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THE FUTURE OF HEALTH CARE IN AMERICA

HEARINGS

BEFORE THE

SUBCOMMITTEE ON EDUCATION AND HEALTH

OF THE

JOINT ECONOMIC COMMITTEE

CONGRESS OF THE UNITED STATES

ONE HUNDREDTH CONGRESS

SECOND SESSION

PART 2

JUNE 14, 16, 21, AND 23, 1988

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TUESDAY, JUNE 14, 1988

AFTERNOON SESSION

THE FUTURE OF HEALTH CARE IN AMERICA

TUESDAY, JUNE 14, 1988

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON EDUCATION AND HEALTH
OF THE JOINT ECONOMIC COMMITTEE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2359, Rayburn House Office Building, Hon. James H. Scheuer (chairman of the subcommittee) presiding.

Present: Representatives Scheuer and Fish; and Senator Wilson.

Also present: Judith Davison, executive director; Robert Tosterud, minority assistant director; and David Podoff and Dayna Hutchings, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE SCHEUER, CHAIRMAN

Representative SCHEUER. Good morning. The hearings on "The Future of Health Care in America" resume today as we turn our attention in the 6th day of this series to: "The Health Care Needs of the Elderly." Of course, it is a truism that the importance of this topic cannot be overestimated. You see this question referred to on the front page of the papers almost every day. Congress itself is now grappling with the enormous challenge of how to meet the health care needs of a population that is growing exponentially in its aging ranks.

The elderly constitute about 11 percent of our population. By the middle of the next century this percentage will go up to about 22 percent—doubling by the year 2050. Per capita personal health care expenditures for persons over 65 are four times the health care expenditures for persons under 65.

So we are faced with major problems, and I hope—I am confident—that the witnesses will shed light on how we can come to grips both with the mission of supplying quality health care for the elderly as well as getting a handle on our per capita health-care costs. As a percentage of GNP they are 50 percent more than the average for the other OECD countries in Europe, Japan, Australia, New Zealand, and Canada; with absolutely no indication that we are getting anything more for the fact that we are spending 1½ times what they are spending.

If our health-care costs continue to go up at the rate that they are now going up, including costs of providing health care to senior citizens, we will hit 15 percent of GNP by the end of the century. About one-fifth of the per capita cost of health care for the elderly is nursing home care.

So we have to figure out how we can finance it. What part of the health costs for the elderly do we leave for the individual to finance, how much to society to finance?

We must increase the efficiency of our health-care delivery system, which was the subject of our first day of hearings. Joe Califano testified that we could save about $125 billion a year in unnecessary duplicative, overlapping, and ill-coordinated programs without affecting quality at all.

One area in which we are hopeful to make advances, both in quality of care and in costs of care is empowering health-care consumers, including the elderly, with far more knowledge about the health-care providers who are available to them. This will enable consumers to make better choices as between doctors and as between hospitals, so that they can avoid the ones that might jeopardize their health, based on the proven record, and select ones, which would include the overwhelming majority of health-care providers, who provide responsible quality health care.

Another area where we have begun to make inroads on health care problems is the Medicare Catastrophic Coverage Act of 1988, recently passed overwhelmingly by both Houses of Congress. The bill will make health care more affordable for senior citizens, and it is expected that the President will receive this legislation sometime this week and sign it in the latter part of the week.

Last week I held a hearing in New York, before the House Subcommittee on Natural Resources, Agriculture Research and Environment, which I chair, of the House Committee on Science, Space, and Technology. The hearing was held in conjunction with a report issued by the Office of Technology Assessment entitled "The Quality of Medical Care: Information for Consumers." In effect, the OTA told us, yes, consumers can make the health-care delivery system more efficient, more cost effective and ensure a better quality of care for themselves if health-care consumers have knowledge—knowledge—knowledge.

There is a luncheon going on at the Library of Congress today on the subject that "Knowledge is Power." I think they are talking about international economics, but it could as well be the subject of a colloquium on health care for elderly people.

The OTA did say there were a number of indicators that could be used legitimately if we spent some time and some research money developing ways of making the data more accessible and more intelligible to the average health consumer. Such indicators include the mortality tables that HCFA, the Health Care Financing Administration is currently putting together, information on repeated episodes of malpractice judgments, on censuring of doctors, on delicensing of doctors on a State basis, on hospitals with two or three times the normal rate of nosocomial infections, that is, open wound infections or other infections you pick up at the hospitals. Information on hospitals that have a far higher rate of iatrogenicity, which is a fancy way of saying physician error.

All of these things could be made available to health consumers in a form that would be fair to the providers, informative to the consumers and would help produce those market forces we hear all about, informed market forces that would streamline the health-care system.

Well, today we resume the hearings of the subcommittee and will continue to emphasize the challenge of trying to get a handle on increasing health care costs while we strive to maintain and even improve quality.

Because of scheduling difficulties, Senator D'Amato will be unable to attend the hearing today. He has requested that his opening statement be placed in the record, which I will do at this point, without objection.

[The written opening statement of Senator D'Amato follows:]

WRITTEN OPENING STATEMENT OF SENATOR D'AMATO

MR. CHAIRMAN, I AM PLEASED TO JOIN YOU THIS MORNING AS THIS SUBCOMMITTEE EXAMINES TWO VITAL ISSUES: THE HEALTH STATUS AND LONG-TERM CARE NEEDS OF OUR NATION'S ELDERLY.

THE RECENT PASSAGE IN BOTH THE HOUSE AND THE SENATE OF H. R. 2470, THE "MEDICARE CATASTROPHIC COVERAGE ACT OF 1988," HAS HELPED TO FOCUS THE NATION'S ATTENTION ON THE RAPIDLY GROWING HEALTH CARE NEEDS OF THE ELDERLY. WHILE THIS BILL WAS DESIGNED PRIMARILY TO ADDRESS THE "CATASTROPHIC" COSTS OF LENGTHY HOSPITALIZATIONS, IT ALSO STIMULATED A GREAT DEAL OF DEBATE ON HOW BEST TO DEAL WITH THE OTHER CATASTROPHIC EXPENSE FACING THE ELDERLY: LONG-TERM CARE FOR THOSE WITH CHRONIC ILLNESSES.

AS THE TESTIMONY OF OUR FIRST PANEL INDICATES, THE PROVISION OF SUCH CARE WILL BECOME INCREASINGLY NECESSARY AS OUR POPULATION AGES. ALREADY, PERSONS OVER 65 MAKE UP ABOUT 11 PERCENT OF THE U.S. POPULATION. BY THE YEAR 2030, THIS FIGURE IS EXPECTED TO RISE TO ABOUT 21 PERCENT. EVEN MORE SIGNIFICANTLY, BETWEEN NOW AND THE YEAR 2030 THE PERCENTAGE OF AMERICANS AGE 85 AND OLDER WILL NEARLY TRIPLE, FROM 1 TO ALMOST 3 PERCENT OF THE POPULATION.

THE GROWTH OF THE OVER-85 POPULATION, ESPECIALLY, IS EXPECTED TO PLACE INCREASING DEMANDS ON OUR NATION'S HEALTH CARE SYSTEM. ACCORDING TO DR. BRODY'S TESTIMONY, THE NUMBER OF NURSING HOME RESIDENTS IN THIS COUNTRY WILL RISE FROM ABOUT 1.4 MILLION CURRENTLY TO APPROXIMATELY 4 MILLION IN THE YEAR 2030.

HOW IS OUR HEALTH CARE SYSTEM GOING TO MEET THE INEVITABLE DEMAND FOR MORE LONG-TERM CARE SERVICES? CLEARLY, AS MEMBERS OF OUR FIRST PANEL SUGGEST, WE NEED TO DEVELOP EFFECTIVE STRATEGIES TO PREVENT SUCH COMMON, BUT DEBILITATING, CHRONIC ILLNESSES AS ARTHRITIS, OSTEOPOROSIS, AND DEMENTIA. IN ADDITION, WE MUST IDENTIFY WAYS TO HELP THE ELDERLY TO REMAIN INDEPENDENT FOR AS LONG AS POSSIBLE, THUS DELAYING OR ELIMINATING THE NEED FOR COSTLY LONG-TERM CARE.

ULTIMATELY, HOWEVER, IT WILL BE NECESSARY TO ENSURE THAT A STRUCTURE IS IN PLACE EARLY TO MEET THE DEMANDS OF THE MILLIONS OF ELDERLY AMERICANS WHO <u>WILL</u> REQUIRE LONG-TERM CARE IN THE NEXT CENTURY. I LOOK FORWARD, THEREFORE, TO THE COMMENTS OF OUR SECOND GROUP OF WITNESSES, WHO WILL ADDRESS VARIOUS METHODS FOR FINANCING THIS CARE.

MR. CHAIRMAN, I COMMEND YOU FOR CONVENING THIS HEARING ON THE HEALTH OF OUR NATION'S ELDERLY, AND I HOPE THAT THE TESTIMONY OF THIS MORNING'S WITNESSES WILL PROVIDE US WITH NEW INSIGHTS INTO HOW WE CAN BEST MEET THEIR LONG-TERM CARE NEEDS.

THANK YOU, MR. CHAIRMAN.

Representative SCHEUER. First, we will hear from Dr. Jacob Brody, dean of the School of Public Health at the University of Illinois at Chicago.

Dr. Brody suggests our goal must be the prevention of the need for long-term care and postponement of its use, and we look forward to hearing from you, Dr. Brody.

What I suggest is that you chat with us informally for 7 or 8 minutes. This goes for all the witnesses. Your prepared statements will be printed in full in the record, and after all three of you have had a chance to testify, I am sure we will have some questions for you.

So it is a pleasure having all of you here this morning. Please proceed, Dr. Brody.

STATEMENT OF JACOB A. BRODY, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF ILLINOIS AT CHICAGO

TRENDS IN HEALTH CARE

Dr. BRODY. Thank you very much. What I will touch upon is a general overview of how, populationwise, we got here, how better data would influence our ability to make better judgments and some future methodology in the area of prevention and postponement.

The impressive thing this century or a way of looking upon what has gone on is that in 1900, only a quarter of deaths occurred in people 65 and over. Now three-quarters, 75 percent of all deaths are occurring after age 65.

Representative SCHEUER. Or putting it the other way, whereas three-quarters of deaths occurred in people 65 and under, now only a quarter of deaths occur in this group. That's even a more dramatic way of putting it.

Dr. BRODY. Exactly. The point I am trying to illustrate or emphasize is that it is the last year or day of life in which we place our major costs and energies. The last year is expensive. Now last years of life aren't among children. They are among people 65 and over; 20 percent of all deaths are occurring among people 80 and over—30 percent, excuse me, 30 percent; 20 percent among people 85 and over. And probably in another 15 or 20 years, maybe 25 years, half of deaths will be occurring in people 80 and over.

That means that those are the ages they will be in contact with this system—medicare, the health costs, the things that fiscally and, of course, emotionally, worry.

So we are dealing with a new array of ages, and we already know they have different disease situations, different social settings, and the approaches will have to change to accommodate that.

Thus a remarkable shift in the knowledge is needed from the time when only 25 percent of deaths occurred in this age group at the turn of the century to now 75 percent and rising.

During this century up to now death rates have been declining pretty steadily, except for one remarkable episode right in the middle of the century. Between 1950 and 1968, death rates stopped declining. And unfortunately, these were years in which very important decisions were made, decisions modifying the original

Social Security Act, and medicare and medicaid came in during a period in which mortality was flat. Life expectancy was 68, and we generally were comfortable with it.

In 1968, things changed. Probably the best explanation is that there had been an accumulation—an increasing rate of heart attack deaths that stopped somewhere in the sixties. Since that time, the normal forces driving us, whatever they be, into longer and longer life resumed their upward trend. Now during that period 1950 to 1968 we should have been wise enough, had we been following the right trends, had we been placing our emphasis on the right studies to see that longevity steadily increasing and what we were seeing was this rush or epidemic of heart attack deaths competing with the increase, making it look flat. With better data we could have set up our institutions like medicare and medicaid to take care of the population once that sudden decline in death rates recommenced which did happen with very little giving up of smoking, a little jogging, a little less fat. In 1968, death rates really started to go down and are continuing down.

And now we don't know how—as you said, the fastest growing population is over 100. We don't know when that is going to stop. But it is remarkable that only a few years ago this was a flat line.

At present, the emphasis is rapidly shifting in health care toward the elderly, at age 65, which, as I mentioned, three-quarters of our population are going to reach, the average life expectancy is 15 years, which brings one-half of them to 80. At 80, life expectancy—or half the people will survive 6 more years. So we are, indeed, dealing with an older population that is living longer.

I think we can safely say that right now people who are 80, 90, or 100 in 1988, will live longer than the 80-, 90-, and 100-year-old's in 1978. What we are doing is adding years at the end.

Representative SCHEUER. Excuse me. If I may interrupt for a moment. We are very happy to have been joined by our distinguished colleague from New York, Representative Ham Fish, and I am very happy that he came in on such a positive note. Thank you for joining us, Ham.

Dr. BRODY. The accumulation then of the elderly is persisting, numerically and in terms of percent of the total population. Now this raises the central issue of an increasing life span, what is the net gain in terms of active life expectancy or those years in which you don't need any assistance, as opposed to comprised years? And right now the data are a little discouraging. It looks somewhere in the range of for every good year, by the definitions used, and we may not be using the right definitions, for every good year we add, we add about 3 comprised years, years in which some support is necessary.

Representative SCHEUER. What kind of support are you speaking of, Dr. Brody?

Dr. BRODY. Help in the activities of daily living, washing, bathing, shopping, getting out of bed. The definition is rather precise. It is when you begin to need someone else. And the something else rapidly a social something else.

In 1985, there were 27.5 million people 65 and over or just under 12 percent of the population. By the year 2000, there will be 34 mil-

lion or 15 percent of the population. In 2020, there will be 52 million people over age 65. They will be 17 percent of the population.

We do a little better than the other developed countries in the world, because we have the baby boom as a cushion. The baby boom turns 65 in 2010.

NEED PREVENTIVE CARE

My final point that I am trying to emphasize is related to prevention. The need for use of services, external services, nursing homes, as an example, the ability to prevent their need exists. The ability to postpone is a functional idea that we can direct effort to. I used in the prepared statement an example, and I will finish with that, of hip fracture. Hip fracture is related to a known aging process, osteoporosis. It starts probably in late adolescence and continues right through life and on or around 40 or 50, we start seeing hip fractures and the rate rises very rapidly with age. Half of the hip fractures occur after age 79.

Now with the scenario that I presented, since we are pushing a far greater percentage and number of people through age 79, we will have more hip fractures. Now by postponing osteoporosis by 5 or 10 years, we can halve the rate of hip fractures, so that instead of the median age being 79, it would be 84. Life expectancy is, say, 78—for women, 79—you will postpone the hip fracture until after death. You will not get the hip fracture.

I think, as we concentrate on the various areas that are particularly difficult in this aged population, we can develop postponing techniques to prolong the good life and limit the needs for nursing homes. Thank you.

[The prepared statement of Dr. Brody follows:]

PREPARED STATEMENT OF JACOB A. BRODY, M.D.

Aging in the 20th and 21st Century

Prepared for

The Joint Economic Committee

Panel on Current and Projected Health Care

Status of the Elderly

June 14, 1988
Washington, D.C.

By

Jacob A. Brody, M.D., Dean
School of Public Health
University of Illinois at Chicago

My name is Jacob A. Brody, M.D. I am Professor and Dean of the School of Public Health at the University of Illinois at Chicago.

I am grateful for the opportunity to discuss population changes and the critical need to monitor health and disease during this period of extraordinary growth in the older segments of our population.

It is difficult to comprehend that in 1900, only 25% of people lived beyond age 65 while by 1985, approximately 75% survived age 65 and more than 30% lived to be 80 or more. Fully, 20% of our population dies after age 85 and if present trends continue, within the next 25 years, half of all deaths will occur after age 80. Most medical attention and costs are expended during the last years of life. Thus, at the turn of the century, our resources were devoted to illnesses in children and young adults. Now, almost all our health care goes to people well over age 65.

Since 1900, death rates declined enormously (Figure 1). The downward trend persisted from 1900 until about 1950 and then suddenly leveled off for almost a quarter of a century. During those years, it was assumed that we had reached the maximum life expectancy of about 67 years, and the formulation of many of our Social Security and Medicare policies developed under this faulty assumption. If we had better data collection systems and analyzing capacity during that period, we would have been more cautious. We would have seen that life expectancy was increasing steadily and that simultaneously heart attack deaths were increasing sharply and these two factors nullified each other producing what appeared to be a horizontal line for the years 1950 to 1968. In 1968, the sharp decline in mortality resumed and still persists. Please recall at the beginning of my discussion, I mentioned that in 1900 only 25% of the population survived to be 65 while now about 75% survive to be 65. Thus, this rapid decline since 1968 is essentially the result of prolonged life expectancy among the elderly themselves. At 65, the average person will live for 15 years while among those age 80, fully half will make it to 86.

We would, of course, like to take full credit for the declines in heart attack deaths as a result of our improved lifestyles and medicines. These changes, however, had not really occurred by 1968 and the specific items, such as eating less fat and smoking less, are essentially American phenomena and not observed in countries such as Sweden and Japan where people live longer than we do. Several issues loom somewhere beyond our current understanding. We are clearly living longer. We do not know when the increasing longevity of the elderly will taper off and we don't really know what is causing the present life extension. People 80, 90 and even 100 years will live longer than those of similar age did in 1978.

The central issue raised by increasing longevity is the issue of net gain in active functional years versus total years of compromised health. Present data are weak, but suggest that for each good active functional year gained, we add about 3.5 compromised years. This debit is piling up. We should be devoting our best minds to improving information about how well or badly we are living during our increased years and apply remedial solutions. At present, our statistical measurements are sparse and crude leaving us with gaps and guesses This prevents appropriate

planning and intelligent preparation of the population for their own, or should I say, our own aging.

At present, there are 28.5 million Americans 65 and over or 12.0% of the total population. By the year 2000, only 12 years away, there will be about 34 million elderly or 13%. By 2020, there will be more than 52 million people 65 and over and they will be 17% of the population. Thereafter, the elderly will comprise 20-25% for the foreseeable future. As the population ages, diseases and conditions associated with older people will predominate. Note that half the hip fractures occur after age 79 and half the Alzheimer's disease cases occurs after age 80. The higher the percentage and larger the size of our elderly population, the greater is the risk and impact of conditions such as Alzheimers disease, deafness and blindness, widowhood, and social isolation. We must be prepared to shift our focus to diseases and conditions of high prevalence in the 8th, 9th and soon, the 10th decade.

To illustrate my point, I discuss three problem areas. First (Figure 2) is hip fracture. There are about 225,000 hip fractures per year in the United States and by the year 2000, this will have risen to almost 350,000. Since repairing a hip fracture is a surgical procedure, we must be careful in our planning to be sure that we have enough surgeons and surgical suites to operate on this increased number of people. By the year 2020, there will be more than 500,000 hip fractures occurring in the United States each year.

Alzheimer's disease (Figure 3), is a more common disorder of the elderly. There are now in excess of 2.6 million patients with Alzheimer's disease. By the turn of the century, there will be almost 4 million people with Alzheimer's disease and by 2020, this number will have risen to almost 5 million.

Finally, let's talk about nursing home residents (Figure 4). There are currently about 1.4 million people over age 65 in nursing homes, half of whom are over age 82. By the year 2000, there will be approximately 2.0 million people in nursing homes and by 2020 the number will have risen to 4.0 million.

I ended talking about nursing home data because nursing home use is a portion of long-term care for which the highest degree of knowledge and solid information is necessary to catch up to the decisions we are already making. Our goal must be the prevention of the need for long-term care and postponement of its use. Without documentation of the population increase and of the specific causes for loss of function and need for long-term care, we remain on the receiving end of paying for an increased need which can be handled less and less well in future years by current means.

The baby boom starts to turn 65 in the year 2010, with startling implications. We now depend very heavily for long-term care on family and other social supports. In the years to come, families will be smaller and women will be working. This puts a predictable strain on the system which we must quantify in order to determine needs.

The most burdensome problems of the elderly increasingly are non-fatal conditions such as blindness, deafness, osteoarthritis and other joint problems, and dementia. Better understanding of these and other age dependent situations could lead to effective prevention. The strategy is prevention through postponement. A good example is related to osteoporosis and hip fracture (Figure 5). In the United States, there are about 150,000 new cases of hip fracture per year among white women. The rate of hip fracture increases exponentially doubling each five to six years from about age 40. Parallel information exists about the progression of osteoporosis from age 20 through age 90. Research into the mechanisms involved in demineralization of bone which could delay the process for only six years would lower the rate of hip fracture by almost 50%. The key is to find the appropriate age and mechanism in a vulnerable structure whose pathology becomes manifest only late in life and postpone the onset of the process (in the above instance, osteoporosis). Ultimate prevention would be to postpone the occurrence of hip fracture to an age beyond death.

