, 1976 graduates of Family Practice Residency Training Programs are establishing practice in small and medium size towns:

	Percent of graduates
Population less than 5,000	16
Population less than 15,000	38
Population less than 30,000	55
Population less than 100,000	79

Physicians are more likely to stay within the state in which they completed residency training than the state in which they completed medical school.

Strong, high quality Family Practice Residency Training Programs will not only provide training for graduates of State medical schools but will attract graduates of out-of-state medical schools to Georgia for their residency training.

Graduates will very likely stay within 100 to 150 miles of where they were trained.

High quality Family Practice Residency Training Programs will attract medical graduates from medical schools outside of Georgia. A significant percentage of these physicians will establish practice in the State of Georgia. Thus, these graduates from out-of-state medical schools will not only stay to practice in Georgia, but the State will not have had to pay for their medical school education.

WHY TRAIN FAMILY PRACTITIONERS?

Presently, the State of Georgia is underserved by family and general practitioners. Even though over 60 percent of the private practice, primary care physicians (family-general practitioners, internists, pediatricians, surgeons, emergency room physicians) are family-general practitioners.

Presently, 16 counties have no family practitioners.

Presently, 111 (70 percent) counties are underserved by family-general practitioners.

Presently, 50 percent of the private practice family-general practitioners are over age 50.

Just to replace these physicians as they reach age 70 over the next 15 years will necessitate training over 800 family practitioners.

Based on population growth and physician retirement at age 70, projected physician deficits are: 1975, 500 primary care physicians; 1980, 700 primary care physicians; and 1990, 1200 primary care physicians.

To train Family Practitioners to meet these needs is a formidable challenge. To meet this challenge:

1. Existing programs must have adequate financial support to provide high quality training for Family Doctors.
2. New residency programs must be begun in the State of Georgia.
3. The State of Georgia must assume significant responsibility for financial support to these programs.

PLAN TO TRAIN FAMILY PRACTITIONERS FOR GEORGIA

To develop Family Practice Residency Training Programs in strategic locations throughout the state.

Location of Family Practice Residency Training Programs to be determined by:

1. Need for Family Practitioners in several county areas.
2. Request from community for such a program.

3. Commitment by the community and area served to financially support, in part, the training program.

4. State funding available to materially support the training program.

This plan would educationally support each community located Family Practice Residency Training Program, and it would be affiliated with a medical school having an active and approved Department of Family Practice.

The 5-year plan proposed by the Joint Advisory Board for Family Practice would:

1. Devote the first year to strengthening the existing Family Practice Residency Programs (Augusta, Columbus, Macon, Rome, and Savannah).
2. Add two new Family Practice Residency Training Programs to the existing programs the second year and each of the three subsequent years.
3. Maintain yearly Family Practitioner manpower studies to aid in the placement, within the state, of graduates from Family Practice Residency Programs.
4. Begin at 80 residents in training the first year and expand to close to 200 residents by the fifth year. Approximately one-third of these residents would graduate into practice each year.

PROPOSAL TO THE STATE OF GEORGIA

We, the Joint Advisory Board for Family Practice, propose that beginning July 1, 1977, the State of Georgia:

Support, by appropriate funding, approximately sixty percent (60 percent) of the total cost of existing Family Practice Residency Training Programs within the state of Georgia. The five (5) year projection of state funds required is:

Fiscal year 1977	$4,041,961
Fiscal year 1978	6,073,287
Fiscal year 1979	7,243,340
Fiscal year 1980	8,466,717
Fiscal year 1981	10,062,906

Provide funds to develop, in an organized stepwise manner, a network of Family Practice Residency Training Programs throughout the state, strategically located to provide maximum assurance that Family Practice Residency graduates practicing in the state will meet the health manpower needs.

To provide funding to assure high quality training programs by salary supplementation of faculty; by providing a communication and data collection system linking all Family Practice Residency Training Programs, a system which will monitor quality and aid in the affiliation of all community hospital based programs with an accredited medical school based department of Family Practice.

The specific funding commitment of the State of Georgia will be as follows:

Support the net cost of training Family Practice residents (approximately 60 percent of total cost) in existing programs and in newly developed residency training programs.

Support of the "start up" costs of newly developing residency training programs strategically placed throughout the state. These new programs would be developed at a rate not to exceed two (2) per year beginning July 1978.

Support of programs to affiliate all community hospital-based Family Practice Residency Programs with an accredited department of family practice in a medical school.

Support programs which will insure high quality Family Practice Residency Training Programs.

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ADDITIONAL INFORMATION

1. "Family Physicians for Georgia, A Budget Proposal to the State of Georgia, Fiscal Years 1977-1978," Submitted to Governor George Busbee, October 1976.
2. "State of Georgia Primary Care Manpower Needs, Now and Future, 1976."
3. "Requirements for a New Family Practice Residency Program to be Considered for Funding by the Joint Advisory Board of Family Practice."

Copies of the above documents may be obtained by writing the Chairman of the Joint Advisory Board of Family Practice, Dr. Wells Riley.

Cost of printing and distribution paid for by the Georgia Academy of Family Physicians.

Senator TALMADGE. Dr. Davis, I want to congratulate you for an excellent statement and in the interest of time, I'm going to suggest that the remaining witnesses insert your full statement in the record, summarize it, and get to the heart of the issue as rapidly as you possibly can. Who's the next witness? Doctor, I believe you are from McIntosh County?

Dr. SNOW. Yes, sir.

Senator TALMADGE. The only doctor in a county of 11,000 population. If you will, insert your full statement in the record and summarize the heart of it. I may suggest that I've read it in detail and I think it's an excellent statement.

STATEMENT OF DR. JAMES S. SNOW, D.O., DARIEN, GA.

Dr. SNOW. Thank you, sir. I appreciate being invited, Senators. I can assure you that we on the marshland coast of Georgia are aware of what both of you are doing on the national level to help us in rural health care and we appreciate it.

You mentioned I practice in a country of about 11,000, actually the population is closer to 9,000, but growing. We are located in McIntosh County on the coast of southeast Georgia. I'm the only physician in this county. The county has no hospital. We must travel a distance of 40 miles or more to the nearest hospital. The hospital I use is the Liberty County Hospital in Hinesville. There is very little industry in our county. There's one small shoe factory and the major industry is the shrimping industry and fishing.

Senator TALMADGE. By the way, how is that shoe factory doing? Most of them are going out of business.

Dr. SNOW. This one seems to be doing fairly well at present, sir, thanks to Federal support, getting a lot of good Government contracts. It's doing very good at present. We hope that support will continue. We need it badly. I came to Darien about 6 years ago after serving 2 years as a Navy physician at Parris Island, S.C., and fell in love with the coast, originally from the North. We decided—my wife and I decided to stay on the coast and found an area that we thought was very medically underserved to say the least. I figured that starting a clinic there and trying to get an office started would attract more physicians to the area, but we haven't been able to do that as yet for reasons I'll try to briefly outline. My patient load averages 100 to 150 a day. I have a staff of about 10 including 3 nurses, a physician's assistant, a physical therapist, an X-ray technician, and a laboratory technician. In addition to the full day at the clinic, which is not an incorporated clinic, it's simply a sole practice, I must travel about 45 minutes to the hospital we use which is in Hinesville. This puts in quite a long

day and is very taxing, as you might imagine, not for myself only. but for my patients. We are one of the lowest per capita income counties in the State of Georgia.

The county is about 50 percent black, 50 percent white. The main problems that we have are heart disease, cancer, and stroke. It is extremely difficult for the people in our county to receive medical care. Many are elderly. Many are poor. If they own a car at all it can barely make it to the grocery store which is likely to be 5 miles away, let alone to the physician's office which may be 25 miles away. There is no organized county transportation. What transportation that is available might be available through senior citizens groups or through neighbors and relatives. Often these people have to pay $5 or more to come see the physician and then the physician's fee if they are not covered under medicare or medicaid. I do accept, in my practice, both medicare and medicaid. How much longer I'll be able to do this, I'm not sure. The fee schedule for medicare and medicaid is far from adequate. I receive, in my area, $8.10 as of July 1, an increase of 40 cents, for a medicare office visit. This is in contrast to the neighboring county and city, Brunswick, 20 miles away, where physicians receive as much as $15. We do not take patients from Glynn County because they do have adequate medical care in that area. As much as possible we limit ourselves only to McIntosh and the southern portion of Liberty County. Under medicaid I receive $7 for an office visit. This is down $1 from when I first started in 1971. Why, I've not been able to find out although I've definitely tried. In addition to that, peer review under medicaid, the Georgia Medical Care Foundation, has cut these even further and cut out services by telling us what we can and cannot do.

For example, a patient may need a shot of penicillin. I give him a shot and if I submit this to the medicaid board for payment, I'll receive back a copy of the peer review stating that oral medication is indicated for the patient and the shot was not. The patients were not seen, of course, by the Medical Care Foundation and this should be really decided by me. The fees are not adequate for a family practitioner to an area where I am unless they have a heavy practice with paying patients. Approximately 60 percent of my practice is based on medicare and medicaid. My overhead has increased—at least tripled—since I began practice. X-ray film has gone up. The cost of my medications has increased, salaries as well, but yet medicare and medicaid fees, if anything, have gone down. I have not increased my office call fee for my paying patients very much because they simply cannot afford it. So, we're in a bind. We need more physicians and we need to increase, immediately, the fee structure in the medicare and medicaid programs, to make it equal to the urban areas, at least to establish on a national level a standard fee for all services. We must cut down and simplify paperwork. We spend too much time and money in filling out medicare and medicaid forms. The most pressing need, however, besides these problems in our county is the need for a small community hospital as Dr. Davis has stressed in his statement. There is no replacement for the personal care that a rural physician can give to the population.

Dr. Skelton mentioned the clinics, which are a fine idea. We've looked into them. However, in our area we run into a lot of redtape,

where they require matching funds, we don't have them. We need more physicians. More physicians have been interested in our area, but the minute they find we don't have a hospital, we're having to travel 30 to 40 miles to one, they quickly move on. We are in the process now of looking into the possibility of building a private hospital. The red-tape is tremendous, as you are probably aware. We're hopeful that we may be able to overcome this and build a hospital in our county. If not, I'm not sure that I'll be able to stay there for a long period, or, I'm certain that no other physician will come to the area. I think Dr. Davis has stated the reasons why a small hospital is needed in the rural areas and I don't need to go through that. A transportation system for rural patients must be improved and in some cases must be set up completely as in our clinic. Something must be done to get these people to the doctor once clinics or hospitals are established. I think that unless something is done soon, especially with fee structures for rural systems, that we are going to lose many of the physicians that are in rural areas. Unless the physician really loves his people and his country and the area that he is in, it is very difficult for him to stay. Another suggestion has been suggested, for example, income tax breaks, increase in fees, but it is really up to the legislature to decide what can be done. I think that this hearing is a very helpful way to do that and I think that other hearings like this could be done on a State level.

This is the first time that I've ever been contacted to appear before a committee such as yourself and I do appreciate it, but I think that there should be more input from rural physicians on the State and National level to be able to find out what they are doing. I appreciate being invited and I hope to participate again soon.

Senator TALMADGE. Dr. Duttera, will you summarize your statement?

STATEMENT OF DR. MAURICE J. DUTTERA, M.D., SYLVESTER, GA.

Dr. DUTTERA. Thank you. I would like to submit the entire statement, if possible.

Senator TALMADGE. We'll state for the record that it's to be inserted and made a part of the record.

Dr. DUTTERA. I would like to dwell, for just a moment, on a single aspect of the rural health problem and that is the problem of retention of physicians once they are in place in rural health. There are a number of programs designed to get physicians into rural practice operational at this point in time. You mentioned the State scholarships earlier. The National Health Service Corps was also mentioned earlier. There are Federal projects including the Rural Health Committee and the health underserved rural areas program. Both of these are designed to set up model practices in rural areas. We're fortunate enough in LaGrange to have just recently received a bureau grant which we hope to begin to deliver care the first of October. The other recent Federal manpower legislation providing scholarships for medical students who will subsequently service in underserved areas also, down the road, implies to me that there will be an increased supply of these physicians. The question is how to keep them in those rural areas once they are there. And to put it very briefly, my solution to the problem is to try to make

the practice environment attractive enough and to institutionalize that environment such that the care and continuity can be guaranteed over a prolonged period of time. Briefly, I think there are three elements that need to go into this institutionalization of care in rural environments. One is allowing the physician, as Dr. Snow was just talking about, to be able to meet the tremendous demand. There are several Federal programs that are directed toward that, the increased number of the physicians, the nurse practitioners and the physician's assistants, and the legislation to reimburse them directly, as you just mentioned, but that clearly is a major issue that must be grappled with, how a physician meets the demand. The second issue is, How the physician can maintain quality care under these circumstances of the very heavy demand and the removal from other colleagues. There, again, are a number of attempts, some of which are not as effective as we'd like. Continuing education programs for physicians are generally set up more for urban physicians who are able to get away, who are able to travel continuously, than for the rural physician. The PSRO program, which is not active in Georgia, is also directed at this issue. So, you have the problems of meeting the demand, delivering quality care, and——

Senator TALMADGE. Will you yield at that point? When will the PSRO program become effective in Georgia?

Dr. DUTTERA. I have no idea.

Senator TALMADGE. January 1 is the establishing point. The project is in planning at this time. Excuse me, go ahead.

Dr. DUTTERA. The third item is something that's been alluded to several times and that is issue of maintaining a quality lifestyle. Integrally related to that issue is the disincentive currently provided by medicare and medicaid in terms of the fee system, and I won't dwell on it anymore. The other item that enters into the quality of lifestyle question for physicians has to do with their practice arrangements. I think here the concept of group practice is essential. In my view, this sort of group practice, or, at least some Georgia communities, ought to involve a network of physicians who work together connecting a number of communities that might otherwise be able to support only one, or less than one, physician with a centrally located group practice and, perhaps, in this same setting, a centrally located hospital of some reasonable size so that several communities can support it. This involves some loss of economy on the part of small communities, but nonetheless I think it compensates somewhat in that the hospitals are larger and therefore more efficient organizations. So, I think the network concept, the group practice arrangement, will offer an attractive alternative to physicians.

Senator TALMADGE. Doctor, will you yield at that point? I understand in Colorado, which probably has one of the most advanced medical practice facilities in urban and rural areas, was established the first PSRO in the Nation. I believe their medical colleges have an arrangement where they send urban doctors out into the rural areas to practice for a time. The rural doctors come into the urban areas and practice in the hospitals and improve their technique with the latest scientific developments and the latest medical developments. I'm informed that it works superbly in that area. You might look into it and see if it might be applicable in Georgia or any part of Georgia.

Dr. DUTTERA. I think that's a good idea. I would hope that on a level earlier than the time that the physician is practicing he'd been exposed to the urban setting. As you know, many medical schools—school faculties—do not consider the practice mode a reasonable alternative anyway, particularly practice in the rural communities. If you could take medical students, get them into the community early, and see physicians that are doing a reasonable job in that setting, then their own ideas can be much different than if they had not had this exposure. Let me summarize by saying that the elements I think necessary to retain physicians are the ability to meet the demand, the ability to deliver quality care, and the necessity to live a quality lifestyle in that setting. I think these elements together can make the rural practice setting attractive enough to keep physicians and this is the kind of model we're working with in the LaGrange area. Thank you.

Senator TALMADGE. Thank you. I have a brief question of Dr. Snow. Once again the situation you described in McIntosh County in terms of the need for preventive health services appears tailor-made for the WIN program. Don't you think we could train people presently on welfare as nutrition aides who could go out into the county and help create better dietary habits?

Dr. SNOW. Yes, sir. I think there is an excellent opportunity in McIntosh County to utilize such a program. I personally would not have the time to do this, perhaps we can find someone that would be able to do that.

Senator TALMADGE. I wish you'd look into that and see if you could put it into effect. In some areas the WIN program is working very effectively. It takes them off welfare, gives them a living, they render a community service at the same time, they become taxpayers and no longer the beneficiaries of charity. The program works exceptionally well for everyone concerned. I have one statement to add to what you've made. I'm familiar with the problems that you've described concerning the extensive delay in medicaid payments to doctors. Legislation which Senator Nunn and I have sponsored would require the States to pay at least 95 percent of the clean claims within 30 days. Hopefully, this would help solve some of the problems which you described.

Dr. SNOW. Yes, sir. I'm familiar with that act. I've exchanged letters with you on that, as you may recall, but this needs to be done within the fee structure that we need to set up to make equalization between urban and rural areas. We appreciate what you have done on that.

Senator TALMADGE. Senator Nunn, do you have any questions?

Senator NUNN. I appreciate the testimony of all of you. One question—I think all of you agreed that the fee structure is inequitable with reimbursement discrimination against rural doctors. I think everybody in their testimony said that, is that correct? And yet Senator Talmadge said that the American Medical Association opposed provisions in the legislation that would have eliminated or reduced this fee structure discrimination. Have you been in communication with your State medical association people, and have you voiced your opinion on that subject? If so, what is the position of the AMA, and why is that position adverse to what you've testified? Dr. Duttera?

Dr. DUTTERA. I think the position of the Medical Association of Georgia is at odds with the AMA at this point. At their annual meeting they voted to explore with the bureau of health insurance, if that's

the correct bureau, the equalization of these fees within the State which is something that apparently can be done in some States on a local basis if it does not increase the total cost to the medicare and medicaid program, so the MAG is at odds with the AMA and I personally testified before the AMA council on medical services about this matter and I'm not sure why they are not responsive. I suspect it would have to do with the fact that the AMA is basically made up of urban physicians at this point just like some of the other organizations are.

Senator NUNN. Thank you very much. There's one other question I have. Do any of you want to comment on that one?

Dr. SNOW. I would like to add that the Georgia Osteopathic Association is in complete agreement with the MAG as well and I was not aware that the AMA had opposed this but we will make a statement on that as well.

Senator NUNN. I think that if rural doctors are aware that it would probably help, over a period of time, to change their position. One other question, Dr. Davis testified, and I don't believe the other two did, about the need to have each patient pay something toward their bill, even if they are on medicaid. I think that's a good suggestion. I think even if you have to increase the welfare check so that they get more money from the Government but then they pay something toward their bill, I think it will make the practice more meaningful. I'd like to hear from Dr. Snow, who has a rural practice, as to whether he agrees with that.

Dr. SNOW. Yes, sir, I think that the best thing the medicaid program ever did was last year when they were allowing a deductible to be charged of $1, I think it was. It not only cut down on unnecessary visits, because a physician can't really turn down a mother bringing in five children. You can't turn down these children to be seen, yet if they have to pay $1 per child, they're going to think twice about bringing them unless they really need to come see the physician, and it certainly didn't cut down the volume of my practice, it just allowed those to be seen that really needed to be.

Senator NUNN. Do you agree with that, also?

Dr. DUTTERA. Yes, sir.

Senator NUNN. Thank you very much. I think your testimony has been very helpful. I'll just say for the record that Dr. Duttera came here from vacation to testify this morning. We appreciate that extra effort very much and I hope you'll express our apologies to your family.

[The prepared statements of Drs. Snow and Duttera follow:]

PREPARED STATEMENT OF DR. JAMES S. SNOW, OSTEOPATHIC PHYSICIAN AND SURGEON, DARIEN, GA.

Gentlemen, I appreciate the opportunity to present my point of view at your fact-finding discussion on rural health care.

Before I give my opinions and recommendations I would like to describe briefly my own rural practice.

I am located in the town of Darien, population about 2,000, the county seat of McIntosh County. Our county is located on the coast of Georgia halfway between Savannah and the Florida line. The population of McIntosh County is about 8,300, totally rural, and about equally divided between blacks and whites. There is no one major industry, only a small shoe factory and a few smaller interprises. Shrimping and commercial fishing are the main industries. It has one of the lowest per capita incomes in the state of Georgia for all counties. Some people commute to work in Savannah, which is 50 to 60 miles to the north, or to Brunswick, 20 to 30 miles to the south. McIntosh County is about 20 miles wide east to

west direction and 25 miles north to south. There is some very small scale farming but most of the land is pulpwood timber. We have one advantage; Interstate 95 runs through the length of the county, north to south. There is a large senior citizen population, but lately there has been an increase in younger persons. The county as a hold gains about 100 people per year. The educational level is low, the average person having completed less than 8 years schooling. There is no sewer system as yet but the City of Darien is in the process of acquiring one. Currently, there are open land field dumps for garbage.

I have practiced alone since coming to McIntosh County. After completing my schooling and internship, I was sent as a general medical officer by the Navy to Parris Island, South Carolina. The tour of duty there was two years.

My wife and I had time to explore the area around Parris Island and we fell in love with coastal Georgia, especially McIntosh County. It has beautiful islands, beaches and marshlands. The county had had no physician for over a year when we moved here. We had little money and the county was not able to provide financial assistance. I had to borrow money and lease equipment to get started, but I have been very busy since the day I opened in an old building that we have remodeled and enlarged since that time. I am 34 years old and have two children.

My average patient load is about 100 per day, mostly acutely ill walk-in's although we do schedule appointments. The average waiting time for a regular appointment is about three to four weeks. We have to turn down a large number of people daily and advise them to go to a distant emergency room because of the large number of people that we handle. My average hospital inpatient census is about 10 per day.

My patient files contain about 10,000 individual cards, each one representing one patient seen. My practice is limited to McIntosh and Liberty County, the bordering county to the north. I take no patients from other counties because of the large volume that we have in the practice from these two counties alone. My practice covers about one-third of Liberty County. Approximately 60% of my patients are on Medicaid or Medicare, which we accept assignment in both cases.

The hospital that I use for patient care is in Hinesville, Liberty County, near Fort Stewart. It is 40 miles from where I live to the hospital, but it is the closest hospital for the majority of my patients, most of them being from central and northern McIntosh and southern Liberty. The Brunswick Hospital is closer for the people in the southern part of McIntosh County but I do not take patients from that county and most of my patients, as I mentioned, are closer to the Hinesville Hospital. There is no hospital in McIntosh County. A small 50 bed hospital, for example, is greatly needed for this area.

I have a staff of three nurses, one lab technician, one physical therapist, one x-ray technician, three secretaries and a maintenance lady. My x-ray technician also doubles as a sort of PA or physician's assistant. He has retired from the Navy after 20 years in the medical corps. He is not qualified, however, to meet state requirements for licensure as a full physician's assistant because of the two year program involved and therefore his duties are somewhat limited.

Health statistics for the county are interesting. I don't have the exact figures at the moment but our major problems are heart disease, hypertension and cancer, especially abdominal and lung cancer. Parasitic infections are common in children and adults. No doubt the diet of the people in the area has a lot to do with some of the medical problems. The basic diet is heavy in starch (rice) and cholesterol (shellfish and fatty meats).

Access to medical care is difficult for the people in the area. They must drive long distances in many cases. The people are poor and have very limited transportation. Some have no automobile at all and must rely on a small senior citizen's agency which transports a few people occasionally.

McIntosh County has an ambulance service and currently is using one unit. We are in the process of acquiring another unit with the help of state funds. We don't have very many emergency medical technicians, however, and we need several more. The ambulance must travel long distances to get to the patients and to the hospitals because there is no hospital in our county.

Our area is a very good example of a critically short rural medical service area. I am basically the only physician for a population of about 12,000 people, including McIntosh County and part of Liberty County. Some of these people do travel to Savannah, Brunswick or other places to see specialists or other physicians. I refer certain cases to specialists in Savannah, Hinesvville and Brunswick as well. These patients are those requiring surgery or more involved orthopedic

work-up's or internal medicine, for example. I do no major surgery, only minor surgery, such as lacerations and simple casting and setting of fractures. I do not do obstetrical cases, in other words delivery of babies because I have no one to cover me in emergencies. These women must be referred to OB specialists, many miles away.

I have enjoyed practicing in McIntosh County very much but it has meant that I must practice under handicaps that this session with you gentlemen will lift. Hopefully this will lead to improvements in rural health care.

I would like to outline what I believe are the problems in our area and my practice in particularly, and give my opinion on how they might be remedied. I will be speaking about McIntosh County, but I think what I say will by typical of many other areas.

(1) NEED FOR MORE PHYSICIANS

More doctors must be attracted to rural areas. In order to do this, incentives must be given to the perspective doctor who desires to practice in a rural area. A number of suggestions have been made but I believe that increases in the payment for medicare and medicaid patients to a level at least equal to what urban practitioners receive for an office visit would be a start. Currently Georgia medicaid allows me $7 for an office visit and the medicare system allows me $8.10. This is one-half to three-quarters what a city physician would get for an office visit. They don't have quite the heavy overhead that rural physicians have because it is necessary to maintain facilities that city doctors can use in hospitals, such as x-ray or laboratory.

Perhaps an income tax break would help to attract more especially younger physicians to rural areas. It is very expensive to set up practice today. It has at least doubled since I began 6 years ago. My costs are continuously rising. Drugs and supplies are going higher all the time.

(2) NEED TO IMPROVE AND SPEED UP THE PROCESSING AND PAYMENT OF CLAIMS

This could be done soon if the problem were really given great attention by those running especially the medicaid program. Medicare, in Georgia, is handled by Prudential Insurance Company. This company does a great job, at least with my claims, in processing them within 2 weeks. This, however, is not true in many other areas as well. Medicaid, however, is very slow and confusing. I am currently waiting on several thousand dollars in claims that date to March 1st of this year. My cash flow is really a problem. I have bills to pay on time but I can't rely on medicaid regularly to pay claims. The Bureau of Medical Assistance in Georgia gives a number of reasons for this, depending on whom you talk to. The reasons include computer breakdowns, employee vacations, change of personnel, and so forth. They also have a peer review program that, although a good idea, results in even further delays. If I were to attempt to set up practice today in this county under those conditions, It would be impossible. In fact, today I must borrow money at high interest rates to pay my bills and taxes. I get no interest on claims that are not processed for many weeks while medicaid holds them.

(3) CUT DOWN AND SIMPLIFY PAPERWORK

A large part of my time and overhead expenses is due to a large amount of paperwork in trying to get payment. This makes it difficult to give patients proper concentration required to treat them.

(4) A SMALL COMMUNITY HOSPITAL IS NEEDED IN THE CENTRAL PART OF OUR COUNTY

A small community hospital would be of great benefit to any rural area where people have to travel long distances. It is also very difficult for a rural area to attract doctors if there is no hospital in the immediate vicinity. I spend 1½ hours on the road a day traveling to the hospital and back. I have made a survey by letter and phone and know that if we do get a small hospital in our county which would be much closer, at least two surgeons and perhaps two general practitioners would be available at this time. This would be a start to improve care in our area and more physicians I believe would come if the hospital were built. A private hospital company is considering our request to make a survey of our area to see if it would be economically feasible to build a hospital. Our county is too poor to build one on its own.

(5) TRANSPORTATION FOR THOSE UNABLE TO GET TO A PHYSICIAN

Possibly a program could be set up to transport certain qualified people to medical facilities.

I hope that I have been able to present an accurate picture of our situation in McIntosh County. I am sure we are not unique and that there are many similar areas in the country. Some of these, no doubt, are in worse shape than we are.

I am not exaggerating the need for something to be done soon to help rural physicians to stay in areas to serve the people. The problems of attracting new doctors can't be solved until it can be said that the currently practicing physicians are satisfied. I, personally, have chosen to sacrifice vacation time, a good deal of family life and many conveniences too great to list here because I love my practice and the people. But it is getting harder instead of easier to practice here. I hope that solutions can be found to improve conditions so that all concerned are benefited. General and family practitioners are still urgently needed as primary care physicians in many areas of the country that are not benefited by Health Maintenance Organizations, clinics and hospitals.

Thank you for your attention.

PREPARED STATEMENT OF M. JULIAN DUTTERA, JR., M.D., PRESIDENT, SOUTHEASTERN INSTITUTE FOR COMMUNITY HEALTH, INC.

Senator Talmadge, Senator Nunn, it gives me great pleasure to speak before you this morning about problem areas in rural health here in Georgia. As you know well, the rural areas of this country are one of the most medically underserved segments of our population. This finding is particularly true of the rural southeast of which Georgia is a part. The magnitude of the problem is well known to both of you and I will not, this morning, try to further emphasize the needs of the area. Rather, I will attempt to suggest specific areas where these needs might be met and mention specifically areas where modifications of current federal programs might be considered.

It is my thesis that for adequate health services to be delivered to rural areas one must first create an environment where the practice of medicine for physicians and other members of the medical team is attractive. An integral part of creating this attractive practice environment is the removal of any dis-incentives in federal programs to practice medicine in rural areas. In the process of creating an attractive practice environment, three areas must be given special attention in the rural setting:

1. Meeting the high demand for patient care.
2. Maintaining a quality life-style for the practitioner and his family.
3. Maintaining quality patient care.

I would like to consider each of these areas separately and relate to specific federal programs where this is appropriate.

MEETING THE DEMAND FOR PATIENT CARE

The daily patient load for some practitioners in rural areas can be overwhelming. It is not unusual in some settings for a physician to see as many as 75 or 100 patients in his office on a given day. This patient demand for medical services is readily acknowledged as being excessive and requires prompt remedy but must, nevertheless, be dealt with. There are three mechanisms by which the excessive demand for medical services can be met. The first is by increased utilization of pre-existing medical personnel such as nurses. There has not been a great deal of interest, apart from nurse practitioner programs, in upgrading the role of the nurse in the rural setting. There are, however, several striking examples of physicians and nurses who have done this on their own initiative.

The second mechanism is the use of physician extenders, such as nurse practitioners or physician assistants, has been advocated as the solution to the medical manpower needs in rural areas and federal funding of these programs has made possible the training of large numbers of these individuals over the past several years. It has been disturbing to me to note that despite the presence of federal funds to educate these new mid-level health professionals, there has been little attention to their performance in their newly created roles and to mechanisms for improved distributions of these individuals to areas where they are most needed.

The third mechanism for increasing manpower in rural areas is the training of additional physicians. Recent capitation efforts by the Department of Health, Education and Welfare and the recent manpower legislation clearly have an impact. The National Health Services Corps has also contributed to meeting patient care demands in some areas. The difficulty with all of these programs, however, is the fact that the practice setting must be made attractive enough for the people who are brought into rural areas to retain these individuals in the rural practice setting. An effort also must be made to see that the individuals who are being brought into rural areas by new programs are carefully matched with compatable communities. This matching may necessitate selection of physicians with backgrounds that will be more compatible with rural communities initially (such as selection of individuals who have grown up in rural communities, represent certain underserved minorities or have done some of their training in smaller community settings).

QUALITY OF LIFESTYLE

Once physicians have chosen rural communities in which to practice the prime determinants in keeping them there are the ability of the physician to lead a comfortable life-style, to be economically rewarded at a reasonable level and to be able to practice quality medicine. A principal element in being able to lead reasonable quality life is the practice arrangement in which the physician enters. It is my feeling that future rural practitioners should avoid the solo practitioner mode that has been so prevalent in the past and organize into small groups. These groups could then cover a network of clinics in several different small towns that would generate demand for the services of three or more physicians. With this kind of group practice arrangement, physicians can share in the economic benefits of group practice, but more importantly can have adequate time off, cross-coverage and continuing education time. The practice arrangement might require that the physicians live in a central community and serve adjacent communities by commuting; but will offer to all communities institutionalization of their medical services such that the continuity of the medical services does not depend on a single individual. Reasonable economic reward from the practice is also a requirement for a reasonable lifestyle. In this area there are clearly disincentives to rural practice built into the Medicare and Medicaid program. A fee system based on geographic and population boundaries exists in many states that discriminates against rural areas when compared to the cost of living within the areas. For instance, there is no reason for an internist to be paid $8.30 by Medicare-Medicaid program in the city of Atlanta for an office visit and allowed only $6.00 in Heard County. The difference in "usual and customary" fee is more than 33 percent and creates a disincentive for practice in underserved areas. This issue is well known to both of you and thus I will not dwell on it.

Of the other social issues that enter into the creation of a reasonable lifestyle, adequate schools for a physician's children is one of the most important. The last 15 years have been a particularly difficult time for the public school systems in the Southeast and particularly in rural areas where a number of private institutions have appeared. The fragmentation of the school systems has created another obstacle for those desiring good quality public education for their children and wanting to live in rural areas.

QUALITY PATIENT CARE

To most physicians practice of medicine is not satisfactory unless it can be done in such a way that meets certain quality standards. The isolation of rural areas and the present lack of group practice arrangements which provide collegues for consultation make the quality of care issue for many rural physicians a difficult one. Again, the group practice setting seems to offer potential solutions for such problems. In particular, the opportunity to take a week or more off a year to attend continuing education seminars is enhanced by the group practice arrangement. Journal Clubs and discussion of interesting medical cases are also more feasible in this setting.

The quality of the hospital facilities with which the physician is affiliated in this setting also plays an important role in the quality of care issue. Here, again, I would favor the collection of resources of several communities together and the construction of hospitals with 100 or more beds to coincide with the

group practice arrangements mentioned above and to avoid the problem of hospitals which are only marginal in terms of financial survival. This requires improved transportation in the rural areas and may require patients to drive 30–40 miles to hospital facilities. The centralization of hospital facilities does, however, enhance the possibility of group practice arrangements and makes possible the immediate availability of secondary care physicians such as pediatricians, internists, obstetricians, and general surgeons.

Integrally related to the problem of quality care are the roles of the various federally mandated agencies and programs with an interest in this issue. The Professional Standards Review Organizations in the State of Georgia are not yet functional. On the other hand the Health Systems Agencies are functional and are currently submitting their health systems plans and annual implementation plans. The North Central Georgia Health Systems Agency has been very helpful to the LaGrange area and our rural health efforts both in its support of our projects and in technical assistance to us. We feel that within the Health Systems Agency rural needs are well represented both on the Board of Directors and on the various task forces. (I am privileged to serve on the Primary Care Task Force.)

In some rural areas, however, there are special problems in relating to the health systems agencies. The law dictates certain priorities for underserved areas, with particular reference to some of the issues I have discussed above. It also dictates that each Health Service Area shall have a "center", and that the Boards of the Health Systems Agency be apportioned roughly on the basis of the population. These requirements create special problems for some non-urban areas which, in order to have its interest adequately represented, need individuals who are particularly well versed in rural health problems and who can vigorously pursue the interest of rural areas. If those who represent the rural areas on the Health Systems Agency Boards are not vigorous in their representation, the rural areas will again find themselves under-represented and the interest of the urban "centers" over-represented.

The concept that I have attempted to present is one of developing an attractive climate for practice in rural areas. The first step in creating this attractive climate from a federal standpoint is the elimination of the dis-incentives in the fee schedules of Medicare and Medicaid. A second disincentive is the avoidance of any inflationary "cap" currently proposed by the Carter Administration which will have particularly severe consequences in smaller communities.

We have been fortunate enough in the last three years to establish the Southeastern Institute for Community Health, Inc., in LaGrange which is a nonprofit organization addressing itself to many of the issues listed above. The Southeastern Institute is a medical community organization with representatives of the following institutions on its Board of Directors: the West Georgia Medical Center, Inc., the Troup County Medical Society, the Enoch Callaway Cancer Clinic, the Lanier Memorial Hospital in Langdale, Alabama, the Chambers County Medical Society in Alabama and the Callaway Foundation, Inc. of LaGrange, Georgia. The Southeastern Institute has also been strongly supported in its initial organization phases by the Clark-Holder Clinic which has allowed me the time to put this organization together. The Institute currently has two major projects. The first is a pre-practice seminar to be held at Callaway Gardens in October, 1977 during which 50 physicians and their spouses will be brought in for a weekend of sessions which address the question of how to create an attractive environment for rural practice in a community. These physicians will all be third year residents who are planning to into practice in Georgia or Alabama during the year 1978. Into this setting we will also introduce representatives from as many as 40 communities who are interested in recruiting physicans for their communities. Most of the cost of this seminar and other initial operating expenses for the Southeastern Institute have been generously contributed as a part of a grant from the Callaway Foundation, Inc. of LaGrange, Georgia.

The other major project of the Southeastern Institute is a Health Underserved Rural Areas Grant Program for the City of Hogansville which is funded to begin organizational efforts August 1, 1977, and begin delivery of care October 1, 1977. This primary care project is designed to incorporate many of the ideas outlined today and is hopefully the first of a network of primary care centers to be established in the LaGrange area.

I appreciate the privilege of presenting my views for you this morning. Thank you.

Senator TALMADGE. Thank you very much. This has been most helpful, constructive, and enlightening testimony, panel. Next is a panel of

county commissioners that includes Hon. Curry Colvin, chairman of the Lincoln County commissioners; Mr. Otha Dent, commissioner of Crawford County; and J. B. Jones, commissioner of Lumpkin County. Gentlemen, we're honored indeed to have you. We appreciate your coming and I would ask that you insert your full statement into the record and, in the interest of time, summarize it as briefly as possible.

Senator NUNN. I'd just like to say that J. B. Jones comes from up in north Georgia and he came a long way this morning to be with us so we have not only south and middle Georgia represented, but we have the more rural areas of north Georgia, too. We appreciate all of you being here.

Senator TALMADGE. Lincoln County is also somewhat removed from here.

Senator NUNN. That's right, Lincoln, too. We appreciate it.

Senator TALMADGE. You may proceed.

STATEMENT OF HON. CURRY COLVIN, CHAIRMAN, LINCOLN COUNTY COMMISSIONERS

Mr. COLVIN. I believe I understood you to say you wanted us to give a summary on this, is that right?

Senator TALMADGE. Summarize it please, in the interest of time. We're trying to get all the witnesses in.

Mr. COLVIN. I think the highlights of what I wanted to say was some time back we were involved in getting a National Health Service Corps doctor and we found an excellent young physician interested in coming to Lincoln County, and that's something that's hard to acquire, getting him to come to a rural county like Lincoln County is, and we were real happy and everything until we tried to get him approved through the different agencies that he has to be approved by, and due to the redtape he could not wait long enough to get cleared before having an income of some type, so he wound up in Baton Rouge, La. In summary, the most severe health problems in Lincoln County and the CSRA is not disease, but the lack of primary medical care. There is a definite physician shortage. Above were mentioned two programs that could possibly help alleviate the physician shortage problem. Congress should reevaluate both programs so that they can truly solve the problems they were intended for. For instance, medical students apply for low-interest loans to serve in rural areas, then upon graduation they pay these loans back. If a large penalty on the payback was imposed, it is my opinion that they would be more likely to stay in the rural areas, once they got to like it, because they are a nice place to live. HEW set up health systems agencies all over the United States. These agencies in the South do not have sufficient public officials on their boards. The local public official in rural areas catches the brunt of health service problems and some of them should be on HSA's to make needs known and to make policies to help meet them. As to the Health Corps site doctors, once a rural area finds one the community should be able to hire him immediately and then HEW could take their 3 months to fill out all the papers. I thank you very much.

[The prepared statement of Mr. Colvin follows:]

HEALTH PROBLEMS IN LINCOLN COUNTY, GA.

Health resources currently available to the people of Lincoln County are limited. Lincoln County has one General Practitioner, age 60, and one Dentist. And, in addition to Lincoln County, the GP treats patients from Wilkes, Warren, McDuffie, Columbia, Richmond, and McCormick Counties. The GP treats patients on a first come first serve basis.

The other health resource in Lincoln County includes a Health Department. Its full time staff consists of one Registered Nurse, one Clerk and one Homemaker Aide.

The Health Department's part-time staff consists of one Family Planning Aide, which is shared with Wilkes County and is in Lincoln County on Tuesday and Thursday. One Family Planning Nurse Practitioner which is in Lincoln County every fourth Thursday of the month. A Family Planning Physician, who serves for family planning one-half day per month, and a Pediatric Nurse Practitioner that serves one day per month. In addition, the Health Department holds one Alcoholic and Mental Health clinic every Monday during morning hours only.

With 67 percent of the county's population being less than 45 years old, Lincoln County has the potentials for a number of health problems in the future. In 1974, based on a projected population of 6,300, there were 55 deaths in Lincoln County which gave the county a rating of 8.73 per 1,000. Two of the leading causes of death were heart diseases (20) and cancer (12). Among others were: Cardiovascular disease (6), diseases of respiratory systems (3), disease of urinary tract (2), and other diseases of arteries and veins (2). On the other hand, the county had 88 live births. Of that number (88), 27 were born to unwed mothers and 3 were premature.

Lincoln County does not have a hospital. A 60-bed hospital is located 20 miles away in Wilkes County. Five hospitals are located in Augusta approximately 40 miles from Lincolnton. The industries in and around Lincoln County, which employ approximately 343 people, now have to transport an injured employee from 20 to 40 miles to get medical attention.

In the immediate area, there are three schools which have a current enrollment of approximately 1,843 students. In the event of accidents during school hours, these children must be transported from 20 to 40 miles for medical attention. Though the county has a good road system, the high cost of personal transportation prevents many people from seeking medical care before a minor health problem becomes a major illness. The county does not have public transportation. The ambulance service is provided by the county. The travel time required to receive emergency medical attention increases the potentials for complications and possibly extends the amount of time lost from work due to illness.

Lincoln County was rated number one (1) in the State of Georgia in 1975 using the Department of Human Resources total component index scores to determine the most severe medically underserved nonmetropolitan counties. The first place was achieved by a total index including infant mortality, poverty population, aged population, and primary care physician indexes.

On July 6, 1976 Lincoln County was designated by the Public Health Service of the U.S. Department of Health, Education, and Welfare (HEW) as both a critical medical shortage and a critical dental shortage area. In addition, the county is also designated as a medically underserved area.

Lincoln County's health problems can be summed up in one sentence. There is a shortage of doctors. Lincoln County, while having one of the most severe health problems in the State, is not unique. In the Central Savannah River Area (CSRA), comprised of thirteen (13) counties including Lincoln, the number one (1) priority in the 1976 Area Development Plan (ADP) was the need for additional doctors.

Primary care physicians (PP) are needed not only in the rural areas of the CSRA, but in metropolitan Richmond and Columbia Counties as well. According to the Georgia Primary Care Manpower Study, 1976, there is a cumulative deficiency of Primary care physicians in the CSRA of forty-seven (47). Only two (2) counties, Wilkes and McDuffie had a surplus of PP's. By 1990, the study predicts that all of the CSRA counties will experience a lack of Primary Care Physicians. The deficit in that year will exceed 70 PP's.

The federal government has two programs that could help eliminate the doctor problem in Lincoln County and other rural areas. The first program is the National Health Service Corps. Lincoln County recently has been designated as an eligible corps site. Yet, when the county began its search for a physician, problems

occurred. Lincoln County found an excellent choice for a doctor. He was very much impressed by the community and their need of his services. The county then tried to have the perspective doctor signed up by the National Health Service Corps.

At this point, the "red tape" that goes with all federal programs came to pass. Our perspective doctor had to be screened and hired by the U.S. Civil Service Commission and the Public Health Service. This process was scheduled to take three (3) months. Because of the delay, our doctor was lost. He just couldn't wait that long for the job. In an area like Lincoln County where physician shortage is chronic, delays such as waiting three (3) months will cause the county to never obtain a doctor to serve our community.

The second program that the federal government has which could possibly help our situation is the Rural Health Initiative Program. As designed, this program could solve problems of rural areas. Yet, in Lincoln County and all the counties of the C.S.R.A. this program is biased against our problems. In order to qualify for funds under this program, an area must be designated as three (3) of four (4) possible problem areas: (1) Medically underserved, (2) critical health manpower shortage, (3) high migrant impact, and (4) high infant mortality.

This criteria will work well in an area such as Texas with a high migrant population. But for Lincoln County and the other C.S.R.A. counties where there is no migratory population, you are required to meet the three remaining. This excludes Lincoln county and every individual county within the CSRA. The only viable alternative under this program is to apply using a multi-county service area. Lincoln County would have to joint with at least three counties to qualify. However, the East Central Georgia Health Systems Agency, Inc. has informed me that they think we meet three of the four criteria. If HEW recognizes this fact then we will be eligible and will be ready to face the red tape battle.

SUMMARY

The most severe health problem in Lincoln County and the CSRA is not disease, but the lack of primary medical care. There is a definite physician shortage. Above were mentioned two programs that could possibly help alleviate the physician shortage problem. Congress should re-evaluate both programs so that they can truly solve the problems they were intended for. For instance, medical students apply for low interest loans to serve in rural areas then upon graduation they pay the loan back. A large penalty for this payback should be imposed and other measures implemented to get doctors in rural areas.

HEW recently set up Health Systems Agencies all over the United States. These agencies in the South do not have sufficient public officials on their Boards. The local public official in rural areas catches the brunt of health service problems and some of them should be on these H.S.A.'s to make needs known and to make policies to help meet them.

As to the Health Corps Site Doctors, once a rural area finds one the community should be able to hire him immediately and then HEW could take their three months to fill out all the papers.

Senator TALMADGE. Thank you, sir.

STATEMENT OF OTHA DENT, COMMISSIONER, CRAWFORD COUNTY, GA.

Mr. DENT. Senator Talmadge, Senator Nunn, the data which is presented for the record is reliable and timely. We have no ax to grind, and the ground rules places upon my people gathering this information and this data was don't tend to make this report negative or positive, just tell what's happening in Crawford County, healthwise. My statement is based not as a medical expert but as a county commissioner with the responsibility and final authority to set the budgets. Crawford County ranks 147th in population out of 159 counties in Georgia. Crawford County is a good place to live but a poor place to attempt to make a living. Latest unemployment data indicates 8.9 percent of our work force unemployed. That percentage represents 165 people

out of a total work force of 1,860, and this during peach season when there is maximum employment. 35.8 percent of our citizens are considered by the Federal Government——

Senator TALMADGE. Will you yield at this point? Dr. Reich, your office is on the phone. Go ahead.

Mr. DENT. 35.8 percent of our citizens are considered by the Federal Government to be below the poverty line. Latest 1977 data, which represents 1974, shows per capita income of Crawford County at $2,232. Compare this with Bibb County at $4,167. Poor health and insignificant health service in Crawford County is of valid concern. Health in Crawford County is placed in the authority of our doctor's clinic, health department, and ambulance service. Health is 21.62 percent of our tax levy. Briefly, doctor's clinic—we have one foreign physician who speaks poor English practicing on a P.S. which is a provisional certificate. He averages about a half day off a week if he can be spared. He states upper respiratory infections are the greatest number of cases which he sees. As the county commissioner, my responsibility and final authority with him is to see that he gets paid. We guaranteed him $36,000 plus all he can make over that. We furnish everything. He also has a side contract with a local nursing home of $3,000—which would equate to about $3,000 a year. In your folder marked "Crawford County—Rural Health" there is a list of our efforts to acquire adequate medical service in Crawford County. This list is a chronological explanation dating from March 1974 to present. Our needs in Crawford County are a new medical clinic with ambulance facilities attached. Crawford County Health Department—the next section in your folder pertains to the Crawford County Health Department. These seven pages are a synopsis of how the demands have grown, how the program has developed into good working order and shown results—however, all this with the same amount of personnel and limited space.

[The folder referred to above follows:]

CRAWFORD COUNTY—RURAL HEALTH

CONTENTS

Testimony by Otha C. Dent before hearing.
Efforts to obtain adequate medical services.
Health department expansion of programs and needs.
Health department budget July 1, 1977 to June 30, 1978.
Health problems as seen by county school superintendent.
Letter from social security reference little known and seldom understood benefits available to citizens.
Example of medicaid form.
Example of medicare form.

CRAWFORD COUNTY

Area (square miles)	313
Population:	
1970 Census	5,748
1974 Estimate	6,100
1975 Estimate	6,487

Crawford County ranks 147th in population out of 159 counties in Georgia.

Crawford County's total retail sales for 1976 were $11,287,000.00 which includes beer, wine, whiskey sales (Georgia Business Division Research—University of Georgia).

Crawford County is a good place to live but a poor place to attempt to make a living. Latest unemployment data indicates 8.9 percent of work force unemployed; that percentage represents 165 people out of a total work force of 1860 (Labor Department), and this during peach season when there is maximum employment.

In Crawford County, 35.8 percent of our citizens are considered by the Federal Government to be below the poverty line. Latest '77 data, which represents 1974, shows per capita income of Crawford County at $2232.00. Compare this with Bibb County at $4167.00.

Poor health and insignificant health service in Crawford County is of valid concern.

Health in Crawford County is placed in the authority of our Doctor's Clinic, Health Department and our Ambulance Service.

A break down on actual monies spent—local effort only:

	Amount	Mileage	Percent tax levy
Doctor's clinic	$14,000	0.52	5.62
Ambulance service	25,100	.65	7.03
Health department	22,495	.83	8.97
Total	61,595	2.00	21.62

DOCTOR'S CLINIC

We have one foreign physician who speaks poor English practicing on a P. S. (Provisional Certificate). He averages a half-day a week off if he can be spared. He states upper respiratory infections are the greatest number of cases which he sees. The county guarantees a salary of $36,000.00 a year and all that he makes over the $36,000.00. We furnish the nurses and all supplies and the clinic plus all utilities. All he has to do is work, and this he does. In additon to his salary the local nursing home contract of approximately $3,000.00 a year is his also. It is our hope that we will operate in 1978 in the black. In your folder marked CRAWFORD COUNTY—RURAL HEALTH there is a list of our efforts to acquire adequate medical service in Crawford County. This list is a chronological explanation dating from March 1974 to present.

Needs: A new medical clinic with ambulance facility.

CRAWFORD COUNTY HEALTH DEPARTMENT

Next section in your folder pertains to Crawford County Health Department. These seven pages are a synopsis of how the demands have grown, how the program has developed into good working order and shows results; however, all this with the same amount of personnel and limited space. Health education is Crawford County's single largest problem. If there was funding for a nurse in the Crawford County school system to teach Health Education, which would include sex education it would go a long way to solve our problems. Nine percent of school age girls became pregnant in Crawford County and this includes all races—30,000 teenagers became pregnant in Georgia last year. With fifty percent of the child abuse deaths coming from these teenage pregnancies. Twenty percent of our teenagers don't know what really causes pregnancy. Along with more education of our people, we need a dentist and a doctor to serve the Health Department clinic.

CRAWFORD COUNTY EMERGENCY AMBULANCE SERVICE

The Crawford County Emergency Ambulance Service has been in my estimation the single most beneficial addition to the health care in Crawford County in recent years. And because of its infancy it has produced the most confusion, most concern and very recently the most criticism. There are numerous examples to pull from but these stick in my mind presently.

A pulpwood worker cuts himself in the woods and is brought to Emergency Ambulance. Emergency Medical Technicians (EMT's) apply first aid, place in ambulance and carry to Doctor's Clinic. He is a medicaid patient as are about

85 percent of Doctor's Clinic patients. Patient receives excellent medical care, lives, takes a couple of days off and goes back to work. Medicaid forms are submitted for ambulance service and denied because ambulance has to go to a hospital, not a clinic, even though Doctor is a medicaid doctor.

Blue Cross and Blue Shield deny any responsibility of charges which occur with our Ambulance Service. In turn we don't get paid for our supplies, our gas and expenses involved in transporting emergency patients to Macon Hospital, to Upson County Hospital and in remote cases, to Atlanta hospitals.

Their reason: We are federally funded. The Federal Government paid 70 percent on a $12,000.00 ambulance and that is the last we have seen of them.

Your small communities are operating a much needed emergency service right out of the Ad Valorem general fund. Your large communities are federally funded and send no statements on emergency service. Atlanta dispatches an ambulance, a squad car and a fire truck to each automobile accident. No one is charged and come budget time they show a paper loss or paper cost of so much per vehicle, and so much per man, thus equalizing for another Federal Grant. The small community is paying a disproportionate share of Emergency Ambulance Service.

Regulations restricting drivers to be EMT are impossible to meet.

Medicare and Medicaid is alive and doing very well in Crawford County. If it was not for these two government programs many of our citizens would not be any better off than they were in the thirties.

EFFORTS TO OBTAIN ADEQUATE MEDICAL SERVICE FOR CRAWFORD COUNTY

March 1974, Practicing physician closed office.

April 1974, Local officials contacted Regional Health Office for assistance in obtaining doctors. Began work on application with National Health Corp to obtain doctors.

Summer 1974, Obtained support and involved local people in application and letters of need.

September 1974, Filed application with HEW and Health Corp for 2 doctors.

January 1975, Notified by Health Corp that county qualified for 2 doctors. Met with Mr. Bob Faggard (HEW) to find out what community needed to do to prepare for doctors. Set up medical council for preparation.

February 1975, No Health Corp doctors in sight. Held public meeting for opinion for county to contract with 2 foreign physicians with provisional license.

March 1975, Contracted with 2 foreign physicians. Medical council with county commissioners located building for offices. Bought equipment and set up offices.

April 1975, Hired nurse and secretary. Offices opened.

December 1975, Offices remained in operation at a loss.

February 1976, Filed application with HEW for Rural Health Initiative Assistance.

February 1976, Proposed: Resident doctors from the Medical Center of Central Georgia, Macon, furnish medical coverage to Roberta and Crawford County. Assistance, liaison, administration would be provided by Mercer University Medical College. Building, equipment, utilities and other financial assistance to be provided by Crawford County.

June 1976, Application approved by HEW, but not funded. Program could not be implemented because resident recruitment was insufficient to staff satellite station as proposed. Crawford County renews contract with one foreign doctor for one year.

January 1977, Because of uncertainties in medical coverage, the Health Corp was asked to reactivate doctor recruitment.

June 1977, Another year contract given to foreign doctor.

July 1977, New doctor's office proposal placed as first priority in construction.

In March of 1973 the only programs at the Crawford County Health Department were Family Planning and Immunizations. There were 10 Crippled Children, 2 Tuberculosis cases and 8 After-care cases.

In April of 1973 we began the EPSDT Program.[1] This consists of a physical appraisal by a nurse and the following items: Medical history; Nutritional history; Sickle Cell testing; urine testing; hematocrit (anemia); vision; hearing; and ear, nose, throat and dental inspection.

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[1] EPSDT—Early Periodic Screening Diagnosis and Treatment.

Proper referrals are made to Medicaid providers and follow-up is done to encourage parents getting necessary corrective measures. Clients are taken from the current medicaid eligible list and encompasses children from 0 through 20 years of age on a regular repeating basis. Current list contains 374 eligibles. A total of 676 have been screened, as the list changes from month to month. Some of these have been screened as many as five times according to age. Two hundred sixty-three (263) home visits have been made just in 1977 as follow-up to this program.

Needs regarding this program are:

1. Another R.N. to help screen.
2. More education on part of parent—at this point there is not enough time to spend on educational sessions.
3. A full time L.P.N.
4. Transportation.
5. A doctor to serve clinic.
6. A dentist to serve clinic.

Early childhood program was begun in April of 1973 with cooperation of school system. Potential kindergarten eligibles were screened in the same manner as the EPSDT program. This lasted for one year only.

Needs

1. To be resumed as many children were found who needed to be placed in special classes according to intelligence and cultural deprivation.
2. Many were found with physical handicaps.
3. A source to get medical attention money-wise.

Family Planning offers a physical examination and birth control method to anyone desiring services. We have 301 active clients.

Needs

1. More time for more education of client.

(*a*) Could be accomplished by a physician or nurse practitioner to serve clinic on a weekly basis. At present it is served by a Nurse Practitioner on a bi-monthly basis.

2. More clerical help.

Immunization program is done on a weekly basis. Two hundred-forty (240) immunizations have already been given in 1977, but still there are a great many who are far behind.

Needs

1. More education on part of parents.
2. More cooperation between schools and health department.

Crippled Children's cases have increased to forty-six (46).

Needs

1. Transportation for clients to get to clinic.

An Alcohol Program was begun in 1976 on a weekly basis.

Needs

1. Cooperation between businesses and clinic to get client to come.
2. More education on part of public.

An After Care Program has been in effect for years. This is follow-up care for persons that have been hospitalized with mental illness. Until July 1977 these clients went to Bibb County for this service. The local health department contracted with Bibb County for this service. The first After Care clinic was held here on July 21 and twelve (12) patients were seen. A psychiatrist from Central State Hospital staffed the clinic.

Needs

1. Mental Health social worker or technician to talk to clients. This is main thing some of them need.
2. Transportation.

Tuberculosis is down. We have only one known case in the county at present.

Vision, hearing and dental screening is required for all children entering school for the first time with a certificate stating they have had it and the results. Follow-up should be done for any abnormalities.

Needs

1. More time for followup.
2. A source to refer low income families for financial help.

The WIC Program is now being administered here. This is funded by Department of Agriculture and is to help children 0–5 years of age, pregnant women and lactating mothers with a problem related to nutrition.

Needs

1. Not enough time for education of parent.
2. Follow-up should be done as a matter of principle on those with extreme problems.

Prenatal clinics are held weekly. The caseload varies. Clinic is staffed by nurses only. For those with problems of pregnancy and falling into the proper income level, state funds are available. These patients have to be seen here as well as the Medical Center in Macon. They have to be delivered at the Medical Center as that is the only hospital in the area that accepts the program other than Upson County Hospital and only one doctor there accepts it.

Needs

1. A doctor to staff clinic.
2. More education for clients.
3. Transportation.

Numerous other services are offered, such as blood pressure readings, B_{12} injections, etc. with a doctor's order.

Vision and hearing is done in schools annually with approximately 1,000 children being screened.

Needs

1. Better follow-up.
2. Financial resources for needy.

V.D. is done on a limited basis, mainly through family planning clinic.

Needs

1. Public education.
2. Special VD clinics.

Mental health consultation is available on an appointment basis to anyone. This is for people who have an emotional problem but have never been hospitalized.

Needs

1. A mental health worker should be available more often—possibly as much as daily.

Sanitation is covered by a worker jointly with Peach County. Approximately 20% of his time is meant to be spent in this county but a great deal more is actually spent. All new buildings, septic tank installations, food establishments, schools and nursing homes have to be inspected.

Needs

1. A sanitarian trainee or technician.
2. More time spent in county.

REMARKS

A great deal of time is spent on paper work. While we recognize that a certain amount needs to be done, some of it could be eliminated. It appears quite often the paper work is more important than the patient.

Also, forms are frequently changed. It has happened that a form is obsolete before it can be put into use.

Another problem is that quite often Medicaid requirements are so strict that the patient suffers for it in that less time can be spent with the patient.

Often a program is begun and the staff has not had proper orientation or training.

Quite often the pressure on the staff is tremendous.

Needs of health department

1. A full time L.P.N.
2. A part time R.N.

3. A full time clerk.
4. A larger building.
5. A paved parking area.
6. A full time sanitarian.
7. A full time aide/maid.
8. A home health service for disabled.
9. More state participation in financing of budget.
10. Health educator or a nurse who does nothing else.

Needs of community

1. More services offered to general publication. Beginning August 16, screening services will be available for clients not served by the EPSDT program.
2. More community education programs—many problems can be prevented with education; such as Diabetes, blood pressure and obesity.
3. Sex education in schools.
4. Screening clinics for cancer, high blood pressure, glaucoma and diabetes.
5. Financial aid for needy families not on medicaid.
6. A doctor to staff clinic.
7. A dentist is greatly needed in county—99 percent of referrals made are for dental problems.
8. Transportation.
9. A school health nurse.
10. C.P.R. courses.
11. First aid courses.
12. Preparation for parenthood classes.

CRAWFORD COUNTY HEALTH DEPARTMENT

[July 1, 1977 to June 30, 1978]

	State	Local	Total
Total budget:			
This year	$19,907	$27,810	$47,717
Last year	17,575	15,458	33,033
Difference	+2,332		14,682
Personal services account:			
This year			44,096
Last year	[1] +10,762		24,406
Difference	[2] +1,730		19,690
Travel expense account:			
This year	[3] +1,152		2,732
Last year	[4] −50		1,030
Difference	[5] +600		+1,702
Equipment:			
Sanitation salary	9,132		
County's part 58.20 percent	5,315		
Other expense account:			
This year			6,590
Last year			6,301
Difference			+289
Nonparticipating items:			
This year	[6] +200		1,496
Last year			1,296
Difference			+200

[1] Allocate sanitarian trainee/sanitarian positions.
[2] M.S. increases.
[3] Sanitarian travel.
Out-of-county travel.
[5] LPN travel.
[6] Conference travel.

GEORGIA DEPARTMENT OF HUMAN RESOURCES—COUNTY BUDGET

SUMMARY

[For the fiscal year July 1, 1977, through June 30, 1978]

COUNTY: CRAWFORD; BUDGET DESIGNATION: PHYSICAL HEALTH

A. Resources:	Amount
1. State	$19,907
2. County:	
Participating	26,316
Nonparticipating	1,496
3. Federal (special projects only)	
4. Fee collection	
5. Other (specify)	
Total	47,715

B. Proposed expenditures:

Account	1st quarter	2d quarter	3d quarter	4th quarter	Total
Personal services	9,682	11,096	11,554	11,764	44,096
Travel expense	683	683	683	683	2,732
Equipment					
Other expense	1,826	1,588	1,588	1,588	6,590
Subtotal	12,191	13,367	13,825	14,035	53,418
State	(4,977)	(4,977)	(4,977)	(4,976)	(19,907)
Local	(7,214)	(8,390)	(8,848)	(9,059)	(33,511)
Fee collection					
Other					
Nonparticipating	424	324	324	424	1,496
Total					54,914

I certify that this is an accurate representation of the anticipated resources and expenditures of the above designated County Board for the period indicated. I further certify that State and any county matching funds included herein shall be expended in accordance with applicable, State, Federal, and local laws and regulations.

Signed ______________________ ______________
Chairman, County Board of Health or Family and Children Services (as applicable) Date

Approved ______________________ ______________
Area network director, DHR Date

Approved ______________________ ______________
Budget Unit, Department of Human Resources Date

PERSONAL SERVICES

[Please refer to budget instructions and sample budget format for listing and order of arrangement of items to be included on this form]

MS Job No.	Name	Merit system title and grade	Proposed expenditures: 1st quarter	2d quarter	3d quarter	4th quarter	Total
	I. PERSONAL SERVICES ACCOUNT						
	A. Regular salaries:						
03201	Betty C. Williams	Senior staff nurse, 15-5, Apr. 1, 1978.	2,919	2,919	2,919	3,054	11,811
03901	Louise B. Fontenot	Clerk-typist, III, 12-7, Nov. 1, 1978.	2,465	2,464	2,465	2,464	9,858
03301	Sanitarian trainee [1]	13-1	2,102	2,101			4,203
03301	Sanitarian	15-1, July 1, 1978			2,465	2,464	4,929
	Total, regular salaries		8,088	9,288	9,677	9,855	30,801
	B. Pensions and benefits:						
	1. Retirement (8 percent)		647	743	774	788	2,952
	2. Social security (5.85 percent).		473	543	566	577	2,159
	3. Insurance (4 percent)		324	372	387	394	1,477
	Total, pensions and benefits.		1,444	1,658	1,727	1,759	5,497
	C. Other personal services:						
	M.C.H. clinician	24 hr at $25/hr	150	150	150	150	600
	Total, other personal services.		150	150	150	150	600
	Total, personal services		9,682	11,096	11,554	11,764	36,898

[1] Budget as sanitarian 15-1 effective Jan. 1, 1978.

ITEMS OTHER THAN PERSONAL SERVICES

[Please refer to budget instructions and sample budget format for listing and order of arrangement of items to be included on this form]

Budget category and description	Proposed expenditures 1st quarter	2d quarter	3d quarter	4th quarter	Total
II. TRAVEL EXPENSE ACCOUNT					
A. In county travel:					
1 nurse at $50/mo	150	150	150	150	600
1 LPN at $50/mo	150	150	150	150	600
Etheridge Plair, Part-time sanitarian	45	45	45	45	180
New sanitation position	288	288	288	288	1,152
Out-of-county training	50	50	50	50	200
Total, travel	683	683	683	683	2,732
III. EQUIPMENT					
IV. OTHER EXPENSE ACCOUNTS					
A. Supplies and materials:					
1. Office supplies	100	100	100	100	400
2. Clinic supplies and materials	125	125	125	125	500
B. Communication services: Postage and telephone	225	225	225	225	900
C. Heat, lights, power, and water	225	225	225	225	900
D. Printing and publicity					
E. Property and equipment maintenance	263	25	25	25	338
G. Contracted services: Part-time (20 percent) services of sanitarian purchased from Peach County	863	863	863	863	3452
H. Miscellaenous	25	25	25	25	100
Total other expense accounts	1,826	1,588	1,588	1,588	6,590

NONPARTICIPATING ITEMS

Budget category and description	1st quarter	2d quarter	3d quarter	4th quarter	Total
II. TRAVEL EXPENSE					
A. Travel supplement:					
Position 0609311	105	105	105	105	420
District director of nursing	39	39	39	39	156
Total	144	144	144	144	576
B. Contingent travel: Subdistrict sanitarian: 12¢/mi—$180 per quarter maximum	180	180	180	180	720
C. Conventions	100			100	200
Total	424	324	324	424	1,496

CRAWFORD COUNTY BOARD OF EDUCATION,
Roberta, Ga., August 15, 1977.

Mr. OTHA DENT,
County Commissioner,
Crawford County Courthouse,
Knoxville, Ga.

DEAR MR. DENT: I am aware of your continued interest in the health care problems of both the citizenry of Crawford County as a whole and the students in the Crawford County School System in particular. I would like to draw your attention to several areas of concern which have been voiced by our faculty, administration and Board of Education.

First of all, the vast majority of our students come to us with poor nutritional habits which I believe in turn lead to substandard health in many areas. For many of our students, the free or reduced lunch which they receive at school is the only standard meal received during the day. I believe that education in this area is the only way to solve this problem.

Secondly, during the extremely cold winters, which we have experienced over the last two years, our students have experienced to a great degree respiratory difficulties. This is probably due to the substandard housing in which many of our students live and the lack of proper clothing.

Thirdly, most of our students have little or no training in planned parenthood. As a result, they experience difficulties with premature parentage, which results in many problems of which you are aware.

I support your efforts in trying to obtain for our rural areas improved health services, both of a preventive and curative nature.

Sincerely yours,

DR. CHARLES M. HILL,
Superintendent, Crawford County Schools.

SOCIAL SECURITY HEALTH INSURANCE CERTIFICATE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
August 4, 1977.

Claim Number: 260-16-7082 M.

Name and address of the claimant or representative of the claimant: Loid H. Amerson, Roberta NRSG HM, Box 146, Roberta Ga. 31078. Date of entitlement: July 1977. Type of coverage: Medical.

This certifies that you (or the person(s) on whose behalf you applied) is entitled on the date indicated to the insurance benefits shown under Title XVIII of the Social Security Act.

A monthly premium is required to keep you medical insurance protection. However, the state in which you live will pay your premiums.

Neither monthly benefits nor premium-free hospital insurance benefits are payable on your record because you have not worked long enough under social security. To qualify for benefits you need 24 calendar quarters of work. For hospital benefits, you need 24 quarters of work. You now have 12. The enclosed leaflet explains how a person earns social security work credits. If you earn the additional quarters, please contact any social security office promptly.

Although you are not now elegible for premium-free hospital insurance, you may be eligible to purchase this insurance at the current premium cost of $54.00 per month. You can get a full explanation of this type of hospital insurance by contacting any social security office.

If you need medicare services before you receive your health insurance card, you may use this notice as proof of coverage. You should receive your card within 4 weeks.

JAMES B. CALDWELL,
Commissioner of Social Security.

GEORGIA DEPARTMENT OF HUMAN RESOURCES—MEDICAID MANAGEMENT INFORMATION SYSTEM

INDIVIDUAL PRACTITIONER AND DENTAL SERVICES

[Provider information: No. 00062224A; Orlando G. Balcos, M.D.; 354 Wright Ave., Roberta, Ga. 31078]

	Type of service—Physician						
Recipient name and ID	Transaction control No.	CAT svc	Prior auth No.	Medical rec No.	Bill date	Date ser/dsp	Amount payment
L. Gibson: 0390020926D	77158-20-099-42-01	43			6- 1-77	5-19-77	$8.00
Emilda Lemire: 0390026271D	77158-20-099-47-01	43			6- 1-77	5-19-77	12.25
Clara Green: 0390013392D	77175-20-030-15-01	43			6- 1-77	5-11-77	4.00
Maggie Jones: 0390026371D	77178-20-061-03-01	43			6-24-77	6- 8-77	8.00
Clarence Rogers: 0390026591D	77178-20-061-04-01	43			6-24-77	6- 8-77	8.00
Florine Harvey: 0390022282C13	77178-20-061-05-01	43			6-24-77	6-15-77	11.00
Angela White: 0390024421C19	77178-20-061-06-01	43			6-24-77	6-20-77	10.00
Lillie Webb: 0390003152D	77178-20-061-07-01	43			6-24-77	6-20-77	14.00
Darrell Hicks: 0390027542C13	77178-20-061-08-01	43			6-24-77	6-13-77	11.00
Travis Morgan: 039002 351C14	77178-20-061-09-01	43			6-24-77	6-13-77	13.00
Vonda Willis: 0390020123C18	77178-20-061-10-01	43			6-24-77	5-24-77	8.00
Lee Mrogan: 0390021351C13	77178-20-061-11-01	43			6-24-77	6-13-77	18.00
Total claims							125.25
Total payment amount							125.25
Current voluntary refunds							0
Amount recouped this run							0
Internal—Adjustment taken							0
Net check amount							125.25

MEDICARE BENEFITS

[July 29, 1977; physician or supplier No. 257043226A]

Health insurance Claim and control Nos.	Physician/supplier name	Dates of service: Beginning	Dates of service: Ending	Service type place	Amount billed	Remark codes: A	Remark codes: B	Amount approved	Deductible	Payment to patient	Payment to physician or supplier
253488348A	Dr. O. Balco		7/9/7	A1	8	1	3	6.80	6.80	0	0
7206-02841	Total				8			6.80	6.80	0	0
259286169A	Dr. O. Balco		7/8/7	A1	8	39	3	0	0	0	0
	do		7/8/7	E1	5	39		0	0	0	0
7206-02780	Total				13			0	0	0	0
0662276968	Dr. O. Balco		4/21/7	A4	8		1	0	0	0	0
7147-01328	Total				8			0	0	0	0
257055049A	Dr. O. Balco		7/8/7	A1	8	1	3	6.80	6.80	0	0
7206-02779	Total				8			6.80	-6.80	0	0

Service type codes: A. Medical care; B. Surgery; C. Consultation; D. Diagnostic X. ray; E. Diagnostic laboratory; F. Radiation therapy; G. Anesthesia; H. Assistance at surgery; I. Other medical service; J. Whole blood or packed red blood cells

Service place codes: 1. Office; 2. Home; 3. Inpatient hospital; 4. Skilled nursing facility; 5. Outpatient hospital; 6. Independent laboratory; 7. Other; 8. Nursing home; 9. Independent kidney disease treatment center.

Health education is Crawford County's single largest problem. If there was funding for a nurse in the Crawford County school system to teach health education, which would include sex education, it would go a long way to solve our problems. Nine percent of school-age girls became pregnant in Crawford County, and this includes all races. Thirty thousand teenagers became pregnant in Georgia last year, with 50 percent of the child abuse deaths coming from these teenage pregnancies. Twenty percent of our teenagers don't really know what causes pregnancy. Along with more education of our people, we need a dentist and a doctor to serve the Health Department clinic. We have no dentist. The Crawford County Emergency Ambulance Service has been, in my estimation, the single most beneficial addition to the health care in Crawford County in recent years. And because of its infancy it has produced the most confusion, most concern, and very recently the most criticism. There are numerous examples to pull from, but these stick in my mind presently. A pulpwood worker cuts himself in the woods and is brought for first aid, placed in an ambulance, and carried to the Doctor's Clinic. He is a medicaid patient, as are about 35 percent of our Doctor's Clinic patients. Patient receives excellent medical care, lives, takes a couple of days off, and goes back to work. Medicaid forms are submitted for ambulance service and denied because ambulance has to go to a hospital, not a clinic, even though our doctor is a medicaid doctor.