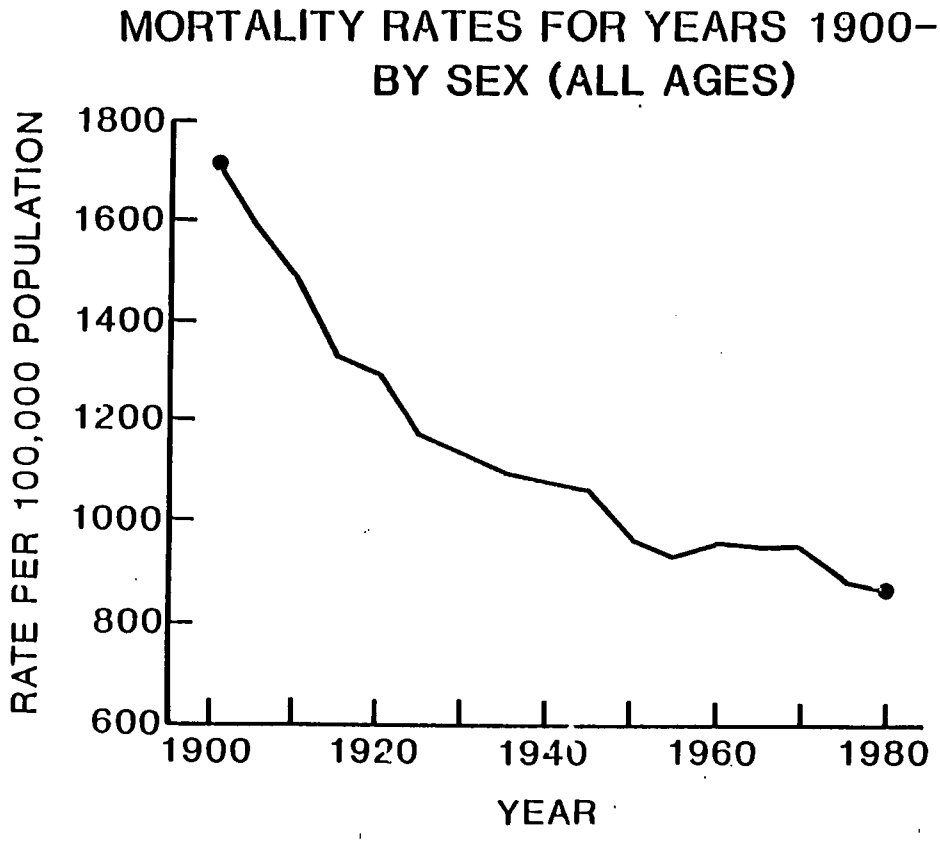
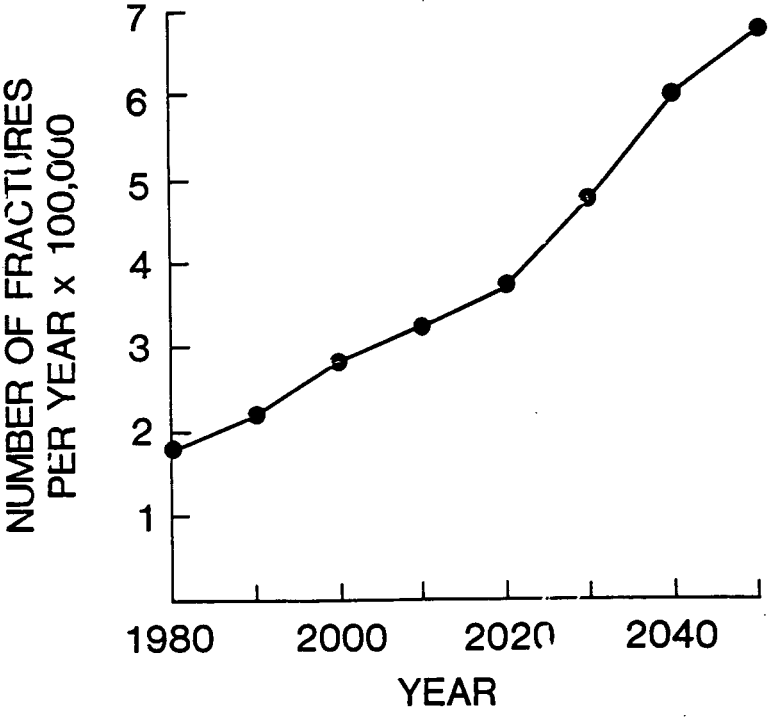

MORTALITY RATES FOR YEARS 1900-1980,
BY SEX (ALL AGES)
RATE PER 100,000 POPULATION
1800
1600
1400
1200
1000
800
600
1900
1920
1940
1960
1980
YEAR

FIGURE 1

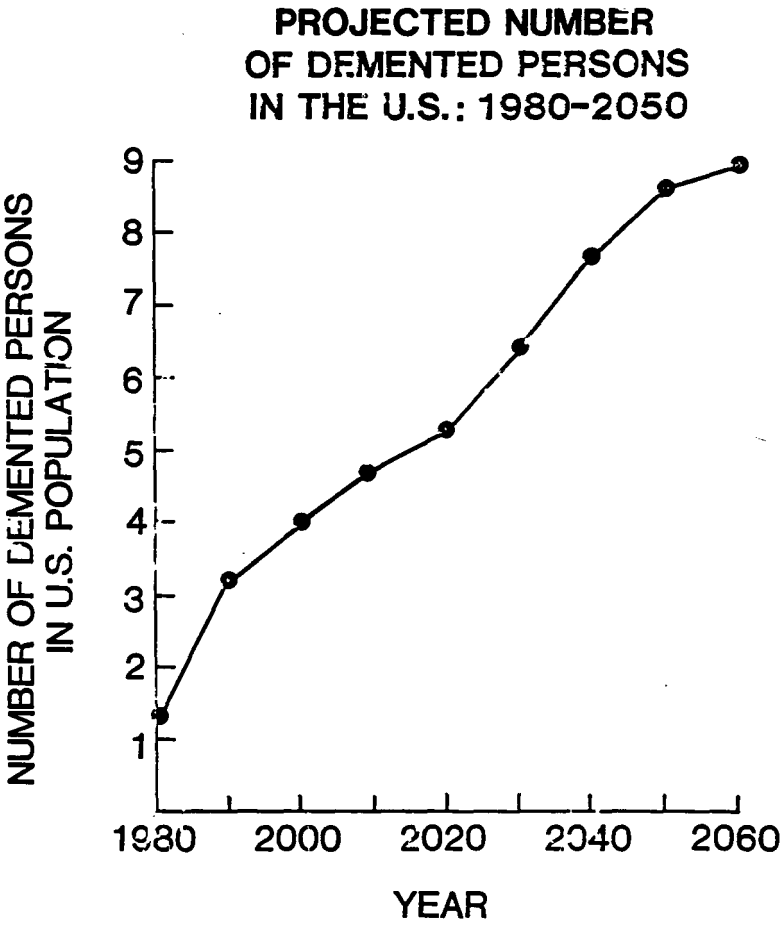
FIGURE 2

PROJECTED NUMBER OF HIP FRACTURES ANNUALLY IN THE U.S.: 1980-2050



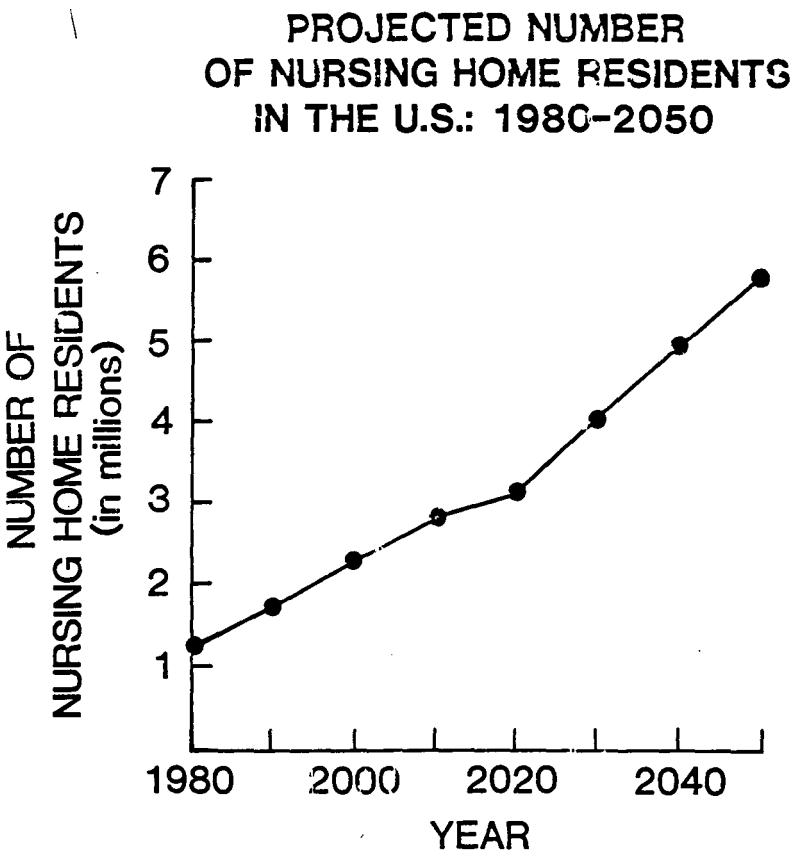
"Source: NCHS and U.S. Bureau of Census projections"

FIGURE 3



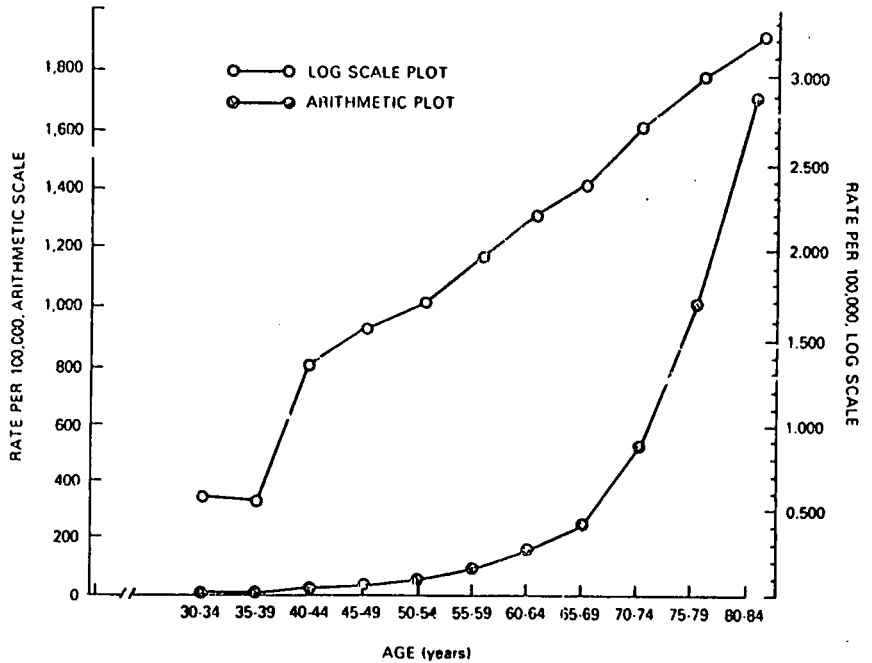
"Source: NIA prevalence estimates and U.S. Bureau of Census projections"

FIGURE 4



"Source: NCHS and U.S. Bureau of Census projections"

AGE-SPECIFIC HIP FRACTURE INCIDENCE AMONG WHITE WOMEN



Source: National Hospital Discharge Survey 1975 to 1979.

FIGURE 5

Representative SCHEUER. Thank you very, very much, Dr. Brody.

Now we will hear from Dr. T. Franklin Williams, Director of the National Institute on Aging at the National Institutes of Health. We are looking forward to hearing your testimony, Dr. Williams.

STATEMENT OF T. FRANKLIN WILLIAMS, M.D., DIRECTOR, NATIONAL INSTITUTE ON AGING, NATIONAL INSTITUTES OF HEALTH

Dr. WILLIAMS. Thank you very much, Mr. Chairman and Representative Fish.

PREVENTION RESEARCH

It is an honor to be joining my colleagues here, and I appreciate your holding these hearings. It is clear from the data that you and Dr. Brody summarized that with the growth of the older population and the inevitable increase in chronic illness and disability, our health care services will almost certainly be overtaxed in the coming years, as well as being highly expensive, unless we can achieve some real breakthroughs. From our Institute's point of view, the goals really are to achieve through research the opportunity to prevent the occurrence of disabling illnesses, to extend healthy life years and, as well, to address the common severe problems that are affecting older people.

Until very recently, the general view of old age was that people were expected to become frail and senile. They were expected to stop working at age 65 and to become nonproductive and nonfunctioning. We are now well beyond many of these previous myths. We know that people can live healthily into their late years. Many people remain quite productive in all sorts of ways and enjoy later life. We already have examples of what is possible. One of the very high priorities of our Institute is to advance knowledge about how to have more people achieve these later years more healthily.

Now, to be a little more specific, we are already finding a number of examples of what can be done. Exercise makes a world of difference when undertaken at any age. Recent studies have shown that even if people in their sixties and seventies who were previously sedentary, engage in a reasonable exercise program, they can improve their functioning; and risk factors, like blood glucose and lipids, improve considerably.

It is even better to start earlier, of course. Similarly, stopping smoking, even if one has been smoking into his or her seventies, is beneficial at any age. Other studies we have supported have shown that the decline in lung function stops, whenever smoking is stopped.

We need more studies on nutritional aspects. We understand some things about nutrition now, but it is a major area where we still have very little data on what would really be the best nutrition for older people.

So there are these challenges, and other aspects about life-style factors as well as physiological factors, where I think we can continue to make progress on maintaining good health into later years. In addition there are the major chronic diseases. I would like to emphasize the conditions that cause chronic disability.

We focus a good bit on the diseases that cause mortality—heart disease, cancer and stroke—and those are obviously important, but the disabling conditions that produce the heavy burdens of care on family members and ultimately on long-time care, such as on home-care services and on nursing homes and on hospital readmissions, are a very important cost item in chronically ill older people.

Dr. Brody has referred to osteoporosis and hip fractures, and, in the general area of problems affecting mobility, there is also the very common problem of osteoarthritis, an area that needs further research.

Certainly, the biggest challenge to older people, percentagewise, is that of dementia of the Alzheimer's type. As we all know, there are something like 2.5 million older people in the United States who now have this condition. The estimates are that this will double by the turn of the century. Costs are estimated as high as $80 billion right now per year for care of Alzheimer's victims, and you can estimate how they will go up in the future.

Representative SCHEUER. The third element in that trio of disabling conditions—in addition to dementia and arthritis—is incontinence.

Dr. WILLIAMS. Yes, sir. Incontinence is another very disabling condition. Very crippling. Exactly right, Congressman Scheuer.

Representative SCHEUER. As I understand it, there is a considerable feeling in the medical community that modest amounts of research devoted to those three crippling and disabling diseases that rob elderly people of their independence, that is, dementia, arthritis, and incontinence—a few hundred million dollars perhaps would have an enormous cost-benefit impact in delaying and perhaps delaying indefinitely the dependence that is so degrading of the quality of life and so extraordinarily expensive.

Dr. WILLIAMS. Yes, sir, I think that is quite accurate to say. We have already made considerable progress through research on urinary incontinence. We have demonstration projects which are showing up to 80 percent relief of this problem, in older women, particularly, with this problem. It is much more common in women, but it is also a problem in older men. We see real opportunities to decrease the burden of that problem already.

In the area of dementia, our total Federal research investment is on the order of $85 million, of which about $60 million is provided through our Institute and $25 million or so through other Federal agencies and other institutes of NIH. That is only about a tenth of a percent of the annual cost of this disease. We are investing more than we ever did before, but we are still investing a very modest amount compared to the cost of the disease. We are, however, seeing exciting breakthroughs. I have firm confidence that we will see real answers to the Alzheimer-type dementia. We have good clues now to the causation, not only the genetic component in some people but also very good clues to extraneous factors that impact on the brain and produce the changes. We will see some more exciting reports within the next few months. I think we have an opportunity to understand the causation of this disease and can then hopefully move to some preventive measures.

We are also, as you are probably aware, testing one promising drug for treatment of the symptoms. Tetrahydroaminoacridine—

THA—already has some promise for relieving the symptoms, and we will know more about it before the year is out.

I think we have a real chance to make an impact, and we need to do the same thing with osteoarthritis and osteoporosis. I think it is fair to say that we have an opportunity to make a big difference with what we can accomplish in research.

GERIATRIC ASSESSMENT

The final point I want to refer to is the importance of careful medical, nursing, and social assessment of the older patient who has complicated and multiple problems. We have just held a Consensus Development Conference that demonstrated the importance of comprehensive assessment on older people, and I believe that we have a good model for geriatric care. One of our major goals is to train more people in the competent delivery of care to older people. I will stop there and will be glad to answer questions.

[The prepared statement of Dr. Williams follows:]

PREPARED STATEMENT OF T. FRANKLIN WILLIAMS, M.D.

Mr. Chairman and members of the Committee, I am Dr. T. Franklin Williams, Director of the National Institute on Aging, of the National Institutes of Health.

Thank you for this opportunity to appear here today to talk about current and projected health care needs of our older population. Others on this panel describe the tremendous growth in the number of older people, projected figures for the future, and forecasts of the concomitant growth in the percentage of those who will likely suffer the various chronic illnesses and disabilities associated with aging. Basic to this discussion is the fact that more and more people are living to age 85 and older.

Obviously, the existing formal health care services (for this increasingly large group of older people) will be overtaxed unless there are major breakthroughs in medical research and until truly innovative approaches to care are developed. This committee's interest in the health needs of our older population is certainly timely.

Most older people are vital and independent members of society. A few decades ago, wheelchairs and rocking chairs, hospital beds and nursing homes were considered normal consequences of age. Illness, frailty, and "senility" were thought to be part of the aging process. Perhaps worst of all, upon reaching 65 years of age, a person was expected to enter the non-productive, nonfunctioning years. Thanks to progress in

medical research and medical care, and the adoption by many of healthier lifestyles, a more hopeful picture emerges of what can be vigorous and enjoyable later years. We often read about Supreme Court justices, artists, composers, and comedians who enjoy a ripe old age. What we rarely hear about is the older non-celebrity who enjoys community life, grandparenting, employment, and travel, and who is very much the norm rather than the exception.

Most people want to be independent and in control of their own destinies for as long as possible. A goal of the highest priority for the National Institute on Aging (NIA) is to conduct and support research to improve the quality of life for people who achieve longevity. Most people think of medical research as performing the important functions of finding first the cause and then the treatment of devastating diseases. In addition to these goals, medical research has a much broader scope. It encompasses prevention techniques, methods of care, and a whole host of biological, social, and psychological problems remaining to be solved. We cannot simply isolate one aspect of illness from another. They are very much intertwined and often create interdependencies which challenge our research and service delivery capacity.

Medical research, broadly stated, must minimize the impact of both deadly diseases and chronic disability for the patient, the family, and society. Breakthroughs in medical research and medical treatment have reduced mortality caused by heart disease, stroke, pneumonia, tuberculosis, and some cancers, among other

conditions common to older people. We must go forward with an all-out effort to inform the public about health maintenance practices which recent research has shown are both convincing and adoptable. We must impress upon people that changing one's lifestyle at any age is desirable. Studies show that it is never too late to begin a program designed to improve health status. For example, an exercise regimen can be started at virtually any age and prove beneficial to most people. We can reduce the incidence of falls by following some very practical remedial changes, and studies by NIA grantees have shown that the cessation of smoking at any age can halt the progressive loss of lung function. Though more research is needed, we also are beginning to understand the impact of good nutrition on the total physical and social well-being of older people.

In addition to addressing the challenges of maintaining good health, the National Institute on Aging and others in medical science are now turning more attention to those chronic illnesses which rob people of their independence. Included here are conditions such as Alzheimer's disease, osteoarthritis, urinary incontinence, and osteoporosis. Falls--which cause 200,000 hips fractures annually--are linked closely to the condition of osteoporosis. The critical problems that are posed by these disease conditions of long-standing concern, as well as newer diseases, may ultimately involve a great many older persons personally, as well as caring family members, and must receive our immediate attention. To help people to maintain, or regain, their independence, rehabilitation research is an

important facet to our studies on these chronic conditions.

Can we envision a world where there is little or no disability? What if, as a result of research advances, few, if any, older people became demented? What if osteoarthritis were no longer a functional problem for so many older people? Our research opportunities and efforts offer realistic hope that we can make such progress. Meanwhile, the burden of care for the millions of older persons who are afflicted with such problems are indeed enormous. A person who suffers from severe osteoarthritis, for example, may be so disabled that daily activities such as dressing, bathing, and meal preparation become impossible tasks. What becomes of this person? For the most part, an informal support system continues to provide care. Unfortunately, not all people have that option and the social and economic strain of caregiving often becomes overwhelming to families and friends. A whole range of services are needed so that disabled older persons can have access to and receive just the care appropriate and necessary to their needs--no more and no less. In addition to informal caregiving sustained by support groups and educational services such as the National Alzheimer's Disease Education Center which NIA is launching, we need integrated networks of affordable, quality in-home care, rehabilitation programs, day centers, respite care, nursing home care and hospice care.

How do we best deploy this range of services needed by older people who often have multiple chronic, disabling conditions simultaneously? To gain a thorough knowledge of such patients on

an individual basis, and to recommend the best type of care, requires a thorough assessment conducted by a team of professionals with a background in geriatrics. A multidisciplinary group consisting of at least a geriatrically trained physician, nurse, and social worker, often supplemented by rehabilitation specialists, pharmacist, psychologist, and dietitian, can best assess the right course of action for each individual and his/her family.

Geriatric assessment is basically a decision-making process in which the best, most appropriate, course of care is developed for and with a particular patient and his/her family members. A patient who appears depressed, has poor vision and is recovering from hip surgery may not require a long-term care facility. A qualified team of experts can assess nutritional status, initiate drug treatment for depressions if indicated, consider the possibility of cataract surgery and arrange admission to a rehabilitation unit. Here, the patient would learn to negotiate with a walker or cane, and patient and family would be helped to plan for managing the usual activities of daily living at home, with some help from a home care service if needed. This system of evaluation and care planning has been shown to lead to decreased mortality, improved functioning and independence, and a diminished need for admission to nursing homes and readmission to hospitals. In October 1987, an NIH Consensus Development Conference, sponsored by the NIA with participation of geriatric leaders at the Veterans' Administration, the National Institute of Mental Health, and the academic community, documented these beneficial effects and

recommended wider use of this approach, together with further research to help identify just which older persons may most benefit.

We need to further address the quality of life experienced by an older person who suffers perhaps a myriad of illnesses. With an integrated assessment by a team of professionals, a care management approach which considers every person as unique, and selection of services to assure only that type of care which is necessary, the welfare of the affected person and his/her family will be improved and the financial burdens on them and society reduced.

In order to achieve the optimum value of the approaches I have been describing, to ensure the best care for our older people, we need to expand our educational programs to include more training in geriatrics and gerontolgy. The report, Personnel for Health Needs of the Elderly Through the Year 2020, submitted to Congress at its request in September 1987 by the NIA, and the Bureau of Health Professions of the Health Resources and Services Administration, with the assistance of other federal agencies, documents the extent of this need. Shortages of faculty members and other leaders with adequate preparation in aging are a serious constraint in the development of further activities in undergraduate, graduate, continuing education, and in-service training programs.

The NIA, in carrying out its Congressional mandate to conduct and support biomedical, behavioral, and social research and training related to aging and the common problems of older

people, is focusing attention in many areas, as well as coordinating aging-related research by other federal agencies and guiding international efforts. Our agenda extends from basic studies of the molecular, genetic, and cellular changes of aging itself, to the major plagues of later life, such as Alzheimer's disease, to preventive measures, treatments of disability conditions, and the appropriate use of multiple components of care. I believe these efforts will continue to achieve for older people better health, increased independence, and improved care. The investment being made today to investigate these and many other conditions is our most certain way to improve the future quality of life for our older citizens and reduce the relative costs to individual and society.

Thank you. I would be glad to answer any questions the committee may have.

Representative SCHEUER. Thank you very, very much, Dr. Williams.

Dr. WILLIAMS. Yes, sir.

Representative SCHEUER. And now we will hear from Dr. L. Gregory Pawlson, director of the Center for Aging Studies and Services at George Washington University.

Please proceed, Dr. Pawlson.

STATEMENT OF L. GREGORY PAWLSON, M.D., DIRECTOR, CENTER FOR AGING STUDIES AND SERVICES, AND CHAIRMAN, DEPARTMENT OF HEALTH CARE SCIENCES, GEORGE WASHINGTON UNIVERSITY, WASHINGTON, DC

IMPACT OF AGING POPULATION

Dr. PAWLSON. Thank you very much. Well, as you know, it is very difficult to project future costs. I think the impact of our aging population is one that this subcommittee is very appropriately focusing on. By my calculations, if we had the same demographics now that we will have in the year 2045, our medicare costs, instead of nearly $100 billion would have been nearly $200 billion. Our medicaid costs for long-term care would have probably approached $75 billion. With the impact of that and because of the fact the working population is not going to grow a great deal between now and the year 2040, and because of this baby boom generation moving through, the effect on the national debt would have been probably $100 billion to $150 billion in additional costs just due to the health care costs. Se we are facing a problem of absolutely great importance.

Now with all due respect to Professor Reinhardt and Mr. Califano, I don't see how we are going to reduce much of the costs except through a much better understanding of the health care system and the diseases that affect elderly.

Representative SCHEUER. I didn't get that. Would you repeat it?

Dr. PAWLSON. I don't believe in that kind of magical solutions of saying, well, we're suddenly going to cut all the waste and inefficiency out of the health care system. Having spent a year as a fellow on the staff of the Senate Finance Committee with Senator Mitchell, I at least came to the point, where most of the time when people came and said we can save $80 billion by doing this, when you investigated it further, you found out that it was much more difficult than they had said. And I think that for us to really begin to control health care costs, it is going to take a tremendous amount of better understanding about the health care system and probably a change in our outlook and our perception in the way health care is used in this country.

Representative SCHEUER. I think that both Uwe Reinhardt and Joe Califano would echo those sentiments completely. Neither of them suggested there were any simplistic quick fixes. You are quite right. It is a very difficult job, and there are a lot of entrenched interests out there who view with a jaundiced eye any attempt to rationalize our health care delivery system. It's grown in a disorganized, chaotic, overlapping, and duplicative manner. It is going to be a very difficult job. But I think the consensus in that first panel was clear. They looked at experience abroad and experience at

home. We are paying 50 percent more, at least, than other advanced developed countries, and we simply are not getting our money's worth. We are not getting superior health outcomes to those countries, and we are spending a heck of a lot more on a per capita basis to get very uneven results. Superb results for portions of our population, painfully inadequate results for other portions of the population.

So you are quite right. It is a very difficult, complicated, sensitive, emotion-laded business, this whole question of recasting and reorganizing our health care delivery system.

RESEARCH PRIORITIES

Dr. PAWLSON. I would agree. I think in order to effect an approach that is going to get us the best we can get for the amount of money that we can spend on health care, we are going to need a multipronged approach, and I would just like to lay out a few of what I think is going to be required.

First of all, the research that I think Dr. Williams very nicely laid out. As a clinician, one is struck by the difficulty in getting people to focus on those diseases which cause disability rather than the more spectacular diseases perhaps that cause death, and it is hard for people to focus on the fact that a disease like osteoporosis or dementia cause such an amount of human suffering. And so we do need increased research in those areas.

The second thing we need is much more research and understanding on the effectiveness of technologies, both diagnostic and therapeutic, when used for older persons. It is absolutely remarkable to me as a clinician, when I realize how little we know about many of the things that we apply. This gets to the point I made about how difficult it is going to be. In this country, we do all that we think or presume will do good in a given situation rather than having real knowledge of what actually has been proven to be good. We use technology that we think might work, and we apply it to everybody in the whole population very quickly, which costs billions of dollars before we really carefully define whether or not it is effective, or cost effective. I think we are going to have to come to a much better understanding of that if we are going to utilize health care resources in a better way.

The third thing we need in terms of more knowledge and research is research on health care systems and especially on those health care systems which deal with the care of the frail elderly. This is the group that can be defined as those who have multiple restrictions in their activities of daily living. We do not have a system that adequately takes care of those individuals. They are put, as you very nicely noted, into a fragmented health care system. We need better methods of assessment. Dr. Williams mentioned geriatric assessment, which I think is an important new tool. We also need very careful management techniques. The idea that, for instance, care at home is going to suddenly reduce the costs of care, I think, has been shown in the last couple years to not be true. It may be better, it may be desirable, but it can cost $65,000 or $70,000 a year to take care of somebody in a home in the

same way, in terms of round-the-clock nursing and so forth, that they may receive in a nursing home.

So it is not going to be a magic panacea.

Representative SCHEUER. I regret interrupting.

HOME VERSUS NURSING HOME CARE

Is there a cutoff line for the kind of home care that not only is much nicer for the individual, perhaps nicer for the family—that's a tough one—and still be cost effective? And that order of magnitude of home care, when you start getting three shifts a day and so forth, where it really becomes a burden to keep that person at home, which is justifiable, perhaps, if the family can pay for it, but if society is going to pay for it, it would be so much more expensive to keep them at home than in an institution that is set up for that, that probably society would opt for the institution, if society is going to pay.

What are the criteria that would constitute a dividing line?

Dr. PAWLSON. I wish I had a nice succinct answer that we had a way of assessing, that this person is better cared for at home and this person in a nursing home—it is really a continuum. In economic terms, as I know this committee deals with a great deal, you are really on the old cost-benefit curve; and there is some point on that curve, and unfortunately, it is a curve. Nature treats us poorly in this way. There is no cutoff. At some point, it would seem like the cost of providing care at home wouldn't meet the criteria that you sort of indicate, in terms of what society is willing to pay.

Representative SCHEUER. Can you give us a simple definition of what might constitute the breaking point, let's say? What are the characteristics that make it seem not cost effective?

Dr. PAWLSON. I think the breaking point probably is where you do need essentially around-the-clock skilled nursing care. That becomes almost, by definition, too costly. But it isn't any simple cutoff. It really is sort of creeping gradualism, and suddenly you are in the point where you need that. I think that is very, very difficult to determine and it is very difficult for us in practice.

PREVENTIVE CARE

The second major area that I think we need to attack is the area that Dr. Brody addressed, and that is the area of prevention. I think we have to be careful, while some areas of prevention are very effective in elderly persons, and we have a great deal to overcome in terms of implementing preventive practices—you know, prevention is not very sexy in practice. You don't get reimbursed well for it. You don't see any immediate results. I can treat a person for pneumonia. They get better. They're very happy that they got better. They thank me. I can prevent a person from having a heart attack—but I don't know who I prevented from having a heart attack out of the 50 people that I convinced to stop smoking.

So it is a very difficult area.

We also have a whole lot of ignorance. Elderly people think prevention is not important to them, and yet because of the decreased reserve that older persons have, sometimes prevention is more im-

portant in the elderly than it is in the younger population. So we need to focus on that, but we can't fool ourselves, because, as Dr. Brody pointed out, if what we do by prevention is delay death more than we delay the onset of disability, we are going to increase costs. There have been a number of interesting analyses in this area. If you live longer, you have more years that you are going to use medicare and social security. So that to couch all this in terms of cost savings, I think is probably misleading. It does enhance the quality of life for some period of time, and I think that is what we ought to be focusing on. We are not just, you know, around to save costs.

BETTER GERIATRIC TRAINING

Finally, I think we need to focus more efforts on the training of individuals to take care, and especially to take care of the frail elderly population. It takes a different mindset to taking care of individuals whose outcomes are very different. You have some elderly persons that you hope to rehabilitate and to raise to a much higher level of function than they are right now. You have others that are unable to achieve any gains. A colleague of mine, Dr. Joanne Lynn has observed what we really do in geriatric medicine is, we try to provide the best alternative future for the patient. We don't necessarily just treat illness, but we have to look at what the best future is for each patient. In some elderly individuals, the best future is really a humane and comfortable death, because there is nothing else we can do. And that has to be recognized. We simply do not have enough individuals in medicine, nursing, social work, or any of the allied health professions who really understand both the problems, the diseases, the illnesses of aging and this multipronged approach that one has to take to caring for elderly patients. Thank you.

[The prepared statement of Dr. Pawlson follows:]

Prepared Statement of

L. Gregory Pawlson, M.D., M.P.H.
Director of the Center for Aging Studies and Services and
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George Washington University

The Future of Health Care in America

Current and Projected Health Status of the Elderly

Congress of the United States
Joint Economic Committee

June 14, 1988

The profound demographic changes that are almost certain to occur in the United States in the next 50 years have become a topic gaining frequent coverage both in the scientific journal and in the popular press. Because of the relatively heavy use of health services by those over 65, the changes in that sector will be large, especially in the period from 2015 to 2050. During that period we will face the twin phenomena of the graying of the baby boom and the impact of changes in longevity that already occurred but which have been largely hidden by the entrance of the baby boom generation into the work force. Compared to present use of health care services by those over 65, we face a two to three fold rise in the use of hospital and physician services and a nearly four fold rise in the use of long-term care services by the year 2040. Projections of the cost of care even ten years in the future are very uncertain. However, it is instructive to note that if our current population were similar in size and age distribution to that which will exist in the year 2040, the Medicare program would have spent nearly twice the nearly one hundred billion dollars we did spend, and the Medicaid program would have spent almost 75 billion dollars on nursing home care alone. Given the fact that the number of those in the work force is not likely to increase substantially between now and 2040, it is likely that our federal deficit would have been over 150 billion dollars greater just due to the increase in health care costs for the elderly.

Thus, it is very appropriate that the Joint Economics Committee is examining the issues surrounding the demographic imperative, and its effect on health care in particular. While my focus will be on the clinical aspects of the care of the older patient, I would like to strongly endorse the need for research, especially on those problems such as dementia, osteoarthritis and cardiovascular disease, which account for a large proportion of the chronic illness that cost our older citizens so much, both in human and economic terms. A moderate increase in support for research aimed at curing or preventing illness in the older individual is one investment that has a high probability of a positive long-term gain. In the remainder of this testimony I will briefly discuss some of the issues surrounding the use of preventative measures in the older person, then examine the special health care needs of those with functional impairments and finish with some observations about health manpower and educational needs. Obviously, because of the need for brevity I will only touch on a few issues and even those in a rather superficial way. I would be glad to work with you and the members of your staff to supply further information or materials on any of the issues discussed.

First, in terms of specific preventative measures, we are reasonably certain that in older persons periodic breast exams, including mammography and PAP smears, to detect cancer of the cervix are relatively effective and under-used. Given the

relatively high incidence of colon cancer in those over 65, it appears that the use of simple non-invasive test for occult blood in the stool is likely to be of benefit to most older persons. The use of more invasive and expensive screening tests, such as colonoscopy or flexible sigmoidoscopy, is of benefit in high risk individuals (such as those with a history of prior colon cancer), but we do not have sufficient information to conclude that such tests should be used in the population at large. The screening of certain high risk population of older persons (such as those in nursing homes) with a skin test to determine exposure to tuberculosis is also efficacious. By contrast, the routine use of the chest x-ray for screening is not useful.

The management of risk factors for cardiovascular disease in older persons can also be an important element of prevention of disease and disability in older persons. The cessation of smoking and control of hypertension produce clear benefits regardless of age. Less evident is whether attempts to reduce cholesterol by diet or with drugs currently available is of sufficient benefit in older persons to warrant large scale interventions. While we do not as yet have all the data we need to be certain, the use of exercise, carefully matched to the individual's capacity, appears to result in several positive outcomes. Finally, the use of the pneumococcal and influenza vaccine in those over 65 in the primary prevention of pneumonia has been shown to be effective in older persons at a cost that is not excessive.

Our efforts to use preventative measures in older persons suffer from three major barriers: ignorance, a lack of well defined research in the area, and our reimbursement system. Many older persons, and sadly many of their physicians, feel that preventative measures are of little or no use in older persons. Yet, it should be noted that because of the high probability of disease in the older population, some preventative measures such as screening test for colon and breast cancer and the use of influenza vaccine and pneumococcal vaccine, may be more cost-effective in the elderly than in younger populations. Indeed, because of a more limited ability to respond to disease, prevention may be the only effective intervention in some situations involving older persons.

The lack of reimbursement for preventative services in Medicare is shortsighted and costly. It would seem, to use an analogy, that we would rather pay to replace the engine, than to occasionally check the oil. Steps to improve reimbursement for preventative measures, such as the inclusion of limited coverage for mammography that was contained in the Medicare Catastrophic Insurance bill, is essential. Finally, as in most other areas of health care services and delivery, we have not invested even the minimal research dollars necessary to determine the efficacy and cost-effectiveness of most preventative measures. I do not see how we can effectively manage the vast, but not infinite, health care resources of this country without a far better understanding of the usefulness of the procedures and interventions that we

apply to patient care.

Even if the research on diseases and conditions of aging, and the use of preventative measures exceed our most optimistic projections, it is almost certain that the period before death for most of us will be preceded by a period of chronic illness and functional decline. Those older persons in this category are often termed the "frail" or "vulnerable" elderly to distinguish them from the majority of those over 65 who are vigorous and in generally good health. It is the frail elderly who use the vast majority of long-term care services.

The more our health care resources become constrained, the more important is the need to improve the efficiency and effectiveness of the considerable quantity of care that is needed by the frail elderly. Thus, the way in which we organize and utilize services in the care of the frail elderly is one of the most critical challenges facing our health care system in the future. Action is needed now if we are not to further compromise our future economic position in the world economy.

While we have not found the perfect health care delivery system for caring for the frail elderly, we are beginning to recognize the basic elements that are important. First I would like to comment on the process known as geriatric assessment. This is a modification of the traditional medical history and physical exam in which a multi-disciplinary group of health care

professionals carefully and systematically determines not only the medical diseases present in an older person, but the range of social, psychological and cognitive functioning present. This assessment, coupled with appropriate problem management, has been shown to be useful in a variety of settings. Applied in a carefully selected subset of the frail elderly (such as some of those being considered for admission to nursing homes), studies have indicated that the process may reduce the length of stay in acute hospitals and the long-range use of nursing homes, as well as improve functional outcomes. Using the results of the geriatric assessment, the providers of care can devise a plan that best meets the needs of the individual patient. While there is a considerable need for further research as to which elements of the assessment and management are most critical, and which groups of elderly obtain a sufficient benefit from the process, the process has already undergone more evaluation than many procedures that are in common use.

Just as important as the assessment is the management of the care in an organized and coordinated fashion with an emphasis on rehabilitation and maintenance of function. Our current system of isolated, fragmented services, with little linkage between hospitals, home care and nursing homes, or between physicians, nurses and social workers, is, for the growing number of frail elderly persons, ineffective and wasteful of resources. More support for research and demonstration projects involving innovations such as the "social" HMO's, nursing home without

walls, and continuing care residence communities will insure that we will be able to meet the challenge we face in the future.

Implications of an aging population on health manpower needs are also considerable. The need for more education and training on the aging and the special need of the elderly have been recognized in most of the health professions. Yet, the response has been late in coming. Geriatrics, which is the application of knowledge about aging and older persons to the clinical setting, has had the misfortune to emerge during a period of increasing competition for clinical training dollars, and in the case of nursing, in a period of scarcity of persons entering the field. The virtual absence of academic and clinical role models; and the lower pay or reimbursement for care in many long-term care settings, has further impeded our ability to educate individuals willing and capable of providing services to the frail elderly. In the area of medicine, the authorization by Congress in 1986, and subsequent appropriation in 1987, of funds to expand the number of advanced trainees in geriatric medicine should significantly expand the number of faculty available in the future. A program, currently being considered by the Senate and House authorizing committees, would provide a small number of "centers of excellence" in geriatric medicine to help insure the education and research base needed for both training and improved patient care. The key role that the Veterans Administration Hospitals have, and must continue to play in the development of geriatric medicine, should also be noted.

In the areas of nursing; dentistry, social work and the allied health professions such as physical, occupational and recreational therapy, there is a major need for expansion of current efforts to train practitioners that are knowledgeable about aging and the care of older persons. As we have noted, a critical element in the effective care of older persons is the active involvement of a well coordinated multi-disciplinary group of professionals. The appropriate education of nurses and social workers is just as critical to the health care needs of many older persons, as the education of physicians.

In closing, I am cognizant that I, like almost everyone else who appears before a Congressional panel, asks for more federal support for their particular area of interest. During the time in which I had the privilege of serving as a fellow on the staff of a member of Congress, I sometimes grew frustrated at the seemingly endless parade of witnesses asking for more federal funds, while there are increasingly limited resources and an ever growing federal deficit. Yet, inaction will only increase the burden that we hand to our children and grandchildren. Thank you for your attention and I will be pleased to answer any questions you might have for me.

IMPORTANCE OF PREVENTIVE CARE

Representative SCHEUER. Dr. Pawlson, how do you explain your statement that preventive care is more important for the elderly, who by definition have a smaller life span in which the preventive health care can be effective, than it is for the young?

Dr. PAWLSON. Let me give a practical illustration.

Representative SCHEUER. Simple logic would sort of indicate that it would be the reverse.

Dr. PAWLSON. Yes. I know. And that is one of the things we sort of struggle against in a sense, because let's take influenza vaccine. In a younger person, giving them influenza vaccine may prevent 5 or 6 days of misery, in terms of high fever, muscle aches, and so on. In an elderly person, it can prevent death, hospitalization, pneumonia. So that in some certain ways—another example——

Representative SCHEUER. In other words, you are saying that because they're more frail, they're sort of living at the margin, and they are more vulnerable to the slightest thing that could send them into a spiral of serious negative health outcomes, that it is just that vulnerability that means that some preventive care can avoid catastrophe?

Dr. PAWLSON. That is precisely right. The margin of reserve is smaller, so that they are much more easily shifted over into a catastrophic illness. The same way in colon cancer. Because colon cancer is much more prevalent among elderly people, the use of some screening for that actually is more cost effective, because you pick up more cases. You have to screen many, many more people at age 45 than you do at 65 to come up with several cases of colon cancer. So it may actually be more effective in certain age groups, and that is a sort of a balance between the fact that you said that people don't live as long as after 65, as they do after 45 versus the prevalence of disease and the amount of damage that is done if they do develop the illness.

So it is something that does need a lot more study before we go out and say everybody should have blank—we do know that——

Representative SCHEUER. I suppose if you waited for the over-85's or even the over-100's, you'd get a more cost effective application of colon cancer tests, because more people in those elderly age groups would be about to get it or would be in the process of getting it.

Dr. PAWLSON. We don't actually have enough knowledge about the natural history and the incidence and prevalence sometimes of that in the very, very elderly, because we've never had that many to study, and that is one of the things that the epidemiologists are starting to tell us a little bit about, is to how many of these people there are and whether the incidence of colon cancer continues to rise, or whether it falls off with time. So that all those who are going to get it have already gotten it because of genetic factors. Maybe the population of over-100's are superpeople who won't get it. So we don't know.

Representative SCHEUER. Congressman Hamilton Fish, a highly contributing and very effective member of this subcommittee.

Representative FISH. Thank you, Mr. Chairman. When you just asked that question about strategies for the young and not the old, I think, first of all, of course, that most children in the United

States get inoculated for the whole series of things that are no longer a problem, but I was reminded that my daughter called me a couple of days ago and said that my 3½ year old grandson had his first—I think she put it this way, his first boy's accident. It turned out to be 16 stitches in his hand and arm from putting it through a window, the whole arm and then attempting to pull it back. But maybe that's the answer, that there's no way to prevent boy's accidents through a certain span of years there.

ANTICIPATING THE NEEDS OF THE ELDERLY

I just want to compliment you on the timing of this particular hearing and the subject. We had a very traumatic time last week, when we dealt with the question of whether or not we should consider the bill proposed by my colleague from Florida, Congressman Pepper, on financing of home health care, and it was quite apparent that the majority of the House, while recognizing this as an important consideration, was not sure of the strategy and not sure of the cost estimate that we had before us, which were really quite varied. I think that Congressman Pepper did a great service in making the House of Representatives focus on this issue and having those who had to speak against his measure to commit to taking it up. So that what excites me this morning is the fact that there we were considering expansion of medicare to take care of people in their homes, and if I have been hearing you three gentlemen, you are saying that—in the words of Dr. Brody—our goal must be the prevention of the need for long-term care and postponement of its use. And certainly that, if nothing else, is a marvelous thing to hear and a challenge to us who operate within this enormous concern of a Federal budget deficit every year.

So with that in mind, it seems to me—this is a question for any one of the panel—it seems to me that we are facing fairly belated recognition of the need to provide special care for the elderly and special training for the medical profession in the care of the elderly.

Well, given the projections of the Social Security Administration, the Census Bureau with respect to increases in life expectancy, shouldn't we have anticipated some of the needs for long-term care prior to this?

Dr. BRODY. Part of my remarks, by pointing to the period from 1950 to 1968 in which life expectancy was not increasing and that was the time we enacted medicare. We didn't realize that it was not increasing because so many people were dying of heart attacks who now are not dying of heart attacks, and now longevity is increasing very rapidly. I think we have to be studying for events like that, because we could easily take a spurt forward or a downturn. The ability to analyze these data rapidly, which is improving, has had setbacks. I've testified on a number of occasions concerning Federal statistical agencies. Unless we buttress these, we will have surprises, which can be particularly costly. We should have anticipated that or at least known by 1965 or 1966, when heart disease—deaths from heart attacks were declining that this was going to prolong life very rapidly.

Dr. WILLIAMS. I just want to add, Congressman Fish, that we have had information at least since the 1960's from studies around the country indicating both the extent of need for long-term care and the possibilities for minimizing it, even if we don't undertake prevention. I certainly start with prevention as our Institute's first goal, but we have had studies—and I refer especially to those where I came from in Rochester, NY, and that region of New York State—where a careful communitywide study showed the extent of need for long-term care, and also the fact that about half the use of nursing home beds was inappropriate and unnecessary. I think you will hear from Mr. Eggert later this morning examples of how steps have been taken to use care more appropriately; that is one of the things it is very clear we can do, and which Dr. Pawlson referred to also. If we make more appropriate decisions about just what mix of care is needed for each individual older person, there is no question that we can decrease the total costs and need for services. That is part of meeting the biggest challenge of prevention. We can do a lot better than we have done in long-term care.