Blue Cross and Blue Shield deny any responsibility of charges which occur with our ambulance service. In turn, we don't get paid for our supplies, our gas, our expenses involved in transporting emergency patients to Macon Hospital, Upson County Hospital, and in remote cases, to Atlanta hospitals. Their reason, we are federally funded. The Federal Government paid 70 percent on a $12,000 ambulance, and that is the last we've seen of them. Your small communities are operating a much-needed emergency service right out of the ad valorem general fund. Your large communities are federally funded and send no statements on emergency service. Example, Atlanta dispatches an ambulance, a squad car, and a fire truck to each automobile accident. No bill is sent. The small community is paying a dispropor-

tionate share of emergency ambulance service. Regulations restricting drivers to be EMT's are impossible to meet for so small a community as Crawford County. Thank you, sir.

Senator TALMADGE. Chairman Jones.

STATEMENT OF J. B. JONES, COMMISSIONER, LUMPKIN COUNTY, GA.

Mr. JONES. Thank you, Senator Talmadge. I guess I'm the chairman, I'm the sole commissioner. I would like to give a different perspective on health. I've had quite a bit of experience in the health field. I am a member of the HSA Board of the Appalachia Georgia Health Systems Agency. I'm also a member of the Lumpkin County Hospital Authority, and I appreciate the help you and Senator Nunn have given us in this program.

Senator TALMADGE. How long did it take to get that approved, about 3 years?

Mr. JONES. Yes, sir, and everyone thought that we'd really done something fast. Without the help of you gentlemen, we couldn't have gotten it that fast.

Senator NUNN. Well, I'm familiar with your efforts, and your prodding was welcome; and without your dedicated efforts, it wouldn't have been accomplished even in twice that length of time.

Senator TALMADGE. That is certainly true.

Mr. JONES. I would like to introduce two people I brought with me: Dr. Sam Davis, who is executive director of GMAPDC; and Thurl West, who is a member of the county health board and also a member of TMR Board up there.

Senator TALMADGE. Would you please stand up? We're delighted to have you here.

Mr. JONES. My remarks toward the health problems in the Georgia mountain area is that we're a little different from the rest of Georgia in that we have a mountainous terrain, and 20 miles to us is like 40 is to the rest of Georgia; we also have a lot of rain and snow in our area. We're sparsely populated but we get sick, too. I've taken the catnip tea, et cetera, but I'd still rather have a doctor. I was raised on such, but in the mountains we are sparsely populated. We're poor. After hearing the other two commissioners, I think we can count our blessing. We have a few blessings bestowed upon ourselves. We also have in our mountainous area 25 percent more aged people than you have in the rest of Georgia—and this creates a problem. As people age, they tend to require more medical service and you'd like to be able to call a doctor and get to see one. We've worked on this in our counties. We have some rural doctors in Dawson County, just south of us, and we're trying to get some nurse practitioners, I call them doctor extenders, in the other northern counties. To me, this is a step we need to take to extend some of these doctors, to us a physician's assistant or a doctor extender for the buy with the cut finger or cut foot or something, so he won't have to ride all the way into Dahlonega or Gainesville. Gainesville really has a lot of doctors, the highest percentage, probably, than any county in Georgia by population and yet to get to see a general practitioner you've got to wait about 6 months or longer because these people are specialists. I read an article that somebody wrote one time—I believe it was about a crisis-oriented society—

but about the only time you get to see a doctor is when you've got an emergency, and a lot of these people die because we don't have the right preventive medicine or the right preventive health care.

We wait until the balloon is ready to burst before we go to the doctor because of the time to get there and the time to get an appointment with the doctor. My mother died of a heart attack several years ago and she hadn't been to a doctor in 3 or 4 years. We have seven doctors in Dahlonega now but we're trying to get some more. Another problem we've experienced in getting new doctors is third-party patients, medicare and medicaid. It took too long to get payments and we were fast going under before we could get payments to the new hospital or to the doctors, not only for us but for the whole State of Georgia. I know at one time we had $50,000 outstanding at the new hospital and we needed that to meet the payroll. We made a few calls, and you gentlemen got some, but anyway we made the payroll and I thank the Lord we didn't have to get the taxes out that month. Another thing we need in the mountains is a system of education. I'm a firm believer in education. I've heard the doctors talking about this and my fellow commissioners. You know, education is a wonderful thing. These nutritional aides are great. I think people should be educated in heart attacks, children should be educated in schools about heart attacks. I didn't know too much about diets until I got in the Army. It fattened me up. If people are educated to the fact that the proper diet and proper care and some preventive things, then we would tend to free doctors for other cases. Now these home health aides that the Senator was talking about on the WIN program, I think this is a fine idea, Senator Talmadge. I endorse that 100 percent. We have some health aides in the north Georgia area.

We have some of these people but we don't have enough. They are doing a good job with old people, they are doing a good job with the young people, and I think an ounce of prevention is worth many, many days in the hospital after the person has already gotten sick and I think this is a way of putting our health dollars forward and also relieving the doctors. We have an early periodic screening program. This screens out children that need medical treatment early, and I think this is a good program. We need more of these. And then, lastly, we need a transportation system to get these people in to the doctors. In the mountain region we might have a fellow that lives 10 miles up the cove and from that cove it's 20 more miles on into Blairsville or Towns County or maybe up into Tennessee. We have a lot of people who don't have the money to get to a doctor and once they do they've used all their money for transportation to the doctor then they don't have the money to pay the doctor with so I think we need to develop some means for some type of rural transportation to get people to and from the doctors, especially these people that are elderly. I thank you.

Senator TALMADGE. Is it a fair statement to say, gentlemen, that what you need primarily in these isolated rural areas is health preventive care? Would you concur in that, Mr. Jones?

Mr. JONES. Yes, sir, health preventive care and then a little flexing of the regulations that we sparsely populated areas can have some of everything that the other areas have.

Senator TALMADGE. Mr. Dent?

Mr. DENT. Yes, sir, sprinkled with a little education.

Senator TALMADGE. Do you agree Mr. Colvin?

Mr. COLVIN. I agree with that, Senator.

Senator TALMADGE. Senator Nunn.

Senator NUNN. I just want to ask Mr. Dent a question about the ambulance service. Basically, what you think is that in your area it's almost impossible to comply with the Federal regulations on ambulance service and you're having to bend that regulation yourself or you don't have any ambulance service, isn't that right?

Mr. DENT. Yes, sir. We presently have three operators that are running 24 hours a day and the Federal regulations state that we have to have a certified EMT, emergency technician, medical technician, physically driving the ambulance. Well, we only have three that are certified so we have to have one that is on 24-hour standby sitting there in the medical facility and then, today before I left the county commissioner's meeting to come here, we got notice that, this was timely also, that he resigned.

Senator TALMADGE. Do you have a fire department either in Crawford County or Roberta?

Mr. DENT. We have a volunteer fire department with four firehouses stationed out into the county.

Senator TALMADGE. I was in Macon a year or two ago and they took me out and showed me a facility which is a combination of fire department and ambulance service. They are trained to do both and handle not only calls for fire but in the event of an emergency ambulance service they have extensive first aid training. They can pick up a patient and get him to the hospital in short order. I don't know if there are other facilities besides that in Macon or not, but I was tremendously impressed because it served a dual function.

Mr. DENT. Yes, sir, and that's what we have.

Senator TALMADGE. You use the same system?

Mr. DENT. We have that same system.

Senator NUNN. I'd just like to—Dr. Reich, I know you've had to be out of the room, but Crawford County poses a real problem and I don't know if it's the law or the regulations that caused the problem with the ambulance service and the distinction between the urban and rural reimbursement. I would like to direct your attention to that statement and perhaps, I know it would take some time, but if you could, get a reply to my office as to whether it's the law or the regulations that's causing the problem and whether you have any suggestions about what can be done to correct it, either from a legal point of view or from a regulatory point of view. I know you weren't in here when the statement was read, but he has a rather acute problem in Crawford County and I think we ought to look into it and I thank Mr. Dent and Mr. Jones and Mr. Colvin for appearing.

[The prepared statement of Mr. Jones follows:]

STATEMENT BY J. B. JONES, COMMISSIONER, LUMPKIN COUNTY, GA.

INTRODUCTION

My name is J. B. Jones. I am a seventh-generation resident of the mountains of northern Georgia and I feel that I understand many of the problems and potentials of this beautiful portion of our state.

I am the Sole Commissioner of Lumpkin County, Chairman of the Board of Managers of the Association County Commissioners of Georgia (ACCG), past President of the Ninth District ACCG, and serve on the Board of directors and

Executive Committee of the Georgia Mountains Area Planning and Development Commission.

I have a special interest in health and devote a considerable amount of time to Board duties with the Lumpkin County Board of Health, the Lumpkin County Hospital Authority, the Lumpkin County Chapter of the American Association of Retired Persons, and the Lumpkin County Program for the Mentally Retarded. I am also a member of the Board of Directors of the Appalachia Georgia Health Systems Agency.

PREFACE

I would like to open my remarks by giving you my perspective on health. The long range goal in the Georgia Mountains Area is to move from a position of inadequate medical care to universal health care, from treatment of the sick to health maintenance and preventive health activities.

Given the relationship between the health services delivery system and the overall development and quality of life in the region, we must work toward this goal.

The establishment of a health system will draw to the area professionals and leaders in medicine and in other fields who can augment already present community leadership resources.

As the health system grows, controlled industrial development can increase employment, wages and taxes which will lead to better housing, better education and better opportunities. A cyclical process results whereby improvement in any one area facilitates and encourages improvement in other areas.

The opposite situation can also occur, of course, where the lack of a decent health care system discourages industries and professionals from locating in the area.

PROBLEMS

Our people face several critical obstacles in their attempts to obtain medical and dental care. The number of health professionals available is really only marginally able to meet the current demands made on the health care system. And even then, it requires long office hours and round-the-clock coverage on the part of the health professionals.

However, this shortage is really just the tip of the iceberg since a large number of people only receive care in extreme or emergency situations because they are unable to afford regular, much less preventive, health services. This underserved segment of the population, unable to pay for routine medical/dental care but ineligible for or unable to afford any typical third party coverage such as Medicare, Medicaid, Blue Cross/Blue Shield or an employees' health insurance policy, is medically indigent. Their income is consumed by the more immediately necessary expenses of food, shelter and clothing. The high cost of medical care, coupled with the high costs of gasoline, housing and food has resulted in this situation and we must take steps to make health care available to all. This would, in turn, put increased strain on the available health professionals, necessitating an increase in general and family practitioners, dentists and physician extenders.

The mountainous terrain in our area, coupled with the sparse population, also work to our disadvantage because eligibility criteria for certain assistance programs have population quotas or ratios which fail to recognize other relevant factors such as travel time and even accessibility, such as in the winter. Many rural areas in the higher elevations are semi-isolated, and standard measures of need are inadequate.

One way to address this issue would be to authorize third party payment under the Medicare system of physician extenders who work at sites remote from their preceptors. These extenders can perform many routine medical functions at much less expense to patients. Federal approval would likely serve as an encouragement to States and to private carriers to also extend their coverages to these allied health professionals under Medicaid and health insurance programs.

A related concern has to do with the lag time which exists between submission of Medicare/Medicaid claims and receipt of reimbursement, and the disparity between the allowable fees in rural and urban areas. Both factors act as a deterrent to the recruitment/relocation of medical personnel.

Doctors and dentists just starting practices, and incurring the necessary costs associated with setting up and equipping offices, can ill afford the delays in recouping claims, and the higher rates in urban areas serve as an extra incentive to locate away from rural areas. Thus, recruitment and retention of health professionals is made more difficult.

And this problem of delays in receiving reimbursement does not just affect individual practitioners. New hospitals can be just as severely affected, if not more so. With no reserve fund built up over years of operation and a less than capacity patient census during the first few months, new hospitals are frequently dependent on the claims for operating expenses.

Once manpower and facilities are available, two other obstacles impede the use of the health care system for our residents. The first is a lack of public transportaiton, a problem magnified by our mountainous terrain and our disproportionately large share of persons 65 and over.

A second problem has to do with illnesses which require a specialist. These health professionals generally locate only in the larger towns and cities, increasing the amount of travel time required to get to their services. They also frequently serve a whole region or area, resulting in a substantial amount of lead time in getting an appointment. People resist making appointments six months, or even more, in advance and, consequently, wind up going to the doctor only when the situation becomes serious. As you know, treating illnesses and diseases in their early stages can often prevent high-cost institutionalization and even death.

On another level, that of health maintenance and preventive health, our most prevailing need is health education and early intervention. Starting in the primary grades, our students need to be made aware of the importance of good nutrition and oral hygiene. A recent program in our area, sponsored by the Appalachian Regional Commission and designed to augment the Early Periodic Screening, Diagnosis and Treatment (EPSDT) phase of the Medicand program, found that almost one third of referrals of medically indigent children were for dental problems! Poor teeth can result in poor diets which can affect everything from hyperactivity to sluggishness.

As students advance into the secondary schools, health education in the areas of substance abuse, family planning, parenting and maternal and infant care must be added to the curriculum.

Finally, patient education in the hospitals for victims of hypertension, diabetes, stroke, heart attack, etc. should be more fully developed, both for the patients' health and comfort and to prevent future institutionalization.

For those patients suffering from chronic diseases, home health care, for instance the monitoring of the blood pressure of hypertensives, is a growing need and one that can be economically filled by physician extenders.

SUMMARY

To sum up, we need more health professionals—doctors, dentists, and physician extenders—and we need a mechanism for helping our medically indigent people—who work and earn a living but cannot afford regular use of the health care system.

We also need to teach our people the basics of good health care and the effect of life style on health, beginning at a very early age and continuing throughout their lives.

Finally, we need to develop a rural public transportation system that will provide our citizens the opportunity to use the health care system when they are sick and, eventually in a preventive health/health maintenance fashion.

Senator TALMADGE. Thank you, gentlemen, for your very helpful comments. Next we have a panel of citizens including Mr. Fred Hancock, president of the National Bank of Fitzgerald, Mrs. Grace Hodges, member of the Board of Governors of the Health Systems Agency of Central Georgia, and Mr. John Neeley, mayor of Butler, Ga. We appreciate your appearance. In the interest of time, would you insert your full statement in the record and summarize it as briefly as you can. Who's leading off?

STATEMENT OF HON. JOHN NEELEY, MAYOR, BUTLER, GA.

Mr. NEELEY. Thank you, Senator. I want to say a little about how I feel about our system. We're one of these rural counties a lot of these city folk have been talking about. We have three doctors in our county.

None of them accept any medicaid patients. We have an ambulance service and we're more fortunate, I think, than Crawford County. We have about 10 volunteer EMT's, all qualified, who man the two ambulances there. We have some, I think, pretty serious health care problems and the three physicians that we have don't accept any medicaid, they don't do any emergency work, they don't deliver any babies.

Senator NUNN. Why don't they accept medicaid patients?

Mr. NEELEY. I think primarily for two reasons. The first would be that they've got all the practice that they can do without it. A typical wait to see a doctor in Taylor County is 3 to 5 hours. The other reason is the delay in getting medicaid payments, I understand there is 3 to 4 to 5 months delay.

Senator TALMADGE. Sometimes longer than that, from what I've heard. Senator Nunn's bill and mine will insist that 95 percent of them be made within 30 days and we think that would stimulate more doctors to accept medicaid payments and also we're trying to simplify the procedure. You know, what you have to do now is if you have 10 different patients you have to fill out 10 different forms. What we hope to do is to have one form for 10 different patients and also give them a bonus to fill out the forms. We believe that will encourage more doctors to accept medicaid patients.

Mr. NEELEY. I heard the story the other day of a doctor, I think, in a neighboring county, who dropped his medicaid practice completely and eliminated two girls in his office due to the decrease in the paperwork. Our emergency health system is pretty well taken care of with the two ambulances that we have in the county. We can probably get a patient that's in bad shape to a good hospital about as fast as they can in downtown Atlanta. The problem that we do have is the typical person who gets the flu or gets sick. He's in the position of having to go to one of the local doctors and face a 3 to 5 hour wait to get a prescription for $2 worth of antibiotics or he has to drive a round trip of 60 miles or so to another town to see one. If you are poor enough and are on medicaid and don't have the transportation, you can go down to the welfare office and they'll provide you with door to door service and pay somebody to take you 30 miles to Thomaston to see a doctor to give you a prescription for $2 worth of antibiotics, then haul you back to Butler so you can go to town and get your $2 worth of medicine. I think that's a high price to pay for——

Senator TALMADGE. It costs more for the transportation than it does the medicine.

Mr. NEELEY. Considerably more. Quite often it's something that could be handled by a nurse practitioner. I haven't been to the doctor to get a prescription in years. It's just too much trouble. Of course, I can pick up the phone and call the doctor and say I've got the flu, how about writing me one. Some citizens fall in the area where they're too rich for medicaid and too poor to socialize with the doctors or are not kin to them and it puts them in a bind to get help. I would have to endorse Dr. Skelton's recommendation to put us some simple mechanics out there to furnish us with this basic stuff, to stitch up a cut, or give me a pill when I've got an infection. Basically, that's about it. I'll turn it over to somebody else. Thank you.

Senator TALMADGE. Mrs. Hodges.

STATEMENT OF GRACE HODGES, MEMBER, BOARD OF GOVERNORS, HEALTH SYSTEMS AGENCY OF CENTRAL GEORGIA

Mrs. HODGES. I'm Grace Hamrick Hodges and I have been a resident of Twiggs County all of my life. I live in Jeffersonville which is about 25 miles southeast of here and am active in many social——

Senator TALMADGE. Will you yield at that point? What kin are you to Earl Hamrick?

Mrs. HODGES. Just a first cousin.

Senator TALMADGE. Then you knew Ross Hamrick?

Mrs. HODGES. Yes, sir.

Senator TALMADGE. He was the first man I ever knew in Twiggs County.

Mrs. HODGES. We've always been very good friends of the Talmadges.

Senator TALMADGE. You don't have to tell me that, I'm well aware of it.

Mrs. HODGES. In addition, I have raised a family of three in Jeffersonville and was in the retail grocery business for 28 years with my husband, and employed by the U.S. Postal Service for 9 years, before being placed on disability retirement because of open heart surgery in November of 1975. These experiences, I believe, enable me to speak with some credibility about some of the major health problems and issues that confront not only the residents of my county, but the residents of other rural counties in Georgia and in the South. I also feel further able to speak with some authority because I am privileged to serve on the board of governors of the Health Systems Agency of Central Georgia, this being the health planning and resources development agency which serves the bulk of the counties in rural Georgia. I also serve on that agency's health services and project review committee which, as you know, has major responsibilities in determining the need for and the distribution of health services and facilities in our health service area. But I'm glad to note for the record that our HSA, which is the Health Systems Agency of Central Georgia, is the only HSA in the State to have adopted its health systems plan and annual implementation plan before the end of the first year of designation and one of the few in the entire Southeast to have accomplished this goal. This is indicative of the broad interest and willingness to participate in this volunteer work by central Georgians serving on the board, its committees, and advisory task forces. At this time, I have a copy of the plan entitled "1977 Central Georgia Plan" as supportive evidence of the health problems and the needs and the potential solutions about which I will speak.

Other important reference documents which I would like to note for the record are the publications of the health systems agency, eight of them in all, which have already been mailed to Senators Nunn and Talmadge. Jeffersonville is a small community of 1,300 population but it is the largest town in Twiggs County which has 8,200 residents. Twiggs County is a part of the four-county Macon standard metropolitan statistical area, but we are far from being an urban metropolis. Although we are a large county in size, our population ranks 113th of 159 in the State and we have a population density of 22.5 persons per square mile. As a comparison, our neighbor county, Bibb County, has 588.8 people per square mile. The Georgia Office of Planning and

Budget projects that the population of Twiggs County will decrease during the next 5 years. We have a very high unemployment rate in our area, exceptionally low average income figures and over 80 percent of the residents of the county who are over 25 years of age have not finished high school. These statistics point to the fact that the financial resources available for health care in Twiggs County are very slim indeed. Using assessed property values as an indicator of county and city tax moneys available for health, social, and educational programs, the net value for the county is just a little more than $35 million compared to Houston County's $214 million and Bibb County's $474 million. And as a further comparison, Fulton County's $3.7 billion. Twiggs County ranks 134th of 159 in Georgia according to the master economic rank.

Many other rural Georgia counties are in the same economic situation. Many have large numbers of poor, undereducated residents who need more than the average amount of health services but they have very few resources, either private or public, with which to provide these services. We have no hospital in Twiggs County and only one nursing home. There is only one physician practicing in the county and he operates in general practice in Jeffersonville. He is not able to handle the large demand for services placed upon him. We do not have a dentist in our county and the county health department provides only minimal services at best. We are fortunate enough to be located within a reasonable traveling time to Macon and its vast array of available health services. This proximity and availability helps those of us who can afford the services, but not those people who can't afford to pay for these services or either who have no means of private transportation to these services. In many places in central Georgia there are no health resources, either in the county or in any of the neighboring counties. If there are health services in the neighboring county, often there is no public transportation system for them to get the potential patients to them. From what I understand, there are Federal programs in place to improve the availability of and the accessibility to health services by helping to provide primary care in underserved areas.

I am familiar with the Federal designation of "medically underserved" since every county in the 37 county health service area served by the Health Systems Agency of Central Georgia is designated as such. In addition, 11 of the counties are considered critical medical shortage areas and 25 of the counties are critical dental shortage areas. Twiggs County holds all three designations because of its extreme lack of physician and dentist manpower. As you probably already know, Twiggs County is one of DHEW's "Positive Programming Counties" for their Rural Health Initiative/Health Underserved Rural Areas since it's considered medically underserved, a critical medical shortage area, a critical dental area, and we have, also, a high infant mortality rate, and have a large percentage of its residents receiving aid to families with dependent children. Theoretically, DHEW should give a high priority to the development of health services in Twiggs County before it considers placing valuable health resources in less needy counties. However, less needy counties have been given preference over Twiggs for these funds. Often, the counties which are most needy either do not know they are eligible for this assistance or do not have the local expertise to assist in preparing the required paperwork. We need

local primary health care resources in Twiggs County. It's often been said that you can't teach old dogs new tricks. Thus, if you can't get doctors to come to the area to practice, perhaps other alternatives should be pursued, with funding provided, reimbursement mechanisms established, and licensure laws amended to allow independent practice for heath practitioners who might be more inclined to live and to work in the rural areas, such as the nurse practitioners and physician's assistants.

Primary health care stations could be instituted throughout the needy areas and could be staffed by these nonphysician personnel to improve accessibility or primary care services. Financial incentives and funding arrangements could be offered for sharing health resources across county lines, and counties could be urged to devote additional funds to provide needed health services. Transportation systems could be developed to take rural residents without their own means of transportation to the site of health care provision. Finally, an emergency medical system could be organized and sustained to provide a means of safe transportation to specialized services and emergency care to critically ill patients. Up until now, I have restricted my remarks to the subject of providing additional medical care services because I believe that more health manpower, more primary health care facilities, better organized health care systems, and more appropriate distribution of health care resources throughout the rural areas of central Georgia is not the only answer to the short term objective of improving the health of the people. However, as a long term objective, I think that ultimately programs in health education and health promotion need to be coupled with the medical care programs if health status is to be improved substantially. We need programs to educate the people regarding the relationship of lifestyle to health, how to prevent disease and promote health, and in the essentials of family planning. And this is very much needed in Twiggs County.

These programs could be carried out by a number of organizations working in concert if funds were available to implement these programs. Some of these would be through the school system, the county health department, health practitioners, community and civic organizations, and private citizens interested in improving health. Definitely, we need an active health education program and when I look at the situation in Twiggs County, and in a number of other rural counties also in central Georgia, I realize the urgency with which programs of action that need to be undertaken and the sooner the better. In closing I would like to say it's been a real pleasure to speak to you this morning. I appreciate having this opportunity to share some of my concerns regarding health with you and I am looking forward to any questions you might want to ask.

Senator TALMADGE. Mr. Hancock.

STATEMENT OF FRED HANCOCK, PRESIDENT, NATIONAL BANK OF FITZGERALD, GA.

Mr. HANCOCK. Thank you. Senators. It's a pleasure for me to be here.

Senator NUNN. Senator Talmadge, I've got to tell you that Fred Hancock managed my campaign in Lowndes County before he moved. I didn't want you to be up on me this morning. I've got one here, too. He had a doctor helping him, too.

Mr. HANCOCK. I'm not an expert in medical services. I am concerned about medical services for our community. I'm from Fitzgerald, Ga., Ben Hill County, which is a small county but we are a county that has—when we concentrate on problems we usually are successful and we have been concentrating on our health care problems and we have concentrated on industrial problems and employment problems and have been very successful in this area. We recently constructed a new 75-bed hospital and felt like that this was probably going to be the answer to——

Senator TALMADGE. That's the hospital I dedicated about 2 years ago?

Mr. HANCOCK. That's it, sir. We felt like that this would solve our major problems as we do provide medical services to Irwin County and Wilcox County and parts of Tift County and parts of Turner County, but since you dedicated the hospital, it only averages about 50 percent occupancy so we began to look around to see if we could determine what the problem was.

Senator TALMADGE. How many doctors do you have in Fitzgerald?

Mr. HANCOCK. We have six doctors. One of them has limited his practice. One of them shares with Douglas on a time basis.

Senator TALMADGE. Have you made a concerted effort to impress on the people to buy Blue Cross/Blue Shield insurance in the communty?

Mr. HANCOCK. I beg your pardon, Senator.

Senator TALMADGE. Have you made a concerted effort to impress on the public in general to buy Blue Cross/Blue Shield insurance in the community?

Mr. HANCOCK. No, sir, we have not.

Senator TALMADGE. Many of the hospitals in the early days when we started building them when I was Governor realized that they were going to have a problem financing. All the civic organizations, the farm bureau and everyone else joined hands and urged the purchase of Blue Cross/Blue Shield insurance and hospitals in very small areas. I remember the case of one of the smallest ones built at that time in Webster or Stewart County, I've forgotten which one, where they sold enough insurance to where the hospital, even though the population of the county was only around 6,000, was operating in the black.

Mr. HANCOCK. I appreciate that information. That's something we need to look into. Our approach to the problem has been that we, through our chamber of commerce and through the help of the University of Georgia Board of Regents, who try to locate doctors that are prepared to set up a private practice. We've had several of these doctors to come to our community, we've entertained them, we offer them—at the present time, we have office space which is under construction, trying to attract new doctors to our community. We are prepared to pay the rent for up to a year.

Senator TALMADGE. Will you yield at that point?

Mr. HANCOCK. Yes, sir.

Senator TALMADGE. One of the provisions in our bill is to let hospitals such as yours which are underutilized and understaffed to have swing beds for nursing homes. Do you think that would be a good idea?

Mr. HANCOCK. Yes, sir, I sure do. We have two fine nursing homes in our community already.

Senator TALMADGE. Are they full?

Mr. HANCOCK. Yes, sir, they are.

Senator TALMADGE. Overcrowded?

Mr. HANCOCK. Overcrowded.

Senator TALMADGE. One of the provisions we have is to let you utilize the underutilized beds for nursing homes and the administration enthusiastically endorses that. It would give you greater utilization in your hospitals. Of course, you know the greatest cost of your hospital is when you have empty beds. You have the biggest costs and those costs continue whether you are 100 percent occupied or 50 percent occupied.

Mr. HANCOCK. That's true and that's what we've found. I'll just briefly make a statement about most of the problems that we've found in recruiting new doctors. We've already discussed the fee situation which I feel like since this hearing today there'll be some revision on that. That's something that's been mentioned to me a number of times by the prospective doctors right out of their training looking for avenues to set up their practice. There is certain concern about the fee structure in a community. One of my recommendations as to these problems is a simple one. That is, if we have a shortage of doctors, it's going back to the old economy of supply and demand. We just need, under some form or fashion, to have more doctors in the State of Georgia. We have found that we've been much more successful in recruiting doctors when they come from an area very similar to our area and they have a rural background. I think that this is very important and I recommend that—and see this morning that this new medical facility at Mercer University is probably going to mean a great deal to us in Fitzgerald.

Senator TALMADGE. Will you yield again? The biggest problem, of course, with doctors is that we're not so muched understaffed on doctors as the doctors are in the wrong places. They prefer to go to urban areas where they believe the amenities of life are more pleasant and entertaining than in rural areas. I don't think so as an old hunter and an old fisherman, I think I'd prefer the rural areas if I were a doctor, but that's not true of most doctors. The problem is to get them located where the need is the greatest.

Mr. HANCOCK. I understand that problem and I've one other suggestion, and as I said, I'm not an expert, and it was mentioned a few minutes earlier, too, and that is at some point in the training of a doctor he be given an opportunity to come to a rural area and try our lifestyle. I think he would be favorably impressed and would understand this and look on it as a choice for him to set up practice.

Senator NUNN. This is why you suggest that there be more emphasis on recruiting people who originate from small towns on the theory that once they've grown up there they would have more incentive to go back and more understanding of the need there, is that right?

Mr. HANCOCK. That's correct.

Senator NUNN. May I ask one question of Mrs. Hodges? Are you through?

Mr. HANCOCK. Yes.

Senator NUNN. You are, I believe, connected with the HSA of central Georgia, isn't that right?

Mrs. HODGES. Yes.

Senator NUNN. I understand Dr. John Watson is also here from Columbus. Dr. Watson, I believe, is president of the HSA. Dr. Watson, would you stand and be recognized. We're delighted to have you this morning. I have heard good things about your HSA. Could you tell us a little bit about what you are doing there—your impression, briefly, of the opportunities and the problems?

Mrs. HODGES. Well, HSA gives—it's an open resource to the people of all the counties that they serve and with the leadership that they have with the consumers and providers I don't see how in the world we could fail a health program if we could have it implemented and someway funded because I am a consumer and I come in contact with a provider and we provide in our talks, we don't dominate each other, so you can see that the organization is well organized and it's essentially to help with a health program, the way that I see it.

Senator NUNN. What is your biggest problem now?

Mrs. HODGES. In Twiggs County?

Senator NUNN. No; with the HSA.

Mrs. HODGES. I don't really have one. Maybe Dr. Watson would like to comment on that.

Senator NUNN. Dr. Watson?

Dr. WATSON. Probably the biggest problem is the vast area we have to cover plus we have to cover two States. We have one county in Alabama and although I think we have an excellent staff we just do not have enough people to begin to cover this area. Our funding of our staff to promote these things—I think they've done tremendous work and I think that the cooperation we've had through this area cannot be improved upon, but we cannot do this on 30 cents on the dollar, as it were, to cover this vast area which is the largest HSA in Georgia.

Senator NUNN. Dr. Watson, do you have pretty good cooperation and communication with the physicians in the area?

Dr. WATSON. Yes, sir, excellent.

Senator NUNN. What is your field?

Dr. WATSON. I'm a therapeutic radiologist.

Senator NUNN. Thank you.

Senator TALMADGE. I have one question, starting off with you Mr. Hancock. What has the State done to help you alleviate your problems?

Mr. HANCOCK. Senator Talmadge, we have found that most of our assistance comes from the University of Georgia's Board of Regents. They have been very helpful to us in supplying us with names and addresses of prospective doctors and I think this has been the single most helpful factor, to me, in recruiting new doctors for our area, and that's our primary concern.

Senator TALMADGE. Mrs. Hodges, did they provide any emergency assistance to meet problems in Twiggs?

Mrs. HODGES. Who do you mean has provided?

Senator TALMADGE. State government.

Mrs. HODGES. Well, they provided the minimum services for the health department. That's the biggest funding that they do and, of course, it's not large enough to care for the problems that we have in Twiggs County as far as health is concerned.

Senator TALMADGE. Mr. Neeley, will you respond to that question?

Mr. NEELEY. Well, I think that, No. 1, the most important single thing the State—I don't know if it was Federal funds or State funds they used—was when they provided the 80 percent grant to purchase our first two ambulances. That's meant more than any one single thing but we continually receive funds through the county health department for a lot of services that I understand are pretty well utilized. We have mental health counselors that come down periodically and do all types of counseling from marriage counseling on up. I think we're pretty well covered on emergency treatment. We're pretty well covered on what I consider the frills—the biggest gap is in the simple basics, when you feel bad and you're sick, where do you go to get it fixed?

Senator TALMADGE. Of course, as you all know, this medicaid program is about to bankrupt all of the States' governments. Medicaid and medicare buying has been increasing at the rate of about 15 percent a year. It's grown some $15 billion over the past 2 years and the only reason our Federal Government isn't in the same shape as New York City, is the Federal Government can print money and New York City can't. It's one of the things that we are trying to get a handle on and there are a number of committees in Congress that are working on it, Senator Nunn's committee, my committee, the Committee on Aging, the Committee on Ways and Means on the House side, the Committee on Commerce on the House side, and perhaps others. It's been found that the waste, abuse, and outright fraud in the two programs combined come to about $6 billion a year. That's the principle purpose that we've got in the medicare and medicaid reform bill that Senator Nunn and I and some 19 or 20 other Senators have already introduced in the Senate. The administration also has a bill there that is parallel, it's not mutually contradictory. Our bill takes a slightly different approach from the administration's bill in that the administration bill would put a flat 9-percent ceiling on revenues passing through certain costs on which they would have no ceiling. Some of us have grave doubts that you could have a ceiling on some portion of the medical program without a ceiling on other portions of the medical program and make it work. If you have no further questions, Senator Nunn, we'll hear from the next panel.

Senator NUNN. Just one thing, I wanted to introduce David Vienna, of my staff, who wasn't introduced. David is on the Permanent Subcommittee on Investigations' staff of the Governmental Affairs Committee, formerly Government Operations, and Senator Talmadge's staff man, Jay Constantine, is one of the most knowledgeable people in this whole area. Jay knows all about the legislation and David Vienna knows all about the fraud, so we're delighted to have both of them here. I just want to make one other comment, Dr. Reich is here and many times the bureaucracy gets an awful lot of blame and some of it is deserved, but at the same time, in observing the fraud and corruption that's going on in many of these programs, I'd have to say that one of the originating causes of that is the fact that Congress created programs, medical programs, faster than management systems could be developed to handle them. I think that's the testimony that has come out over and over and over again and that's one of the reasons that I said in my opening statement, and

want to reemphasize, that I believe we would really be building on quicksand if we went into another massive kind of program now until we learn how to handle the programs we already have on the books. Dr. Reich, I don't want you and your capable people to think that you bear the only burden here. I think Congress and the executive branch also bears a burden in seeing if we can properly, effectively, and efficiently manage the program before we give you another nightmare.

Senator TALMADGE. I concur fully in that statement. We establish programs with no real course of control. We direct the Government to write a check and the recipient fills in the amount. Thank you, we appreciate your valuable contributions. Next we have a panel of hospital administrators, Mr. Thomas J. Owens, administrator of Wheeler County Hospital, Glenwood, Ga., Mr. Donald Tate, administrator of Rockmart-Aragon Hospital, Rockmart, Ga., and Mr. Ed Tinnermon, administrator of Candler Memorial Hospital, Savannah, Ga. We've delighted, indeed, to have all of you. If you will insert your full statement in the record, gentlemen, and summarize it as rapidly as you can.

STATEMENT OF THOMAS J. OWENS, ADMINISTRATOR, WHEELER COUNTY HOSPITAL, GLENWOOD, GA.

Mr. OWENS. Thank you, I guess I'll start off. I'm Tom Owens, of Wheeler County. I will try to speak and give just a few points and be fairly brief. One is on manpower and I feel that the physicians concentrated in metropolitan areas are dentists, nurses, and other health workers. There are about five times as many physicians in proportion to the population in the most populous urban counties as in the least populous rural counties. Rural areas of the United States include about 18 percent of our population, but only about 8 percent of our physicians. In 1975, 138 out of the 3,000 U.S. counties had no physicians, 1,307 counties fewer than one physician per 3,000 inhabitants, and 769 counties and medical service areas were designated as critical health manpower shortage areas. The scarcity of physicians in rural areas is made more severe by the fact that not enough general physicians are being graduated from U.S. medical schools. Since 1945, the emphasis has been on the specialist as opposed to the generalist, yet about 85 to 90 percent of the U.S. medical problems are being treated by generalists.

I think we must train more physicians in family practice and we must utilize more the physician's assistants and nurse practitioners in the rural areas and find a means of reimbursing these people through medicare and medicaid programs. The present third party and Federal reimbursement policies is a distinct disincentive for rural practice. I'd like to go ahead to the paperwork that's involved for hospitals. It's absolutely horrendous. Claims to third party payers could probably save health institutions about $80 million a year by adapting a single claims form nationwide. I think Senator Talmadge alluded to the fact that this is what they're trying to do now and I think that's a fantastic step forward. One report that I read recently said that hospitals are asked to complete an average of 68 surveys a year. The average completion time per survey was found to be

3 hours and 40 minutes. Mandatory questionnaires, which account for 27 percent of all surveys, average 7 hours and 15 minutes to complete. Eighty-four percent of all the surveys were found to be recurring, so we keep getting surveys and we keep giving answers over and over again. We're also constantly under a barrage of inspections from various agencies. Studies in individual hospitals show that they must report to more than 150 separate bureaus, agencies, departments, and organizations of Federal, State, and local government, county governments. I think that inspections, in some cases, should be combined or eliminated, and I point in my statement there to the fact that nursing homes are inspected annually by a State agency and also by the Veterans' Administration. In my opinion, the VA does a much better job at a lower cost so why couldn't they just have one inspection instead of two and then coming back in 3 months to be sure that you've corrected all your deficiencies?

Senator NUNN. That makes too much sense for the Federal Government.

Mr. OWENS. I think one of the biggest problems in rural health care is the unwillingness of adjoining county officials to cooperate with one another in providing the facilities and recruiting the manpower and taking care of its indigent citizens. I think legislation is needed to require that each county take care of its indigent citizens regardless of where that person is treated. The present regulations for hospital personnel is very stringent. It is almost, if not completely, impossible for a small rural hospital to meet the same criteria that is required of a 500- or 1,000-bed facility.

Senator NUNN. Let me ask you a point right there. Do you know of any counties in rural areas that are joining together across county lines to try to improve conditions and pool their efforts?

Mr. OWENS. Yes, sir, I do. We are working together with Montgomery County, adjoining county to us, presently, and we have been able to get one physician into Montgomery County——

Senator TALMADGE. Do physicians from McRae, Ga. practice in your hospital?

Mr. OWENS. No, sir, most of the physicians are from Glenwood, Alamo, Mount Vernon, Dr. Powers from over at Vidalia drives over and helps us out.

Senator TALMADGE. Why aren't the McRae doctors practicing over there?

Mr. OWENS. Apparently, I guess, they have as much as they can do——

Senator TALMADGE. More than they can do in Telfair County?

Mr. OWENS. Right. Nearly 31 percent of all patients admitted to Georgia's 20,026 beds in 1975 were beneficiaries of Federal health programs. They received nearly 40 percent of all daybed, or inpatient. care provided. In order to care for these 258,538 patients, the hospitals had to measure up to strict standards established by the Federal Government.

Generally, every hospital has to meet these extensive standards, whether it is a small 22 bed rural hospital or whether it be a 1,000 bed metropolitan institution. There has never been an overall health goal or set of goals stated in any of our laws, although from 1935 to 1975 there were 129 selected Federal health acts passed and funded. The

preamble to the Comprehensive Health Planning and Public Health Service Amendments of 1966 is the closest Congress has come to setting an overall goal, and yet Congress did not attempt to be all inclusive in that. The 129 pieces of national health legislation that I previously mentioned may be looked upon as efforts to move forward these conditions. The path, however, has never been clear or consistent. During this same period of time there were 35 health commissions and reports. But yet after all this we are still faced with the ever increasing problem of providing adequate health care to rural America. Financial—In 1970 the ratio of medicaid recipients to persons with income under the poverty index was 1.03 in the Northeast, 1.16 in the West, but less than 0.33 in the South. Even though approximately 45 percent of the poor live in the South, this region in 1972 had only about 20 percent of the medicaid recipients and accounted for only a little more than 15 percent of the payments. Payments per poor person were $525 in the Northeast and $85 in the South. Realizing that their economic salvation lies in increasing their patient volume, many small hospitals are expanding both facilities and services to attract new physicians and more patients. Others are just quietly going out of business. The result is that smaller hospitals are getting smaller and the large larger. Ironically, this is happening while the Federal Government is spending billions to correct the maldistribution of health care services, particularly in rural areas. The most realistic solution is not massive spending through a massive new health planning bureaucracy.

Senator NUNN. Let me ask you one question here. These statistics on the bottom of page 7 and the top of page 8, I've heard some of this and it is really, I think, startling, that the average payment per poor person in the Northeast is $526 and $85 in the South. Now, I know you can't generalize completely from that, but do you think this indicates, primarily that the poor people in the South are being deprived or does it mean we are doing a better job of not overutilizing and that there's less fraud in the programs here?

Mr. OWEN. I think that's a very accurate statement, that there's less fraud in this area, and I also believe that their access to physicians and health facilities are lower, so it's a combination of both.

Senator TALMADGE. I'm informed by staff—if you'll yield at that point, Senator Nunn—the involved benefits are far greater when prescribed by States. As you know, the medicaid program is jointly funded by the Federal and State programs and the State government prescribes the benefits. The Federal Government has to pay a considerable share of those benefits. Benefits in the North are much more liberal and the payments much greater as I understand it.

Mr. OWENS. I think it's a combination of those several facts that you've alluded to. I think I would be remiss if I did not comment on the administration's proposed cost cap on hospitals. I think we've already seen one dismal failure of this tactic in the health field. I'll quote from Senator Talmadge:

> Uncertainty over the wisdom of a cap on hospital revenues stems from a series of concerns: First, that a cap may become a floor; second, that with all the exceptions, the cap may be ineffective as a ceiling; third, that a cap is arbitrary and tends to penalize those who have been efficient.

I know that to be a fact. It has been recognized that community health planning can pervent waste of money and fragmentation and

duplication of services. There is a need for more efficient use of available health manpower and resources. Nowhere is the need greater than in rural America and rural Georgia. Thank you.

[The prepared statement of Mr. Owens follows:]

STATEMENT OF TOM OWENS, ADMINISTRATOR, WHEELER COUNTY HOSPITAL

I am Tom Owens, administrator of the Wheeler County Hospital in Glenwood, Ga. It is a rural 22-bed general hospital serving residents of Wheeler, Montgomery, Treutlen, and portions of Telfair, Jeff Davis, and Toombs counties. In addition to being the administrator I am also a licensed medical technologist, licensed physicians assistant, and a licensed nursing home administrator. I point these licensure facts out, not to extol my expertise in these areas, but to say that it is obvious that health care in rural America needs help.

I moved to Wheeler County in 1967 when neither Montgomery or Wheeler County had a physician or any health facilities other than the local health departments. We recruited one physician and remodeled our existing building to meet standards and opened in 1968 as a 12-bed facility. In 1970 we built an additional 10 beds. In 1972 we requested permission to add another 20 beds, our occupancy rate at that time was 96 percent. It was suggested by one agency that we not expand because of the lack of property and the condition of the remodeled building, but that we should consider building a new facility. We proceeded with that suggestion and after convincing my board, county commissioner, and others and after many hours of work and much expense we submitted our plans and justifications in the form of an 1122 and was told that the additional beds were not needed. We are at this day still in a so called substandard facility and still running a better than 90 percent occupancy rate. We hope that we will soon have a facility that will join 2 or more counties together in providing health care for the 15,000 or so inhabitants of our rural area.

What's wrong with health care in rural America? If you will let me touch upon just a few of the things that I feel needs correcting.

MANPOWER

Physicians are concentrated in metropolitan areas as are dentists, nurses, and other health workers. There are about 5 times as many physicians in proportion to the population in the most populous urban counties as in the least populous rural counties.

Rural areas of the U.S. include 18 percent of our population, but only 8 percent of our physicians. In 1975, 138 out of the 3,000 U.S. counties had no physicians, 1,307 counties fewer than 1 physician per 3,000 inhabitants, and 769 counties and medical service areas were designated as critical health manpower shortage areas.

The scarcity of physicians in rural areas is made more severe by the fact that not enough generalist physicians are being graduated from U.S. medical schools. Since 1945 emphasis has been placed on the education of specialists for every generalist. Yet 85 percent to 90 percent of U.S. medical problems can be treated by generalists. We must realize the fact that is primary care physicians which locate in rural areas must have reasonable access to inpatient services. If doctors are willing to locate in the rural areas then we must be able and willing to provide him with facilities where they can hospitalize and treat patients.

We must train more physicians in family practice. We must utilize more the physicians assistant and the nurse practitioners in the rural areas and find the means to reimburse these people thru the medicare and medicaid programs. The present third party and Federal reimbursement policies is a distinct disincentive for rural practice. It will be of little help that if 5–10 years these rural practioners that we now have leave the rural areas.

The distribution of health professionals, particularly physicians and dentists has been especially critical for rural America. An effective lasting solution will depend not only on economic incentive but on the development of a health care delivery system in rural America that links providers to hospitals, that decreases professional isolations and that utilizes physicians extender personnel in isolated areas. The development of rural health care systems must be linked with the development of schools for health professionals in nonmetropolitan communities and of measures and incentives to work the residency training of more physicians out of metropolitan areas.

In addition, there is a need to more expeditiously and thoughtfully forward a rational system of health care financing that provides for the distribution of the costs of care over a broader population and gives effective incentives for cost control and quality assurance. It will be most important to develop this system so that it can accommodate increases in services that the American people may expect in the future.

Historically Federal approaches to health problems have been categorical, most programs have focused on individual group or populations with specific problems or diseases or special beneficiary status. It is necessary to reconsider this approach, especially in the growing number of rural areas with critical health manpower shortages and/or significant resource shortage.

Implementation of a more effective Federal initiative in rural health will require closer ties among local, State, and Federal activities, those conducted by consumer and professional groups and those being supported through other funding. I can see a potential problem in the Public Law 93-641, although I agree with the concept of the law and of HSA's.

The survival of hospitals necessary to support the practice of primary care in rural areas will come into conflict with locale planning agencies. The concern of the cost of medical care will bring pressure on HSA planning groups to reduce the underutilized hosiptal beds, as a result many nonmetropolitan small hospitals may be closed. The HSA's will find it easier to close down 50 beds in a rural hospital than to close down 50 beds in a metropolitan hospital, because the board and medical staff in the metropolitan facility would probably have more political leverage.

Pressing problems we now face and some possible solutions:

Paperwork is horrendous.—Claims to 3rd party payers could save health care institutions approximately $80 million dollars annually by adapting a single claims form nationwide.

Case studies from California hospitals using a prototype show that the number of employees can be reduced; billing time can be cut by 3 to 10 days, thus increasing a hospitals cash flow: photocopy requests are reduced; and the time it takes to train billing clerk's is cut from 6 to 3 weeks, resulting in savings to each hospital of approximately $25,000 annually.

Reducing the number of data requests made to institutions by federal, state, local and private agencies. A single, uniform questionnaire should be used and let the Federal Government's Cooperative Health Statistics System collect the necessary information. One report that I read recently said that hosptials are asked to complete and average of 68 surveys a year. The average completion time per survey was found to be 3 hours and 40 minutes. Mandatory questionnaires, which account for 27 percent of all surveys, average seven (7) hours and 15 minutes to complete. Eighty-four (84) percent of all the surveys were found to be recurring.

Inspections.—Hospitals are constantly under a barrage of inspections or surveys. Studies in individual hospitals show they must report to more than 150 separate bureaus, agencies, departments, and organizations of Federal, State and local government. They should be combined or in some cases eliminated. I say eliminated because in some cases the same survey is carried out by one agency and then duplicated by another. Case in point—The Department of HEW surveys nursing homes annually and so does the Veterans Administration. The Veterans Administration does the same work but at a lower cost. A combined survey of nursing homes would save the Government $5 million to $8 million biennially.

I know this is getting away somewhat from the topic but using a single form for all public assistance programs, including food stamps, welfare, and medicaid would save untold thousands of dollars. At present an applicant must file a separate but similar form for each assistance program.

One of the major problems of health care in rural America is the unwillingness of adjoining county officials to cooperate with one another in providing the facilities and recruiting the manpower and taking care of its indigent citizens.

Legislation is needed to require that each county take care of its indigent citizens regardless of where he is treated.

The present regulations for Hospital personnel are stringent. It is almost, if not completely impossible for a small rural hospital to meet the same criteria that is required of a 500-bed metropolitan facility. This is true in almost every category from nursing to laboratories, from X-ray to dietary.

Nearly 31 percent of all patients admitted to Georgia's 20,026 beds in 1975 were beneficiaries of Federal health programs. They received nearly 40 percent of all days of bed (inpatient) care provided.

In order to care for these 258,538 patients, the hospital had to measure-up to strict standards established by the Federal government. Generally, every hospital has to meet these extensive standards, whether it is a small 22-bed rural hospital, or a 1,000 bed metropolitan institution.

There has never been an overall health goal or set of goals stated in any of our laws, although from 1935–75 there were 129 selected Federal health acts passed and funded. The preamble to the Comprehensive Health Planning and Public Health Service amendments of 1966 is the closest Congress has come to setting an overall goal, and yet Congress did not attempt to be all inclusive.

The statement reads:

"The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshalling of all health resources national, state and local—To assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practices of medicine, dentistry, and related healing arts."

The 129 pieces of national health legislation that I previously mentioned may be looked upon as efforts to move forward these conditions. The path, however, has never been clear or consistent.

During this same period of time there were 35 health commissions and reports. But yet after all this we are still faced with the ever increasing problem of providing adequate health care to rural America.

FINANCIAL

In 1970 the ratio of Medicaid recipients to persons with incomes under the poverty index was 1.03 in the Northeast, 1.16 in the West, but less than 0.33 in the South. Even though approximately 45 percent of the poor live in the South, this region in 1972 had only about 20 percent of the medicaid recipients and accounted for only a little more than 15 percent of the payments. Payments per poor person were $526 in the Northeast and $85 in the South.

A utilization deficit for rural residents is also suggested by an analysis which has been made by Aday and Anderson of data pertaining to individuals who had experienced a disabling illness during a specified 2 week period. The ratio of physician visits to days of disability was less than 12.5 for residents of rural areas but greater than 15 for residents of metropolitan areas. Rural residents generally experienced longer travel time and longer periods of office waiting. The problems of access would appear to be responsible for the utilization deficit.

Local government, supported by a smaller per capita tax base, also finds it more difficult to fully support or to pay a reasonable stipend to its local hospital to cover the cost of care provided to nonpaying patients.

Realizing that their economic salvation lies in increasing their patient volume, many small hospitals are expanding both facilities and services to attract new physicians and more patients.

Others are quietly going out of business.

The result is that smaller hospitals are getting smaller, and the large larger. Ironically, this is happening while the Federal Government is spending billions to correct the maldistribution of health care services, particularly in rural areas.

The most realistic solution is not massive spending through a massive new "health planning" bureaucracy.

The solution largely lies in the relatively simple process of reimbursing hospitals on the basis of their full economic needs, and not according to unrealistic and inequitable formulas applied equally to all hospitals, regardless of size, ownership and location.

I would be remiss if I did not comment on the Administration's proposed cost cap on hospitals. We have already seen a dismal failure of this tactic in the health field. I'll quote from Senator Talmadge, "Uncertainty over the wisdom of a cap on hospital revenues stems from a series of concerns: first, that a cap may become a floor; second, that with all the exceptions, the cap may be ineffective as a ceiling; third, that a cap is arbitrary and tends to penalize those who have been efficient."

It has long been recognized that community health planning can prevent waste of money and fragmentation and duplication of services. There is a need for more efficient use of available health manpower and resources. Nowhere is the need greater than in rural America.

Senator TALMADGE. Mr. Tate.

STATEMENT OF DONALD TATE, ADMINISTRATOR, ROCKMART-ARAGON HOSPITAL, ROCKMART, GA.

Mr. TATE. Senator Talmadge and Senator Nunn, from the August 9, 1977 issue of the Atlanta Constitution editorial section I read, and I quote:

This nation's system of public welfare has been long on good intentions and short on satisfactory results. We have developed programs of public assistance that have resulted in encouraging families to break up, of making it profitable to drop out of the work force and of creating cycles of welfare families that run for generations.

Taking this matter into application within my own hospital, I can see clearly the results of this in the number of able-bodied persons who flock to our emergency room and also for our inpatient treatment for every little problem imaginable and with little regard as to whether these services will be paid for or not. This results in those who are responsible citizens having to pick up the slack if the health care institutions are to survive. We also see this in the problem we have in our accounts receivable collections. The poor state we are in is partly caused by the fact that we were built with partial Federal funds under the Hill-Burton program and are a public not-for-profit institution which causes us to be at the mercy of all those deciding to use our facility. As I see it, many of the woes of the public not-for-profit general hospitals are brought about from within the State with all the agencies each constantly doing their own thing without any cooperation with the other agencies in the State.

From the Federal level we have to consider the factors which are overtaxing health care institutions and in the main these are regulations from Federal agencies which increase the paperwork we must do in order to be in compliance and which often have no bearing on the quality of direct patient care, but which does in fact increase our cost of operation. Some examples of this would be in the areas of the medicare program, social security, unemployment premium payments which is forthcoming as of January 1, 1978, for the not-for-profit authority-type hospitals, failure to effect any control over the malpractice insurance providers, poor planning and lack of cost impact studies on many of the federally sponsored health care programs. In our own area we have watched unions drive the hourly workers wages up and up while we have been forced to keep our salaries down. The employees at my hospital worked for 3 years without any cost of living adjustment and at that their salaries were already the lowest in the community. The unemployment rate has not helped the health care industry because it is a fact that persons who are willing and able to work but are jobless have more emotional and physical problems, or at least they become magnified, when they are not working and yet their cost of living continues. For that reason they use health care facilities more often and are less able to pay for the services rendered.

The doctrine of charitable immunity which used to protect not-for-profit hospitals is now alive only in a few areas. And with that is the increased malpractice insurance premiums. At our 44-bed hospital in 1974 we paid $10,786 in malpractice insurance, in 1975, $22,967, and in 1976, $24,134, and that with a history of no claims paid since the hospital opened in January of 1953. That 1976 figure of $24,134 represents a cost of $566.91 per patient bed. At the annual meeting of the Federation of American Hospitals on March 9 in San Francisco, Senator Abraham Ribicoff, in agreement with the Carter administration's announced plans for hospital payment controls, said, and I quote, "We need approaches that make sense and which can make a real long-term impact on the problem of rising health care costs." He stated that the Government needs to look at underlying expenses and not just legislate the arbitrary percentage cap on hospital care. The result of the medicare and other regulatory demands of paperwork upon physicians that volunteered for it has driven my medical staff from the hospital-oriented practice to their offices where much fewer requirements of paperwork are demanded. The small community physician simply does not have the time to stay at the hospital dictating page after page of notes on each medicare patient and still take care of the tremendous overload in his office and also be responsible for the care of his patients 24 hours per day, 7 days per week. Therefore, I do not lay any fault at the feet of the rural physician because they are already overtaxed due to the rural community's lack of physicians. My hopeful and optimistic answer to the problem of physician shortage in the rural community has been to go outside the country and try to attract the American medical student in Guadalajara.

The rural community which, like Rockmart, is near a specialized hospital really only has a critical need for more family practitioners and not the specialists. Although President Carter's "cap" plan is not spelled out in detail we do know that he intends it as a quick means to curb escalating hospital costs. We do understand that it will mean, if passed, that no hospital could increase its overall charge structure more than the "cap" ceiling. Health care experts, as well as we hospital administrators, do recognize that this plan is intended as a prerequisite to a future national health insurance. We have heard that the ceiling will probably be decided to be 10.2 percent. This is obviously an arbitrary ceiling since nothing has been proposed for putting a limit on wages, and the prices which we hospitals must still have to pay for essential goods and services necessary to our survival. No one has figured how hospitals can continue to provide the high quality of patient care which the public demands and which the Government demands when such costly items as wages, goods, and services purchased by hospitals, and costly Government regulations continue to escalate with little if any restraints. The Medicare-Medicaid Administrative and Reimbursement Reform Act which you, Senator Talmadge, are sponsoring, has been the most positively received of any proposed legislation involving the health field. We appreciate the fact that you, Senator Talmadge, are viewing it as a long-term answer to rising health care costs and not just as an alternative bill to President Carter's proposed short-term legislation.

At this point I would like to mention that I think Georgia is a leader in improving our medicaid program. I think we owe Senators like

you, Senator Talmadge, and you, Senator Nunn, a debt of gratitude for your leadership in the interest of this State. I agree with those who feel that it would make more sense to look to the future initially and develop an appropriate program geared to long-term needs which is what Senator Talmadge's bill proposes to do. It should be realized by the legislators and the press and the general public that even the rural community hospital is inspected annually by many agencies. To mention a few, who just in June, July, and August were in my hospital, the Department of Human Resources, Standards and Licensure Unit, who spent about 130 hours, the State board of pharmacy, the State fire marshal's office, the State environmental team, the insurance company which has our blanket policy which includes malpractice, the workmen's compensation inspector, the county health sanitarian, monthly, the medicare-medicaid auditors, the Food and Drug Administration technicans, and the laboratory unit and the X-ray units were checked. Someone has suggested that these agencies should stop operating as entities within themselves and work cooperatively sharing their reports and thereby cutting down on the duplication of inspections. In closing let me simply state that I know of no one who has done more to keep costs down and still provide high quality service than have the majority of the Nation's and Georgia's hospitals.

We have had to do that with almost constant Federal and State interference. We have had to try to stay alive and compete in the job market while the starting rates in our local communities for unskilled workers and for skilled workers has continued to increase. I do not think the President's plan for putting a ceiling on hospital charges will do anything but close many of the small community hospitals. I will always maintain that even with all the requirements for providing uncompensated services to the general public, the Hill-Burton program was an excellent idea. It is less costly to everyone to remain in his own community and have his health care needs taken care of there. The news media, with assistance from governmental agencies, have, in my opinion, made hospitals out to be the culprit for the health care costs increasing. There should be an assertive effort on the part of all of us engaged in health care delivery through hospitals to get to the public and to our legislators with the fact that the blame has been wrongly placed upon our doorsteps. It is my hope that there will be more public hearings with the facts truly presented. I believe only then will we not be the public enemy No. 1 to the public and to those involved in legislation who have not taken the time to really understand why health care costs are continuing to increase. Thank you very much.

Senator NUNN. Thank you very much, Mr. Tate. I want to say one thing. Senator Talmadge and I are now in the process of discussing and probably will ask the General Accounting Office to look into these duplications that you have enumerated and the paperwork about which we've heard so much, the overlapping between agencies which are involved in hospital care, to determine if we can maintain the standards that everybody wants without having so much duplication, excess paperwork and Government regulations. I think your statement is excellent in that regard and I would ask staff, when we do get in touch with the General Accounting Office, to make this available plus the other information that others have submitted at this hearing here

and in Atlanta that is relevant to this point. We think that your suggestions are most helpful and we certainly will benefit from your statement.

Mr. TATE. Thank you.

STATEMENT OF ED TINNERMON, ADMINISTRATOR, CANDLER MEMORIAL HOSPITAL, SAVANNAH, GA.

Mr. TINNERMON. Senator Talmadge, Senator Nunn, thank you very much for coming to the State to hear our problems and concerns of rural health in Georgia. Every State, I'm sure, thinks it has unique problems and grievances. In my opinion, I guess you can cluster Georgia's uniqueness around the following two points: No. 1, Georgia has more small or rural, Hill-Burton, not-for-profit, public authority-type hospitals than any other State in the Union. No. 2, in my opinion, your State's health care industry has worked harder at complying with health care legislation than any other State in the Union. I couldn't be more sincere in my remarks than the sincerity in which I emphasize the last two remarks. Let me elaborate, in the planning law passed in early 1975 it stated that within 18 months there would be guidelines published for review and would then be given to each local HSA as guidelines, not regulations, in making local planning decisions.

According to my calculations, these guidelines should have been published for review by mid-1976. As of today's date there are no official guidelines. However, some unofficial guidelines were sent to the State comprehensive health planning agencies sometimes back and these recently have been mailed to local HSA's. These guidelines, which are treated as law, allow for 80 percent occupancy plus a minimum of four inpatient hospital beds per 1,000 population. This is going backward. Why? In 1965, pre-medicare/medicaid, all graduate schools of hospital administration used a 4.5 bed factor in their studies for calculating use in individual areas. Now HEW is using four beds as a guideline which is totally inadequate. Let me show you some statistics of which I'm sure you are aware. The United States as a whole has 4.9 full beds per 1,000 population. Your State of Georgia has 4.55. The metro Atlanta area has 4.70. The southeast Georgia coastal area has 4.86.

Now, any knowledgeable individual knows that these guidelines cannot be applied absolute across the country. Why not? Different average age groups—our area and the Florida area have a higher average age population than such areas as Oklahoma. Certain areas of the country has greater disease problems. For example, the coastal area of Georgia and up into South Carolina has a higher cardiovascular incident rate than any other local area in the North American Continent.

Both of the above factors seem to indicate that a greater intensity of health care facilities are needed in our area. The metro catchment areas have to be considered for more beds per population than most rural areas. Why? Rural areas patients are referred to the metro areas for greater specialization. For example, 40 percent of our hospital patients come from rural Georgia outside of Chatham County. This difference is not being recognized by the HEW guidelines which are being enforced as law for our treating of the rural populous.

In actuality, most of the State comprehensive health planning agencies and local HSA's are having to work backward in computing needs to comply with the new 4-bed-per 1,000 and 80-percent-occupancy guidelines, as passed under HEW. Now, I will elaborate further with our own case as an example. By using the 4-bed guidelines, the planning agencies who have been directly under HEW has stated that Chatham County is not increasing in population, which we think is erroneous, and is 200 beds overbedded. Therefore, they state that the next hospital who came in for capital expansion request, would have the entire area's bed excess removed from the one institution.

We at Chatham are only asking for the right to replace our current licensed and current medicare and medicaid approved beds. I ask you, is it right to reduce the so-called bed excess from only one of the three institutions in our area? I realize there are some areas in the country where there have been shifts in population. Therefore, 50 percent occupied hospitals should not be allowed to completely replace themselves in new construction programs when new construction is indicated. But, in our area, Savannah has an overall occupancy of 74 percent with each of the hospitals currently averaging between 69 percent and 77 percent with our own occupancy rate falling right in the middle.

Currently we are licensed for 339 beds. We are the oldest continuous existing hospital in the South with one of the buildings we are currently operating out of going back to the 1890's. I don't think you could get much more utilization out of it. Within 70 miles of us in rural Georgia there is a 138-bed Hill-Burton public hospital that has only 75 beds open with an occupancy rate of less than 70 percent. Therefore, applying the 4-bed-per-1,000 population, regulations indicate that we should cut back in the Savannah area.

If we went ahead and built a new facility at the recommended reduced bed level, which we attempted to economically justify by the comprehensive State planning agency of only 275 beds, we would be 96-percent occupied on today's census. We believe that is foolish to move in that direction. I am simply pointing out that the people in Georgia are trying very hard to comply with the regulations from HEW as they are being interpreted and enforced as the law; therefore, the spirit of the planning law is being destroyed and our health industry is being tremendously hampered.

I guess what we will have to do when a rural hospital's emergency room calls and says they're transferring a neurosurgical patient, our response would be that we have no beds, use your 50 percent unoccupied beds and we'll send the neurosurgeon to you. I ask you, is that likely? No, not that the neurosurgeon is too good to go to the rural area to practice, but because there is not enough neuroproblems to utilize his abilities fully. We in the health care industry know that many areas of the country are ignoring the HEW regulations and are ignoring the attempt of the planning law.

I believe Senator Nunn referred to that earlier in his opening comments. But, Senators, your folks in Georgia are trying very hard to make it work, but HEW regulations are legislative and in fact they are superseding your law. You have to restrain this area of administration. My second point, and very briefly, is as follows: President Carter's 9-percent-cap program—while we sincerely appreciate the President's

efforts and while we believe he is sincere, his proposal will completely stagnate the health care system. No. 1, it will become an inoperable monster as did the wage and price freeze under the Nixon administration.

Where the loopholes have become the name of the game and the hospitals who were sincerely complying with the spirit of attempting to control costs and the inflation will end up being totally destroyed. I can speak from experience since I was the administrator of a small hospital in North Georgia where we worked to find the loopholes and, therefore, our hospital survived. Candler Hospital worked at complying with the theme of deterring inflation and stayed within the wage and price freeze, did not pursue the loopholes, and, believe you me, Senators, we have not recovered yet.

Be it a 15 percent or 6 percent or an overall average of 9 percent cap, this does not allow an increase in the revenues or cost for new services. For instance, if we determine that an item of equipment, such as a linear accelerator for the treatment of cancer, is cost justifiable, needed, and will be used to prolong the life and productivity of a cancer patient, we cannot buy it and charge for it even if it is approved by the planning agencies because of the fear that we will be going over the 9 percent cap which will be consumed by the following: No. 1, increase in cost and wages, No. 2, increase in utility cost, No. 3, increase in normal supply cost, and No. 4, increase in malpracttice insurance premiums. If all industries are capped, then we endorse the cap program.

Therefore, we in our area believe in cleaning up what we have before we plow new ground. Senator Talmadge, your efforts to clean up the medicare/medicaid program received our overall endorsement. You had some specifics in which we strongly disagree with but overall the concept of cleaning up what we have before introducing new legislation is extremely important. However, Senator, the law of supply and demand is taking care of the hospital-based physician's income. That was a problem 8 to 10 years ago but nowaday, supply has caught up with the demand; therefore, your attempts to regulate these areas I think are no longer necessary. Therefore, please, no more regulations.

I will be happy to share with you some of the experiences in the Savannah area if you desire. Overall we are having problems delivering health care due to the regulations which are destroying the intent of the law. Also, the central control of HEW is heading in the direction of the British health care system where centralized control has destroyed the ability of the local citizenry to make the decision about their health needs. This is quoting the British health experts and not just my interpretation.

Also, the President's cap program is like applying a 1-inch-by-1-inch Bandaid to cover a 12-inch long, 4-inch wide, 2-inch deep laceration. The patient will bleed to death. Finally, your bill to clean up medicare/medicaid, with the exception of leaving the supply and demand to control hospital-based physician's income, has our support and prayers. I thank you very much for giving us the opportunity to express our concern.

Senator TALMADGE. Mr. Tinnermon, when we were holding hearings on our so-called medicare/medicaid reform and cost contained bill,

some representative purporting to represent a number of hospitals including Candler Memorial Hospital made the flatfooted statement that they supported the 9 percent cap. I asked him specifically if he was speaking for Candler Memorial Hospital. His answer was in the affirmative. Do you deny that statement?

Mr. TINNERMON. Yes, sir, it was not me.

Senator TALMADGE. You don't support that?

Mr. TINNERMON. Absolutely not, no, sir.

Senator TALMADGE. I've forgotten the gentleman's name—John Horty, do you remember the name of such an individual?

Mr. TINNERMON. Mr. Horty is an attorney in Pennsylvania.

Senator TALMADGE. He represented a group of 50 or 60 hospitals, one of which was alleged to be Candler Memorial Hospital in Savannah, Ga.

Senator NUNN. Maybe that's an expense you can cut.

Mr. TINNERMON. I did come to—I did have the opportunity to appear with a friend but I did not get to speak before your hearing last year and I do appreciate that opportunity.

Senator TALMADGE. Now you, I believe, operate the oldest continuing operating hospital in the South?

Mr. TINNERMON. In fact, they are——

Senator TALMADGE. With reference to the hospital related physicians, and I take it you disagree with my proposal in that regard, you are aware now that the American Medical Association College of Surgeons has agreed with that statement, are you not?

Mr. TINNERMON. No, sir, I was not aware of that.

Senator TALMADGE. I understand it is now supported by the pathologists, anesthesiologists, and also the radiologists. You do believe in the old American principle of a fee for service based on service, do you not?

Mr. TINNERMON. Yes sir, that's exactly——

Senator TALMADGE. That's what we are trying to get at. I have no complaint with the pathologist, the neurologist, the anesthesiologist, for we do know that they are really the heart of medicine. We've found illustrations, I don't think we've found them in the southeastern hospitals, but we did in some of the eastern hospitals and some of the midwestern hospitals where some pathologists were representing two or three small midwestern hospitals and had a gross income of $300,000 or $400,000 a year, and one pathologist in a 132 bed hospital, as I recall—where was it? Maryland? What was his income? $300,000 plus? You don't agree with that, do you?

Mr. TINNERMON. No, sir, I think you have a very good point. When I first came in this field there was such a vacuum in that area and when there is a vacuum and that much income, it filters and has taken care of itself, and I see that happening in our area——

Senator TALMADGE. We're aware of what you are going through now in getting your new hospital going and we'll do everything we can to help. I hope we'll get complete cooperation from the State government and the Federal Government. You estimate that your new hospital will be 95 percent occupied?

Mr. TINNERMON. If we build on the amount of beds approved by medicare/medicaid, we would be 96 percent occupied today.

Senator TALMADGE. I want to congratulate all of you and you're really on the firing line as administrators of hospitals with funds to make the services available and of course you have to deal with your physicians. The physician in the final analysis must determine what he's going to prescribe to the patient and how and what length and all of you will agree with that, I'm sure. In order to reduce hospital costs we're going to have to have the complete cooperation of the administrators and every member of the staff. Someone has referred to us, a member of our committee as a matter of fact, has referred as the 9 percent cap as the survival of the fattest, would you agree with that statement?

Mr. TINNERMON. No, sir, I don't necessarily agree with that statement, I'm just saying I think it would deter anything in the future in the way that it's done.

Senator TALMADGE. All of us I think want to put a cap on the tremendous expense of medical costs. We've got to. We have no other alternative. It's absolutely essential and it's absolutely mandatory, but I think there are better ways and more effective ways of doing it than saying 9 percent, and that's all when your costs go up 12 percent to 14 percent. That would put you out of business in a hurry, wouldn't it?

Mr. TINNERMON. Yes, sir.

Senator TALMADGE. Senator Nunn?

Senator NUNN. I agree with your statement on that and I appreciate the testimony of all here. I've been in touch with Ed Tinnermon some and I would ask Dr. Reich if you could take a look at this matter. You heard his statement of some of the exceptional problems Candler has as opposed to the general trend and we would appreciate your attention to that, too.

Senator TALMADGE. Thank you very much gentlemen, for your very complete and thorough testimony. The last and final panel of witnesses we have today is the panel that's representing the Mercer University Medical School including Senator Hugh M. Gillis of Soperton, chairman of the Senate study committee on health and medical education, and Dr. Walter Rice, coordinator of development of Mercer Medical School. Gentlemen, we've discussed the Mercer Medical School in some detail already. The mayor of Macon has presented the case very well. Dr. Rufus Harris has also stated it very thoroughly. We also have a statement from Dr. Milford B. Hatcher, Macon surgeon, former member, board of trustees, and member, president's council, Mercer University, Macon, Ga., and I'd ask that his statement be made a part of the record at this point. Without objection it is so ordered. Who's first Hugh, you or Dr. Rice?