Dr. PAWLSON. One other just quick thing, another reason we didn't recognize it is the whole thing has been hidden by the baby boom. You know, we had this longevity increase, but because we have had this huge influx of young people into the workforce, it got hidden, because the number of people paying into social security suddenly has exploded over the last few days. You know, I think it is a phenomenon that society sort of focuses on the group that is the largest and most vocal, and so on, and we have sort of lost it. We've lost a couple of valuable years. And I would just—while I don't want to, in any way, diminish the fact that we need much more focus on prevention and on research into actually preventing diseases, I think we would be fooling ourselves if we only recognize that and don't take some very positive steps to deal with the financing of long-term care, not only now but more importantly in the years that we are going to have these incredibly difficult demographics form 2020 to 2050. I think that is a gift we can leave our children and grandchildren, if we choose to deal with it.

DISABLING CONDITIONS MOST EXPENSIVE

Representative FISH. I missed, I think it was Dr. William's statement here, and I just wonder why the focus is entirely on these disabling conditions, such as arthritis, hip fracture, dementia, and we are not talking about strokes, we are not talking about heart attack victims.

Dr. WILLIAMS. These are several reasons why I stressed the disabling conditions. One is that, when it comes to the costs of care for older people, it is these disabling conditions which may persist for some years. Average survival with Alzheimer disease is 8 to 10 years. Also, people live many, many years with severe osteoarthritis or osteoporosis, the sequelae of hip fractures, and urinary incontinence. It is these prolonged periods of disability that are the most costly, while the killers, cancer, heart disease, and strokes, are, relatively speaking, short-term events for very old people. We do invest through the National Institutes of Health, obviously, a great deal of our resources in trying to find the cause and prevention of

these conditions, but that is because they are lethal. They do not add as much to ongoing health care costs as the disabling diseases.

Representative SCHEUER. Would my colleague yield for a single question?

Representative FISH. Yes; go ahead.

Representative SCHEUER. Yes, they are lethal, but these disabling and crippling diseases; arthritis, dementia, incontinence, they are not lethal, but they are very expensive.

Dr. WILLIAMS. Yes.

Representative SCHEUER. And they are quality-of-life-reducing, very much.

Dr. WILLIAMS. Yes, sir.

RESEARCH IN DISABLING CONDITIONS

Representative SCHEUER. Would you say that lookiing at the comparatively modest level of funding for research on these three areas: incontinence, arthritis, and dementia, and the enormous order of magnitude of the funding, let us say, on cancer research, that in terms of improvement to the quality of life for elderly people, as well as reducing the period of dependency that if you were dealing with a limited bag of researc dollars, and that probably isn't true, that it would make more sense on both a compassionate basis and on a cost-effectiveness basis, to transfer some of those many billions of dollars that we are spending on cancer research to research in these areas that are very much underfunded and that seem to hold a hope of significant reductions in the term of dependency and disability for elderly people?

Dr. WILLIAMS. I certainly think it is justified to say that we could very well, very usefully and valuably, spend more funds on research in these disabling conditions. I don't think we are wasting money on cancer research, because some of the fundamental discoveries in any of these fields spill over into the others. We are now finding that the work on oncogenes, the cancer-producing genes, has some implications for trying to understand aging itself. There is now evidence for antioncogenes that stop proliferation which may be a factor in aging and may actually be an important contribution eventually to controlling cancer. This is a very interesting area where the fields of cancer and aging meet. All I can say is that I am sure we could valuably do more research on the disabling diseases. At the same time, I don't think we are wasting money on cancer.

Representative SCHEUER. I didn't mean to suggest that we are. I yield back to my colleague.

Representative FISH. Thank you. Dr. Brody, what can you tell us about the status of research efforts directed at the causes of disabiling, debilitating diseases and research to devise preventive strategies for these illnesses? You did talk somewhat about Alzheimer's disease, I believe, but on the whole range of these diseases we're talking about, what is the status?

Dr. BRODY. The status is, until recently, they have been stepchildren. They have now gained a great deal of our attention. Dr. Williams mentioned that the funding for Alzheimer's disease and dementia has increased but is still a small amount in relation to the

disease. Osteoarthritis has been a battlement in terms of getting a grip on it, but the Institutes have recognized this and have targeted osteoarthritis and other joint diseases. Incontinence is receiving minimal support with very good results. If we could only get these expanded. There are several other nasties with age—blindness and deafness, in which I don't feel we are using the cutting edge physicians or researches. They are still in cardiology and cancer and not aging.

On these also very debilitating, distressing events of later life, we are getting away from the idea that they are inevitable, finally. But certainly in terms of the amount of funding received and the state of the art, we are finally bringing people into it, but at a slow rate, and in fact, we are at the stage where we are saying what we need most is training, to get a few people to attract a few more people to come in and join the good fight. It is the bright kid right out of—the Ph.D. or M.D. who goes into other areas, and we know that the older you get, you learn these are the areas that should be receiving more attention. I am gratified, though, to say that we are, in general, attracting more and more interest.

PROBLEMS WITH INTERNATIONAL COMPARISONS

If I may take the liberty to add or to make a comment on Califano and Reinhardt's remarks about our GNP. An item which is left out of most of the calculation, and I think should be included more in the future is that we make comparisons with other countries and comparing amounts spent becomes very difficult. We have a higher infant mortality rate than most of the developed countries, and so they have longer life expectancies, and so you make a calculation on that. If you look at the data, however, on life expectance at age 65, we still have this huge baby boom to come through age 65, we do as well as the top five countries in the world. Life expectancy in the United States at age 75 is the longest in the world. Now those are the sickest years. And so we have more people at compromised ages, and I think it is going to become increasingly important in making these calculations, not to just give it away and say it is costing us too much but to actually analyze with the demography in place, who the services go for and what they are likely to need. Thank you.

MAINTAINING INDEPENDENCE OF THE ELDERLY

Representative FISH. Thank you, Dr. Brody. Dr. Williams, you discussed the importance of maintaining the functional capabilities of older Americans. What can be done to ensure that a greater number of elderly people maintain their independence well into those advanced years?

Dr. WILLIAMS. A number of things could be done. In the first place, I would stress good lifestyle practices. We have good recent research on this documenting better than ever how much difference regular exercise can make, even if undertaken by previously sedentary older people. We know a good bit about nutrition, but we need to learn more. We certainly know that stopping smoking is beneficial at any age. We know that modest or no alcohol intake is beneficial, and we know that we can do things—in relation to

something Dr. Brody has just commented about to correct hearing and visual defects.

Beyond these ways of improving daily living and lifestyle, we can also go further than we have in screening and preventive measures. Dr. Pawlson also referred to some of this. Actually, there are beginning to be reasonable sets of recommendations about what would be good, effective, and cost-effective screening and preventive steps to take with older populations. I am part of a group here in Washington, the United Seniors Health Cooperative, which is about to complete a plan for recommended screening procedures for its members and to negotiate arrangements for reasonable costs to have these done.

But this comes down to the point of having good data on just which screening procedures are useful. For example, at what frequency are mammography and screening for cancer of the colon cost effective and valuable, At what frequency should influenza vaccine to given? What about pneumococcal vaccine? We are getting better data on these things, and I think we can approach laying out a regimen of screening and preventive procedures, as well as good lifestyle factors. Dr. Pawlson may have some other comments about that, too.

NEED CARE ASSESSMENT AND DEMONSTRATION PROJECTS

Representative FISH. Thank you, Dr. Williams. Dr. Pawlson, do you have anything to add to that?

Dr. PAWLSON. I would just add that it is very important as we begin to apply these in sort of initial demonstration projects that we very carefully gather data and evaluate the effects of the procedures, both not only preventive procedures but other new kinds of technologies that we are going to be applying. It is something that this country just hasn't seemed to want to do as much, as pay for things before we know whether they are any good or not. And I think that as you face the very real problems in the Federal deficit and our inability to sort of infinitely expand our spending, we are going to have to pay more attention to those things. We are going to have to pay more attention to the quality and cost effectiveness of things that we use rather than sort of rushing headlong into a new program. So that some money set aside for evaluation is absolutely key.

A number of the things that Dr. Williams had mentioned in terms of delivery of care to older persons, again, has not received the kind of careful evaluation and funding demonstrations that we really need to move forward, so I think it is very important to look at that side.

EDUCATION AND BETTER HEALTH

Representative FISH. Thank you. And if the Chair would indulge me for one more question. This is to any one of the panel that cares to respond.

Some experts say that because future generations of elderly will be better educated than their parents, these aging baby boomers will enjoy good health for a longer portion of their lives. Do you agree with that statement?

Dr. BRODY. Some of the most convincing evidence is the association of education with healthy life. The differences now in the U.K., where they have had national health insurance since 1948, between—they divide social classes into five—between the lowest and the highest social class is about 6 years of life expectancy, and this is with universal health coverage. So that the education itself seems to be a driving force in preserving longevity and an active life. This is an area we can, in prevention, postponement strategy, utilize. A better-informed—your opening remarks—a better-informed elderly population will live longer.

Representative FISH. Thank you very much. Thank you, Mr. Chairman.

Representative SCHEUER. Just to continue that thought, doesn't our experience prove that as Americans have made significant behavior changes, individually, to accommodate their health concerns about life-threatening happenings, the accommodation has been best and foremost among the educated, more educated people in our society, who are in on the information loop, so to speak. And I am talking about changes in behavior like smoking, alcohol, drug addiction, diet, exercise, and avoidance of violent situations.

I think you can make a good case that smoking is very quickly becoming a sickness of the uneducated, the ill-informed, the ignorant and of people who are not processing information that they may receive through books, magazines, newspapers, radio or television. And I think that phenomenon is probably increasing in our society.

Dr. BRODY. I would certainly agree with that. Right now, even obesity and very shortly over the next 2 or 3 years, AIDS, as it becomes more a disease of intravenous drug users and less in the homosexual, all those diseases—and conditions—are congregating in the least-educated portion of society. There is no evidence that the least-educated portion has reduced its smoking at all.

Representative SCHEUER. Well, I think every single demographic group in our society is reducing its smoking considerably, except, unfortunately, young teenage girls. Why they should be an exception I don't know. But if you look at the increase in smoking from a global point of view, the real increase in smoking is taking place in the poorest of the poor countries of the developing world, where a chap will get a job in a coal mine and his first entry into the cash economy, his first paycheck, he won't send money home to his family so his kids can get the clothes to go to school, so that they can get the books to go to school, he will go out and buy a couple of cartons of cigarettes with his first check. And of course, the cigarette companies are very well aware of this, and they see an educated citizenry being their worst customer, to paraphrase the clothing store ad, and so they are concentrating now vast amounts of advertising to make the uneducated feel that smoking is chic and upscale. Cigarette companies are doing all the things that they did successfully a generation ago in America, in these poor countries because now they are finding it increasingly difficult to do this with a far more sophisticated, far better informed, nonsmoking public in this country.

Dr. PAWLSON. If you want a kind of a penultimate example of what you are talking about, if you look at smoking, cholesterol,

obesity among physicians, and there's some very interesting epidemiologic work that is now being done and actually using physicians as an experimental group, and a couple of very interesting studies on risk-factor reduction. The cardiovascular deaths were so low that it was almost impossible to show much of the effect of the intervention, because the whole thing was—if I remember correctly—two or three times below what was expected in the nonexperimental group. And if you go to medical meetings and so, it is absolutely almost a rarity to ever see a physician smoke.

So I think that that just shows that you can—people will change risk factors and especially those people who really know what the risks are, and I think that along with some of the prevention measures we talked about is an area. I think one of the things we have to——

Representative SCHEUER. Let me just interrupt you one second, in defense of my own profession, this whole symbol of the "smoke-filled room," that is a figment of history.

Dr. PAWLSON. That's right.

Representative SCHEUER. There are no smoke-filled rooms around Capitol Hill. A generation ago, all of us would have been smoking. A lot of the folks out there would have been smoking. We still don't have prohibition of smoking in the Capitol, but I don't see a single person in this room that is smoking. And I will then further suggest to you that out of the 535 Members of the House and Senate, we do not have a single obese Member, not one.

Dr. PAWLSON. Yes.

Representative SCHEUER. We have some big guys [laughter]——

Representative SCHEUER [continuing]. But we don't have a single obese Member of Congress.

And you know, I occasionally point that out quietly to a constituent or two who has an obesity problem. [Laughter.]

DISINCENTIVES TO PREVENTIVE MEDICINE

Dr. Pawlson, you were talking about the difficulty you have in quantifying the effect you have when you counsel people about their health, tell them to stop smoking. You don't know how many of them did. You have a hard time figuring out how cost effective that time is, although you probably think it is well worthwhile.

How do we identify those elements in the reimbursement formulas that discourage exactly the kind of preventive medicine that you would like to encourage? And how would we alter the reimbursement formulas to encourage counseling by doctors, probably the most important care they could possible render? And any others of you, when Dr. Pawlson is finished.

Dr. PAWLSON. I think it is a difficult problem for a couple reasons. One is that one has to be careful, and this is something I hoped I learned last year when I was a staff member in the personal office of Senator Mitchell in the Finance Committee—to insure events that occur to everybody is kind of difficult, because—what I mean, insurance generally covers illnesses or events, like a fire in our home that we don't expect. And so if we say we are going to provide preventive services to everybody through an insurance principle, it isn't really insurance. It is really coverage or first-

dollar coverage. And the problem with that is that it can greatly increase utilization. So what is very important is defining the benefit very carefully then, so that we don't get overutilization, so people aren't getting screening services every week, when they really only need them or it's probably more beneficial to get them only every year.

So that is one major factor.

Counterbalancing that is the problem that I mentioned that from the standpoint of satisfaction of physicians, at least the way we are training them now, prevention doesn't bring as much satisfaction. It is more difficult to see, and I think we need not only better training in geriatrics but more emphasis in training our health professionals in prevention and allowing them to get more positive feedback, so to speak.

Representative SCHEUER. Well, let's elaborate on that.

Dr. PAWLSON. Yes.

PROMOTING PREVENTIVE MEDICINE

Representative SCHEUER. How do we get the vast majority of physicians to change their behavior and their priorities in a way that I think you three experts would feel is desirable, more concern with counseling, more graduates of the medical schools going into geriatric care and family care rather than some of the high-tech specialties that seem more glamorous? How do we provide some carrots out there? I don't think anybody wants to provide a stick, but how do we provide some carrots to encourage them to go into the portions of the health-care spectrum where they are most needed and to provide the preventive-health-care services that are the most cost effective and the most needed?

Dr. PAWLSON. I think that, first of all, we have to focus on the training and education, and we have to have ways of attracting some of the brightest and most capable, not only in research but in teaching, into those areas of prevention. And our medical school economies are sort of set up, based on the same reimbursement system, in a sense that I think it is to your major point, was that we now pay for technological procedures at a much higher rate per minute, per unit of time invested, and oftentimes when we do not, as I pointed out before, do not have good evidence as to whether what we are paying for is that efficacious or not, but we go ahead and we do it. At the same time, reimbursement for services where we are trying to provide counseling or preventive services or, for instance, geriatric assessment, which is the process that Dr. Williams alluded to, we don't reimburse adequately for that.

I don't think we have to increase the total pot, but the present reimbursement system grew up with some very peculiar kinds of influences which are far from the market, in terms of determining how much we pay any health care professional, whether it is physicians or nurses or social workers, in terms of technological versus cognitive kinds of procedures. So I really think that we need a readjustment there to, as well as the adjustment in the training and education, appropriately, sort of the effects of the reimbursement system.

Dr. WILLIAMS. May I just comment on this, Mr. Chairman?

Representative SCHEUER. Yes, indeed.

Dr. WILLIAMS. I certainly support those positions. It seems to me there are other things that also can be done. Where we have "health maintenance organizations" or health maintenance systems, we can go back to basic principles; these organizations were really initiated with the goal of health maintenance and the members were expected to get preventive procedures as a matter of routine and the physicians were reimbursed as part of the group to do this.

In our pluralist system, we also employ individually paid physicians and I think we need to take steps to adjust the overall rates of payment to include the costs of preventive and screening measures. The other comment I wanted to make concerns a very interesting model that I was told about recently from Oxford, England. The health officer there has introduced a health prevention nurse into the general practices in Oxfordshire, paying for it out of health department moneys. What he has done that nobody else has done is to have another supervisory nurse go around regularly and be sure that this prevention staff person is carrying out the prevention procedures. All the general practitioners said, "Yes. Sure we want to do prevention. Be glad to have the help." But the fact was that they weren't getting it going until this supervisory nurse came around and reminded them and showed them how to put it into effect in an efficient way in their office practices.

I think there are some organizational things we could do even in our country.

ALTERNATIVE CARE FOR THE ELDERLY

Representative SCHEUER. Let me just follow up on that question.

Doctors are overstressed, nurses are overstressed. The average nurse in this country doesn't have time for counseling. There is a tremendous nursing shortage in this country and we just saw an example of it on television this morning. So neither of those two professions, overstressed as they are, have time for counseling.

Do you think it would make sense for us to organize the delivery of health care, let us, at least say, for senior citizens with either some paraprofessionals or nonprofessionals who could be given a 3 or a 6 months course in geriatric care, who could take care of senior citizens and really be able to spend time counseling them on simple behavioral things?

Should we try to include, in a major role in the delivery of health care to frail or sick senior citizens, well senior citizens as a resource?

Is there a manpower pool—a womanpower pool out there, senior citizens in the last half of their sixties and perhaps the first half of their seventies who constitute an untapped source of talent, who have a lot of life experience, who have a lot of wisdom, and who, with a comparatively little bit of professional training could provide a significant percentage of health care services to seniors, including this all-important business of counseling them? And of course, they would have to be trained to detect when there is a real physical problem, an illness problem that would require a doctor or

a nurse, but in the broad array of just behavioral problems, they could play a very significant role on a very cost-effective basis.

Dr. WILLIAMS. I would like to comment on that. I think that is certainly a step we are going to need to go to, Congressman Scheuer. Models are beginning to be developed around the country of this type of approach of groups of older people who are helping themselves and ideally tied in with the health care system where they need it. I think it is a very important step, and I believe we will be seeing more examples of this, hopefully.

Representative SCHEUER. We are very happy to have Senator Wilson joining us. Senator, we are asking questions of the first panel, and if you wish to participate, I would be happy to yield to you.

Senator WILSON. Thank you very much, Mr. Chairman. I gather the purpose of the first panel is to find out whether or not we want to grow old. [Laughter.]

Representative SCHEUER. I think we are taking that as a given.

Senator WILSON. I am delighted that the hearings are being conducted, and I will simply listen. My questions really relate more to the second panel. Thank you.

Representative SCHEUER. Very Good. Thank you. We are running very late on this panel. It has been an extremely interesting panel. I have one last question for all of you.

LIFE EXPECTANCY AND HEALTH STATUS

Based on present knowledge, what are the trends in life expectancy at age 65 and how do these vary by demographic group?

Dr. BRODY. The life expectancy at age 65 has been increasing over the last 30 or 40 years, over the last century, really, dramatically. Life expectancy at age 75 is increasing. The United States seems to be responsive, and our older citizens are health-conscious and health-aware. The trend does not seem to be diminishing but rather increasing and the concept of this idea of prevention, postponement is something that is being accepted. The entire prevention effort in this age cohort seems to be promoting longer and healthier lives by the ways we can measure it and, of course, the ultimate or easiest way to measure it is that, at each age, we are living longer.

Dr. WILLIAMS. I would just add that we will still have very rare survival beyond age 110 to 120, because of the concatenation of multiple risk factors that come to play as time goes on. I don't know what my other colleagues would say about this.

Representative SCHEUER. You consider that area more or less the maximum theoretical limit?

Dr. WILLIAMS. It is pretty much the limit, because of the concatenation of multiple events that inevitably we are likely to have inflicted on us.

Representative SCHEUER. Let's take a figure of 110, as a example.

Will it be possible for us to perceive of most of those years, up to 110 as being reasonably happy, reasonably rewarding years, or will this phenomenon continue that for every year of healthy life expectancy extension, there will be, as Dr. Brody suggested, 2 or perhaps 3 sickness-afflicted years?

Dr. WILLIAMS. My judgment, Congressman Scheuer, is that we will actually see healthier years, but that is a judgment without adequate supporting data, thus far. My impression is that we are seeing more people who live into their eighties and nineties reasonably healthy, who, when they suffer a heart attack or stroke or cancer at that age, die very quickly and do not have a prolonged disabled period. But to carry out my hope, as much as a judgment, of limited disabled years, it really means we have to control or prevent dementia and arthritis.

I don't know what Dr. Brody thinks. He is very cautious about these predictions.

Dr. BRODY. I've been probably among the noted pessimists, with the sense that somehow the lungs and the heart were made of better stuff than the joints and the eyes and the brain and can preserve the body longer than various faculties can maintain it in a healthy and productive state. This means these are the challenge: blindness; deafness; dementia; osteoarthritis; and other things that we can postpone, because we now think we have pretty good general defenses against most diseases to propel us to, say, age 100. This is worth a tremendous investment in basic research and in the ways of implementing our prevention, postponement techniques.

Representative SCHEUER. Dr. Williams, we had testimony here in this subcommittee in one of our earlier days of hearings from Dr. Jack Feldman of the National Center for Health Statistics, and he wasn't quite as sanguine as you are. In fact, he implied that there has been virtually no improvement in the health status of the elderly and that was mostly because the functional limitations of the elderly have not been significantly reduced.

Am I reading a conflict, an inconsistency between your testimony and his that really doesn't exist?

Dr. WILLIAMS. I think we have a different view about it, and I think we really need more data, more sound information, to help resolve this difference. His agency and the Census Bureau, as well as some of our Institute's epidemiologic studies, will help provide this information. The National Center for Health Statistics' National Health and Nutrition Examination Surveys are one of our basic data sources. The 1990 census is going to be extremely important. I think it is conjecture rather than certainty, either way.

Representative SCHEUER. Well, this is not a conjecture, but it is a certainty that this has been an exceptionally interesting and enriching hearing for us, and we very, very much appreciate your testimony. The fact that we went as far over time as we did is testimony to how we were fascinated with you all. Thank you very much.

Dr. WILLIAMS. Thank you.

Dr. BRODY. Thank you very much.

Dr. PAWLSON. Thank you.

THE LONG-TERM CARE PROBLEM

Representative SCHEUER. All right. Now we will call Mr. Joshua Wiener, who is a senior fellow at the Brookings Institution; Mr. John Holahan, director, Health Policy Center at the Urban Institute; and Mr. Korbin Liu, senior research associate, Health Policy Center

of the Urban Institute; Ms. Marilyn Moon, director of public policy for the AARP, the American Association of Retired Persons; and Mr. Gerald M. Eggert, executive director of the Monroe County Long-Term Care Program.

I would like to recognize Senator Wilson for any opening statement that you may have, Senator.

Senator WILSON. Thank you, Mr. Chairman.