[The statement of Dr. Hatcher follows:]

STATEMENT BY MILFORD B. HATCHER, M.D., SURGEON, FORMER MEMBER BOARD OF TRUSTEES, AND MEMBER PRESIDENT'S COUNCIL, MERCER UNIVERSITY

Back in the 1960's, a number of physicians in Macon and Bibb County realized that there were too few physicians to adequately take care of the medical needs of the people—mostly the rural people—living in middle and south Georgia. Therefore, in 1969, the Bibb County Medical Society passed a resolution which requested the proper authorities to investigate the feasibility of, and then, if it were feasible, to develop a medical school in Macon.

The thinking was that there was sufficient local physician talent to educate 30 to 40 Primary Care Physicians per year. The Macon Hospital (now called the

Medical Center of Central Georgia), had a "track record" as a medical educational facility. This hospital had been training physicians for General (Family) Practice and for some of the specialties, namely Surgery and OB–GYN, for many years. General (or Family) Practice has always been recognized as the fundamental Primary Care activity. The Macon Hospital had had its General Practice-Primary Care training program since the 1930's. There was ample clinical material; there were well-trained, well-qualified medical staff to do the teaching, and there were successful ongoing programs. The graduates of the Macon Hospital Program were scattered throughout area towns like Gordon, Cordele, and Tifton, but the numbers were not sufficient. Many doctors thought that 30 to 40 doctors per year could be trained in Macon and utilized in this area.

When he took office, Governor Carter of Georgia appointed a commission to make an extensive study of Georgia's needs and the aspirations of its people. The report, "Goals for Georgia," was published in 1972. A section of this study revealed the fact that there was a shortage of physicians in the middle and southern parts of Georgia, particularly south of the Fall Line. Many counties had lost physicians and some were without physicians. All of the medical facilities were understaffed.

With the passage of the Health Manpower Act of 1972, Congressman Carl Vinson, recognizing the physician shortage in the state, and particularly in our area, requested that a medical school be established in Macon and that Mercer act as the educational vehicle. The Officers of Mercer University knew that they were unable to finance a medical school; but they also knew that with Federal assistance, with the community's backing, and with Mercer as the academic base, one had all tho ingredients of a community-based medical school. The Greater Macon Chamber of Commerce, along with Mercer, then started the process of establishing a medical school in Macon.

Five years have gone by. We are prepared. Mercer has agreed to act as the academic vehicle for the formation of this school. The Medical Center of Central Georgia has agreed to act as the clinical teaching facility. The Bibb County Medical Society has endorsed the project, and over 120 regional physicians have volunteered to assist in teaching.

The school will be different. Classes will be small. Training in Primary Care will be the emphasis. There'll be some training in rural areas under the supervision of both the faculty and the practicing rural physicians so as to give the students insight into this type of career.

The new medical school at Mercer is a case of private enterprise working with governmental agencies and together furnishing a critical need of health manpower to the Middle and South Georgia areas, to the entire state, and thus to the nation. Students would be carefully selected; the intent is to have them return to physician shortage areas and as near home as possible. Because of its emphasis upon professional careers in Primary Care, the young physicians this school will train will be more interested in going into this field of medicine than the physicians trained in larger institutions where emphasis is upon specialty care.

As I see it, the State and Federal governments will get a great bargain in getting trained physicians and ancillary medical personnel. It will be a bargain because of Mercer's ability as a private institution to obtain endowment funds and operating funds from private individuals, from foundations, from trusts, and from other sources. These are the kinds of funds generally not available to state institutions. For example, in 1976, 43 percent of the charitable funds donated by the American public were given to church-related groups. Mercer, being a Baptist-oriented school, would be eligible for these kinds of funds. (Yet, admission policies will be "blind" to an applicant's religion, just as they will be to an applicant's sex and race.) Mercer, having always had to run a "tight ship" in its fiscal policies, will gurantee that each dollar is wisely spent.

Mercer University has proven for more than a century that it is capable of carrying out such a program. Mercer University's century-old Walter F. George School of Law, and its Southern School of Pharmacy are preeminent schools in their professional fields. Mercer University could develop an equally impressive, community-based School of Medicine turning out badly needed Family Practitioners.

BIOGRAPHICAL INFORMATION

Name: Milford Burriss Hatcher, M.D.

Date of Birth: May 5, 1909.

Present Professional Position: Practice of general surgery, Macon, Ga., for past 35 years.

Education: Furman University, B.S., 1931 (magna cum laude); Medical College of Georgia, M.D.; internship and surgical residency, University Hospital, Augusta, Ga.

Professional Experiences and Honors: Chief of general surgery, Finney General Hospital, Thomasville, Ga. (Army Medical Corps, 1941–46); attending general surgical staff, Medical Center of Central Georgia, 1931–41; 1946; chairman, Department of General Surgery, Medical Center of Central Georgia, 1960–1972; chief of staff, Medical Center of Central Georgia, 1956–1957; instituted and directed Surgical Residency Program, Medical Center of Central Georgia, from inception through 1972; consultant in surgery, Baldwin County Hospital, Upson County Hospital, Monroe County Hospital, Jasper Memorial Hospital, and Milledgeville State Hospital; member, Medical School Task Force, Greater Macon Chamber of Commerce; diplomate, American Board of Surgery; fellow, American College of Surgeons; diplomate and fellow, International College of Surgeons; organizer and first chairman, Georgia Medical Political Action Committee; received first distinguished service award from Medical Center of Central Georgia; member, Vocational Rehabilitation Advisory Council; member, Governor's Committee on Aging; past president, Medical College of Georgia Foundation; board of trustees, Mercer University.

Publications: Numerous scientific papers.

Senator GILLIS. I'll be first.

Senator TALMADGE. Lead off.

STATEMENT OF SENATOR HUGH M. GILLIS, SOPERTON, GA.

Senator GILLIS. Thank you, Senator Talmadge, Senator Nunn, I appreciate the opportunity of appearing before you today. Incidentally, if you have a copy of my statement——

Senator TALMADGE. We will insert it in full in the record.

Senator GILLIS. I will delete pages 4 and 5 in order to conserve time.

Senator NUNN. I'm sorry both of you had to wait so long but we had a lot of witnesses. I know you've been sitting here all the morning, both of you, and I appreciate it very much and apologize for the delay.

Senator GILLIS. I am here as a resident of a small community and of the general assembly representing the people of my district, and as chairman of the Senate study committee on health and medical education, also as a citizen desiring to promote better health care in Georgia. Like many of my fellow Georgians who live in smaller communities, I know from experience that there is a shortage of physicians and the delivery of health care. Early in the governorship of now President Jimmy Carter, almost 6,000 Georgians were polled about what they thought needed improvement. Here are some excerpts from the report entitled "Goals for Georgia," and I'm sure Senator Nunn is very familiar with this, as he headed it up.

> Education ranks with health as the highest priority of public concern. Georgians are disturbed by the shortage of health professional people. There are just not enough healing hands to go around, especially in small communities. Establishment of a statewide system of comprehensive community health centers is badly needed by more than three-fourths of the people polled. Mental health services also should be provided statewide in community centers.

Five out of six of those polled thought that there should be incentives for doctors to locate in smaller communities. The evidence is overwhelming that there is a shortage of physicians, especially of the primary care and family practice areas. In counties I represent like Wheeler, Montgomery, and Johnson, there is a definite shortage of doctors. I represent four other counties, and they have a doctor, but I'm sure that they're all below the State and national average. If Georgia's population grows as it is expected to grow, the physician shortage

will become even more real. The best information that I can find was a recent study by the Southwest Georgia Health Systems Agency, Inc. This is a study of 27 counties in southwest Georgia and here's a copy, Senators, of the report. It was financed by HEW.

[The report was made a part of the committee file.]

Senator TALMADGE. Without objection it will be made a part of the record.

Mr. GILLIS. It's a 1977 edition and the study was made by a task force of about 175 people knowledgeable in health care and supported by the HEW grant. It shows that there is a shortage of over 100 doctors in this 27-county area with 3 counties with no doctors at all. The study also shows that only two counties in the area have adequate primary care physicians and I believe that these figures would be comparable to other areas in south Georgia. Incidentally, the national average for dentists according to our population is 1 for 2,186 people. The State average is 1 for 2,985 while in this southwest Georgia 27-county area the average is 1 for 3,989. Senator Talmadge has dedicated a much needed hospital in my home county about 25 years ago. It operated successfully for over 20 of these years serving thousands of people. But due to a shortage of health care personnel it was closed about a year ago. In spite of the physician shortage, there is no shortage of young Georgians who want to become physicians. Interest in medicine as a career apparently is growing. In 1974 there were 6,900 applications for admission for the 283 places at our 2 medical schools in Georgia. This was four times as many applications as were submitted just 3 years before. Many of these applicants could become good physicians, if they just were able to be admitted to a medical school. A lot of good, well-qualified young men and women are eager to serve, and eager to become good doctors, and have to turn their talents elsewhere. In Georgia's 159 counties, 41, most south and middle Georgia counties, are categorized by the HEW as critical medical shortage areas, more than 425,000 people live in these counties. More than the population of Wyoming. If you add the total area, it's greater than that of the States of Maryland, Delaware, and the District of Columbia combined.

In a television program just a week ago, a 2-hour special on WTCG, it was mentioned that the Georgia Academy of Family Practice would add 35 more counties to the critical medical shortage area. So the doctors themselves recognize that a terrible shortage exists. At least 75, or almost half of all Georgia's counties now need doctors. Georgia imports a good many of these physicians from other parts of the United States and foreign countries. If it didn't our conditions would be even worse. Incidentally, a great number of Georgia medical school graduates are forced, for lack of appropriate opportunities, to go to other States for internship and residency experiences. Not many of these young people return to Georgia to practice. In December of 1974, which is the latest data available, there were 801 graduates of Georgia medical schools in internship or residency programs. Only 304, or 38 percent, were in training in this State. Therefore, almost 500 of our graduates were serving, and probably will continue to serve, the citizens of other States. Actually, of the 5,700 living graduates of Georgia's medical schools, only 2,800, or 49 percent, were practicing in Georgia in 1974 and of these 3 out of 4 were practicing in metropolitan areas of Georgia.

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Senator NUNN. Mr. Gillis, let me ask you a question there. Why is is that we don't have the internship or residency opportunities. Have you looked into that? What causes that condition?

Mr. GILLIS. Senator, I think it's lack of cooperation between our hospitals in Georgia. The ones that graduate from Augusta are spread out all over the United States and if we had proper cooperation with them I think we could be using them, and they will be used in the future in Macon, Columbus, Augusta——

Senator NUNN. Has that began to improve some now?

Mr. GILLIS. It has improved, yes, sir.

Senator TALMADGE. Let me ask Dr. Rice to comment on that, Senator Nunn.

Dr. RICE. I hesitate to really comment definitively on that since I don't have the figures, but the development of the residency program depends on the presence of qualified instructors and physiciars to handle those programs, and, of course, the more incentives arouna the State where such people are collected such as in Macon, the more creditable the program to be.

Senator NUNN. How would the Mercer school address this problem?

Dr. RICE. The development of a residency program is almost essential to a medical school and the fact that the residents themselves although they are under training, they are also integral to the educational process. The way American medical education developed is that it's the graduate of the system's responsibility from the first day the student resident meets the patient to the final day when the resident is released to practice and through that period of time the senior person intends to instruct and demonstrate to the junior person so the presence of a good residency program is essential to the educational program and it's part of the concept we have for the Macon medical school.

Mr. GILLIS. I would like to comment on the development of the medical school in Macon, a school whose graduates could substantially alter this picture. In addition to a well-rounded medical school composed of a dedicated faculty and the students selected are interested in primary care and rural environments, they are planning a regional program involving several hospitals and a number of regional, mostly rural, clinics. Properly operated, such a regional residency program would insure that there'd be no need for the school's graduates to look elsewhere for graduate educational opportunities. There'll be no wasteful exportation of our students to other parts—other States. Lastly, the faculty will assume the responsibility for providing continuing educational opportunities for the physicians and other health care workers in the middle and south Georgia areas. In the early 1970's when the idea for the school caught on, most fiscal support for new medical schools came from the Federal sector. In 1972 the city of Macon and Mercer University received an urban grant to purchase almost 50 acres of land for this school. But the flow of Federal funds for the operational and construction costs of new medical schools has slowed down substantially. Both the State and the community in the broadest sense have come to the rescue. Gov. Jimmy Carter and the Georgia General Assembly appropriated $5 million for the school's operations. I should like to note that as a member of the Senate Appropriations Committee, I have been pleased that two subsequent gen-

eral assemblies have reappropriated the $5 million in the hope that this school will soon become a reality.

On the local level, I believe I heard Senator Talmadge mention earlier, there has been $2 million raised. They have also passed a bond issue for over $7 million and they are currently applying for a quarter of a million dollars in Federal "startup" funds and they also expect to apply for an additional $1.5 million within the next few months. I've also been told that a large endowment has been given to the school. Providing Federal funds can be received, the financial picture is very good. Like other people who have testified here today, I think this medical schol at Mercer University is a great asset to the people of this region, to the State, and to the Nation. But we do badly need recognition and assistance from Congress as well as the executive branch. The valuable help that you have given us in the past must continue if this enterprise is to remain viable. It's a privilege to be here today to try to promote better health care in Georgia.

Senator TALMADGE. Dr. Rice.

STATEMENT OF DR. WALTER RICE, COORDINATOR OF DEVELOPMENT, MERCER MEDICAL SCHOOL

Dr. RICE. Senator Talmadge and Senator Nunn, I appreciate the honor of being able to represent the Mercer Medical School to you this morning. I would like to make my comments brief rather than lengthy and make a few points taken from my general statement.

Senator TALMADGE. The full statement will be inserted in the record.

Dr. RICE. I approach this assignment with a certain amount of trepidation and fear of being presumptuous. I have been involved with the Mercer medical program since April. I must admit that I have been fully immersed—if that's an appropriate word in this situation—in this program and have learned a great deal about it and have become convinced that it presents a unique opportunity, and I mean unique to the country, to develop a system of education that is responsive to demand and meets the local needs.

I'm not unfamiliar with education around the country. I have conducted or participated in possibly 30 or 35 accreditation surveys. I've been on the staff of the Association of American Medical Colleges. I have served under the director of planning for the University of Michigan Medical Center, and I was dean of the Medical College of Georgia for 9 years, so with those credentials and my limited experience with Macon, I will proceed to tell you what we have found here.

This community, in my judgment, and it has been noted elsewhere this morning, presents a unique opportunity in that there is a tremendous commitment throughout all segments of the community—the academic community, the people of the area, the physicians of the area—are all committed and interested in establishing a program of medical education that would be responsive to the needs of this particular area. Given that, it seems only reasonable that there should be ways devised or methods should be devised so that this could be done.

A great deal of work, as you know, has gone on in the past 4 years in developing programs here and devising such things. It was my sug-

gestion, and this was received and approved by the trustees of Mercer University and the citizens of the community and the administration of Mercer, that rather than taking the traditional route for the school, that we should utilize the resources that are present in the community immediately. The traditional route would involve the establishment of science departments, and then after those were underway, then subsequently the establishment of the clinical departments.

The proposal has been presented to the Federal Government suggesting that rather than do this we utilize the resources that we know are in the region, from Florida, from Alabama, from the State of Georgia for the education and basic sciences of selecting students, and enter them and put all of our energies into the development of a program of primary care of excellence on the base that there already exists the demand, utilizing the other hospitals and other good clinics in the region. This concept would allow students to be selected immediately, assuming we could make arrangements with the other institutions, and would then give us the quickest possible response in terms of providing physicians who would serve in the region.

The main approach or main concern that we had was to develop—to have students that would return; we've heard it over and over again this morning, about the problem of having the physicians locate in a particular region and stay with it, and one of the—there are many facets to this problem, and certainly one of them has to do with the professional satisfaction that a physician can obtain in practicing in isolation versus the physician who is practicing in the major urban center and has access to the many specialists and hospitals and facilities. It seemed that this would be the responsibility of the medical school if it was to meet the primary care of the region, that the responsibility would not end at the point of graduation, would not end at the point of qualification for specialty care, but would be a lifelong responsibility of the center so that a continuing relationship would eventually develop between the physicians who were serving the primary care role of the area and the medical center.

I think Senator Talmadge alluded earlier to the program in Colorado. This is not too unlike that. We borrow from many experiments that are being undertaken in the country to develop in the Macon area a program that will respond to the people of this area—to utilize these experiments and experiments that are being conducted elsewhere. The essential part of the program would be that the students recruited into the Macon program or the Mercer program would be selected from this region. I think we heard also earlier allusions to the concept that students or the candidates for medicine who were derived from a particular area were more likely to return to that area.

They know that the good hunting and fishing is there, and they know there is a good life in this region. They also know there's a good opportunity to serve. We think that by careful selection of students this way, we won't have to use coercion or bribery or any other methods to have them return to the area, that you can already have students committed to return. One of the problems that happens when students—and there are experiments where this is being done, in Minnesota, in Pennsylvania, that I know of, and some others—one of the problems is that the student—well, I was going to use the word "students," but he does get seduced by the glamor he achieves when he

goes into the large medical school which is specialty oriented, and those intentions that were good when he started, he gradually changes his mind so the traditional systems where family practice and primary care programs are conducted in large specialty-oriented centers with specialty-oriented faculties, the results are less likely to be positive. In our system we would propose that the students, once recruited into the program, be continually reinforced utilizing the concept that I think one of the county commissioners mentioned and have from the first year, even before this experience is so extensive, to have these students identify with physicians in the region who would become their preceptor and mentor. Hopefully, this would lead to a long and lifelong commitment and friendship between the individuals.

So in the process of selection or recruitment of students, we would then add the necessity to reinforce the commitment to indicate to them the opportunity to serve and also indicate to them the backup qualifications or qualities of a first-class medical center, and in this respect I would like to say that, as I've said in my statement, that although the current need is for redistribution of physicians, we are taking care of the number, I think, nationally certainly, redistribution of physicians seems to be the current aim or redistribution of specialties.

This does not mean that there is no longer any need for biomedical science nor for specialty education because, as noted also earlier, with more primary care, with more case findings that occur and some of these other situations, there is obviously going to be more need for specialty care because it's frustrating to find a cancer of the cervix and not have a radiotherapist to give the necessary therapy, so we're not saying when we make these arguments that the primary care school should be substituted for specialty care or for biomedical sciences but to be in addition to and a necessary complement to it if total health care is to be effective in this country.

I would like to mention one concept that we have, and of course, I think is again responsive to many of the things you've heard this morning, and that is in the development of the educational program at Mercer, I think there is a cliche or saying that when you establish a university or an academic program, one of the first things you should have is a library, and certainly this is one of the first things that has been planned here, and there is actually a library in operation, but the concept of the library as an information system, of course, is well known, and the concept of the library as a resource of information using computers and all the other technology that is available is also well known.

It would be our proposal, however, that we extend this and make this a center of information not only for medical students, not only for the faculties, but also for health care people who are in the region. That is not a particularly unique idea, but I would like to extend that one step further and make it a source of education in preventive care or the management of disease for people, that is for the patients in the area. I think this would improve not only the health of the region as a whole but certainly improve the satisfaction of the physician carrying out the health care of the region and help make it more reasonable for him to establish the idea in groups as has been suggested or even singly, practicing in an underserved area. So the concept of the total information system I think is reasonable and feasible and I

think it could provide a unique opportunity to demonstrate it to other parts of the country how this could be done. I would like to say that there is some experience in this State in this. When I was at Georgia the chairman of the department of obstetrics, Fred Grossman, who is now chairman at Iowa State, developed a very effective program in education and some of the illiterate people using their own language in terms that they understood. I would like to say one more thing and I'll stop. In the course of our development of the concept of this operation, it appeared that there were some, in my view, unnecessary and maybe, if not destructive, potentially inhibiting competition between medical educational institutions and it would seem that this was unreasonable. We're all, after all, pursuing the same goals, maybe in different directions, in fulfilling the needs, and therefore I said and it was rapidly accepted in Macon that we should operate a program in a spirit of cooperation with the other institutions and I would like to say that we have had a very interesting response from Morehouse. Morehouse as you know is in an urban area.

There are a large number of blacks in this area and very few black physicians and in our discussions it seemed we received very favorable responses to suggestions that we work in a cooperative way together while they develop their major science programs and concentrate on the problems of the underserved people in the urban area than we could provide them with an access to this program to the problems with the people in this region who are dispersed and present a different type of problem. Those discussions have proceeded to the point that president Harris and president Foster are in the process of setting up a meeting on this issue sometime in early September. There are other aspects of this thing but I think I've covered the essentials and am open at this time for any questions.

Senator TALMADGE. Dr. Rice, about 2 years ago I made the commencement address at the University of Georgia Medical School and either the president of the college or the dean of men, I've forgotten who, told me more and more graduates there were offering for family practice. Is that in agreement with your findings?

Dr. RICE. I think that's a national phenomena. I believe, sir, that it is also a reaction of students against the system of education that we now have. The system of education as I noted in my statement has tended to become impersonal for reasons that are not easily understood, especially the care that tends to be impersonal. The rapid movement of students through a system of a few days here and a few days there allows for very little personal contact with the instructors and the students.

Senator TALMADGE. That's one of the reasons for the rapid escalation of malpractice suits, isn't it?

Dr. RICE. That's true. I believe it.

Senator TALMADGE. I do, too.

Dr. RICE. Well, medicine is a personal matter between the physician who is examining you and you as a patient. Our system of education does not reflect this. The system of education itself has become impersonal. Students, I think, have generally, and I'm sure it's true at Augusta, students have generally reacted unfavorably to this and have leaned over backward to say we reject the role that our instructors are producing for us and we would rather be personal physicians and go into private care and this was true at Michigan when I was there.

It was a large school, very impersonal, highly biomedically oriented and highly specialty oriented yet the students produced in that school were also 50 percent to 60 percent for family care which this is a very interesting phenomena. I hold, however, that the large specialty oriented school, although it may provide an environment for family practice or for primary is not the best place for that to be carried out. I stated that in a statement that the family practice programs that I know of, the primary medicine programs that I know of, even the primary care programs that I know of, with notable exceptions, are more or less considered as a second choice.

After all the people that are running the medical centers are specialty oriented and to suddenly tell them this is not the best way, there's another way, is not always received very well and I think that one of the things that the Macon program allows, not only allows but encourages, would be the development of primary care, and at the time being certainly the major objective of this type of program and all the students who were here and all the faculty that was here would then be motivated to this objective. I think this would produce an entirely different atmosphere and I would hope that into that program instead of it being a second-class operation that it would attract the very best students.

Senator TALMADGE. Senator Gillis, in your statement you said that in 1974 there were 6,900 applicants for admission, 293 places——

Mr. GILLIS. 287.

Senator TALMADGE [continuing]. At the two medical schools in Georgia. Do you have any figures indicating how many of those 6,900 applicants were residents of Georgia as opposed to out-of-State applications?

Mr. GILLIS. Senator, I would think that probably 90 percent of them would be residents of Georgia. I have just called the university over at Augusta yesterday and asked about the enrollment for September and they plan to enroll 180 students, 9 of them would be from out of State.

Senator TALMADGE. They're going to enroll 100 and how many?

Mr. GILLIS. 180 freshmen.

Senator TALMADGE. Out of how many applicants?

Mr. GILLIS. I didn't ask how many applicants, but I'm sure they had probably——

Senator TALMADGE. Ten times that many?

Mr. GILLIS. Yes, sir. Now, one other interesting point in this 180 students, 102 of them would be from the metropolitan areas of Atlanta, Macon, Athens, and Columbus, Savannah, Augusta.

Senator TALMADGE. What assurance, if any, is there that the graduates from the new school, or at least a substantial portion of them, will remain in Georgia?

Mr. GILLIS. Well, Senator, we have been trying to get our university over at Augusta for many, many years to admit qualified boys and girls from rural areas but they don't seem to give them any preferences. This bears it out because they are just admitting 102 out of 180 from the metropolitan areas and they will immediately probably go back to the urban areas to practice. This is one advantage, I think, of Mercer Medical School. They intend, so I understand, to major on boys and girls from rural areas.

Senator TALMADGE. What assurances, if any, are there that we will get a substantial number of new doctors in our rural communities from the programs of Mercer Medical School?

Mr. GILLIS. Well, there again, Senator, I think if you have students from down in Telfair County or my county of Treutlen, or Johnson or Laurens, and they went to Mercer, I believe they would go back to our area to practice, knowing the need there is and we've shown a definite need and I believe they'll go where the need is.

Senator TALMADGE. Are we getting enough qualified applicants from those areas?

Mr. GILLIS. Yes, sir.

Senator TALMADGE. Senator Nunn?

Mr. GILLIS. Let me add one other thing, you asked about our interns and one reason, and I'll go ahead and answer your question too, about the changes to family practice. The Georgia Legislature has passed a number of resolutions asking our school over at Augusta, you know you can't direct, both of you are familiar, you can't direct the board of regents to do anything, but we did pass a number of resolutions asking them to devote the majority of their time trying to recruit students that would go into family practice. Now the reason probably for the interns going out of the State is because in the past 80 percent of them were specializing and they would go to a hospital in New York or the Mayo or somewhere where they could further their education in their specialty field. I think with the Mercer plan they would intern in Georgia.

Senator TALMADGE. Senator Nunn?

Senator NUNN. I would like to briefly recognize Bill Haywood and Cloyd Hall who have done an outstanding job with the Mercer project for a long time. Will you stand, Bill and Cloyd? I appreciate your coming and the good work. Dr. Rice, could you tell us briefly what problems you are having with this particular application now, the funding under section 788–G, and then I want to ask Dr. Reich to give us a report on what he has found out this morning since we convened.

Dr. RICE. The problem, I think, revolves around the fact that our proposal is somewhat different—these comments apply not only to the review processes in the Federal system but also in the accreditation process which, of course, has been recognized, for the time being certainly, by the Federal agencies. The review process is carried out, well, is technically carried out by peers but is actually handled by staffs and when you come up with an overload and come up different, then no matter how logical it is, if you come up different than the formula you received in the past, then naturally there is a certain amount of questions amongst the staff and I think probably amongst the peers. So the peers are recruited also from the system and we essentially are challenging that, the system being the system of specialty care and the emphasis on biomedical research. We're not challenging that in the sense that we suggest that those are not really good objectives, they are and they're essential. We do think that there should be a place, however, in the system for a program which is more responsive to local needs that is tailored to local situations and is responsive to this particular problem of distribution, maldistribution, of the young physicians and we'd like those active in health care in underserved areas and we think we can design a program, we think we have designed a program, which will respond to that.

Senator NUNN. What is the basic criticism you have of your application?

Dr. RICE. It's not traditional.

[The prepared statement of Dr. Rice follows:]

STATEMENT BY WALTER G. RICE, M.D., COORDINATOR OF PROGRAMS, SCHOOL OF MEDICINE AT MERCER UNIVERSITY, MACON, GA.

Senator Talmadge and Senator Nunn, this is a statement regarding the concepts that have gone into the planning of the School of Medicine at Mercer in its attempts to meet the health care needs of Middle and South Georgians.

All people, rich or poor, urban or rural, have expectations of the health care system. They expect the care to be available when needed; they expect that the care will be humane and personal; they expect that those who give the care will have the best skills and knowledge that biomedical science can offer; and they expect that the care will be provided in an economic manner.

The American system of medical education, supported by private and government funds, has responded to these needs—most effectively in some ways and less effectively in others. In the area of specialization—an area that requires technology, organization and skills—the American medical educational system has evolved into a system which is second to none.

Highly specialized faculties produce highly specialized students. A list of American achievements in specialty education would be long and impressive. At the same time, the biomedical sciences have advanced dramatically and have received international recognition and acclaim. However, it is apparent that while our medical schools are turning out young doctors more skilled and more knowledgeable, the patient's other expectations are not being met. Indeed, if anything, there has been a general loss of the personal relationship between physician and patient, there has been a diminution of ready access to care to large parts of the population, and there certainly are great questions regarding the economics of the system.

The immediate needs for a greater number of physicians were recognized in the Bayne Report in 1959. Subsequent Federal, State, and private policy statements stimulated then existing medical schools to expand and new schools to be established. The goal was that by 1980 the annual output of medical schools would be at least double the output of 20 years earlier. The traditional medical schools with their biomedical research facilities, their scientists, and their highly-qualified medical specialists did expand their student body size. But they did not change their approach. It was soon apparent that merely increasing the number of physicians through increasing the size of the student bodies was not going to solve the problem for the individual patient who expects personal and accessible health care. In fact, increasing the size of student bodies often by as much as 100 percent tends to impersonalize the educational process. Students become separated from instructors; the student becomes less identifiable as an individual. By its nature, medical care is a very personal, a very individualized process from the time of delivery into the world to the final act of dying. The medical educational system, emphasizing specialization, flooded with increased numbers of students, has become more and more impersonal. Students take courses in groups for short periods of time—interestingly called "rotations." They revolve through the system and are exposed to as many facets of medicine as time allows. Instructors have less and less personal contact and can take less personal interest. Department chairmen are frequently required to certify students for graduation, students they know only at second or third hand. All schools wtih large student bodies have experienced student challenges to such impersonality. The impersonality of the educational system is incongruous in the presence of recognized personal needs of the relationship of patient to physician.

A second factor which has significant effect on the medical education environment is found in the biomedical sciences. Traditionally, these were the sciences "basic to medicine." But as knowledge and technology developed, the teacher-scientist has gradually become a scientist-teacher. The scientist-teacher has become more committed to "pure" biological science. It is here that the excitement of research, the national and international recognition, and the grant funds are to be found. Teaching medical students becomes a "load," frequently to be avoided by the more senior faculty, and frequently, too, to be carried out with less enthusiasm than he gives to his research and to the training of other biomedical scientists. The trend is definite. The trend is reflected in the curricula

of a significant number of established medical schools. The first year in medicine is directed in concentrated form to "pure" biomedical science. In the second year the student enters "clinical medicine." But, inevitably, this year becomes one of "applied" biomedical science with the sciences related to clinical practice being taught under the labels of clinical departments.

An effect of these emphases on specialization and on the biomedical sciences has been to make the student's contacts with patients less and less personal. Science prizes objectivity. It is often difficult to have sympathy and to relate subjectively to a patient who is also the subject of a research study. Students have long recognized and recently rebelled against this pattern which occurs too frequently in a large Medical Center.

The faculty rewards in terms of recognition, peer approval, promotion, competition for prized positions, and in salary are given for scientific achievement. Only recently have some large schools recognized clinical achievement as equivalent to scientific achievements. These experiments are in difficulty. It is difficult, if not impossible, for a faculty which has developed in one direction suddenly to reverse and become interested in primary care, in the maldistribution of access to health services, and similar people-oriented issues.

This argument is not put forward as one opposing either the highly specialized clinical education system as it has evolved, nor the trends in the biomedical sciences. Indeed, in the necessary balance of a system of health care, both of these elements are essential and must be supported. The increased numbers of sick persons who inevitably will be found as Primary Care is extended must be given access to the first-class specialty care which is also a fundamental expectation. Biomedical science must continue to advance so the conquest of ill health and disease can continue. We cannot—we should not—abdicate our scientific leadership to other countries. But we do question whether great emphasis on scientific activity is essential to a medical school which is committed to turning out primary care physicians. The development of primary care educational programs in existing schools should not be carried out at the expense of these aeas in which excellence is already a matter of record.

However, if public expectations are to be met, it is necessary to examine the existing system to devise means whereby significant numbers of the best students will be stimulated to pursue careers as primary care practitioners who deserve status equal to the "specialist" in institutions as well as in the community. One solution has been to mandate and fund programs in family medicine, or in other types of primary care in traditionally organized medical schools. This solution has not been a resounding success. The patterns and roles of an entire generation of medical school leaders whose educational goals have been directed toward specialization and growth of the biomedical sciences are not easily or rapidly changed. Primary care or family medicine continues to be viewed as a secondary pathway, a pathway not suitable for the most gifted students. There are outstanding exceptions to this statement, but the fact tha, they do stand out emphasizes the secondary place of primary care in the curricula of the day.

A number of new and developing schools have attempted, in various ways, to address the problem. New curricular designed to emphasize primary medicine have been planned. New schools have experimented with the recruitment and selection of students so that these will (a) return to the underserved area, and (b) select primary care as a means of getting the greatest personal rewards and satisfaction. Each of the new programs has particular features and characteristics which address the particular needs of a give area. The Macon-Mercer program has similar, unique combinations of features so that it relates directly to the particular needs of Middle and South Georgia.

One of the disadvantages of the affiliation of a community hospital with a large remote medical school is the difficulty that the larger institution has in being responsive—or even appearing to be responsive—to the needs of a far-off community. Those at the medical school believe that the best equipment, the best faculty, and the best students will be retained at the center and those less desirable will be assigned to the satellite. The satellite, in effect, gets the leftovers. There is a decision-making and administrative hierarchy which impedes progress and makes initiative at the remote site virtually impossible. There is the unfavorable view of the absentee landlord. The programs are imposed with nominal and minimal input from the community being served. The Macon community has had such experiences in the area of Allied Health. In spite of excellent programs conducted elsewhere in the State, the local needs were never met until there were established locally supported, accredited programs in these fields. Now regional hospitals are being staffed from this educational source. This type of experience

serves to support the view that the same would apply in an educational program in primary care.

The reasons why physicians elect not to practice in a town relatively far from a major medical center are many and complex. Specialists require the support services and concentration of patients provided by the urban center. Primary care physicians, on the other hand, by the very nature of their mission, will be dispersed and to a certain degree isolated. It is recognized as important that this professional isolation be minimized or abolished if professional satisfaction is to be achieved. Programs in continuing medical education represent major efforts in this direction. However, these programs tend to be formal and to be scheduled. Professional problems with patients tend to be unscheduled. It is the intention of the Mercer plan to develop a continuing, lifelong relationship between its graduates serving the region and the faculty of the medical school. This will be a collegial relationship with each supporting the other. The primary physician will rely on his teachers to keep him abreast of developments and to continue the educational challenge and stimulation that began in medical school. At the same time, the faculty will recognize the primary physician as an essential extension of themselves, carrying out the immediate care of people beyond the urban confines of Macon. The responsibility for quality care at the primary level will thus be jointly borne.

This new concept of joint responsibility has been termed visionary and impractical by some. Nevertheless, there is enough experience from the past and there are enough experiences in the present to make it a worthwhile goal. That is why it is one of the primary objectives of the Mercer plan.

Except for the last six paragraphs what follows has been excerpted from a recent grant request.

The proposed project is based on the following assumptions. Each of which may be evaluated against experience:

1. That a compact, locally accountable medical educational program is more likely to generate local support and be responsive to local needs than larger and more dispersed programs. Local support can be measured by: (a) utilization of the clinical facilities through increased occupancy of the hospital; (b) political support from elected officials through continuing contribution of funds; and (c) private financial support from individuals or corporations.

2. That a program targeting the specific needs of an under-served region should be given priority in developing plans for medical education. The ability to maintain the target of producing family medicine and primary care physicians with consistency will establish the value of this assumption.

3. That the program should cooperate and utilize the available educational resources of the region as fully as possible, for the mutual benefit of all, and in order to make the operation as economical as possible. The ability to develop cooperative agreements with hospitals in the region, and to develop contracts or cooperative programs with other medical institutions (Morehouse, Emory, or the Medical College of Georgia, specifically), will indicate the usefulness of this assumption. A continuing monitoring of the costs will establish its economic quality.

4. That quality of students and quality of faculty should not be compromised. Objective data on faculty and students will be a continuing means of evaluation. Subjective data may be more difficult to use, but will be obtained systematically in order to establish the issue of quality in broader terms than MCAT and other exam scores, publication-lists and other, strictly academic, measures.

5. That skills and resources available in the clinical areas should be mobilized and used in order to make the quickest progress. Selecting and admitting a first year class at the earliest date possible will establish this point.

6. That a continuum of student-faculty relationship developed in the context of a small school in which faculty are also the providers of health care is the best means for establishing long term continuing education. Evaluating this assumption will take a long time and will depend upon measuring changes in the quality of health services, improvements in access, and statistical changes in frequency of disease.

7. That recruitment from more mature students who have served in the health field in the underserved region is a logical way of increasing the return of these persons to the region. Documentation of the return of such students to family medicine or primary care in the region will be a continuing study.

BACKGROUND

For about ten years there have been determined efforts to develop a medical education program based in Macon. Political support in response to community

pressure has maintained and strengthened the efforts. In 1972, Mercer University agreed to be the academic sponsor of the program. A Dean was appointed late in 1973. Plans were then developed to establish a traditional medical education program. Following his resignation, the current Dean was appointed and the plans continued for the traditional program, directed toward establishing a Basic Science Division with simultaneous organization and establishment of clinical departments. The overall intent to have a medical education program which was community-based and directly responsive to community needs was maintained. In spite of tangible demonstrations of political and community support, the original program has not come to fruition.

In April, 1977, a new strategy and concept was introduced and accepted by both the Mercer University and the community leadership. This called for the indefinite deferral of the basic biomedical science development on traditional lines, and for concentration of effort and resources in the clinical area while maintaining the overall commitment to primary care objectives and direct accountability to the community and area served. The plan presented additional advantages in the form of immediate opportunities to initiate cooperative activities with other medical educational institutions, the prospect of immediate visibility, the quickest route to producing physicians, and not the least, the chance to develop an innovative model which might prove useful in other contexts.

The medical service needs of Georgia and of the southern region have been documented by several different groups. The population to be served is largely rural with small towns and villages interspersed. The largest city between Atlanta and the Florida border is Macon.

By addressing the issue of physician distribution directly, it is planned that through the vehicle of this medical educational program that the deficits in access to health service produced either by geographic maldistribution of physicians or maldistribution of services to particular elements of the population will be relieved.

The Macon Hospital—now called the Medical Center of Central Georgia—has had a long and active interest in medical education. Some medical students are assigned in the clinical years to educational programs in the hospital. There are also approved residency programs in Surgery, Obstetrics and Gynecology, and Family Medicine. The plan, therefore, is to add the proposed medical education program to these ongoing programs.

The acceptance of the plan, as outlined, has led to a series of additional developments which will emerge in the following text.

INSTITUTIONAL GOALS

The institutional goals are simply stated. It is the objective of the program to improve the access to health care in the region of increasing the number of well-trained, well-educated primary care or family physicians as quickly as possible. An essential principle is that the quality of the program should not be compromised for expediency, but through the faculty, the students and the efficiency of the organization an environment of excellence could be extended into the surrounding undeserved region with its low-density population. A third objective is to provide personal and continuing contacts between those providing tertiary care and those providing primary care so that in a continuum of specialty care that is the inevitable outcome of primary care case-finding the impersonality that occurs in most referral systems would be minimized and even obliterated. Through small classes with continuing personal attention from teachers and perceptors, students are expected to develop long term collegial relationships that can only enhance the quality of health services being provided. In this atmosphere, the student, who frequently rejects the impersonal relationships generated by a large student body and a faculty distracted by complex obligations and aspirations, may find a satisfactory model for primary health service closely identified with secondary and tertiary services in the same geographic and cultural setting.

ENROLLMENT AND ESTIMATE OF NEW SCHOOL SERVICE IMPACT

Projections of enrollment are based partly on estimates of the numbers of students that could be placed in basic science programs in medical schools in the region, partly on estimates of the capacity of the clinical resources which are known to be available, and partly on the objective of establishing a small, intimate program in which the relationship between student and instructor is continuing and continues beyond graduation and the residency period.

We realize that students entering our programs might elect to leave in order to train in Secondary or Tertiary Care specialties. These students will not be discouraged when there are strong indications of a change in motivation. However, by maintaining personal contact, by reinforcing the originally stated objective to provide health care at the primary level, and by maintaining the Macon-Mercer identity of the studets even while they are attending basic science instruction in another school, it is expected that attrition through change in plans will be kept to a minimum. Persuasion and example will be used in the place of coercion. When vacancies do occur, a limited number of transfers from traditional programs will be accepted. The projected class size is twenty-four, increasing to thirty-six in two or three years. Subsequent increases will be considered as we gain experience and after gauging the political, economic, and academic environment.

The admissions process will have three major criteria:

1. Geographic. Students who grew up in the region as revealed by their grade and high schools will be given priority because it is within this group that there is the greatest expectation of a desire to stay.
2. Academic. Performance in undergraduate school and the results of MCAT testing will be utilized. Persons with certain non-cognitive personality characteristics will be sought.
3. Social. Motivation to serve in humanitarian causes will be evaluated. Evidence of activities indicating involvement and leadership in services to the community will be evaluated. Priorities will be established for students who are qualified and have already had experience in health delivery in the region. It is hoped that a significant proportion of the class can be recruited from more mature individuals who have seen some health-related or community service and view the study of medicine as a means to further that individual aspiration.

PROJECTED OUTPUT, FAMILY MEDICINE AND PRIMARY CARE

	1978	1979	1980	1981	1982	1983	1984	1985
Residency programs	9	9	12	14	26	32	32	32
Undergraduate programs					24	24	24	24

ENROLLMENT, REVISED PLAN

	Fiscal year 1979 (1978)	Fiscal year 1980 (1979)	Fiscal year 1981 (1980)	Fiscal year 1982 (1981)	Fiscal year 1983 (1982)	Fiscal year 1984 (1983)	Fiscal year 1985 (1984)	Fiscal year 1986 (1985)
1st year	24	24	24	36	36	36	36	36
2d year		24	24	24	36	36	36	36
3d year			24	24	24	36	36	36
4th year				24	24	24	36	36
Total:								
Mercer/Macon	0	0	24	48	48	60	72	72
Contracting schools	24	48	48	60	72	72	72	72
All years	24	48	72	108	120	132	144	144

Note: Figures do not allow for estimated attrition of 5 to 10 percent.

Under the proposed plan, the initial output from residency programs directed to Primary Care might be expected to begin immediately and to reach a maximum in the mid-eighties. The first class of undergraduates admitted in the fall of 1978 would enter practice after three years residency in 1985. The projected outputs would total more than 160 new physicians ready to practice by 1985. While this is an uncorrected number and does not allow for attrition and inevitable changes of direction, a three-quarters retention rate would have produced 120 new Primary Care physicians for the area by that time. This is a reasonable objective against which the effectiveness of the program could be evaluated.

It is reasonable also in view of the statement (in "*The Need for More Family Doctors*," published by the Georgia Council for Family Practice Education, 1974), that 488 additional family physicians (only one segment of Primary Care) will be needed in Georgia through the year 1980.

The school's faculty will render services at the teaching sites and, in many cases, in their private practices. (A Family Practice Plan is being developed.)

It is estimated the immediate service impact of our faculty in the "private sector" to be equivalent to seven to ten new full-time physicians in the area.

An essential feature in developing a reasonable distribution of physicians is the development of an environment in which satisfactory health care can be delivered and the primary care physician does not develop feelings of frustration and inadequacy. Two major elements in the plan are designed to effect this. In the first place, as previously noted, the development of a continuing relationship between the undergraduate student and his instructors who are also the leaders in providing primary, secondary and tertiary health care, should establish the rapport and professional basis for continuing relationship during practice years. Such continuing relationships will be a part of the formal Continuing Education Program, but will have a more meaningful nature by virtue of the continuous personal relationship and mutual respect between instructor and student.

A second feature which reinforces the first will be the establishment as the core of the academic program of a center for learning and information. Designs and organizations of such centers are many, and this one will have to be developed to meet the particular needs of the region. A major element in this will be a program in public and community education tailored to the culture and people who are being served.

Finally, in the development of an educational environment, even with wide dispersal of individuals, it is the experience of others (e.g., Allentown, Pennsylvania), that there is an improvement in the attraction for physicians already qualified to settle in the area. This factor, along with the modest increase in numbers of practicing physicians on the full- and part-time clinical faculty. can be expected to provide an immediate effect.

PRESENT STATUS

The plan has been reviewed by several individuals who have knowledge and experience in this field. They have stated it is feasible and uniquely responsive to the local situation. However, in the review and accrediting process, there are emerging expressions of concern and opposition which are discouraging. The Mercer administration has dealt openly and forthrightly with all the reviewing groups and has attempted to conscientiously respond to all requests. There has been less consistency in the response from viewing or accrediting groups.

The HEW review process for grant applications and the accreditation process ostensibly depend upon objective peer reviews for final decisions. The peers are recruited or selected from similar or identical pools with a dominance of professional medical educators. There are only a limited number of medical school deans available at any one time. Given the recent history of medical education, it is inevitable that such groups will be strongly biased toward the more traditional biomedical science—specialty system. Most members of the group have spent their professional lifetime committed to this way of teaching medicine. Programs which differ from the traditional or which suggest a new trend may appear as challenges to established ways. These newer programs are not viewed favorably. The Mercer program has innovative features which may be viewed in this way. It recognizes a local responsibility as being more important than nominal academic approval from a distance. It recognizes the need for combined responsibility between academic institution and community. It plans to begin with immediately available resources and experience. It recognizes the applied biomedical scientist as being an important part of the educational process. It looks toward mutually supportive rather than competitive confrontations between institutions with complementary goals.

For these reasons there is a real danger that the Mercer program will not survive the so-called peer reviews. True peers with the experience and knowledge of education directed explicitly toward primary care would be more receptive.

The review systems do not allow direct access by the petitioners to the decision-makers. Contacts must be made through intermediaries. It is inevitable that much will be lost or changed in the translation. The Mercer project is medical education is at a critical period in its development. Independent reviewers have indicated that the plan is well-conceived. It has expectionally strong and tangible support in the community. Public subscriptions and a multi-million-dollar bequest have placed the plan in a fiscally viable position. But without the mark of approval from the HEW reviewers and the AMA–AAMC Liaison Committee for Medical Education, the project will die. It should be noted parenthetically that the Liaison Committee on Medical Education is recognized officially, at least

temporarily, by the Federal Government. Should this barrier not be surmounted, the city's bonds will not be sold, the Georgia Assembly's appropriation will be withdrawn, the subscribed funds will revert to donors, and the bequest will go to worthy alternatives. Macon will lose its vision and the people of the whole state will continue to wonder why they cannot get access to health care.

Seator NUNN. Well, 2 years ago they were saying it wasn't innovative.

Dr. Reich, can you give us a status report please?

Dr. REICH. I called Washington as you directed and they have the application and it's being reviewed under section 788–G.

Senator NUNN. I've been saying 288, it's 788, is that right?

Dr. REICH. 788. The review will be completed very shortly and will go to the National Advisory Council on Medical Education which meets August 29–31 and that's the council of peers that Dr. Rice was talking about.

Senator NUNN. Is this a group of people outside the Government?

Dr. REICH. Yes, sir. It was established by the manpower law that these applications must go to them for their examination. They, in turn, then recommend to Secretary Califano what should be done.

Senator NUNN. The decision will be made at the Washington level, will it not?

Dr. REICH. Yes.

Senator NUNN. Is there a recommendation from your regional office that is going to accompany that process. Does your office make a recommendation?

Dr. REICH. No, sir. Our office was directed to keep our nose out of it.

Senator NUNN. Well, we've been told that there was, of course, a person here from your office. What was his role in that? What was his name?

Dr. REICH. I knew it but I can't think of it. He is on my staff. I'm not sure why he was down here. Perhaps he was directed to, I don't know. I'll have to find out.

Senator NUNN. Well, I've been told, and this is an allegation, I don't know who came and I don't know which person it was, but someone made the statement that your bureaucracy had no difficulty in securing or changing the will of Congress regarding this. I hope you'll check that out.

Dr. REICH. I certainly will.

Senator NUNN. We know that is sometimes true but we hate for people to brag about it.

Senator TALMADGE. Doctor, could you use your good office to help stimulate this proposal?

Dr. REICH. Yes, sir, I have, when I was on the phone.

Senator TALMADGE. We appreciate it greatly and if there is no further comment from Senator Nunn or anyone else we'll stand in recess until 9 a.m. in Atlanta on Thursday morning.

Senator NUNN. Senator Talmadge, let me make one brief statement. Cheryl Davis, of my personal staff, has been very helpful in this and I know you've got a personal staff person that's done a tremendous job in helping put this together and I wanted to commend them.

Senator TALMADGE. I concur fully. They've all done an outstanding job and we are grateful indeed. Thank all of you for your participation and very helpful suggestions.

[The hearing recessed at 1:45 p.m.]

HEALTH CARE PROBLEMS IN RURAL AND SMALL COMMUNITIES—ATLANTA, GA.

THURSDAY, AUGUST 18, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON FINANCE AND THE
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Atlanta, Ga.

The committees met, pursuant to notice, at 9 a.m., in Suite 341, Georgia State Capitol, Senators Talmadge and Nunn presiding.

Present: Senators Talmadge and Nunn.

Senator TALMADGE. It is a pleasure to be here this morning with so many people who share our concern over the high costs of hospital and medical care.

Hopefully, at the end of the day, we will have a better picture of some of the reasons for the explosive and continuing increases in health care costs. These are costs which take ever-larger shares of public and private dollars.

In 1970, total U.S. payments for hospital care were $26 billion. But, this year those expenditures are estimated at $65 billion—a 150 percent increase in 7 years.

In 1970, total expenditures for doctors' services were $13.4 billion—in 1977 those costs are estimated at $30.5 billion.

We have a great deal to be proud of in our hospital system in this country. There is a real sense, at the same time, that much could be done to improve upon the current situation. President Carter has proposed across-the-board controls on hospital revenues. Four congressional committees have been actively working on health care cost control legislation.

Unfortunately, while the health care cost problems are urgent and major, we have, at best, only partial answers. Maybe, as a result of hearings such as this, we legislators can make rough justice a little smoother. Maybe, we can moderate those whose zealous efforts could result in throwing the baby out with the bath.

Senator Nunn and I have been working closely together in an effort to cut redtape and bureaucracy in the Federal health care programs and to put a stop to the fraud and abuse in medicare and medicaid which costs the Nation billions of dollars each year.

Sam Nunn and I sponsored the original legislation last year which led to the establishment of an Inspector General for the Department of Health, Education, and Welfare. The Inspector General is head of strengthened antifraud activities. Now we'll see whether he does the job.

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There is a good example of how hard it is to get the job done in Washington. Sam Nunn and I sponsored legislation to consolidate the administration of medicare and medicaid so as to cut out duplication, eliminate redtape and bureaucrats and to provide a means to have uniform policymaking instead of conflicting policy in these areas. The administration adopted our idea, before it was enacted by Congress, and set up the agency, the Health Care Financing Administration, by administrative order.

But here is an example of how the Federal Government cuts out waste and duplication. There were 43 different units before the consolidation; at last count the new agency was going to have 75 units. There were 13 top level Government employees, in the agencies being merged. They have now proposed to have something like 25 or 26 superbureaucrats. This is the agency, by the way, which is supposed to show hospitals how to become more efficient and cut out waste.

I assure you that this kind of reorganization is not my idea of cutting out inefficiency or waste.

And now, I look forward to hearing from all of you who have kindly consented to spend time with us this morning.

Senator NUNN. I welcome the opportunity to be in Atlanta this morning to listen to our State, local and community leaders, medical care providers, educators and citizens discuss the problems of rising medical care costs and urban health problems.

Senator Talmadge and I are hopeful that the hearings in Atlanta today and the hearings in Macon this past Tuesday will be the first in a series of hearings in several States which will focus on health care problems. Our purpose in these hearings is to learn first hand about the problems of health resources, costs and access to care so that Senator Talmadge and I can feel confident that the legislation which we propose and on which we vote will be responsible and responsive to the needs of the people.

For the past 3 years, I have directed several Senate investigations of health programs. In one State, we found that physicians were charging to the medicaid program fancy penthouses, cabins and boats. We found a hospital that had Government health programs pick up the tab for expensive gourmet meals and $80 a bottle wines, which were served daily to the doctors.

Obviously, I realize that the large majority of health care professionals are conscientious and ethical; however, there is still a great deal of waste in our health delivery system which we must recognize and work to eliminate.

I believe we must eliminate waste in our present programs, identify the abuse and develop legislation responses to it, and prosecute those who defraud the programs. I believe we must assure ourselves that we can manage those programs we already have before we consider any national health insurance program.

It is essential that we bring effective and efficient management to Government programs as we identify the changing needs of our people. We must do this if we are to appropriately address the urgent health care problems of Georgia and America.

Let me discuss for a moment a few of those problems. According to information supplied by the Health Systems Agency of Central Georgia, more infants per thousand die in the first year of their lives

in Webster, Treutlen, Wheeler, Schley, and Hancock Counties than in Russia, Czechoslovakia, Bulgaria, Jamaica, Singapore, and Italy.

No one can convince me that babies born in even the most rural counties in Georgia should have a poorer chance for survival than babies born in Russia or Bulgaria.

I feel that the problems which result in such shocking statistics are attributable to the poor distribution and allocation of our resources.

There are problems in our urban areas, too. This morning we will hear from J. W. Pinkston, Jr., the administrator of Grady Memorial Hospital, which has established satellite clinics in underserved areas of Atlanta, and from Dr. Louis Sullivan, the dean and director of the new Morehouse College School of Medicine. There are in Atlanta and other major American cities neighborhoods with thousands of poor and elderly Americans who do not have sufficient access to medical care.

While access to care may be physically difficult for some, the rising cost of care is of grave concern to working men and women of moderate incomes as well as their employers.

Taxes are increasing to finance the rising cost of Government health care programs. Health insurance premiums are increasing, causing working men and women to forgo some wage increases. And we are all paying more for goods and services as industry passes on their health care fringe benefits costs to the consumers.

Eastern Airlines, for example, reported that its health insurance costs per employee rose from $430 in 1973 to $850 in 1976. Though the cost nearly doubled in 3 years, Eastern said there were only minor increases in benefits. Bethlehem Steel said that its per employee costs of health insurance rose from $371 in 1970 to $1,069 in 1976. And General Motors says that the cost allocation of health insurance to each automobile it produces now exceeds the cost of steel in each car.

When we know that babies are dying in rural Georgia; that the poor and the elderly in the cities are not receiving the care they need; and that hard working men and women cannot receive care that they can afford, then, all of us are faced with a matter of conscience. Whether we are in Government, business, labor, education or the health care services industry or whether we are simply citizens, each of us has a duty to respond to those in need of health care.

I feel confident that we can work together to meet those needs and responsibilities. And I look forward now, to hearing from the witnesses invited to this hearing today.

STATEMENT OF HON. GEORGE BUSBEE, GOVERNOR OF THE STATE OF GEORGIA

Governor BUSBEE. Senator Talmadge and Senator Nunn, on behalf of the State of Georgia, I welcome you back to the State capitol where you both served Georgia's citizens with the same distinction and dedication that you now evidence in the U.S. Senate. I appreciate the opportunity to testify before you today on Georgia's health problems and programs.

A healthy population is a cornerstone in the foundation of a strong and vibrant State. Healthy children are a prerequisite to quality education, and a work force made up of healthy adults is essential to an expanding economy.

In the last 100 years we have made remarkable progress in improving the health status of Georgians. We have all but eradicated the debilitating diseases of the past such as polio, smallpox, typhoid fever and cholera. The life expectancy of Georgians has increased from 39 years back in 1870 to today's 70-years plus. Infant mortality rates have dropped from 115 per 1,000 to 18 per 1,000 live births.

This is a record that we can look at with pride. We all owe a tremendous debt of gratitude to the dedicated public and private health professionals who have made it possible.

Unfortunately, we can't afford to bask in the warm glow of our past accomplishments. Today we are confronted with a new set of health problems which are as insidious as those of the past.

Although many diseases remain for which we must find cures, our No. 1 health problem now is accessibility to care. The best professionals, techniques, and remedies are useless if the patient can't get to them.

There are two major barriers to quality health services in Georgia. The first is a maldistribution of health care professionals both by geography and specialty.

As Dr. Skelton pointed out at your hearing in Macon, the shortage of health professionals is particularly acute in Georgia's rural counties. One hundred and seventeen counties and parts of 30 more, are "medically underserved" according to Federal criteria. Since the early 1960's, over one-third of Georgia's 159 counties experienced a drop in patient care physicians. Many of the physicians practicing in the rural areas are approaching retirement and young doctors are not replacing them fast enough.

In addition to geographic distribution, distribution of professionals by specialty presents a significant barrier to health care. We have a surplus of specialists and a shortage of primary care physicians—internists, pediatricians and general practitioners.

A recent article in the New York Times Magazine, pointed out that:

> Officially certified specialties have been a part of the health-care scene since 1917, when eye doctors founded the American Board of Ophthalmology. Since then physicians have created more than 20 board-recognized specialties along with some 200 sub-specialties, and each year they have attracted a larger proportion of medical school graduates. In 1931, only 17 percent of the Nation's doctors were specialists; today the figure is 72 percent.

The second major barrier to quality health care is money. As a Nation we now spend more than $100 billion a year for medical care, and costs are rising by 15 percent every year. It is ironic that in this prosperous country, many hardworking American taxpayers can't afford to pay their doctor and hospital bills.

Since becoming Governor, I've faced the problem of health care inflation daily in my battle to bring the frightening growth of the medicaid program under control. In fiscal year 1968, the first year Georgia participated in medicaid, we spent $28 million; this year the bill has risen to an unbelievable $386 million.

Many factors contribute to the problem of rising costs. Medical technology has become more and more sophisticated; health facilities and equipment have proliferated at a rapid rate, and we all demand more and better health care.

The question which must be answered is, "How can the quality and quantity of health care be improved without increasing the costs?" Just as there is no single cause, there is no single solution.

We have looked too long for that one magic answer that would "fix" the "health care system" like you would fix a car. It hasn't worked, because there is no carefully planned "health care system." There is only an aggregation of professionals working to provide medical care to people who are sick.

Many proposals offered to date haven't taken this into account. Stopgap solutions simply have not recognized that real solutions to our health care "crisis" will require plain hard work and individual sacrifice.

It's time to step laying blame on this group or that group. It's time to stop offering up one "quick-fix" after another.

It's time to start laying a course of action which will make quality health care available to every Georgian and every American at an affordable price.

I think we are seeing a new willingness in Washington to do just this.

Congress took a major step to deal with this problem when it passed the National Health Planning and Resources Development Act. For the first time we have set forth our national health goals.

Another major initiative being undertaken by both the administration and Congress is in the area of cost containment. In fact, Senator Talmadge, I know that you have taken the lead in this area with the Medicare-Medicaid Administrative and Reimbursement Reform Act. This proposal represents a long-term basic structural approach to rising costs.

Additionally, President Carter has proposed the Hospital Cost Containment Act of 1977. I think the aim of this legislation is commendable, especially since hospital costs make up about 40 percent of the health care bill. However, I am somewhat concerned about the arbitrary 9-percent cap on hospital operating cost increases. I'm afraid that this provision may tend to penalize some hospitals and detrimentally affect service.

As legislation is perfected in Congress, I thing that some consideration should be given to modifying this proposal to allow for greater flexibility in dealing with individual hospitals.

It is true that these proposals have generated considerable controversy, but it is also true that all important public policy initiatives create controversy. However, I think that most health care professionals recognize the need to cooperate in establishing and implementing a reasonable cost-restraining program.

Another proposal which offers some promise of improving health care is national health insurance. It has been a topic of discussion in the United States for nearly half a century. Currently, at least five major proposals are under consideration and the administration is developing its own proposal. Although four-fifths of the U.S. population is covered by some kind of health insurance, the protection afforded is often insufficient and unreliable. In last year's recession an estimated 27 million workers and their families were deprived of coverage because of lay offs. Many of the policies in force fail to protect patients against the costs of home care or visits to the doctors office. Even families with very good health insurance policies face limited coverage. The most prudent family can be threatened with disaster by one terrible illness. Almost half the people who file pleas of bankruptcy each year do so because of medical debts.

I don't pretend to be an expert on all of these proposals. However, as a Governor there is no question in my mind that some form of catastrophic coverage is needed to protect our citizens from the threat of financial disaster.

We haven't been sitting idly by here in Georgia, however, waiting for the answers to come from Washington. We have taken a number of initiatives on our own to change the direction of health care.

Traditionally, health services have been focused on crisis or acute health care needs. The principal thrust has been directed toward treating people after they became ill rather than preventing illness from occurring.

During my administration, Georgia has developed a "New Health Outlook" which recognizes that disease patterns in Georgia have changed significantly in the past 50 years, while the pattern of health services has remained much the same. This new model identifies biology, environment, life style and personal health services as the fundamental factors which determine Georgia's health status and emphasizes prevention as well as treatment.

Georgia also has one of the best early and periodic screening diagnosis and treatment (EPSDT) programs in the country. The program represents medicaid's single most ambitious venture into the preventive health sector. The program is valuable and ought to continue, but constant threats of Federal fiscal sanctions to compel State participation at levels established by HEW should end.

I am going to submit this in full but I will skip a portion of my remarks.

Senator TALMADGE. Without objection, it will be inserted into the record.

Governor BUSBEE. All right. Going from that point:

Presently, States have no authority to require recipients to participate in the screening program that I just referred to, but we are held accountable for screening approximately one-third of the eligible recipients each year. Furthermore, the sanctions are not even levied against the medicaid program. Instead, they are levied on the AFDC program. Technically, if one center out of 229 in Georgia failed to meet its qouta or have sufficient information on file, a 1-percent penalty could be levied against the State's entire AFDC budget for the quarter.

Another problem arises if a medicaid eligible is screened and treatment begins and then the family loses eligibility, then treatment stops. This problem is not uncommon among the working poor in Georgia. I understand that President Carter's comprehensive health assessments program will solve this problem by keeping the child in the program once treatment has begun.

I support the administration's intentions to improve and expand child health programs. However, any such expansion should build as much as possible on the foundation provided by EPSDT.

Another area in which our people are interested is that of alternative health services. There are certain types of illnesses, which do not require hospitalization or institutionalization. They may be treated equally well or better at home or in an extended care facility. But many times these alternatives are not readily available to large numbers of Georgians.

I am particularly concerned about the plight of the elderly. A ma-

jor problem in providing health care for the elderly is that medicaid program limitations often force a person who needs assistance to leave his or her home and enter a long-term care facility. This type of care is generally more expensive. In many cases medicaid is needlessly paying for long-term institutional care for elderly persons who do not need that level of care. There is no excuse for these unnecessary expenditures, but even more inexcusable is the removal of productive citizens from their homes and communities.

The only way to begin to solve this problem is to make available a complete continuum of care to all elderly citizens including ambulatory services, medical and nonmedical day care, adult foster care, homemaker services, transportation services, long-term care facilities, and acute hospital care. States will be able to develop such a continuum only if Federal financial assistance is available for alternative care in at least the same proportion as for long-term institutional care.

In addition to rectifying the lack of Federal funding for alternative care, a coherent national policy for health and social care of the elderly should include: Financial incentives, including tax incentives, to families who continue to provide care and shelter for the elderly; increased State latitude to combine funds from more than one federally matched health or social program to meet special needs of the elderly; Federal financial assistance and flexibility for States that experiment with new treatment and care methods believed to be more cost-effective and humane; federally funded research to determine the most appropriate kinds of care for elderly persons in various states of health. If these types of assistance are not provided, the expensive, needless and inappropriate mushrooming of long-term care will continue unabated.

We have a pilot program underway in Athens and Atlanta to test alternatives to institutionalization, but without Federal changes we won't be able to expand these options to the whole State.

These recommendations are part of the report of the National Governors' Conference Medicaid Reform Task Force which was adopted unanimously last February.

On Tuesday, Dr. Skelton testified in detail on the problems of rural health in Georgia. The provision of basic health services through primary care centers is the number one priority of my Appalachian health program. Georgia currently has 12 primary care centers in operation and other applications pending. I also anticipate requests for several such centers in the Coastal Plains area.

I have consistently emphasized the need for the centers to become self-sufficient within 3 years. The approval of a measure now pending in Congress which will allow medicaid and medicare reimbursement of physician extenders is essential to their survival. For some time it has been acknowledged that physicians can delegate a substantial number of tasks that they have traditionally performed to well-trained nurse practitioners and physician assistants.

I am going to abbreviate at this point and have inserted in the record——

Senator TALMADGE. It might interest you to know that the Senate Finance Committee unanimously approved that bill which we attached to a House-passed bill. We hope the House will concur in it because it will be highly beneficial on serving the needs of some areas of Georgia that are normally served by physicians in Georgia.

Governor BUSBEE. I might say, Senator, I was aware of what the Senate had done. I do hope this becomes law and I don't know of anything in the Appalachian area, particularly where we have this need, to be served better or by any other means.

I would like to go on and state: In Georgia, we also have moved aggressively to bring the medicaid program under control.

In the early years of the program, claims were paid virtually without question. Providers were overpaid, underpaid, paid for the same service more than once and paid for services which were not actually rendered. There were no guidelines for service providers participating in the program. In addition, quality control systems for detecting ineligibility, fraud and abuse were ineffective or nonexistent.

The obvious result of these problems in the medicaid program has been the waste of hard-earned tax dollars. Such waste is especially intolerable in a time of high inflation and rising demand for governmental services.

We have attempted to clean this mess up through a series of actions. For example we have:

Created a new department of medical assistance;

Speeded-up our claims processing system so that now a properly submitted claim is paid within 30 days;

Implemented a system of copayments for drugs and other optional medicaid services to halt overutilization;

Developed a new classification system for our nursing homes which is more equitable to providers and allows the State to implement effective cost control measures;

Adopted statewide policies and procedures for medicaid so that everyone would know the rules of the game;

Implemented a medicaid management information system with operational surveillance and utilization review subsystem.

To me any doctor or patient who would wilfully deceive the Government in order to make money is no better than a common criminal and they should be treated as such, and we are now treating them that way. I think that we are making progress, and I want to commend the Congress for its attitude now because I think this is a very serious problem in the medicaid program.

Senator Nunn, I know that you have been particularly interested in fraud and abuse and have been working with Senator Talmadge to curb the abuses which have been rampant in medicaid and medicare. The actions which we have taken in Georgia will take us a long way toward eliminating these problems from our program.

The significance of the accomplishments in Georgia is that we are trying to make what we have work. Before a lot of new programs are developed, wasteful overlap and duplication must be eliminated from our current programs. Public health professionals spend as much time filling out forms and trying to figure out eligibility requirements as they do providing service.

If States are going to be responsible for managing health programs, then we need the authority and flexibility to do it properly. Increased funding for section 314D of the Public Health Services Act would contribute significantly to this aim. We can use these funds, with minimum reporting requirements, to support our county health nurses, sanitarians and other basic health programs. Unfortunately, Federal funding under this program hasn't increased for 5 years.

In conclusion, let me add a personal note; a concern that I think you share with me, and that I hope will be reported. I've made many observations on our health programs, and I certainly hope Congress will take to heart the specific suggestions and proposed changes I have outlined this morning. But let me tell you this: All the Federal and State proposals and regulations under the sun, already written or on the drawing board, aren't going to solve the problems of spiraling costs and maldistribution of health services. We certainly need improved coordination and understanding between levels of government, but real progress in these areas of costs and distribution is going to depend on hard work and a new sense and a spirit of trust and cooperation between the levels of our government and the private health care sector.

To achieve the goals of affordable and accessible health care, we have to have sound commitments to action and not just lipservice. We need solid commitments from the health professionals if society is to work toward controlling costs, and I know this can be done without denying anyone a decent living. Furthermore, we need good faith actions on the part of health care professionals in policing themselves. That way, well-meaning public servants like ourselves won't feel tempted or inclined to burden the professions with more Government regulations.

But most of all, we in government need involvement by the people. Nothing will be done substantively on all our health problems unless the people clearly demand it. All of us, Senators, Congressmen, Governors and the medical profession leadership need and must have the benefit of citizen's counsel and a clear expression of support for these goals.

I thank you for giving me this opportunity to share my thoughts with you on health care.

Senator TALMADGE. I congratulate you on the very excellent statement. You spoke about fraud and abuse, and we have had a number of committees in the Congress, both the House and the Senate, looking into that. It is estimated to be as high as 10 percent of the total cost, up to as high as probably $10 billion a year. We are trying to correct that, and we hope that the bill Senator Nunn and I originally sponsored will become law this year will go a long way toward correcting that.

Among other things, it will change the offense from a misdemeanor to a felony, and if we send some of these people to the penitentiary, I think it will have a salutary effect on some of the others.

You also spoke of catastrophic coverage. I know that you are familiar with the fact that the Senate Finance Committee has been working in that area for several years. On two different occasions, we have reported the bill from the Senate Finance Committee for catastrophic coverage. That, in my mind, is the next step the Governors ought to take.

Before we go any further, I think it is going to be absolutely essential that we get a handle on our excessive costs, fraud and abuse that we have at the present time.

Governor, I wonder what you've found to be the greatest obstacle in getting a handle on State health care expenditures.

Governor BUSBEE. Senator, when I testified in Washington before you, we were discussing fraud, and I think that this is a very superior area, absolutely essential to the State, to cooperate with the Federal

Government in this area. But, you know it was estimated at that time that overutilization is three times larger than fraud itself; and unless the Federal Government can give the tools to State governments that actually administer this program in the field of overutilization, I don't think that we can have any cost containment in the program.

Senator TALMADGE. We hope to do exactly that with the bill we have.

Governor BUSBEE. I would say that is the most important thing we have now, is discretion in both of these areas.

Senator TALMADGE. I know you are pressed for time. I am not going to burden you with many questions, but you stressed the need for preventive health centers. You indicated a need for more health workers, such as home health aid. Why can't we use the work-incentive program, take people off the welfare rolls by training them as preventive health workers?

Governor BUSBEE. We can. I thought I had it with me—I don't have my hands on it at the moment—but we are, in many counties in this State at the present time, taking people that are on welfare rolls, training these people, I believe, for a minimum of 80 hours, and letting them go into homes of the elderly, provide hot meals and perform chores that cannot be done by these people.

Now, I met in this very room a group of elderly citizens, and the last thing that they want in life is to be placed in an institution such as a nursing home. And we found if we can just have a minimum of help from these homemakers that we can do two things. One is, we can give gainful employment to someone who is now on welfare; and that one worker can keep 12 people or families out of these nursing homes. I have the cost factors, and if I might file them for the record later when I put my hands on them [1]——

Senator TALMADGE. We would appreciate it. I might add, Governor, that the State of New Mexico took 150 people off of welfare through the work-incentive program, through just exactly what you are talking about, to keep people out of nursing homes.

Governor BUSBEE. This would be the other area that I would suggest, in answer to your question, we had 100 in 1976, I believe. But the cost savings on this is unbelievable, comparing home care to institutionalized care.

Senator TALMADGE. Senator Nunn.

Senator NUNN. Governor, first of all, let me say that your name came up in our investigation of fraud and abuse last year in reference to the medical management information systems, but it came up in a good way. We found that the State of Georgia was far in front of most all other States in trying to set up a medical management information system, and a management system; and I commend you for that effort because I also know it didn't come about just through the efforts of your department, it came about through your tremendous personal involvement, so I commend you for that.