Representative SCHEUER. And then when the witnesses have finished their statements, I am going to recognize you before posing them any questions myself.

OPENING STATEMENT OF SENATOR WILSON

Senator WILSON. Thank you. I am most grateful for your courtesy, and I want to particularly commend you for holding these hearings on what is obviously one of the most critical, complex, and urgent issues, because it is the source of perhaps more gnawing anxiety for the elderly, I think, even than the fear of so-called "catastrophic illness." The fear of long-term illness is becoming an increasing reality for so many, and one of the most difficult parts of my job when I return to California is encountering the fears that senior citizens quite rightly have perceived. As they grow older there is a very grave prospect of their requiring and being unable to find the kind of long-term care that in fact they will need. Their families talk about losing everything that they have worked for, because they can't protect themselves against the financial burden of supporting a family member for an extended period in a nursing home.

Medicare pays only 2 percent of nursing home expenses and private insurance covers only 1 percent, which means that medicaid and uninsured individuals must struggle with the majority of the enormous financial burden that long-term care makes necessary. Many people tell me that they would jump at the opportunity to purchase long-term care insurance independently or through their employers, but that the insurance is just not available.

The House's defeat of the Pepper bill confirms that Congress still has grave reservation about the idea of committing substantial Federal funds to finance a further expansion of medicare. Most Members agree that Congress needs to find viable solutions to this problem without imposing what they think will be unrealistic new expenditures upon the Federal Government for those who are paying medicare premiums.

I look forward to hearing from our distinguished panel with respect to their views on this matter, and I have specifically invited their comments and will ask questions with regard to what I think to be one possible solution—in a way that I think is most innovative and cost effective. It was not my idea, but I was struck by it and it gained my attention and certainly enjoys my full support as an idea deserving of the most aggressive exploration. It is an idea developed by the Office of Personnel Management.

The proposal, simply stated, is to offer nursing home care and home health care coverage to, in this instance, Federal employees as a demonstration group who are enrolled in a group life insurance plan. The idea is a very simple one. The idea is that when a

young breadwinner is seeking to protect his young family against the contingency of his being taken from them or her being taken from them, he or she most likely will buy life insurance, determined to provide that security to that young family. But as the family grows older and as the young children whom the breadwinner has sought to protect, themselves achieve independence, at about that point the breadwinner, now aged, is confronted with new health care challenges of his own or her own and that is, of course, precisely what we are confronting today when we begin to worry about our ability to maintain independence in old age, about becoming a burden to children and about having the ability to obtain and to afford the kind of nursing home care that is increasingly a prospect.

I am told that some 43 percent of those between the ages of 65 and 69 can anticipate a prolonged stay in a nursing home at some point during the balance of their lifetime.

The OPM plan would allow Federal employees to convert their life insurance to long-term care insurance at no additional expense to the Federal Government and at a relatively modest additional expense to the members of that group life plan. The basic idea rests upon the convertibility of the built-up equity in the group life plan. OPM would finance a prepaid health care, that is, up to 3 years of either nursing home care or home health care by nursing professionals, in a way we have found to be actuarily sound under certain circumstances.

The idea that someone age 50 who had been a member of such a plan for 10 years could buy an additional $11 per pay period to achieve that kind of coverage, I think is appealing to many. And obviously, the idea is appealing as it looks beyond the immediate demonstration group. If it works for a sufficiently large group to afford the risk-sharing opportunity in the case of Federal employees, why would it not also do so in the case of any large affiliated group of employees, be they those of Pacific Telephone or General Motors or the University of California, whoever it may be.

In the case of Federal employees, there is a pool of over 3 million active Federal workers who do offer a rather tempting opportunity for that kind of a demonstration and tested incentive. It would seem to me too that it offers to the private sector, to private carriers, a potential new market that should tempt them to engage in a competition which presumably will benefit not just the immediate test group but the many others that would, I think, be at least as able to take advantage of the kind of risk sharing and convertibility offered to the demonstration group of Federal employees.

So it is my hope that by taking the lead to create a market in this area, the Federal Government can create a long-term care "domino effect" with more insurance carriers entering the market with existing insurance programs expanding to offer competitive services, and as a result of that prices will fall. The fall, the decrease in prices, presumably then will make it possible for private companies and for State and local governments to offer a long-term care insurance benefit plan, with this convertibility feature for individuals, so that they can purchase their own private coverage.

It is obvious that this is not a solution that will cover the entire universe of need. On the other hand, it seems to me to offer poten-

tial for covering a very considerable portion of that universe and to leave uncovered, as the burden for Federal efforts in some other fashion, a significantly smaller burden than would otherwise be the case if we were to seek direct enrollment of everyone over the age of 60 or 65 or whatever we determined to be an age at which we are entering upon the threshold of that kind of expectancy of nursing home care.

So I will be very interested in listening to our panel and hope that they will address that specific solution, along with the many others that are, of course, available.

I have been involved in a social HMO in the Long Beach area which I think has been distinctly successful. There certainly are other approaches, and it may be, Mr. Chairman, that what we will find is that a variety of approaches will be necessary in order to afford both the range of coverage at costs that are affordable and the opportunity for individual choice, which I am sure we would agree is desirable and a means that is, at the same time, affordable to the American taxpayer.

There clearly is a limit to what we can do by way of medicare or by way of medicaid. And the alternative to some kind of innovative approach of this kind or some of the others along the same line is to look, I think, to an expansion of medicaid, which it seems to me has real visible limitations.

So I would thank you, Mr. Chairman, for your extreme courtesy and look forward to the testimony of our panelists and then being able to question.

[The attachments to Senator Wilson's opening statement follow:]

PETE WILSON
CALIFORNIA

COMMITTEES
ARMED SERVICES
AGRICULTURE, NUTRITION, AND FORESTRY
COMMERCE, SCIENCE, AND TRANSPORTATION
SPECIAL COMMITTEE ON AGING
JOINT ECONOMIC COMMITTEE

United States Senate
WASHINGTON, DC 20510

October 6, 1987

Dear Colleague:

It is now estimated that Americans who reach age 65 have a 43 percent risk of spending sometime in a nursing home during the rest of their lives. Yet, currently less than one percent of the elderly have long-term care insurance. Unfortunately, even the limited availability of long-term care insurance is so expensive that it is beyond the reach of most families. As a result, many individuals are unable to receive the care they need or in many cases are forced to sell virtually everything they own just to pay the bills, which average about $60 a day or $22,000 a year.

For this reason, I have introduced legislation to make long-term care (nursing home and home health care) insurance available to some 2.7 million federal workers in the hope that this action will stimulate employers in the private sector to offer their employees group coverage. Furthermore, the extension of long-term care insurance to federal workers will provide the insurance industry with valuable information that should encourage the growth of long-term care insurance nationwide.

Here's now the proposed option would work:

* When an employee reaches a minimum age of 50 with 10 years' participation in the Federal Employees Government Life Insurance Program (FEGLI) he would be given an opportunity to convert to long-term care insurance;

* He would convert a portion of the face value of his Basic FEGLI (e.g., $25,000) and associated reserve funds to long-term care insurance and would retain a minimum $2,000 death benefit;

* He would continue to pay his share of the regular Basic FEGLI premium for any amount of life insurance remaining and would pay an additional long-term care premium based on his age at conversion;

* He would receive stated dollar benefits for nursing home or alternative home health care in accordance with the specific long-term plan selected at the time of conversion;

* He would be eligible to purchase coverage for his spouse at group rates without evidence of insurability, and to purchase additional life insurance;

* The Government would continue to pay its usual contributions for Basic FEGLI but contributions associated with converted life insurance would be redirected to the long-term care option. (There is no additional cost to the Government.)

* Premium rates and dollar benefits would rise automatically with increases in the General Schedule pay scale.

In addition, employees ineligible for the FEGLI conversion, or who for any reason do not wish to convert, could elect the long-term care option. Because not everyone would be interested in long-term care insurance, participation in the program would be entirely voluntary.

Should you have any further questions, contact Bruce Millis at 224-5422.

I hope you will join me in this effort.

Sincerely,

Pete

PETE WILSON

Long-Term Care Insurance

A National Need...

A Response

U.S. Office of Personnel Management
Washington, D.C. 20415

September 1967

The Need for Long-term Care

- The over-65 population is growing faster than the population as a whole. In 1980, there were 25.5 million Americans over 65. In 2000, it is projected that 34.9 million will be over 65. Today, there are about 2.5 million Americans over 65; 8 million is the projection for 2020.
- Out-of-pocket payments for long-term care are the leading cause of catastrophic health expenditures. Approximately 43% of the over-65 population can expect to spend some time in a long-term care facility.
- At an average cost of $67 a day, a stay in a nursing home can cost between $20,000 and $40,000 a year.
- Less than 1% of the nation's population has any private insurance coverage for long-term care services.

The Implications for Federal Employees

For most purposes, Federal employees are well insured. The Federal Government has offered group life insurance benefits to the workforce since 1954 and group health insurance since 1960. Like most other Americans, however, Federal employees have no protection against the catastrophic costs associated with long-term care for chronic, debilitating illness and few vehicles are available in the current market place to provide such protection. For Federal employees, as for Americans generally, the most significant uninsured event of potentially catastrophic impact is the expense associated with nursing home or other long-term care arrangements.

The Proposal

Federal employees would be given an opportunity to protect themselves from the devastating costs of long-term care by adding a new option to the current life insurance program (known as FEGLI).

Through a competitive selection process, the Office of Personnel Management (OPM) would select several private sector insurers offering varying benefit levels to participate in the new Federal employee long-term care option.

Here's how the proposed option would work:

- When an employee reached a minimum age of 50 with 10 years' participation in FEGLI, he would be given an opportunity to convert to long-term care insurance;
- He would convert a portion of the face value of his Basic FEGLI insurance (e.g., $25,000) and associated reserve funds to long-term care insurance and would retain a minimum $2,000 death benefit;
- He would continue to pay his share of the regular Basic FEGLI premium for any amount of life insurance remaining and would pay an additional long-term care premium based on his age at conversion;
- He would receive stated dollar benefits for nursing home or alternative home health care;

- He would be eligible to purchase coverage for his spouse at group rates and without evidence of insurability, and to purchase additional life insurance;

- The Government would continue to pay its usual contributions for Basic FEGLI but contributions associated with converted life insurance would be redirected to the long-term care option. (There is no additional cost to the Government.)

- Premium rates and dollar benefits would rise automatically with increases in the General Schedule pay scale. Additional inflation protection might be available in some plans.

Because not everyone would be interested in long-term care insurance, participation in the program would be entirely voluntary. Further, employees ineligible for the FEGLI conversion, or who for any reason do not wish to convert, could elect the long-term care option and pay the full cost of their coverage.

Why Use the Life Insurance Program To Solve a Health Insurance Problem?

- As an employee reaches his mature years, his need for large amounts of life insurance coverage decreases and his need for long-term care insurance increases. Instead of carrying a large amount of life insurance coverage into retirement, as is the current practice, many employees would be better served if their Basic coverage and the reserve funds associated with it could be converted to long-term care insurance.

- Long-term care presents a special funding difficulty. While health insurance is generally priced to cover the near-term health costs of the affected group, long-term care would best be financed by setting aside funds today for a need which may not arise for many years in the future. The life insurance program provides such long-term financing.

- Employees who need to retain large amounts of life insurance could opt for long-term care conversion since they would still have access to the optional coverages under FEGLI which provide death benefits of up to five times salary.

Why Act Now?

- The need for long-term care will reach crisis proportions soon, yet most Americans are largely unaware of the impending threat to their financial well-being.

- By acting now, we can educate our work force -- and Americans generally -- concerning their vulnerability to chronic illness and their need for long-term care.

- We will be able to keep the price of protection low enough so that people in their middle years will be motivated to buy insurance they are likely to need in old age.

Represenative SCHEUER. Thank you very, very much for your opening remarks.

MAIN ISSUES IN LONG-TERM CARE

We will now go to the second panel, which will discuss Long-Term Care Costs and Coverage.

The panel includes, as I noted, Mr. Joshua Wiener, senior fellow at the Brookings Institution; Mr. John Holahan, director, of the Health Policy Center and Mr. Korbin Liu from that same center of the Urban Institute; Ms. Marilyn Moon, director of public policy for the AARP; and Mr. Gerald Eggert, executive director of the Monroe County Long-Term Care Program.

Well, we are delighted to have you on this panel. We regret that we are running a little behind. We would ask you to chat with us informally for 5 or 6 minutes, hopefully not reading from your prepared statements, which will be printed in full in the record. I am sure that after you have made your remarks that Senator Wilson and I will have a number of questions. So why don't we start with you, Mr. Wiener.

STATEMENT OF JOSHUA M. WIENER, SENIOR FELLOW, BROOKINGS INSTITUTION, WASHINGTON, DC

Mr. WIENER. Thank you. It is a pleasure to be here today. The basic problem is that the United States does not have either in the public sector or in the private sector satisfactory mechanisms for helping people anticipate and pay for their long-term care. The disabled elderly and their families find often to their surprise that neither private insurance nor medicare covers the costs of long-term care. Instead, the disabled elderly must rely on their own resources and when those have been exhausted turn to welfare.

The aging of the baby boom population that was described in the earlier panel, combined with the falling mortality rates, will lead to sharply increased demand for long-term care far into the next century.

Before additional stress is put on this inadequate system, we need to carefully consider whether there is some better way to help care for long-term care. Now as part of that effort, we at the Brookings Institution developed a computer model to project long-term care use and expenditures into the future. We had four interesting findings.

First, as indicated by the first panel, the number of older people will grow rapidly and the number of very elderly, those 85 and older, will grow most rapidly. While the number of people aged 65 and over over the next 30 years is projected to increase by 61 percent, the number of people in nursing homes is projected to increase by 76 percent.

Second, older people will be significantly better off financially than they are now by the year 2018, but that the income and the assets of the younger elderly will increase more rapidly than those of the very old. We project that the income of the population aged 65 to 74 will roughly double in constant 1987 dollars over the next 30 years, but the incomes of those 85 and older who have the pri-

mary risk of institutionalization will increase only 17 percent in real terms.

Third, long-term care spending will increase rapidly, especially for nursing home care. We project that in constant 1987 dollars, nursing home spending for the elderly will increase from about $33 billion in 1988 to $98 billion in 2018. Moreover, medicaid spending will increase even faster than total long-term care expenditures. This last result is surprising, since the overall economic well-being of the elderly is expected to improve substantially over the period. The basic reason that medicaid expenditures increase more quickly is that for the population most at risk of needing nursing home care, those age 85 and older, their income does not go up enough to compensate for the rising costs of long-term care. So in fact that population will be worse off relative to the cost of nursing home care in the future than they are now.

Finally, although the number of disabled elderly likely to use long-term care will increase dramatically, there is another part of the equation that is often forgotten, and that is that the economy as a whole will also grow. The financial burden of long-term care will largely depend on how fast the economy grows. Under a low-growth assumption, 1 percent real growth per year, total long-term care expenditures increase from a little less than 1 percent of GNP in 1988 to almost 2 percent of GNP by 2018.

By contrast under a high-growth assumption, 3 percent real growth per year, total long-term care expenditures will grow to only 1.05 of GNP by the year 2018. While long-term care will clearly be an additional economic burden, moderate levels of economic growth should lessen that stress.

FINANCING LONG-TERM CARE

Now how are we going to help pay for long-term care in the future? Well, one strategy—one mentioned by Senator Wilson—is to rely on private sector financing mechanisms. And our projections indicate substantial potential for growth for private sector financing mechanisms. A multibillion market is currently virtually totally untapped.

On the other hand, we found no evidence in our simulations to suggest that private sector financing mechanism could become the dominant form of long-term care financing. For example, with fairly generous assumptions about who would be willing to participate and the willingness of the insurance companies to offer policies, we estimate that by the year 2018, insurance sold to those age 65 and older might be purchased by something between 25 and 45 percent of the elderly, may account for 7 to 12 percent of total nursing home expenditures, and may reduce medicaid nursing home expenditures and the number of people who spend down to medicaid by 1 to 5 percent.

These general conclusions also apply to other private sector financing mechanisms, such as social health maintenance organizations, continuing care retirement communities and individual medical accounts.

So if the private sector is not going to make the public sector wither away, the question we face is what kind of public sector pro-

grams do we want? And here I think the basic issue is: Do we want to stay with a means-tested welfare program as our principal means of financing long-term care or do we want to move to more of a social insurance program?

The principal argument for staying with a means-tested approach is that medicaid, despite its many deficiencies, does, in fact, meet the most urgent needs of the low-income, disabled population at minimal cost to the taxpayer. The spend-down requirements insure that medicaid finances only that part of care that is beyond the financial resources of the elderly. While targeted on the poor, medicaid also provides a safety net for middle income people with high long-term care expenses.

Although incremental improvements in medicaid are attractive, public charity always carries some stigma, and efforts to reduce taxpayer costs are likely to perpetuate a two-class system with inferior care and status for medicaid patients. Moreover, it is an odd program where a majority of people using services end up on welfare. A majority of people who enter nursing homes end up on medicaid before they leave. In other U.S. welfare programs, such as aid to families with dependent children and the supplemental security income program, we expect only a small minority of the population to financially qualify.

In my view, it would be greatly preferable to recognize that long-term care is a normal insurable risk of the elderly and should be covered under a social insurance program, one that leaves a substantial role for the private sector.

Representative SCHEUER. Excuse me. Did you say a normal and insurable risk?

Mr. WIENER. Right. By that I mean that we have a situation where a minority of the population will end up having catastrophic costs. Thus, it make sense to have a risk-pooling strategy where everyone pays in, but only a minority of the population ends up using services.

Now the public costs of such a program and the taxes necessary to pay for it will clearly be substantial, but need not be totally unmanageable. While the costs of any public program would clearly depend on its designs, we have estimated that the fully implemented cost of a public insurance program in 1988 would range somewhere between $38 billion and $47 billion compared with the $22 billion we spend now under current policies and compared to the roughly $42 billion that we spend on total long-term care services, both public and private. We estimate that a payroll tax of somewhere between 2.4 and 3.1 percent, half on employers and half on employees, with no cap on taxable salaries, would be required to finance the program.

By means of comparison, if current long-term care public programs were financed on a payroll tax basis, which they are not currently, we estimate that over the next 62 years, it would require a 1.6 percent payroll tax to pay for those programs.

In conclusion, although financing long-term care has traditionally been viewed as an insolvable problem, it is actually one of the more tractable social problems that we face in the United States today. Indeed, unlike crime, poverty, racism and teenaged pregnancy, financing long-term care has a range of known and feasible so-

lutions. The question is whether we, as a society, have enough political will and ingenuity to choose among them and put an improved system in place. Thank you.

[The prepared statement of Mr. Wiener follows:]

PREPARED STATEMENT OF JOSHUA M. WIENER

CARING FOR THE DISABLED ELDERLY: WHO WILL PAY?*

Joshua M. Wiener, Ph.D.
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* These opinions are those of the author and should not be attributed to other staff members, officers, or Trustees of the Brookings Institution.

Testimony presented at a hearing on "The Health Care Needs of the Elderly," Joint Economic Committee, Congress of the United States, Washington, D.C., June 14, 1988.

It is time for Americans to face a serious problem--how to organize and pay for long-term care for the disabled elderly. More and more Americans are living past 75, 85, and even 95. Consequently, many more elderly than ever before suffer not only acute illness requiring hospitalization and a doctor's care, but also chronic disabling conditions that require long-term care either at home or in a nursing home.

Alzheimer's disease, osteoporosis, heart disease and stroke predominate among the many diseases that cause chronic disability among the elderly. These conditions bring both physical and emotional pain as people experience and relatives watch a decline in the ability to do things that most of us take for granted. Long-term care is the help needed to cope, and sometimes to survive, when physical or mental disabilities impair the capacity to perform the basic activity of every day life, such as eating, toileting, bathing, dressing and moving about.

The United States does not have, either in the private or the public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care. The disabled elderly and their families find, often to their surprise, that neither private insurance nor Medicare covers the costs of long-term care to any significant extent. The disabled elderly must rely on their own resources or, when these have been exhausted, turn to welfare. The aging of the baby boom generation combined with rapidly falling mortality rates for the

elderly will lead to sharply increased demand for long-term care that will require substantially greater public and private spending far into the next century. Before additional stress is put on this inadequate system, Americans should carefully consider alternative ways of financing long-term care and what role the federal government might play in them.

How Do We Pay for Long-Term Care Now?

Most elderly people are not disabled. Of the 28.6 million Americans aged 65 and over in 1985, less than a quarter (6.3 million) were disabled. But the incidence of disability is high for the very elderly. Only about 13 percent of people aged 65-74 were disabled in 1985, but that proportion rises to 58 percent for people aged 85 and over. Mortality rates at advanced ages have come down dramatically in recent years, bringing increases in the number of disabled elderly.

Most disabled elderly are cared for at home, which is where they greatly prefer to be. Caregivers are usually relatives--generally spouses, daughters, or daughters-in-law--and occasionally friends. This unpaid care which frequently put great strain on families, is sometimes supplemented by paid services, such as home health workers, homemaking help, or by adult day care and respite care. Only about 21 percent of the disabled elderly were in nursing homes in 1985.

Most families who seek nursing home care find it beyond their financial reach. The cost of a year in a nursing home averages about $22,000 and can be much higher. Although families are the predominant

provider of long-term care in the United States, nursing homes dominate long-term care financing.

Only a trivial portion of total long-term care bills are now covered by any form of insurance--public or private. The disabled elderly who pay for long-term care do so out of their own or their family's income and assets. They turn to Medicaid, which accounts for 71 percent of government spending on long-term care, if they are poor or have "spent down" their income and assets to levels that make them eligible. Out-of-pocket spending amounts to a little more than half, and Medicaid for a little less than half, of all expenditures for nursing-home care.

The dominance of private out-of-pocket spending and Medicaid in long-term care finance creates a two-class system of care. Medicaid reimbursement rates are below rates charged private-pay patients. As a result, Medicaid patients tend to receive lower-quality care and often find an inadequate supply of services and waiting lists for admission. The fact that Medicaid normally covers nursing home care, but little home care introduces an institutional bias into the system. Financing long-term care through Medicaid is perceived as demeaning by beneficiaries, especially middle class beneficiaries who never expected to be on welfare, as inadequate by providers, and as expensive by state and federal taxpayers.

Although the United States has a highly developed private insurance industry and broad social insurance coverage, especially for the elderly, little attention has been paid to ways of financing long-

term care. The development of insurance approaches has been inhibited most likely by uncertainty arising out of two characteristics of long-term care:

- Because long-term care is needed primarily by the very elderly, a long time is likely to elapse between the time provision for financing might be made and its use. Possible changes in mortality rates, income, inflation, use of services and the risk of disability over this period creates major uncertainties both for buyers and sellers of long-term care financing.