Governor BUSBEE. Senator, although I know you have a lot of distinguished witnesses as always that would like to testify today, but I want to say that when I became Governor in 1975, you know we had mandated a system of MM, medicaid management information system. We were one of the earliest States to implement it, and it was on-

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[1] The material was not available at press time.

going when I got here. But, at that time I would not turn my back to as many doctors as I am doing this morning, because when I inherited this thing, it was about like a pea-shelling machine when you first cranked it up and peas, you know, going up to the roof. I will say that we have made great progress, and I think other States fall behind us and are going to benefit from our experience and I'm glad we are where we are today.

Senator NUNN. I commend you on it. I know even Georgia has a lot of problems remaining, but you are far ahead and your personal involvement has done this.

On this question of overutilization, I'm not going to take much time, but what is Georgia doing in this regard? You mentioned that the Federal Government should give more flexibility to the State government. I have always had the theory, even if you increased welfare payments on one hand and Government actually spends the same amount of money, theoretically it is better if everybody who is the beneficiary of a service pays something toward that service, even if it is a small amount, so that they will realize that they are participating. So this overutilization question, perhaps, can be put in better perspective, tell us what you are doing in that regard, and specifically what additional authority you need.

Governor BUSBEE. All right. Let me give you an example in the drug area, all right?

In Virginia there's a copayment of 50 cents up to $10, $1 over $10 on drugs, this reduced the utilization by one-third. We have that. The drug program is not a mandatory program, and I am able to have a copayment program. You do give the Secretary of HEW some discretion to conduct pilot programs and experiments. We also had the same type containment in other areas of copayments, and it was very effective until it was thrown out by some review process. I know you know the history.

Senator NUNN. We worked on that with you. What is the status right now?

Governor BUSBEE. Well, the status is that you passed a law, when they were experimenting on syphilis patients in Alabama that any experiment involving human risk has to go before a review board. The Secretary, Matthews, at the time gave us the authority to implement many of these cost-restraint programs as a pilot program in Georgia. One in Federal court. The Federal court upheld the right to do this, and also pointed out that this law they passed for the syphilis required this to go before a review board in the Department of Human Resources, and they said copayment involved human risk, you know, because you might have someone who couldn't pay for it.

Senator TALMADGE. Yes, sir. We have a provision in our bill to give you back that authority.

Governor BUSBEE. Thank you. I will say this: I don't know of anything more important than to give us these to work with, but in detail, the things that are suggested in the medicaid task force—and you've done much of this—as the Senator pointed out, in this one area, but there are many areas, nursing homes, institutions, in many areas we could have this same discretion, which I think would help.

Senator NUNN. So that people participate to some degree in it.

Governor BUSBEE. I just want to close with this: I recognize that

you have some people that cannot afford to pay one dime, but as long as it is right to charge blind, old and disabled people of this country under medicare, sometimes 20 percent, then, I say it is right to have cost containment in medicaid.

Senator NUNN. Well, I agree with you on that.

One final question: What will happen if no changes are made for the State budget? What will happen to the State budget if we keep going in the way we have gone in the past, without taking action at the State level and the Federal level?

Governor BUSBEE. Well, as I just testified in 1968 we were spending $28 million and now we are spending nearly $400 million and if we continue at the same rate, the size of the medicaid budget alone will exceed the State budget today within a period of 10 years.

Senator NUNN. Within 10 years the medicaid budget will exceed the State budget. What is the State budget today?

Governor BUSBEE. Slightly over $2 billion.

Senator NUNN. Thank you, very much, Governor.

Senator TALMADGE. Thank you, very much, Governor.

Governor BUSBEE. Thank you, sir.

Senator TALMADGE. We appreciate your testimony.

The next witness is the Honorable Maynard Jackson, mayor of the city of Atlanta.

Senator NUNN. Mayor, how are you this morning?

STATEMENT OF HON. MAYNARD JACKSON, MAYOR OF THE CITY OF ATLANTA, GA.

Mayor JACKSON. Senators, good morning.

Senator TALMADGE. Mayor, we are delighted to have you with us. You look so young and healthy and vigorous, I almost didn't recognize you.

Mayor JACKSON. Thank you, Senator.

Senator TALMADGE. Delighted to have you with us.

Mayor JACKSON. I was preparing for this hearing this morning.

Senator TALMADGE. You may proceed in any manner you see fit.

Mayor JACKSON. Thank you very much.

Senator TALMADGE. If you would like to summarize, you may; you may proceed in any way you like.

Mayor JACKSON. Thank you, Senator.

Senator Talmadge and Senator Nunn, distinguished panel, and ladies and gentlemen, I am delighted to be here this morning, and thank you for coming to Atlanta, of course, for another hearing on a matter of great importance to the citizens of our city and, of course, to our State. I come not only as mayor of Atlanta, but as one who almost got into the medical profession. When I was at Morehouse College, at least a couple of years ago, I took freshman chemistry from Dr. Henry Cecil McBay, and I think it was like about 80 percent of our class who were presuming that their calling was to become a physician. Dr. McBay then showed his real talent, and that is, he has called more people to the law and to the ministry than the Good Lord has probably by virtue of discouraging us in freshman chemistry.

So I come today as one who is not a physician, but as a son of Morehouse. In addition to Morehouse——

Senator TALMADGE. Will you yield at this point?

Mayor JACKSON. Yes, I will.

Senator TALMADGE. You are also aware that Morehouse has furnished more distinguished black physicians than probably any school in the United States.

Mayor JACKSON. Very much aware of that, Senator, and it is appropriate, I think, that that comment be made, especially at this gathering because the school of medicine at Morehouse College is a critically important need for the city of Atlanta and the State of Georgia, and I mean literally the entire State of Georgia.

The school of medicine at Morehouse College seems to me, at this point, needs even more encouragement than it is receiving. It needs more State help, more aggressive State help and it needs even more aggressive Federal help. Of course, what it has received, it is very grateful for, and Dr. Sullivan, I am sure, will speak quite extensively on the question, and also more articulately than I can on the school of medicine at Morehouse. But, I come as an enthusiastic supporter and I come as the mayor of Atlanta, very proud to represent the people of this city. It is a very distinct privilege to speak before this distinguished group and to share with you, Senator Talmadge and Senator Nunn and the committee, our perspective on this crucial matter: The health of the American people.

As mayor of Atlanta, I do not have jurisdiction over any medical services. The State of Georgia has ruled that it is the responsibility of the counties and State to provide health care and welfare services to the people of Georgia. As a result, I come before you today to offer my testimony, not as an expert on health care plans, but as the mayor of a major metropolitan center, concerned about meeting the needs of the people I was elected to serve.

The concept of a national health care plan for the people of the United States is an idea that has been discussed, studied, and debated for many years. Recently, several actual plans have been tendered as the Government has searched for the so-called right one. As of this date, however, as we all know, we have no such national health care policy and no one will hazard a guess as to when all Americans will be protected from the vicious spiral of health costs.

Now, why do we not have such a policy? Is it because we don't need it? Obviously, we know the answer to that question. We do need it, desperately so. The need for national health care insurance and the comprehensive health care plan for America is a desperate need. The reason we do not have it is, I suggest, the people who need this protection the most are the least able to lobby for it, the poor, the infirmed, the unemployed, Afro-Americans, other minorities, and others, the powerless, the unheard.

I do not intend to sit here today and to justify the obvious need which I am sure all of us know, and you know far better than I do. In fact, our national health care policy, I am sure that all of you on these committees have heard all of the statistics, all of the horror stories of people caught between poverty and pain. We should not have to be convinced further that all Americans, particularly the poor and the oppressed, of all races, deserve medical services. "Deserve," I emphasize the word, medical services.

What I do stress, respectfully, in my testimony today, is our responsibility as those elected to serve those who cannot speak for themselves. It is our responsibility, I suggest, respectfully, and our mission, to act with the spirit of urgency and concern that this crisis deserves. Certainly, after years of discussion, research, and review, we can come up with what could be called a basic starter program to begin alleviating the disgraceful policy of neglect of the past decade.

At times, the answer seems fairly simple. Federally financed block grants could be allocated to regions, allowing them to administer these funds on a local level, each region according to its needs. Community health clinics could be set up to provide each citizen with a medical counselor--a nurse, an intern, a specially trained paraprofessional of some kind—who would follow the patient along through the various fields and needs, rather, of regular health care, as well as to provide the knowledge of seeking specialized help when necessary. This, I remind all of us, is only a start. The school of medicine at Morehouse College, for example, also is another critically needed and important start. This is our tax dollar, finally returning to us in comprehensive caring. This is listening to the people themselves, and providing them with what they so desperately want and so desperately deserve and need.

When I am reminded that even as we sit here another morning in another meeting, one which all of us very much appreciate and applaud, that someone out there somewhere has ignored another symptom of disease out of ignorance, someone somewhere out there in our State and in our city of Atlanta, again, has been refused treatment for lack of money alone. Someone somewhere out there has died for no reason we can find at all, except that there was no place to go for help. We who can afford to buy portions of our own health care must not deny assistance to those who are not so privileged. We have been asked to speak for them, and we do so.

Thank you very much.

Senator TALMADGE. Thank you, mayor, for an eloquent and succinct statement.

What have you found to be the principal problem in health care in Atlanta?

Mayor JACKSON. I would suggest that the principal problem among Atlantans, so far as health care is concerned, is the inaccessibility medically to many people who are poor and only because they are poor, of needed health care.

Senator TALMADGE. In other words, the medicaid program is not working as intended. Is that what you are saying?

Mayor JACKSON. Senator, I would suggest that the problem is one of immediacy of the health care to people who are poor. What I specifically had in mind is that among those who must use Grady Hospital, which is a great medical facility and which still is inadequate, in my opinion, at this point to be able to react quickly to the emergency needs of poor people, many of whom still must wait hours for service, although some are able to get some attention quickly, is a major concern to all of us here.

I get complaints at city hall, even though that is not our responsibility. We have set up a Bureau of Human Services in this administration to try to serve as an advocate for those who cannot speak for

themselves in the areas of health care, social services, welfare, and so forth. We don't deliver those services, but we simply advocate for those who need the help. I do believe that medicaid, insofar as it goes, Senator, is better than not having it, but I suggest that there is a need for the Congress, respectfully, to be able to find a way for Americans to get more immediate health care on a broader basis, and with absolutely no cost to those who cannot afford to pay for any medical services at all.

I don't think there is any great redeeming value in requiring people to pay anything, if, in fact, they are poor and cannot pay for it, in this Nation especially.

Senator TALMADGE. Would more clinics throughout the city be of help?

Mayor JACKSON. I think so, but I would also recommend at this point, as we move in that regard, we move with and not in disregard of the established medical health providers, as well as the medical advocates, and so forth.

I want to just touch on one point, as we discuss what are the basic needs in the city of Atlanta. I am sure you will be getting testimony from the North Central-Georgia Health Services Agency. I had the pleasure of serving on that from its very beginning; and for about a year or so thereafter.

There was very little justification of a direct service delivery point of view, from the mayor's job and point of view; in that we don't deliver health care, the cities, the State. But as mayor of Atlanta I felt an obligation to protect the people of the city of Atlanta the best we could. But we ended up in a district that is about 22 to 24 counties, which I suggest to you, insofar as Atlanta, metro-Atlanta is concerned, the 5 counties, 7-county region, even though they now say it is 15 counties, as absolutely unrealistic. It is not able to deal, in my opinion, with the metro area as effectively as is needed because of the tremendous impact, the density of the need in this metro area.

In that regard, therefore, we have sought that there be a smaller health systems agency, HSA for the metro region. I don't mean just the city of Atlanta, but the metro region, recognizing the special impact, the special density of need here, and that was not allowed. But, I would certainly hope that as HSA's are reviewed, that it might be reconsidered.

Senator TALMADGE. Senator Nunn.

Senator NUNN. Thank you very much, Mr. Mayor, for a very good statement, a very helpful one.

First of all, what kind of relief would you envision, assuming that the Morehouse program goes ahead full steam and we are able to get all of the funding necessary, certainly Senator Talmadge and you and I are dedicated toward seeing that accomplished, how much relief would that give, and in what areas would it provide the most relief, and in what timeframe?

Mayor JACKSON. I understand Dr. Sullivan will speak to that, of course, in some great detail. He has been doing a superb job. He was born in Grady Hospital, by the way, grew up in this city and knows Georgia, is a son of Georgia. In terms of finding someone who is living in the city right now in a section where there is a need for care, and

Morehouse being able to help that person today, next week, or next year, the answer is that is unlikely, but there is an urgent need that Morehouse can address, and that is the inadequacy of physicians in this State. Doctors are both physicians and ministers, although I think the dental forum is only scheduled for way down the line, that suggests, therefore, in terms of beginning to address an immediate need for physicians, the school of medicine at Morehouse College can respond, will respond, and also can serve as a community consulting mechanism, spreading out even while those who will be trained ultimately as physicians are being trained, providing whatever care they can, consultation they can, advocacy they can, is a tremendous community and State resource that is desperately needed, and we appreciate very much your support of that, and very much the support of Senator Talmadge of that, as well.

Senator NUNN. I think it is going to have an effect not only in the urban area of Atlanta, but all over Georgia.

Mayor JACKSON. I think certainly it is a program that commands our total support.

Senator NUNN. One other question: You make mention on page 3 of federally financed block grants to regions. We have got a lot of different programs on the books right now, a lot of them supposedly are in the nature of grants, and yet they do have a lot of strings attached, and so forth and so on. Are you suggesting a new program that would have nothing to do with existing programs, or are you suggesting the reallocation of existing programs that would have less strings attached and more local discretion?

Mayor JACKSON. I have in mind the latter, more local discretion, but within broad parameters of Federal guidelines. I suggest that to you because even now, as we administer, for example, other block grants in other areas, not health, for example, we are still to some degree, in my opinion, suffering from what was the Nixon desimplification, that was in terms of a national impact, an oversimplification. That is my opinion, anyhow. There are many block grants that are existing now, but with the needs that we have, obviously, they are not enough. I don't know what the answer is, and that's, of course, why I must defer to the U.S. Congress in its ultimate wisdom in being able to make those judgments. But I do believe that if we are able to allocate regions that can specify to you, as those who, of course, are making these decisions in the U.S. Congress, what the local needs are, justify those needs, and if we can do so on regions that are responding on a community of interest basis, and again, I come back to what I was saying about the HSA. For example, I think we will be able to define more succinctly what those needs are. Atlanta's needs in some ways are identical to those in Ludowici, but in many, many ways are dramatically different. Just the numbers of people alone, how many impact on the system at one time alone is justification for special understanding of the problems, the special attention to their problems, that I suggest a 24-county HSA cannot address.

Now, those who served on the HSA, I think, are doing their very best, are serving with a great deal of dedication. I mean to tell you they have been really working hard. I think they ought to be applauded. I think this region is too big. It is much larger than the HSA of 15 counties, and even that is bigger than the actual health-impacted area that we represent here.

Senator NUNN. Thank you very much, Mr. Mayor.

Mayor JACKSON. My pleasure, Senator Talmadge, Senator Nunn; thank you.

Senator TALMADGE. Thank you very much, Mr. Mayor.

The next group of witnesses is a panel of citizens which consist of Mr. Morris Bryan, president of Jefferson Mills, Inc., Jefferson, Ga.; Mr. Rawson Haverty, Atlanta businessman; Mr. Herb Mabry, executive director of the Georgia AFL-CIO.

Gentlemen, you may take your seats at the witness table.

Senator NUNN. We are going to have to switch one microphone back and forth here; I think we are one short.

Senator TALMADGE. You may insert for the record as full a statement for the record as you desire and summarize, or proceed in any manner you see fit.

Who is first?

STATEMENT OF MORRIS BRYAN, PRESIDENT, JEFFERSON MILLS, INC., JEFFERSON, GA.

Mr. BRYAN. Sir, my name was on top of the list, so I will proceed, Senator.

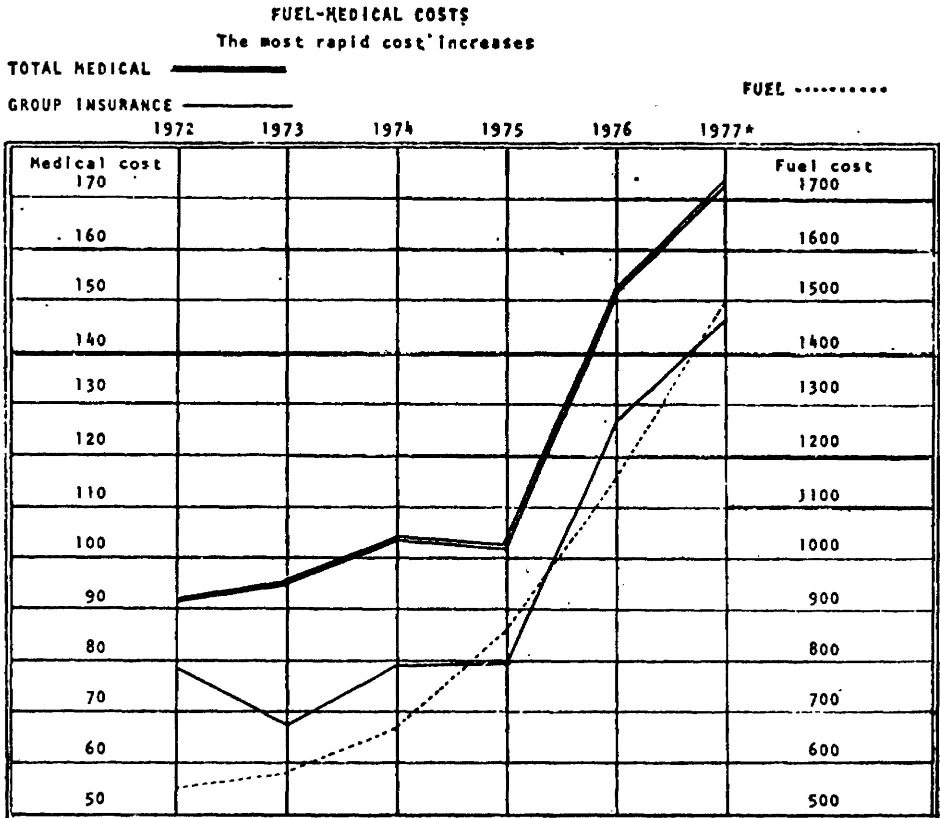
May I begin by saying, Senator Talmadge, Senator Nunn, we are most grateful to you for the leadership you are providing in this very serious area. I find it my lot to be president of a relatively small company up in Jefferson, Ga., Jefferson Mills. We employ approximately 400 people. We have a very fine insurance program, it centers on a major medical plan, $25,000. It emphasizes, Senator Talmadge, taking care of people with a catastrophe. We feel that most any of our employees are able to find $50, but none of them, including the president, are able to find $5,000, to cover an emergency medical program.

On our retired people, we are pleased to be able to say that our plan does cover that which medicare and medicaid misses. We have an emphasis on preventive medicine. Our plan provides rather generous incentives for all of our employees and their families to have annual checkups, which we have found to be very helpful. We also have a tremendous emphasis on physical fitness in our company. Both of you gentlemen have honored us in Jefferson by coming and serving as honorary meet directors for our high school State track and field championships. Those facilities are used in a physical fitness program in our plant. In spite of these things, if you will be kind enough to look at the chart I have given you, you will see that our——

Senator TALMADGE. Is this the chart here?

Mr. BRYAN. Yes, sir.

[The chart referred to follows:]



* Fuel costs based on fiscal year ending Sept. 30. 10 months actual, 2 months estimated.
Medical costs based on calendar year. 8 months actual, 4 months estimated.

Mr. BRYAN. You will see that our medical costs in this program were very steady for approximately 4 years, and then all of a sudden they have, in the last 2 years, doubled. I told my staff that I felt that this was the fastest growing cost in our company. They quickly reminded me that it was second only to fuel, and we are all aware of the rapid growth in our fuel and power costs. So we thought it might be of interest to present that on this chart. The fuel and power costs have grown 3 to 1 and the medical costs 2 to 1, second only to that tremendous growth in fuel and power costs.

I'm aware I am among experts, and I hesitate to make any suggestions at all, but to be very brief, I would like to suggest that perhaps, as in the case of fuel itself, which we know will never be solved until supply is adequate, that perhaps to some lesser degree the cost of medical care could follow in that same category.

We are a rural community. He have one county hospital. It has grown. The cost of medical care in that hospital has also grown tre-

mendously. We would submit that perhaps a look at the Government regulations that make it difficult for communities, such as mine, to have smaller hospitals; hospitals that would not be designed to take care of open-heart surgery, but would be designed to take care of childbirth and other matters of this kind, we think, have a place in a city like Jefferson, Ga., just as we heard testimony that such might find a place in the city of Atlanta.

The same would apply in the supply of doctors, and any further program that could be done by the Federal Government to encourage doctors in rural communities certainly would help in our matter and our cost. We submit that matters of cost, such as malpractice insurance, seem to us to be ridiculous, and the banks—Jackson County Hospital in Commerce, Ga., our Jackson County main medical supply center, 4 years ago the premium for malpractice insurance was $10,000. Last year the premium for malpractice insurance was $10,000.

Senator TALMADGE. That is in Jefferson, Ga.?

Mr. BRYAN. That is in Commerce, Ga., which is——

Senator NUNN. That is the hospital?

Mr. BRYAN. That's the hospital's malpractice policy premium.

Senator NUNN. 700-percent increase in what period of time?

Mr. BRYAN. About 4 years.

Senator NUNN. 700 percent in 4 years?

Mr. BRYAN. Yes, sir.

Senator NUNN. Has that hospital had many successful claims against it?

Mr. BRYAN. Senator, I am not too familiar with the exact claims they have had. I do know they have had some against the hospital and not against the medical profession. We submit that the smaller hospital could have much more family care. You are familiar, I am sure, with the Temple University Hospital program, which has provided means by which several rates can be charged, depending on how much family care it is taking care of. A smaller hospital, we would suggest, would be worth looking at in Jefferson, could be worth doing the same thing.

We do know that there's much that companies like mine, industry can do, and we do think that an increased emphasis on physical fitness by us and management with all of our people, providing the facilities, such as the track we mentioned earlier, the swimming facilities, if not available otherwise, bowling alleys, if not available otherwise; and a tremendous emphasis on physical fitness for our youngsters coming along would be great.

In the previous decades, people that grew up on a farm didn't have to worry about physical fitness, but now that we are in the big cities like Jefferson, we do have to have means of improving our physical fitness.

We are aware of your desire to straighten out what we've got before you add something new, and we commend you for that. We do hope, and we do know, that some cap has got to be put somewhere on this cost. We think the smaller hospital would improve the competitive cost picture in this matter of putting the cap on it. We are sure that you will not make the cure worse than the disease.

We thank you very much.

Senator NUNN. I wish I was as sure of that. I also wish I was as sure of that as what is referred to as the ultimate wisdom of Congress; sometimes I doubt that.

All right. I think what I will do is go ahead and come back with questions after we hear from all of the members of the panel.

Our next member is Mr. Rawson Haverty, a good friend of mine, a businessman. He is chairman of the board of trustees of St. Joseph's Hospital in Atlanta. He and his family have been deeply involved in St. Joseph's Hospital for some 25 years. He will discuss the changes over the years that have contributed to increasing costs of hospital operation.

Mr. Rawson Haverty, we are delighted to have you.

STATEMENT OF RAWSON HAVERTY, CHAIRMAN, BOARD OF TRUSTEES, ST. JOSEPH'S HOSPITAL, ATLANTA, GA.

Mr. HAVERTY. Thank you, Senator Nunn.

I feel a little as if I am on the specific hot plate because this is the place the money is spent, but I would like to give you a little background on St. Joseph's Infirmary, so that you will understand our problems.

It was opened in 1880. It is the oldest hospital in Atlanta. It originally had 10 beds when it was opened, and it has been operated since that time in generally the same block and location.

St. Joseph's Infirmary is a nonprofit corporation operated under the State laws of Georgia. It is sponsored by the Sisters of Mercy. It is operated and governed by a board of 20 trustees, 9 Atlanta businessmen and 4 physicians, and 7 Sisters of Mercy.

Its present administrator and chief executive officer is Mr. Charles Burge. He is in the room here.

At present, the organization is well into the final stages of a major building and relocation project, a $31,600,000 building program to provide an entirely new 300-bed hospital, which will replace the downtown St. Joseph's Infirmary location, which has a 339-bed authorization.

In addition to the new hospital building now under construction, there will be next to it a doctor's office building/parking lot joined for efficient operation. I believe the main point of interest for this hearing is the cost of health services, and my specific assignment is, I think, to tell you about the move of St. Joseph's Infirmary from the central city, the financing of that move, and I assume, comment about operating costs now and anticipated operating costs in the years ahead. St. Joseph's downtown location, with a 339-bed authorization, has, because of diminishing demand in that area, reduced its current bed capacity to 159. I would like to point out at this time if, in further comments, others mention bed capacity and unused bed capacity, I will hope that they will qualify that because there are many kinds of hospital beds, authorized beds, beds that are not staffed but authorized, there are special licensed beds as to type of patients, as well as just general beds. It is not a simple subject and a simple statement to draw.

Our hospital sought to remain in its present position and to serve, but for a number of reasons I have outlined in extended remarks,

which I hope you will permit me to submit, we felt it was necessary to move. I will point out the principal reason for moving. Now, we found that the primary doctors, the general practitioners, and internists that the patient sees first when they feel bad, were leaving the central city, following their patients as residential areas moved away from the central city.

Our hospital is built primarily around specialists. We cater to difficult type of operations. The specialists require a close association with these primary doctors for their referrals, and they felt that for their own survival, it would be necessary for them to follow their primary doctors that referred patients to them, and many of them began to do so.

In moving, we sought to develop and design an efficient hospital, one specifically oriented not only to general medical practice but to handle the more difficult operations that have become St. Joseph's specialty and expertise.

Our initial costs were estimated to be in the neighborhood of $20 million. To finance the new project, we looked in all different directions, hospital bonds, talked a good length to Ziegler Co.—many of you are aware of his expertise in that. We investigated the potential financing through county authorization bonds, county authority bonds. We looked into insurance financing. We found the most attractive was HEW loan guaranteed financing, if and when available. In this, we were very fortunate. Projects with higher priority in this area were delayed or canceled, and all of a sudden St. Joseph's became No. 1, and we took advantage of it.

As we developed building plans, building costs began to escalate. An additional request was made from HEW and, again, we were fortunate. These funds were on hand at this time. A guaranteed loan was approved in the amount of $23 million, and we received a grant in the amount of $750,000. Our overall budget looks somewhat as follows: $31,611,000 project; how was this financed? 29 percent of that was equity we were able to provide out of our operations, and special funds, about $1,300,000. We had a fund drive for $2½ million. We had to reserve about $1 million of that to repay borrowings. We borrowed on property that we owned. Our line of borrowing is $7 million. The Hill-Burton grant of $750,000 gave us $9.5 million or 29 percent of the total cost. The Hill-Burton loan of $23 million made up the remaining. We feel that it was a sound piece of financing, and that we can handle it.

There will be substantial changes in our operating budget in the new location. Currently, we are operating from a fiscally sound basis, with earnings after depreciation last year of $224,000. That's not much for a hospital, but in our location, with a diminishing call on our beds, it was in excess of our expectations, and we were pleased.

Our charge for basic rooms is currently about $88 a day. We anticipate this will be about $95 a day in the new building. That's an increase of 8 percent. It will be required to meet financing charges.

I believe we will be competitive at those prices. We know we will. The two principal increases will be in depreciation and interest. We anticipate that in those categories, the increased costs will be about $194,500 a month. Normal operating expenses have been substantial over the past year. We expect an increment of inflation to continue, and that's our main item of increase in cost.

In our new hospital, we anticipate that we will be able to operate more efficiently with less cost per bed, and that's highly to be desired.

Our nursing service and charges per patient bed should be reduced. Again, the financial burden will be substantially increased for interest and depreciation. By way of illustration, we find that over a 7-year period beginning in 1969 and ending with the past year, 1977, we show an increase in dollars for general insurance of 168 percent; utilities 210 percent. We have been reducing nursing staff and services as we have reduced the number of beds staff, so that our payroll costs have shown only a 31-percent increase, but relative to patient days, there has been an increase of 234 percent for salaries.

I would like to inject at this point a comment that while this seems a very heavy burden, our salaries, I think, are relatively modest in the hospital field, those that I am aware of. When I relate nursing earnings per hour to comparable wages of truckdrivers, of lift truck operators, people not nearly as extensively trained in handling as important positions relatively to life and death, our salaries are quite modest. I think they will be increasing in the future, but on what rate I do not know.

Malpractice insurances, as my friend, Mr. Bryan, pointed out, are a subject of their own. From August 1962 through May 1975 actual settlement claims against St. Joseph's amounted to $63,600. Our insurance premium for that year was $68,000, slightly more than all of our claims over the period 1962 to 1965.

For the year 1976, on a somewhat reduced coverage, the only people we could get to talk to us at all about malpractice insurance submitted a premium of $232,500 for coverage. We thought that totally unreasonable and we did not buy it.

Senator NUNN. In other words, your total, the total claims your hospital paid for 1962 through 1975 were $63,000, and in 1 year your insurance premium exceeded the total claims or the total successful claims for a 13-year period?

Mr. HAVERTY. That's correct, and the next year they jumped to $232,000 with no additional claims. So we do not have malpractice insurance. We are taking quite a risk, but I don't think we can add that to our——

Senator NUNN. You are basically self-insured?

Mr. HAVERTY. We are self-insured, not insured.

The cost of keeping up with the latest medical technology and maintaining quality service has become very expensive, and I would like to give an example. It happened just last week. We have an extremely competent physician in charge of cardiology at the hospital. About 3 years ago, at his request, we invested in about a $25,000 piece of machinery, which is based on the sonic system, old sonic-wave principle around a submarine, where an impulse is bounced off a substance and creates a picture, which a trained physician can read and translates. It is used frequently to evaluate, to diagnose, and evaluate, whether heart surgery is necessary, and such as that. Our machine is used quite heavily. The charge for its use is approximately $80. This past weekend, the doctor made a request for a new piece of equipment, basically the same diagnostic tool, but he explained that this is a second-generation tool where the sonic rays not only go in one wave but go in two, and give a much more complete, indepth picture, allowing a more thorough and accurate diagnosis.

This piece of equipment costs $95,000, and it will replace the other piece of equipment. The doctor tells me that the typical fee for the use of this equipment, to cover all costs, readings, and so on, is about $200. I asked him how this new equipment will save money for the patient, and he replied that in many instances it would permit him to better determine whether a cardiac catheterization process or other would be needed, and the fee for that latter, the cardiac catheterization process, runs around $600. So, if for an investment of $200 per patient, he could save $600, it seems worthwhile; however, I discussed this in more depth with him and I learned that this machine will also more clearly point out that the patient may need a catheterization process.

So, in effect, what we have is a more expensive piece of equipment, involving a larger capital investment, a larger fee, that does approximately the same thing we are doing with an older piece of equipment, yet we are doing it more accurately and more reliably.

He is upgrading his medical practice. We face the choice of: Do we spend this money, do we increase the cost of medicine to perform a better service, an upgraded medical service for our patient? The question has become routine; $90,000 has to be relatively small in the way of medical equipment. We face comparable decisions of $600 to $700,000 for investment in scanners, radiation therapy-type equipment, three-quarters of a million dollars, and I find these decisions are very difficult, far more difficult than the normal, daily business decisions, for they involve not just profit and loss, but they involve the element of human life and the value judgments become extremely difficult when you face that.

I think the principal question before this forum must be: Are the high costs of health services worthwhile? What is going to be the trend in the future? And what can we do about increasing costs? I find that in attacking these factors, I wear several hats. I am a civilian, I am a taxpayer, I am, in part, responsible for hospital administration, and I have a conflict of interest. I'm not sure the U.S. Government has a stated national health policy, but I think it has assumed responsibility for medical care for many groups: The indigent sick through medicaid, the elderly through medicare. County and local governments, through their charity and local hospitals, do an outstanding job in providing for many of the poor that do not fit into this category. There are other groups especially the veterans, the Indian, and so on, group insurance, Blue Shield and Blue Cross, plans covering an increasing number of employed people and individuals. Many of these have deductible features which do keep a patient aware of costs. An increasing number provide catastrophe coverage, which is essential in preserving family financial capabilities after a major illness. All together, for a hospital such as St. Joseph's third-party payers cover about 90 percent of hospital care expenditures.

If the quality of medical services rendered 20 years ago had been retained, we could be serving with far less cost. Improvement in medical care, the increasing number of people that we serve, and the increasing number of third-party payers which do not question too heavily the cost of the expenditures, have led to major increases in expenses, and I think this will continue.

We have to have capital expenditures and basic facilities, equipment, finance research, and increasingly complex and expensive med-

ical equipment and training that it takes to use this equipment and to serve it.

As one involved in the development of a hospital and its administration, I am grateful to our Federal Government, who has provided the funds for capital improvement that we could not have provided otherwise. It has underwritten the cost of quality service for an increasing number of people.

As a taxpayer, I am not sure that we can afford to continue this, and I don't know the answer. A decision to cut back in quality is just unthinkable, much can probably be done in overall planning for better use of services available through the sharing of services, through the cooperation and coordination. There is little incentive on the part of the patient to reduce his costs when all of the bills are paid by third parties. Deductibles, payment limits, offset perhaps by coverage for catastrophic injuries are what I think keep people alert to costs of medical services through small and unnecessary procedures, yet provide and assist to really damage it.

There are in hospital operations many secondary areas where increased efficiencies, savings, elimination of waste, can be affected—many of them are negligible, but if we put them all together, they could be fairly substantial.

I hope all hospitals are working toward that end, but much more can be done. I do hope that hospitals and those associated with medical services will not continue to be decried as the villains and those responsible for high cost of medical services, for it can be recognized that more people are receiving higher quality services than ever before. The trend is continuing. People are living longer, more diseases can be handled promptly. It is a healthier Nation. From where I stand, it appears that, in general, we are getting good returns for our medical dollar invested. Whether we can afford all that we are buying, however, I don't know. It becomes what you would desire, and your moral requirements versus your economic capabilities, and I wish I could give you a substantial answer.

Senator NUNN. Thank you.

Senator TALMADGE. The next member of the panel is Mr. Herbert Mabry, who is the president of the Georgia AFL-CIO. In addition, he is a member of the board of the North Central-Georgia Health Agency, and the State director of the Committee for National Health Insurance. He will advocate national health insurance, will discuss the impact of rising health care costs on the working man and woman, and he will also advocate national health insurance. We are delighted to have you with us, Mr. Mabry. You may proceed in any manner you may see fit. If you would like to insert your full statement in the record, summarize it in any way you see fit.

STATEMENT OF HERBERT MABRY, PRESIDENT, GEORGIA AFL-CIO

Mr. MABRY. Thank you very much, Senator.

Senator NUNN. I am delighted to have you here this morning.

Mr. MABRY. Senator Nunn, I appreciate very much the fact that you would take time from your schedule to come in and allow the people of the State of Georgia and Atlanta today to have some input

as to our feelings in regards to what the future of health care holds for this country.

I would like, with your permission—I had a prepared statement made but some of the testimony has been brought out here this morning in regard to figures that are available to your office, that you have yourselves—deviate from my prepared statement and go into some of the things——

Senator TALMADGE. Any way you see fit, Mr. Mabry, we would be delighted.

Mr. MABRY. There are several things that I would like to touch on in my prepared statement. That 40 million Americans have no health insurance at all, and those that are covered receive only about 40 percent of the health care cost through their insurance. The Government has reported that health-related costs increased by 14 percent in fiscal 1976. Medical costs averaged $638 for every man, woman, and child in this country last year, a figure which is three times greater than per-capita cost 10 years ago. The cost of personal health services increased more than twice as fast as other cost of living items in 1976. The average American works 1 full month of the year just to pay for medical care and private health insurance costs.

Just some of the things that I wanted to bring out, a report published by the Human Resources Administration of HEW in January of this year, revealed the following comparative statistics on health care in urban and rural areas: In cities, 7.8 percent of the residents in 1973 had never had a routine physical examination. In rural areas, 14 percent had never had an examination. In cities, 10.9 percent of the residents age 17 years and over had never had a chest X-ray. In rural areas, the figure was 17.2 percent. In cities, 8.9 percent of persons aged 3 and older had never had an eye examination. In the rural areas, it was 11.3 percent. This indicates to you and I the need for some kind of health services made available to the people in the rural areas.

Let me at this point, Senators, deviate from it and tell you I have the honor, in addition to serving on the North Central-Georgia Health Systems Committee for national health care, to serve on the Cancer Society of this city, and also the Leukemia Board, and also Muscular Dystrophy. I have an overall picture, and by no means am I an expert on any of it, as to what the need for health services and health care in our area is. I would like to go into this with you, in regards to the union membership that I represent, and approximately 200,000 affiliated with my organization, we have one local union that I am going to give you some facts and figures on. We were the forerunners in negotiating contracts for health care. We, the carpenters union here in Atlanta, have approximately 5,000 members, of only whom 1,600 are covered by a negotiated contract for health care for the checkoff. Out of the 40 cents per hour that we pay for each man-hour worked in our union per member, we, as I said, only have 1,600 covered. This is because that a person must make 275 hours in a quarter in order to maintain and stay in benefits. We have been notified by the insurance carriers that we must contribute 10 cents more per hours for man-hour worked in order to maintain the same benefits that we have in force today.

Now, our membership under Federal law has to approve any deduction that comes out of their paycheck, and they have refused to increase the 10 cents per hour into this fund. So that means that the

coverage they have is going to have to start dwindling away, or we are going to have to drop it altogether. We have approximately 3,400 of the members that aren't covered now, unless they are covered through a private carrier themselves, and not through this benefit.

An additional 10 cents an hour would mean that $16 more per month would bring it up to $80 per month: that a person has to pay——

Senator NUNN. Does that include the employee contribution alone, or is that employer and employee?

Mr. MABRY. Well, it is a negotiated benefit. It's a contribution of—it would be 40 cents an hour out of the hours worked. There has always been an argument with us and the employer as to who pays it. They say they pay it, we say we earn it.

Senator NUNN. Right. Ten cents an hour would be—what I am trying to arrive at is where would the 10 cents come from, because you have already got the negotiated contract?

Mr. MABRY. It would have to come out of the wages that had been negotiated.

Senator NUNN. It would be a direct deduction?

Mr. MABRY. Our contract was for an 85-cent increase over a period of 2 years. Now, how much of it we want to put into health and welfare and pension is up to us.

Senator NUNN. Right.

Mr. MABRY. But it would come off the total package. It would not be in addition to the wages that had been negotiated, so unless we are going to find a lot of people and, you know, we hear a lot of talk about catastrophic coverage, to you and I and maybe some of the other people, catastrophic would mean a lot more than it would—I mean it would not mean as much to us as it would to a mother of five or six children that did not have the money to make a car payment or house payment, payment on insurance, if she had no insurance on her family, that she had to pay $10 or $25 out of her week's money in order to have medical treatment for one of her children. That becomes catastrophic. You and I read in the paper, I am sure you did, about over in Alabama where the young black man cut his hand, went to the doctor, had his stitches put in it, and because the mother couldn't pay the bill, the doctor removed the stitches and sent him on about his way.

In 1947, in the State of Georgia, we were $336 below the per capita income in the State. Today, we have seen the cost of living increase. We have seen medical costs increase, but we, in the State now, are $786 below the average per capita income in the State. We can't continue to see our wages decline and purchasing power, and the cost of living continue to rise. You must remember, in Washington, that there's more policyholders than there are insurance companies.

Thank you.

Senator TALMADGE. Thank you very much, gentlemen, for a very thorough and precise statement.

My first question is for Mr. Bryan. What effect does your insurance payroll costs have on the ability of Georgia textile to compete with foreign imports?

Mr. BRYAN. Senator, every cost increase that we have, be it medical or fuel or what not, that the foreigners do not have, makes us that

much less competitive. We are not competitive now, and every dollar that we spend for medical care, that they don't spend, I have yet to find a foreign country that would have that cost tacked on to their cost of production to the extent that we do.

Senator TALMADGE. In other words, you can't pass these costs and prices on to your customers; is that your answer?

Mr. BRYAN. If the import is there, and the import is there for less money, then there is no way in the world we can get more money for our product, that's correct.

Senator TALMADGE. My next question is to Mr. Haverty.

You described some very high-priced hospital equipment in your statement. Of course, it is not just the capital costs, but the operating costs that have to be considered. Isn't there the possibility that investment in high-cost equipment can stimulate overuse in order to justify that investment and pay it off?

Mr. HAVERTY. Senator, I would like to make an example. I think if we are to maintain quality service in hospitals, particularly in those hospitals which do emphasize the difficult operations and specialties, we need the finest equipment that we can have, and it is expensive.

We find that some of this equipment can be bought by doctors, and I'll use the illustration of the scanner, which is a very high-priced piece of equipment, very new in diagnostic treatments, but good. Groups of doctors can buy these and own them themselves. There are very substantial tax advantages from the standpoint of depreciation to an individual. I hear—I have no substantiation for it—that a doctor might be tempted—not knowingly, but tempted—to overuse that because he would like to be sure that he gets his maximum amount of use and benefit from it.

In the hands of a hospital, that's not possible. There are no depreciation advantages to a hospital, charity hospital, such as our own. A physician does not have the incentive to give overuse in a major piece of equipment owned by a hospital. It is not very valid. He does not benefit by that. It is operated by the hospital.

So, the question is, in the hand of a hospital, equipment owned by them, controlled by them, I don't think the danger is substantial. In the hands of a physician ownership group, I am concerned.

Senator TALMADGE. My understanding is the scanner costs $600,000 or $700,000 to purchase; is that right?

Mr. HAVERTY. That's right, from $400,000 to $600,000.

Senator TALMADGE. How many scanners do we have in Atlanta?

Mr. HAVERTY. To the best of my knowledge, there are five or six. There could be——

Senator TALMADGE. Is there any planned co-op use of those scanners? Do we have too many scanners in Atlanta? Could these hospitals make agreements with each other, if you don't buy a scanner, we will let you use ours?

Mr. HAVERTY. It is possible, but they are highly competitive in the city of Atlanta, and they do not particularly want to share patients. If one sends a patient from one bed over to the hospital, the doctors lose their patients, the hospital loses income. It is a highly competitive situation. The answer is: It should be. We should be able to cooperate, coordinate better than we do, but we don't.

Senator TALMADGE. My next question is to Mr. Mabry.

Herb, as you know, you and I have talked about national health insurance on several occasions. Do you honestly believe we could have a comprehensive national health insurance policy until we get some handle on the rapidly escalating costs that we now have?

Mr. MARBY. Senator, I question how we are going to get a handle on it without the test scanner you are referring to about being utilized by all of the different groups. This is a constant source of—I don't want to say argument among the people, because Mr. Higginbotham and I—that you will hear from a little later—served on the review committee, North Central Georgia Health System, and to get out of that committee meeting by 12 o'clock at night you are very fortunate, and it goes on as late as 1 o'clock, and most of our argument is on just such as this, about where one hospital has it, and if they have a patient that is needing that service, to have to put the patient in an ambulance and take him over to the other side of town to one, the patient, they fear, they don't, maybe, come right out and say it, they fear the next time the patient will want to go there without having to have the ambulance cost to transport him over there. So how do you cope with it? How do you stop? They say that it's only being 40-percent utilized at one hospital. Why put one 3 miles away that would take part of that, and maybe then both of them have a 20-percent utilization of their equipment?

The other arguments is, then, if they are the only one that has it, they can charge what they want to.

Senator TALMADGE. Now, of these 200,000 members that you represent, AFL–CIO, how many of them have hospitalization or health insurance policies that were negotiated with their employers?

Mr. MABRY. I would say that 75 percent of them.

Senator TALMADGE. Seventy-five percent?

Mr. MARBY. Yes. Some of the members in some of the smaller plants and all maybe do not have.

Senator TALMADGE. That means the other 25 percent are either uncovered or have to buy their own policies.

Mr. MABRY. At the mercy of the world.

Senator TALMADGE. Now, what is the extent of the coverage? What I am getting at, do you have coverage that includes what is normally referred to as catastrophic coverage?

Mr. MABRY. Yes. Well, that would depend as to what the definition of catastrophic would be.

Senator TALMADGE. Let me give my definition of catastrophic coverage now and see how it compares with your own. And, as you know, I think that's the greatest dominant need in America. We now have coverage in medicaid for our very poor people, as you know, and we have medicare, which covers our elderly that are retired under social security. We have the middle group, who's neither elderly nor extremely poor, that includes your group primarily, about 80 percent of them have some type of hospital or medical benefits. Usually they are quite limited in scope. What I think the greatest dominant need in America today is—and I will describe it—take a man who is 40 years of age, he is the only breadwinner in his family, he earns, we will say, $12,000 a year, and probably has an equity in his home, he might own his automobile outright or at least have an equity in it. He might have

a child in college. That breadwinner, we will say, takes cancer, lingers on for 18 months, finally dies. The hospital and medical expenses under those conditions would be $40,000, $50,000 to $60,000. The family would not only be bankrupt, but they would also have lost their breadwinner, too.

Don't you think that's the greatest dominant need in the health coverage we have got at the present time in this country?

Mr. MABRY. I will agree with you that it is a real unmet need, but it is also—I would question, Senator, whether or not it would be the greatest, not with 40 million Americans that have no coverage at all. They do not even have an opportunity to go to the hospital to die. They die at home.

Senator TALMADGE. Senator Nunn.

Senator NUNN. Well, this question of need versus cost is the ultimate question. I think we can all agree on the need. I don't think anybody at this panel here would disagree on the severe problems we have in health care, and I don't think anybody would also disagree that we've made improvements, we've made substantial improvements in recent years. But, how do we balance? Mr. Haverty addressed the issue and said that he didn't know the answer. I agree with him, I don't know the answer either, but I ask you and Mr. Bryan, you are both taxpayers, you work, he works; as an employer, he works with employees; and how do we balance this question of health need versus cost, I mean? What rules do we use? How do we assess it? It is not like the bottom line of a business, because you've got people's lives at stake. Tell us——

Mr. MABRY. Senator, one of the most "cussed" and discussed pieces of legislation that has come out of Washington is the social security system. When the social security system was enacted, I am sure that there was a lot of discussion, which was a little bit before my time. But, there was a lot of discussion pro and con about social security, but there's millions of older persons today that are existing now, merely existing, they aren't living, they are existing as a result of social security, whether it is right or wrong; and if we don't enact some kind of legislation that would give the people of this country a right—listen, medical treatment in this country should be a right, not a commodity that is traded over the counter—but we need to pass legislation that would give people a right to be able to go to a doctor or to a hospital, and if we make a mistake in it, Lord knows, we have made them in a lot of other legislation.

Senator NUNN. I know it.

Mr. MABRY. It can be corrected.

Senator NUNN. Including social security. I am hearing from a lot of your members that don't want to pay any more social security, and I am hearing from a lot of employers who don't want to pay any more social security, and I am hearing from almost everybody that they don't want it taken out of a general fund, so unless we develop a social security tree where the money will shake out of it, I don't know where we are going in social security.

What I am saying, as we go into other programs, I think we are going to move into catastrophic—I fear that at least at some point in the near future, but as we go into these other programs, if we duplicate errors that we have made in the last 20 or 30 years in programs, this Nation is going to be literally bankrupt.

We are running $70 billion deficit right now, $70 billion, and we haven't got any funds for retirement of Federal employees, the military retirement system alone in the next 24 years is unfunded. There is no money available, unfunded liability is going to be over $400 billion.

Senator TALMADGE. Would you yield at that point, Senator Nunn?

Senator NUNN. Yes, sir.

Senator TALMADGE. The Medicare Trust Fund now is $9 billion short.

Senator NUNN. And at the same time, foreign competition, as you know, we spend a lot of time, management quarrels with labor and labor quarrels with management, and we are all in the same boat. We are all in the same boat. If we get these costs up, if we continue to get them up, up, up, we're going to have to go to a system of protectionism. That is going to bring about a world depression, because your products are not going to be competitive with the world market. So it is an economic question as well as a human question. Both of them come into play and the balance is very difficult for me to arrive at.

Mr. MABRY. May I ask the Senator: You mentioned that we are $9 bilion short in medicaid?

Senator TALMADGE. Annually.

Mr. MABRY. Annually?

Senator TALMADGE. Yes, sir, medicaid.

Mr. MABRY. How much of this is brought about by fraud?

Senator TALMADGE. We estimate that there's a minimum of $6 billion in overutilization, in fraud, and possibly as high as $10 billion, and that's what we are trying to correct. But, what we are going to have to do, Herb, first, we've got to correct fraud and abuse, and then, in addition to that, we have got to adequately fund medicare, Social Security Trust Fund, and then we've got to adequately fund social security that you have alluded to. If we do nothing there, that fund will be absolutely bankrupt within a matter of about 3 years, and I get hundreds of pitiful letters almost daily from elderly who are retired that they are existing, as you pointed out, not living well, wondering whether or not they're going to continue to get their checks.

Mr. MABRY. Well, as I said, I appreciate very much both of you coming here and listening and trying to solve a problem that is a cancer, eating away at the very everyday life of American citizens.

Senator NUNN. I agree with you on the need completely. It is a tough one. Mr. Bryan, would you address that issue?

Mr. BRYAN. Well, as you say, it is need versus cost. Of course, the healthier our Nation is, Senator, the less need there is; and there is a tremendous, in our opinion, a tremendous untapped area of health and guidance of interest that can be shown in the preventive side of this matter by improving physical fitness, particularly as the younger generation comes along, through our schools, through recreational programs, through physical fitness.

Senator NUNN. You are really looking for the most return per dollar. The preventive area, the education area, is the area where the most return is.

Mr. BRYAN. Could very well be, sir. I think in our company, where we have had our preventive maintenance, that's what we call it, our health preventive maintenance, where we have provided the funds for

them to go annually for a checkup, a good, thorough checkup, and this has been worth a $100 checkup versus a $1,000 hospitalization. We have encouraged this, we put this in our plan. There may be a place where it can be encouraged on a national basis.

Senator NUNN. Thank you very much.

Mr. BRYAN. I, too, want to thank you two men, particularly the stand on this issue you take.

Senator TALMADGE. Thank you.

Thank you very much, gentlemen, for a very enlightening and informed discussion of what is one of the greatest issues confronting the American people at the present time. We appreciate your contribution.

[The prepared statements of the preceding panel follow:]

STATEMENT OF RAWSON HAVERTY

I believe the main point of interest for this hearing is the cost of health service. My specific assignment is to tell you about the move by St. Joseph's infirmary from the central city, the financing of that move, and, I assume, comments about operating costs now, and projected operating costs in the future would be a proper part of that presentation.

St. Joseph's downtown location, with a 339-bed authorization, has, because of diminishing demand in that area, reduced its current bed capacity to 159 beds.

The Hospital sought to remain in its present position and to serve; but, for a number of reasons which I have outlined in extended remarks submitted with this, they found it necessary to move if they were going to survive as the type of hospital giving the service that it knew best how to supply. There were multiple reasons for moving, but the most important was that we found that "primary" doctors, general practitioners and internists, were leaving the central city and moving to more convenient neighborhood locations for their offices and practice; and the surgeons, the specialists, which formed St. Joseph's principal practice, felt it necessary for their own survival to follow the primary doctors from whom they received referral.

In moving, we sought to develop a design for an efficient hospital one specifically oriented to serve not only General Medical Practice, but to handle the more difficult type operations for which St. Joseph's had developed its own expertise.

HOSPITAL BACKGROUND

St. Joseph's Infirmary was opened on May 2, 1880, almost a hundred years ago, as Atlanta's first hospital. It was founded by the Sisters of Mercy. Originally it had ten beds. The present St. Joseph's Infirmary operates from the same location.

St. Joseph's Infirmary is a non-profit corporation operating under the state laws of Georgia and is sponsored by the Sisters of Mercy. It is operated and governed by a Board of twenty Trustees, which includes nine Atlanta business leaders, four physicians, and seven Sisters of Mercy. Its present Administrator and Chief Executive Officer is Mr. Charles Burge.

At present, the organization is well into the final stages of a major building and re-location project. The $31,600,000 building program will provide an entirely new 300-bed hospital which will replace the present downtown St. Joseph's Infirmary location which has a 339-bed authorization.

In addition to the new hospital building now under construction, there will also be a doctors' office building and parking lot immediately adjacent and joined with the new hospital building. Both are currently under construction.

[The above by way of background.]

Our initial costs were estimated to be in the neighborhood of $20,000,000. To finance the new project, the Trustees studied hospital bonds, namely through R. D. Ziegler Company. They investigated the practicality of County Authority Bonds, looked closely into insurance financing with a number of companies, and found that the most attractive was an H.E.W. Loan Guarantee.

In this, we were extremely fortunate with our timing. Projects with higher priorities had been delayed or cancelled. St. Joseph's request was suddenly Number One.

As we developed our building plans, building costs began to escalate. An additional request was made from H.E.W., and we were again fortunate in that excess funds were at that time on hand.

Our overall H.E.W. Guaranteed Loan was approved in the amount of $23,000,000. A grant was approved in the amount of $750,000.

There will be substantial changes in our Operating Budget in the new location. Currently we are operating from a fiscally sound basis, with Earnings After Depreciation last year of $224,000. This was in excess of our expectations. We plan to move in January of next year. We have completed a budget for the coming year, which includes six months' operation in the present stand and six months in the new building.

Our charge for basic rooms is currently $88 a day. We anticipate a charge of $95 a day in the new building. This is an increase of 8 percent. It will be required to meet increasing financing charges; and we believe we will be competitive at that price.

The two principal increases will be Depreciation and Interest; and we anticipate that those two categories will increase about $194,450 monhly—a substantial burden.

Normal operating increases have been substantial over the past years, and we expect the increment of inflation to continue and to affect our operating costs. In our new hospital stand we anticipate that we will be able to operate more efficiently and that our nursing service and charge per patient bed should be reduced, though the financial burden will be substantially increased.

By way of illustration of current expenses, we find that beginning with the year 1969 and ending with our recently completed 1977 year, we show an increase in dollars for General Insurance of 168 percent—Utilities, 210 percent.

We have been reducing our nursing staff and service staff as we have deactivated patient beds, so that our Payroll costs have shown only a 31.3 percent increase for that period; but, relative to patient days, there has been an increase of 234 percent—showing that we are becoming less efficient as our beds are closed down; and we hope to reverse that in our new location.

Malpractice Insurance costs are a subject of their own. From August 1962 through May 1975 actual settlement claims against St. Joseph's amounted to $63,689. Our insurance premium for that year was $68,141. For the year 1976, on a somewhat reduced coverage we were billed $232,500. We thought that totally unreasonable related to our actual losses, and we did as many other hospitals did—went "bare."

The cost of keeping up with the latest medical technology and maintaining quality service has become very expensive. Let me give a specific illustration.

We have an extremely competent doctor in charge of Cardiology at our hospital. About three years ago he asked for about $25,000 to furnish a piece of diagnostic equipment based on an ultrasonic principle. This is based on somewhat the old sonar of the submarine where an impulse is bounced off as substance and creates a picture of the area. A trained physician can read these, and it becomes a diagnostic process, assisting him in determining whether a cardiac procedure will be necessary. It is used frequently to evaluate the necessity for open-heart surgery.

Our machine is used quite heavily. The charge for its use is approximately $80.

This past weekend the same doctor has made a request for a new piece of equipment—basically the same diagnostic tool, but it is a second generation, wherein the sonic rays, as he explains it, move in two directions and give a much more complete and in-depth picture, allowing a more thorough diagnosis.

This piece of equipment costs $95,000. It will replace the other equipment. Our doctor tells me that the typical fee for the use of this equipment will be about $200.

I asked him how this new equipment will save money for the patient; and he replied that in many instances it would permit him to better determine whether a cardiac catherization process would be needed. Now, the fee for a normal cardiac catherization runs about $600; so, if for an investment of $200 the patient could save $600, it would seem worthwhile.

However, I learned, as I discussed this with him in greater depth, that this machine would also more clearly tell that a catherization would be needed.

So, what we have is a more expensive piece of equipment, involving a probable larger fee to do approximately the same thing we are doing now with an older piece of equipment; yet, we will, without a doubt, be doing the job more accurately and more reliably. We would be upgrading our medical practice.

So, we again face the choice: do we spend the capital funds for this new piece of equipment which represents a technical advance over an older piece of equipment which will do the same basic job, but do it better? It will add to medical costs.

These questions have become routine. Ninety thousand dollars happens to be relatively small as costs for medical equipment go. We face a comparable decision with a $600,000 to $700,000 investment for a full-body scanner. Shall we spend $750,000 for radiation therapy equipment? I find these decisions far more difficult than the normal daily business decisions, for these involve not just profit and loss—they involve human lives; and value judgments are different.

Now, I think the principal question before this forum must probably be: Are the high costs of health care worthwhile? What is going to be the trend of the future? What can we do about increasing costs?

In analyzing the various factors, I find I wear several hats: I am a civilian, I am a taxpayer, and I am responsible for hospital administration. I do have a conflict of interest.

I'm not sure the United States has a stated national health policy, but its Government has apparently assumed responsibility for medical care to certain groups: the indigent sick, through Medicaid; the elderly, through Medicare. County and local governments generally do an outstanding job in providing care for the poor who do not fit into these categories. There are other special groups—the veterans, the American Indians—for which special provisions are made.

Group insurance, Blue Shield and Blue Cross plans cover an increasing number of employed people and individuals. Many of these have deductible features which do keep the patient aware of costs. An increasing number are providing catastrophe coverage, which is often essential in preserving the family financially. Altogether, for a hospital such as St. Joseph's, third party payers cover about 90% of hospital care expenditures.

If the quality of medical care of twenty years ago were sustained, costs would be substantially less than they are; but it has been our policy to continually seek improvement in medical care and continually seek to serve an increasing number of people and various groups with quality medical service. To do this, we have to make heavy capital expenditures in basic facilities and equipment, finance research and increasingly complex and expensive medical equipment and training. We have accomplished a great deal toward these ends. It has been expensive.

As one involved with the development of a hospital and its administration, I am extremely grateful that our Government has provided the funds for capital improvements and has underwritten the cost of quality service for increasing numbers of people.

As a taxpayer I am not sure that my fellow taxpayers and I can afford it.

A decision to cut back in quality is almost unthinkable—but, much can be done in overall planning, in the sharing of services, in cooperation and in coordination; and a little financial coercion might be helpful toward this end.

There is little incentive on the part of the patient to reduce his costs when all of his bills are sent to third party payers. Deductibles, payment limits, etc., offset by improved coverage for catastrophic injuries would, I believe, keep people alert to the cost of medical services, particularly in the many small and perhaps unnecessary procedures, yet provide and assist in the really damaging ones.

There are in hospital operations many secondary areas where increased efficiencies, savings, elimination of waste can be effected—many of them negligible in the individual, but perhaps consequential in the total. Much little and much major things can be done to improve efficiency and service.

But, I do hope that the hospitals and those associated with the medical service will not continue to be decried as the villains and those responsible for the high cost of medical service; but that it be recognized that more people are receiving higher quality service than ever before. And, this trend is continuing—people are living longer, more diseases can be handled more promptly, it is a healthier nation. From where I stand, it appears we are, in general, getting good returns for our medical dollar invested. Whether we can afford all that we are buying, I don't know.

Statement of Herbert H. Mabry, President, Georgia State AFL-CIO

Thank you very much for this opportunity to speak with you today about the rising costs of health care and the difficulties which many working people, especially in our state's rural communities, face when trying to obtain adequate medical attention.

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It is with a great deal of concern that I come before our two distinguished Senators today to discuss an issue which has long been of great importance to the labor movement in this country—the health of the American people. For several years the AFL-CIO has actively supported the national health care legislation known as the Health Security Act, introduced in the Senate this year by Senator Edward Kennedy and in the House by Representative James C. Corman. We feel very strongly that such legislation is necessary to insure that every American, regardless of income, has access to adequate medical care in time of sickness. After 40 years of effort, the private health insurance industry has failed to provide universal health care coverage. Almost 40 million Americans have no health insurance at all, and those who are covered receive only about 40 per cent of their health care costs through their insurance.

The government has reported that health-related costs increased by 44 per cent in fiscal 1976. Medical costs averaged $638 for every man, woman, and child in this country last year, a figure which is three times greater than per capita health costs 10 years ago. The cost of personal health services increased more than twice as fast as other cost of living items in 1976. The average American worked one full month of the year just to pay for medical care and private health insurance costs.

The Department of Health, Education and Welfare reported that total U.S. spending for health care last year reached $130.3 billion, as compared to $122.2 billion in 1975. Since price controls were lifted at the end of the Economic Stabilization Program in April of 1974, health care expenditures have increased by $44 billion, or 31 per cent. As a percentage of gross national product, health expenditures have grown from 7.8 percent in 1974 to 8.4 percent in 1975 and to 8.6 percent in 1976.

Hospital care expenditures, totalling an estimated $55.4 billion in fiscal 1976, increased by 15 percent from the previous year. Spending for doctors' services totalled $26.4 billion, also up 15 percent from fiscal 1975.

This problem of rapidly rising medical costs affects every American, but the situation is especially serious in rural areas—which generally have more poor and elderly people with more health care needs, and proportionately fewer doctors, dentists, and registered nurses.

A report published by the Human Resources Administration of HEW in January of this year revealed the following comparative statistics on health care in urban and rural areas:

In cities, 7.8 percent of the residents in 1973 had never had a routine physical exam. In rural areas, 14 percent had never had a physical.

In cities, 10.9 percent of the residents age 17 years and over had never had a chest x-ray. In rural areas, the figure was 17.2 percent.

In cities 8.9 percent of persons age three years and older had never had an eye exam. In rural areas, 11.5 percent never had an eye exam.

The figures are similar for other specific areas of medical care. In 1975, rural America had roughly 30 percent of the nation's population and only 12 percent of the doctors and 18 percent of the nurses. For the nation as a whole, there was one doctor for every 665 persons; in the cities the ratio was somewhat better one doctor for every 500 persons. In rural America there was only one doctor for every 2400 persons. A rule of thumb has traditionally been that one doctor can provide adequate medical care for 1000 people, indicating an obvious shortage of medical personnel in our rural areas.

Residents of rural areas on the average have incomes considerably below the average income of city residents. In addition, rural residents are much less likely to have health insurance coverage. A paper by Karen Davis and our present Secretary of Labor Ray Marshall states that "residents of the South are less likely to have hospital insurance coverage than others, and non-metropolitan South residents have the lowest hospital insurance coverage of any group—about one-third of non-metropolitan non-farm residents have no hospital insurance, and about one-half of farm residents in the South have no hospital insurance."

Every industrialized country in the world, with the exception of the United States, has some form of national health insurance or directly provides health care to its citizens through a nationalized health care system. The time has come for this country to provide American citizens with comprehensive personal health care services, equally available to all of our citizens.

The Health Security Act, S. 3, is the legislation best able to provide adequate health care for all Americans. This bill would be of special benefit to residents of rural areas, who have the greatest difficulty obtaining adequate health care.

The Health Security Act provides a number of incentives for physicians to practice in rural areas, particularly through the elimination of any connection between payment or reimbursement and the "prevailing fee." The act provides for the reimbursement of a complete range of medical services not generally available in rural areas at the present time. The bill provides fund for the construction maintenance and staffing of primary health clinics which are so necessary in rural areas, as well as money for transportation and communication costs which are higher in rural areas.

Considering the rising costs of health care for those who can afford it along with the fact that the medical needs of many poor, near-poor, and working Americans are not being met at all, America is currently paying a high price to private health insurance companies for an ineffective and inefficient health care delivery system. Health Security would combine both the private and governmental costs of health care and would not cost much more than is currently being spent. Over time, costs would actually be reduced. Health Security will insure that the poor, the disadvantaged, and the working people of America have the same right to health care, and to life itself, as do the privileged and the wealthy.

Thank you very much for your time and your consideration.

Senator TALMADGE. Our next witness is Mr. Fred R. Higginbotham, president of Blue Cross and Blue Shield, Atlanta, Ga. You may insert your full statement in the record, if you desire, or summarize it in any manner you see fit, Mr. Higgenbotham.

STATEMENT OF FRED R. HIGGINBOTHAM, PRESIDENT, BLUE CROSS AND BLUE SHIELD, ATLANTA, GA.

Mr. HIGGINBOTHAM. Thank you. I would like to submit it for the record.

Senator TALMADGE. To be inserted in full in the record? It will be inserted in full.

Mr. HIGGINBOTHAM. Thank you, Senator Talmadge, Senator Nunn, ladies and gentlemen. I am Fred Higginbotham, president of Blue Cross and Blue Shield of Atlanta. This plan serves a 28-county area of northwest Georgia, which includes the Metropolitan-Atlanta area. A second plan based in Columbus serves the remainder of the State. Our current enrollment in the private business market is some 430,000 members, and income from private business in 1976 amounted to more than $97 million. Our plan also serves as medicare intermediary under part A, which provides hospital and skilled nursing benefits for approximately 190,000 beneficiaries. We also administer the program for employees of the State of Georgia.

We believe the financial and statistical data accumulated on this significant segment of our population are extremely pertinent to this hearing on health care and hospital and insurance costs.

We at Blue Cross and Blue Shield share the local, State, and national concern about the extraordinary rise in medical care costs, and sincerely appreciate the efforts the two of you are making toward a beneficial and lasting solution.

We have prepared a statement that we believe contains data that will be helpful in your deliberations. In these few minutes, I wish to focus on a few specific points from the statement. I have prepared graphs and they are included in your statement. Share with me, if you please, the figures contained in the graph that is represented by attachment 1. You will note that between 1971 and 1979 the average charge per-patient claim doubled. That is, it moved from $486 in 1971

to $970 in 1976. At that same time, the number of admissions per thousand members increased by nearly 20 percent, and the number of days of care per thousand members increased by 17 percent.

Upon closer examination, you will see that the increase in utilization experience has, in fact, taken place actually beginning in 1974. We have included on the graph the experience for the first 6 months of 1977, less than the full year, which indicates the trend is continuing, and thus far, even at an accelerated pace. You will note—and I think it is gratifying—that the average length of stay continues to remain at a low level. It is, in fact, lower than the national average. Included in the statement are other graphs that we have not produced here.

Attachment 2, as you have been furnished, gives a comparison between the utilization experience of the Atlanta Blue Cross plan and other southeastern plans. You will notice that the utilization experience there, again, indicates that the experience is higher in the Atlanta plan area than in the other areas within the southeast. Included, also, as attachments 3 and 4, we give specific information relative to admission ratios, broken down for surgical and medical admissions for two very large employers in the Atlanta area, compared with experience of those employers in other areas in which they have plant locations. In fact, the use of health care benefits for the employees of one plant located in Atlanta for company B is the highest of any of their locations in the United States.

Senator NUNN. Well, can we deduct from this that the people in the Atlanta area—I mean, is there a conclusion we can draw from this, that the people in the Atlanta area are getting better care? Is that possible, or is it an overutilization problem or are we seeing an abuse of the system?

Mr. HIGGINBOTHAM. Well, we believe, Senator Nunn, that the utilization is indeed higher in this area than it is in some other areas of the country. We will project two possible reasons, and certainly I think there are many others.

The attachment 5, just for your information, is a comparison of company C, which compares the experience of one large employer with the experience in the other southeast States, including North and South Carolina, Florida, and Columbus, Ga.

The next attachments, 6 and 7, as depicted by the graph here, give a picture of the admission ratio of the members within this plan area, compared with other areas. I would like to observe at this time, Senator Talmadge, Senator Nunn, that even though this plan, this Blue Cross plan area includes 28 counties in northwest Georgia, approximately 85 percent of all our members' claims are for care provided in the seven-county Metropolitan-Atlanta area.

You will note the Atlanta experience of admissions per thousand shown by the red line, the dotted line being the experience of the Blue Cross members in the Columbus plan, and the blue line representing all the Blue Cross plans throughout the United States. You will notice, beginning in 1973, the increased utilization in this plan area. At the same time there is a downward trend in the Columbus experience and the national experience on a slightly-declining plane since 1967.

It must be pointed out and recognized that during the years along 1967 to 1971, because of a great population increase in the Atlanta area, that there was a bad shortage here.

The next graph has to do with the number of inpatient days of care provided per thousand members, and you will notice similar trends between the Atlanta plan experience, the Columbus experience, and the experience nationwide represented by the blue line. Our admission ratio in the Atlanta plan area is some 43 percent higher than the national average, and 28 percent higher than in the Columbus area.

At Blue Cross we continually endeavor to identify reasons for these trends, in an attempt to develop programs and take actions that will impact on these issues. As set forth in the statement, many factors influence these trends. Certainly, I must acknowledge that the third-party payers, ourselves included, have had an impact on the utilization of services. Certainly, as we have seen first-dollar coverage increase through negotiations and through what individuals, as well as employers, have bought, certainly we recognize that the increasing technology available has played an important part in this increased utilization. It is difficult for us, however, to rationalize the difference between different areas just of this State. We think the comparison of these two graphs and the information contained on your attachments 8 and 9 certainly establishes a definite correlation between utilization and the availability of services and facilities.

You will notice from the additional graph that is there that the number of beds increased by 38 percent from 1971 through 1976, while at the same time, according to the figures we've obtained, our population in this metro area increased only 5 percent. Relating also to the increase in services, is the increase in the number of private physicians within the urban area of Metropolitan-Atlanta, which does, in fact, exceed by a great deal the population increases. Our figures indicate that between 1972 and 1976 there was an increase of some 21 percent in Fulton County, and 22 percent in the Metropolitan-Atlanta area.

When the graphs relating to utilization are reviewed beside those showing the availability of facilities and services, it appears more persuasive. There is a definite correlation between the supply and demand aspects of medical care and utilization. Certainly, the estimates made by various groups that Atlanta has an overabundance of beds is projected by various experts in the field to be in the neighborhood of some 2,500 to 4,000 causes one to speculate about the relationship of increasing utilization to increased number of facilities and services.

This makes clear that areawide planning, in my opinion, of health facilities, has not been effective in this community, and makes the development of a strong health systems agency extremely critical for the future. I am sure that Senator Shapard will present information on that subject later on this morning.

I am pleased to be a member of that North Central-Georgia HSA. It seems especially critical to note with regard to the data presented for the Atlanta area that the cost control legislation proposed thus far seems to have only incidental impact on the critical issue of this community, and that is, increased utilization. There is even some danger that a bill that does not provide for local flexibility might freeze the system at this high level and discourage or prevent attacks on the problem. Services come in with caps or revenues at a level that maybe would be wrong. We believe the basic concepts of the Talmadge bill has positive incentives for good performers and penalties for high-cost hospitals seem superior to the rigid across-the-board approaches which penalize well-managed hospitals.

We firmly believe that the key to improved efficiency and cost effectiveness within the health care delivery system lies with the types of longer term, permanent cost containment tools that are underway—health planning, prospective and other incentive payment systems, utilization review, alternative delivery systems, and innovative health care benefits such as home health care, and certainly more effective health education programs. Incentives should be established for hospitals to operate more efficiently by substituting for inpatient services and consolidating or converting excess capacity. We also believe that these tools must be closely integrated, for no one tool can be expected to do the whole job, as each deals with only selected facets of the costs problem.