- Long-term care is currently provided primarily by relatives. Once financing is available, there is considerable risk of "moral hazard" (greater use of paid care once financing is available), especially for home care.

Whatever the reasons, the United States so far has relied for long-term care financing on a patchwork of private out-of-pocket spending and a means-tested welfare program. Pressure on this patchwork system will mount as the population of disabled elderly increases.

Increasing Strains on the System

Over the next several decades, the bill for long-term care is certain to use rapidly. Using the Brookings-ICF Long-Term Care Financing Model, we have made detailed projections of the disabled elderly population to the year 2020, together with their income, resources and likely use of long-term care, assuming that mortality rates continue to decline, incomes and inflation continue to grow at moderate levels and current policies with respect to financing long-term care do not change. Over the next three decades, they show:

First, the number of older people will grow rapidly and the number of very elderly will rise even faster. Because they will be older,

more of the population over 65 will be disabled. The increase in disabled elderly will mean more users of long-term care, especially nursing home care. While the number of people over 65 is projected to increase 61 percent over the period, the nursing home population will increase 76 percent. Nursing home residents will also be older--51 percent of them will be over 85 in 2018, compared with 42 percent in 1988.

Second, older people will be significantly better off financially by 2018, but the income and assets of the younger elderly will increase much more rapidly than those of the very old. Real incomes of people aged 65-74 will more than double over the three decades due to more and higher pensions, increases in Social Security benefits and income from assets. Incomes of the 85 and over group, who are most likely to be users of nursing homes and home care, will go up only about 17 percent in real terms. This group is already in their fifties and will not benefit as much as younger cohorts from expected increases in pension availability and labor force participation by women.

Third, long-term care spending will increase rapidly, especially for nursing homes. If nursing home costs rise 5.8 percent per year (compared with a 4.0 percent increase assumed for the general price level), nursing home spending for the elderly will more than triple, rising from $33 billion in 1988 to $98 billion (in constant 1987 dollars) by 2018.

Medicaid spending will rise faster than total long-term care spending and the proportion of nursing-home patients dependent on

Medicaid will not decline. This last result is surprising. Since the overall economic well-being of the elderly is expected to improve substantially over the period, why should they not become less dependent on a program intended for the poor? The answer is that long-term care costs are projected to rise faster than the incomes of the very elderly, the group most likely to use long-term care. Thus those with the greatest risk of needing care will actually be worse off in the future in terms of their ability to pay for it.

Finally, although the number of disabled elderly likely to use long-term care will increase dramatically, the economy will grow as well. The financial burden of long-term care will largely depend on how fast the economy grows. Under a low growth assumption (1 percent real growth a year), total long-term care expenditures increase from 0.89 percent of GNP in 1988 to 1.92 percent in 2018 (and 4.22 percent in 2048). In contrast, under a high growth assumption (3 percent real growth a year), total long-term care expenditures will only grow to 1.05 percent of GNP in 2018 (1.28 percent in 2048). While long-term care will clearly be an additional burden on the economy, moderate levels of economic growth should lessen that stress.

Options for the Future: The Private Sector

There are a wide variety of alternative ways that long-term care might be financed in the future. We focused first on several widely discussed private sector initiatives including:

- increasing incentives for private saving by creating individual medical accounts (IMAs), savings accounts earmarked for long-term care that would receive favorable tax treatment by the federal government;

- increasing the ability of older people to use the equity accumulated in their home (normally their principal asset) to pay for long-term care through home equity conversions (HECs);

- pooling the risk of high long-term care expenses through private long-term care insurance;

- establishment of continuing care retirement communities (CCRCs) or residential complexes with independent living units for older people and a guaranteed availability of care (from occasional home care to full nursing home care if needed) for the life-time of residents;

- formation of social/health maintenance organizations (S/HMOs), an extension of the health maintenance organization concept of prepaid health care financing to include long-term care services.

In projecting the potential market for private sector initiatives for the next three decades we made optimistic assumptions about the number of people who would participate in private sector financing. Our purpose was to determine the most that can reasonably be expected from the private sector with respect to participation, proportion of long-term care expenses financed, and reduction in the use of Medicaid.

Our projections indicate substantial potential for growth of private sector financing mechanisms for long-term care. A potential multibillion dollar market is almost entirely untapped. People purchasing these products will have better financial protection.

Even under our optimistic assumptions about who would participate, however, private sector financing cannot be relied on to do the whole job. Private sector approaches are unlikely to be affordable by a majority of elderly, to finance more than a modest proportion of total nursing home and home care expenditures or to have more than a small

impact on Medicaid expenditures and the number of people who spend down to Medicaid financial eligibility levels. For example, we estimate that by 2018, private long-term care insurance sold to those aged 65 and older may be affordable by 25-45 percent of the elderly, may account for 7-12 percent of total nursing home expenditures and may reduce Medicaid expenditures and the number of Medicaid nursing home patients by 1-5 percent. Those general conclusions also apply to individual medical accounts, continuing care retirement communities, and social/health maintenance organizations. Home equity conversions and private insurance sold to people under age 65 are only the options in which a substantial majority of the elderly might participate. However, home equity conversions have limited potential for paying large long-term care bills directly, and thirty years from now, private insurance sold to people under age 65 might pay for only 17 percent of nursing home expenditures.

Private sector options have a limited impact because they are so expensive that most elderly cannot afford them. Since total long-term care expenditures per capita age 65 and over exceed $1,300 a year, this is hardly surprising. Total (public and private) long-term care costs roughly equal Medicare Part B expenditures and exceed three-fourths of Medicare Part A expenditures. Thus, costs never become trivial even when spread over the whole elderly population.

Although private long-term care insurance policies are rapidly evolving, policies now available are also limited in the amount of financial protection that they offer. For example, policies often have

prior hospitalization requirements, pre-existing condition exclusions, age restrictions on who may purchase policies, and limits on the levels of nursing home care covered. Very little home care is covered. Reimbursement levels usually do not increase with inflation, which can be a serious problems because a payment level that is adequate today will not be adequate in the future. An indemnity policy with a $50 per day nursing home benefit purchased at age 65 when its relatively affordable needs to pay over $150 per day at age 85 to have comparable purchasing power. The problem is that improved coverage and affordability are tradeoffs. That is, coverage improvements are likely to make products more expensive, thus reducing affordability. For example, indexing the indemnity level to inflation would probably increase premiums for the elderly by about 30-40 percent.

Options for the Future: The Public Sector

While it is desirable for the private sector to play a much greater role in financing long-term care, our projections indicate that it is not reasonable to count on private initiatives to reduce substantially Medicaid spending for long-term care or to decrease appreciably the number of lower- and middle-income people spending-down to Medicaid eligibility. The question then is: should the nation stick with a means-tested welfare public program as its major program for financing long-term care or should it enact a new program of social insurance?

The principal argument for staying with a means tested approach is that Medicaid, despite its many deficiencies, does meet the most urgent

needs of the low-income disabled elderly population at minimal cost to the taxpayer. The spend-down requirements ensure that Medicaid finances only that part of the care that is beyond the resources of the elderly. While targeted on the poor, Medicaid also provides a safety net for middle-income people with high long-term care expenses.

Making the Medicaid means test less onerous and reimbursement rates more adequate would make life better for the elderly, but would retain the fundamental welfare character of the program. Desirable changes include increasing the personal needs allowance and the level of protected assets for patients and raising the amount a Medicaid patient's spouse is allowed to retain for living expenses.

Although incremental improvements in Medicaid are attractive and not inconsistent with more fundamental restructuring of the public role in financing long-term care, public charity always carries some stigma, and efforts to reduce taxpayer costs are likely to perpetuate a two-class system with inferior care and status for Medicaid patients. Moreover, it is an odd welfare program whose eligibility requirements are met by a majority of the people using services. In other U.S. welfare programs, such as Aid to Families with Dependent Children and the Supplemental Security Income program, only a small minority of the population is expected to be financially eligible.

It would be greatly preferable to recognize that long-term care is a normal, insurable risk for the elderly, which should be covered under a general social insurance program like Medicare and not through a welfare program like Medicaid. Everyone should contribute to public

long-term care insurance and earn the right to benefits when they need them without having to prove impoverishment. Social insurance coverage, however, should not make long-term care free, or even nearly free to Medicare beneficiaries. Substantial cost-sharing is appropriate to control increases in service use that might occur if financing were newly available to the large number of disabled elderly who do not now receive paid care. Indeed, with respect to home care, where the risk of increased service use is far greater than for nursing home care, limitation of benefits to the severely disabled, strictly defined, would also be desirable.

Public costs and the taxes necessary to pay for a public insurance program would be substantial, but need not be unmanageable. Moreover, most of the costs of a public insurance program would be incurred by society with or without a new program. We estimate that the near-term (1988) public costs of a fully implemented public insurance program would vary from $38 billion to $47 billion depending on program design, compared with $20 billion under current policies.

A payroll tax of between 2.4 and 3.1 percent, half on employers and half on employees with no cap on taxable salaries, would be required to finance the program. If current public long-term care programs were financed by a payroll tax, the cost would amount to 1.6 percent of payroll. The incremental tax can, and should be reduced through estate or inheritance taxes, income tax surcharges, or excise taxes; through premiums paid by the elderly, and by retaining some state financial responsibility for long-term care.

Conclusion

Major new initiatives are needed both in the private sector and in the public sector to improve the financing of long-term care. Americans should recognize that long-term care is a normal risk of growing old that needs to be anticipated. A large potential market exists for private long-term care insurance and other private initiatives. Development of that market by the private sector with encouragement from the government could make long-term care much more affordable for a substantial fraction of the population. However, even with maximum likely development of private options, public spending for long-term care, mostly under Medicaid, will increase rapidly for the foreseeable future. Since continuing to rely on a welfare program to finance long-term care for a large part of the population is undesirable, ways should be found to broaden Medicare coverage to include long-term care.

Although financing long-term care has traditionally been viewed as an insolvable problem, it is actually one of the more tractable social issues facing the United States. Indeed, unlike crime, poverty, racism and teenage pregnancy, financing long-term care has a range of known and feasible solutions. The question is whether we as a society have enough political will and ingenuity to choose among them and put an improved system in place.

Representative SCHEUER. Thank you very much, Mr. Wiener. Now Mr. Holahan.

JOINT STATEMENT OF JOHN HOLAHAN, DIRECTOR, AND KORBIN LIU, SENIOR RESEARCH ASSOCIATE, HEALTH POLICY CENTER, URBAN INSTITUTE

Mr. HOLAHAN. Thank you. My testimony is joint testimony with Korbin Liu.

COSTS OF LONG-TERM CARE

We make three major points in our testimony.

First, that the current long-term care system, such as it is, has been extremely successful in keeping the costs of that system under control. This is in contrast to other health services such as hospital care and physician payments.

Second, that these efforts to control the cost of the system have led to a system with many problems.

Third, that despite these problems, efforts to solve them through extension of long-term care financing are likely to be very expensive and we caution that public policymakers must proceed very carefully.

The main characteristics of the system are the dominance by the medicaid program which finances most of long-term care, the limited role of medicare, the broad social insurance program for the elderly which affects the long-term care system principally through some coverage of home health services; the presence of a range of other programs that finance long-term care, such as Older American Act programs, veterans' programs, title XX, and so forth; that a large amount of the long-term care system is financed privately, principally through out-of-pocket payments by the elderly; and finally that private insurance has a very, very limited role.

We mention some of the efforts that public programs, principally medicaid have used to control costs. These are strict limits on benefits for home health services, both for medicare and medicaid; medicare payment policies for nursing home care that are low relative to the cost of serving medicare patients and thus limit the participation of nursing homes in medicare; and a broad array of perspective payment systems in medicaid which again limit the costs of nursing home care in the medicaid program.

The results of these efforts to control costs have been very successful. Public expenditures on long-term care in the United States are $24 billion. This may seem like a lot; but it is only 0.6 percent of GNP in 1985. The growth in nursing home expenditures has been relatively rapid, but when one looks behind the data, the reasons for growth are very different than they are for, say, hospital care, which has grown at similar rates.

Hospital sector growth has been due to increases in service intensity, largely the introduction of new technologies, and inflation in hospital costs above the rate of general inflation.

In the nursing home sector, which has had comparable rates of growth, about 17 percent per year from the early seventies through the mideighties, most of this growth has been due to either demographic change, that is increases in the population that are over

the age of 65 or the proportion of the elderly that is over the age of 85, and second, to growth in the nursing home bed supply and utilization that accompanied the introduction and early years of medicare and medicaid up through, roughly, 1975.

Thus, the costs of long-term care in this country cannot really be regarded as large and the growth in costs can't be regarded as being essentially out of control, as they often have been characterized.

PROBLEMS IN LONG-TERM CARE

This success in controlling costs has left us with a system with many problems. These are as follows:

Problems of heavy-care patients or especially sick people in getting into nursing homes, problems of access of medicare beneficiaries getting into nursing homes, quality of care, the financial impoverishment that individuals must undergo before receiving medicaid benefits, and, finally, limited publicly supported home care which thus puts most of the burden on families, friends, spouses, and so forth.

LONG-TERM CARE OPTIONS ARE EXPENSIVE

While the system then has many problems, these problems are not going to be easily solved. The demographic changes that others have referred to this morning are very real and mean that the costs of long-term care are going to grow even if there are no changes in financing. The aged population between the years of 1980 and 2000 will grow from 26 million to 35 million, the population over 85 will double. This is important because this population is three times as likely to enter a nursing home. The calculations that we have done show that the individuals with three or more ADL dependencies and the number of people in nursing homes will grow by 64 percent between the years 1980 and the year 2000 and by 126 percent between 1980 and the year 2020.

Again, these factors mean that the cost of long-term care will grow greatly even if there is no change in financing. Changes in financing, of course, will mean that the system will cost more. Looking at nursing home care, for example, without any changes in financing, nursing home expenditures will grow from $27 billion as it was in 1980 to $47 billion in the year 2000. With some expansion of the nursing home system in response to, say, improved nursing and reimbursement rates or higher quality standards, expenditures could easily reach $70 billion by the year 2000. This is in constant 1985 dollars.

All of this means that the potential costs of the long-term care system are very great. At the same time, the core of the medicare program faces substantial financing problems; the expenditures for both part A and part B are expected to grow faster than current projected revenues; the gap between expenditures and revenues will be fairly substantial as we move out into the next century. Unless we are extremely successful with containing hospital costs and physicians expenditures or in shifting some of this burden to the elderly, it will mean that more of the burden will be shifted to

the general population through income tax or payroll tax payments.

Thus, it seems likely that any expansion of the long-term care system must proceed very, very carefully and with serious consideration of different approaches of targeting benefits on either the poor or catastrophic coverage or some method that allows this system to expand in a very controlled manner. Thank you.

[The joint prepared statement of Mr. Holahan and Mr. Liu follows:]

JOINT PREPARED STATEMENT OF JOHN HOLAHAN AND KORBIN LIU

LONG TERM CARE FINANCING: ISSUES AND PROBLEMS

Testimony before the U.S. Congressional Joint Economic Committee

Hearing on the Future of Health Care in America

June 14, 1988

by

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Long term care consists of a fairly wide array of services, all of which can conceivably be provided in a wide range of settings, rendered to persons who have lost all or part of their ability to care for themselves. Long term care in the United States is financed through a combination of private resources and a mixture of public programs. As shown in Table 1, most private spending is directly out of pocket. In 1985 Americans spent $19.8 billion directly out of pocket on long term care expenditures. Private long term care insurance is currently very small, contributing only $800 million to long term care outlays. The bulk of public spending is through the Medicaid program, which contributed $18.2 billion in 1985. Most Medicaid spending is for nursing home care. The Medicare program spent $2.9 billion, mostly for home health services; much of this spending is for individuals recuperating from acute care episodes and is not strictly long term care. The Veterans Administration, the Older Americans Act, Title XX, and SSI also contribute some funds towards the long term care system.

The result of this combination of financing mechanisms is, first, that individuals are at risk for very large long term care expenditures. Second, most public spending is provided by Medicaid, a program designed to care for the poor. Third, most public financing is for nursing home care, while support for noninstitutional services is limited and highly fragmented among a variety of programs. Finally, and very importantly, most noninstitutional services are provided by families and friends.

The long term care system in the United States has been exceedingly successful in controlling its outlays. Medicare, for example, limits its role

Table 1

Distribution of Long-Term Care Spending for Fiscal Year 1985, by Source of Payment and Type of Service (in billions of dollars)

	Nursing Home Care	Home Care	All Long-Term Care
Private Sources			
Out of Pocket	16.15	3.65	19.80
Insurance	.30	.49	.79
Other	.28	.43	.71
Total Private	16.73	4.57	21.30
Federal Programs			
Medicare	.59	2.35	2.94
Medicaid	9.46	.55	10.01
Veterans Administration	.82	.01	.83
Older Americans Act	0.00	.67	.67
Title XX	0.00	.74	.74
Total Federal	10.87	4.32	15.19
State and Local Programs			
Medicaid	7.74	.46	8.20
Other	.42	.50	.92
Total State and Local	8.16	.96	9.12
Total Public	19.03	5.28	24.31
Total All Sources	35.76	9.85	45.60

Sources: Preliminary Congressional Budget Office Estimates based on data supplied by the Actuarial Research Corporation.

a. Nursing home care expenditures are distributed by levels of facility certification. The levels represented are skilled nursing facility (SNF) intermediate care facility (ICF, a combination of SNF and ICF (SNF/ICF), intermediate care facility for the mentally retarded (ICF/MR, and not certified).

b. The home health agency services represented are: nursing care (nurse), home health aids (HH Aide), speech therapy (speech), physical therapy (phy-T), occupational therapy (Occ-T), and medical social services (Med-Soc). Payments for adult day care, meals, and transportation services are also included in the estimates.

in the long term care system through very strict coverage of requirements for skilled nursing facility care and for home health care. Medicare reimburses for nursing home care on the basis of average facility costs. The marginal costs of Medicare patients is usually quite higher. Most nursing homes either do not participate in Medicare or limit their participation to a small share of their available beds.

The Medicaid program has also been quite successful in constraining the growth in its expenditures. Medicaid programs have been innovative and quite successful in adopting prospective reimbursement systems for nursing home care well before such systems were employed in the hospital sector. Medicaid prospective payments systems can vary in their sophistication but the evidence suggests that, in general, they have been very successful in controlling the rate of growth in costs. Medicaid financing of home care services has also been limited, primarily through limiting the criteria established for coverage. The home and community based care benefit has grown in recent years, but even this has been limited by federal policies which constrain its outlays to be no greater than what institutional and noninstitutional services would have been had the state not adopted a waiver program. States have also used certificate of need to limit the bed supply. Together with tight reimbursement policies, nursing home bed supply has been seriously constrained in many states. Bed availability in the United States varies from 22 beds per 1,000 elderly in Florida to over 90 beds in Minnesota.

The result is a long term care system that has been successful in controlling its costs. The rate of institutionalization of elderly Americans is amongst the lowest of all industrialized countries (1). While twice as many severely disabled elderly individuals are in the community for every individual

in the nursing home, paid outlays for this population are minimal. Of all noninstitutional services provided to the elderly, only about one fourth are provided by formal care providers. The total out-of-pocket outlays for noninstitutional services for the elderly disabled are amounted to only about $1 billion in 1982 (10). Long term care outside of nursing homes therefore is largely provided by spouses, family and friends.

The argument that long term care costs are not high may seem at odds with evidence of rapid growth in nursing home expenditures that are frequently cited. Expenditures for nursing home care increased about 5-fold between 1972 and 1984. This rate of growth is comparable to those observed in the hospital sector for which there has been serious concern resulting in the adoption of the Medicare prospective payment system (PPS). However, careful analysis of the data shows that there are important differences. Most of the growth in the hospital sector between 1965 and 1985, above that due to increases in general inflation, has been due to increased intensity of care; that is, more services per patient day largely driven by the growth of new technologies. In addition, hospital input price inflation also exceeded general inflation by 1 to 2 percent per year.

The growth in nursing home costs is very different. Most of the nursing home expenditure growth has been due to changes in the percentage of people over 65 and the percentage of the elderly population that was very old. Moreover, there were very rapid increases between 1965 and 1975 as utilization responded to the introduction of new federal programs that financed long term care and the resulting growth in the bed supply. Once demographic changes and the initial increases in utilization are controlled for, there has been very little real growth in nursing home spending over this period. Stated

differently, there is no reason to believe that growth in nursing home expenditures is "out of control."

While the U.S. long-term care system is not costly, there is also reason to believe it is significantly underfinanced. One problem that is frequently mentioned is the lack of available beds in many areas. The result of bed supply shortages is that access for low-income and heavy-care patients is limited. Scanlon has shown that it is difficult for Medicaid patients to obtain access in markets with fewer beds; in contrast, private patients face no access problems anywhere (12). Research by Weissert and Scanlon has also shown that patients with heavy care needs have more difficulty obtaining placement in markets with limited supplies of beds (15). Over 90 percent of unmarried severely disabled individuals over 75 years of age are in nursing homes in states with many beds per capita while only 50 percent of similar individuals are in nursing homes in states with few beds. A recent study by Kenney has shown that Medicare patients are less likely to be placed in nursing homes in the post-PPS era in markets with fewer nursing home beds (7). In a market with fewer beds, nursing homes can choose the patients that are more profitable. The evidence overwhelmingly suggests that they choose either private-pay patients or Medicaid patients with more limited care needs. Heavy-care Medicaid patients and Medicare patients are less likely to be served.

There is also evidence that markets with limited numbers of nursing home beds result in more patients remaining in hospitals. Under Medicare's prospective payment system, hospitals have a strong incentive to reduce lengths of stay and to discharge patients as quickly as possible. Hospitals that are unable to discharge patients promptly often continue to care for these patients and thus suffer relative financial losses in comparison with hospitals in

markets with a more abundant supply of nursing home beds. There is also evidence that low-income Medicare beneficiaries have more difficulty being placed in nursing homes and are more likely to be discharged home than other patients. Thus, bed supply limitations, again, result in access problems for low-income patients.

The quality of care in nursing homes is also a source of considerable concern. Many studies have documented deficiencies in nursing homes, ranging from inadequate staffing, fire code violations, insensitive staff, etc. (5, 14). Quality of care problems are in part related to bed shortages. With a tight bed capacity, homes have less need to compete for patients. Because quality is one of the dimensions on which nursing homes compete, a reduced need to attract patients may seriously affect incentives to maintain high-quality facilities. With a tight bed capacity, states have been unwilling to close deficient facilities because there are no alternative settings for placing patients. Facilities remain open and the state must increase monitoring to assure minimal standards are met. The enforcement efforts are costly in terms of state resources and are often doomed to failure because sufficient resources are not applied.