Similarly, we believe that effective design and implementation of these tools is a shared responsibility. Consumers, health providers, government, labor, business, and payers must all work together to insure success. Hospital trustees, hospital administrators, physicians, and other health professionals, must understand the dimensions of the problem and actively contribute to its solution. The efforts by our Blue Cross plan to contain costs are briefly described in an appendix which is a part of the statement, and I will not take the time to review it here.

In conclusion, I express my sincere appreciation for your interest and concern on this critical issue, and assure you of the continuing efforts and resources of Blue Cross and Blue Shield which will be dedicated to impacting on the cost of care and the improved health of all people. It is gratifying to us—and I'm sure to you—that there is indeed greater interest and an attitude of concern and cooperation between management and labor, physicians, hospitals, carriers, government, our members, and the public at large, on this very critical issue.

Through cooperative, participative programs, I am optimistic that we can impact on the cost of medical care, and yet arrive at long-range solutions that will not diminish the quality or needed availability of medical care for all persons.

I thank you very much.

Senator TALMADGE. Mr. Higginbotham, what do you estimate is the annual cost of 2,500 hospital beds that you believe to be surplus in the Atlanta area?

Mr. HIGGINBOTHAM. There have been figures quoted bv many different experts on that, Senator Talmadge. I certainly would recognize and believe that the beds, even though maybe mothballed or not in operation, not even open, certainly do have a cost because of the capital expenditure that was required. I would hesitate at this time to give a figure, but would be glad to furnish——

Senator TALMADGE. If you can furnish the best estimate for the record, we would be grateful.

Mr. HIGGINBOTHAM. I would be glad to do that.

[The following was subsequently supplied for the record:]

The North Central Georgia Health Systems Agency estimates there were 3,500 excess beds in 1976 in their 24-county area. There are various estimates as to what an empty bed costs to maintain and the amount probably varies widely by institution. The cost to maintain a bed in an open, functioning fully-staffed nursing unit is very different than those to maintain a bed in a closed, dark wing which is not staffed at all. Thus, the cost of an empty bed might range from 10% to 50% of the cost of an open bed depending on a variety of such factors. During

1976 the average hospital charges per claim to Blue Cross and Blue Shield of Georgia/Atlanta were approximately $200 per day.

Based on these assumptions, the range of unused bed costs could be estimated to be between $25.5 million to $127,750,000. This wide range of estimates is due to the fact that there is little consensus on both the number of excess beds and the costs to maintain them, so such estimates should be interpreted cautiously.

Senator TALMADGE. Am I correct in assuming from your statement that first we need professional review to assure that hospital use is appropriate, and that once that is determined, we need a reasonable indication as to how much was paid for hospital care.

Mr. HIGGINBOTHAM. Senator, certainly we believe that utilization review, properly conducted in institutions is very important. We have worked with our hospitals and are working with the hospitals in this area on those types of programs at the present time, attempting to move in the direction of more effective utilization review. As you know, we have had utilization review programs under the medicare program since 1966.

Senator TALMADGE. Yes, sir. I understand that saved substantial money; is that correct?

Mr. HIGGINBOTHAM. Yes. Our experience here, Senator Talmadge, when we started an effective utilization review program for medicare in 1973, has been that there are fewer days per beneficiary used in the Atlanta plan area than any of the southeastern areas.

Senator TALMADGE. PSRO's, I believe, have become operational in Georgia January 1; is that correct?

Mr. HIGGINBOTHAM. Senator, I do not believe that a PSRO has yet been established in Georgia, nor has it been applied for.

Senator TALMADGE. Applied for a plan, I believe, to become effective January 1; is that right? They started working on it January 1.

Mr. HIGGINBOTHAM. I believe the law is there should be one established by January.

Senator TALMADGE. I have read records, wherever they are operational, particularly in the State of Colorado, they have saved substantial money; is that correct?

Mr. HIGGINBOTHAM. I have read that, but I don't have that information with me. I understand they have been effective in some areas.

Senator NUNN. I think your statement is very helpful. It seems to me that the fundamental problem identified here—and maybe I am wrong in assessing your testimony—but, basically what you have said is that your statistics indicate that when the supply of hospital beds and doctors go up, then there is a corresponding increase in demand and increased utilization causes the price to go up. Is that what your statement is?

Mr. HIGGINBOTHAM. Our facts indicate that certainly there are those factors at play. We have to recognize that there are many other elements that do impact on utilization of costs, not the least of which would be the advances in medical technology, and I think even the malpractice or defensive medicine situation, but we do think that there is an aberrant pattern here. I am very pleased that we have formed, through our board, which consists of hospital officials, public members, and doctors, a cost accountability committee addressing these very things, developing and implementing programs and attempting to come up with the answers.

Senator NUNN. I don't want you to say anything you don't want to say, but it seems to me your charts show a direct connection between increased supply and increased utilization and increased price.

Mr. HIGGINBOTHAM. Yes. I believe certainly the increased utilization is impacted by the increase in beds as well as other factors. The increase in bed supply parallels very closely the increase in utilization.

Senator NUNN. And as the doctors increase——

Mr. HIGGINBOTHAM. We believe, certainly, since the doctor is the one who does the ordering, the admitting, the discharging, et cetera, that that is a very important part of that equation.

Senator NUNN. It seems to me, then, we reverse the traditional laws of supply and demand. I know Senator Talmadge is very familiar—in agriculture—more than I am, with this year, for instance, we have got a tremendous increase in grain supply. The price has been down. The price has gone down, but what we are seeing here in the medical field is the reverse between the laws of supply and demand that we know in other fields. Now, why is that situation reversed? Is that because we have had such an inadequate supply for years that the demand is now catching up, or are we rewriting the laws of supply and demand in the medical field?

If all other laws of supply and demand don't apply to the medical field, then I think we have to rethink some of these whole concepts that we are talking about.

Mr. HIGGINBOTHAM. I certainly, Senator Nunn, do not claim to be an economist, but I do not believe the same principles and the same laws of supply and demand, at least, apply to the health care field as they would to agriculture or other industries.

Senator NUNN. You are saying it is——

Mr. HIGGINBOTHAM. I think it is——

Senator NUNN. I understand there was a doctor at UCLA many years ago, several years ago, that came out and said that this was, in fact, true, and they called that Roemer's Law. Have you ever heard that?

Mr. HIGGINBOTHAM. I am familiar with Roemer's Law.

Senator NUNN. Do you subscribe to Roemer's Law?

Mr. HIGGINBOTHAM. I think there is certainly a lot of merit to it. There seems to be a way to get some of these beds used.

Senator NUNN. Thank you very much.

Senator TALMADGE. Maybe Parkinson's Law would be a better application.

Mr. HAVERTY. Senator Nunn, would it be out of order if I made a comment on that?

Senator NUNN. Be glad to have you comment.

Senator TALMADGE. Happy to have your comment.

Mr. HAVERTY. I feel like the culprit here is the Federal Government and the third-party payers, because if you had a hospital with empty beds and one with full beds, there's no competition. I can go to a third-party payer, either one I want, and get my bill paid without any competition at all.

Senator NUNN. You are basically saying that if the Federal Government was going to buy all of that excess grain at the same price as when there was a scarcity 3 years ago, that the price of grain would also stay up. The law of supply and demand is still good.

Mr. HAVERTY. But there's an intervening third-party payer here that distorts that law of supply and demand.

Senator NUNN. Exactly.

Senator TALMADGE. Thank you very much. Mr. Higginbotham, for your contribution.

[The prepared statement of Mr. Higginbotham follows:]

STATEMENT OF F. R. HIGGINBOTHAM, PRESIDENT BLUE CROSS BLUE SHIELD OF GEORGIA/ATLANTA

STATEMENT ON HEALTH CARE COSTS

My name is Fred R. Higginbotham; I am President of Blue Cross Blue Shield of Georgia/Atlanta. This Plan serves a 28-county area in Northwest Georgia extending from the Atlanta metropolitan area north to Chattanooga. A second Plan in Georgia, based in Columbus, serves the remainder of the State. Our current enrollment in the private business area is 430,503 and income from private business during 1976 amounted to $97,464,000. The Plan also serves as Medicare intermediary under Part A and handles approximately 255,000 bills per year. We have approximately 450 employees in our Blue Cross Blue Shield Plan.

Concern About Health Care Costs

We at Blue Cross Blue Shield share the national concern about the extraordinary rise in health care costs. For example, claims data for our area (*Attachment 1*) show that the average hospital inpatient charge per claim for our Blue Cross Plan increased from $486 per claim in 1971 to $1,073 in June of 1977. This increase of more than 120% in five years has been accompanied by an increase in the admission rate per 1,000 mmebers from 143 in 1971 to 174 for the first half of 1977. Similarly, the days of inpatient hospital care per thousand members has increased substantially during this same five and a half year period from 840 to 1,026 days per thousand members.

The important thing to note is the Atlanta Plan utilization increases, as measured by admissions and days of hospital care used, is contrary to national patterns which show these rates to be stable or even declining slightly. There seems to be a special problem in the metropolitan Atlanta area. It should be observed that, even though our Plan area includes 28 counties, approximately 85% of our members' claims are for care provided within the seven county metropolitan Atlanta area.

Information compiled from various sources confirm the high use patterns in the Atlanta Plan area. For example, *Attachment 2* compares Atlanta use to other Plans in the Southeastern area and our admission rate for 1976 is 171 compared to rates of 133 for Florida, 133 for Columbus, 140 for Chattanooga, 127 for North Carolina, and 129 for Kentucky.

This special problem is confirmed by data from several nationally enrolled groups. *Attachment 3* shows data on a major employer for 1975 which indicates that Atlanta use rates in terms of admissions per thousand are number one of the twenty comparable plans serving this company for surgical admissions. *Attachment 4* for Company B, another national group, shows the Atlanta Plan number one in the nation for both medical and surgical admissions; one large Atlanta area installation of this company uses more health care benefits than any comparable facility in the nation for this large corporation. An example of another national group is Company C (on *Attachment 5*) which operates in four Southeastern States involving 5 Plans. In 1973 Atlanta was lower than the company-wide averages for employees in our geographic areas and by 1976 the pattern has reversed and our admission rate for this particular account is 135 per thousand utilizing 757 days of inpatient care while company-wide the comparable figures are 138 admissions with 714 days of care.

Attachments 6 and 7 are graphs indicating data on use for all Atlanta Plan subscribers to use rates of the Columbus, Georgia Plan and national averages. Again, these data confirm the extraordinarily high utilization rates in the Atlanta metropolitan area. Our admission rate is 43.7 percent higher than the national average and over 27 percent higher than the comparable rate for the Columbus, Georgia Plan which serves the rest of the State. Again, similarly when days per thousand members are considered we are 24 percent higher than the national average and 32.4 percent higher than the Columbus Plan. I again note that our trend is the wrong way when compared to national trends.

I apologize for the multiplicity of statistics being presented here, but they are of extraordinary importance in indicating that this community faces a unique problem. Any serious effort to get at the issue of health care costs in Atlanta must first focus on the utilization question. Probably every metropolitan area has its own set of financing and delivery institutions and associated unique problems. Health care remains very much a local community affair despite extensive involvement by State and national governments. Effective interventions and strategies to control costs, improve access, or achieve any other goals in the health care system must relate to individual local communities. This is one of the strengths of having a Blue Cross system united to achieve national goals but yet tied into local communities. Health care costs and the increased utilization trend are of extraordinary concern to the Atlanta Plan, its groups and individual subscribers, and the providers in this area.

We have, of course, attempted to find out the causes of this increase in costs and utilization. Certainly a host of factors are involved including rising consumer demands and expectations of the medical care system; lifestyle factors, such as diets, smoking, and lack of exercise which make for increased demands on the system; technology with its new drugs, surgical and diagnostic techniques and equipment; undoubtedly some fraud and abuse of public and private programs; inflation in the general economy; excessive facilities and services; and many other factors that have been identified by this committee and will be discussed by other witnesses.

A major factor which has been the object of considerable attention stems from the fact that the Atlanta Plan utilization rates changed drastically in the past few years. Prior to that time, our rates were comparable to or even slightly lower than national and regional averages. Only in 1973, 1974, and subsequent years have we seen the dramatic changes described here. In this regard, it is important to note *Attachments 8* and *9*, which describe the number of hospital beds and doctors in parts of the area we serve. First, with regard to hospitals and beds in our 28-county Plan area, the number of hospitals has increased from 56 institutions with 7,135 beds in 1971 to 71 hospitals with 9,838 beds in 1976. It is variously estimated by different groups that Atlanta has an overabundance of hospital beds projected in the neighborhood of 2500 of 4000 beds. One can only speculate about the relationship of increasing utilization to increasing beds. The number of hospital beds represents a 38 percent increase during the five-year period accompanied by only a 5 percent increase in population according to our estimates from 2,126,000 in our 28-county area to current estimate of 2,363,000.

For physicians, accurate data are difficult to obtain, but again Attachment 9 shows a dramatic increase far exceeding increases in population. For example, there was a 21 percent increase in physicians in Fulton County between 1972 and 1976 and a 22 percent increase in the metropolitan area during this period.

When Attachments 8 and 9 are related to Attachments 6 and 7, it appears there is a definite correlation between the supply and demand aspects of medical care utilization.

Comment on Cost Caps

You are aware that the BCA has testified on H.R. 6575, the Administration proposal, and S-1470 introduced by Senator Talmadge. I generally support the views they expressed.

There is a need for a short-term program to contain health care costs. The data presented here are alarming; our groups and subscribers cannot tolerate 15–20 percent rate increases indefinitely. I hope a transitional program will evolve from the legislative process that is effective and minimize some of the real problems of rigidity and inequity inevitably associated with such legislation.

In this regard, the basic concepts of the Talmadge Bill with positive incentives for good performers and penalties for high cost hospitals seem superior to the rigid across the board approaches which penalize well-managed hospitals.

I also believe that the concurrent introduction of a temporary capital expenditures moratorium program should go a long way toward preventing fragmentation and duplication of health facilities and services whereas a revenue limitation program applies only to hospital acute care services. Such a moratorium would allow time for more fundamental and permanent reforms in the Health Planning Act.

We firmly believe that the key to improved efficiency and cost effectiveness within the health care delivery system lies with the types of longer term, permanent cost containment tools that are currently underway—health planning, prospective and other incentive payment systems, utilization review, alternative delivery systems, and innovative health care benefits such as home care. Incentives should be established for hospitals to operate more efficiently by substituting for inpatient services and consolidating or converting excess capacity. We also believe that these tools must be closely integrated. No one tool can be expected to do the whole job, as each deals only with selected facets of the cost problem.

Similarly, we believe that effective design and implementation of these tools is a shared responsibility. Health providers, government, labor and business must all work with us to ensure success. Hospital trustees, hospital administrator, physician and other health professionals must understand the dimensions of the problem and actively contribute to its solution. The efforts by the Atlanta Plan to contain costs are briefly described in an appendix; I will not take time to review this here.

It seems especially critical to note with regard to the data presented for the Atlanta area that the cost control legislation proposed thus far seems to have only incidental impact on the critical issue for this community-increased utilization. There is even some danger that a bill which does not provide for local flexibility might "freeze" the system at this high level and discourage or prevent attacks at this problem. I urge you to be aware of this danger.

Conclusion

I express my sincere appreciation for your interest and concern on this critical issue and assure you of the continuing efforts and resources of Blue Cross Blue Shield which will be dedicated to impacting on the costs of care and the improved health of all the people. It is gratifying to us and I am sure to you that there is greater interest and an attitude of concern and cooperation between management, labor, physicians, hospitals, carriers, government and the general public on the issue.

Through cooperative, participative programs, I am optimistic we can arrive at long range solutions that will not diminish the quality of care available to all Americans.

Thank you.

ATTACHMENT NO. 1

SELECTED DATA OF BLUE CROSS—REGULAR AND FEP INPATIENT CLAIMS

	1971	1972	1973	1974	1975	1976	January to June 1977
Admissions per 1,000 members	143	138	137	162	158	171	174
Days per 1,000 members	840	830	808	903	897	984	1,026
Charges per claim	$486.11	$569.77	$620.21	$699.90	$834.97	$970.63	$1,073.38
Charges per day	$79.56	$96.86	$105.53	$122.21	$147.31	$170.70	$186.57
Average length of stay	6.11	5.88	5.88	5.73	5.67	5.69	5.75

ATTACHMENT NO. 2

PRIVATE BUSINESS DATA FOR COMPARABLE SOUTHEASTERN PLANS

	1974		1975		1976	
	Admissions	Days	Admissions	Days	Admissions	Days
Atlanta	162	903	158	897	171	984
Florida	154	790	136	789	133	806
Columbus, Ga	128	841	130	768	133	743
Chattanooga	140	888	141	884	140	877
North Carolina	132	872	129	838	127	819
Kentucky	128	796	133	842	129	803

ATTACHMENT No. 3

COMPANY A—1975 INPATIENT HOSPITAL CLAIMS DATA, HOURLY EMPLOYEES

[Rank by number of admissions per thousand members]

Surgical admissions		Medical admissions	
Name of plan	Admissions per 1,000	Name of plan	Admissions per 1,000
Georgia, Atlanta	120	Missouri, St. Louis	139
Virginia, Richmond	114	Ohio, Toledo	134
Missouri, St. Louis	113	Virginia, Richmond	127
Missouri, Kansas City	112	Illinois	124
Ohio, Cleveland	105	Missouri, Kansas City	121
Illinois	100	Minnesota	118
Kentucky	100	California, Southern	114
California, Southern	98	Kentucky	106
Tennessee, Chattanooga	95	Tennessee, Chattanooga	105
New York, Buffalo	93	Georgia, Atlanta	104
Ohio, Cincinnati	93	Ohio, Lima	102
Indiana	90	Ohio, Cleveland	97
Ohio, Toledo	89	Michigan	95
Minnesota	86	Ohio, Cincinnati	87
Ohio, Lima	83	Indiana	80
California, Northern	77	California, Northern	64
Michigan	72	New York, Buffalo	59
New Jersey	60	New Jersey	58

ATTACHMENT No. 4

COMPANY B—1975 INPATIENT HOSPITAL CLAIMS DATA, HOURLY EMPLOYEES

[Rank by number of admissions per thoussnd members]

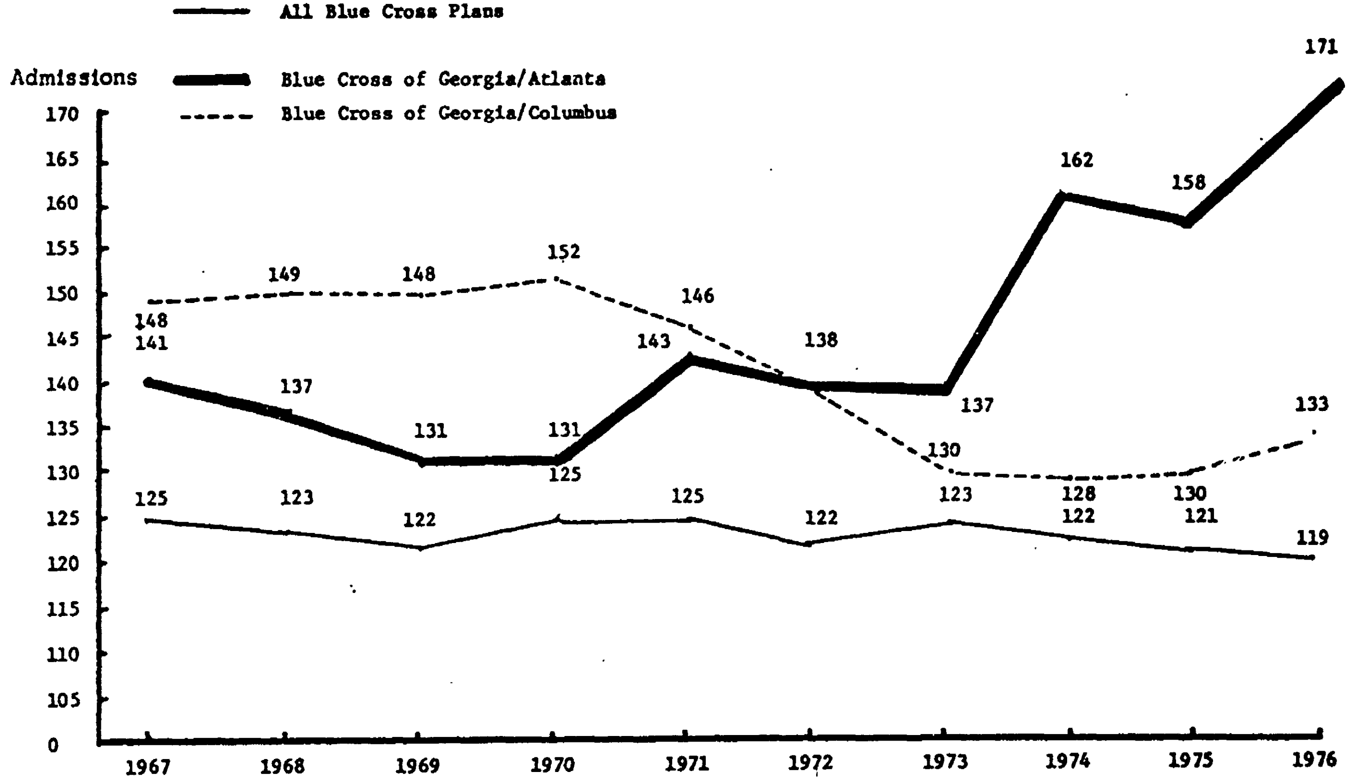
Surgical admissions		Medical admissions	
Name of plan	Admissions per 1,000	Name of plan	Admissions per 1,000
Georgia, Atlanta	153	Georgia, Atlanta	165
Illinois	132	Illinois	133
Texas	130	Texas	133
Missouri, Kansas City	110	Ohio, Toledo	123
Missouri, St. Louis	106	Missouri, St. Louis	122
Ohio, Youngstown	101	Missouri, Kansas City	121
California, Southern	95	Michigan	110
Ohio, Cleveland	93	California, Southern	102
Ohio, Toledo	89	New Jersey	88
New York, Buffalo	89	Ohio, Cleveland	87
Wisconsin	84	Ohio, Youngstown	86
New York, New York	80	Indiana	82
New Jersey	78	Ohio, Cincinnati and Dayton	82
Maryland	78	New York, Buffalo	77
Ohio, Cincinnati and Dayton	76	New York, New York	76
Michigan	73	Wisconsin	73
Indiana	73	Maryland	61
New York, Rochester	57	New York, Rochester	54

ATTACHMENT No. 5

ADMISSIONS PER 1,000 MEMBERS AND DAYS PER 1,000 MEMBERS FOR COMPANY C

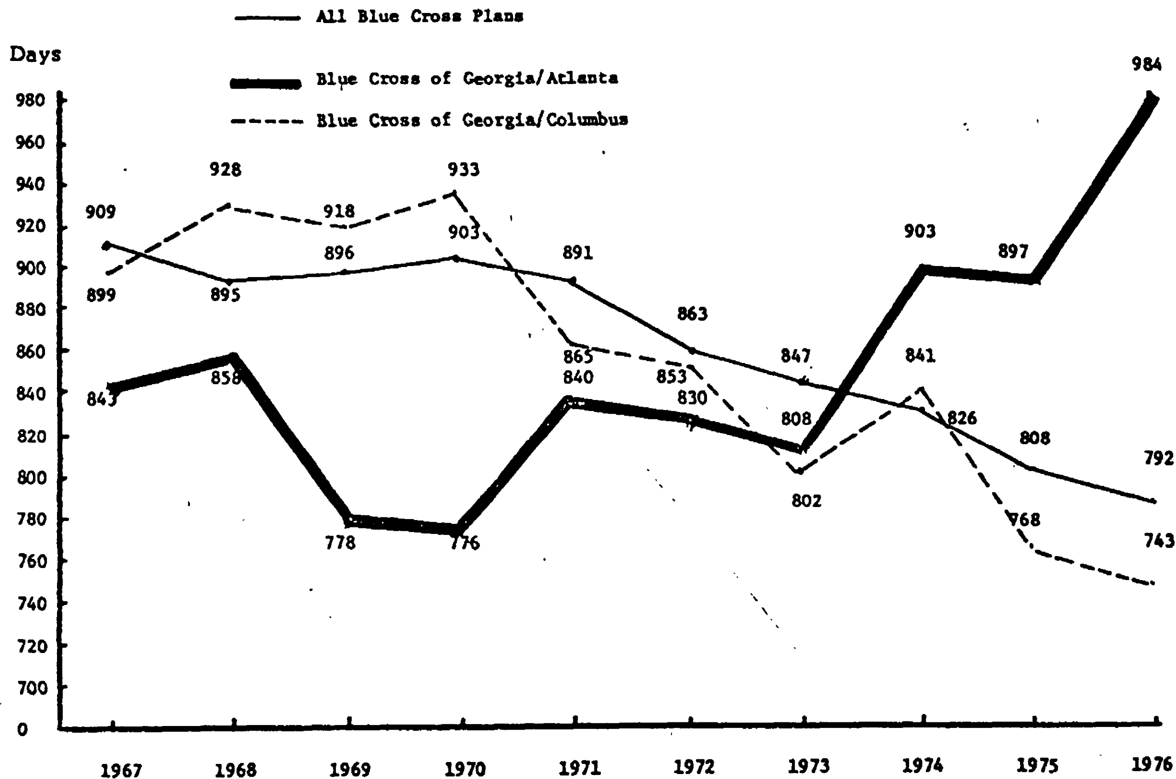
	Atlanta		Total company C	
	Admissions	Days	Admissions	Days
1973	124	624	131	691
1974	131	585	132	694
1975	133	678	131	709
1976	155	757	138	714

ADMISSIONS PER 1,000 MEMBERS



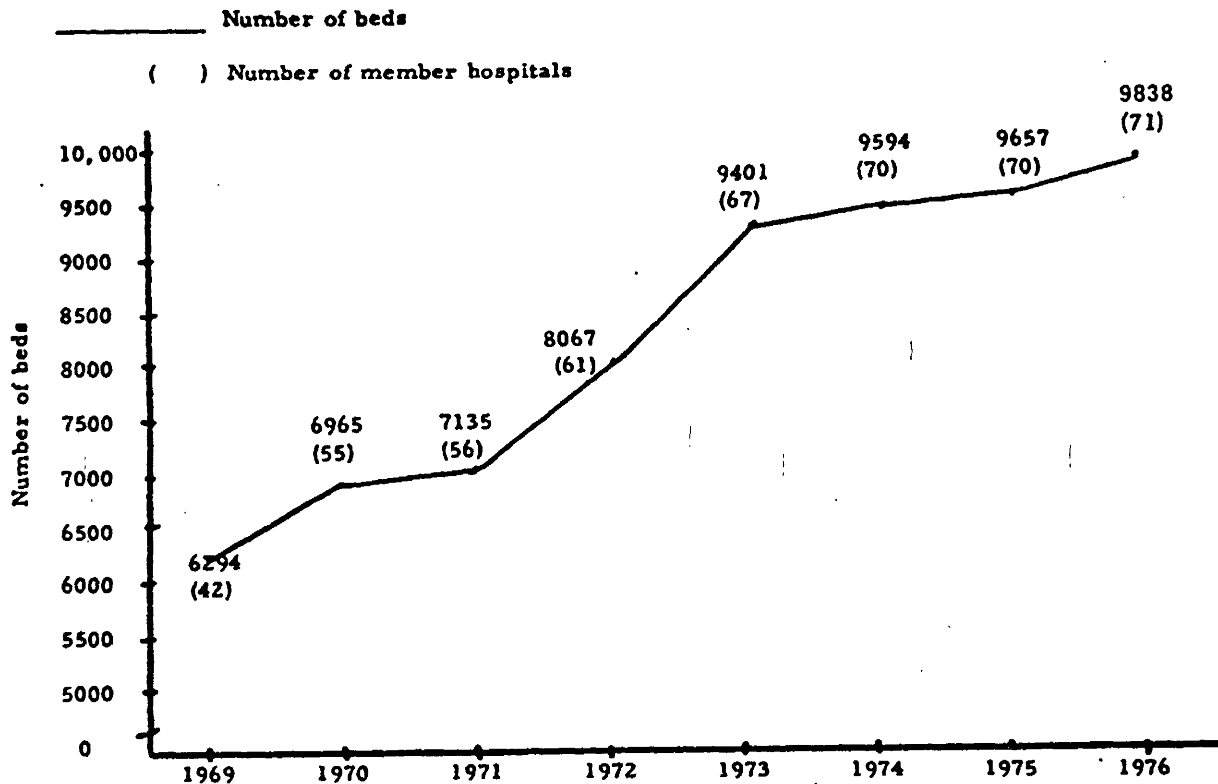
ATTACHMENT 6

INPATIENT HOSPITAL DAYS PER 1,000 MEMBERS



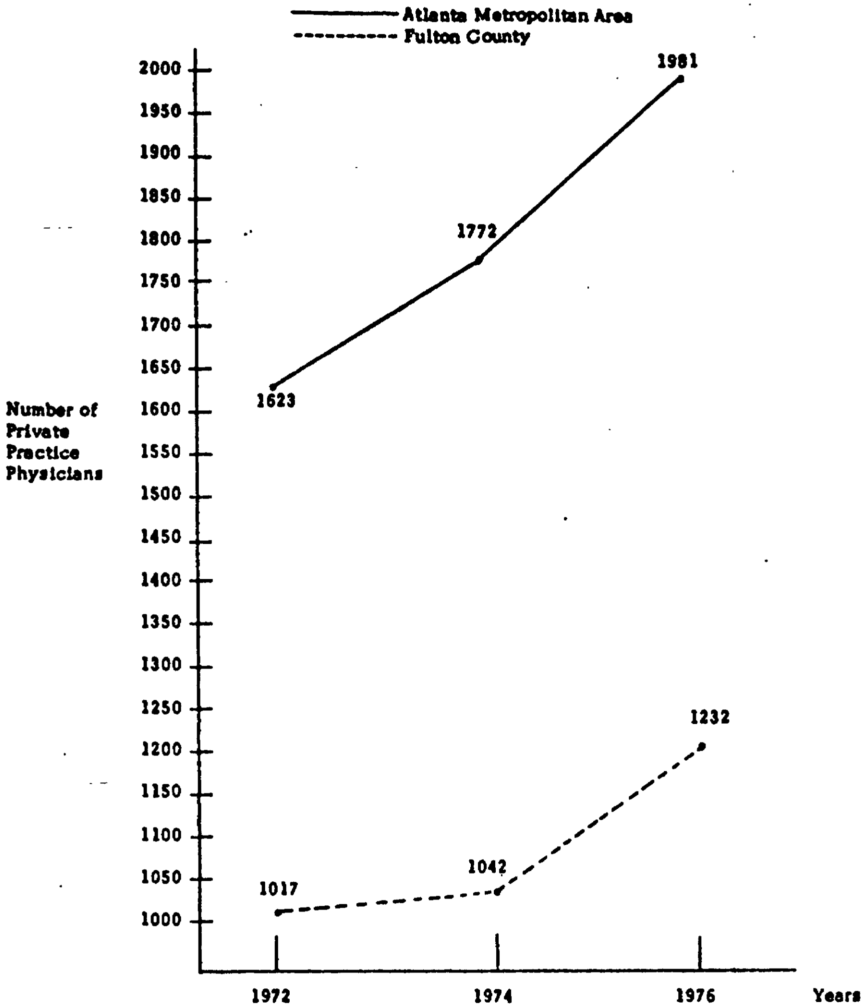
ATTACHMENT 7

NUMBER OF MEMBER HOSPITALS AND BEDS



ATTACHMENT 8

ATTACHMENT 9



APPENDIX

COST CONTAINMENT EFFORTS—BLUE CROSS BLUE SHIELD OF GEORGIA/ATLANTA

Blue Cross Blue Shield has long been concerned about health care costs and at the moment are very active in formulating new initiatives in this area. We have always been concerned, but the problem has become more acute in recent years and particularly the utilization problems have only recently come into focus. I will outline here only briefly some of the cost containment efforts underway or planned by the Atlanta Plan.

One important step taken is to create a Board level committee on cost accountability, charged with forming a cost containment program. This committee has been actively meeting during the last year and is formalizing the program presented here:

Utilization Review—We are currently actively working in the design to develop and design a utilization review program in cooperation with hospitals and doc-

tors. Ten hospitals which were represented on our Board participated in a five-month pilot program of a particular utilization review program which was shown to be cost effective. We are currently working with hospitals targeted on a January 1, 1978, implementation date for this major effort. We are very hopeful that it begins to impact on the serious utilization problems demonstrated previously in this testimony.

Community Meetings—Another step which we are hopeful of undertaking and are in the early stages of organizing is a series of community meetings in the fall and winter involving consumers, group buyers, carriers, doctors, and hospitals on the health care costs and related problems. It is important that a broader understanding of the general problem and specific concerns in the Atlanta area be achieved. No cost containment can be conducted by any one group alone. This Blue Cross Plan, for example, with an approximate 18.1 percent penetration cannot and does not desire to impose any solution; we don't have a solution to impose. The problem is too complex for that. It seems important to us that all representatives of society come together and discuss and understand the problem so that intelligent plans and programs may be developed and meaningful tradeoffs can be made. Any serious cost containment proposal involves change in behavior and lifestyles by all those involved in public and private sectors.

No one group is responsible for the problem or the solution. There has been too much of a tendency to resort to glib generalizations and assume that all hospitals are bad or that all doctors are wastrels or that consumers have infinite demands for medical care or that government is the real culprit. These cliches will not solve the problem. We believe we simply must begin to talk to each other more before we can really move forward with solutions.

In this regard, some of Secretary Califano's comments on hospitals seem genuinely unfair. This community, as do many others, has excellent institutions of high quality which have been cost conscious and have distinguished records of effective efforts in cost containment.

One of the important factors for Blue Cross Blue Shield Plans is that our cost containment efforts get built into rates. We often find many third party payors, while giving lip service to cost containment, simply pay claims and do not employ professional provider relations staffs of qualified people to develop strategies and programs aimed at cost accountability. Some government programs are going to carriers who provide nothing more than a paper and dollar conduit and whose administrative costs are extremely low because meaningful claims administration and adjudication procedures are not performed. This is possible for certain software houses to do in many cases, but the government gives up many important ancillary benefits that a Blue Cross Blue Shield Plan tied into a local community can offer.

Coordination of Benefits—Coordination of benefits means that under the provisions of a group's contract, Blue Cross and Blue Shield coverage is coordinated with other coverage available to a subscriber through another group program. The purpose of the COB provision is to avoid duplicate benefit payment in cases of duplicate coverage.

In many families, both the hubsand and the wife are employed. Duplicate coverage for health care expenses occurs if both are included under their respective employers' group health care plans. Each probably includes their children for coverage. Not only are the husband and wife enrolled for coverage, but their children as well, under two or more programs. Duplicate coverage is not considered a problem—it helps the family with their hopsital and doctors bills. However, it can become a serious cost factor.

If an individual patient receives benefits fom more than one program for a given service rendered, that patient is making a profit on illness that eventually is paid for by every component of the health care industry. Through coordination of benefits, liability for costs incurred during an illness are divided between health care carriers so that whenever possible a subscriber may meet his expenses in full—and yet not collect more than his actual charges.

During 1976, a new methodology of handling COB was introduced and savings under the Atlanta Plan's COB amounted to $5.1 million. This means approximately a six percent savings on eligible charges.

Benefit Design—This is another area where Blue Cross works very hard in in the design of our benefit packages in such a manner to favor outpatient and less expensive modes of treatment as opposed to putting incentives on patients to go into the hospital to receive care. For a long time, Blue Cross Plans probably were guilty of this, but the focus in modern benefit packages is very much on less

costly outpatient alternatives. In our Plan, we are also experimenting with deductibles and co-pays moving away from first dollar coverage and designing studies to measure their impact on group rates and utilization patterns.

Medical Necessity Project—On the physician's side or Blue Shield area of our business, we similarly are active in cost containment activities. One recent effort which shows great promise for the future is the medical necessity project. The Blue Shield Association worked with a group of providers and came up with a list of 28 outmoded procedures for which many times payment is still being made. We are currently reviewing these procedures and intend to request physicians who desire to be paid a fee for doing these tests to specifically justify their medical necessity. Similarly, our usual, customary, and reasonable program (UCR) is designed with the goal of curtailing physician fee inflation. We are also attempting to evolve procedures and policies toward evaluating new medical techniques in terms of costs and quality before we pay for them.

To support this program as well as improve the quality of care, the Atlanta Plan has a contract with the Metropolitan Atlanta Foundation for Medical Care where panels of peer physicians review claims submitted to Blue Shield for charge determination, medical necessity, and quality of care considerations. We consider this a very vital service to our subscribers.

Planning Agency Support.—Our Plan has been active in support of planning agencies in the past and current HSA development effort. I serve on the Board of the North Central Georgia Health Systems Agency and on its review committee. It is crucial that this effort succeed although I admit that the progress of planning and efforts to control the proliferation of health care facilities in this area has been painfully slow and largely ineffective. I note the proposed capital controls in various legislation currently before the Congress and a tightening here seems crucial.

Senator TALMADGE. The next witness is the Honorable Virginia Shapard, Senator from Griffin, president of the North Central-Georgia Health Systems Agency, Inc. We are delighted to have you with us, Senator. You may insert your statement in full in the record, and summarize it in any manner you think fit.

Senator NUNN. We are glad to have you.

STATEMENT OF HON. VIRGINIA SHAPARD, STATE SENATOR FROM GRIFFIN, GA.

Ms. SHAPARD. Thank you very much, Senator Talmadge and Senator Nunn. I apreciate the opportunity to be here today. I would like to make this observation as a fellow legislator, there are many people who think that ministers only work on Sunday or that legislators only work when their legislative body is in session, and I commend you for taking your vacation in this manner.

Senator NUNN. We call it a recess; the press calls it a vacation.

Ms. SHAPARD. Right. I am not a doctor, as Mr. Higginbotham might have led you to believe, however, I am a mother of four children and do practice medicine without a license. I don't intend to read you my full statement. You have it. I hope that you will have the opportunity to read through it. Much of it is redundant. You've heard a great deal of the same concerns expressed today.

I am, in addition to being president of the North Central-Georgia Health Agency, which incorporates 24 counties, including statistical Metropolitan-Atlanta, a member of the Senate Human Resources Committee. I also serve as the chairman of the Joint House-Senate Study Committee on Services for the Aging and have been involved for some time in problems that face our citizens as far as health care delivery is concerned.

In the passage of Public Law 93-641, the Congress has given a great responsibility to the health systems agencies across this country. You

have asked that these agencies impact on access availability and cost containment; and they are, in fact, across the country today trying to follow through upon this very difficult mandate. There is, of course, the difficulty in gaining access to a physician when in need of medical services. The high and uncertain cost of medical care and the solution is certainly more simple than educating more doctors; however, as you are both aware, since I have been corresponding with you about it, I think that it is very vital that we look at the Mercer and the Morehouse program. I notice with interest that you intend to help to foster the development of the family practice project at Mercer and shake loose some of those funds. We, in the General Assembly of Georgia, are very supportive of it and have appropriated funds to go along with that, and we are appreciative of your efforts in that area. The solution, I guess, I submit, must begin with coordinated and comprehensive planning efforts. Many of the problems that we have today are problems that exist, I think, because the system sort of grew, and it grew on the basis of demand, and not necessarily on a calculated view of what the population based needs were.

There's been talk about overbedding. Well, overbedding is a very real problem. There is no question about that; but, I submit to you that the overbedding occurred prior to the existence of comprehensive planning, and the health systems agencies that are now in place are charged with the responsibility of reviewing capital expenditures now that we are under the "conditional" designation, but when we are fully designated, and there are only a couple in the country that have attained full designation, we will also be reviewing appropriateness of services. When that takes place, we will have an opportunity to look for other utilization of some of these facilities as well.

The nature of the health care industry, as you've just been addressing with Mr. Higginbotham, is that it differs significantly from the competitive marketplace. The complexity of private professional and public interest affecting the decision-making makes it extremely difficult to distribute services more equitably and efficiently and the consumer has little information about the specific services he or she requires, or their relative value; and there is not really a mechanism for shopping around. As a consequence, it is most difficult to make an informed choice with regard to medical care insurance.

During some eight public hearings that the health systems agency held throughout these 24 counties, we heard expressed from the public some of the major concerns that you have heard today as well. These needs of poverty, lack of education, limited access, the problem of the elderly, you are familiar with all of these. I'm going to leave with you a draft of our health systems plan and our annual implementation plan that are a requirement of Public Law 93-641 that we have worked very diligently on. You have heard testimony from several other members of the board of directors of the health systems agency today. As you are well aware, that is comprised of a majority of consumers, and we receive, also, input from our health care providers on the board.

As to the health systems plan itself, really this first year. What we have concentrated on is finding out what we have in place out in the 24 counties, and then looking at the annual implementation plan, addressing those things that we think we can break out, maybe, and do something about within the next year. It is a very important resource

document, and the first overall view of this type that we have had of our health care system.

Duplication of services, as we've noted, is one factor that can be elicited as leading to costs increase, and the health systems agency is responsible at the present time, as I mentioned, for reviewing projects under consideration for capital outlay currently under A-22 and A-95 reviews.

The North Central-Georgia Health Systems Agency has been reviewing projects for approximately 9 months. During that time, we have conducted 57 reviews, and these 57 reviews represented $43,039,-553 in expenditure. I think it is interesting to note that in summary we have—and I believe this is in my statement as well on page 6—in that period of the 1,122 projects, 57 percent of the proposed expenditures were approved, and 43 percent of the proposed 1,122 expenditures amounting to $14 million were disapproved or withdrawn.

Now, the "withdrawn" is significant, because we believe that most of them were withdrawn because they thought they weren't going to be approved. I'm going to leave with you, in addition, a summary of those reviews and——

Senator NUNN. That will be a part of the record.

Ms. SHAPARD. Fine.

Senator NUNN. All of your information that you leave here with us will be made a part of the record without objection.

Ms. SHAPARD. Fine. Thank you.

There are several ways that health systems agencies will be impacting. Duplication, review, and how those reviews are conducted, as Herb Mabry testified, many, many hours, and these are volunteer hours, go into that procedure. Generally, although we have established criteria for the various special services as well, the general overall criterion that must be met is that a project must show that it's needed. We look at the population of the area, we look at the staffing, we look at the manpower, we look at cost containment, we look at the financial feasibility, and we look at the institution's plans for future development.

In the appendix of one of these exhibits that I will leave with you, we have the criteria that we use for each facility, type facility. For instance, we have one set of criteria for nursing homes, and another for hospitals, another for special services, but the overall factors that I've mentioned are consistent in all of the reviews.

When you look at health planning, and you look at the history of health planning and the legislation that has been passed, you see a history of trying one thing and then trying another thing, and then trying a third thing. And I guess perhaps the health systems agency concept might be called the fourth thing. We've had the Hill-Burton plans, the comprehensive plans, the regional medical programs, and then with the passage of 93-641, you have finally put into one agency the responsibility for coordinating, planning, reviewing, and you've given it some clout. I would ask you gentlemen to give it a chance to work. The formulation of this agency was a long and difficult one, in that there are many factors specified within the law, and I think well taken, that required that we proceed deliberately and slowly, and we have just begun reviewing projects.

For example, for just 9 months—and I might add that I think that our particular health systems agency, the North Central-Georgia

one, has been moving along very progressively—but we really have just developed our first health systems plan, which is a document that will be changed as we go along, as we are able to get more data. We have not gone out and made studies. We have used coordinated/collated data as available, but there has not been a sufficient period of time to say whether the health systems agency concept of health planning is going to be a way to get a handle on the overall problems of health care and delivery. I think the concept is excellent. I think that by going outside of your already existing agency, such as HEW, and in Georgia, we have chosen the private nonprofit corporation route, and the Governor designated the areas, and allowing the bulk of the board to be consumers, that you are saying—this is my interpretation of what the Congress is saying—that we want to give the private sector the opportunity to address these problems.

Now, there have been some difficulties in all areas of the country, of what the public perception of the role of the health systems agency is, and there have been some very heated debates all over the country, and I might add we currently have a group that have filed suit against us in Federal court questioning the makeup of our governing board; and there are a lot of people who view possibly the development of a health systems agency as "John The Baptist" for socialized medicine.

I agree with you, Senator Talmadge, and I believe you indicated also, Senator Nunn, your concern for the catastrophic situation. I used the term "medically indigent." There are many people—and I think you were describing the same sort of individual about whom I am speaking—who can meet their day-to-day obligations, but who would be medically indigent if faced with a severe problem. These people, as the saying goes, "fall through the cracks," because they are the working people who are bearing the greatest tax burden in this country, and yet cannot get services that they vitally need. We run into some difficulties, of course, with Federal legislation sometimes, and some of those I understand because I understand the difficulty that you have. It is just about impossible to legislate for the State of New York and at the same time to have that legislation be applicable to the State of New Mexico. You have such a diverse situation in the United States. Of course, on a miniscale, we have the same problem here in Georgia.

There is a great deal of difference between legislating in the Georgia General Assembly what might be beneficial for the city of Atlanta, say, and also for Ludowici; but, we find some obstacle in some of the regulations and the paperwork. I think the Governor's statement was outstanding. I think it was well rounded and touched on almost all of these things, but I will give you an example of the difficulty that we have. Now, we are all agreed, as the Governor pointed out, that home health care is one way that we can really cost-effectively impact, and also allow our older citizens to have independence with dignity.

Now, with the Social Security Act, the title XX, there is provision made for homemaker services. Title XIX of the medicaid, which deals with medicaid; title XVIII deals with medicare. Well, we have situations in Georgia where we are trying to develop home health care, if these three titles could be combined, consolidate these three titles, we would be able to deliver homemaker/choremaker home health

care, much more effectively so, that we don't have to send out a legion of different workers.

It's sort of like the education title I programs. You know, only title I ears can listen to records purchased with title I money.

We've got the same sort of situation where you cannot send a home health aide to one because they are title XIX eligible, as opposed to title XX eligible, who can only have homemakers, and there's such an overlapping of need that the consolidation of those three titles would affect the home health care services program, fantastically.

The Governor mentioned the physician extender and the need for medicaid reimbursement for this. I think this is crucial as well. Again, of course, as a State legislator, and particularly as a member and as the president of this HSA, I would like to say that I think it is tremendously important that you allow us to make our decisions at the local level, particularly as far as planning is concerned, because of the very thing that I have mentioned about disparity.

I would like to address a comment that Mayor Jackson made about the size of the HSA and its makeup. To just review briefly, as you, I'm sure, recall, the legislation required that the Governor of the State indicate the areas, and that none of the statistical metropolitan areas be divided. In addition, the legislation states that no area may be smaller than 500,000 nor greater than 3 million. The North Central-Georgia Health Systems Agency has a population of approximately 2 million people. Now, while I'm sympathetic to the fact that the mayor believes that Atlanta should be separated out of a 24-county area, I would submit to you that Atlanta is not an island by itself, but does, in fact, house all of the major tertiary area care services for the State.

The rural/urban mix, I believe, is vital in planning, because the urban serves as the highly-specialized area. We talk about duplication of services, you cannot and we should not ask every hospital that's located in the various counties in the State to be everything to everybody.

Senator NUNN. You are saying if there are two separate HSA's that basically you would lose an awful lot of the very purpose of the legislation, that is, that you would probably find an HSA covering outside of Atlanta area allowing a tremendous duplication of equipment, services, beds, and so forth, that already exist in the metropolitan area of Atlanta.

Ms. SHAPARD. Yes. And I don't think that's appropriate or necessary. Of course, in our review of procedures, we look at this very sort of thing. There is no burn unit, for example, or any need for one in Spalding County, my home county, but yet we have one of the finest ones in the State available at Grady Hospital.

Another thing would happen: Since the money is allocated on a per capita basis, if you split off into very small health systems agencies, you will not wind up with an adequate staff, and we are looking at long-range problems and, of course, each one of these health systems agencies, you realize, was developing their plans and then we had the State health planning agency also established under this legislation, and they will be looking at the overall picture. Because, in addi-

tion there is the very important factor that Grady Hospital, for example, is not just a resource of this health systems agency, it is a State resource. It trains physicians, for example, through its education program, that go out all over the State, and it acts in many ways as a regional hospital for the State.

By the way, I am on a Senate study committee that's looking at hospital authorities and what their regional responsibilities are, and also at what the State's responsibilities are to the medically indigent, that I've already outlined, and the financial responsibilities of the counties that do not have care available, primary care available, in their county. I have listed in my statement, and they are listed also in an address to the plan, many ways that I think that we can serve the underserved area.

One of the exhibits in the plan, in my statement, shows the maldistribution of physicians in some areas. In some there's an overabundance, in some there is a deficit. But, we have really just begun to fight, so to speak, as far as the health systems agencies are concerned. When we begin review of appropriateness of service, then I think that we will get into better utilization of some of these facilities.

Now, I would like to try and answer any questions that you might have for me.

Senator TALMADGE. Thank you very much, Senator Shapard, for the very fine statement. We will be very brief. We have a number of witnesses yet to be heard and we want to give them all an opportunity to be heard.

Ms. SHAPARD. I understand.

Senator TALMADGE. What specific proposed hospital projects have you rejected?

Ms. SHAPARD. I have got a list here, Senator, and I'll leave that with you. But, for instance, I can just off the top of my head recall DeKalb General Hospital wished to purchase some very expensive radiology equipment, and we felt that it was duplicative and we turned it down. Cobb General came in with a proposal for a cardiac cath lab and we rejected that originally; they've come back with what they believe to be some more justifications. We have deferred action on that because Kennestone Hospital, also another public hospital in the same county, has another proposal coming up next month for the same sort of thing.

Now, it happens to be my personal belief that every guy on the block doesn't have to have a CAT scanner or a cath lab. So in looking at the overall picture, we are going to try and look at those two projects at the same time. That's the sort of action we have been taking.

Senator TALMADGE. Will you file a full list for the record, please?

Ms. SHAPARD. Yes, sir, I have it here.

Senator TALMADGE. Is there opposition to the work of the HSA's? I believe you told me a lawsuit has been filed against it.

Ms. SHAPARD. Yes. The lawsuit has been filed, and is in Federal court. At the present time we are not alone in that suit. By the way, that suit has been filed against all the HSA's in the State, the Governor of the State, and the Secretary of HEW, Mr. Califano.

Senator TALMADGE. Where does the opposition come from and what is its basis?

Ms. SHAPARD. All right. Now, that particular opposition comes from a group of people who feel that the consumer voice hasn't been heard sufficiently. Now, as I indicated, the consumer number on the board is the majority, and we feel, of course, that we have made many efforts to go out and talk with the consumers, and also we do have various income levels represented on our board.

Senator TALMADGE. Who is the consumer? I thought everyone was.

Ms. SHAPARD. Well, everyone is a consumer, Senator. There is no question about that. But, some people are consumers and providers at the same time, and a provider is an individual who has a fiduciary interest in the health care system.

Senator TALMADGE. In other words, where there may be a conflict of interest?

Ms. SHAPARD. Well, the legislation stipulates, for instance, that you cannot serve on a board and be considered a consumer, if your husband is a physician. So, anyone who has a fiduciary interest in the health care delivery system is considered a provider under the law. And by the way, approximately 20 percent of that board is comprised of public-elected officials.

Now, I am sure you recall the debate on the bill when it was in bill form in the Congress, there was a great debate as to the percentage or recommendation of public-elected officials to be included on that board. The law does not require that we have 20 percent public-elected officials, but since we, public-elected officials, have an ultimate responsibility for looking at how those health care dollars are spent, we felt that it was in the public interest to have them included. Now, you asked about opposition. Now, that is one form of opposition that we have faced. Of course, you understand, in addition, that any time you try to make changes in the way you address problems, there are always going to be people who feel threatened and who are upset; and I think the health care providers themselves, who have been delivering health services in a certain manner, take "fee for service," as an example, the practice of "cottage medicine" has a great—and I think—a very fine history in this country, but we have come to the point where I firmly believe that that is not practical as the only alternative.

We need to look at something such as health maintenance organizations and physician extenders, as have been mentioned. Since there are some who view the health systems agency as a potential "John The Baptist" for socialized medicine, I do not, I've indicated I view it as an opportunity for the private sector to impact through planning, many provider physicians have felt threatened by it, and because you have put some clout in this legislation, and I think rightfully so, there are an awful lot of people who feel threatened as well.

Example: We do have the potential when we are reviewing for appropriateness of services to say—I can give you an example. In Coweta County, which is also in my senatorial district, there are two hospitals. One is a private one and one is a public general hospital. They are both operating pediatric departments. They are both operating OB/GYN, and more than likely it is much more logical that one can do pediatrics and the other one can do OB/GYN. That sort of thing.

When we are fully designated under the law, we have the clout to be able to say "this service is not appropriate." And consequently, those who have a vested interest do feel threatened.

Now, one very interesting—I know you have other people to come—but I think one very interesting observation that I have noted is that, all right, we have a 69-member board; we have 24 counties. We have tremendously rural areas that have no health providers, and so forth. And as we all came together originally on this board, and there have been some rotations off and on, but essentially since we have only been in place for about a year, everyone, almost everyone came to this board with a very parochial attitude; either their vested interest in whatever their health provider specialty was, be they optometrists or whatever, or the rural representative from a small county who thought, oh, the big city guy is going to get us again. They will get all the funds allocated up there, and that sort of thing. But, through the 1½ year of working very closely together, I see parochialism slipping backward and a team spirit coming forward.

I have great hopes for this concept that you have developed. Again, I would like to emphasize that I hope that you give it time to see that it does work.

Senator TALMADGE. Senator Nunn.

Senator NUNN. Thank you, Senator Shapard, for an excellent statement. It will be very helpful. Just one question: Last week in Cobb County, I understand a superior court judge ruled in favor of five physicians who sued the hospital there. I believe it was Kennestone Hospital.

Ms. SHAPARD. That's right.

Senator NUNN. For failing to let them treat hospital patients with a $450,000 brain scanner they had purchased, instead of the hospital's brain scanner. I understand this decision hasn't been fully received yet, and I am not asking you to comment on the specific merits of the case or the decision, but just what is your general kind of jurisdiction over the purchase of equipment that would normally be thought of as hospital type of equipment by physicians, and having that used instead of the hospital equipment?

Do you have jurisdiction over that?

Ms. SHAPARD. The question was asked earlier, and I got the answer, about the number of CAT scanners. There are nine in place in the metropolitan area, and that is in hospitals in the metropolitan area, and none throughout the rest of our health systems agency area; and one of those is at Kennestone, as you've mentioned.

Senator, the way the law is currently written, we have no say so whatsoever over the private practicing physician or groups of physicians who may choose to group together to provide equipment of this type.

Senator NUNN. You have no jurisdiction over this kind of private purchase at all?

Ms. SHAPARD. No, not over the private purchase.

Senator NUNN. Simply your jurisdiction would be over the hospital itself?

Ms. SHAPARD. That's right.

Senator NUNN. Would the existence of private brain scanners, for instance, be part of your determination in determining whether a hospital that is applying for a brain scanner should have one or not have one?

Ms. SHAPARD. Well, there is the ongoing question in conflict about the free enterprise system. I don't know if you read the Saturday

Review, but Goodman happens to be one of my favorite contributors. He calls it the "Fee Enterprise" system. But, there is the ongoing debate about how far the Government—and we, of course, face this in the State legislature as well—how far the Government should or can go in regulating the free enterprise system.

You have chosen in this law to say that we don't. Now, would they take into consideration the fact that there is one in existence? I would say that certainly under our criteria that we would. We would also have to look at the many other factors that we looked at as we review projects; and that is how accessible is that to the bulk of patients, and what are the charges being made for that service? Is it really available to the general populus?

Senator NUNN. You say there are nine CAT scanners in the Atlanta area?

Ms. SHAPARD. In hospitals.

Senator NUNN. In Atlanta. What is the approximate value of each one of those?

Ms. SHAPARD. Well, as you heard earlier, they vary in price. Somewhere around $600,000.

Senator NUNN. Do you have knowledge, off the top of your head, about the utilization rate of those? In other words, are the nine used pretty often? Are they fully utilized, or do we have an undersupply or oversupply?

Ms. SHAPARD. Well, what we do is look at how many scans they are doing and the cost that they charge, and we do have that information, and it is detailed.

Senator NUNN. It is in there. Would you generally say whether it is an underutilization or overutilization? Do you know?

Ms. SHAPARD. I think the ones that are in place now are probably being well utilized.

Senator NUNN. Well utilized?

Ms. SHAPARD. And as each new bit of technology develops, each group, you know, wishes to get into that particualr field of technology; and that is one of the jobs of the HSA, to say, "Well, now, every guy on the block doesn't have to have one."

Senator NUNN. Thank you very much. We appreciate your testimony.

Senator TALMADGE. Thank you, Senator Shapard. We appreciate your comments. They have been very helpful.

[The prepared statement of Ms. Shapard follows:]

STATEMENT OF SENATOR VIRGINIA SHAPARD

During the past two decades, our government has moved toward the provision of equal opportunity in areas such as education, employment and voting. Attention is now focusing on the opportunity for all citizens to obtain an acceptable standard of medical care. A major effort in this regard must be to remove barriers to care, whether they be economic, social or geographic, which now prevent many citizens from obtaining adequate health care.

In response to the growing concern of a large majority of the people in this country that there is a "crisis" in medical care, the Congress passed P.L. 93-641 in 1974. The public's perception of the medical care crisis is derived, I believe, from two major concerns: (1) difficulty in gaining access to a physician when in need of medical services and (2) the high and uncertain costs of medical care. Although there are many other problems in the delivery of health services, public concern arises mainly from inadequacies and discontinuities in the de-

livery of primary medical care services. The solution is much more complicated than simply educating more doctors. Such efforts have not and cannot resolve the difficulties the public experiences in obtaining basic medical care services. The solution, I submit, must begin with a coordinated, comprehensive planning effort, accomplished on a regional scale and based on the identification of the needs of our citizens. Such an effort has now begun by health systems agencies throughout the U.S. which are mandated by law to do health planning, to review health facility and services projects, and to develop health resources and services to meet these needs with improved delivery techniques and systems. The purposes of P.L. 93-641 are to promote accessibility to health care and availability of health care while at the same time containing the cost of care.

The nature of the health care industry differs significantly from the competitive market place. The complexity of private professional and public interests affecting decision-making makes it extremely difficult to distribute services more equitably and efficiently. Despite vast and increasing public and private expenditures, and a large and well-trained manpower pool, we have not been able or willing to organize our resources to meet the needs of the American public. Since the need for medical care is usually irregular and unpredictable the average person develops little experience in purchasing medical services. The consumer has little information about the specific services he/she requires or their relative value and there is not mechanism for "shopping" for medical services. As a consequence, it is most difficult to make an informed choice with respect to medical care insurance for those who can afford coverage. It is likewise equally difficult to cover all of the needs of the medically indigent and elderly through government/public health programs. An informed public and a better system of health education is certainly indicated. The following goals are taken from the first draft of the Health Systems Plan (HSP) 1978-82 developed by the North Central Georgia Health Systems Agency.

The purposes of the health systems agencies, as set forth in P.L. 93-641, the overview of the health of the population of Area III, and the present health delivery system of the area indicate the need for the following general goals for Area III:

Improve the health status of the population by addressing health problems through the areas of biology, environment, life style, and the health care system.

Assure the availability, accessibility and continuity of quality health care throughout Area III, but particularly in undeserved areas.

Promote the availability and appropriate distribution of adequate numbers of trained health manpower.

Encourage the development of alternative methods of delivering and financing health care that will assure the provision of quality health care at a reasonable cost.

Support the development of health education programs to assist citizens in obtaining maximum personal and professional health care.

Reduce unnecessary duplication of health facilities and services.

In addition, the following were the major health concerns identified at the eight public meetings held by the agency in December of 1976 and January 1977: Health Care for the Elderly, Mental Health Services, Health Care for the Low-Income Population, Manpower Shortages, and Rehabilitation Programs.

Concerns expressed in the public meetings were, in general, about the needs of the relatively helpless elements of society. These needs stem from poverty, lack of education, age, and limited knowledge on the part of the people affected. The lack of concerns about health care for the relatively well-off verifies what has generally been known on a national basis. The evidence also points to a large number of unmet needs which have important economic and cost implications for the future of the health care delivery system.

Meeting the above needs, most of which deals with access to care and the availability of care, highlights the formidable task confronting health planning agencies, i.e., improving access to care and availability of care while endeavoring to contain spiraling costs.

In the area of primary care, specifically, the top priority goals developed in the first HSP are as follows:

Goal 1.1.—(Priority No. 1). Promote the concept of a primary care relationship for each person in Area III with a provider or facility which also recognizes the Primary care relationship. (System)

Goal 1.2.—(Priority No. 2). Assure that primary care settings (clinics, centers, offices or combinations thereof) offer comprehensive services (diagnosis and treatment, prevention, health maintenance, patient education as well as emergency and urgent medical care), either on site or by formal referral. Emergency, urgent and other necessary services shall be available on a 24-hour, 7-day-a-week basis. (System)

Goal 1.3.—(Priority No. 3). Ensure that appropriate numbers and types of qualified primary health manpower are effectively providing services and that future demands on the available supply of manpower will be anticipated by training programs in a timely manner. (System)

Coal 1.4.—(Priority No. 4). Increase the accessibility to primary care services by reducing the economic barriers which urgently exist. (System)

Goal 3.1.—(Priority No. 5). Encourage educational efforts among target populations for example: the elderly, women, school children, workers, as well as the general public be directed toward: a. preventing and limiting illness; b. increasing the acceptance, support and appropriate use of health facilities and services; c. self-help skills, CPR and other emergency techniques. (System)

The medical marketplace also differs from the competitive model due to the monopolistic situation often required because of the capital cost and the specialized nature of many medical services and facilities. Most communities cannot support more than a single hospital or limited number of specialty and subspecialty services. Duplication of facilities and services also often results in a higher total cost for the community as well as inefficient use of manpower and facilities.

Review criteria and cost

One of the primary functions of a health systems agency is to assure that adequate resources are available and accessible to meet the identified health problem needs of the population. However, the financial resources available to meet needs are finite and the HSA's Review Committee, in reviewing applications for additional facilities and services, ascertains that these proposals do not unnecessarily duplicate identical and/or underutilized facilities and services, which in terms of geographical convenience can be utilized without detriment to patient well-being.

Two of the national health priorities listed in P.L. 93-641 address the problem of preventing duplication of facilities and services directly:

(1) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).

(2) The development of multi-institutional arrangements for the sharing of support services necessary to all.

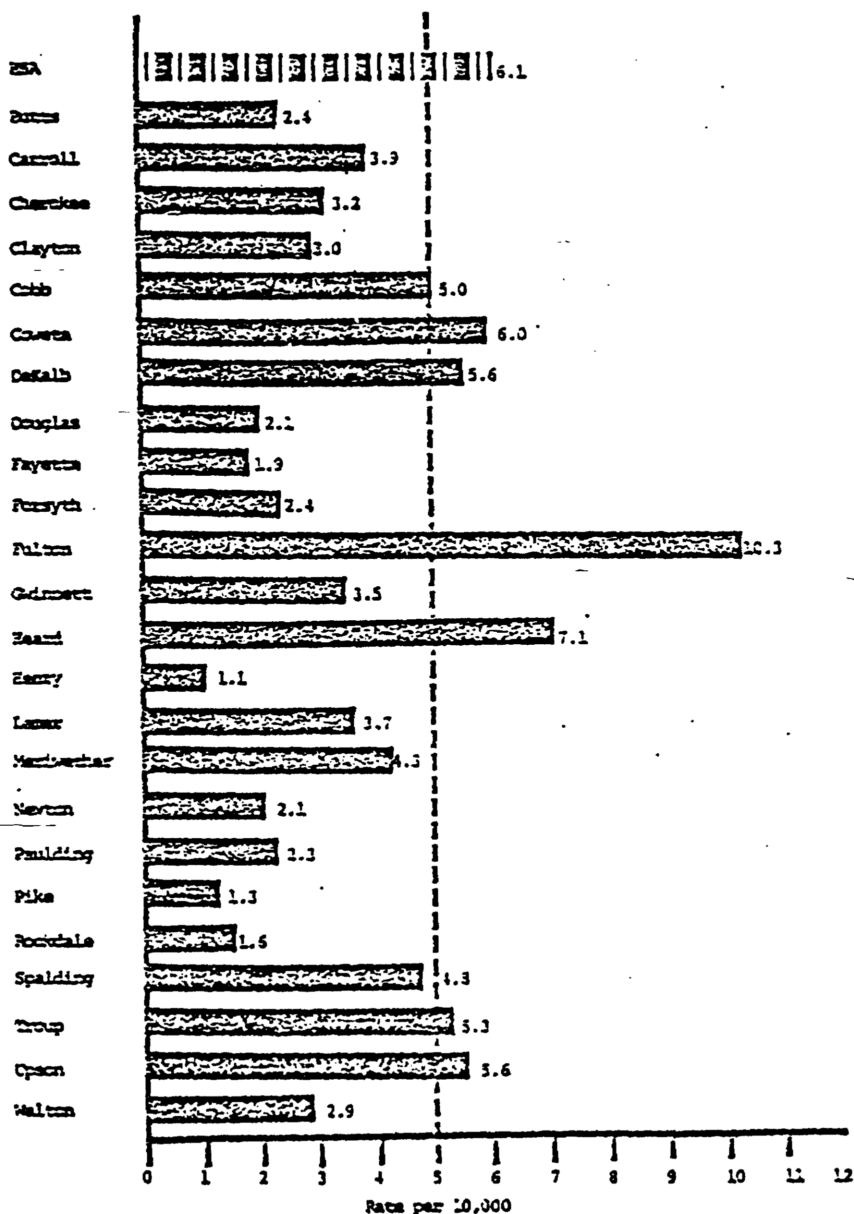
The Review Committee, composed of Board members, base its recommendations for facilities and services on these national priorities.

The review function is a systematic and in-depth examination of proposals for the establishment, construction, renovation or modification of health care facilities and programs. The process attempts to produce decisions based on an informed sense of the proposal in terms of cost and service to the community. The review function is one of the most important and visible functions to the community of the health systems agency.

In the period from November 1, 1977 to June 30, 1977, some 57 projects were reviewed of which 39 were 1122 substantive or non-substantive. Of these 1122 Projects, 57 percent of the proposed expenditures were approved, and 43 percent of the proposed 1122 expenditures amounting to $14,114,341 were disapproved or withdrawn. The Review Committee constantly in its deliberations relates the applications for facilities and services to the long range regionalization plans required of the health systems agency and documented in the Health Systems Plan.

In understanding the difficulties associated with (1) achieving greater access, (2) increasing informed consumer behavior, and (3) obtaining a more effective distribution of physicians and facilities relative to population, it must be recognized that physicians have had great control over the provision of medical care. In our health service area, which comprises 24 counties, we find that many counties are medically underserved while a few, primarily the metropolitan counties have a more than adequate supply of primary care physicians. (See figure 1 below).

PRIMARY CARE PHYSICIANS* PER 10,000 POPULATION**
FOR THE NCG-HSA AND THE HSA COUNTIES, 1975



*GP-FP, Internists, OBG, Pediatricians.
**1975 CPB Population Estimates used to calculate rates.

SOURCE.—Georgia Department of Human Resources, Physician Register, 1976.

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A detailed analysis of manpower distribution has been included in our HSP; however, current detailed data is very hard to obtain. We are hopeful that agreements can be arranged with state licensing bureaus and professional associations in order to obtain information that will make planning more accurate and timely.

The use of mid-level professionals such as nurse practitioners, physicians assistants, dental hygienists, and others is a means of extending medical coverage and increasing the availability of primary care services in underserved areas, both rural and urban. However, there are political and legal barriers that preclude the transfer of certain aspects of primary care to qualified mid-level professionals. As an example, currently, Medicaid does not reimburse for services rendered by nurse practitioners. The use of physician extenders is an area that is being considered as a means of both increasing access and reducing costs. In addressing the problems of improving access to care, it is recognized that there is a wide range of problems brought to physicians which reflect not only physical disease but also failure to cope with life's problems and a need for social support. To handle problems of this scope in our society, any policy on access to medical care must recognize the many facets of demand and provide the varied talents and resources required to meet the needs. Policies for increasing access to medical care require not only the appropriate identification of problems (which the HSAs are now in the process of doing) but must also provide for a system of checks and balances to ensure that excessively technical and/or costly approaches such as excessive and unnecessary use of surgery, drugs, and other diagnostic and treatment procedures are not overutilized. A solution to the crisis in medical care requires a coherent coordinated national health strategy. Attempts to correct individual problems without consideration of the implications on the balance of the health care system as a whole area doomed to failure.

Many people are puzzled by all the attention being devoted to our health care delivery system. Certainly our technological and scientific accomplishments are impressive as in the vast amount of dollars required to support the current system—some 139 billion in 1976. The crisis stems not from our lack of technical expertise but rather from our inability to provide citizens equal access to humane, responsive and affordable health care to all.

To those with lower incomes, the barriers are economic and have to do with the hardships of purchasing care. For middle-class persons, a frequent concern is the possibility of catastrophic illness. For the aged, increasing inflation, and gaps in the Medicare program that require expenditures from their limited personal resources is a source of concern. People in general, worry about impersonal interest in the patient as a person by the providers of medical care.

Rapid social change and progress have led to more mobility in our jobs and places of residence and the roots of community life become evermore shallow. Because of this transience, many traditional sources of help have broken down—such as family or long-time friends being readily available for assistance. More and more reliance is being made upon institutional care which can be impersonal and in some cases could be avoided. Alternatives such as home health care, adult day care centers and congregate living are discussed in our HSP and we intend to study these models in detail.

In short, we recognize that part of the current demand of medical facilities indicates a failure of other social institutions. Nevertheless, illness is a major cause of incapacity to perform social functions and is a sign of the failure of man's capacity to cope with his environment. We recognize that although the technical achievements of healing overshadow the broader functions of health care, the more intangible caring functions constitutes an essential aspect of primary medical care. This is the reason for one of our priority goals which relates to establishing a primary care relationship for every person in our area. It may be that the establishment of long-term primary care relationships will do more than any other endeavor to promote appropriate utilization of health resources with resulting cost reductions.

Most of us have an appreciation of the high standard of medical care possible in the United States. As our expectations have risen, failure to find accessible, responsive, and affordable services has led to growing dissatisfaction with the ability of the health delivery system to meet needs. The poor, see their difficulty as one more example of their particular condition. They have a greater prevalence of illness, disability and restriction of activity because of health problems, have less accessibility to health services and often receive lower quality care. It is also well known that environmental resources influence the maintenance of health and prevention of illness and are distributed in society in relation to the ability of a group to economically command them.

The crisis in medical care exists for other groups as well as the poor. Along with the increased specialization that has accompanied the growth of medical knowledge and as activity has organized around specialized technical functions, some of the important psychological needs of patients have been neglected and many citizens are finding it increasingly difficult to obtain a personalized source of care. Unfortunately, the proportion of physicians in primary medical care has been decreasing as specialization proliferates. We feel that the recent trend to encourage medical students to enter family practice ought to be established in rural areas as one means of attracting primary care manpower to underserved areas. Our experience with the planning process initiated by NCG–HSA indicates that consumers want to be involved and need to be educated. Hopefully, consumer concern will help to encourage primary care manpower to practice in underserved areas.