Medicaid reimbursement policies can also result in reductions in quality. Studies have shown that nursing homes in states where Medicaid reimbursement policies have strong cost control features have lighter casemix and less staffing (2). There is also evidence that nursing homes respond to strong rate-setting pressures by reducing costs in nursing and patient-care cost centers (3).

Another serious problem with the current system is the Medicaid spenddown. To become eligible for Medicaid benefits, individuals must use up most of their

assets and income before Medicaid coverage will begin. Individuals at the top of the income distribution can finance long-term care through asset earnings and social security payments. Individuals whose resources are insufficient must use up these assets before becoming eligible. They therefore must impoverish themselves before gaining Medicaid eligibility. Liu and Manton have recently analyzed a non-Medicaid population of individuals living in the community in 1982 who entered nursing homes between 1982 and 1984 and remained there in 1984 (8). The study found that 41 percent became Medicaid eligible; the remainder continued to pay for nursing home care from their own resources at the time of the 1984 survey. Of particular importance is the issue of spousal impoverishment. A married individual enters a nursing home and the family assets are used to pay for care, leaving the spouse remaining in the community with only SSI payments to finance normal living costs.

The final problem with the U.S. long-term care system is the limited amount of publicly supported home care. As noted, only 5 percent of Medicaid expenditures go for home care services. Much of this is in New York. Medicare provides little home care that is truly to long-term care recipients. Only 25 percent of all care provided to the disabled elderly is provided by formal care providers, and virtually all of this is paid out of pocket (13). This imposes substantial burdens on informal care providers, namely spouses, family, and friends. While this may be appropriate, there is a very large opportunity cost (14) in terms of foregone leisure, earnings, etc.

Because of the many problems with the long term care system, interest in reforming financing arrangements has risen greatly. Long term care for the first time has become an issue of a presidential campaign. The upcoming debate over long term care reform will include issues of whether expansion should just

address current problems with the nursing home sector or focus on expanding care in the community or both; whether coverage should be universally provided through a social insurance mechanism or be targeted on the poor and near poor; whether coverage of individuals should extend to those with three or more ADLs, to all the disabled elderly, or to all of the disabled; the size of deductibles and the accompanying role of the private insurance market; and finally the extent of Medicaid improvements if a less than comprehensive bill was enacted. These would include the amount of protected assets, personal needs allowances for individuals in nursing homes, and protection of spousal income.

Extension of the long term care financing system is heavily affected by impending demographic change. While 1.3 million elderly Americans were in nursing homes in the early 1980s, 5 million disabled individuals were in the community. Of those that were severely disabled (3 or more ADL dependencies), approximately 920 thousand were in nursing homes, while almost 1.7 million similarly disabled individuals were in the community. Between the 1980s and the year 2000 the number of elderly Americans will increase from 26 million to 35 million. The population over the age of 85 is projected to double when 5 million persons will be in this age group. The importance of the growth of this age group is the high risk of entering nursing homes that these individuals face. The 85+ population has a risk of being in nursing homes that is 3 times greater than their younger counterparts. Table 2 shows that the number of nursing home residents and number of community based disabled elderly will grow by 64 percent between 1980 and 2000 and by 126 percent between the year 1980 and 2020 (9). Thus demographic change in itself will put considerable pressure on our ability to finance long term care services even without any expansion of the financing system.

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Table 2

Number of Nursing Home Residents and Number of Community-Based Disabled Elderly, 1980-2040 (numbers in thousands)

	1980	2000	2020
Community-Based Disabled Elderly (3+ ADLs)			
Age 65-74			
IADL Only	679	787	1,291
1-2 ADL	624	726	1,191
3-4 ADL	271	317	522
5-6 ADL	316	371	607
Age 75-84			
IADL Only	545	878	1,044
1-2 ADL	617	980	1,156
3-4 ADL	250	405	480
5-6 ADL	308	504	604
Age 85+			
IADL Only	181	382	539
1-2 ADL	311	666	939
3-4 ADL	140	300	424
5-6 ADL	186	401	565
Age 65+	4,427	6,717	9,363
Nursing Home Residents			
Age 65-74	225	263	443
Age 75-84	497	762	888
Age 85+	522	1,130	1,590
Age 65+	1,243	2,155	2,921
Total Elderly Community-Based + Nursing Home Residents	5,670	8,872	12,284

Source: Korbin Liu and Kenneth G. Manton (9).

Note: Totals may reflect rounding.

Table 3 indicates the potential costs of expanded home care for severely disabled individuals. The table shows that home care services will grow from 3.2 billion to 4.6 billion by the year 2000 solely due to demographic change and without any change in financing arrangements. Expanding care for persons with 3 or more ADLs will increase costs significantly. The ultimate costs are highly sensitive to the extent of elderly participation in expanded public programs. Making three alternative assumptions about participation shows that covering home care services could easily become a very expensive program. The recent Channeling demonstration, for example, achieved rates of participation of about 90 percent (6). Thus, over time, as the supply of services expands to meet increased demand, a 90 percent participation rate is not unrealistic. Under this assumption, home care services in the year 2000 could cost $13.3 billion. These projections assume no increase in inflation.

Even greater expenditure growth will occur in nursing homes. Due to demographic change alone, nursing home expenditures will increase $47.4 billion in the year 2000 and $64.2 billion in the year 2020. But an enhanced long term care financing system that increases nursing home reimbursement rates is likely to generate an increase in the supply of nursing home beds; the expanded supply would reduce the current unmet demand that now exists in many states. Reforms that improve the quality of care in nursing homes could also increase the demand for nursing home care, which in turn could increase utilization if bed growth permits.

In Table 4 we show projections based on increased levels of utilization among elderly Americans. For example, in 1980 4.9 percent of the 65+ population was cared for in nursing homes; with an expanded supply of beds 6 or

Table 3

Community Long-Term Care Expenditures (in billions)
Projections Under Different Assumptions
(in 1981 dollars)

	1980	2000	2020
Base Case[a]	$3.2	$4.6	$6.4
Expanded Care for Persons with 3 or more ADLs[b]	(pop = 1,471,000)	(pop = 2,298,000)	(pop = 3,202,000)
25% participation	2.4	3.7	5.1
50%	4.7	7.3	10.3
75%	7.1	11.1	15.4
90%	8.5	13.3	18.5

a. Estimated 1982 costs per disabled elderly person based on $734 million for Medicare (remainder of Medicare expenses were nondisabled persons), $495 for Medicaid, $950 million other public programs and $1 billion private.

b. This scenario reflects total public expenditures when care management and enhanced service and payments are provided to persons with 3 or more ADL's. The costs reflect the annual cost of $6,420 for the "Financial Control" model of the National Long-Term Care Channeling Demonstration Project. These costs partially, but not fully, offset existing base case costs.

Table 4

Nursing Home Expenditures (in billions)
Projections Under Different Assumptions

	1980	2000	2020
Base Case (4.9%)			
Nursing Home Patients as Percent of 65+ Population	4.9%	6.2%	5.7%
Number of Patients	1,243	2,155	2,921
Expenditures	$27.3	$47.4	$64.2
6 Percent Model			
Nursing Home Patients as Percent of 65+ Population	6.0%	7.6%	7.0%
Number of Patients	1,532	2,653	3,599
Expenditures	$33.7	$58.4	$79.4
7 Percent Model			
Nursing Home Patients as Percent of 65+ Population	7.0%	8.8%	8.1%
Number of Patients	1,788	3,073	4,165
Expenditures	$39.3	$67.6	$91.6

7 percent of the population might have been served. Table 5 shows the resulting increase in expenditures accompanying greater levels of nursing home bed supply. We have combined our projections of demographic change with assumptions of an increased bed supply and made calculations of the effect on nursing home expenditures. The result is that nursing home expenditures of $27.3 billion in 1980 could grow to well over $50 or $60 billion by the year 2000. These projections of the likely fiscal impacts of expanded home health care and nursing home care are clearly sobering.

Consideration of long term care policy is not likely to be viewed in isolation from the financial problems that the core of the Medicare program already faces (4). Studies have shown that the current Medicare program faces severe fiscal problems over the next 20 to 40 years. These problems are not easily solved through cost containment policies or by shifting more of the financial burden to the elderly. These fiscal realities are important in consideration of policies to expand the long term care system. They suggest that any public insurance approach to long term care financing in the United States will be limited. The need to choose among the menu of options that very carefully target coverage and benefits is very great. We may as a nation have to choose to cover only the poor through a liberalized Medicaid program or to adopt an approach such as Senator Mitchell's which would provide catastrophic insurance in an effort to encourage expansion of the private market. Or alternatively we could, perhaps, expand Medicare to cover all elderly for only the medical, nursing, and therapeutic aspects of long-term care. But it seems unlikely that a comprehensive long-term care program—one that would provide universal coverage of impaired persons and a broad package of nursing home and home care services with minimal cost sharing—would be feasible in the United States for the foreseeable future.

Table 5

Medicare's Total Fiscal Gap (HI plus SMI)

	Percentage of GNP	% of Projected Program Revenues Under Current Tax Burdens[a]	Billions of Dollars in Relation to 1990 GNP[b]
Intermediate Assumptions			
1990	0.07%	3.8%	$4.0
2000	0.51	25.0	27.3
2010	0.84	40.9	45.1
2020	1.43	68.3	77.1
Pessimistic Assumptions			
1990	0.18	9.2	9.8
2000	1.16	55.3	62.5
2010	2.21	100.9	118.8
2020	3.92	167.0	210.9

Source: John Holahan and John Palmer, "Medicare's Fiscal Problems: An Imperative for Reform," Journal of Health, Politics and Law, Vol. 13, No. 1, Spring 1988.

a. Calculated by holding constant the HI payroll tax at 2.90 percent of payroll, SMI premiums at 25 percent of projected program costs and the general revenue contribution to SMI at its 1987 percentage of GNP.

b. The numbers in this column are calculated by applying the percentage of GNP in the first column for the corresponding year to the projected level of GNP for 1990.

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Representative SCHEUER. Thank you very much, Mr. Holahan. And now we will go to Ms. Moon, representing the AARP.

STATEMENT OF MARILYN MOON, DIRECTOR, PUBLIC POLICY INSTITUTE, AMERICAN ASSOCIATION OF RETIRED PERSONS

COSTS OF CURRENT LONG-TERM CARE SYSTEM

Ms. MOON. Thank you. I am very pleased to be here today. One way or another, it is clear that we are going to pay the costs of long-term care in the United States. It is not a question of not having enough money to do so. It is not a question of being able to avoid those costs. Those costs will be incurred. The question is, who exactly will pay?

Actual current expenditures on long-term care are high and you have heard Josh Wiener discuss some of the numbers, but in addition, a lot of family hardships go on under the current system, when people give up work in order to care for an aged parent, for example. Also, families may have problems in caring for their children in households in which there are two generations needing care.

Perhaps even more important are the costs that we do not see in terms of unmet need. The hardship placed on individuals who do not have access to a long-term care system in the United States are hardships of older persons alone in their homes, or of young families with severely disabled children struggling to provide services that they simply aren't able to afford.

One way or another we do pay the costs, and unfortunately, in many cases, we pay the costs in terms of unmet need. As a consequence we believe that costs will and should rise over time, particularly if we do something about unmet needs. We need to be very careful, of course, to make sure that costs don't rise unnecessarily, and the kinds of concerns that were just expressed by Mr. Holahan are important. Nonetheless, whenever we think about improvements in a long-term care system, we do have to assume that there will be increased costs if we improve access to those who are not now receiving care.

ALTERNATIVE APPROACHES TO LONG-TERM CARE

AARP believes basically that we should take a social insurance approach to spread those costs as far as possible, so that the burden does not fall on persons who are unlucky enough to have chronic and disabling illness as opposed to a kind of illness that is now covered by, for example, medicare. As a consequence, we are spending a considerable amount of time looking at ideal models for a social insurance approach and thinking about ways in which to provide such coverage.

On the other hand, I don't want to talk so much about those things today, because we are not talking about enacting an ideal national system within the next year or 2 years. Thus, I wanted to talk today, as the prepared statement does, about some of the more limited approaches that are going to be considered in the meantime.

In doing that, we need to consider whether or not these alternative approaches lead logically to an improved system and what are the costs and benefits. In particular, the tradeoffs, in terms of leaving some needs unmet and some people uncovered will be crucial. It is in this context then that my prepared statement looks at five different limited approaches.

The prepared statement examines restrictions on covered services as one approach. For example, the Pepper bill would have limited coverage simply to home health services. That kind of an approach is certainly one way to limit the costs of a system and lead to a long-term expansion or coverage of benefits over time. It is one which deserves considerable further attention. I don't believe that we have seen the end, for example, of Congressman Pepper's bill by any means. But this type approach is also one that can be combined with restrictions of other sorts that I want to talk more about today—restrictions on coverage that go beyond what services are covered.

The other four approaches that the prepared statement examines deal with ways in which to restrict benefits either in terms of the length of time that they are provided, the waiting period necessary for achieving coverage, or simply an expansion of the medicaid model.

Let me start first with stimulating private sector activity. AARP believes, and has been convinced by the findings of the Brookings Institution, that private sector approaches are not going to provide comprehensive coverage now or in the future. They may provide a very important part of the puzzle, and they may be something worthwhile to do, but we should move very cautiously in stimulating the private sector activity through, for example, tax incentives, in which we could implicitly end up spending considerable resources through the Federal Government from the fiscal drain of tax benefits. Such benefits would have the same effect on the deficit as actual expenditures. Moreover, we could end up with an inefficient system, mainly stimulating purchase of private long-term care insurance by individuals who would likely purchase insurance anyway.

The question is, would tax incentives truly stimulate middle and lower middle income individuals to buy such insurance? That represents a big question mark. Middle-income people not now covered well by medicaid or only covered after they spend down all of their assets and income, would not likely be very well-protected by private sector activity, and it is those groups that we are particularly concerned about.

A public program with a long waiting period is another approach that people sometimes talk about, often linking that with efforts to stimulate private sector long-term care insurance by guaranteeing insurers that they would only have to cover, say, 2 years or 3 years of care. After that, a public program would take over.

Again, in many ways this would disproportionately help the relatively affluent groups. Statistics show that most individuals will have spent down onto medicaid long before many of these waiting periods would take place

So again, the concern would be will people buy insurance? Will insurance companies participate sufficiently to extend that cover-

age to the middle-income groups that are at this point so vulnerable?

In many ways, a long waiting period constitutes a catastrophic type of approach, where the coverage would begin only after a couple of years. Unfortunately, the costs of both home care and nursing home care today mean that catastrophe generally strikes long before that waiting period of a year or 2 years has been reached. Not very many of our older persons can really afford to wait a year and pay the $25,000 or more in a nursing home to become eligible for such a program.

A third approach that is beginning to be considered turns the whole notion of catastrophic coverage on its head. This approach would offer limited benefits that would start immediately and terminate after a period of time. Here the assumption is that after a year, for example, most individuals in a nursing home do not return home, and you would be largely protecting their assets if you continue to pay benefits. Thus, after the initial coverage this approach would expect persons to have either purchased insurance to provide benefits or to spend their assets and go onto a medicaid type of program. This approach, again, tries to limit costs while assuring access.

The final approach of expanded medicaid, we believe, basically would extend the cost substantially because many medicaid States' programs have deficiencies. Coverage and benefits vary across the States. Moreover, a basic medicaid approach is one that carries with it not only the actual burden of spending all one's assets and income, but the stigma and loss of dignity come at a point in time when people are alone, disabled and ill. Thank you.

[The prepared statement of Ms. Moon follows:]

PREPARED STATEMENT OF MARILYN MOON

I am very pleased to be here today to speak on long term care cost and coverage issues. The American Association of Retired Persons, representing over 28 million people aged 50 and above, believes this critical issue needs careful debate and discussion, but most of all a commitment to protect persons of all ages against the catastrophic problem of long term illness and disability.

I will focus my remarks on three areas: who now pays the costs of long term care, the need for a solution, and possible public approaches.

Paying the Current Costs of Long Term Care

Today, society in one way or another does pay for the costs of long term care. But it does so by placing inordinate burdens on a few individuals and their families, often robbing the family of dignity and independence in the process.

1. Community Based Long Term Care

Older people or their relatives are bearing the brunt of practically all of the cost of community-based long term care. The vast majority of long term care (71%) is provided in the community rather than in institutions. And family members are the cornerstone of the long term care delivery system. According to the 1982 National Long Term Care Survey, almost 3 out of 4 functionally impaired older Americans rely exclusively on unpaid

sources of care provided by families and friends, and another 21% on a combination of support from families and paid providers. Only 5% of the elderly rely solely on paid providers.

Public funding for the less formal portions of long term care services comes from a variety of sources. The Social Services Block Grants given to states fund some home and community based services, although availability of such services varies dramatically around the country. The Older Americans Act funds meal programs for many homebound individuals. And state supplements to the Supplemental Security Income program sometimes have provisions for elders living in congregate housing or who need special attendants.

2. Nursing Home Care

By far the most devastating health care expense for older Americans is that of long term, chronic illness. Nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care (about $25,000 per year). Indeed, the amount older persons paid out-of-pocket for nursing home care in 1986 exceeded the amount they paid out-of-pocket that year for all hospital inpatient care, physician services, and drugs combined.

The need for long term care leads almost inevitably to an unmanageable financial burden because the cost of care -- be it in an institution or in the home -- is often enormous. Medicare and private insurance combined pay only a minuscule proportion of

nursing home costs (less than 3% in 1985). And while Medicaid picks up a substantial share, more than half of nursing home costs are paid out of the pockets of residents and their families. And the familiy's share of this burden has been rising in recent years as Medicaid's contribution has fallen.

Few people can afford the expense of an extended nursing home stay, so many eventually end up on Medicaid, but only after financial catastrophe has occurred. Almost one-half of Medicaid dollars for nursing home care is spent on behalf of persons who enter nursing homes as private paying residents. The process of "spending-down" one's income and depleting one's assets to qualify for Medicaid can occur very quickly.

3. Unmet needs

But perhaps most important of all are the hidden costs of suffering, deprivation and isolation of those in our society who get no care or inadequate or substandard help. These indirect "costs" are not counted in the numbers of dollars spent on long term care. Indeed, if a comprehensive long term care system were put in place, the overall expenses on services should rise as these underserved individuals are offered care.

Recognizing the Need for a Solution

Given the magnitude of the burden on older persons and their families, it is not surprising that there is growing support for

change. In a public opinion poll conducted for AARP in the fall of 1986, 82% of Americans aged 45 and older said that they would favor a government program to help pay for long term nursing home costs for persons not covered by Medicaid; 68% went on to say that they would still favor such a program if it meant a small cost to them to finance it. These findings were buttressed in a public opinion survey of 1,000 registered voters of all ages conducted for AARP and the Villers Foundation this past summer. Not only did 86% of respondents favor government action on long term care rather than "leaving long term care entirely to the individual", but large majorities--in all age and income groups--said they would be willing to pay substantially higher taxes to help fund a federal program of long term care for the elderly.

But even after recognizing the issue, it is sometimes asserted that the problem is primarily one of income -- those who can afford long term care services should pay for them, and those who cannot should continue to be protected under Medicaid, a means-tested welfare program.

There are several flaws in this argument. First, aside from the very wealthy, few persons in our society can afford intensive long term care. Recent research by the Brookings Institution also indicates that only a small proportion of the current and future elderly can afford private long term care insurance. Since the very poor are protected under Medicaid, those most at risk of financially devastating long term care expenses are middle income families, who must deplete their

savings of a lifetime in order to afford care. It is inherently inequitable that those unlucky individuals who happen to require nursing home care have to relinquish their life savings, while others do not.

Second, the Association does not believe it is wise to rely upon a welfare program, Medicaid, as our nation's only long term care program, a purpose for which it was never designed. For many, if not most older Americans, the social stigma associated with Medicaid prevents many poor older Americans from even applying.

Most important, the very nature of the need for long term care lends itself to an insurance approach based on shared risk: (1) relatively few persons in our society need long term care at any one time; (2) it is nearly impossible to predict who these individuals will be; and (3) the lifetime risk of needing nursing home care is much higher than most people think, e.g., estimates of the lifetime risk of institutionalization at age 65 range from 36% to 63%. These facts argue inherently for universal protection based on an insurance approach to the problem. The costs to any one person will be small, while offering protection to all against financial devastation.

It is essential for the government to play a much stronger role in directly financing long term care. Neither private sector initiatives alone nor tax-subsidized efforts in the private sector can solve this problem. Thus, it is important to consider a broadly conceived social insurance plan and one that

involves the federal government.

Our nation has had a long and successful tradition of providing protection through social insurance against risks that threaten the basic security of Americans. Social Security, for example, has proved effective in providing basic protection against the risk of lost earnings due to retirement, disability, and death. Medicare has made major strides in protecting acutely ill older people from unmanageable health care expenses. And Medicare is able to return about $0.98 in benefits for every $1 of financing, a loss ratio which private insurance could never hope to achieve. Moreover, these funds for insurance would come from shifting the burden away from the few who must now bear the brunt of the load to a broader population.

AARP believes that universal protection against the financial burdens of long term care is needed to provide a true "safety net" for Americans. Such a program, of course, must be designed to work in tandem with private sector approaches, just as our nation's private pension system complements our public pension system.

Alternative Limited Approaches

Concerns about costs and the administrative and delivery structures engendered by such a universal program have given pause to even strong supporters of a federal long term care system. Consequently, much of the initial debate about a federal

role is likely to center on less comprehensive approaches, often leaving the current Medicaid System in place and carving out at least some formal role for private long term care insurance. Although AARP is seriously examining a comprehensive long term care proposal, my statement today focuses on the less extensive approaches now being discussed.

Less comprehensive systems can scale back coverage across a broad range of dimensions including types of services provided, deductibles and copayments, and eligibility. All generate important tradeoffs between cost and comprehensiveness that ought to be fully evaluated. Some of these developments lend themselves to future expansions; others would result in more permanent changes not amenable to later deelopment.