The rising cost of medical care is a central concern of the average citizen, but in spite of the increasing number of tax dollars that go to health care there is a general acceptance that persons in need ought to receive adequate medical care. Some of the issues which the NCG–HSSA has identified and is attempting to deal with in our health service area include:

(1) Duplication of Services.

(2) Use of Mid-Level professionals as physician extenders.

(3) Health Education as a preventive means as well as a way of achieving accessibility.

(4) Informed Consumer Behavior.

(5) Alternatives to Institutional Care such as home health care, ambulatory care centers, etc.

(6) Removal of Barriers, economic, social, geographic, and political.

The following programs are being considered by NCG–HSA as a means of increasing accessibility to Primary Care:

1. Practice Commitment Plus Loan Forgiveness: An Incentive for Rural Location of Medical Practice.
2. Rural Preceptorships: Impact on the Decision to Locate in Rural Practice.
3. Family Practice: The Primary-Care Specialty.
4. Efforts to Increase the Number of Physicians: Impact on Access to Medical Care.
5. New Health Practitioners: A Solution for the Problems of Old Health Practitioners.
6. National Health Service Corps: Increasing Access in Areas of Health Manpower Shortages.
7. Medicare: Elimination of Financial Barriers to Care for the Aged.
8. Medicaid: Elimination of Financial Barriers to Care for Low-Income Persons.
9. OEO Neighborhood Health Centers: Comprehensive Health Care for Low-Income Inner-City Residents.
10. Children and Youth Programs: Comprehensive Health Care for Children of Low-Income Families.
11. Health-Maintenance Organizations: Alternative Access to Medical Care.

The following are high-lights of the NCG-HSA HSP which indicate some of the other problems that have been identified in the health service area:

Environmental/occupational health

In the area of environmental/occupational health problems, the plan addresses the need for the efficient coordination among federal, state and county agencies responsible for ocupational health and safety. At the present time, there is a need for an approved State Occupational Health and Safety Program. Data indicates that 80% of the cancer cases may be environmentally produced. To reduce costs, preventive measures must be initiated. The need for the State to establish laboratory facilities for State Occupational Health Units is necessary in order to relate environmental factors to mortality and morbidity.

The need for sufficient and qualified manpower as it relates to occupational health and safety must be met. To do this an industrial medicine specialty should be implemented in Georgia medical schools. Occupational Health/Safety Hygiene courses should be included in all Georgia colleges and universities with environmental health programs, and an increased emphasis must be given to occupational health training for district and local environmental sanitarians.

Industry must promote the reduction and eventual control of occupational and safety hazards by developing a basic occupational health program regardless of

the size of the operation. This means that pre-employment physicals should be required: emergency first-aid must be available to employees: occupational nurses should be employed or available, and an industrial hygienist should be available to identify hazardous conditions.

The reduction of the incidence of occupational diseases also must be promoted by reducing the level of toxic and carcinogenic substances in the work environment (for example, bisinosis in the textile industry). More emphasis on occupational disease research is needed.

The reduction of the use of abusive substances by the work force must be sought. To avoid the above recommendations is to continue to wait until workers are required to be hospitalized, which then costs the company and society in terms of expensive hospitalization, and man-hours away from productivity.

Although citizens may be aware of noise they must also be protected from noise that interferes with physical and mental well being. An extensive public awareness program of health problems caused by ambient noise should be promoted. Citizens should encourage the review and revision of the proposed State Bill regulating ambient noise and present their views to the State Legislature for action. The identification of noise sources in the area is essential to determine their effects so that protection strategies can be developed. Local governmental bodies should be encouraged to enact noise ordinances.

Water supply has received a great deal of attention over the past year, however quality potable (drinking) water can be assured only with the implementation of the Georgia Safe Drinking Water Act, whereby all public water supplies must be certified. Controlled public water supply flouridation should be provided. Priorities also must be set for water use including water supply, waste water disposal, recreation, flood control, hydroelectric power, and navigation. The media can be most helpful in educating the consumer regarding water conservation practices.

Prevention and detection

Public Law 93–641 was enacted in the hope that through planning improvements in the health care system could be developed that would more efficiently utilize available resources to meet the health needs of our society. Prevention/early detection offer the best means to conserve resources.

In the area of teenage pregnancies, our area exceeds the national average. The documentation of health needs certainly suggests that medical complications of pregnancy are more likely for the teenager, particularly during labor. Some studies even suggest that women under 20 have 15% greater chance of having a stillbirth and 30% greater chance of dying in childbirth. Infants born to teenagers, also are more likely to be premature, and thus run the risk of associated complications.

To deal with this problem, we must endeavor to reduce teenage pregnancies in our area to at least the U.S. average or lower, or from 156.4/1,000 to 100.4/1,000 live births. We must strive for a reduction and the eventual elimination of unwanted and unplanned pregnancies. To accomplish this, information on sex education and family planning must be available to all persons and all schools in our area. Contraceptives and pregnancy testing services and other birth control methods to all persons must be available regardless of ability to pay.

Infant mortality rates which are 5.3% higher than the national average need to be reduced by promoting the availability of first trimester prenatal care to all women. Hospital obstetrical units that meet minimum standards for delivery must be accessible; and women must be educated to the availability of supplemental food through the Women, Infants and Children Program (WIC).

Hypertension control services must be available as hypertension is highly preventable. Services must be accessible and attractive to high risk segments of the population through hypertension screening programs and health education programs. Only then can morbidity and mortality caused by hypertension be reduced.

Coronary heart disease can be reduced by promoting the establishment in each county of demonstration programs in identification of community risk factors and intervention for control of high blood pressure, high cholestorol, and cigarette smoking.

Cancer mortality rates in our area should be reduced to at least the state mortality rate. Participation of hospitals in the Georgia Cancer Registry Program is a first step in such reduction and should be encouraged.

Secondary/tertiary care

The secondary/tertiary component of the health care system is the most costly. The HSP has addressed this problem by suggesting a mechanism to prevent dupli-

cation of services. To do this, a plan to develop the categorization of health care conditions into levels for delivery of care in specific health problem areas will have to be initiated.

Presently one-half of the hospitals in our area are being utilized at under 70 percent occupancy. This must be improved. The average cost per hospital day in the area is $170. In the past bed needs and services were determined by a *demand* model rather than a *needs* model. The needs model, by assessing the health status of the population, can develop and/or collate the criteria for facilities and services to meet the needs. Then bed needs and service requirements based on the present population and projected growth in population can be more accurately assessed. An additional dimension is added to the planning process by regionalization of which geography, population density, health status information, and other demographic factors are considered in determining levels of care which are required of facilities.

Although the current national hospital cost containment bill is still being developed and reworded, discussions have been ongoing in Washington as to the role of health system agencies. At this time, it is speculated that HSA's will take an active role in monitoring and implementing certain aspects of the Bill. Even now, through the HSA Review process of capital expenditures, facilities and services are reviewed as to need, financial feasibility, manpower, and cost containment.

In the area of special health problems, thirteen problem areas were identified and priorities assigned. For example, the need to develop a secondary cancer treatment center to serve the southern counties in our Area is a goal. Within one year, the plans should be complete and the location of a center identified.

Heart disease, renal disease, hypertension, trauma, and long term care have also been addressed. Goals which deal with emergency medical services and regionalization of facilities and services as they relate to specific problems have been developed. The HSA also recognizes that the dialysis capacity to serve various outlaying counties must be established, as well as pediatric dialysis in the Atlanta metropolitan area. The needs in these areas are becoming more clearly defined, yet the emphasis on meeting needs without duplicating services in order that full utilization may result remains the key to secondary care.

Health care for the elderly is a major concern. The HSP emphasizes maintenance of independent living by promoting the development of programs designed to help the elderly remain healthy and mobile. For example, the plan encourages the development of day care centers to enable families to care for their elderly members at home and to encourage the development of reimbursement programs to enable family members to stay at home to care for the elderly.

In our area, 85 percent of the nursing homes had more than 81 percent occupancy in 1975. The necessity to study the need for extended care facilities to reduce costs has been identified. Other goals address rehabilitation programs for the elderly and financial barriers which are a special problem for senior citizens.

Mental health

The mental health component of the HSP sets as its top priority goal the development of coordinated mechanisms for monitoring mental health status problems and identifying intervention methods as appropriate. The plan points out this area as being rampant with fragmented services. Individual client and community mental health needs must be met by assuring the provisions of a balanced service delivery system model emphasizing a continuum of care. Financing community mental health community centers is a problem, as no increase in federal funds for community mental health services has been appropriated, yet the outpatient client load increased from 25/10,000 in 1970 to 169/10,000 in 1976. This increase may be attributed to the high use of mental health centers since private insurance coverage for mental health services is often poor.

Service functions must relate to client needs, i.e., children and adolescents, the elderly, the developmentally disabled, mentally ill retarded offender, emotionally disabled, mentally retarded clients. All must be provided with a comprehensive range of mental health services and early intervention program must reach the population at risk.

Mental health services should include education, prevention, and promotion in order to eliminate or lessen the occurrence of mental health disorder or disease. The assurance that adequate mental health care be provided to individuals and families regardless of any inhibiting factors such as low family/personal income, age, race, and sex was set as a high priority goal.

Our area significantly exceeds the U.S. in leading causes of death in the area of homicide, suicides, and cirrhosis of the liver. Mental health goals support efforts to reduce mental health status indicator rates in such areas as driving under the influence, mortality from violent causes, juvenile status offenders, high school dropouts, suicides, alcohol and drug related mortality, child abuse, narcotic drug arrests, cirrhosis of the liver, and drug-related hepatitis.

Summary

In conclusion, improvements in the present health delivery systems can only result from a coordinated comprehensive planning effort, and to this end the HSA has dedicated itself.

Miss HASKELL. Senator, I would like to say——

Senator NUNN. Could you identify yourself, please?

STATEMENT OF SUSAN HASKELL, NORTH CENTRAL GEORGIA HEALTH SYSTEMS AGENCY

Miss HASKELL. I am Susan Haskell with the North Central Georgia Health Systems Agency; and presently, I would say cath scanners are underutilized. There's about 50-percent utilization. We have no control over the physicians' offices and really wouldn't know if the physician or group of physicians were to purchase a cath scanner.

Senator NUNN. You say they are about 50-percent utilized? Now what would be the ideal percentage in terms of effective dollar use, 75?

Miss HASKELL. About 80; 70 to 80 percent.

Senator NUNN. 70 to 80. Thank you very much.

Senator TALMADGE. Thank you.

Next is a panel of physicians consisting of Dr. Nelson McGhee, Jr., Dr. Harrison Rogers, Dr. A. Cullen Richardson.

Dr. McGhee is the president-elect of the Georgia State Medical Society; has spent 5 years in general practice in rural Gainesville; has been actively engaged in the practice in Atlanta since 1966.

Dr. Rogers is chairman of the Georgia delegation to the American Medical Association house of delegates; and he is vice speaker of the AMA house of delegates. He represents the Medical Association of Georgia at the hearing.

Dr. Richardson is a member of the Medical Association of Georgia; he's been active in local cost accountability projects.

Now, how do you want to proceed, gentlemen, in the order named?

Dr. MCGHEE. In the order named.

Senator TALMADGE. All right. We will hear now from Dr. McGhee. You may insert, if you see fit, Doctor, your full statement in the record, and summarize it as briefly as possible. We are still only about half through with our panel of witnesses.

Dr. MCGHEE. It is not too long, Senator.

Senator TALMADGE. Dr. McGhee, you may proceed, sir.

STATEMENT OF DR. NELSON McGHEE, JR., PRESIDENT-ELECT, GEORGIA STATE MEDICAL ASSOCIATION

Dr. MCGHEE. Senator Talmadge, Senator Nunn, and distinguished members of the Senate committee: I am Nelson McGhee of Atlanta, Ga., and I am honored and pleased to represent the Georgia State Medical Association at this hearing. Our presence here has an extraordinary signifiance in that one of our major complaints throughout the years has been that we were not represented as a medical entity on issues that affect our practices, our lives, and the lives of our patients. Again, we are grateful. We wish to preface our statement with an

expression of appreciation to Senators Talmadge and Nunn for the assistance provided by their staffs in our efforts to launch programs to improve the quality of care for our patients, in particular, and for Georgians in general.

We still, however, have some problems and we left our recent State convention with cautious optimism.

As a general principle the members of the black medical community and all of the allied health professionals take strenuous exception to the historical and traditional position in which we have been placed through the years and that is having to react to decisions that impact directly upon our livelihood without our initial input. We would strongly urge that members or representatives from the black medical community be contacted and included at the inception of plans designed to impact upon our lives and the lives of our patients. Our thinking is that this is not an unusual or extraordinary request, but simply one which is aimed at equity in delivery at every level from the Federal to the local city government.

There is serious discussion going on in the country related to designating hospitals into secondary and tertiary groupings. Our interpretation of these laws spawning this classification and the criteria would seem to litigate further against the continued existence of certain of the hospitals in the Nation directed toward minority care primarily. Public Law 93–641, for instance, almost mandates that hospitals under 200 beds, and therefore not considered viable, should be closed. It is a fact that most of the 25 or 30 remaining minority-oriented hospitals in the Nation have as a general rule 150 to 200 beds. Thus, all such hospitals would fall into this category marked for closing. While we may sympathize with the overall planning effort toward improving the total health care delivery picture one must recognize the significance and the far-reaching implication of the closing of all of the black-oriented hospitals in this country. We don't believe this would be the intent of the authors of the law or the developers of the guidelines. Historically, however, regulations and implementation of same have penalized the physicians and the hospitals in the black community. In many instances, the act was not intentional, but due mainly to lack of input and adequate research about the people and/or the area for which some well-meaning programs have been devised.

It is difficult, if not totally impossible, for a bureaucrat from Nantucket to develop a program for people from Waverly Hall, Ga., or Ludowici, Ga, or Biloxi, Miss. The high rate of unsuccessful Federal programs is directly related to lack of input by recipients and providers of such programs. At this time there is much discussion in Congress on national health insurance. There are subcommittee meetings on cost containment and, as fate would have it, we see very little involvement of minority physicians and minority hospital administrators, or minority consumers. Again, those people who would be affected most by the legislation are having no input. We are aware that regional offices of HEW are to hold public hearings. Historically, however, these meetings are held when most minority recipients and providers are still on their jobs and often in areas remote from the community, creating an accessibility problem for many recipients. Finally, there is little encouragement by agencies and bureaus to have minority representation at these hearings.

We wish to make a statement about social security. If media reports are correct, there is a move afoot to raise the age from 65 years to 70 years for full social security benefits. We feel that there should be no confusion between mandatory retirement age and the age at which one receives full social security benefits. Our concerns lie in the realization that most black people die before the age of 70. Despite reports that the average age of death is now 81 years, we are convinced that the black female lives to the age 65 to 68 years, and the black male lives to approximately 64 years. Hence, the average black male already dies 1 year before full social security benefits are available. We are, therefore, made to ask the question: Is the badly needed shot in the arm for the Social Security Administration to come at the expense of black people?

Mr. Chairman, I beg your indulgence for a final statement. And this deals with Senate bill S. 143, the medicare-medicaid antifraud and abuse bill as relates to cost containment. The National Medical Association has already testified before the Subcommittee on Health, and the Committee on Ways and Means on H.R. No. 3. We submit that physicians who remain in the inner city should be applauded rather than harassed. The criteria used to determine who should be audited is discriminatory from the start, in that the high-volume providers are singled out first. This means that almost all providers in lower income areas and rural areas would be subject to audit. How can we have the Georgia State Medical Association or any association, for that matter, tell young prospective physicians to return to the rural areas and to the inner city areas so that they can work from Sun to Sun an average of 70 hours a week, see many poor people that no one else can or will see, and because 50 to 90 percent of their income will inevitably be medicaid-medicare, the reward will be an audit and the publishing of their names in the newspapers.

Make no mistake about it, we feel that abusers should be dealt with whether they be physicians, patients, or State-administrative personnel. We must challenge, however, some investigative methodology that borders on entrapment. The act of sending "well patients" to physicians and then accuse the physicians of abuse violates the basic medical philosophy that all patients are ill until proven otherwise. We assume further that patients are truthful to the best of their knowledge. An example of this is frequently quoted, wherein a urine specimen was taken to a physician's office, and he gave a negative report to whoever took it there. Well, the physician had to assume that whatever was in the bottle was urine; and our tests are devised to check urine. So if he checked for sugar, there was no sugar there, it would be negative. If there was no protein or blood there, it would be negative, and hence, a negative report. If people come into the office saying that they are ill, and the physician does not find pathology on physical examination, he must resort to other tests. And I contend that this is not abuse. A negative spinoff of the recent audit, especially those in Georgia was the proliferation of a general feeling that all inner city physicians were crooks, because they comprised a higher percentage under examination in this audit. What was found on that is not available to us. We do have an Ohio copy, but that of Georgia has not been returned.

We think that this assumption was primarily due to a lack of education on the part of recipients; hence, when they were called by the

auditors to verify treatment, the natural assumption was that the doctor had committed a crime.

Georgia State Medical Association submits that in your deliberations on cost containment, consider that it costs more to the physician to treat patients who qualify under title V, XVIII, and XIX. This is based on lower fees than paid by private patients, increased paperwork as required by the States, frequent rejection of claims despite what we have heard this morning, and delayed payment of claims. Where the usual overhead is 40 to 45 percent, it may well be 55 to 60 percent when dealing with the above category of patient. And if an individual has an 80-percent medicare-medicaid practice, this latter figure is further inflated if you consider that one often has to borrow money to pay office rent and office personnel while waiting to receive his subsidy from the State.

We of the Georgia State Medical Association, applaud your efforts on cost control. We feel that money should be well spent. We also feel that a country is no stronger than the health of its people. This means to us that health should be a high priority, perhaps second only to national defense. We cannot compromise on health care. The continued amendment of the legislation, the continued change in regulations can only serve to usurp the original intent of the law. Legislation aimed at physician extenders cannot and will not replace the physician. Perhaps the institution of the Morehouse Medical School and other such schools will provide the necessary physicians to cover the rural and inner city areas, where they are badly needed. We need more physicians, especially minority physicians. The physicians need encouragement, not discouragement. Let us not penalize or incriminate physicians who happen to practice in low-income areas. I can assure you that if the Government persists in witch hunting, harassment, failure to require local governments to pay promptly, few will remain in the inner city and none will go to the rural areas.

But with all of these negative points made, the Georgia State Medical Association still, as always, supports medicare-medicaid. We also take the position of our parent organization, the National Medical Association, in support of a properly structured national health policy, with a good means of financing and proper health education.

With that in mind, we recommend training more physicians, subsidizing those in the rural and inner city by helping and assisting with loans. We suggest that we break out costs when discussing costs, that of the physician from that of the hospital. Perhaps there should be some cap placed on hospital costs, institute a good health education system for consumers, establish adequate means of hard data on people for whom programs are planned, and require the States to pay their claims promptly.

Mr. Chairman, I close by saying to the honorable Senators from the State of Georgia, we need your help and your blessing. If not to you, then who, and if not now, then when?

Thank you.

Senator TALMADGE. Dr. McGhee, in the original bill that I drafted, I prohibited HEW from releasing these figures that they were paying to physicians. The reason I did so was because they were full of errors. They had enormous fees paid to some physicians that weren't even practicing. Many others that were totally erroneous, and then the

press stated that after all, this was tax money, we couldn't conceal how tax money was being paid. I realized the correctness of that act.

When Secretary Califano was before my subcommittee, I interrogated him in detail about these erroneous reports, and he assured me that in the future they would make every effort to see that they were absolutely accurate. I hope that he will do so. You may rest assured that my subcommittee and others interested in this field will try to make certain that the pledge he has made to us is carried out to the nth degree.

The next witness is Dr. Harrison Rogers.

STATEMENT OF DR. HARRISON ROGERS, REPRESENTING THE MEDICAL ASSOCIATION OF GEORGIA

Dr. ROGERS. Thank you, Senator. I appreciate being here. I will not read my statement but——

Senator TALMADGE. It will be inserted in full in the record, Doctor, and we are honored, indeed, to have you with us.

Dr. ROGERS. The message that we have brought to you in an informal fashion today—and I would like to give you a few additional words, if I may—I am representing the Medical Association of Georgia here today. And historically, organized medicine has acted as the patient's advocate starting back early in this century, when quality of care was the first issue that was really a problem for this country. Organized medicine in this country responded and upgraded education, upgraded licensure, it upgraded and began and initiated continuing medical education with accreditation of personnel and institutions. The quality of care issue has been faced, I believe, by organized medicine.

The second problem of access to care. Organized medicine has worked in many different areas to provide coverage in physician population to rural and ghetto areas. We have a rural health committee of the AMA, and of our State organizations, which are actively seeking doctors to go into rural areas, and also into the ghetto areas. We are actively engaged in supporting efforts to provide more primary care physicians for our State and Nation.

The third area, and the one that you address here today is the cost of health care. Two years ago, the AMA, because of its awareness of cost as a problem in health care, set up its cost commission. The results of which study will be available within the next few months. Two years ago, the Medical Association of Georgia, in response to the figures that you saw today, presented by Mr. Higginbotham, and that we have been aware of ourselves, also set up a cost accountability committee. I was honored to be the chairman of that committee during its first year of operation and continue on as a member.

We have worked hard in that committee, trying to identify the problem and trying to identify solutions. In April of this year, 1977, the first year's recommendations were presented to the annual legislative body of the Medical Association of Georgia; and their recommendations were adopted with very minor changes. I would like to go over these six recommendations for you, if I could, very briefly.

First is the establishment of community meetings on cost. We felt that this was probably the most important thing that we could say about this problem. As you've heard today, from people in the insur-

ance business, people who were in business, people who are representing Government, people who are representing labor, all these people have a certain degree of expertise in the matter of cost of health care. Certainly, we as providers feel that we have an area of expertise here. We feel, however, that we are totally unable to solve the problems presented by ourselves. It must be a cooperative effort.

We have proposed that throughout the State of Georgia there be community meetings held, in the Metropolitan-Atlanta area, in the Macon area, in the Savannah area, in all major areas of the State, and involving all these people in these community meetings, so that the problems can be identified for the public, and that solutions can be found.

There are many things about the cost problem that cannot be solved by simply the doctor alone, simply the hospital alone, or simply the insurance company alone. The second recommendation that was adopted were that insurance changes should be made, and Mr. Higginbotham has already addressed these, as have others. The first dollar coverage problem has been with us, and is certainly a continuing one. The provision of better outpatient coverage, staying away from the expensive hospital setting is certainly an important part of any insurance benefit package that should be considered.

The third recommendation is a 100-percent utilization review of your hospitalized patients, whereas at the present time only a small number of patients in the hospital receive utilization review, we feel that all should.

No. 4, restrict third-party coverage of expensive luxury items, if you will, the private nurse, the private room; if the patient wants this, let him buy it as an extra, but let's not include this in the public's health care bill.

No. 5, the hospital should have plans for level of care differentials, and the hospital association is working on this, providing intensive care where intensive care is needed, and very minimal care where minimal care is needed.

No. 6, the hospital's medical staff's education on cost. Dr. Richardson, who will follow me, will address this in considerable detail. I think that this is an extremely important area from ours, the physician's point of view. The physician, in general, in the past, has not been aware of cost as a problem. We have been directed primarily at getting the patient well. We have not been directed primarily at watching the cost. The physicians in our country have got to be aware of this, and I think will be in the future.

No. 7, physician activity in the health planning efforts as described by Senator Shapard, I think, are vital.

No. 8, the cost awareness program must be a part of the medical school curriculum. As young physicians are being trained, they have got to be aware the cost is important to the public as a whole, and they have got to address this.

I would say that physicians agree, Georgia physicians agree, with those who feel that the federalization of health care in the name of economy is a snare and a delusion. The private sector is motivated by economic incentives that Government simply will never have. Federal hospital care is twice as expensive as private hospital care. You deal with such things as the HMO programs that have been enacted.

These were touted 6 years ago as the answer to the cost problem, and have not proven effective.

Furthermore, Senator Nunn has pointed out these efforts have introduced the lowest form of marketing in California, and I really would sincerely hope that we can avoid this, here in Georgia.

Senator NUNN. Dr. Rogers, let me say that there are some that are good.

Dr. ROGERS. Certainly.

Senator NUNN. That are working, and there's some where there is internal abuse, but I make no judgment about what Georgia ought to do. But, there are many lessons that can be learned. I would hope from California particularly, in this area, if Georgia is going to go into this area, because the abuse there in some areas has been rampant and the people who have really paid for that have been the poor people and the patients who were intended to be benefited, as you well know.

Dr. ROGERS. Organized medicine has traditionally resisted efforts to change, I think you know. I am an old and stodgy doctor and I am slow to change, but I think that organized medicine has, in our State and across the Nation, accepted these new methods of providing health care.

I call your attention—I don't have any particular data about it—but I would call your attention to the North Fulton project that was in operation here in Fulton County several years ago, in which the Medical Association of Atlanta undertook the health care of the medically-indigent in the north part of the county under contract from the county commissioners, and successfully operated this as an HMO-sort of operation. It was called the North Fulton project. It was, in essence, an IPA, because all the physicians in the northern part of Fulton County were automatically available to serve this. These people received Grady Hospital-type services, but received them in the doctor's offices and in the hospitals in that part of the county. So that physicians in general have been opening up their doors to the vistas of HMO's, IPA's and other methods of saving money on delivering health care.

I call your attention to the fact that the Federal Trade Commission has taken physicians to court to stop the use of the relative value scale; and by their rulings, will encourage the hucksters of health care—and I really would decry this—I know that Senator Talmadge has been active in this area. I would say, in closing, that the answer lies not in a single effort by you gentlemen, Government, although I certainly think that your efforts are of paramount importance, I think you have got to include the private sector. I think that the providers, the physicians, the hospitals, the nurses, and everyone else are concerned with providing, I think, that management. I think that labor, I think the media, have got to be concerned with this, the public as a whole. This is a nationwide problem that is going to require nationwide attention.

Thank you.

Senator TALMADGE. Thank you very much, Doctor.

[The prepared statement of Dr. Rogers follows:]

STATEMENT OF THE MEDICAL ASSOCIATION OF GEORGIA PRESENTED BY HARRISON L. ROGERS, JR., M.D.

I am Dr. Harrison Rogers, an Atlanta general surgeon. I am a member of the Cost Accountability Committee of the Medical Association of Georgia and serve as vice-speaker of the American Medical Associations' House of Delegates.

The Medical Association of Georgia is pleased to participate in these important hearings. In our role as spokesman for our 4700 members, we welcome all opportunities to provide our input and to demonstrate our interest to you on this issue.

Our association is vitally concerned with the costs of medical and health care. With our national health bill now exceeding $140 billion annually, few would deny that national concern is indicated and late in coming.

As physicians, we recognize the great responsibility we have in the provision of health care, whether it be the assessment of diagnostic needs or the direction of therapeutic measures. Until most recently, the physician has maintained the traditional role as advocate for his patient with only secondary consideration given to the cost of care delivered. This has changed now and many organizations like ours and the AMA have begun aggressive programs to improve public understanding of the cost issue. Our organization, for example, has had a Cost Accountability Committee for two years. The report we presented to our major governing body this year should be of benefit to you in your deliberations and we enter it as a part of this testimony. Our report deals with four basic areas; physicians, hospitals, insurance companies and the public in general.

It is our considered opinion that although physicians are generally the controlling factor in the provision of health care, many doctors have no concept of the cost of care. We have taken an inward look and have identified some of the causes for this and will be developing educational and informational programs that address these areas.

A major component, for example, of physician involvement is the manner in which doctors order diagnostic tests for patients. There must be a better system of coordination between physician and physician, and physician and hospital. We see duplication of tests and the ordering of tests that at times do not significantly affect our ability to diagnose an illness. We agree working on pilot programs in Georgia where doctors would get copies of patients bills just so he can see what has been ordered and how much a particular procedure costs.

Any discussion of testing must include the dramatic affect that the potential for malpractice suits has on the numbers and complexity of diagnostic studies doctors are requesting. The litigious nature of our society is having this type of affect on all professions, not just medical practitioners. For us, herein lies a major cost containment opportunity.

The next component in the equation is the hospital facility. In many cases, hospital facilities are used inappropriately and inefficiently in the treatment of certain diseases. Some procedures might be done at less cost, without sacrificing quality - in a doctor's office for instance or at an out-patient department.

Another area of great cost in the hospital is tied up in the equipment that each offers. It is helpful that all hospitals can offer modern scanning devise and the latest in cancer treatment equipment. However, in many cases, the patient useage of this equipment is not great enough to justify the large cost to the facility or the extra expense to the patient. Obviously, this cost must be absorbed through other services offered by the hospital.

It seems appropriate that hospitals work together in the sharing of services. - You will be interested to know that the Georgia Hospital Association is, addressing this problem now. We in no way wish to impede the rights of anyone, however, it makes good economic sense to frontally address this particular problem. Through sound advice and counsel the various planning-agencies could be of great assistance with this.

The next element is the role of the insurance carrier.

Health insurance companies have been relatively responsible in controlling the cost of care. Through advertising and direct contact, they advise subscribers on ways to reduce health care costs.

We think health insurance carriers should place more emphasis on the out-patient coverage offered, as opposed to more costly in-patient care.

Another area that definitely can be addressed is the payment method of health insurance.

Most policies are written for first dollar coverage with the patient assuming little or no responsibility, except in premiums for the costs they incur. With gradual rises in premiums annually, it is difficult for the individual to appreciate how costs have risen.

We favor the elimination of first dollar coverage and would like to see wide useage of co-insurance and deductible policies. We think this should include all forms of health insurance, including Medicare and Medicaid.

We endorse the concept of extending in-hospital utilization review procedures to all patients. The use of effective review procedures and medical audit techniques can be used effectively by the hospital medical staff in their efforts to upgrade procedures overall.

Lastly, is the role played by the patient. The health care consuming public must assume more responsibility in keeping the cost of care at a reasonable level. Patients are going to have to pay more attention to those things about their health that only they can control. Such things as what they eat and drink, how they exercise and how they drive automobiles.

The public has to be willing to take care of some of the in-hospital services they now pay dearly for - such things as going to a cafeteria for meals, where practical, making their own beds and getting medication from a central station for self administration. These may seem to be minor things but considering all the hospital admissions annually and all the personnel needed to serve the public, the figures could be dramatic.

The public must realize that doctors' offices and hospital beds are not places for pure social interaction. Over-utilization of services is one of the most significant problems faced in resolving our cost dilemma.

As our population gets older and our technology improves, we begin facing new and quite different challenges.

Legislative bodies at all levels of government must become more aware of the cost impact of the various programs they initiate. A prime example of what I am talking about is the Renal Dialysis Program. It is a fine program that is showing good results. However, the program was assigned a moderate budget and we now see that with implementation of the program, the costs have risen precipitiously.

If we are to make cost a major priority, we must answer questions like: Who is to tell the 80 year old patient with chronic heart disease that it is too costly to do a coronar- bypass operation? Who is to tell the parents of a mongoloid child that we can't afford to give it a kidney transplant; or, that we cannot utilize all available technology to fight disease?

Our Association firmly believes that the cost problems we face can best be handled by the private sector. We have, I think justifiable and documented fears about the nationalization of our health system. This appears to be 'cost containment at any cost'. With virtually unlimited services available and decidedly limited resources, we must move with great caution lest we be trapped into paying more and more and getting less and less.

Our Association is embarking on an aggressive plan of community action to bring these various interest groups together so firm understanding can be built and viable answers offered in our effort to reduce costs and maintain our high quality of care.

A concerted effort of all parties, business, labor the general public, practitioners and government is needed. We are committed to assist and welcome this and other opportunities to work with you in your deliberations.

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MAY / 1977

WHAT PRICE HEALTH?

Physician Page 2[illegible]
Cost Containment Special Issue
[illegible] Page 302
MAG Committee Page 282
Insurance Page 291
Hospital Page 29[illegible]

Four areas in which health cost can be controlled are discussed and recommendations are made.

Report from MAG's Committee on Cost Accountability

MEMBERS OF THE COMMITTEE/HARRISON L. ROGERS JR., M.D., *Chairman**

IN CONSIDERING the ways in which the cost of health care might be controlled, the Cost Accountability Committee considered four major areas which influence the cost of health services.

1. **Physicians** must look at the cost of health care. They must be aware of the cost of the services ordered. This would include checking into the necessity for continued testing and coordination between physicians on tests ordered for a patient and between the physician's office and the hospital, so there is no duplication.

Medical schools should emphasize somewhere in their curriculum the cost of medical care. It should be recognized that physicians in training order greater numbers of tests and procedures, so their orders particularly should be monitored.

2. In many cases, **hospital facilities** are inappropriate and inefficient to perform certain procedures. Such procedures might be better done in a less costly setting such as the physician's office or in the outpatient department rather than on an inpatient basis. The hospital should carefully evaluate bills sent to insurers and to patients to be certain that the patient had actually received the services they had been billed for. The hospital ought to provide some mechanism for periodically informing the physicians of the charges being made for procedures provided to their patients.

3. The **health insurance industry** has taken a relatively responsible position in controlling the cost of health care. They advise their subscribers of how to keep health care costs down. In addition to this, however, the insurers ought to emphasize their outpatient coverage so that the individual will get as much of his services provided there as possible, as opposed to on an inpatient basis. Labor and management should make an effort in the use of deductibles or of co-insurance as a method for controlling utilization. The health insurer can assist the physician in controlling utilization by advising labor and management of the magnitude of the problem, when the physician is faced by an over-demanding patient or family.

4. In the long run, it is only **the public** who can have a long term effect on the cost of health care. Only if they drive with greater care, eat better, quit smoking, restrict alcohol intake, and agree with strict policies for use of services and facilities will utilization of health services decrease.

Controlling Hospital Costs

The major impact to be made in the area of cost containment must be in the hospitals. This can only be done at the local level through the efforts of individual physicians, hospital personnel and patients. The Committee agreed that it could not do much directly to reduce cost. This committee could be useful in preparing responses to medicine's critics. Also, it could develop informational items for newspapers, radio, TV and a general public relations approach to emphasize the concern of providers in reducing costs.

It is obvious that both management and labor have become more and more concerned with rising health care costs. Representatives of these groups could become involved with providers in an effort to look at this problem. It was suggested that on a regional or local basis, the county medical society and other provider representatives get together with labor, management and the media to look into rising health care costs in their areas and determine what

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* Members of the Committee are: H. Duane Blair, M.D.; B. W. Forester, M.D.; Ronald Frost Galloway, M.D.; James R. Logan, M.D.; O. Bertling Smith, M.D., Adam R. Jablonowski, MAG staff representative.

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should be done in order to reduce rising costs or to moderate the increases occurring.

It was suggested that out-patient benefits with low deductible attached, while high deductible and co-payment for in-patient care was included, might be a method for stimulating the use of lower cost care by patients. Representatives of the Blues pointed out that this was an extremely complex field and that any effort made in an area such as this had to be analyzed thoroughly, because it was possible that another aspect of the health care delivery system would be adversely affected. The Committee believed that there should be an effort made to eliminate the first dollar coverage under health insurance plans. Also, deductibles and co-insurance should be encouraged, not only for private coverage but also for Federal programs like Medicaid and Medicare.

Another area in which the hospitals could reduce costs is in efforts with patients' self care. This would include expansion of ambulatory care units in the hospital. There should be renewed emphasis placed on the use of cafeterias, self-medication by the patient, and a general effort to have the patient take care of himself while hospitalized.

Utilization review should receive greater emphasis in the hospital and be better coordinated so that problem diagnoses, physicians and patients, could be more easily identified and reviewed. The committee felt that an upgrading of all medical audits should be undertaken in the hospital and that utilization review should cover 100% of the patients. There was general agreement that hospital controls are much better than control efforts made by insurance companies or government. The insurance company or government can sometimes be used as an "excuse" by the physician in order to explain to the patient that certain services cannot be covered. It was suggested that insurers consider elimination of such items as private room coverage, private duty nursing, etc., unless alternative services such as intensive care units are not available in the hospital.

Government interference in medical practice through a requirement that certain tests be performed was brought up as another example of added costs. It was suggested that tests for admission to hospitals, extended care of nursing homes be examined to be sure that duplicate testing was not being done and considering whether or not certain tests were at all needed prior to or at admission.

Review of technical advances was felt to be necessary in order to control rising costs. A physician ought to look at his practice and the type of patients he has, to determine whether he really needs expensive procedures performed by new technologically sophisticated equipment. He should determine whether the test results he obtains from this equipment will make any difference in his diagnosis or treatment of patients. It was also pointed out that procedures such as kidney dialysis both on an in-patient and home basis, ought to be looked at from the point of view of the quality of life available to the individuals undergoing this procedure. Certainly there is a significant cost differential between in-patient and home treatment which also ought to be examined. It was suggested that possibly the Medical Care Foundations could become involved in developing guidelines for new technologies such as CAT scanners.

Out-patient surgical services seem to be an area which can help reduce medical care costs. Ambulatory surgical centers are not generally available in Georgia and are not licensed. There were some questions raised whether or not licensure was the appropriate way of dealing with the accreditation of, or making a determination of the quality of services provided in these facilities. It was suggested that the individual third party payers might establish some sort of agreement with the ambulatory surgical centers rather than providing licensure for the facilities.

The Committee reviewed the possible ways in which local accountability committees could help their hospitals reduce costs. It was suggested that the hospitals post the charges for the 20 most common procedures so that the physician could easily see what the cost of services was. It was also thought that by listing the cost of services on the patient's chart for a period of time, the physician might become more conscious of what his patients were being billed.

Sending a copy of the hospital bill to the physician from the hospital might be another way of alerting the doctor to the cost of care. Simply maintaining a listing of tests, lab procedures, x-rays, and keeping their costs posted would be a method of informing staff members who order these tests as to what they are really doing in terms of adding to the bill of the patients. This could be done on a departmental basis in larger facilities and an overall hospital basis in smaller facilities. The Committee strongly supported the concept of the hospital staff looking into the endorsement of pre-admission testing.

Another area which may be a very significant impact on health care is the HSA. The Committee felt that physicians should be strongly encouraged to participate in the activities of the HSA's in their area.

Recommendations

In conclusion, the Committee suggested that the following should be made as recommendations to the

MAG House of Delegates as part of this Committee's report:

1. Support the establishment of regional councils on health care costs to be composed of representatives from labor, management, local county medical societies, hospitals and the media. These councils are to serve as a continuing forum for education of both the public and providers.

2. Urge insurance companies to eliminate first dollar coverage and to institute the use of deductible and co-insurance. Out-patient benefits should be expanded with consideration given to higher deductible and co-payment for in-patient care. The concept of co-insurance and deductible should be extended to Medicaid and Medicare.

3. Endorse expansion of utilization review methods to cover 100% of hospital patients. Medical audit procedures should be upgraded with assurance that findings are brought to the attention of the medical staff for their consideration of changing hospital procedures as indicated.

4. Support restrictions on costly additional services such as private room and private nurse services by insurance carriers. Elimination of duplicate testing for admission to the hospital, extended care or nursing home facilities should be strongly encouraged rather than required, as is often the case in government programs.

5. Hospitals should be urged to consider introducing or expanding self-care by the patient, including self-medication, room care, and use of cafeteria facilities.

6. Hospital medical staffs should be encouraged to inform themselves about costs of medical care in their facilities. This might include:

a) Posting the charges for the 20 most common procedures performed in the hospital so that physicians will see the prices in a prominently placed display.

b) On a periodic basis listing on his chart the cost of services provided to the patient.

c) Sending a copy of the hospital bill to the patient's physician by the billing office.

d) Keeping the medical staff members informed on hospital costs such as lab procedures, x-rays, tests, etc.

e) Establishing a "Cost Control" Committee of the medical staff or assign this to an existing committee.

7. Encourage local physician involvement in health systems agency activities through membership on task forces, committees and boards of directors, to assure that the best interests of patients are considered in all HSA decisions.

ADDENDUM: This Committee report was presented to Reference Committee D at the Annual Session of MAG. The reference committee adopted the report with the following changes: Recommendation 1, which calls for MAG to "support the establishment of regional councils," was changed to read "support the establishment of community meetings on health care costs to be composed of representatives from labor, management, local county medical societies, hospitals, the media and consumer interest groups."

Recommendations 2-8 were accepted as is, and a ninth recommendation was added: "that the Committee on Cost Accountability continue to study the issue of cost accountability with particular reference to ways in which expenditures for health services can be influenced by (1) high deductible insurance, (2) making sure that the patient receives the services he pays for, (3) maintaining restraint on the rise in physician fees, (4) continuing to upgrade the quality of care, and (5) denying loudly the concept that medical care is a public utility.

The House of Delegates accepted the Committee report as amended by the Reference Committee.

A physician shares his observations and discusses specific recommendations.

Cost Containment—At All Costs!

HARRISON L. ROGERS JR., M.D., *Atlanta**

As CHAIRMAN of the MAG Committee on Cost Accountability, I was asked to prepare an article on the subject for this issue of the *Journal*. By the time this appears, our MAG House of Delegates will have acted upon the recommendations of this Committee, favorably I hope, and a great storm of activity will be under way across the state. Your editor has also invited the views of a hospital administrator, a health insurance carrier and a government official. Their articles also appear in this issue.

The MAG Committee was constituted by the 1976 House of Delegates and charged to investigate health care costs and subsequently make recommendations for MAG action. Members of the Committee were aware of growing concerns by the public and to a lesser degree by health care providers in the matter of costs, but were totally unprepared for the deluge of reports, articles, speeches and legislative proposals on this issue. The files of our Committee are literally bulging with information collected during this year and consequently the charge to investigate rather is a charge to attempt to assimilate all the available information. In addition to our own efforts, the AMA has a nationally constituted cost committee whose report will be issued this year.

Public concern with health care, its accessibility, quality and cost has mushroomed during the same period of time that most of the spectacular advances have been made in the product which we as physicians deliver. This is certainly not happenstance, for with advances in drugs and devices, as well as diagnostic and therapeutic measures, all delivered in "deluxe" facilities, costs have risen geometrically. In 1966, Congress first passed Medicare, then Medicaid, to provide for the financing of medical care to the elderly and the poor. Though many factors were important in the passage of these two laws, cost was of prime concern. Subsequent passage of the PSRO law in 1972, widely touted as a quality assurance program but more realistically a cost containment effort, was the next step. Public Law 93-641, signed into law by President Ford in 1975 as a planning law, is directed at control of the health delivery system and its attendant costs. Finally, with serious consideration of a national health plan or NHI, the administration and the Congress is responding to what they perceive to be a mandate to cope with health care costs.

With a price tag of 140 billion dollars for all health care in the U.S., none would deny that efforts to control the escalation of this amount are indicated and are indeed late in coming. However, to see a federally operated, controlled and financed system as the answer to this problem is sheer folly. Where has the federal government operated any program more efficiently or less expensively than a comparable program operated by private industry? The U.S. is often denigrated for its role as the last major industrial country without "socialized medicine," but when we look at the cost as well as the quality of care in such places as Great Britain, this accusation should turn to an accolade! "Cost containment at any cost" by federalizing our health care system is a cruel hoax to perpetuate on the American taxpayer who would in fact be destined to receive less and pay more.

William Lilley III, former director of the President's Council on Wage and Price Stability, has been quoted in the *American Medical News* (March 14, 1977) as stating: "As presently structured, there are few incentives within the provider system to

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control costs, to economize, or to weigh the costs of a proposed action—whether it is the purchase of new equipment, the expansion of a hospital, or the selection of a course of treatment—against its benefits . . .

"We have seen, in every phase of our investigation into this problem, that cost-control incentives proposed by the private sector—that is, by industry and labor—promise to be more effective than those imposed by the multitude of government agencies which have attempted to tackle the problem. Numerous industry and labor efforts have been aimed at controlling costs while maintaining quality. . . .

"The private sector is motivated by economic incentives which the government will simply never share.

"We have heard consumer groups and labor organizations say that their members, and the American people generally, are becoming increasingly unwilling to devote an ever larger portion of their personal income to health care. When that day comes, we believe the people of this country will turn to the federal government and demand that it solve the problem. Absent any major changes in the structure of the medical care system between now and then, the federal government will step in, and when that happens, we are going to be faced with a permanent problem which will defy solution. . . .

"This does not have to happen. An alternative to federal control of the health care system is available if promptly seized: a concerted and unified effort on the part of industry and labor to control costs. We have been very favorably impressed with efforts we have seen initiated to date. . . .

"Witnesses at the hearings told us of strong opposition from a highly respected, well-organized medical establishment. Private efforts at cost-control are difficult to undertake in the face of this opposition. But we remain convinced that the goal of quality health care, at reasonable costs, is attainable within the context of a largely privately disciplined system. Indeed, it is only within the context of the private system that it is attainable."

Another view of the Congressional perception of the problem of rising health care costs was voiced by Alice Rivlin, Ph.D., director of the Congressional Budget Office, who said "Congressional concern about the cost of health care and the excessive use of health care resources has now overridden concern about widening access to the system . . . clearly, we're getting more for our money, but there's a widespread concern that we may be getting too much."

With this background, the Committee agreed with the magnitude and importance of the problem. We know of no "strong opposition" to cost control efforts from within organized medicine; indeed the AMA, as well as many state medical associations have already embarked on active cost containment efforts. We agree completely that improvement can only come from within the private system and have witnessed efforts by the American Hospital Association as well as health insurance carriers to slow the precipitous rise in health care costs. However, we find fault with Mr. Lilley's conclusion that improvement can only be attained with a concerted effort by industry and labor. The provision and receipt of health care involves this large segment of the American public, but in addition, the entire population represented by the Congress, the providers (both individual physicians and hospitals) and the health insurance carriers. As we viewed the problem and made recommendations for its solution, it was apparent that each of these components of our society has a special opportunity and a special responsibility in solving the problem as follows:

1. The physician has literally a vital responsibility, for it is his lot to assess the diagnostic needs of his patient and then subsequently direct the therapeutic measures to be employed. The physician has traditionally assumed this role as the prime advocate of his individual patient with only secondary consideration given the cost. Indeed, in health our patients are concerned about increasing premiums of health insurance, but when illness presents, "money is no object" is the usual admonition.

It is his responsibility to determine initially whether disease is present and what diagnostic studies are indicated to confirm this or disprove it. Whether these studies should proceed in the office or in a hospital is a critical decision with regard to the cost involved, for the latter route immediately raises the cost precipitously. Whichever locus is selected, the physician's determination of how the diagnostic evaluation should be carried out is important. He may simply order "blanket" studies, special procedures and consultations, or instead choose the narrower path which he feels will be the most fruitful. In evaluating each procedure to be ordered, the potential value to the patient, possible harm involved and certainly the cost of each must be evaluated. Too few physicians have any concept of the cost of these studies individually or the impact of this total cost on the "third party" who may be paying the bill. A program directed at informing all physicians of these specific charges would certainly prove an eye-open-

"No one would deny that efforts to control the escalation [of health costs] are indicated and indeed late in coming."

ing experience, as would a copy of an occasional patient's hospital bill. Thorny diagnostic problems, the threat of malpractice suits and other factors may dictate the "blanket" approach, but consideration in each instance should be deliberate. Increased use of utilization review may well serve to bring unsuspected problems to light.

When hospitalization is necessary, careful planning will minimize delays. Admission of elective patients before weekends or holidays has been well documented as an important factor in higher hospital bills. More difficult to document are the wasted hospital days caused by delays in consultation or in getting on the operating room schedule—days which might have been saved by planning ahead. Early planning for discharge can also be beneficial so that the patient, his family or perhaps the nursing home to which he is being sent can be prepared.

The physician has always had the responsibility for his patients care; this is the job for which he has been trained. Today, however, society is telling us that we must also consider the cost. The physician

"[Perhaps] the most promising [recommendation] is the establishment of regional intrastate councils on Health Care Costs."

alone is able to weigh benefits and liabilities, as well as cost.

2. Hospital charges account for 40 percent of the "health care dollar" and so have a particular responsibility for frugality. A subsequent article focused on hospitals addresses specific areas of concern, but certainly good management procedures and resistance to unneeded but glamorous and costly services will require attention.

3. Our health insurance carriers have a difficult task, i.e., to design the best benefits package for the least in premiums and then be able to market this product. (I trust the problem will be solved by our author from the industry whose article follows.) All studies would suggest that a mechanism must be developed by the carriers to encourage utilization of the least costly and most effective means of delivery of health care. Some means of "cost-sharing" by the recipients of benefits would seem beneficial and this concept, if valid, can best be "sold" to business and labor alike by the carrier.

4. The Public, individually as well as collectively, via its elected governmental representatives, must assume its role as the single most important factor in the complex equation of health care costs. The collective public must keep its demands for health care, as well as promised benefits, related to our country's economic resources. Health care now accounts for 8.6 percent of our gross national product and is predicted to rise to 10 percent in the next few years. Our citizens must decide whether they can afford the deluxe health care which some of our federal programs mandate. Each government program, whether a "service" program or a "control" program, adds an unbelievable layer of administrative personnel—plus an ever-increasing paperwork burden—to both individual and institutional providers, adding to their cost of operation and ultimately to the "Health Care Dollar."

The public as individuals has a most important role in this equation. Our patients must first be informed of the magnitude of the problem, and then agree to act responsibly. They must agree to drive more carefully, for auto accidents and their inevitable costs are a major factor in health care costs. They must agree to eat more sensibly, drink less alcohol and finally agree—not just in theory, but in practice—to strict policies for use of services and facilities. Our patients must assume responsibility individually for curbing "voluntary" overutilization of either offices or hospitals. If a particular service can be offered equally well on an ambulatory basis as in the hospital, the former must be chosen. When the day of discharge has been selected on a medical basis, this should not be delayed for "social" reasons. When maximum recovery has been attained, our patients must not seek additional "sick leave," and requests for disability will have to be related to disease and not desire.

In conclusion, our committee felt that the magnitude of this problem precludes solution by any one or two of the listed groups. Each has a special role to play if this is to be a successful effort. We have given a number of specific recommendations in our report to the House of Delegates, but feel the most promising one is the establishment of regional intrastate councils on Health Care Costs. Included would be physicians, hospitals, health insurance carriers, labor, management, public representatives and the media. Continuing on an indefinite basis, these councils would provide a forum for education as to the problems, identification of new problems and hopefully solutions. I sincerely hope that the recently concluded House of Delegates has favorably considered our report and that our state is in the process of a cooperative attack on Health Care Costs.

Health Care Costs—Quo Vadis?

FRED R. HIGGINBOTHAM, *Atlanta**

"SURELY YOU'VE GOT to be kidding!"—"Another rate increase?"—"You raised our rates just last year."—"I don't see how we can afford to provide the same level of benefits. Can they be reduced to keep the rates down?"—"Why?—Why?—Why do the costs for health services keep going up faster than everything else?"—Questions and comments like these are heard many times each day at Blue Cross and Blue Shield of Georgia/Atlanta.

At the national, as well as the local level, our employer groups who pay the benefit dollars are expressing extraordinary concern and want to know what we are doing about costs. Our marketing force is faced with the character-building task of presenting 20, 30 and 40% rate increases year after year.

In any discussion relating to health care costs, it is important that we begin by accepting the fact that the continually escalating cost for health care services is a problem of gigantic nature. We must resist those who want to simply explain the cost problem as not very serious, and we must beware of those who are screaming "crisis" and want to blame doctors and hospitals for all the ills of our health system. Too many among us have been unable to resist easy generalizations about the problem and various proposed superficial solutions. We need to open our minds and face the problem analytically, armed with the facts that are available, while recognizing that broad gaps exist in our understanding of health economics.

A few statistics on Blue Cross and Blue Shield of Georgia/Atlanta susbscribers may be helpful. During the five-year period from 1971-76, the average amount we paid on a hospital claim increased from $432.31 to $851.43. This near doubling was accompanied by an increase in admissions from 143.0 per thousand subscribers to 170.5 during the same period. Currently Atlanta Blue Cross subscribers' utilization is one of the highest in the country at 895 days per thousand members, compared to a national average of 808. It is probably not a coincidence that utilization increased dramatically in 1973-74 following the period when many new beds were added to Atlanta hospitals.

Here's what Blue Cross and Blue Shield is doing to fight rising health costs.

Reasons Are Complex

The reasons for the rise in health care costs are complicated and involve inflation in the broader society, rising demands, government regulation, growing technology, and a vast number of other factors. Because the problem is complex, no easy solutions are possible; no panaceas are available for intractable problems. Financial "juggling," such as cost caps, front-end deductibles on insurance policies and changing physician reimbur- ent, has a role to play—but alone will not solve the problem.

We must not over-promise. Cost controls, cost accountability, cost containment, cost management, or whatever term is preferred will take time to be effective. Hundreds of hospitals, thousands of doctors, and millions of consumers are involved, and substantial changes in their behavior and its cost implications will come—not overnight, but rather after much hard work.

Must Act

Nevertheless, complexity and difficulty should not be used as an excuse for inaction. It is time to act

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more boldly. One of the great strengths of the health field is its abundant—at times excessive—energy and vitality. It is full of competent, well-motivated physicians, executives, nurses, technicians, and institutions. The challenge now is to channel some of this innovative capacity into cost control and to get the rise in health care costs more in line with the cost of living increases and the growth of the Gross National Product. The field and its costs will grow, but the 15-17% increases of recent years must be moderated.

Cost containment should not be seen as solely the concern of government—as something to be imposed on the health field. Government has a role, but private institutions and voluntary initiative are more crucial and more likely to succeed over the long pull. The private sector has more flexibility, a better sense of the trade-offs between costs and quality, and continuing contact with patients and their needs and desires. Many of the difficult decisions that cost containment requires must be made at the community level.

The public requires that the cost issue be addressed, and the effectiveness of our response—the voluntary health financing and delivery system—is crucial to the success of the effort. We also need to find new ways of working together in this effort. Alone, the efforts of Blue Cross and Blue Shield Plans, the hospitals, the doctors or consumers, are destined to be ineffective. Cost containment will affect us all and requires joint effort and cooperation in new arenas.

The focus must be on public service. Doctors and organized medicine have a great heritage of dedication to the sick and injured and this is shared by many, including the non-profit Blue Cross and Blue Shield movement and most hospitals. We must unite around these goals and minimize our differences. Our future ability to serve hangs in the balance, for if we fail to work together and cope with the cost issue, there can be no question that more and more government intervention will result.

"The public requires that the cost issue be addressed, and the effectiveness of our response is crucial to the success of the effort."

The Blue Cross and Blue Shield Program

At Blue Cross and Blue Shield of Georgia/Atlanta because of our size and close relationship with providers of care, we feel we have a special obligation to work to contain costs. As a corporation we have been addressing these issues on a number of fronts.

1. **Administrative Costs**—Internally we have attempted to set our own house in order by controlling our administrative costs carefully. During the current year, our budget represents only 8.6% of total benefits, a substantial reduction over previous years.

2. **Benefits**—New benefits, including the Blue CHIP (Comprehensive Health Insurance Program) series —which provides for front-end deductibles and copay provisions to involve the consumer in the costs at the time of the service—have been created in an effort to promote cost consciousness. We intend to evaluate the impact of these benefit changes. In recent years, we have substantially broadened outpatient coverages to reduce the incentives for unnecessary hospitalizations.

3. **Work with Medical Care Foundations**—The Atlanta Plan works with the foundations for medical care, both the Metropolitan Atlanta Foundation for Medical Care and the Georgia Medical Care Foundation, in the areas of cost and quality of care, and substantial savings are achieved.

4. **C. O. B. (Coordination of Benefits)***—Our basic job is processing claims accurately (in accordance with the contract) and quickly. One specific aspect that influences costs is coordination of benefits, during 1976, we had documented savings of $5.1 million.

5. **Utilization Review**—An important facet of our effort in the near future will be a Utilization Review Program. During the latter part of 1976, we conducted with ten hospitals and their medical staffs a pilot program to test the cost-effectiveness of utilization review. Over 5,200 claims were reviewed and statistics on unnecessary days and costs were carefully recorded.

The results of this study are encouraging. On the one hand, only 4.3% of the total days were identified as medically unnecessary. This is a good result and is probably lower than many critics would have guessed. However, the study did conclusively demonstrate that a utilization review program could reduce this somewhat and be cost-effective, saving between one and two million dollars for Blue Cross and Blue Shield subscribers. Thus, utilization review can be a useful tool in saving one or two percent; this is desirable, but is an example of a program that should not be sold as the panacea. It is one effort; others are needed.

The Board of Blue Cross and Blue Shield of Georgia/Atlanta has voted to require utilization review in participating hospitals, effective January 1, 1978. A cooperative effort here by hospitals and doctors can be a substantive effort to demonstrate to

* Coordination of Benefits means that under the provisions of a group's contract, Blue Cross and Blue Shield coverage is coordinated with other coverage available to a subscriber through another group program. The purpose of the COB provision is to avoid duplicate benefit payment in cases of duplicate coverage.

the public our genuine concern over costs.

The program will be designed to minimize paperwork and bureaucracy. Any hospital that demonstrates through good performance a given level of effective utilization will be granted a waiver similar to Medicare and no days or stays will be denied. Institutions which do not perform effectively and show poor utilization patterns will not receive waivers and our attention will focus there. We are sure that most hospitals do not over-utilize and will achieve waiver status.

"Complexity and difficulty should not be used as an excuse for inaction. It is time to act more boldly."

The best utilization review is done by the hospital and its medical staff, and our goal is to utilize this and design a program with a minimum of hassle for patients, doctors, hospitals, and the Blue Cross and Blue Shield Plan.

Other Steps

Other steps are planned. Recently a Board-level Cost Accountability Committee was created. It is chaired by W. Daniel Barker, Administrator of Crawford W. Long Memorial Hospital, and includes physician and hospital members, with consumers to be added in the near future.

This committee proposed an interim policy and program on costs which the Board has approved. This includes the following recommendations:

1. **Every hospital should have a cost containment committee or assign the functions to an existing committee.** This committee should be interdisciplinary, but physician involvement and commitment is basic. Physicians can be more aware of the cost consequences of their actions. How many know the cost of a day of care, a set of electrolytes, a G.I. series, a tetracycline prescription? An effort to publish hospital charges to the medical staff and distribute an occasional patient's bill to the attending physician can be beneficial.

2. **Community meetings on health care costs should be held.** All of us—doctors, carriers, hospitals, and consumers—must understand the cost problem better and participate in designing solutions. Real cost containment must have real impact; it requires change by all of us and tinkering in painless ways with the status quo will only build cynicism.

We need to understand each other better. Consumers must know that cost containment can impact quality and access to care. Providers need to feel the depth of business and public feeling about health care's consuming a greater and greater share of our economic resources. Public meetings, with media coverage, can illuminate the problem and lead to concrete action.

3. **The Blue Cross and Blue Shield Plan should develop and distribute data to the public and providers on health care costs to identify problems.** Blue Cross and Blue Shield of Georgia/Atlanta has a reservoir of data on costs and utilization patterns by physicians, hospitals, and patients, which can help define problems and point the way toward specific corrective actions. We need to look at the incredible variation in charges and costs for comparable services between providers and determine if they are justifiable.

Visibility of a broader range of data can be a major force for progress.

4. **Health planning must be encouraged.** There is overwhelming evidence that the Atlanta area is vastly overbedded. The capital and continuing operating expense associated with this are an enormous burden. Market forces, such as competition, work poorly in health care for a variety of reasons. Effective institution and areawide planning can lead to more effective use of scarce capital in the future and perhaps redeployment of current excess facilities into alternate uses.

Commitment

The cost problem will never be fully solved; health costs will continue to increase in the years ahead. The public will always resent the necessity of paying for services which, if they had a choice, they would not buy. But we must all recognize that there is much to be done and much room for improvement and get about the job in a credible way that the public can accept.

We need not be defensive about this. The cost problem ironically is the result of considerable success in health. Government has broadened access through Medicare and Medicaid programs and improved care through the vigorous National Institute of Health's varied research effort. Dedicated physicians continue to specialize, develop new techniques and provide a consistently high quality, complex service to a vast, heterogenous population that is demanding (and mostly getting) what it wants. Third parties cover more people with broader benefits than ever before.

Change is in order but not revolution. Needed is a consolidation of our considerable achievements and a new balance of our attitude and concerns, with economy given more priority. Our entire economy faces similar challenges; we are not alone. The auto industry, utilities, oil, education, and numerous others face pressures and challenges to do more with less. All are responding. Can we do less? Let's get our forces organized and get on with it!

A hospital administrator's prospective on the cost problem.

The Anatomy of Hospital Costs

W. DANIEL BARKER, F.A.C.H.A., *Atlanta**

CRIES FOR COST containment or cost control in the health care industry are being shouted by an increasing number of disgruntled, discouraged, and, in many cases, deceived consumers, payers and public servants. These cries reflect the overwhelming evidence that documents the dramatic increase in the cost of medical care during the past two decades.

The unrelenting health care cost spiral has transferred a substantial proportion of our nation's productive capacity to the health care industry. For example, the proportion of our Gross National Product spent on health care increased from 4.6 percent in 1955 to 8.6 percent in 1976. The final result is a relatively smaller market basket of other goods and services available for the American consumer.

Bombardment with all sorts of statistics depicting the rise of health care costs have become routine for most of us in the health care industry. We live in a computerized data processing age where mountains of statistics can be generated almost at will. Perhaps many of us have become shellshocked with the barrage.

The statistics have told us everything about health care costs—except what we need to know. We know the What, How and When of health care cost inflation. Unfortunately, we still do not have a universally accepted solution for cost control.

Until cost pressures in the health care industry abate, cost containment will continue as the industry's most important policy issue. Solutions for cost control are critical, but they must be soundly based. Too often crisis conditions lead to political rhetoric which suddenly becomes legislation.

Because hospitals receive approximately 63 percent of all public health care expenditures and 34 percent of private health care expenditures, we find that we are in the forefront of criticisms regarding our present high cost situation.

The table below highlights a few statistics which summarize the hospital cost situation in Georgia and compares these figures for the last three years which are available with national averages. Except for the number of personnel per 100 patients, hospitals in Georgia rank considerably below the national average as far as cost per patient day, average annual salary, average length of stay and cost per admission. It is also significant to note that our rate of increase in Georgia is more rapid, percentage-wise, than for the nation as a whole.

What are some of the causes of these cost increases? Hospitals are not immune to higher consumer prices. Last year's budget does not stretch any further in a hospital than it does in your home or office. And the only way for hospitals to make ends meet, unfortunately, is to increase their only source of income: charges to patients.

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In 1975 (the latest year for which detailed statistics are available), inflation was the single biggest influence on hospital costs. About 45 percent of the increase in charges was directly caused by price increases in the general economy. Because of the impact of inflation on hospital costs, it may be helpful to examine inflation in some detail. *Inflation* is a term which describes a period during which the price level for services and factors of production is generally rising. It is simply a descriptive term which is not intended to convey any explanation of the reasons for the rising prices.

Economists have defined two basic kinds of inflation: *Demand-pull inflation* arises when an insufficient supply of a good or service is increasingly desired by consumers, and prices are driven up by competition to meet these demands, *cost-push inflation* occurs when the prices of factors of production increase. The manufacturer or provider must raise his charges to consumers for the finished product to cover the higher costs he incurs in producing the product or service. From World War II until about 1970, charges for hospital and health care services increased because of the growing demand for health care. This experience corresponded to the economists' demand-pull inflation. The public's demand for such services grew faster than the industry could provide them. Greater health insurance coverage and a rising standard of living contributed to the growing demand for health care services, and that increased demand resulted in increased charges for hospital services averaging 9-11 percent per year between 1950 and 1967. After the implementation of Medicare and Medicaid, demand was augmented by the removal of many of the financial barriers to care for the aged and poor. Between 1967 and 1970, the average rate of increase in hospital charges was about 17 percent. Although this rate of increase was considerably greater than during the earlier period, the cause was the same—a growing demand outstripped the supply.

The rate of increase in the cost to the consumer of hospital services as measured by conventional indices had begun to abate by 1971 when wage and price controls were instituted throughout the economy. The hospital industry was the last from which these controls were lifted, in April, 1974. Because hospital charges were tightly controlled during this period, hospitals were restricted in their ability to pass on to consumers the higher prices they had to pay for the goods and services they purchased. Thus, when controls were finally lifted, hospitals were forced to "catch up" to the rest of the economy by raising their charges to cover, for example, higher wages. In 1974 and especially in 1975, the prices of the inputs (goods and services purchased) necessary for hospitals to provide their services increased at a rate more than 150 percent higher than the goods and services represented in the Consumer Price Index. The recent increase in the price of malpractice insurance, fuel, and household and maintenance costs have had an especially severe impact on the prices for hospital services.

The components of inflation can be analyzed in several ways. One way is to examine the pattern of hospital purchases over a period of time. The chart on page 300 compares these purchases in 1969 and 1975. In 1969, over 65 percent of the increase in hospital purchases over a period of time. The chart on page 300 compares these purchases in 1969 and vices, and labor inputs purchased. In 1975, increased prices or *inflation* was responsible for over 73 percent of the increase in this statistic (cost of goods and services plus wages). In 1969, hospital prices rose

SELECTED GEORGIA AND NATIONAL COMPARISONS FOR YEARS 1973, 1974, 1975

	1973	1974	1975	Percent Change
Cost per patient day				
Georgia	$ 88.95	$102.82	$122.14	+37.3
Nation	102.44	113.55	133.81	+30.6
Personnel per 100 patients				
Georgia	291	303	312	+ 7.2
Nation	282	290	300	+ 6.[illegible]
Average annual salary				
Georgia	$6,134	$6,725	$7,350	+19.8
Nation	7,368	7,787	8,635	+17.2
Average length of stay				
Georgia	6.7	6.6	6.4	− 4.7
Nation	7.8	7.8	7.7	− 1.3
Cost per admission				
Georgia	$596	$679	$ 782	+31.2
Nation	799	886	1,030	+29.9

Source: Hospital Statistics, American Hospital Association.

because hospital services were in great demand, and additional quantities of materials and personnel had to be purchased to provide them. By 1975, the demand for hospital service was no longer increasing at such a rate, but the general economy-wide increase in prices—combined with the prolonged periods of economic controls—forced hospitals to pay an increasingly greater amount for the inputs required to sustain even current levels of service. This threatened the long-range survival of many hospitals which had to borrow or deplete their endowment to meet current financial needs.

The prospects for a steadily increasing demand for hospital-related health care on the order of that prevailing during the 1950s and 1960s until the passage of Medicare and Medicaid has not been diminished by the prolonged period of inflation. Charges for hospital services are likely to increase at a less rapid rate in the future due to the gradual diminution of the influence of ESP on hospital finances. Nonetheless, the charges for hospital service may continue to rise above the rate of the Consumer Price Index because of the continuing demand for the most technologically advanced and readily accessible health care.

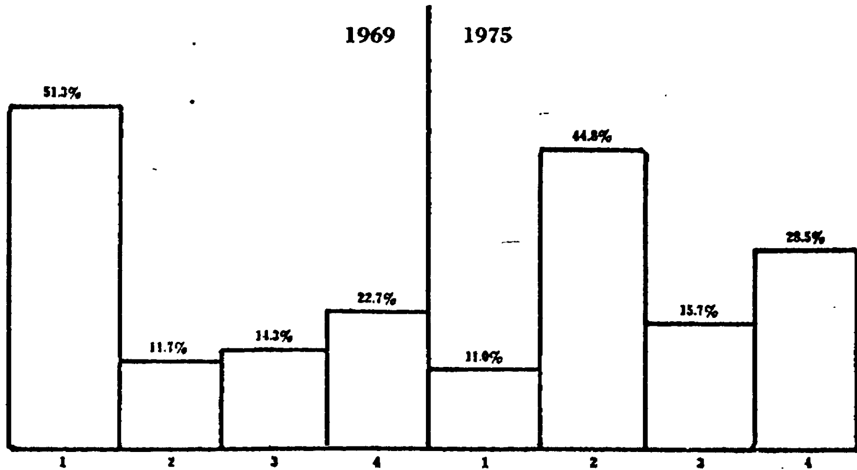
Where does inflation hit hospitals the hardest? In many of the same areas it hits your pocketbook: food, household items, heating and electricity. The cost of soaps and detergents purchased by hospitals have increased 21 percent in the last year, sheets are up 9 percent, the costs for electricity are 15 percent higher, and natural gas costs nearly 40 percent more than last year. The most dramatic change is the 200 percent increase in the cost of malpractice insurance.

As hospital administrators, we try to economize wherever possible, but we cannot influence the overall trend of spiraling costs due to inflation. Because of this, it is important that hospital administrations and medical staffs work together to control those elements of cost over which we have some influence.

In 1975, at its annual meeting, the Georgia Hospital Association unanimously passed a resolution "urging each of its member institutions to establish committees or other appropriate organizational structures, as a means whereby Trustees, Medical Staff Members, Administrators, Department Heads, and other employees may more effectively intensify their activities in the area of cost containment and productivity."

Such a committee was established at The Crawford

COMPONENTS OF TOTAL HOSPITAL INFLATION, 1969 AND 1975, BY PERCENT



KEY: 1—Increases in the quantity of goods and services purchased
2—Increases in the cost of goods and services purchased
3—Increases in the quantity of personnel employed
4—Increases in average wages

(Source: The Hospital Economy, 1975, Division of Information Services, American Hospital Association, 1976.)

W. Long Memorial Hospital of Emory University and some of our areas of activity to date are:

1. Included as a part of our regular medical audits a review of the hospital charges associated with the disease entity being audited. We have found that the range of cost for most episodes of illness studied to date is approximately 200 percent. When analyzed by physicians, we find that the range is much smaller and the variance is closer to plus or minus 20 percent.

2. We have analyzed cost per admission by discharge diagnosis with a comparable diagnosis for the prior year. In those instances where the cost has increased more than the Consumer Price Index, special studies are being instituted to try to discover the reasons for the higher cost.

3. We have analyzed the 20 most common causes for admission and developed detailed profiles of the services rendered these patients. These studies are analyzed on the basis of the date of admission, the attending physician, the age of the patient, and the distance the patient lives from the hospital.

4. Quarterly conferences with members of the medical staff in which itemized bills of selected patients treated by them during the last quarter are summarized and given to the physician so that he would have some idea of the cost involved in the treatment rendered.

5. We are in the process of instituting an on-line computer ordering system. One of the programs involved in this system will let the physician know the price for each service, test or procedure which he is ordering.

6. The above is just a partial list of some of our internal activities designed to keep the medical staff informed as far as costs are concerned.

Most of us will agree that we cannot put a price tag on health. When we are sick, we want to get well—whatever the cost. New technologies, new diagnostic procedures, monitoring systems, and surgical advances make possible a level of care undreamed of just a few decades ago. Technologies like these and the personnel who have been trained to apply them, do raise hospital charges. In many cases, high hospital charges are the price which we all must pay for up-to-date health care. But some of the cost of health care could be lowered and that is the purpose of our Cost Containment Committee.

In all of the discussion which is now taking place about health care cost, it is important that we always remember that the most important cost to be avoided in a hospital is the cost of human life.

CARTER HOSPITAL CONTROL PLAN LABELED THREAT TO PATIENTS

The Carter Administration's hospital cost containment proposal, announced April 25, is viewed as "unrealistic and a threat to the quality of patient care in our nation's hospitals" by Michael D. Bromberg, director of the Federation of American Hospitals (FAH), representing investor-owned hospitals.

According to Bromberg, the Carter plan calls for singling out hospitals and imposing a ceiling on them, while allowing all other sectors of the economy to go unchecked.

"Such a proposal is unfair and arbitrary," Bromberg said, "and it will not work. Not only is it impossible to inhibit inflation by law, but there is a real danger that by legislating a ceiling on hospital costs, the Administration would be directing hospitals to cut back on the quality of health care delivery," he explained.

Calling the Carter program "nothing more than a camouflaged version of the Nixon Phase IV controls," Bromberg urged Congress to reject it. "Our representatives should attack the problem of escalating health care costs 'head on' by legislating an end to the primary cause of inflation—cost reimbursement for hospitals."

FAH advises prompt action on a Medicare/Medicaid reform bill, to be introduced shortly by Senator Herman Talmadge, chairman of the Subcommittee on Health of the Senate Finance Committee. "That bill provides for an incentive payment system offering economic rewards for efficiency," Bromberg said.

"That would be the most effective and equitable means of containing health care costs, a goal shared by the Carter Administration and those of us involved in the delivery of health care," he continued. "Together with strengthened health planning and peer review, it is the fairest approach."

GOVERNMENT INVOLVEMENT IN HEALTH CARE BENEFITS NONE, SAYS NOBEL PRIZE WINNER

The present trend toward ever greater government involvement in health care is against the interests of patients, physicians, and hospital personnel, according to Milton Friedman, Ph.D., noted economist and distinguished University of Chicago professor.

Friedman delivered the keynote address, "The Economics of Healthcare," at the 11th annual Federation of American Hospitals' (FAH) convention in March.

The 1976 Nobel Prize winner in Economics believes that government involvement initially seems to serve the interests of at least hospitals and physicians by increasing expenditures on healthcare. "But this is a transitory phase, as the experience of other countries has demonstrated," he said.

"When government control becomes nearly complete, expenditures will shrink," Friedman continued. "Those sections of the health industry that have favored further government involvement are working against their own long-term interest."

This government official doesn't think government has to be the answer.

Wake Up, Doc!

DOUGLASS M. RICHARD, *Atlanta**

As a life-long practicing bureaucrat (GP, that is, not a specialist), I have available to me all the statistics one would need to fill up not just the space devoted to this one article but rather this entire issue. The things I could "prove" by use of these stats run the gamut from A to Z, and also from Z to A.

I could "prove" for example, that physicians are the cause of the horrendous annual increases in health care costs. I could also "prove" that physicians play no role whatsoever in those increases. I could "prove" that Medicare and Medicaid have been the primary contributors to the increases in health care costs over the past ten years. I could also "prove" they had a relatively insignificant part to play in that escalation. I could "prove" the whole country's going under if we don't get ourselves a national health insurance program, and soon. And, yes, I could also "prove" NHI's the last thing we need and would, in fact, have us bordering on the brink of bankruptcy very soon after it took effect.

In other words, I could "prove" just about anything I wanted to by strewing around *selected* statistics which, in and of themselves, would actually *prove* nothing. What's really frightening about all this is that it happens all the time. And you and I latch on to those statistics that appeal to us without really looking behind them, without really being informed, without really recognizing that in and of themselves they prove little or nothing. So I'm going to indulge in a little editorial freedom here and, in the body of this presentation, use statistics sparingly if at all.

What, then, does a bureaucrat write about if he can't spew out ominous statistics. Well, he can always prognosticate the future. That's pretty safe, because by the time the prognosticated events come (or do not come) to pass, few readers will remember what he said and practically none of those who remember will care. One in my position can't very well deal in "policy." I'm an administrative officer, not a policy officer. And I've said more than once (three times, in fact!) that in the government an administrative officer is to policy as a eunuch is to sex. (And that, I submit, ought to clarify that little detail!)

No, no stats, no policy. Just some thoughts developed over the past 4,213 days I've been involved (at this writing) in the Medicare program. None of that which follows is very profound, little of it is new, and much of it might not "set" very well, as we used to say down home in Savannah. But as Regional Medicare Director for the Southeast for 11 years, I've had an unusual vantage point from which to view the passing health scene. A vantage point, you say, that would tend to give one a distorted or biased view of things? Perhaps. But consider as well my credentials as a "consumer" of health care (a rather tortured bit of terminology, yet I know of no better way to put it). Given the fact I've a wife who's had two heart attacks in the last ten years plus other assorted ills, such as hypoglycemia, 11 hospitalizations in such diverse places as Atlanta and Johns Hopkins in Baltimore, with the accompanying expenses of insurance, costs above insurance, drug bills equaling if not exceeding physicians' costs—given all that, plus my own past-middle-age physiological creakings, groanings, and deterioration, you surely would agree the view isn't really all that slanted.

Speaking to the Florida Society of Internal Medicine during its annual meeting, I expressed one thought that quickly captured the wandering attention of that august group. I said to them (and I say it now to you, because I remain convinced of it to this day) that after working with and being subject to the ministrations of physicians over the years, I really believe the average practicing physician doesn't know what the hell is happening to him. I further said that if he doesn't begin to learn what's happening, if he doesn't begin to become involved in *causing* things to happen, he's going to look around one bright and shiny day and discover—to his great surprise and utter horror—that the practice of medicine is no longer what it once was (and what he wanted it always to be).

Oh, I'm not talking about those of you who are really involved in organized medicine, who are society officers, convention delegates, etc. I'm talking about the fellow who won't read his *Journal* because he's too busy, about the fellow who won't go to association or society meetings because they conflict in terms of time with hospital rounds, about the

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fellow who doesn't know (and one wonders whether he would care if he did know) that there are hundreds upon hundreds of bills affecting his vocation and the way he practices that vocation submitted to the Congress each year. I repeat: I'm thoroughly convinced that poor guy doesn't know what the hell is happening to him. And that's sad. It's sad, too, that I read these journals much more thoroughly than do most physicians. It's sad, too, that in one city where there are about 3,700 physicians, the Medical Association can't muster a quorum at meeting after meeting. No, the poor guy doesn't know what's happening.

What has all this to do with the broad subject of health costs or health financing, to which I understand this issue of MAG's *Journal* is devoted? A great deal, I submit.

Where there is a void, it will be filled. And in the absence of action by the private sector, it will be filled by the government. There was a void, and we got Social Security. There was a void, and we got Medicare. There were voids, and we got Professional Standards Review Organizations, Health Systems Agencies, Program Review Teams, and a myriad of other governmental agencies and actions bearing on the health scene, on health care costs, among other things.

I'm not suggesting these things are bad, mind you. By the same token, I'm not suggesting they're good. I'm an administrative officer—remember the eunuch? What I *am* suggesting, though, is that each of these actions by the government would have been far better, both conceptually and in terms of implementation, had there been involvement to a much greater degree of practicing physicians—the people who really know with a real degree of certainty what it takes to render good health care and, conversely, what it *doesn't* take to do so. Had there been greater broad-scale involvement of practicing physicians in peer medical utilization (not fee) review, PSRO probably wouldn't ever have come ambling down the legislative pike. (And don't think you're going to "escape" PSRO just because you're in Georgia. It's coming. Inevitably, inexorably it's coming, either

"I'm thoroughly convinced that the poor guy doesn't know what the hell is happening to him."

under the aegis of organized medicine or under some other sponsorship.) Health Systems Agencies would still be a figment of someone's imagination had there been forceful, meaningful involvement of practicing physicians in local and area health planning.

And that all leads to another thought. If we really want to do something about health costs, we need to face up to a few things. Despite the pummeling physicians have received in recent years about costs, it's a fact that hospital costs in this country are approximately twice as large as physician costs. I don't know what percentage of hospital costs goes for personnel, but it's large, and it'll get larger. And there's nothing much we can hope to do about that. (As the husband of a registered nurse who served in hospitals for years, I've never really understood the logic that apparently assumes hospital personnel can buy groceries at the A&P on their good looks and therefore don't need wages equivalent to those of people in other professions.)

No, we can't do much about that, but something can and *must* be done about the *proliferation* of high-

"HSAs would still be a figment of someone's imagination had there been forceful, meaningful involvement of practicing physicians."

ly technical, extremely sophisticated, horribly expensive new equipment. CAT scanners come to mind. At $450,000 to $700,000 per scanner—those are very round figures—how much does a hospital add to each patient's cost per day when it purchases one? Easy now—I'm not suggesting that CAT scanners aren't just great, even though there still seems to be some division of opinion in the medical community about that. I'm simply suggesting that heavy physician involvement in the determination of *need* (as compared to prestigious desirability) of such items in a *given* hospital is badly, badly needed. You wonder if physicians can do anything about this? One small example: When an established, recognized and effective planning agency refuses, in effect, to permit hospital "X" to purchase a CAT scanner as unneeded, is the medical community serving the total community when physicians then band together to purchase one and set it up in the professional building next door to the hospital? I think not. Whatever became of peer pressure?

One could go on, but space doesn't permit. To sum up, it's my firm belief that because the average practicing physician doesn't know what the hell is happening to him, he isn't involved, he isn't influential, and he doesn't play the role he should and must in the overall health activities of this country. And because he doesn't, because he sits figuratively contemplating his navel while the whole scene changes around him, everything and everybody suffers, costs continue to shoot up, and the government of necessity continues to fill the void. And that's sad, because it doesn't have to be that way.

One final thought: I believe we've made it to this point without the use of statistical charts and columns of figures. Any time a bureaucrat can do that, there must be some hope for us left!

Responsible Restraint—A Key to Cost Control

PERHAPS PHYSICIANS should all be put on the public payroll. Perhaps each doctor should have to accept a certain number of Medicare and Medicaid patients in order to retain hospital privileges.

At least a ceiling should be placed on physicians' fees and hospitals expenditures should be limited to a 9% increase per year—regardless of the rate of rise of expenses.

Ideas such as these—as unworkable as they may sound—have been receiving prominent play in the press and on radio and T.V. Suggestions such as these have been given lip service by such influential persons as legislators, editors, Ralph Nader committeemen and the President of the United States.

These arbitrary ideas largely ignore the basic mechanisms underlying increased health costs. Increased costs throughout our economy are but a reflection of the general inflation perpetrated by increased deficit budgeting in our government. Only responsible restraint by the people we send to Washington to represent us can begin to halt this trend. The politician who promises the uniformed citizen more services from his government without apprising him of the economic consequences of deficit spending and spiraling inflation can only be guilty of a cruel hoax against the American people in order to perpetuate himself in office. The future of our economy is jeopardized by these "free lunch counter" pitchmen.

There is a well-recognized, increasing demand for utilization of pre-paid medical insurance. This urge seems to stem from such logic as "If I've paid for it I want to use it" or "I've paid into Social Security all these years and I deserve it." These attitudes are particularly crucial in a hospital environment where increasingly sophisticated, expensive, and well-publicized diagnostic tools are becoming available. Increased malpractice suits with their escalating influence on medical costs through the practice of defensive medicine constitutes a significant factor. Responsible restraint on the part of the physician in situations like this can help to hold the lid on costs. It is hoped that more reliance on sound clinical judgment rather than blind faith in machines may become more acceptable to patients.

Perhaps an effective deductible clause in all medical insurance—including Medicare and Medicaid—would promote responsible restraint among patients in the use of their prepaid medical benefits. Each consumer of medical care could better identify with the cost element inherent in any needed and valuable service. It would go far to dispel the "something for nothing" illusion for everyone. This would also tend to promote responsible restraint among that minority of physicians who tend to hospitalize patients for relatively minor complaints.

We are fortunate to have in this special-subject issue of the *Journal* some positive recommendations from authors representing the medical profession, hospital administration, insurance carriers and the federal government. With the information gleaned from these papers we should be better prepared to discuss these factors intelligently with our patients and ultimately to help formulate plans for more effective cost control. Your elected representative in Washington also needs your counsel.

Give us your thoughts.

Edgar Woody Jr., M.D.
Editor

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Senator TALMADGE. The next witness is Dr. A. Cullen Richardson.

STATEMENT OF DR. A. CULLEN RICHARDSON, REPRESENTING THE MEDICAL ASSOCIATION OF ATLANTA, GA.

Dr. RICHARDSON. Senator Talmadge and Senator Nunn, my name is Cullen Richardson, I am a practicing physician in Atlanta in the field of obstetrics and gynecology.

I am pleased to represent the Medical Association of Atlanta at this hearing and present some of its views on health-care costs.

The Medical Association of Atlanta has 1,400 physicians as members, and I am a member of the association's committee on cost accountability. We, as physicians, are the first to admit that health-care costs, particularly hospital costs, have increased more rapidly than the cost-of-living index. We are aware of the magnitude of the total expenditures for health care, which now consumes approximately 8.6 percent of the gross national product. Physicians' services, however, represent only 17 cents of each health care dollar. Obviously, a much larger share goes to hospitals and nursing care facilities, or roughly 70 percent. Yet, physicians admit patients to hospitals and nursing homes, and it is under our direction that hospital dollars are spent. While we generally are the ones who order and direct the services and have responsibility, we have little, if any, control over the cost of the specific hospital services.

I would like to talk briefly about some of the reasons behind these rising costs, some ways in which we, as physicians, can help with cost containment, some factors outside the health care industry that can effect costs and, finally, I would like to touch on what we feel are upcoming very difficult, but very important ethical issues.

There are three major reasons for the rise in health-care costs: (1) inflation in the general economy; (2) expanding expensive technology, and (3) increasing patient demand and expectation. I would like to look at each of these in a little more detail.

First, inflation of the general economy. Obviously, as wages and prices increase, so does the overhead in physicians' offices, hospitals, nursing care facilities, pharmaceutical companies, et cetera. This needs little examination.

In the past three decades, we have seen more money expended on medical and scientific research than in the history of man up to World War II, with a major part of this in this country, being subsidized directly or indirectly by the Federal Government. This research has paid off. We are able to do more for people today than ever before. Procedures, which a few years ago, seemed to be pure science fiction, such as open heart surgery, total hip replacements, and/or salvage of a very small premature baby, are today commonplace and done routinely in the average general hospital. These procedures and many others like them are very expensive. The equipment, the hardware, such as computerized monitors, the heart-lung machine, et cetera, are very costly to build and require highly skilled personnel to operate them.

I was recently discussing with the administrator of a 500-bed general hospital, hospital personnel requirements today as compared to 30 years ago. At that time, 30 years ago, other than the full-time MD's and R.N.'s no job description required a college graduate. Today, this

same hospital employs over 100 college graduates, about 30 jobs require master's degrees, and several require the equivalent of a Ph. D. These highly educated and experienced people demand and deserve above-average salaries. About 65 percent of every hospital dollar goes to pay for employment costs, wages, salaries, and benefits. In spite of Mr. Califano's comments about "fat cats," no hospital employee of my acquaintance draws a "fat cat" salary.

The third cause is increasing patient demand and expectation. As mentioned before, our expanded technology enables us to do more to relieve infirmity than ever before. In this day of instant communication, the patient is informed as rapidly as the medical profession. On television shows, such as "Medical Center" or "Marcus Welby," no miracles are too big or impossible. Naturally, the public expects the same miracles. They are led to believe that almost any illness can be cured, that almost any pain can be relieved. There are many painful infirmities that can be relieved today that could not be helped by medicine a few years ago.

Let's look at one example. Only a few years ago, severe arthritis of the hip joint could literally condemn a person to severe invalidism for the rest of his life. Today, many of these can have a total hip replacement where the defective or diseased joint is removed and an artificial joint is inserted. This artificial joint is made from extremely expensive material, special alloys of stainless steel and plastic, but it can restore virtually normal activity.

Certainly, we, as a profession, have a responsibility to strive constantly for cost containment. Let me tell you some of the things that we, as physicians, are doing at a particular hospital in Atlanta where I carry out the major portion of my practice. To begin with, we are doing utilization review on all patients in concert with Blue Cross-Blue Shield and the medicaid-medicare program, as mentioned by Mr. Higginbotham. But, in addition, we are trying some other things.

To begin with, we are trying to start an educative program to make all physicians cost-conscious. At the present time, at midnight each night, our computer prints out a list of each physician's patients. When a physician arrives in the hospital each morning to make rounds, he can pick up the list which shows each patient's name, the total hospital bill to date for each, and the charges incurred in the last 24 hours. Within the next few months, when our online computer is fully operative, these charges will be printed directly on the patient's chart as they are incurred. This will allow the physician to know precisely what charges are put on the patient's bill for lab tests, X-rays, medications, and other physicians' services.

Next, the Joint Commission on Accreditation of Hospitals now requires that each service within the hospital conduct two or more audits each year of a particular treatment or particular disease to determine the quality of care being rendered by the hospital staff. We are now including the hospital bill as one of the parameters to be studied in all audits. Since instituting these measures, we can actually show a small but significant decrease in the average hospital bill for several of the more common operative procedures.

We are also in the process now of preparing a computer program for ongoing, concurrent audits for the 20 most common diagnoses or operative procedures which require hospital admission. This would in-

clude hernias, appendectomies, hysterectomies, cholecystectomies, tonsillectomies, prostatectomies, and such diseases as myocardial infarction, pneumonia, pyelonephritis, hypertension, et cetera. The 20 diagnoses that have been chosen comprise 60 to 65 percent of all of our hospital admissions. Once these programs are finally written, each of these diseases or procedures will have a constant and concurrent audit so that we can, at all times, know exactly what the costs are, what the results of treatment are, and this will give us better ideas on how to effect cost containment.

We are looking at a variety of other factors that influence total hospital bills. For example, certain patients admitted for medical diagnostic evaluations, had a significantly higher hospital bill if admitted on Friday than if admitted on Monday. These are inefficiencies in our system we need to look at.

Next, we are attempting to do cost/benefit analyses to determine both the cost and benefit derived from some of our new technology. For example, at the present time, we are conducting a study of coronary care units. As I'm sure you are aware, 15 years ago few hospitals had an intensive care unit specifically for a person who had had a myocardial infarction or a heart attack. Today, a person who is admitted to the hospital with an acute myocardial infarction is carried to a coronary care unit, and here he receives very intensive but inevitably very expensive care. The hospital bill for a patient with a myocardial infarction is now more than twice as much by today's dollars as it was 15 years ago, before the advent of this specialized care. However, we are saving more lives. What we need to know is precisely how much it is costing us to save each life. Further, we need to know the quality of the survival of these extra lives that we are saving.

I mentioned earlier that there are some things that can be done outside the health care field that can have an impact on health care costs. The causes of illness are very subtle, and many times grow out of a social background and environment from which a patient comes. Sometimes the causes are surprising and indirect, and right here I would like to give you a very graphic example that Senator Nunn referred to earlier today.

One often hears about infant death rates in this country compared to other countries in the world. It is pointed out that our infant death rate is higher than that of Sweden, and it is then concluded that our health care services are not as good as those in Sweden; however, if one really tries to understand infant death, you will find that over 90 percent of perinatal deaths occur as a result of premature birth. They do so as a result of a baby being born before they are fully formed and capable of extrauterine life.

Therefore, the ultimate factor that is involved in the reduction of infant mortality is the prevention of premature birth. A definable cause of prematurity can be assigned in less than 10 percent of the patients who go into labor prior to roughly 8½ months of pregnancy. That is, there are few conditions, such as abnormalities in the womb of the mother, chronic kidney infection, et cetera, that can be identified as the initiating cause of premature labor. A vast majority of these patients seem to go into labor for no, as yet, definable cause. Yet if one begins to study population groups within our society, we can divide people by age and race and one thing and another, and find variables

according to these factors. There are some minor racial differences in that blacks seem to have slightly higher premature rate than whites, and girls who are pregnant out of wedlock seem to have a higher prematurity rate than those who are married. But, these variances are slight. Surprisingly, the one factor with which prematurity varies more directly than any other factor is the educational attainment of the mother of the infant. In Georgia, if we look at all races, both legitimate and illegitimate, if the mother has zero to seven grades of formal education, she will have a prematurity rate of roughly 15.5 percent. If she has had 8 to 11 grades of education, the premature birth rate drops to 11 percent. If she has had a high school education, it drops to 8 percent, and if she has had any college, it drops to about 5.5 percent. Therefore, you can see that we have a variance of 300 percent, from 5 percent to 15 percent, based on the educational attainment of the mother. You can say that this is all socioeconomic. However in couples who are legally married, the educational level of the husband, which is a better index of social and economic status, does not prove to be as reliable a determinant of prematurity as the educational attainment of the mother.

Now, if you think that the cost of prematurity is negligible, you need to realize that the intensive newborn centers are very expensive to operate, although they do enable us to salvage some babies. Today we not only salvage these babies, but return them to society as effective citizens—babies who would have been a public care problem for society for many years to come. But it is not uncommon for a baby born weighing 2 pounds to leave the hospital 6 weeks after birth weighing 5½ pounds, but with a hospital bill of $35,000. So we are not talking about small costs. We are talking about gigantic costs.

We are able to salvage these babies today when we couldn't previously, but how much better would it be if we could prevent the premature birth rather than spend our dollars to treat the premature baby after he arrives.

Really, if we want to make a big impact on infant death, we need to have a better educational program that prepares people for living in our complex society. We need to develop ways of keeping our children in school until they are well educated.

Another way of putting it is, if you want your grandchildren wellborn, be sure your daughter goes to college and gets married. So here again, one thing that will have the most significant impact on infant mortality is something completely outside of the health care field, and that is education.

But before we bog down entirely in a numbers game, we must remember that at the bottom line, so to speak, is not quantity of dollars or days, but quality of life. Our health care industry is unique, in that we have a built-in 100 percent ultimate failure rate. Everybody is going to die eventually, and although we are all concerned about the quantity of our days, we must also be even more concerned with the quality of our hours. Our aim cannot just be long life, but enjoyable, effective and productive life. I submit we have failed to accumulate the data base necessary to truly evaluate costs and arrive at a good cost/benefit analysis. If we find that by increasing expenditures for health care services, we reduce absenteeism on the job and improve productivity, this could be a more than fair trade off.

Physicians are trying and must continue to practice good stewardship of health care dollars. We are constantly aware that all dollars for health care ultimately come out of someone's pocket, whether this is by direct payment of a bill, by the payment of insurance premium, or by taxation. Ultimately, it comes out of someone's pocket, regardless of by what route.

This fund of health care dollars has to be a finite quantity. I like to think of it as the medical common fund. If we dip too deeply for one cause, ultimately some other cause will suffer, and this brings us to the consideration of something that we, as physicians, are actually fearful of, and that is, the ethical question that will ultimately arise when it becomes apparent that a decision has to be made about how many dollars can be draw from this common medical fund to save one more life. Suppose we have the technology to save one more patient with coronary disease by spending an extra $50,000 or $100,000 or $200,000. How are we going to decide whether it will be worthwhile?

There's a hospital in England now that refuses to admit to the coronary care unit anyone with a heart attack who is over the age of 65 because it is too expensive. Do we want to see a time when we decide that all people over 65 are expendable? This is going to be difficult, and this should not be a decision that is made ultimately by physicians alone. Here we need input from many sources, and the public needs to be thoroughly aware that this decision ultimately is going to have to be made, and we must consider the potential for the quality in the lives saved. You remember the *Karen Quinlan* case.

In summary: We must continue to improve our efficiency in order to contain and even reduce costs for routine treatments and operative procedures, thereby offsetting, to some extent, the expanding costs of new technology. But, we must continue to monitor this new technology with cost/benefit analysis studies.

Next, we must look beyond the health care system itself and into other areas of society to identify conditions that cause the health problems that result in high cost of care.

We also need to accumulate a data base in concert with industry and the insurance carriers to evaluate absenteeism and productivity in comparison with health care costs.

We need to prepare ourselves, and this includes all society, not just physicians and Government, for the difficult and ethical issues that we inevitably must face.

And finally, we must remember that while costs are a problem with which we are obliged to deal, we cannot forget that the ultimate aim of all health care is quality of life.

Thank you.

Senator TALMADGE. Thank you very much, gentlemen. Your statements have been tremendously clear, and so precise, in the interest of time, also, I would not ask any questions.

Senator Nunn.

Senator NUNN. I thank you very much. This last statement, Dr. Richardson, about the cost benefit is one that does challenge our whole society, medically, morally, and ethically, and I think you have outlined some very provocative questions, and I also very much appreciate the other witnesses this morning. I wasn't here for the first statement, but I read it and caught up, so I appreciate all of you being here.

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Senator TALMADGE. The next witness is Dr. Louis Sullivan, who is dean and director of the school of medicine of Morehouse College, and who will be dean of those students with respect to the first class of students, those of September 1978, at the new medical school to train as physicians.

Dr. Sullivan, it is a pleasure indeed to have you before us. If you desire, you may insert your full statement in the record, and you can summarize it as briefly as you care.

Dr. SULLIVAN. Thank you, Senator Talmadge.

Senator TALMADGE. And incidentally, we have in addition to Dr. Sullivan, another panel, which is composed of hospital administrators, immediately following that Senator Nunn and I will have a statement to be made about Morehouse College, and we want Dr. Closter, Dr. Sullivan, and Mr. Marx at the podium at that point, and then Senator Nunn, subsequent to that, and I will respond to questions.

You may proceed, Dr. Sullivan.

STATEMENT OF DR. LOUIS SULLIVAN, DEAN AND DIRECTOR, SCHOOL OF MEDICINE, MOREHOUSE COLLEGE

Dr. SULLIVAN. Thank you. Senator Talmadge and Senator Nunn, ladies and gentlemen, I appreciate the opportunity of appearing before you today to give my views and those of the school of medicine at Morehouse College about serious problems of access to health care, which confront us throughout the Nation, but are most acute in the Southeastern United States, including our own State of Georgia.

Morehouse College and the school of medicine wish to acknowledge your longstanding interest and support of our efforts to establish a new medical school, designed to train more physicians for careers as primary care practitioners, to serve our poor and minority communities and our underserved, rural, and inner-city areas. Without your support the school of medicine at Morehouse College would not have made as much progress as has occurred over the past 2 years.

Georgia lags behind most of the United States in physician manpower. In 1974, there were 5.141 physicians in Georgia for a population of 4.6 million people. This gave a ratio of 112 physicians per 100,000 population, compared with a national average of 153 physicians per 100,000. Georgia ranks 36th among the States in physician/population ratio. With the possible exception of Florida, all of the States in the Southeast fall below the national average.

Of some 375,000 physicians in the United States, only 6,600 or 1.8 percent are black. This means that, nationally, there is 1 physician for every 538 whites, but only 1 black physician for every 3,900 blacks.

In 1974, there were 14 counties in Georgia with no physician and 30 additional counties which had two or less physicians. Thus, at least 28 percent of the counties in Georgia have a serious shortage of physicians. Of 159 counties in Georgia, 139 have no black physician and 12 have 1 black physician. Thus, only eight counties in our State have more than one black physician.

Of the 5,141 physicians in Georgia, 139 or 2.7 percent are black. This compares with a black population in Georgia of 26.1 percent. Compared with the optimal ratio of 1 physician for every 650 people, as determined by the American Medical Association, Georgia has 1 white

physician for every 677 whites, but only 1 black physician for every 8,617 blacks. Therefore, almost all of the physician deficit in the State of Georgia is due to the serious shortage of black physicians. If we were to adopt equity of representation in the medical profession as a desirable social goal, then instead of the 139 black physicians in Georgia, there should be 1,836. This is not to say that all medical care for blacks should be, or need be, dispensed by black physicians, nor should black physicians limit their professional care to black patients. However, there should be a certain minimum representation of blacks and other minorities in medicine, and this should certainly be greater than the existing 2.7 percent of Georgia physicians who apply.

There are some 768 Georgians who have applied for entry to U.S. medical schools in the fall of 1977. Eighty-two of these or 11 percent of of them are from ethnic minorities and 77 of the 82 are black. By way of contrast, only 3 of 292 freshman medical students at existing medical schools in Georgia in the 1976–77 academic year were black. This compares with a freshman minority enrollment of 10 percent of the same two institutions in 1971–72. The total minority enrollment in all four classes at these two medical schools for the 1976–77 academic year was 3 percent. It is clear that these two institutions are not meeting the need for more physicians for our poor and minority communities.

We now turn to some of the health indices for Georgians, which have already been alluded to this morning. The infant mortality differences and infant mortality rate between blacks and whites is striking. For blacks, 25.2 per 1,000 and for whites it was 14.5 per 1,000 births. That is a 42 percent greater mortality rate for black infants than for whites. These figures illustrate the reasons for the poor health statistics in Georgia, being predominantly those of a black population. Approximately 29 percent of the Georgia population is estimated to have high blood pressure. Black people have 4 to 5 times the prevalence of hypertension as whites, probably only 20 percent of these individuals have adequate control of their blood pressure. The incidence of diabetes, cancer, and arthritis is also higher among our black citizens. Related to health care, of course, is the issue of poverty, and as well as rural location. About 40 percent of our citizens live in rural areas and 20 percent have been classified as existing in poverty.

Of the physicians in the State, only 31 percent were primary care practitioners in 1974, and two-thirds of our physicians were located in the eight most populous counties in our State. It is because of the extreme need shown by data such as these that Morehouse College is committed to developing more training opportunities in medicine, especially for our poor and minority communities. The college has a long history of interest and commitment to the premedical sciences, having provided the undergraduate education for more than 7 percent of all of the black physicians in the country—more than any other college in the United States of comparable size. Morehouse is one of four institutions in Georgia with a chapter of Phi Beta Kappa—the other three being the University of Georgia, Emory University and Agnes Scott College.

The Atlanta University Center is a consortium of six institutions, including Morehouse, Clark, Morris Brown, Spelman, the Interdenominational Theological Center, and Atlanta University. There are

some 7,500 students in the center, making this the largest private center for black higher education, not only in this country, but in the world. The institutions have trained a number of leaders in the black community known to you and citizens around the country. Therefore, the development of a medical school within the Atlanta University Center will not only help to meet the need for more physicians in Georgia, but will also provide the kind of national and international leadership in medicine in the future that these institutions in the center have provided in other areas in the past.

Our plans are to open in 1978 as a 2-year school of basic medical sciences with a class of 32 students. We will have affiliation to Emory, the Medical College of Georgia for transfer of our students, and we hope to cooperate with the developing program at Mercer. Our long-range plans are to evolve into a 4-year school with a class size of 96 students by 1983.

In our efforts, we have received endorsements of many individual and public officials, including Governor Busbee, Lieutenant Governor Miller, resolutions of support from both houses of the Georgia Legislature, endorsements from various medical societies, including the American Medical Association, the National Medical Association, the State and local medical societies.

In 1976, the Carnegie Council on Policy Studies in Higher Education supported the need and endorsed the development of the School of Medicine at Morehouse College. Morehouse was the only developing medical school in the South to receive such an endorsement.

In 1976, the school also received letters of support from the Assistant Secretary of Health and the Administrator of Health Resources Administration, DHEW.

In the Senate report accompanying the Health Professions Education Assistance Act of 1976, the Morehouse medical program was cited as an institution which was intended to be supported by the new medical school startup authority in this bill.

The Liaison Committee on Medical Education awarded the school a letter of reasonable assurance of accreditation approximately 6 weeks ago. This indicates that we have developed an acceptable plan and program for medical education, which should lead to full accreditation of the medical school.

Thus, when our first students are admitted, approximately 1 year from now, this school will become only the third predominantly black medical school of some existing 117 schools in the country. It will be the first such institution to be founded in this century by an historically black institution.

I believe that the data presented herein amply documents the need for more physicians for our poor and minority communities in Georgia and elsewhere in the Nation.

In addition, the mission of our institution will be to orient our medical students for careers as primary care physicians, to serve the shortage areas in our State. We also plan a strong academic environment to provide for training of other kinds of physicians as well, those who will become health administrators, teachers and medical researchers.

To improve the health status of Georgians, therefore, will require multiple efforts from both public and private sectors of our economy. It will require not only more physicians, but other health care person-

nel as well as previously mentioned this morning. Studies in recent years have shown that medical students from rural and inner-city backgrounds are more likely to return to these areas to practice. For example, Dr. Lloyd Elam, president of Meharry Medical College in Nashville, has reported that more than 80 percent of that historically-black institution practice in rural and inner-city areas. A second study published by the Association of American Medical Colleges last year showed that 79 percent of black medical students currently in medical school indicated a preference for working in a physician shortage area, as did 65 percent of students from families with an income of less than $5,000.

In 1974, the average family income of white applicants to medical school was $18,976, whereas that of black applicants was approximately half, $9,565. Meanwhile, tuitions in medical school have risen rapidly, and all students have experienced increasing difficulty in gaining acceptance to public and private schools in States outside of their own.

The School of Medicine at Morehouse will therefore not only meet a regional and national need, but will have its greatest impact here in Georgia. We therefore request your continued assistance in securing Federal support for our efforts from the Congress, from DHEW, and from other Federal agencies. Because our institution is a young and developing one, we obviously have many and diverse needs, including funds for: Construction of facilities; renovation of existing college facilities; scholarship support for our students; and, also health profession service scholarships, which have a payback clause for those student who are willing to go into underserved areas.

National and regional needs, in addition to our needs in Georgia, will be significantly aided by your attention to these manpower shortages.

Direct health care needs, including funds for such programs as nutrition for children and the elderly, more immunization programs for our inner city and rural areas, adequate prenatal care for expectant mothers, health education programs for consumers, to hopefully change health behavior and continuing professional education for practicing physicians in our State.

In summary, there's a significant shortage of physicians in Georgia, reflected by the fact that our State ranks 36th among the 50 States in physician manpower. Most of this deficit is in inner city and rural areas, affecting our poor and black citizens disproportionately. Our two existing medical schools, who are cooperating with us, do not have the capacity to meet the need for more physicians in Georgia, and have a very small enrollment of black students. The developing School of Medicine at Morehouse College will add to the educational opportunities for medicine in Georgia, and thus assist in the alleviation of the shortage of physicians, especially our underserved areas. Federal and other support of diverse kinds for our medical school to insure its optimal development, Federal support of diverse kinds for the medical school at Morehouse is needed to insure its optimal development. Federal support for direct health and preventive services is also needed to decrease the mortality rates of our citizens and to promote their health and well-being.

Senator Talmadge and Senator Nunn, let me again express my appreciation to you for your interest and your support of our efforts and the opportunity to bring these needs to your attention.

We look to you for your guidance and assistance as we continue with the development of the school of medicine, an institution which all Georgians will be proud of in future years. Your contributions to our efforts will be significant, lasting and appreciated by many generations of Georgians to come.

Thank you.

Senator TALMADGE. Thank you, Dr. Sullivan, for a very well-documented and very well-thought-out and very well-reasoned statement.

Are there any ways of assuring that the majority of the graduates of the new medical college will stay in Georgia, practice in our underserved rural and metropolitan areas?

Dr. SULLIVAN. Indeed, for each individual student specifically, this is a difficult problem. However, because of the data that I mentioned that has shown that 80 percent of the physicians trained by Meharry have, indeed, gone into underserved areas long before the demonstrated national need and commitment development over the past 2 years, we feel that we already have a constituency that will be going into such areas. Second, because of the presence and availability, now, of loan programs and scholarship programs through the National Health Service Corps, which will require a payback clause in underserved areas, this, we feel, will help to insure that there will be physicians going into such areas.

Third, we intend to orient our curriculum including experience for our students working in such while they are still undergraduate students, to provide an orientation and exposure to them of the professional opportunities and the real satisfaction that will exist from working in such areas, that we, indeed, hope to have a very high percentage of our students going into such areas.

Senator TALMADGE. As you know, Senator Nunn and former Congressman Andy Young and myself, and many others, have been working in behalf of Morehouse College and this project for many years, as you are aware. You are also aware, I am quite sure, that Mercer University is also very much interested in obtaining a medical school to serve underserved areas. They've floated bond issues down in Bibb County, they have raised some $2 million of private contributions. Just 2 or 3 days ago, some charitable beneficiary left several million dollars in their will for Mercer University, to the medical school.

Do you see any conflict in interest of a medical college at Mercer University and Morehouse College?

Dr. SULLIVAN. No, there's no conflict whatsoever. Indeed, many of our goals are the same, that is, to provide for more physicians in underserved areas, going into careers in primary care. We have had some discussions with officials at Mercer and we have agreed that we have a common interest and we hope to cooperate with them in every way we can.

Senator TALMADGE. In other words, you think you could work cooperatively together to achieve the same goal, to wit: Underserved medical areas primarily in Georgia?

Dr. SULLIVAN. That's correct.

Senator TALMADGE. Senator Nunn.

Senator NUNN. I don't have any questions, Dr. Sullivan. I would like to just express my gratitude for your dedicated leadership and to

express my support, and I look forward to joining you at the press conference in a few minutes with some good news.

Dr. SULLIVAN. Thank you.

[The prepared statement of Dr. Sullivan follows:]

STATEMENT OF LOUIS W. SULLIVAN, M.D., SCHOOL OF MEDICINE AT MOREHOUSE COLLEGE, ATLANTA, GA.

Senator Talmadge and Senator Nunn, I appreciate the opportunity of appearing before you today, to give my views and those of the School of Medicine at Morehouse College about serious problems of access to health care which confront us throughout the nation, but are most acute in the Southeastern United States, including our own State of Georgia.

Morehouse College and the School of Medicine wish to acknowledge your longstanding interest and support of our efforts to establish a new medical school, designed to train more physicians for careers as primary care practitioners, to serve our poor and minority communities and our underserved, rural and inner-city areas. Without your support the School of Medicine at Morehouse College would not have made as much progress as has occurred over the past two years.

Georgia lags behind most of the United States in physician manpower. In 1974, there were 5141 physicians in Georgia for a population of 4.6 million people. This gave a ratio of 112 physicians per 100,000 population, compared with a national average of 153 physicians/100,000. Georgia ranks 36th among the states in physician/population ratio. With the possible exception of Florida, all of the states in the Southeast fall below the national average.

Of some 375,000 physicians in the United States, only 6,600 (1.8%) are black. This means that, nationally, there is one physician for every 538 whites, but only one black physician for every 3900 blacks.

In 1974, there were 14 counties in Georgia with no physician and 30 additional counties which had two or less physicians. Thus, at least 28% of the counties in Georgia have a serious shortage of physicians. Of 159 counties in Georgia, 139 have no black physician and 12 have one black physician. Thus, only 8 counties in our state have more than one black physician.

Of the 5141 physicians in Georgia, 139 (or 2.7%) are black. This compares with a black population in Georgia of 26.1%. Compared with the optimal ratio of one physician for every 650 people, as determined by the American Medical Association, Georgia has one white physician for every 677 whites, but only one black physician for every 8617 blacks. Therefore, almost all of the physician deficit in the State of Georgia is due to the serious shortage of black physicians. If we were to adopt equity of representation in the medical profession as a desirable social goal, then instead of the 139 black physicians in Georgia, there should be 1836, (an additional 1697!). This is not to say that all medical care for blacks should be, or need be, dispensed by black physicians, nor should black physicians limit their professional care to black patients. However, there should be a certain minimum representation of blacks and other minorities in medicine, and this should certainly be greater than the existing 2.7% of Georgia physicians.

There are some 768 Georgians who have applied for entry to U.S. medical schools in the Fall of 1977. Eighty-two of these (10.7%) are from ethnic minorities and 77 of the 82 are black. By way of contrast only 3 of 292 (i.e., 1%) freshman medical students at existing medical schools in Georgia in the 1976-77 academic year were black. This compares with a freshman minority enrollment of 10% of these same two institutions in 1971-72. The total minority enrollment in all four classes at these two medical schools for the 1976-77 academic year was 3%. It is clear that these two institutions are not meeting the need for more physicians for our poor and minority communities.

If we now turn to some of the health indices for Georgians, data from the Southern Regional Council show that the general mortality rate for black Georgians is 29% higher than for white Georgians. The infant mortality rate in 1975 was 14.5/1000 for whites and 25.2/1000 for blacks; that is a 42% greater mortality rate for black infants. These rates illustrate the reason why the U.S. has a higher infant mortality rate than approximately 15 other countries.

1975 in Georgia: 1 out of 4 pregnancies in non-white Georgians were teens; approximately ½ of the births at Grady Hospital are to teens; ⅔ of the total births are to unwed mothers.

There were 18,821 abortions performed on Georgians in Atlanta last year. This was greater than the total number of births which were 16,594. For each 1,000 live births to Fulton County residents, there were 897 abortions. Therefore, we must have improved family counseling, sex education and the availability of both family planning and abortion services.

Elimination of Federal assistance for abortions for the poor would have great short and long term consequences in terms of mothers and children's health, family disruptions and the great burden on society of unplanned and often unwanted children.

Approximately 29.5% of the Georgia population is estimated to have high blood pressure. Black people have 4 to 5 times the prevalence of hypertension as whites. Probably only 1 out of 5 Georgians with hypertension has his blood pressure controlled. The great need for accessibility and affordability of treatment programs for hypertension is clear.

The incidence of diabetes, cancer and arthritis is also higher among our black citizens. Almost 40% of Georgians live in rural areas; 20% live in poverty.

Of the physicians in Georgia, only (31%) were in primary care practices in 1974, and 3400 (66%) were located in the eight most populous counties in the State.

It is because of the extreme need shown by data such as these, that Morehouse College is committed to developing more training opportunities in medicine, especially for our poor and minority communities. Morehouse College has a long history of interest and commitment to the pre-medical sciences, having provided the undergraduate education for more than 7% of all the black physicians in the country—more than any other college in the United States of comparable size. Morehouse is one of four institutions in Georgia with a Chapter of Phi Beta Kappa—the other three being the University of Georgia, Emory University and Agnes Scott College.

The Atlanta University Center is a consortium of six institutions, including Morehouse College, Clark College, Morris Brown College, Spelman College, the Interdenominational Theological Center and Atlanta University. There are some 7,500 students in the Center, making this the largest private center for black higher education, not only in the United States, but in the world. The institutions in the Atlanta University Center have provided many of the local and national leaders in the black community for many years—leaders such as Martin Luther King, Jr., Whitney Young, W. E. B. DuBois, Martin Luther King, Sr., and others.

Therefore, the development of a medical school within the Atlanta University Center will not only help to meet the need for more physicians in Georgia, but will also provide the kind of national and international leadership in medicine in the future, that the institutions in the Atlanta University Center have provided in other areas in the past.

Our plans are to open in September 1978, as a two year school in the basic medical sciences, with our first class of 32 students. Our long range plans are to gradually expand to a class size of 96 students by 1983, and to evolve into a four year school in that same year.

In our efforts we have received many endorsements including letters of support from Governor George Busbee, Lt. Governor Zell Miller, resolutions of support from the Georgia Senate and the Georgia House of Representatives, and endorsements from the American Medical Association, the National Medical Association, the Georgia State Medical Association, the Medical Association of Georgia, the Medical Association of Atlanta, the Atlanta Medical Association and the Metropolitan Council of Medical Societies.

In 1976, the Carnegie Council on Policy Studies in Higher Education supported the need, and endorsed the development of the School of Medicine at Morehouse College. Morehouse was the only developing medical school in the South to receive such an endorsement.

We have also received the support of the presidents of the six A.U. Center institutions and endorsements by the Trustees of five of them.

In 1976, the School also received letters of support from the Assistant Secretary of Health and the Administrator of the Health Resources Administration, DHEW.

In the Senate Report accompanying the Health Professions Education Assistance Act of 1976 (PL 94-484), the Morehouse Medical Program was cited as an institution which was intended to be supported by the new medical school start-up authority in this Bill.

The Appropriations Committees of the U.S. House of Representatives and the U.S. Senate also issued reports of commendation in 1977.

The Liaison Committee on Medical Education awarded the School of Medicine a Letter of Reasonable Assurance of accreditation on June 30, 1977. This indicates that we have developed an acceptable plan and program for medical education, which should lead to full accreditation of the medical school.

Thus, when we admit our first medical students in September 1978, the School of Medicine at Morehouse College will become only the third predominantly black medical school, of some 117 medical schools in the country, and will be the first medical school in this century to be founded by an historically black institution.

I believe that the data presented herein amply document the need for more physicians for our poor and minority communities, in Georgia, and elsewhere in the nation.

In addition, the mission of our institution will be to orient our medical students for careers as primary care physicians, to serve in rural areas and our inner cities, which are presently underserved. We plan to have an educational milieu which will be strong and diverse, to provide for not only the education of primary care practitioners, but also support the efforts of the smaller numbers of our students who will train for careers as medical researchers, teachers, health administrators and health planners.

To improve the health status of Georgians, therefore, will require multiple efforts from both the public and private sectors of our growing economy. It will require the training of more physicians and other health care personnel, and the provision of greater fiscal support for preventive services, such as health education, immunizations, improved nutrition and in our rural areas, improved water purification facilities.

Studies in recent years show that medical students from rural and inner city backgrounds are more likely to return to these areas to practice. Dr. Lloyd Elam, President of Meharry Medical College has found that 80% of the graduates of that historically-black institution practice in rural or inner city areas. A study in 1975 by Mantrovani, Gordon and Johnson, of the Association of American Medical Colleges showed that 79% of black medical students indicated a preference for working in a physician shortage area, as did 65% of medical students from families with an income of less than $5,000.

In 1974 the average family income of white applicants to medical school was $18,976, whereas that of black applicants to medical school was $9,565. Meanwhile, medical school tuitions have risen rapidly in the past few years, and all students have experienced increasing difficulty in gaining acceptance to public and private schools in states outside their own.

The School of Medicine at Morehouse College will therefore not only meet a regional and national need but will have its greatest effect in Georgia.

We, therefore, request your continued assistance in securing federal support for our efforts from the Congress, from DHEW and from other federal agencies. Because the School of Medicine at Morehouse College is a developing institution, our needs are many, including funds for:

1. Construction of health education facilities, including a basic medical sciences building, a clinical sciences building, an ambulatory care clinic and a premedical sciences facility.
2. Renovations of existing college facilities for student teaching and faculty research.
3. Scholarship support, for students of exceptional financial need, for the first two years of medical studies.
4. Health Professions Student Loans and National Health Service Corps scholarships for students who will make a commitment to serve in a physician shortage area.

National and regional needs in addition to our needs in Georgia will be significantly aided by your attention to these manpower shortages.

Direct health care needs include funds for:

1. Nutrition programs for children and the elderly
2. Immunization programs for children
3. Adequate prenatal care for expectant mothers
4. Health education programs for consumers
5. Continuing professional education for practicing physicians

In summary:

1. There is a significant shortage of physicians in Georgia, reflected by the fact that Georgia ranks 36th among the 50 states in physician manpower.
2. Most of the physician deficit is in our rural areas and inner cities, affecting our poor and black citizens disproportionately.

3. The two existing medical schools in Georgia do not have the capacity to meet the need for more physicians in Georgia and have a very small (3%) enrollment of black students, although 26.1% of Georgians are black.

4. The developing School of Medicine at Morehouse College will significantly add to the educational opportunities for medicine in Georgia and thus assist in the alleviation of the shortage of physicians, especially for our underserved rural and inner city areas, and our poor and minority communities.

5. Federal support of diverse kinds for the medical school at Morehouse is needed to insure its optimal development.

6. Federal support for direct health and preventive services is also needed, to decrease the mortality rates of our citizens and to promote their health and well being.

Senator Talmadge and Senator Nunn, let me again express my appreciation to you for your interest and support, and for the opportunity to bring these needs to your attention.

We look to you for your guidance and assistance as we continue with the development of the School of Medicine at Morehouse College, an institution which all Georgians will be proud of in future years. Your contributions to our efforts will be significant, lasting and appreciated by many generations of Georgians yet to come.

Senator NUNN. I think I might say at this point, Senator Talmadge, that a number of people have asked to testify that time would not accommodate today, but I think we would intend to keep the record open for any kind of written testimony which we will review and make a part of the record.

Senator TALMADGE. That would certainly be true. In addition to that, the testimony that we heard both in Macon, day before yesterday, here in Atlanta today, will be printed as a document. If you will write Senator Nunn's or my office, we would be delighted to send that document to you.

The final panel of witnesses for today is a panel of hospital administrators.

Mr. Ernest Bacon, administrator of the Hamilton Memorial Hospital in Dalton, president-elect of the Georgia Hospital Association;

Mr. J. W. Pinkston, Jr., administrator of the Grady Memorial Hospital in Atlanta, president of the Georgia Hospital Association; and

Mr. Carl Ridley, administrator of the Griffin-Spalding Memorial Hospital in Griffin, Ga.

I suppose we will take them in the order that your names were called, so Mr. Bacon, you may proceed. I had the opportunity of visiting your very fine hospital at Dalton, Ga., and I know what an outstanding job you do there.

STATEMENT OF ERNEST BACON, ADMINISTRATOR, HAMILTON MEMORIAL HOSPITAL, DALTON, GA.

Mr. BACON. Thank you, sir.

Senator TALMADGE. As a matter of fact, I visited all three of your hospitals and can make the same statement about all of them.

Mr. BACON. Thank you.

Senator Talmadge, I have made available earlier some full comments.

Senator TALMADGE. They will be inserted in full in the record, and you may summarize it in the interest of time, if you will, sir.

Mr. BACON. Thank you. I would also enter into the record a publication entitled "Community Hospitals in Georgia—An Analysis by the Georgia Hospital Industry."

Senator TALMADGE. Without objection, that will be made a part of the record.

Mr. BACON. This will provide additional information for our track record for review.

[The analysis referred to follows:]

COMMUNITY HOSPITALS IN GEORGIA; ANALYSIS OF A VITAL GEORGIA INDUSTRY

INTRODUCTION

According to the U.S. Congress, the nation has been unable to achieve its national health priority because of the massive intrusion of the Federal government into the health care system.

In enacting Public Law 93-641, the National Health Planning and Resources Development Act of 1974, the Congress said:

"The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal government."

The law then says:

"The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources."

That massive infusion of funds primarily came through the Medicare program, enacted July 1, 1965, and made operational July 1, 1966, and through the Medicaid program which followed.

It is a well-known axiom that what the Federal government finances it also controls. Thus, the infusion of funds has been accompanied by a massive intrusion into the operation of the health care system through the rules, regulations and guidelines promulgated by the multitude of bureaucracies charged with administration of the laws and their numerous amendments.

It is for these reasons that reform of the Medicare and Medicaid programs will be one of the major priorities of the new 95th Congress and Carter Administration.

That reform will probably be accomplished through the massive Medicare and Medicaid Administrative and Reimbursement Reform Act, introduced in the 94th Congress by Herman Talmadge, Senator from Georgia.

In announcing his intention to reintroduce his bill into the 95th Congress, the Chairman of the Senate Finance Committee's health subcommittee indicated such reform is an absolute necessity before the government can undertake to expand health care benefits in any form.

"It is inconceivable to me that anyone would want to compound the present difficulties by piling on more governmental coverage," he said.

The Georgia Hospital Association strongly supports the achievement of the national health priority. Therefore, it strongly endorses the general intent of Senator Talmadge's bill introduced in the 94th Congress, the revised legislation prepared for introduction in the 95 Congress, and many of its key provisions. But the Association may be compelled to oppose some provisions if they tend to increase government control in the health field.

Direct payment (out-of-pocket) for hospital care only amounts to about ten percent of the average patient's bill.

Even so, every person should be deeply concerned about the Medicare and Medicaid programs, and the efforts now underway to reform them.

They should be concerned because these programs have greatly inflated their health care bills, especially in the hospital. In addition, they have had a direct and massive impact upon the quality and scope of services hospitals are able to provide their community, and will be able to offer in the future.

The programs, however, must be of special concern to some very special publics in our State and Nation. They include:

The owners of business and industry who must pay, in whole or part, health insurance premiums for their employees.

Labor organizations and workers in general who must often forego wage increases in lieu of costly increases in health care fringe benefits at the bargaining table.

State and local government which carries the responsibility for assuring the health and welfare of every citizen, and which must often share the administrative burden of Federal programs.

Opinion leaders, including civic and business leaders, and the news media, who must be able to make informed judgements about programs affecting the overall status of health care in their communities.

This study has been especially prepared for these special publics.

In providing this study, the Georgia Hospital Association recognizes it must accept certain risks.

The complexity of hospital socioeconomics makes certain data subject to misinterpretation and misrepresentation. In addition, some data could reflect adversely upon the Georgia hospital system.

The major concern of the Georgia Hospital Association, however, is to assist its membership in meeting the health care needs of the people of Georgia.

That commitment requires full and open discourse in order that those affected—the people of Georgia—can make informed judgments concerning the future status of their health care system. This paper is offered in keeping with that spirit and intent.

FEDERAL RULES, REGULATIONS, AND GUIDELINES DICTATE ROLE OF COMMUNITY HOSPITALS

The Federal government . . . and state and local government and various agencies acting on its behalf . . . by controlling 40 percent of services rendered throughout Georgia's community hospital system, it effectively controls 40 percent of the system.

Nearly 31 percent of all patients admitted to the system's 20,026 beds in 1975 were beneficiaries of federal health programs. They received nearly 40 percent of all days of bed (inpatient) care provided.

In order to care for these 258,538 patients, the hospitals had to measure-up to strict standards established by the Federal government. Generally, every hospital has to meet these extensive standards, whether it is a small 50-bed, rural hospital, or a 1,000-bed metropolitan institution.

Federal rules, regulations, and guidelines, directly or indirectly dictate how long Federal program beneficiaries can stay in the hospital, what kind of services they will receive, the quality of the services provided, and how much will be paid to the hospital for the care.

These rules, regulations and guidelines are enforced through numerous programs, "systems", and inspections which literally cover every phase of the hospital operation.

Thus, while the Federal government only has direct control over about 40 percent of the hospital's business throughout Georgia, in reality it has de facto control over the entire system.

For example, relatively new laws (Public Laws 93–641 and 92–603) contain provisions to control capital expenditures, telling a hospital what kind of equipment or service it may add or expand, and when. Other provisions have laid the groundwork for uniform rate setting which will tell the hospital how much it can charge for services to any patient.

This Federal grip on Georgia hospitals and others throughout the nation, received its impetus from the Medicare program, enacted in 1965 and implemented in 1966, and the Medicaid program which followed.

Since being enacted, these programs have been supplemented through amendments to the original enabling laws dozens of times, and have been accompanied by entirely new omnibus laws, affecting the entire national health system, such as the National Health Planning and Resources Development Act of 1974 (PL 93–641).

The rules, regulations and guidelines issued by the various bureaucracies charged with administering these laws are too numerous to list.

Studies in individual hospitals show they must report to more than 150 separate bureaus, agencies, departments and organizations of federal, state and local government.

Few people fully understand the pervasiveness of the government influence which has accompanied the increase in Federal spending for health care since 1965.

Between 1960 and 1965, private spending for health care was increasing faster than public (governmental) spending. During that 5-year period, private spending increased 8.3 percent compared to 7.1 percent increase in public spending.

But between 1965 and 1974, private spending only increased 17.5 percent while public (government) spending increased 37.4 percent.

As the government's share of the national health bill has grown, so has its concern over its ability to pay for the benefits or services promised as established by Federal statutes.

The health care system was handed inequitable (and often unworkable) price-fixing rules and regulations.

While some price-fixing efforts have been successful in reducing the amount the government must pay for the care of its program beneficiaries, they have greatly inflated the hospital bills of patients not subsidized by federal programs.

These inequitable federal price-fixing rules and regulations have often been imposed upon hospitals on the basis of generalizations which cannot be factually supported: The government pays "cost plus" for the care of its patients; that federal payments unfairly subsidize care for non-federal patients; that hospitals are generally inefficient and wasteful, and that the hospital system is reaping huge "windfall profits" as a result of the federal largess.

The U.S. Congress does not entirely agree with these generalizations, most often emanating from the Executive branch of government.

As a result, reform of the Medicare and Medicaid program is felt by The Congress to be an absolute necessity before any further expansion of federal health care programs can take place.

The Georgia Hospital Association agrees, and this study explains why.

COMMUNITY HOSPITALS HAVE CHANGED; THEY'RE REALLY HEALTH CENTERS

Most people think of a hospital as a center for short-stay, acute care; a place where you go when you're seriously ill or injured. It is. But in the past decade it has become something more.

For example, in 1975 the State's 153 community hospitals cared for 804,401 bed patients (inpatients).

But they also cared for another 3,527,344 patients on a "walk-in, walk-out" (outpatient) basis. That means that for every three patients admitted to beds, the hospital cares for 13 patients on an outpatient basis, generally through the "emergency" department.

Studies show that more than 70 percent of all patients treated in the hospital emergency department are not suffering a true medical emergency. They require "primary care", like you receive in the doctor's office.

Thus, hospitals have become major primary care centers as well as acute care centers.

This new role for hospitals is growing rapidly. There was only a 16.2 percent increase in admissions to beds, from 1969 to 1975, while the number of outpatient visits increased 60 percent.

That's not the whole story about the changing role of the hospital, either.

Since 1965, the health care field has been in the midst of a major scientific and technical revolution, with new "space age" technology becoming available faster than the hospitals' ability to implement it.

Much of this new technology is exceedingly expensive; so expensive it cannot be afforded by many health organizations and practitioners. As a result, diagnostic medicine is more and more being centered in the hospital, rather than the doctor's office. So now hospitals are caring for entirely new categories of patients in addition to the acutely ill or injured.

Georgia community hospitals now care for the "worried-well" people who want to find out if something might be wrong, and people with troublesome, but not disabling, symptoms who need to find out what is wrong.

Georgia hospitals in essence, are now true community health centers, providing a full-range of medical care.

Provision of this new and improved kind of care has been costly. In 1969, the average hospital could provide an adjusted patient day (APD) of care at a cost of $53.16. In 1975 the hospital's expense per APD had risen to $121.83; a 129 percent increase.

(Adjusted Patient Days: The primary measurement of a hospital's service. It is the aggregate of inpatient (bed) days of care provided, plus an estimate on the volume of outpatient service equated to inpatient days in terms of level of effort.)

HOSPITALS CREATE MORE THAN $2.5 BILLION OF CASH FLOW IN GEORGIA'S ECONOMY EACH YEAR

The significance of the community hospital system to the State's total economy is probably less well understood than its service characteristics.

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In 1975, the net worth of the 153 community hospitals was nearly $1 billion.
They hired nearly 50,000 full-time employees and paid out wages and salaries totaling $366,755,000. That's an average wage of $7,341.

In addition to this payroll expense the hospitals spent another $346,158,000 for supplies, goods and services purchased in large part from the local economy.

Economists estimate that each dollar pumped into the economy by a business like a hospital multiplies itself four times.

This means hospitals create more than $2.5 billion of cash flow in the Georgia economy each year, making the Georgia community hospital system one of the most important economic units in the state.

The significance of this data should not be overlooked by those concerned with the economic well-being of the state. A major recession or depression in hospital economics could well trigger one throughout the entire economy or, at the least, seriously affect the total economy.

It may not be an overstatement to say that the economic well-being of all Georgia citizens is at least partly dependent upon the economic well-being of their community hospital system.

UNIFORM APPLICATION OF FEDERAL RULES INEQUITABLE; HOSPITALS ARE NOT ALL THE SAME

One of the perils of federal control is that it is applied uniformly, with little or no regard to the size, ownership and location of individual hospitals.

Thus, these "uniform" federal rules, regulations and programs often harm some institutions while not harming others.

The federal government insensitivity to the unique characteristics of individual hospitals cause serious communication problems.

For example, data from the federal government pertaining to health identifies the hospital industry as a homogeneous, unitized system. As a result, people who read this material about hospitals are encouraged to persist in that erroneous belief all hospitals are pretty much alike.

An examination of the Georgia Community Hospital System shows how erroneous this concept is.

The following table shows the different kinds of general ownerships of our hospitals.

Ownership	Number	Total (percent)	Beds	Total (percent)
Non-Government (not for profit)	26	16.9	4,618	23
Investor owned (for profit)	21	13.7	1,923	9.6
State and local government	106	69.3	13,485	67.3
Total [1]	153	100.0	20,026	100.0

[1] Percentages will not equal 100 if added due to rounding.

Immediately apparent from this table is the fact that the Georgia Community Hospital System is not, by and large, a profit-making industry. Less than 10 percent of the state's community hospital beds are located in profit making institutions.

By law all non-profit institutions must return all excess revenue over expense (operating margin) to the institutions.

The accumulation of a profit by an investor-owned institution, however, must be vigorously encouraged. These institutions are crucial to the service capability of the state's hospital system. Individuals and organizations which make available risk capital to make possible the availability of a local hospital are entitled to an adequate return on their investment.

The table also shows that an exceedingly large percentage of the state's community hospitals are owned by state and local government, generally operated through a hospital authority.

While 69 percent of all community hospitals in Georgia fall into this category of ownership, only 30 percent of the nation's total community hospitals are owned by state and local government. The average for the Southeast Region is 35 percent.

The following table shows the composition of the GCHS according to size, and shows changes over a three year period:

Bed size	Hospitals 1972	Hospitals 1975	Hospitals Percent change	Beds 1972	Beds 1975	Beds Percent change
Total	145	153	5.5	17,870	20,026	+12.0
6 to 24	4	4		84	85	+1.0
25 to 49	50	46	−8.0	1,863	1,768	−5.1
50 to 99	38	42	+10.5	2,385	2,704	+13.3
100 to 199	26	28	+7.6	3,642	3,970	9.0
200 to 299	12	15	+25.0	2,925	3,600	+23.0
300	15	18	20.0	6,971	7,899	13.3

FEDERAL PROGRAMS PAY LESS THAN HOSPITAL'S FULL FINANCIAL REQUIREMENTS, SO OTHERS PAY MORE

As any businessman knows, the cost of doing business is not the cost of staying in business. Every business—even hospitals— must have an excess of revenue over expense.

In the hospital business, this "extra" money is called the operating margin, or "provision for progress", and its significance will be explored later in the study.

The essential point is that paying the hospital just on the basis of its cost of providing care does not meet its full financial requirements.

This is why Congress specified that the government would reimburse hospitals on the basis of costs so long as they were reasonable.

Unfortunately, Congress did not define "reasonable." This has been left to administrative interpretation through rules and regulations governing reimbursement.

Our study shows that the average cost to the hospital to provide a patient a day of care in 1975, or its equivalent in outpatient care, was $141.82.

This expense per adjusted patient day is lower than the average in the Southeast region, and nine percent lower than the national average.

The state's community hospital only received an average payment of $114.52 for each day of care provided to federal program beneficiaries, which is 6 percent less than the average cost to the hospitals.

Non-federal patients, on the other hand, paid an average of $147.69 for a day of care, which is 21 percent above the average hospital's expense per day.

Here is how this "two class" pricing system came about:

The federal agencies stated that it was not reasonable for their programs to pay any costs not directly associated with the care of their patients. Consequently, they did not pay a fair share of the hospital's cost for research, education, expansion and modernization, and a hyriad of other hospital financial requirements. Proportionate payment was not forthcoming for the hospital's expense for bad debt and charity care; so-called "free care" rendered to those who will not or cannot pay some or all of their bills.

So hospitals have been forced to inflate their charges to other patients to make up this federal underpayment.

Here is why the payments by non-federal patients are so high:

Seventeen out of every 100 patients in 1975 could not or would not pay their bills. Theoretically, the remaining 83 patients should have helped pay this "free" care expense through proration.

However, 31 of the patients—those under Medicare and Medicaid—do not share in these expenses. Thus it was left to the remaining 52 "regular" paying patients to carry the full financial burden.

Stated another way, if all patients could have been billed equally and equitably, the average payment from paying patients in 1975 would have been $132.16.

To have achieved this equitable patient care payment, federal program beneficiaries would have had to pay about 15 percent more and the regular paying patients about 11 percent less.

As it turned out, however, the average payment from all patients only amounted to $112.29, which was eight percent less than the hospital's actual cost. This figure of $112.29 takes into account the 15 percent of patients who did not pay anything.

This illustrates a crucial point. Contrary to the widely held belief that hospital charges are excessively high and result in huge overpayments, charges for services to patients are in reality too low.

Revenue from services to patients did not pay the total operating expense of the Georgia community hospital system in any year during the 1969–1975 study period.

In 1975 the average hospital's net patient revenue fell short of meeting operating expense by $368,438.

The total deficit in patient revenue for all 153 community hospitals amounted to $56,371,014.

The average hospital was successful in overcoming this deficit by obtaining an additional $498,484 in other income; a total of $67,295,340 for the 153 hospitals.

Much of this income came from local government stipends—often provided in the form of lump-sum appropriations. But the bulk of it came from hard work by hospital management in the form of endowments, gift shops, cafeteria sales, fund raising efforts, and other ways of raising funds.

In other words, while hospitals find themselves being condemned for "inefficient and wasteful" management, it has only been the resourcefulness of hospital administrations that has kept the system from going bankrupt.

FEDERAL UNDERPAYMENTS HAVE SEVERE FINANCIAL IMPACT ON SMALL HOSPITALS

The most severe ramifications of federal underpayment will be found in smaller hospitals, generally under 100 beds in size.

The percentage of Medicare and Medicaid patients will be much higher in smaller, rural hospitals, often running 50 percent or more.

As a result of the higher percentage of federal patients, the small hospital has fewer regular paying patients among which to prorate the losses encountered in caring for the federal patients. In addition, the smaller hospitals find it much more difficult to pay for many services hospitals must provide.

Some services are "marginal" in terms of patient utilization and revenue producing capability because of low volume of activity and must be "cross subsidized" by revenue from more lucrative services, or by nominal "mark-ups" to all patients.

Larger hospitals can more easily support these costly services because they have a higher volume of patient utilization.

For example, an expensive x-ray machine in a 50-bed hospital may only be used ten times a day. But in a 500 bed hospital it could be utilized to maximum capacity. Thus, revenue derived from x-rays in the large hospital would be substantial, while the small hospital may show a deficit in its x-ray department.

But both hospitals must have this piece of essential equipment.

Regardless of the cost to the hospital to provide this equipment, the government will only reimburse what is reasonable as determined by "profiles," rather than on the basis of the true cost to the individual institution.

Small hospitals, generally being located in rural areas, also must live with the reality that the people they serve generally have a smaller income than urban residents. Thus, they are likely to have a higher percentage of people who cannot pay their bills.

Again, the Federal government will not pay its full share of these uncollectible debts.

Local government, supported by a smaller per capita tax base, also finds it more difficult to fully support or to pay a reasonable stipend to its local hospital to cover the cost of care provided to non-paying patients.

Realizing that their economic salvation lies in increasing their patient volume, many small hospitals are expanding both facilities and services to attract new physicians and more patients.

Others are quietly going out of business.

The result is that smaller hospitals are getting smaller, and the large larger. Ironically, this is happening while the Federal government is spending billions to correct the maldistribution of health care services, particularly in rural areas.

The most realistic solution is not massive spending through a massive new "health planning" bureaucracy.

The solution largely lies in the relatively simple process of reimbursing hospitals on the basis of their full economic needs, and not according to unrealistic and inequitable formulas applied equally to all hospitals, regardless of size, ownership and location.

THE MYTHS CONCERNING HOSPITAL INEFFICIENCY AND WASTEFULNESS

As we've already shown, Georgia's community hospitals are not accumulating large "windfall profits" or excessive financial reserves from caring for patients.

In fact, they are losing money from patient care.

This raises the question as to whether that loss is due to inefficient management.

One common point of criticism is the "cost of maintaining a hospital bed."

Critics will divide a hospital system's total operating expenses by the total number of beds provided, the result purportedly being the "cost of maintaining a bed." The figure would amount to $35,500 for Georgia community hospitals in 1975.

They then look at the system's occupancy rate which, in the case of the GCHS, was about 70 percent in 1975. The lowest level in the last 4 years.

Since 30 percent of the beds were unused, that means the GCHS maintained about 6,000 empty beds at a total annual cost of about $21.3 million, according to this fallacious reasoning.

There are several reasons why this kind of reasoning is wrong.

First, a hospital bed is not a hospital bed. Different numbers of beds are reserved for different kinds of patients, and in many instances laws and sound medical practice prohibits "mixing" patients.

Thus, if the demand for obstetrical beds suddenly declines during this month, empty beds simply cannot be converted to general surgery beds. Surgery patients require a different kind of nursing care than do obstetrical patients, obviously. So staffing patterns would have to be altered, as well as the supply system.

And what if the need for obstetrical beds suddenly increases?

To allow for peak demands for different kinds of services, hospitals must attempt to maintain a reserve of different kinds of hospital beds above what is normally used. And there is just no way you can predict when that peak demand will occur, or how large it will be.

This is why planners say a hospital must maintain a 15 percent bed reserve, although this 85 percent occupancy figure has never been established through any scientific study.

But the Georgia Community Hospital System only showed a 70 percent occupancy rate during 1975. Is this an indication of poor management and inefficiency?

Not at all. In fact, the lower than average occupancy rate is a sign of above-average efficiency when related to the average length of stay.

Finally, it must be remembered that the modern community hospital provides more than bed care. For every three patients treated in a bed, the hospital cares for 13 on an outpatient basis. So not all the hospital's operating expense can be allocated to bed care.

In comparing the number of community hospital beds provided in Georgia with the national average, along with admissions and patient days of care provided, we begin to see that the GCHS might be a victim of its own efficiency, in regard to lowering the cost of hospital bed care.

Following is the comparison:

Beds per 1,000 population:	
United States	4.4
Georgia	4.1
Admissions per 1,000 population:	
United States	157.0
Georgia	163.0
Patient days per 1,000 population:	
United States	1,217.0
Georgia	1,042.0

In examining this comparison, we see that Georgia provides fewer beds per 1,000 population, but admits more people, and keeps them a shorter time.

In recent years, most knowledgeable students of the hospital system have concluded that hospital expense can most easily be reduced (1) eliminating the need for hospitalization through better primary and preventive care, and (2) by reducing the amount of time a patient must stay in the hospital, and eliminating unnecessarily long stays.

To see the effectiveness of this approach, we only have to calculate what would have happened in 1975 had Georgia Community hospital patients stayed in the hospital as long as the average length of stay (ALOS) for the patients nationally.

The ALOS for Georgia in 1975 was 6.4 days. Nationally it was 7.7 . . . 1.3 days higher.

Had the 804,401 patients admitted to Georgia hospitals stayed an extra 1.3 days, they would have required another 1,045,721 days of care.

At a cost of about $122 per day, this means the operating expense of the Georgia Community Hospital System would have been about $127.6 million more during the year.

This is why the Federal government has launched an all-out effort to reduce the average length of stay through new laws and regulatory programs.

If we accept the validity of this approach in measuring the efficiency of a hospital system, then we must conclude that the Georgia system is among the most efficient in the Nation.

The ALOS in Georgia during 1975 was 1.1 days lower than the average for all states in its region, and 1.3 days below the national average.

This very low ALOS (44th lowest in the nation) does much to explain the low occupancy rate of available beds.

Georgia's 20,026 community hospital beds can provide 7,309,490 days of bed care per year. In 1975, they only provided 5,133,510 days; an average occupancy of 70.2 percent, which is five percent lower than the national and regional averages.

But had the 804,401 patients admitted to Georgia hospitals during 1975 stayed in the hospital as long as the average patient in its region or the nation, its occupancy rate would have been 85 percent which is considered optimal even by the harshest hospital critics.

So here we find a classic dilemma. The more efficient our hospitals become, the more subject they become to criticism that they are inefficient and wasteful because they "have too many beds."

Even though the data shows Georgia community hospitals are doing an average job of containing costs through reduction of the patient stay, they are still subject to other criticisms especially in regard to labor costs.

Critics delight in making the unsupported generalization that hospitals are wasteful and inefficient when it comes to the use of human resources. . . . They correctly point out that hospitals are extremely "labor intensive" with more than 50 percent of their operating budgets being allocated to wages and salaries.

Reduce the labor costs through more efficient management, they reason, and you'll dramatically reduce, or at the least, contain hospital costs. This is exactly what Georgia hospitals have done.

Payroll costs, as a percent of total operating expense, have decreased from 59 percent in 1969 to only 51 percent in 1975—a 13.6 percent decline.

Stated another way, had the hospitals not improved their worker productivity, labor expense could have been 13.6 percent higher, adding nearly $50 million of additional expense to the system. Another factor is the higher costs for medical equipment, supplies, liability insurance, utilities, etc. Ironically, our hospitals have been able to achieve this record in the face of national legislation which has added significantly to labor costs. In recent years, hospitals have become subject to Taft-Hartley laws, permitting collective bargaining (and strikes) in hospitals. Since 1965, hospitals have been included under the federal minimum wage laws. The amount of Social Security money hospitals must pay in behalf of employees has risen dramatically. Finally, when we compare the financial aspects of a 1975 day of care in a Georgia community hospital with the averages for Georgia's region and the nation, we see that, on the average, Georgia hospitals provide a day of care at less expense, charge patients a lesser amount, and end up with less net total revenue.

Even so, the operating margin per adjusted patient day of care is higher than the average for its region and the nation.

This can hardly be construed as a sign of inefficient management. To the contrary, it is proof of above average managerial efficiency.

IF GEORGIANS WANT MORE AND BETTER HOSPITAL CARE, THE COST OF THAT CARE MUST INCREASE

In considering the "rising cost" issue, most people make two basic assumptions: (1) the cost of hospitalization is too high, and (2) the rise in the cost of hospitalization must be stopped or, at the least, slowed.

Because the first presumption is totally erroneous, the second is exceedingly dangerous. Here is why:

Comparing the cost of a day of care in 1975 with the cost for 1969 (or any other year) is not only meaningless, it is totally invalid.

The U.S. Department of Health, Education and Welfare in its publication THE SIZE AND SHAPE OF THE MEDICAL CARE DOLLAR: CHART BOOK/ 1975 says: "Rising prices (inflation), population growth, increased use of services, and technological changes have stimulated growth in the personal health-care dollar."

It then explains how the health-care dollar has changed between 1950 and 1974:

Of this 24-year rise (in health care costs)

About 46 percent can be attributed to higher prices . . .

Another 15 percent . . . is the result of population growth . . .

The remaining 39 percent is due to the public's increased use of services and to a wide variety of lifesaving, but often costly medical techniques.

In another publication HEW minimizes the validity of measuring hospital costs through the Consumer Price Index (CPI) because it merely measures the increases in a few hospital prices without regard to improved quality (value) of the services rendered.

A new, more sophisticated method of measuring hospital costs developed by the American Hospital Association shows that when you take into account improved intensity (scope of services) and quality, and factor these elements out of the rise in prices, the cost of hospital care has increased no faster than costs in the general economy.

The entire issue, however, can best be understood through this question: A day of care in the average Georgia community hospital cost less than $50 in 1969 and more than $112 in 1975. If you had your choice, would you prefer a day of care at 1969 prices with that year's intensity and quality of care, or would you prefer a day of care at current prices with its current level and quality of care.

If the people of Georgia, and the rest of the nation, want more and better hospital care, the cost of that care must (and inevitably will) increase.

The capacity of the hospital industry to institute new (and often exceedingly costly) life and health-saving technology appears limitless, while the ability or willingness of people and/or their governments to pay for such care appears limited.

Thus, we are confronted with an apparent dilemma. How much hospital care is enough, and what are people willing to pay?

We cannot answer that question. Only the people of this nation can do that. But in answering this question, it must be remembered that ultimately a hospital . . . any hospital can only provide the scope and quality of care that its income will permit it to provide.

And there is no "free" care. Somebody, in some form, must pay . . . directly, through health insurance premiums, through "hidden" subsidy, or through direct or indirect taxation.

The Federal government has experimented with arbitrary price controls, and similar action is being contemplated.

You need to know the consequences of these kinds of actions in the past, as they have affected your community hospital system.

A SERIOUS PROBLEM: NET PATIENT REVENUES ARE NOT PAYING HOSPITALS' OPERATING EXPENSES

The expense of providing hospital care, and the resultant prices to patients, have more than doubled between 1969 and 1975.

We also see that the gap between net revenue from patients and total operating expense has widened considerably, while the difference between expense and net total revenue has narrowed.

The inability of net patient revenue to pay operating expense is very serious. Between 1969 and 1975 the deficit between net patient revenue and total operating expense has grown 177 percent ($27.5 million deficit in patient revenue in 1969 versus $76.3 million in 1975).

This extremely large and rapid growth in the inability of patient revenue to meet operating expense is largely attributable to the Federal government's control of the wage/price structure during 1971 through 1974 under the Economic Stabilization Program (ESP).

The system's operating margin began to drop in 1971, the year in which the ESP wage/price "freeze" was imposed on hospitals.

It declined more in 1972 and then leveled out during 1972–1973 fiscal years when the total economy was subject to the wage/price freeze.

Then the system's operating margin dropped sharply, as reflected in the 1974 data. This reflected the disastrous hardship encountered by hospitals under the final phase of ESP. For more than a year, the prices hospitals could charge were strictly limited by ESP, while the rest of the economy was "decontrolled".

The prices hospitals had to pay for all goods and services escalated rapidly, but they could not raise their prices to compensate for the increased cost of doing business.

Consequently, their operating margin almost vanished. Numerous hospitals were forced to expend cash reserves which had been set aside for improvement of their service capability.

Others had to borrow heavily to stay in business, or curtail services to reduce their overhead.

The hardship is illustrated by the consistent decline in adjusted patient days until, in 1974, the system showed its first year-to-year decrease in service in their contemporary history.

Service capability is directly related to the hospitals' operating margin. As the operating margin decreases, so does their service.

It is true that hospital charges increased dramatically in 1975, and the increase is reflected in an improved operating margin for that year. But even with the "catch-up" increase in charges, the operating margin has not gotten back to its pre-ESP levels, nor the 7-year average.

Why is an adequate operating margin so essential? Because it is the system's "provision for progress" which enables it to provide its patients the intensity and quality of care they need.

Has the decline in the operating margin really hurt the quality of care provided by the Georgia community hospital system?

The answer to that question is that the scope of services offered by the GCHS is now behind that offered in its region and nation.

Federal price-fixing rules, regulations and programs do lower or contain the rising cost of hospital care. But they also lower the overall quantity and quality of care offered.

Is this what the people of the State of Georgia, and their elected representatives in government, want. Probably not.

But if they are concerned about preserving the current level of health care services the community hospital sytsem can provide for them, then they need to understand the financial needs of their hospitals and urge their elected officials to see that those needs are met.

Decisions are now being made at the state and federal level which could make the impact of the Medicare decade insignificant by comparison.

Those decisions will affect every Georgia citizen, and they therefore must be made in light of informed public opinion, for acquiescence through ignorance could well spell the collapse of our community hospital system.

Mr. BACON. Senator Talmadge, Senator Nunn, as administrator of Hamilton Memorial Hospital, it is a privilege to present these comments today.

The evolution of Hamilton Memorial Hospital from a 73-bed general care hospital to a 220-bed regional center shows the response of the hospital to changing community needs and the awareness and support of the community for the necessity of these changes.

Hamilton Memorial Hospital is located in Whitfield County, with a population of approximately 60,000, and serves an area of approximately 100,000 population. This area ranges from Whitfield to the rural outlying areas of Gilmer. As a regional center, the hospital meets not only the needs of the population which supports it through taxes, but also the requirements of the outlying rural patient who may or may not have funds to pay.

As an indication of the services required, almost 40,000 patients were treated in our emergency department this past year. Seventy percent of these patients were nonacute clinical patients. The activity in the emergency department has required full-time staffing of qualified medical personnel in order to meet the patient demands.

The tax base of surrounding counties shows a significant relationship for services provided at our facility. Last year $97,000 of indigent care was provided by Hamilton Memorial for patients from just one neighboring county. The question naturally follows, in reference to this indicator, who is financially responsible for this care? This particular county has a population of 17,000, 27 percent of whom are below poverty level.

This is indicative of problems concerning access to care. Our emergency department is vital to the area, not only as a trauma center for acute emergencies but as an entry point into the health care system.

The hospital, in providing its hospital services, must address the needs of all of these type patients. Being more than a community hospital, we experience problems regarding indigent care that are comparable to large, urban facilities.

Conflicting expectations of the Government and the public have caused a dilemma. On one hand, we are subject to the pressures of the public demand regarding the style and manner. On the other hand, we are subject to a host of governmental regulations, which in many instances increase costs beyond any conceivable cost-benefit ratio. Fulfilling the needs of the using public within the framework of governmental regulations, regulations that not only dictate many aspects of the physical plant, but also the type of personnel used, and their rate of pay, add tremendously to the cost of services provided. This, coupled with a general inflationary trend, fueled by a pattern of Federal deficit spending, causes hospital costs to increase, thus bringing hospitals under attack from both the using public and governmental agencies.

Other areas affecting hospital costs have experienced increases that cannot be explained by general inflation alone. Our utilities cost increased 72 percent in 1976 and 41 percent in 1977. Our malpractice insurance costs almost eight times as much as it did 5 years ago.

As an indication of the effects that uncontrollable costs will have on Hamilton Memorial, following are three items and the corresponding annual increased cost they will occasion: Cost of the proposed minimum wage increase, assuming that the minimum wage is increased to $2.65 per hour, will cost our facilities $504,000 annually. Cost of unemployment compensation tax, $115,000. Increase in FICA tax effective January 1, 1978, $10,000, for an annual cost of $629,000.

This increase of $629,000 in our operating expenses represents only three items, but yet adds 4.56 percent to our cost of operation that we have no control over.

Acknowledgment of these uncontrollable costs by both the public and the Government is necessary before a realistic analysis of health care costs can be made.

Now comes the administration's Cost Containment Act. The problems posed by the bill for our hospital will demonstrate how unrealistic it is when applied to an actual situation.

Our budget for fiscal year 1978, which in our case is October 1, 1977, through September 30, 1978, has recently been approved by our governing board. It is felt to be a sound, objective document.

Although the budget projects a net loss of $432,000, our concern for the high cost of health care has led us to adopt a budget without any increase in rates and fees. This projected $432,000 represents 3.5 percent of our total operating expenses. We hope to minimize this

loss through continuing cost control efforts, and plan to fund any remaining deficit from our limited reserves rather than to raise rates.

Provisions were not made, however, for the now pending increase in the minimum wage. If the pending increase in the minimum wage is implemented, an increase in rates will be unavoidable.

Nor did our budget envision passage of the administration's Cost Containment Act. If the revenue limitations proposed therein are implemented, we will be denied $493,000 of the revenue projected. This $493,000 added to the projected loss of $432,000 will simply be intolerable from the standpoint of fiscal responsibility, and can only work to the long-range detriment of the patients we serve. It is our belief that implementation of the administration's proposal will do irreparable harm to the Nation's hospitals. We urge its abandonment.

What would be our recommendations for realistic cost containment? First, the problem of malpractice professional liability insurance, which we have, must be addressed within a framework that will afford necessary protection for the patient, and at the same time allow the physician to practice medicine as his judgment dictates without fear of ruinous malpractice suits. A tremendous reduction in the use of ancillary services would be an initial direct result.

Second, the problems of reimbursement methods must also be addressed. The current form of retrospective reimbursement, with its allowable cost for Government-sponsored patients and full charges by others is filled with inequities. A system of State budget review boards, operating similarly to public service commissions which govern public utilities should be established to accomplish prospective review and approval of hospital budgets and charges.

Third, control of overutilization could be established through legislative action by requiring that every patient—with certain exceptions—should share "out of pocket" in the expense of health services beginning with first dollar costs. Without question, first dollar coverage for third-party payers leads to overutilization, and sometimes frivolous use of health care services.

Our fourth recommendation holds greater potential for the reduction of health care costs than any of those mentioned previously, and concerns reorienting the public's attitude on health. The current prevalent attitude appears to be that the medical profession has the ability to recover one's health no matter how the body has been abused or neglected. Health protection or health maintenance is not only more logical in that it is preventative in nature, but it is also less expensive than health recovery after the body has succumbed to abuse, neglect, or disease.

These four recommendations would do much to eliminate the inequities and injustices prevalent in the current reimbursement systems, and would reduce costs of nonessential services which are currently occasioned by first-dollar coverage by third-party payers and the defensive practice of medicine by physicians.

Any type of cost control program must take into account at least four components of health care delivery systems and their responsibilities. The four components include: An awareness on the part of the patient of his responsibility for preventative health care; the role of the Government in promulgating regulations only after a cost impact has been accurately determined. Congressional mandates implemented through the regulatory process must continue to be monitored to insure that the

original intent of the legislation is not lost; awareness by the physician that his role and his active participation on an active cost control program is imperative; continued hospital awareness with management emphasis on cost control.

Only through the effective integration of these four components can an efficient health delivery system be established that will provide for the accessibility of quality patient care to all individuals who need the care while, at the same time, keeping the cost within bounds that permit all segments of the population its use.

Thank you, Senator Talmadge and Senator Nunn for allowing me to make these comments.

Senator TALMADGE. Thank you, Mr. Bacon.

Mr. Pinkston.

STATEMENT OF J. W. PINKSTON, JR., ADMINISTRATOR, GRADY MEMORIAL HOSPITAL, ATLANTA, GA.

Mr. PINKSTON. Senators, I would like to include a statement from Mr. Damon King of the Medical Center of Central Georgia in Macon, in the record. He asked that we bring it to give to you, and I would like to do that, please, sir.

Senator TALMADGE. Without objection, it will be inserted in full.

Mr. PINKSTON. And one copy of the interim statement of the Commission on Public Hospitals, which has been prepared by Mr. Arthur Hess.

Senator TALMADGE. Without objection, it will be inserted in full.

[The statement referred to follows:]

Government Ediot: 1978 Effects on Cost of Operating Our Hospital

1. Increase in minimum wage by 35¢ per hour: Approximate annual cost	$1,000,000
2. Unemployment compensation for hospital employees: Approximate annual cost	250,000
Total increase in annual cost	1,250,000

NOTE: The above converted to daily room and general services charge will require a rate increase of approximately $14 a day. Why do health care costs continue to escalate!!

COST CONTAINMENT PROGRAM EFFECTS

Statement from Elmer Staats, Comptroller General. Ceiling affect agencies in several ways:

"Essential work is deferred or cancelled and work backlogs are increased.

Imbalances between clerical and professional staff and shortages in certain skills occur.

Managers become more concerned with the number of persons actually employed on one particular day than with getting essential work done through the more efficient and economical use of people.

If agencies cannot directly hire enough people to accomplish programs . . . they must pay employees overtime or obtain the services of additional people indirectly through contracts with private institutions and state and local governments.

These people are neither included in employment ceilings nor counted as part of the federal work force, but must be paid from federal funds.

The report added:

Although employment ceilings may be a tool to assure that concerns about the total number of federal employees are met, ceilings are at best an inferior substitute for effective management. . . ."

Why Hospital Costs Have Risen

(By Damon D. King, administrator, Medical Center of Central Georgia, May 3, 1977)

Few Americans realize why hospital costs have risen more rapidly in recent years than other segments of our economy. There are many reasons why this has happened. However, I would like to point out four that go beyond normal inflation, which has effected every business, and have had the greatest effects upon this escalating cost.

First, the catchup period that the health industry has had to go through in wages and salaries in relation to private industry is probably the largest single factor involved in the escalating cost of health care. If you will recall, back in the early part of the century and up through the mid-1960's, health care workers, and hospital workers in particular, worked for wages that were in a range of one-third to one-half of that of the industrial community. Starting in the mid-1960's, this gap began to close rather rapidly. This was due primarily to 2 factors. One was the government passing the minimum wage law for hospitals, and the other was the demand by registered nurses and other technical and non-technical hospitals workers for a greater portion of the wage and salary dollars flowing through our economy. Since hospital costs are made up about sixty percent by personnel costs, you can readily see that during this catchup period, which continued through 1977, hospital costs were forced by this pressure to escalate at a greater rate than the other segments of our economy.

Second, hospitals and the health industry both have lived with a technology explosion in recent years. It is a terrific asset for those of us who use the medical facilities in our country to have these advancements available to us. However, development and purchase of these technologies is extremely expensive. Ironically, technological breakthroughs in the medical field generally mean greater expense to the patient and/or the user rather than decreased expense, as in the industrial community. As most of us have experienced in our career, when an industry experiences a technological breakthrough it means their cost of production goes down, i.e., development of a machine that produces goods at a much faster rate with a resulting layoff of personnel and a decrease in the unit cost of production. In the health industry, the opposite is generally the case. For instance, when a technological breakthrough comes in the health industry, it generally means the hiring of more people who are more highly-trained to deliver the care. The classical example of this is the I.C.U. concept for coronary, medical, surgical and other type patients that has come about in the last twelve to fifteen years. This is a terrific breakthrough. However, it meant the hiring of more highly trained people at a greater cost, in greater numbers, to deliver this service to our community. This development alone has saved thousands of lives during its short history. After all, that is what our business is all about.

Number three is obsolescence. All industries deal with this cost problem. In the health industry, it has been more acute in recent years because of the technological explosion. It seems that in recent years the development of new products and techniques have been so rapid that each year there is a newer piece of equipment or a better technique for doing a great many medical procedures. This, of course, adds cost when a hospital attempts to keep pace.

Fourth, our federal and state governments have added greatly to the cost of delivering health care in our country through passage of regulation after regulation. Several dollars of the cost required to render a day of care to a patient is a direct result of government regulation. We have already reached the point of having one regulating group checking on another regulating group and every indication is that it is going to get worse.

The above discussion has pointed out four specific areas causing the cost of hospital care to rise at a more rapid rate than other segments of our economy. There are other factors contributing to this problem. However, space does not permit their discussion.

It needs to be soundly communicated to all potential users of hospitals across the country that the president's proposed 9% caps on the cost of hospital care in its reported form simply will not work. First of all, it does not take into account factors such as described above. Secondly, it simply violates the known fact that it is impossible to control prices and wages on one segment of the economy and not control prices and wages on all other segments of the economy. After all, the hospitals of this country go to the same marketplace for the purchase of goods and services as do the industrial companies across the land. Third, it has

been shown over and over again that wage and price controls in a free enterprise system simply do not work. In fact, there is every indication wage and price controls (which this is without question), are counterproductive in their results.

The government should control its outlay of funds for health care by controlling the number of services and the volume of service government will pay for rather than using a shotgun approach of placing caps on expenditures in general for health care. The caps will not reduce the demand or expectation of the individual citizen for health care. Certainly, we must determine how much health care we can afford for ourselves in the U.S. When this is determined, we then must limit volume of service and not the quality that will be provided each individual at government or company expense. The placing of arbitrary caps on how much the cost of health care can rise in any one year is simply an inappropriate way to address this problem and can only result in lower quality of care in the long run.

STATEMENT OF WINFIELD C. DUNN, VICE PRESIDENT, PUBLIC AFFAIRS, HOSPITAL CORPORATION OF AMERICA

The purpose of this statement is to provide for the record an account of actions being taken through the private sector to improve the quality and control the costs of health care available to the United States citizen. The uniqueness of our health care delivery system in America, the irrefutable fact that hospitals are businesses and must be operated on a business like basis and the crucial decisions which are currently contemplated at all levels of government, make this hearing and the information provided by participants highly appropriate.

The people of this nation, by word and deed, have clearly expressed their commitment to excellence in health care for citizens from all walks of life. The commitment has been made by health related agencies, organizations, institutions and individuals, as well as by governments at all levels.

More than 7,000 hospitals throughout the United States functioned today as solid evidence of the commitment which has been made. No country in history has achieved as much and in no society can there be found a greater potential for meeting health care needs than in America.

Each hospital is a distinct business entity within an industry which has undergone drastic change in recent years. A hospital stay today cannot be compared to such an event ten years ago. The demand for and quality of service is so different that reasonable comparisons are not possible. This is, in part, because of proven innovations such as intensive and coronary care units, burn units, blood banks, cobalt therapy, nuclear medicine, radiology and a host of other techniques which are now standard services in many hospitals to save and sustain life.

Hospitals have been hit with severe inflationary and regulatory pressures over the past eleven years. Following the passage of medicare and medicaid programs in 1966 government has become the largest single purchaser of health care. Consequently, the health care market, in which each hospital must conduct all aspects of its business, has been increasingly artificial because of government control over both the supply and the demand for services.

The economic plight of providers and consumers of health care is today a national centerpiece of attention. This hearing, predicated upon the concern and commitment of elected public servants, rightly addresses the problem by turning for insight and guidance to those who labor in the health care arena on a daily basis.

We desire a health care system which provides prompt access, high quality, restrains cost, and gives relief to both government and hospitals from the bureaucratic nightmare which besets nearly every aspect of hospital operations.

An analysis of the various forces which affect the health care system suggests that the private sector is capable of solving many of the problems which regulations, skill shortages and costs have conspired to create.

It is apparent that the explosion of health care costs constitutes the real crisis which commands the attention of the public, the medical establishment, our market system and the executive and legislative branches of government at all levels.

No single person or agency is fully prepared to understand the extent of the crisis, much less anticipate its proportions. Yet, because of the nature of our market system for the delivery of health care, practical, effective results are currently being obtained in dealing with the complexities of costs. The same holds true for an ever increasingly higher level of quality of care.

The multiple unit, acute care hospital management companies which have developed over the past decade are producing such results.

Hospital Corporation of America currently operates 93 acute care community hospitals in 23 states. More than 32,000 employees carry out their duties under the direction of management teams whose knowledge and expertise through the development of systems and procedures is continually being upgraded. A number of outstanding management systems and techniques demonstrate the progress that is being made and the knowledge that is available for wide dissemination throughout our health care delivery system.

MANAGEMENT SYSTEM FOR MATERIALS MANAGEMENT

HCA's materials management system provides centralized procurement and control of supplies, equipment, and materials used in each facility. The concept provides for more efficient planning, coordination and control of all supply and equipment needs prior to actual utilization of the materials.

This integrated materials management system provides an organizational arrangement which establishes a single manager with authority and responsibility for policies and actions related to determining the material requirements, acquisition of material, quality level verification, receiving, storing and issuing materials, maintaining inventory records, scheduling materials into use, and disposing of materials which are excess to need.

A quality control program is implemented simultaneously with the materials management system. Designed to measure the quality and effectiveness of the new system, the quality control program also serves as an aid in pinpointing problem areas.

The entire materials management system, along with quality controls, strictly adheres to each hospital's primary objective—to provide services of the highest quality while holding costs of those services to a minimum.

QUALITY ASSURANCE PROGRAM

HCA established a formal quality assurance program in October of 1974 by creating a corporate Quality Assurance Department. Charged with the responsibility of measuring and improving the quality of patient care, this program has three specific goals: (1) To secure the interest and cooperation of several thousand physicians and assist them in seeing that the program results in improved patient care; (2) To develop a data base providing quantitative measures of the desired and actual level of quality care; (3) To document specific improvements in patient care that have resulted from the corrective action steps of patient care evaluation studies.

Since the corporate Quality Assurance Department was created, 1,300 health care professionals, including 450 physicians, have attended workshops on patient care evaluation. Over 1,500 patient care evaluations and 400 critiques have been completed, and positive effects of the program are already apparent. Documentation, especially by nurses, has improved. Innovation and documentation, combining nurses' and physicians' progress notes, has not only simplified data retrieval but has helped foster a team approach to patient care.

An important consequence of the P.C.E. program is the reduction in the time spent by the physicians and nurses in the evaluation process. Additionally, the program has resulted in reduced costs of malpractice insurance.

MANAGEMENT SYSTEMS FOR DRUG DISTRIBUTION

A drug distribution system has been developed which provides quality drug distribution for hospitals of varying sizes. This system: (1) assures the delivery of correct medication to the right patient at the proper time; (2) provides effective control of drug charges; (3) provides accountability for medication; (4) simplifies record keeping; (5) obtains optimum utilization of pharmacy and nursing personnels; and (6) reduces cost through the reduction of drug credit.

This system has been designed to permit the pharmacist to review a copy of the physician's original order prior to sending medication to the floor for administration. Thus the pharmacist utilizes his knowledge to monitor any drug—drug interreactions, drug—drug diet interreactions or drugs that might alter the results of laboratory tests. A patient medication profile is also maintained by the pharmacist so that the patient's complete medication record is readily available.

This system inherently provides an excellent means of controlling medication in the hospital. Further, the charge capturing system is designed so that the patient is only charged for the medication actually administered.

The system is designed to permit each clinical element to be interdependent, therby strengthening relationships. It may be easily revised or modified to meet the individual needs of a particular hospital. By centralization of drug preparation in the pharmacy, a considerable amount of work is removed from the medication nurse thus freeing her for other duties. In hospitals where the system has been implemented, medication errors have been reduced 70 to 90%.

The HCA medication system permits centralization of all drug preparation in the pharmacy where effective controls can be continuously applied.

PRODUCTIVITY REPORTING SYSTEM

HCA has implemented a Productivity Reporting System for the purpose of relating labor requirements to labor utilization. Since no one set of work standards is applicable to every hospital, the system of productivity reporting lends itself to a variety of settings.

In implementing the system, standards are defined by examining the organizations, operations, reporting systems and work activities of each hospital department. To verify the data, random observations of employees are made over a period of time. If there is little or no correlation between productivity calculated and productivity observed, further discussions are held with department heads. A high correlation indicates reasonably correct standards.

With standards established, productivity reports can be generated. Data can be used to establish staffing guidelines, to aid in budget preparation, and to define scheduling systems.

As a follow-up to the Productivity Reporting System, HCA has implemented a Quality Control Program. Quality Control check sheets are designed for each department of the hospital by management. The purpose for the Quality Control System is two-fold: (1) To establish a quality level for performing stated functions and activities, and (2) to monitor the quality of the functions as they relate to productivity.

It is necessary to constantly guard against a situation in which increasing productivity results in a diminishing level of quality.

MANAGEMENT SYSTEMS FOR NURSING SERVICE

HCA utilizes services of full-time registered nurses whose responsibilities include the implementation of carefully developed nursing systems. An individual system for the management of nursing services based upon criteria established within each hospital is the result. The nursing management system consists of Quality Control, Patient Classification and Staff Allocation.

I. Quality control

The nursing Quality Control System is based on the use of objective techniques to determine quality of care on a daily basis. The results are summarized on a daily, weekly, and monthly basis. Graphic presentation of overall quality is thus available for examination.

The Quality Control questionnaire has been designed to pinpoint problem areas in the following categories:

a. patient welfare and safety;
b. patient confort and assessability of immediate needs;
c. patient rooms;
d. patient charts; and
e. nursing units and medication systems.

The categories are weighted according to importance and the overall score indicates the quality of care delivered.

II. Patient classification

The Patient Classification System is designed to provide an objective tool for advanced assignment of nursing care based upon the following five functions of dependency:

a. ambulation;
b. feeding;
c. bathing;
d. continence; and
e. special procedures.

This information is used to assign patients to staff personnel on an equitable and reasonable basis and to insure that each patient receives the amount of nursing care required.

The patient Classification System is comprised of three basic documents:

a. The Nursing Care Plan;

b. The Patient Classification Sheet; and

c. The Patient Condition Sheet.

The Nursing Care Plan is used to record the necessary data for classification of patients. The Condition Sheet is used to record the results of classifications for use with patient conditions in making assignments. The Patient Classification Sheet links the nursing care plan to the Condition Sheet by converting care plan information into objective care requirements.

III. Staffing and scheduling

The staffing and scheduling system is based on the patient classification system coordinated with base care requirements. Patient classification pinpoints only differential nursing care requirements. The basic amount of care which each patient receives, regardless of the dependency, must be determined. The combination of patient classification data and base care requirements are used to produce detailed staffing patterns by units and by shift. Cycle schedules are then drawn up to approximate the staffing patterns as closely as possible and to provide maximum flexibility.

Variable staffing by units is accomplished through the system on nursing care requirements. It involves using personnel from underutilized units in overutilized units. True variable staffing is accomplished by the development of a P.R.N. pool of on-call, part-time people. The corps staff is set at a minimum expected census and the P.R.N. pool is used to cover increases. This method of staffing minimizes nursing costs and staffs. HCA has realized as much as a one and one half hour per patient day decrease by implementing this nursing management system without sacrificing the quality of patient care.

As a final demonstration of the influence and impact of the private sector on prospects for controlling costs, and enhancing the availability of high quality health care costs, consider the following:

Hospital Corporation of America has recently founded The Center for Health Studies, an entity dedicated to conducting pragmatic research into ways of improving the economic effectiveness of health care delivery. Education and training for the people in the health care industry, as well as interested publics, will be provided.

The Center will share selective areas of expertise developed by the Company with responsible groups and individuals. Many of the programs which have significantly contributed to the performance of our 93 hospitals will become available through seminars, media, and consulting services to hospitals and other health care providers. In addition, The Center is designing new programs which we believe will improve the competency of hospital executives, middle management and hospital employees to meet the future demands placed on their performance.

The Center for Health Studies also has been assigned corporate responsibility for research and development. Among the priority research areas is the effective application of technology in hospitals to assure the most productive investment of capital. Major research is also being conducted into the forms of ambulatory health care services which can substantively contribute to lowering health care costs to the American people while offering improved health care more rapidly to the emerging nations of the world.

Other projects include developing techniques by which consumers in business and industry can optimize their investments in health care services to employees through better understanding of techniques for personal health maintenance and for physical limitations. Selective research will also be considered for other organizations interested in health. The future for better health for all Americans is bright, indeed. As we seek solutions to problems, we must be careful to avoid actions or overreactions which tend to put in jeopardy the various aspects of our health care delivery system.

Mr. Pinkston. Grady is operated by the Fulton-DeKalb Hospital Authority, and is a public hospital for the community. The first issue you asked me to talk about was the issue of rising hospital costs. Dr. Richardson has mentioned the three items that really go to make up the hospital cost increases. The inherent inflation, and that's the first thing that we wanted to show you. We had prepared a chart that illus-

trates how much the prices of typical supplies necessary to run a hospital have increased over 10 years.

Do you have that now in front of you?

Senator TALMADGE. I don't have it here.

Mr. PINKSTON. Here's the chart over here.[1] I thought it was attached to the document. Most of those changes, while that is a 10-year period, you see the fuel oil has gone up 339 percent. To our organization, most of those things have happened in the last 4 years. Those are 1976 figures and there are one or two of them that have made dramatic changes again in 1977. But I just wanted to pick out a few items and show you what the percentage change is.

The next chart compares our 1966 items with 1976. You can see what the salaries were in 1966 in medical care facilities in this community. The minimum salary in this community was 85 cents an hour 10 years ago. Now, this community in the medical field is generally paying, as of the end of 1976, $2.54 an hour, an increase of almost 200 percent. There are just some items listed there.

You will see what has happened to malpractice insurance in 10 years' time. Actually, most of that change occurred in 1974, which showed the increase in postage, in electricity, gas, food, and drugs. Those are just items that I wanted you to see what had happened in this 10-year period.

In addition, we have added a number of specialized facilities during this period, such as an artificial kidney center, a greatly increased psychiatric program, a burn treatment center, many intensive care units, a drug-abuse program, four satellite clinics, a unit to care for high-risk newborns, and a center to care for women with high-risk pregnancies. These services have greatly expanded our ability to save lives and serve humanity, but they also have driven up our operating costs.

Another factor which causes hospital costs to go up is the increased life expectancy of today's Americans.

The next issue raised is the access to health care. I would like to talk about our geographic access and financial access.

One of the most promising developments in health care recently is regionalization. Not every hospital can or should be everything to everyone. Specialized service—such as the treatment of very critical medical emergencies, severe burns, and others I've mentioned a few moments ago—are only economical when used by large numbers of patients.

The answer is to have them available regionally. We are beginning to plan health care on a regional basis through the HSA. The idea behind these organizations should be positive steps toward cost effectiveness in hospital care.

A health care region is where the people are. Here in Fulton and DeKalb Counties, we would have 22 percent of the entire State's population, so we are definitely a region in these two counties.

Geographic access to care at Grady is enhanced by our location in the central city, right in the heart of our two-county health care region. Grady is located at the intersection of three interstate highways. We have good ambulance service. We operate four satellite

[1] Charts may be found in prepared statement on pp. 228–29.

clinics, three in Fulton County, one in DeKalb, which are remote from the downtown hospital. These provide primary care in otherwise medically underserved neighborhoods, where many of our patients live.

These have been open in conjunction with the health departments of the two communities working very closely together, so that we did not have to build new facilities. We had to enlarge and remodel, but new facilities were not required. We have been using physicians and nurse practitioners in these programs. Grady is accessible 24 hours a day to adults and children through its five emergency clinics for medicine, pediatrics, surgery, obstetrics, and psychiatry.

I believe financial access to Grady is good. Our responsibility is to treat the poor of Fulton and DeKalb Counties. Our rates are on a sliding scale, depending on the patient's ability to pay. Even with many patient fees covered by medicare or other third parties, there is a substantial gap between our revenues and expenses. This chart shows this gap. Fulton and DeKalb taxpayers make up this difference between our income and outgo. You will see the green is the medicaid income, the blue is the medicare income, the yellow is the income from patients and third parties, and then the difference is what has to be made up by the taxpayers of Fulton and DeKalb Counties.

This year the two counties are having to put in about $27 million to operate the hospital. In April 1977 we established a cash-in-advance policy in our pharmacy and outpatient clinics for patients who can pay part of their hospital care. Those who can't pay make arrangements with the supervisor. The policy is working well. By far, the greater number of patients have adjusted to it.

There is a real question, however, as to how far local property owners are willing and able to be taxed. We believe that some additional State or Federal relief must be provided for regional hospitals, especially for those who treat a high percentage of the poor or of the near poor. We need a broader base of financial support than local property taxes can provide.

You asked us to address whether Federal Government policies or procedures present any particular problems for hospitals. Beginning in January 1978, Grady and all other public hospitals will be required to contribute to unemployment insurance. This could increase our operating cost between $500,000 and $700,000 a year. We will face an even greater cost increase with the higher minimum wage.

Duplications of inspections and inquiries by Federal and State agencies add unnecessarily to the cost of operating a hospital and must be examined. We need to examine certain provisions of regulations, such as life safety codes, to make sure that they do not force hospitals to make excessive allocation of their limited resources, to guard against situations that might occur, while failing to meet necessary day-to-day requirements for health care.

Another proposal just now in the talking stage would prohibit Federal funds from being used to cover the care of any patient assigned to a hospital room with more than four persons. Grady has a number of eight-bed units. The loss of medicare and medicaid coverage on patients in these units would have a very adverse effect on our operating budget.

I think that it is critically important for rulemakers and others to understand how such measures can have a profound impact on health care costs.

You've invited each of us to state his position on existing or proposed remedies to the problem of rising health care costs, and I'd like to conclude by doing that.

One potentially controllable factor contributing to rising health care costs is overutilization of services. This could be minimized by requiring every patient to pay part of the cost through copayments and/or deductibles. This should be based on the ability to pay. There are some, of course, who are too poor to pay anything, and they should be excluded.

I believe we must move for some kind of budget approval, and rate review commission for all hospitals. I won't say any more about that. That was just covered by the previous speaker.

Next, I believe that health insurance reimbursement mechanism should encourage the use of less-expensive methods of health care delivery. Preventive care and treatment, home health care must be encouraged. The problem of health insurance coverage or catastrophic illness has been mentioned, but I need to emphasize that one more time.

In a recent 2-week period at Grady, we discharged 32 patients whose bills exceeded $5,000. If these figures were projected for a year, it would mean that 2.1 percent of our admissions account for some 13 percent of the total budget. This illustrates the severe problem of catastrophic illness today. There are proposals that could prohibit the use of Federal funds to pay for abortions for poor people. Without going into any of the religious or moral ramifications of this issue, I believe that if such a proposal is adopted, we will again begin treating patients who find it necessary to seek unsafe abortions. This situation will actually serve to increase health care costs.

I presented valid reasons why costs have risen and have stated that regionalization of services can hold these increases down to some extent. I have stressed the need for added assistance because of the taxpayers. We have emphasized the need for rulemakers and others to take full account of the impact that laws and regulations can have on health care costs. I've concluded by presenting the view that I believe could help hold the line on the cost of health care.

Senator TALMADGE. Thank you very much.

Mr. Ridley.

STATEMENT OF CARL RIDLEY, ADMINISTRATOR, GRIFFIN-SPALDING MEMORIAL HOSPITAL, GRIFFIN, GA.

Mr. RIDLEY. Senator Talmadge, at this time, if I may, I would like to just take excerpts from my paper in the absence of having repetition.

Senator TALMADGE. It will be inserted into the record.

Mr. RIDLEY. That's very good. I will take excerpts from it and go back just a moment. I will go back to the beginning of the Hill-Burton program, when at that point in time we were thinking of more hospital beds and equipment, and other supplies that went into this area. In the next 25 years, we have come a long ways, some of which I think

have just evolved. But, there is one thing that hasn't changed from that day, and that's the fact that we can only give what we can afford to pay for. I would like to highlight from my testimony only six areas here that I think is of vital importance as an administrator out in the field of delivery health care.

One area is financial. Second is administration, 3d distribution of the care, 4th the control of it, 5th the scope of the coverage, and 6th the change in the method of care.

I would like to allude first to the financial aspect as a matter of cost control, as to how shall the distribution of this health care be utilized. At the moment, we have so many cross-references that we have to refer to, from the standpoint of auditing. To mention a few, we have Federal audits, State audits, individual audits, and then the joint commission on accreditation—a lot of which is duplicated—I guess, gentlemen, what I am saying here is that we are deluged with redtape, so very much that it takes a lot of our time to guess what is required.

I think in the administrative area alone, if I could eliminate a lot of duplicative redtape, that the administrative cost in the Griffin-Spalding County Hospital could be reduced at least 30 percent.

Senator NUNN. On that point, I was going to wait until all of the testimony was in, but I think it would be well said here. At the hearing on Tuesday, Senator Talmadge and Iraised the possibility of a joint request from us to the General Accounting Office for a complete evaluation of all Federal and State requirements, and survey the paperwork on hospitals. This effort would include the consideration of all hospital surveys and certification activities from all sources, such as the State and Federal agencies, and the joint commission on accreditation of hospitals; and similar consideration would be given to all paperwork requirements, including the numerous claim forms that you have to deal with.

The purpose of the General Accounting Office effort would be to determine where and to what extent overlap occurred, the extent of the use of the information required, and the validity of the survey requirements and their frequency. We would also ask the GAO to consult with hospital organizations in pursuing this.

Now, my question would be to you, each of you, gentlemen, and your associations: We would like to get your help in drawing up such a request to the General Accounting Office, because we would like to frame it in a way that would be most meaningful. It would probably take some time and there would be a considerable amount of man-years of efforts involved. But, I think Senator Talmadge and I both are leaning in that direction. If you think it would be of some help——

Senator TALMADGE. In that connection, also, I would like to point out when we were reorganizing the committee structure this year, I got the Senate to agree to a committee rule that every time they report legislation, the committee reports it to the Senate for action, they must file a regulatory impact statement as to who is going to be affected, and how many, how much, and who for. I think if we do that we might impede to some degree this multiplicity of legislation that they pass with the best intentions on the face of the Earth, but set loose a swarm and a horde of bureaucrats to harass you to death from then on.

Senator NUNN. Well, I think that's one of the most significant moves that we have had in the Senate since I have been there, and I

applaud Senator Talmadge's efforts in that regard. If that is enforced, I assure you the thorough legislative effort will be slowed down.

Would that kind of assistance from GAO be of help?

Mr. PINKSTON. Very definitely.

Mr. RIDLEY. Yes, sir.

Senator TALMADGE. We can count on you to help us?

Senator NUNN. We will ask Jay Constantine, then, to be in contact with you as we pursue that.

Mr. RIDLEY. May I continue?

Senator TALMADGE. Yes, you may continue, Mr. Ridley.

Mr. RIDLEY. Thank you.

I would propose as a means of being more effective, that we need to look at something that is small enough to reach the people, and I'm thinking about sick people in the community, but large enough to meet their needs. I am thinking that probably the HSA's or health service areas, that so many people have put a great deal of time in on both Federal and State levels, can be effective.

I've listed some things here that will eliminate redtape—just a few of these are in areas in which this can be done and be more effective and less away from us, so to speak.

The amount of work required per patient admission is excessive. I am going so far here as to say in these admissions the hospital is creating a multiple of charges. If we had some kind of set per diem rate, we would know what we are going to be paid. We should receive full cost and omit exclusions, based on existing conditions on some established criteria, that assures we will get a certain amount of money for a service rendered. Another thing I would like to point out here, being mainly from the old school, is the fact that the concept has been on a cost-plus basis. I believe that we should be rewarded for good service at the average or below-average cost and be penalized if we go the other way.

I think that if we deal with that concept, there would probably be less scanners around. Because if there is a hidden income, probably that would manifest itself if it were on an average basis, and it would sure be easier for us in the field. I am suggesting we now have a duplication of goods and services.

Senator TALMADGE. Will you yield at that point, Mr. Ridley?

Mr. RIDLEY. Yes, sir.

Senator TALMADGE. That is the basic thrust of the bill which I have introduced, as you know.

Mr. RIDLEY. Yes, sir. That can be most effective, as I think about it from an administrator's standpoint.

Another point I would like to touch on briefly, and then I will really summarize the others, that is in the administrative area. I think that if this HSA or Health Systems Agency I referred to or whatever hospital administrative service you want to term it, a phase of that, but at least be under that canopy. Some input needs to be put into it by the Georgia Hospital Association as a controlling and averaging and feedback to the health providers. We feel pretty lonely out there sometimes wandering through 800 pages, more or less, to try to know really what applies to us in the data we receive from the various sources.

In summary, I would like to have to come out to us information whereby we would not be required to devote so much time in trying to

figure out what we should or shouldn't do. Input from Blue Cross, from private insurance carriers, and from third-party payers would help solve this problem.

I am suggesting the coordination of these ideas be the function of HSA's in this area. I think the financial distribution and services should come from a system whereby the Federal Government would participate, the State would participate, and the local government, meaning cities and counties, to have some financial input in it, and of course, the private sector, so that everybody is going to be in the financial act. Because they are all in it together.

Now, the question will arise, of course, as to how, particularly in the local sector—and this is more or less just a surmise on my part—it could be by distribution of population, from a per capita income, or prior financial local participation, or the economic needs, or a combination of these are some of the things you would probably want to look at in evaluating who would pay what in this area in which they all have participated.

The control on this is more or less statistical based on reliable data from a central source. The scope of the coverage should extend to hospitals and the medical, and here I am thinking of medical in the physician's area should be covered also.

Another thing that I think we must do more of, and that's outpatient care, like home care, more clinics, relate State programs and areas such as this in order to afford what we are doing, the change in method of care—and I'm not intending to be too redundant here, but let me reiterate. The system of care must be changed.

I think preventive care needs more emphasis. Payment should be made on a unit of service, both hospital and medical, more outpatient service, more home care programs, and better utilization of the paramedical sources. I think we are going to have to do this out in the field, and unless I appear as a pessimist, I think the present system, as I see it out in the five-county area that I cover, that we cannot afford to go on as we are going. We don't have the manpower to do it, and to meet the present system would be almost impossible from a financial standpoint, because dollars are not available as has been brought out here today to meet the requirements under the present system.

Thank you very much.

Senator TALMADGE. Gentlemen, I want to congratulate each of you on a very able and very thorough statement. I intended to ask you questions, but we've already run about 1½ hours longer than we anticipated. Most of us are already late for other engagements, but I do have one question for each one of you, and I hope you will answer it in one sentence or one paragraph.

I will start off with Mr. Bacon. The same question will be applicable to each one of you.

What would a flat 9-percent cap do to your hospital?

Mr. BACON. We couldn't live with it because of the growth of the area as it relates to increased activity occasioned by anticipated admissions.

Senator TALMADGE. In other words, you couldn't serve the patients and you would have to reduce some employees; is that it?

Mr. BACON. That is correct. And we would have to—as I indicated, we would be losing or penalized $493,000 of other projected revenues by reason of the decrease in activities.

Mr. PINKSTON. There wouldn't be any reason to say any more. We couldn't live with it either.

Mr. RIDLEY. We could live with it on one condition, if the cost of living was not continuing to go up in all areas. If the minimum wage doesn't come, that is going to affect us very seriously over and above what is happening to the man on the street over here, and then the unemployment compensation, which we will be faced with here in January. Under those conditions, there's no way.

Senator TALMADGE. Senator Nunn.

Senator NUNN. I just want to thank you, Mr. Ridley, Mr. Pinkston, and Mr. Bacon, for appearing. I think your testimony will be very helpful. I don't have any one-sentence questions, Senator Talmadge, so I am going to waive mine right now.

[The prepared statements of the preceding panel follow:]

STATEMENT OF ERNEST BACON, F.A.C.H.A., ADMINISTRATOR, HAMILTON MEMORIAL HOSPITAL, DALTON, GA.

CHANGING ROLE OF HOSPITALS

The emerging role of the hospital since 1960 has been and continues to be as a medical center. The hospital, in its emerging role, has a corporate responsibility for the patient care in the institution and as such has progressed from its role as a haven of care, to a center of service, education and research. This hospital growth has come about as a result of the response to the demand for hospital services by the public and the technological demands of the medical community.

Through its evolution, and as the hospital industry has expanded and modernized, a tremendous infusion of funds was necessary to attain the goals set by public expectations. Answering this need was the federal government. Due to the increase in the extent of financial involvement, hospitals found they were subject to increasing control the larger purchasers of service. By the 1960's health care had become a major public issue ranking alongside economic well-being, housing and education as a cause to be championed by contenders in the political arena.

Hospitals have moved from isolationism to the spotlight of public scruitiny and have become susceptible to political involvement and legislation action in the name of good works.

In Georgia, these same general evolutionary pressures have been felt by our community hospitals. The community hospital of today has changed to a community health center. For every patient admitted as an inpatient in Georgia, 13 patients are seen on an outpatient basis. Hospitals have become major primary care centers as well as acute care centers.

The evolution of Hamilton Memorial Hospital from a 73-bed general care hospital to a 220-bed regional medical center shows the response of the hospital to changing community needs and the awareness and support of the community for the necessity of these changes.

Hamilton Memorial Hospital is located in Whitfield County with a population of roughly 60,000. Its service area is a six-county area serving a population of roughly 100,000. This six-county area ranges from the urban center of Whitfield County, Dalton, to the rural outlying areas of Gilmer County. As a regional medical center, the hospital must not only meet the needs of its urban population, but also the requirements of the rural patient.

The urban population in Whitfield County is only one-half of the total population served by the hospital. The service area of the six-county catchment provides a population of approximately 100,000. The population in the counties served range from a high of 60,000 in Whitfield County to 9,000 in Gilmer County. From this service area come significant trauma, burns and head injuries with an intensity one might expect at an urbanized center such as Grady Memorial Hospital in Atlanta.

Interstate I-75 also requires attention from the hospital and exerts a considerable pressure on the necessary services to be provided. With 35,000 vehicles passing through Whitfield County each day, a significant number of individuals seen in the Emergency Department and admitted to the hospital come from the Interstate expressway.

As an indication of the services required, almost 40,000 patients were treated in our Emergency Department this past year. Seventy percent of these patients were nonacute clinical patients. The activity in the Emergency Department has required a full-time staffing with qualified personnel in order to meet the needs of the surrounding areas and Interstate traffic.

The tax base of surrounding counties shows a significant relationship to the services provided at the hospital. Last year, $97,000 of indigent care was provided by Hamilton Memorial Hospital for patients from a neighboring county. A question naturally follows: Who is responsible for this care? This particular county has a population of 17,000, 27 percent of whom are below the poverty level. This county's budget last year totaled $350,000. Nevertheless, the health need presented was recognized and addressed aggressively by Hamilton Memorial Hospital. As another example of Hamilton Memorial Hospital's aggressive uniqueness is the provision for newborn care via a secondary care center special care nursery. Of 2,000 deliveries anticipated in 1977, 160 will be premature births. 16 births will have heart defect problems. The need for a secondary care center was defined by these needs and a referral mechanism to a tertiary care center has been provided. This application of a shared-resources concept is one example of cost containment that health care industry leaders have often advocated.

Another example is our inpatient recuperative mental health unit. This also has been recognized as a need of our service population. Patients requiring long-term hospitalization are referred through our unit to the appropriate facility.

The unique position of Hamilton Memorial Hospital comes about because of its urban/rural service population and a tremendous influx from I-75. The hospital, in providing responsible services, must address the needs of all these types of patients. Because of our uniqueness, we experience problems regarding indigent care that are comparable to large urban hospitals. We must provide services for patients that are not provided by other facilities within the immediate area. The inherent problems of the rural population indicated by the activity in our Emergency Department must continue to be addressed. At the same time, we must also continue to provide for the medical problems of our urban population.

The hospital dilemma

The evolving hospital, as a community health center, exists for the purpose of providing for the health care services of the public. Conflicting expectations of the government and the public have caused a dilemma. On one hand, we are subject to the pressures of public demands regarding the style and manner in which services are rendered. Necessary responses to these demands result often in increased cost of the services.

On the other hand, we are subject to a myriad of governmental regulations which in many instances increase costs beyond any conceivable cost-benefit ratio. Fulfilling the needs of the using public within the framework of governmental regulations, regulations that not only dictate many aspects of the physicial plant, but also the type of personnel used and their rate of pay, add tremendously to the cost of services provided. This, coupled with a general inflationary trend fueled by a pattern of federal deficit spending, causes hospital costs to increase, thus bringing hospitals under attack from both the using public and governmental agencies. It apparently does not occur that the attainment of the expectations and requirements of both the public and the government contributes to high costs. These cost increases are beyond the hospital's control.

Other areas affecting hospital costs have experienced increases that cannot be explained by general inflation alone. They include utilities (which have increased almost five fold in the last three years for our hospital; a 12% increase for 1978 is projected despite a $40,000 expenditure for energy conservation equipment), and malpractice or general liability insurance which costs almost eight times as much as it did five years ago.

As an indication of the effects that uncontrollable costs will have on Hamilton Memorial Hospital, listed below are three items and the corresponding annual increased cost they will cause:

Cost of proposed minimum wage increase	$504,000
Cost of unemployment compensation tax (effective Jan. 1, 1978)	115,000
Increase in FICA tax (effective Jan. 1, 1978)	10,000
Annual cost	629,000

This increase in operating expenses of $629,000, representing only three items, adds 4.56% to our cost of operation that we have no control over.

In addition to these items, examples of lesser but equally important in their impact are the increased costs of supplies. For example, the cost of x-ray film has increased 70% in two years, and I.V. fluids and drugs, 40% and 17% respectively.

It is clear that many items are major contributors to the dramatic increase in health care costs and are beyond the provider's control. Acknowledgement of these uncontrollable costs by both the public and the government is necessary before an analysis of health care costs can be made. Hospitals must continue to realize the role that they, too, must play in cost control. Any attempt at cost containment must be a joint venture of the health care industry, the government and the public.

Cost Containment Act of 1977

Now comes the Administration's Hospital Cost Containment Act, H.R. 6575/S. 1391 which is mis-named and ill-conceived. It is mis-named because it in no way "contains" hospital costs. It simply "limits" hospital revenue and leaves the hospital to its own devices to deal with the excess of cost (whether the hospital is "responsible" or not for increased costs) over the "allowed revenue". It is ill-conceived because it applies a simplistic, "meat-axe" approach to an extremely complex and many-faceted problem.

The problems posed by the bill for our hospital will demonstrate how unrealistic it is when applied to an actual situation.

Our budget for fiscal year 1978 (10/01/77 through 9/30/78) has recently been approved by our governing board. Approval followed a most careful study and definitive analysis by our governing board. It is felt to be a sound, objective document.

In our budget, we are projecting a net loss of $432,008, although the budget was adopted without any increase in the rate and fee schedule for services rendered. This projected $432,008 loss represents 3.5% of our total operating expenses. We hope to minimize this loss through continuing cost control efforts, and plan to fund any remaining deficit from our limited reserves rather than to raise rates.

Provisions were not made, however, for the now pending increase in the minimum wage. If the pending minimum wage law is implemented, an increase in rates will be unavoidable. Nor did our budget envision passage of H.R. 6575/S. 1391. If the revenue limitations proposed in H.R. 6575/S. 1391 are implemented, we will be denied $493,000 of the revenue projected. This $493,000 added to the projected loss of $432,008 will simply be intolerable from the standpoint of fiscal responsibility and can only work to the long-range detriment of the patients we serve. If H.R. 6575/S. 1391 is implemented, irreparable harm will be done to the nation's hospitals. We urge its abandonment.

Recommendations for realistic cost containment

1. The problem of Malpractice (professional Liability) insurance must be addressed within a framework that will afford necessary protection for the patient, and at the same time allow the physician to practice medicine as his judgment dictates without fear of ruinous malpractice suits. A tremendous reduction in the use of ancillary services would be an initial, direct result.

2. The problems of reimbursement methods must also be addressed. The current form of "retrospective" reimbursement with its "allowable" costs for government-sponsored patients and "full charges" by others is rife with inequities and injustices. A system of State Review Boards, operating similarly to Public Service Commissions which govern public utilities, should be established to accomplish prospective review and approval of hospital budgets and rate and fee schedules. The approved rates and fees would be applicable to all classes of patients, including government-sponsored and private patients alike. This would provide the public an adequate protection from increased cost and allow an equitable sharing of costs.

3. Control of over-utilization could be established through legislative action by requiring that every patient (except, for example, public wards and Medicaid recipients) shall share "out-of-pocket" in the cost of health services beginning with first dollar cost. Without question, first dollar coverage by third-party payers leads to over-utilization and sometimes frivolous use of health care services.

4. Our fourth recommendation holds greater potential for the reduction of health care costs than any of those mentioned previously and concerns reorient-

ing the public's attitude on health. The current prevalent attitude appears to be that the medical profession has the ability to allow recovery of one's health no matter how the body has been abused or neglected. Health "protection" or health "maintenance" is not only more logical in that it is preventative in nature, but it is also less expensive than health "recovery" after the body has succumbed to abuse, neglect, or disease. A vigorous program of orientation and education would include provisions to reorient the public to the wisdom (and economy) of good, simple health habits.

These four recommendation, if adopted even in a related form, would do much to eliminate the inequities and injustices prevalent in the current reimbursement systems, and would reduce costs of nonessential services which are currently occasioned by the defensive practice of medicine by physicians and first-dollar coverage by third-party payers.

Any type of cost control program must take into account four components of the health care delivery system and their responsibilities. The four components include:

1. Awareness on the part of the patient of his responsibility for preventive health care.
2. The role of government, both State and Federal, in promulgating regulations only after a cost impact has been accurately determined. Congressional mandates implemented through the regulatory process must continue to be monitored to insure that the original intent of the legislation is not lost.
3. An awareness by the physician of his role and his active participation in a cost control program is imperative.
4. Continued hospital awareness with management emphasis on cost control.

Only through the effective integration of these four components can an efficient health delivery system be established that will provide for the accessibility of quality patient care to all individuals who need the care while at the same time keeping the cost within bounds that permit all segments of the population its use.

Statement of J. W. Pinkston, Jr.

Senator Talmadge, Senator Nunn, I am Bill Pinkston, Executive Director of Grady Memorial Hospital here in Atlanta, and I am also serving this year as president of the Georgia Hospital Association.

It is a privilege to comment briefly on the issues you presented and to submit lengthier remarks for the record.

First, the issue of rising hospital costs. We have prepared a chart that illustrates how much the prices of typical supplies necessary to run a hospital have risen over the past 10 years. See Chart 1.

The next chart compares our 1966 operating budget with this year's. It also illustrates how certain basic operating costs have mushroomed in a ten-year period. See Chart 2.

In addition, we have added a number of specialized facilities during this period, such as our artificial kidney center, a greatly increased psychiatric program, a burn treatment center, a neurosurgery intensive care unit, a drug abuse prevention program, four satellite clinics, a unit to care for high-risk newborns, and a center to care for women with high-risk pregnancies. See Chart 3.

These services have greatly expanded our ability to save lives and serve humanity, but they also have driven up our operating costs.

Another factor which causes hospital costs to go up is the increased life expectancy of today's Americans.

You know, when auto manufacturers or grocery stores pass along the effect of inflation in their prices, consumers gripe, but usually accept it. Yet, when hospitals do the same thing, there is a great hue and cry about the outrageous cost of health care. In a way, I guess it's a left-handed compliment that people have come to expect good health care as a basic right. I just wish we could get them to understand what really causes health care costs to go up.

The next issue you raised was that of access to health care. I'd like to talk about geographic access and financial access.

One of the most promising developments in health care recently is regionalization. Not every hospital can or should be everything to everyone. Specialized services—such as the treatment of critical medical emergencies and severe burns and others I mentioned a moment ago—are only economical when used by a large number of patients.

The answer is to have them available regionally. We are beginning to plan health care on a regional basis through the Health Systems Agencies. The idea behind these organizations should be a positive step toward cost effectiveness in hospital care.

A health care region is where the people are. Here in Fulton and DeKalb counties, we have 22% of the entire state's population, so we are definitely a region in just these two counties.

Geographic access to care at Grady is enhanced by our location in the central city—right in the heart of our two-county health care region. Grady is located at the intersection of three interstate highways. Many of our patients use the existing surface mass transportation system which has several stops near Grady. We have a good ambulance service, and we operate four satellite clinics remote from the downtown hospital. These provide primary care in otherwise medically underserved neighborhoods where many of our patients live.

Grady is accessible 24 hours a day to adults and children through its emergency clinics in medicine, pediatrics, surgery, obstetrics, and psychiatry.

Financial access to Grady is equally good. We treat the poor of Fulton and DeKalb counties. Our rates are on a sliding scale, depending on the patient's ability to pay. Even with many patient fees covered by Medicare or other third parties, there is a substantial gap between our revenues and expenses. Chart 4 illustrates that.

Fulton and DeKalb taxpayers make up this difference between our income and outgo.

In April, we established a cash-in-advance policy in our pharmacy and outpatient clinics for patients who can pay part of the cost of their care. Those who can't pay make arrangements with a supervisor. The policy is working well. By far, the greater number of patients have adjusted to it.

There is a real question, however, as to how far local property owners are willing and able to be taxed. We believe that some additional state or federal relief must be provided for large regional hospitals—especially those which treat a high percentage of poor or near poor people. We need a broader base of financial support than local property taxes can provide.

You invited us to address whether federal government policies or procedures present any particular problems for hospitals.

Beginning in January 1978, Grady will be required to contribute to unemployment insurance. This could increase our operating costs somewhere between $500,000 and $700,000 a year. We will face an even greater cost increase if a high minimum wage is established.

There is legislation which will require modification for the handicapped of all buildings to which the public has access. This, too, will be costly to hospitals.

Duplication of inspections and inquiries by federal and state agencies add unnecessarily to the cost of operating a hospital and must be examined.

We need to examine certain provisions of regulations such as life safety codes to make sure that they do not force hospitals to make excessive allocation of their limited resources to guard against situations that might occur while failing to meet necessary day-to-day requirements for care.

Another proposal, just now in the talking stage, would prohibit federal funds from being used to cover the care of any patient assigned to a hospital room with more than four persons. Grady has a number of eight-bed units. The loss of Medicare and Medicaid coverage on patients in these units would have a very adverse effect on our operating budget.

I think it is critically important for rule-makers and others to understand how such measures can have a profound impact on health care costs.

You invited each of us to state his position on existing or proposed remedies to the problem of rising care costs. I would like to conclude by doing that.

One potentially controllable factor contributing to rising health care costs is over utilization of services. This could be minimized by requiring every patient to pay part of the cost of his or her care through co-payments and/or deductibles. This should be based on the ability to pay. There are some, of course, who are too poor to pay anything and they should be excluded.

I believe that we must move to some kind of budget approval and rate review commissions for all hospitals. These should be established in each state, but have federal guidelines as a basis for their actions and decisions. It would be important for these commissions to approve hospital budgets, not just their charges. Because of its complexity, it is important that the commissions be composed of fulltime, knowledgeable individuals with adequate professional staffs. They must be independent—not composed of health care professionals, third party payors or larger purchasers of services.

Next, I believe that health insurance reimbursement mechanisms should encourage the use of less expensive methods of health care delivery. Preventive care and treatment which can be delivered in outpatient clinics, doctors' offices, and homes must be encouraged to improve health and reduce admissions to hospitals. Trends now underway in this direction should be encouraged.

The problem of health insurance coverage of catastrophic illness must be examined more thoroughly. In a recent two-week period at Grady, we treated thirty-two persons whose bills exceeded $5,000. If these figures were projected for a year, it would mean that 2.1% of our admissions account for some 13% of our total budget. This illustrates the prevalence of catastrophic illness today.

There are proposals afoot which would prohibit the use of federal funds to pay for abortions for poor people. Without going into any of the religious or moral ramifications of this issue, I can tell you that, if such a proposal is adopted, we will again begin treating patients who find it necessary to seek unsafe abortions. This situation will actually serve to increase health care costs.

Gentlemen, I have presented valid reasons why hospital costs have risen and have stated that regionalization of services can hold these increases down to some extent. I stressed the need for added assistance to regional hospitals providing special services, particularly those which treat significant numbers of poor people.

I then emphasized the need for rule-makers and others to take full account of the impact that laws and regulations can have on health care costs. I concluded by presenting views that I believe could help hold the line on the cost of health care.

I have run slightly over my time, but I deeply appreciate your kind attention and the opportunity to bring these facts to your attention.

It will be my pleasure to attempt to answer any questions that you may have at the appropriate time.

Thank you.

FULTON-DEKALB HOSPITAL AUTHORITY, ATLANTA, GA.—TYPICAL SUPPLY COSTS, 1966–76

Item	1966	1976	Percent
Fuel oil (gallon)	7.9 cents	34.6 cents	339
Gasoline (gallon)	19.3 cents	47.0 cents	143
milk, ½-pint sweet milk	5 cents	8.8 percent	71
Bread, 16-oz., white (loaf)	7 cents	26 cents	271
Coffee, 1 lb	52.5 cents	$2.34	344
X-ray film (thousand)	$589.80	$872.80	48
Aspirin, 300 mg tabs (thousand)	70 cents	$1.98	183
Digoxin (per thousand)	$2.60	$4.72	82
Nitroglycerin, tablets (thousand)	91 cents	$9.10	900
Sponge, surgical (2,000 per case)	$17.50	$45.02	157
Toilet paper (case)	$8.25	$20.30	146
Paper towels (case)	$2.75	$6.87	150
Implantable pacemaker (each)	$525	$1,450	176
Heart valves (each)	$325	$1,200	269
Hip prothesis (each)	$82	$154	88

GRADY MEMORIAL HOSPITAL, COMPARISON OF SELECTED COSTS

	1966	1976	Percent
Budget	$12,831,000	$58,100,000	
Salaries:			
Minimum salary	85 cents per hour	2.54 cents per hour	198.8
Registered nurse	$325 per month	$185 per month	150.8
LPN	$225 per month	$592 per month	163.1
Medical technologist	$395 per month	$840 per month	112.7
X-ray technologist	$300 per month	$686 per month	128.7
Ambulance driver	$350 per month	$655 per month	87.1
Intern	$300 per month	$870 per month	190.0
Malpractice insurance	$20,017	$2,100,000[1]	10,391.1
Postage (1st class letter)	5 cents	13 cents	140.0
Electricity	$230,630	$671,330	191.1
Gas and fuel oil	$128,544	$648,806	404.7
Food and dietary supplies	$569,060	$1,145,441	101.3
Drugs and pharmacy supplies	$813,679	$2,561,654	214.8
Total expenditures		$58,100,000	352.8

[1] Minimum if insurance were purchased.

Grady Memorial Hospital new services since 1966

	Year
Kidney Dialysis Center	1966
Physical medicine and rehabilitation service	1966
Psychiatric Day Hospital	1969
Drug abuse program	1970
35 GYN beds	1970
Nephrology inpatient service	1970
Trauma service	1970
Psychiatry observation	1970
Pulmonary ICU	1970
Medicine Observation Unit	1970
Pediatric ICU	1970
Pulmonary function lab	1970
33 Medicine beds	1971
Neurosensory lab	1971
Diabetes Detection and Control Center	1971
Abortion and sterilization	1971
Plastic surgery	1972
Audiometry	1972
Speech pathology	1972
OB Intensive Care Unit	1973
Medical Intensive Care Unit	1973
First of four satellite clinics	1973
Neonatal ICU	1973
Burn Unit	1974
Neurosurgery ICU	1974
Oncology service	1974
Kidney transplant	1974
Surgical intensive care—Expansion	1974
CAT scaner	1976
Perinatal Center	1977

STATEMENT OF CARL A. RIDLEY, ADMINISTRATOR, GRIFFIN SPALDING COUNTY HOSPITAL

As we recognize the rising cost of hospital and medical care and access to care, the complexity of this mammoth undertaking deserves the input we are experiencing here today.

I would like to address my remarks to six topics that is of primary concern to me as a hospital administrator representing five counties in the Griffin area and as a part of the designated hospital service area incorporating twenty-four counties in the greater Atlanta health service community. The broad areas of concern include: 1. Financial, 2. Administrative, 3. Distribution, 4. Control, 5. Scope of coverage, 6. Change in the method of care. These are some of the every day involvements that affect the delivery of health care.

1. Financial.—First I will elaborate on the financial aspect as it relates to cost control through related knowledgeable sources. The source for assimilating financial data could be expedited through hospital service areas (HSA). This body would be responsible to the consumer for allocation of hospital beds, equipment and other service under the same financial umbrella. The management evaluation and control of this process will be explained under administrative control. Other HSA functions would include eligibility for outpatients that would expedite payment for this service without extended delays that is now the rule and not the exception. An enormous amount of work and expense could be saved by establishing a day rate (per diem) with a cost of service concept. A broad sampling of service in classified situations could channel funds to the patient instead of personnel and supplies. If it is known the reimbursement that will be received for a days stay in the hospital, budgeting and cost containment would be much easier. This can and should be done.

Hospitals should be compensated for efficiency and penalized for elevated cost. As long as we are on a cost plus basis, health care will continue to increase at a rapid rate.

Under our present system of allocating cost by the various services rendered, there are so many variables we are lost in the maze of inspections, audits and the ever present computer.

One of the largest cost of patient care under our present system is loosely referred to as room and board, or routine care. This charge is on a day rate basis even though there are many variables. If the remaining charges could be so classified our hospital could reduce our administrative payroll by at least 30%.

This testimony is not attempting to present a cure all method but to point out a problem that has resulted from the continued demand for more detailed reporting without any end in sight.

2. *Administrative.*—I have previously alluded to administrative procedure and control. This process must have checks and balances. The summary of which should come from various sources, one of which should be the Georgia Hospital Association (GHA). This would serve as a State wide distribution center to all hospitals within the State of Georgia.

Other input should come from Blue Cross, private insurance carriers and other third party payers. With this broad administrative input and control an assigned agency such as HSA would be in a position to evaluate and allocate funds. Compare the value for services and the need for equipment or additional facilities.

We are now subjected to a multiple of reviews, audits, inspections, evaluations and overlapping requirements that is not only frustrating but confusing and expensive.

I am suggesting one source of requirements that is big enough to be effective but small enough to be the representative for a comparable group of hospitals. This would make our role as administrators and representatives of our people much easier.

3. *Distribution.*—The distribution of Health services is largely contingent on funds and manpower. First I would like to speak of the distribution of funds. Allocations should be made on basic needs based on reliable data. These allocations should be identified in at least three broad categories. One, patient care; two, education and three, research. Priorities should go to patient care. This area should be for physical needs as opposed to cosmetic or other desired hospital care.

The sources of funds should be the responsibility of State, Federal, local and private participants. It may appear redundant to suggest that Medicare and Medicaid and other programs are State and Federal obligations. At this point it is not so much as to whom but how. In some areas there are very little if any local obligation assumed for patient care. There should be legislation requiring local financial input for patients in a given area with an established need. It is grossly unfair for sick people to pay for the patient who is financially unable to pay for medical care. This concept should apply to all third party payers.

The sharing or allocation of appropriated funds may differ in that in urban areas a distribution based on population may be satisfactory; or a per capita income may work for a suburban location; or the community may have adjusted to a prior local financial participation while other areas would depend on the economic need.

Meeting the community needs would be the objective that would hopefully eliminate the mammoth boiling pot into which we must search for information about individuals that may not even be scrambled in the red tape.

Manpower is considered a problem in para-medical departments. A more accurate appraisal could be made if more reliable comparisons were available. Most of our comparisons are on a state or national basis with unknown input that would distort the evaluation from an efficiency of operation standpoint.

The obvious manpower shortage is in the medical sector. The areas needing more physicians is more acute in the rural areas than in the more affluent metropolitan geographical locations. It is obvious that some incentive must exist to supply acute shortages and that supporting para-medical specialties must be available for routine work now being done by physicians.

Centralized clinics would be of enormous help in helping to combat localized manpower shortages.

4. *Control.*—Control must begin on a community comparative basis. These competitive operating procedures should extend to broader areas whereby national evaluation by our lawmakers would be easier when appropriations and procedures are made.

Periodic summary reports to committees such as this one should be made on a scheduled basis for their evaluation. It is incumbent upon us as administrators to see that their requests are satisfied and justified.

Probably one of the most overlooked groups are hospital authorities. Since they are really the responsible authority on the community level, they should extend their expertise beyond the scope of this individual hospital. Their influence, by necessity, must be utilized. If the health area is small enough to have more than token representation from authorities, an indepth community approach will expedite many existing problems.

Much of the State-wide process can be evaluated through the Georgia Hospital Association and dispensed to its members.

5. Scope of Coverage.—The health program should include both hospital and medical coverage. Emphasis need be placed on out-patient care. Out-patient care as opposed to emergency care should include home care, established clinics, related State aid programs with the general concept of preventative hospital care that would admit the patient for in-patient service.

6. Change in Method of Care.—The change for the delivery of medical care is inevitable. In summary it may be necessary to consider preventative care or pay to stay well. A simpler way must be devised to cut red tape and divert the cost to the intended source, the patient. More out-patient care is a step in the right direction. Home care is on the horizon. More programs are needed to develop para-medical resources.

It would be encouraging if the social and economical concept could become part of this development.

Finally gentlemen, I submit there must be a change in the delivery of health care because we cannot continue with the present system for three obvious reasons:

1. We can't afford it.
2. We don't have the manpower.
3. The need is not met under the present system.

Again, gentlemen, I thank you for this honorism and privilege of appearing before you today.

Senator NUNN. I want to express my appreciation to Dr. Wright and Mrs. Virginia Smith and the other people who are here from HEW and other Federal agencies who play such a key role in this area.

I think you have been very wise, and also very patient in coming to this hearing today and also to Macon. I know it will benefit us immeasurably and I hope it will benefit you, also.

Senator TALMADGE. May I also add my gratitude.

The hearing is now concluded.