Although the merits of each of various proposals will be debated at length over the next few years, it is not too early to begin to discuss the differing philosophies, the likely beneficiaries, and the basic structures of each. Five basic limited approaches have thus far received considerable attention:

1. Coverage of only certain benefits such as home health care;
2. Medicaid coverage supplemented with incentives for private long term care insurance;
3. Comprehensive coverage with major "time deductibles";
4. Comprehensive coverage immediately with time limits on benefits; and

5. Expanded Medicaid.

1. A Limited Service Approach

Some proposals have tried to take an incremental approach to offering long term care at the federal level by focusing on only some services. Congressman Pepper's bill on home health care represents the major example of such an approach. By expanding only some services, the hope is that costs can be kept to a reasonable level and, in the case of home care services, that an under developed service sector can be expanded. Such approaches are often viewed as a first step toward a more comprehensive system. Although the Pepper bill would offer very comprehensive home health coverage, it would also be possible to add restrictions such as are discussed in the remaining categories. Thus, in looking at alternative approaches, I will examine more closely the other four, keeping in mind that limitations on benefit coverage are also possible.

2. Emphasizing Private Long Term Care Insurance

Supporters of private long term care insurance often advocate a public sector approach--either at the federal or state level--that is confined to improving incentives for the private sector and maintaining a limited Medicaid program. Such approaches could be very limited, offering only improvements in tax laws covering insurance companies' activities, such as exempting interest on long term care insurance reserves from

taxation. Much broader--and more expensive--options would offer tax breaks to individuals who purchase insurance products. These broad tax benefits might be required to make coverage affordable and thus expand the numbers of people purchasing insurance. And, we should not discount the substantial costs to the Treasury associated with such tax benefits--costs that can be just as troublesome from a fiscal (deficit) standpoint.

Controversy also exists over what role Medicaid would play. Expansion of Medicaid could help fill in the gap between those who could afford insurance and the very poor who are now covered. In some states where these proposals have been debated, however, proponents have argued to keep Medicaid very restrictive so as not to make it an attractive option for persons deciding whether or not to purchase insurance.

The basic dilemma of this overall approach is that the most likely beneficiaries of tax breaks are those who are least in need of protection. The likely purchasers of private insurance are those with considerable resources and incomes (or employer-sponsorship). Would tax benefits bring in those with more modest incomes? And if so, at what cost? These issues are at the heart of such proposals. We do know that many of the tax benefits would go to the relatively affluent; experience with Individual Retirement Accounts (IRAs) suggests that this system would leave at least many people with modest incomes uncovered. The extent of insurance coverage might be even less than the penetration of IRAs of about 16 perent in 1985. The size of the gap between

those with Medicaid coverage and those with insurance is subject to considerable debate.

Encouragement of private sector efforts would probably be less amenable to later development of an extensive federal role. Strong resistance to change might come from the insurance industry and customers happy with their private insurance. If penetration of private insurance is very good, this would not constitute a problem. But, if as many analysts expect, insurance offers solutions to the long term care problem for only a minority of the population, it may be difficult to expand coverage under a federal program to those of low or moderate incomes.

3. Benefits with Long Waiting Periods.

One of the the most often discussed approaches to long term care is a system that would require individuals to pay for their own nursing home and home health benefits for 6 months, a year or (or in the case of nursing homes under Senator Mitchell's bill) two years. Only after that waiting period would public benefits begin. (Usually Medicaid would remain in place to cover those who cannot afford care during this waiting period). These proposals generally assume--and some would require--the purchase of private insurance to cover the waiting period. In that sense they are closely related to a private insurance approach.

This use of a "time deductible" would hold down the costs to the public sector since many persons do not have long stays in

nursing homes. But, a majority of older persons who do have long stays exhaust their resources within a year. These individuals would then need to rely upon Medicaid. That is, many of the net new costs of the program would go to aid those with the means--either in resources or insurance coverage--to survive the time deductible with some resources remaining. In this sense then, programs with long time deductibles may effectiely be most important in offering asset protections and perhaps in encouraging the development of private sector approaches.

Supporters of this approach point to it as aiming more at the catastrophic side of long term care rather than providing first dollar coverage. But this raises the critical issue of when catastrophe occurs--and for whom. The definition of financially catastrophic expenditures relies critically on the levels of resources of the family. A one year time deductible for nursing home expenses would cost about $25,000--an amount beyond the resources of three quarters of women who live alone, for example. And many of them could not afford insurance protection either. For such older Americans, a one year deductible long term care proposal would not offer catastrophic protection, since catastrophe would already have occurred. For those with high incomes and considerable resources it would provide reasonable protection.

This time deductible approach could be made more inclusive over time by reducing the waiting periods, perhaps in conjunction with the build-up of trust funds to support the needs of future

long term care patients. But, the irony of such an approach is that the current generation of individuals with chronic and disabling conditions is less able to last the waiting period than will be future generations.

4. Time Limited Benefits

An interesting, and very different, approach to putting limits on long term care would offer coverage with no initial waiting period. After receiving benefits for a period of time (for example, 6 months), individuals would begin spending their own resources for nursing care until they became eligible for Medicaid, or would buy insurance coverage. Senator Kennedy has been discussing this type of approach for a possible bill. The logic of this approach is to assure access immediately and protect the assets of those likely to return to the community after a bout in a nursing home. Traditionally, long stayers have not returned home and if no spouse is present, continued first dollar coverage would mainly protect assets for the heirs. Proponents of this approach argue that such asset protection is the least important goal for a long term care system.

Such approaches often don't tackle holding down costs on the home health care side, however. Moreover, they send a message of hopelessness to individuals at the point when they are sick and alone. If spousal protections are maintained, cost savings from this approach would arise mainly from limiting benefits to single women in nursing homes--a group where the vast majority

have few assets to spend down. Nonetheless, this approach represents an important recognition of placing the emphasis on initail access. It would be quite amenable to later expansions in coverage, particularly if the public sector were initially involved in offering subsidized insurance to cover the end of a nursing home stay.

5. Expanded Medicaid.

Few observers of current long term care efforts under Medicaid argue that we adequately protect our citizens. But some advocate shoring up the current system as a modest approach to improving such coverage. About 14 states effectively limit their coverage to the categorically needy. And some states with medically needy or expanded income eligibility programs have very restrictive limits that also cover few additional persons.

National minimum standards are often a first step in proposals to expand Medicaid. Second, Medicaid now has a strong bias toward nursing homes at a time when most experts agree that home health care needs to be expanded. Third, required spend down of assets and income are often viewed as unnecessarily restrictive. Finally, payment levels in many states have created problems in ensuring access to good quality nursing homes when such facilities believe they are not being fairly compensated.

"Limited" approaches to expanding Medicaid very quickly can become expensive. Moreover, states that cannot or will not now expand their programs may be very reluctant partners. Some have

also suggested that critical programs for low income mothers and children might be cut back by further changing the original focus of the Medicaid program to expand long term care benefits.

The recently released Brookings Institution study clearly demonstrates that if Medicaid essentially remains the same, its costs grow rapidly as the costs of long term care outstrip the growth in incomes of elderly families. And the expansions mentioned here could be quite expensive. Such an approach could hold down costs as compared to other options by continuing to require individuals to "spend down" to eligibility (albeit allowing them to keep more resources than under the present system) and from retaining the basic "welfare" approach to eligibility that often inhibits participation.

Conclusion

It is important to recognize that just because the costs of a program do not register in the federal budget, they may nonetheless represent real costs to society. This statement began with a discussion of how the burdens of the current system are shared. It is critical to recognize that the costs of long term care <u>are</u> now borne by society, but in a very uneven way. A publicly provided program would help to spread those costs in a more affordable manner across the population, while providing assurance that all our citizens would have access to care when needed. An increased public role does not imply that the

society's costs have risen as well. Alternative solutions, such as mandating employers to offer such care or encouraging private insurance might lower the impact on the federal budget, but society's costs would remain and the benefits would not be universally available. Thus, in evaluating the desirability of various options, AARP believes that we should consider families' benefits and costs and not just government's burdens.

The Association wants to work with Congress to find realistic solutions to the long term care financing problem. We believe Americans are ready to face this challenge to protect current and future generations of families from the devastating costs of a long term illness.

Representative SCHEUER. Thank you very, very much, Ms. Moon. Now Mr. Eggert.

STATEMENT OF GERALD M. EGGERT, EXECUTIVE DIRECTOR, MONROE COUNTY LONG TERM CARE PROGRAM, INC./ACCESS, ROCHESTER, NY

REALLOCATE RESOURCES TO FINANCE LONG-TERM CARE

Mr. EGGERT. Thank you, Mr. Chairman. It is a pleasure to be here. When we were asked to testify, we tried to think of a reasonable way to kind of approach it. And I guess one way to look at it is that as far as paying for long-term care, there are about three basic approaches.

One is to get new private dollars, which is Senator Wilson's approach. One is to get new public dollars, which is Congressman Pepper's approach. And the third and what I would like to talk about, is a way to reallocate existing dollars in the system, principally, medicare dollars that are spent on hospital care.

We think that a reasonable argument could be made that some expansion of long-term care, namely, nursing home and home health, could be achieved through reallocation of hospital expenditures that go for a small proportion of people in hospitals, but people who are in hospitals repeatedly or for extended lengths of stay.

While we are talking about hospitals reminds me of this joke I first heard about Willie Sutton. The New York Times interviewed Willie Sutton. He was a famous New York bank robber, and the reporter said, "Willie, why do you rob banks?" And Willie said, "Well, that's where the money is."

Why are we talking about hospitals. In the long-term care system, that is where the money is. In an acute care system, that is where the money is. Our point is that chronically ill people who are also at high risk of nursing home and home health services also use extensive amounts of hospital care.

So what we need to start thinking about are ways to start setting up management systems to reallocate some of these hospital expenses that we are incurring, and to use it as a way to make medicare more flexible, so that we can use nursing home and home health services as means of reducing, postponing, or preventing entirely some readmissions.

It is almost like the concept of automobile insurance, where you have assigned risk pools. Certain number of drivers are going to have accidents, they have had accidents, and at some point, they are not insurable through the standard mechanisms. So what States do is to create assigned risk pools in which there are certain conditions, the premiums are higher, but there is some attempt to try to work with drivers to reduce the number of accidents.

Well, we are talking about medicare people in hospitals, or high use medicare people. There have been several studies that have pointed out that a small proportion of medicare enrollees use a disproportionate amount of services or costs. As an example, 4 percent of medicare enrollees use 49 percent of expenditures. Or the 2.6 percent who are admitted to the hospitals five times or more, use

20 percent of expenditures. As far as nursing homes go, nursing home residents are big users of hospital care.

We did this study in Rochester, and we found that 30 percent of those admitted to a nursing home were readmitted to the hospital within 2 years. There was a study done in California that showed 39 percent of those admitted to a nursing home were transferred to the hospital twice in 2 years and another 21 percent were transferred four times in 2 years.

What we need to do is to start developing ways to reduce readmissions to hospitals and then trade off the money, the funds that would have been spent on hospital care, to improve long-term care and to finance more nursing home care or home health care.

We tried three different programs in Rochester that had some limited success. And the first one I would like to talk about is what we call our "sudden decline" benefit. We had some medicare waivers that waived the 3-day hospital stay that allowed us to pay a higher rate to nursing homes and that allowed us to pay for physicians to visit daily in nursing homes for people who were about to be admitted to hospitals.

So we worked with nursing homes, and they identified potential patients who were going to be hospital readmissions. A physician went in and did a comprehensive assessment. The assessment was based on Dr. Williams' work when he was in Rochester. In an examination of the first 100 readmissions that we prevented, we felt that 60 percent of them would have been readmitted, and the cost savings was about $3,000 to medicare and about $1,000 to medicaid or to private pay. This is one of the cases in the system where there is double payment. When a person is readmitted from a nursing home to a hospital, medicare pays in the hospital, but medicaid or self-pay pay for the vacant nursing home bed, because that is one of the ways to get people back to nursing homes from hospitals.

One potential area of opportunity is to look at nursing home populations and the frequency to which they are readmitted to hospitals with ways of improving nursing home care to prevent or reduce the number of readmissions.

The second area is the extent to which chronically ill people in the community are readmitted to hospitals. We have some evidence that the number of days in some studies has been reported to be as high as 50 and as low as about 4. If the national standard is about 4 days per year in hospitals, and if a group is admitted about 50 days per year, that is about 10 or 12 times greater than the average.

We were successful in looking at ways to combine case management with expanded medicare benefits for nursing homes and home health, and with duly eligible people, people eligible for both medicare and medicaid, we were able to reduce public expenditures by about $200 per month.

In summary, there are ways, and people are just beginning to look at them, to try to reduce the number of readmissions to hospitals. In Rochester and Monroe County, 10 or 15 years ago, we were talking about developing models that would reduce nursing home admissions, but we quickly gave up on the idea, when we found out that home care was probably as expensive as nursing home care

for people who were similarly disabled, and home care is not an inexpensive bargain. You pay for what you get in life.

And so we quickly decided that home care probably should be expanded primarily as a matter of choice, options, and that, in the long run, it may prevent or may reduce the need for building additional nursing home beds. The opportunity, we felt, was in hospital care. Now in New York State, we have always had a problem with people being in hospitals beyond medical necessity. In Rochester, we have had anywhere from 5 to 13 percent of the beds occupied by people who cannot be admitted to nursing homes in a timely fashion. But with DRG's, the medicare payment problem is resolved. I mean, sombody has to pay, and it is usually medicaid or the hospitals or self-pay, but with DRG's, the issue becomes readmissions. And we think that we need to start looking at ways to start reducing readmissions by elderly, chronically ill survivors.

It reminds me that there are a couple of programs under medicare, one is the hospice benefit, but that is primarily for people who are going to die within 6 months.

Another special benefit is for renal dialysis, and that is for people with a specific problem.

But there is really no benefit, there is no organized management approach, for what I would call the chronic survivors, people who are chronically ill, who will be chronically ill, and who are going to survive for a number of years.

I guess one of the classics is dementia, where the length of survival between first identification and death is 9 years. And I think we need special units, special management initiatives to try to reduce the acute expenditures and reallocate funds into long-term care.

The pioneers in this area have not been the Federal Government but really have been private insurance companies. In high cost case management, there have been articles in the Wall Street Journal and other publications. I am reminded that Metropolitan has set up a special unit called Met Life, and they claim to have saved $17 million the first year of their operation. Aetna has a special group that is claiming $60 million worth of savings. Blue Cross of California has set up a special unit and off of approximately 400 people, they saved $1.8 million in the first 6 months.

So it seems to me that we, in the Federal perspective, can look to the private sector and try to learn what they are doing and see how much of that is applicable to medicare, because in the short run, the best we can do is work with what we have, and that's basically medicare. Thank you.

Representative SCHEUER. And that's basically medicare.

Mr. EGGERT. Medicare.

Representative SCHEUER. Yes.

[The prepared statement of Mr. Eggert follows:]

PREPARED STATEMENT OF GERALD M. EGGERT

Special Medicare Benefits and Patient Care Management Models For High Cost Patients

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and

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This paper was prepared for "The Health Care Needs of the Elderly", one of a series of hearings on "The Future of Health Care in America" held by the Subcommittee on Education and Health, Joint Economic Committee, Congress of the United States, June 14, 1988.

I am very pleased to have the opportunity to testify before the Joint Economic Committee of the Congress on "The Future of Health Care in America", and specifically on "The Health Care Needs of the Elderly". The more seriously chronically ill elderly who use nursing home and home care also use extensive amounts of acute hospital care. While new private and public sources are needed to finance long term care, an equally important task is the creation of special benefits features and management models within Medicare directed toward the more seriously chronically ill. Special Medicare benefits linked to new models of patient care management can result in reductions in acute hospital use as well as expanded resources to pay for care in nursing homes and at home. The objective is to reallocate acute hospital expenditures to all forms of long term care without compromising appropriateness and quality of care.

Hospital Use Among Long Term Care Patients

Many elderly long term care patients use substantial amounts of hospital care. The 1985 National Nursing Home Survey found that half (430,000) of all live discharges from nursing homes were to hospitals (Sekscenski, 1987). In Monroe County (Rochester), New York, 30% of patients admitted to nursing homes in 1982 were transferred to the hospital during the next two years. Significantly, while 27% of skilled nursing facility (SNF) patients were transferred, the proportion of intermediate care facility (ICF) patients admitted to the hospital was even higher - 42% (Barker, Zimmer, Hall, Ruff, and Eggert, 1987). A considerable number of patients "bounce" back-and-forth between hospital and nursing home (the so-called "ping-pong effect"), often for a year to two until they die. A study of nursing home

discharges found that of those who survived the initial discharge, 39% were transferred between hospital and nursing home two or more times during the next two years, and 21% were transferred four or more times (Lewis, Cretin, and Kane, 1985). In Monroe County 8% of all SNF admissions and 13% of ICF admissions were hospitalized two or more times during the two years following admission (Barker, et al., 1987).

The number of hospital days per nursing home patient per year is often considerably higher than for the elderly population in general, who use an average of about four hospital days per year. In three studies in Massachusetts, nursing home patients were found to use 5.1 (Mark, Lennox, Jainchill, Kavesh, and Master, undated), 7.2 (Mark, Willemain, and Master, 1976), and 9.6 days annually (Mark, et al., undated).

We are unaware of any national data on hospital use of long term care patients living at home. However, data is available for many of the home, community-based, and long term care studies carried out during the past few decades. The populations of patients participating in these studies exhibit a very wide range of hospital use. Of the "most rigorous and generalizable" home and community care studies of the past thirty years (Weissert, Cready, and Pawelak, 1987), the average number of hospital days per person per year for the control and comparison groups ranges from a low of 3.4 days to a high of 54.4 (see Table 1). Reductions in the number of hospital days occurred in two-thirds (16) of the 24 studies for which data was available. Seven of the programs achieved significant decreases, ranging from 23% to 86%. Increases took place in another seven, two of which were very large (50% and 118%). One program experienced no change.

Table 1

HOSPITAL USE
AMONG LONG TERM CARE
STUDIES AND DEMONSTRATIONS

	Hospital Days Per Person Per Year for Control Group	Treatment Group Use
ACCESS:Medicare - Medicare/Medicaid Group	54.4	-86%
ACCESS:Medicare - Medicare/Private Pay Group	51.1	-34%
Acute Stroke	50.4	- 2%
Post-Hospital Support	38.4	-24%
Channeling Financial Model	26.8	- 4%
South Carolina Community Long Term Care	20.0	-10%
Channeling Basic Model	19.8	- 3%
Nursing Home Without Walls - NYC	16.2	+ 9%
Section 222 - Homemaker	16.0	+12%
Nursing Home Without Walls - Upstate	15.9	+17%
New York City Home Care	14.9	-25%
Chicago Five Hospital Homebound Elderly	14.0	-11%
Section 222 Day Care	13.0	-23%
Wisconsin CCO/Milwaukee	12.2	-84%
Chronic Disease	11.6	+ 5%
Benjamin Rose Hospital Home Aide	11.4	-40%
San Diego Allied Home Health Care	9.1	- 6%
Alarm Response	6.6	- 4%
Highland Heights	6.4	- 8%
On Lok	5.4	-13%
Congestive Heart Failure	5.4	+ 2%
Worcester Home Care	4.0	0%
Georgia Alternative Health Services	4.0	+50%
Triage	3.4	+118%
Mean	17.9	- 7%
Median	13.5	- 5%

Source: Hospital Days from Table 5 in Weissert, Cready, and Pawelak (1987); Treatment Group Use calculated from Tables 5 and 6 in Weissert, Cready, and Pawelak (1987)

The opportunity of reducing the number of hospital days, as well as the likelihood of generating significant dollar reductions, seems greatest among those Medicare patients who experience the most hospital use. While all of the studies reviewed were designed for elderly persons or people at risk or in need of home care or nursing home care, four provided care to patients with high hospital use (38-54 days per person per year), twelve cared for persons using a moderate amount of hospital days (11-27 days per year), and eight served people with low hospital utilization (less than 10 days per person per year).

- Three of the four studies serving high utilizers of hospital care achieved substantial reductions in hospital use, ranging from 24% to 86%.

- Among the studies caring for patients who were moderate users of hospital care, two-thirds achieved reductions in hospital use while one-third experienced increases. While the increases were generally low, several of the studies that achieved decreases had considerable reductions, ranging from 23% to 84%.

- Among the home and community-based care studies that enrolled low utilizers of hospital care, three-quarters had very small decreases, no difference, or a very slight increase. However, two experienced extremely large increases, 50% and 118%.

Most of these studies were not cost-effective. However, only four of the 24 had as a primary or secondary goal the reduction of hospital days. Most

important, however, two of the three studies that achieved significant decreases among high users of hospital care were cost-effective.

High Utilizers of Medicare Expenditures

A small proportion of persons eligible for Medicare account for a disproportionately high percentage of expenditures. Between 1974 and 1977, 2.6% of the Medicare population experienced more than five hospital discharges and accounted for 20% of Medicare inpatient hospital expenditures, while 12.5%, who experienced at least three hospital discharges, accounted for 58% of expenditures (Anderson and Steinberg, 1984). In 1982, 4.0% of Medicare enrollees accounted for 47.9% of total Medicare expenditures, averaging $17,897 per person. The top 2.0% averaged $23,818 per capita (Riley, Lubitz, Prihoda, and Stevenson, 1986).

Most of the patients who experience repeated hospital admissions are chronically ill. It has been estimated that the elderly population consists of two groups:

> a well-elderly population consisting of six out of seven persons, who only enter a hospital once very eight years - until they become chronically ill and/or die - and a chronically ill population consisting of one out of seven persons who enter the hospital about 1.3 times per year (Gruenberg and Tompkins, 1985).

Many of the latter are also likely to be heavy users of long term care services.

Special Benefits and Patient Management Models for High Users

The greater opportunity of achieving significant reductions in hospital expenditures among high users of hospital care, coupled with the reduced likelihood of significant decreases among low users, has added relevance since Medicare enrollees in health maintenance organizations (HMOs) are apparently lower utilizers of hospital care than the overall elderly population. A recent evaluation of twenty TEFRA HMOs found that their enrollees averaged only 2.2 hospital days per person per year (average use per plan ranged from 1.4 to 3.8 days) (Langwell, Rossiter, Brown, Nelson, Nelson, and Berman, 1987). Because the high users account for a large proportion of Medicare expenditures and only 3% of the Medicare population is currently enrolled in HMOs, more efforts should be directed toward reducing Medicare hospital expenditures among high cost Medicare patients not enrolled in HMOs. How might we do this?

There are two important issues regarding health care expenditures that need to be considered. These are coverage and management of care. The coverage issue involves the financing of various services while management is concerned with achieving efficiency and effectiveness in the actual delivery of those services. There is an adage in health care that "Form follows financing". In other words, the type and setting of health care service delivery is primarily determined by rules for third party reimbursement. Unfortunately, many elderly people receive care in less appropriate and more expensive settings than necessary (primarily the acute hospital) because Medicare is not flexible enough in its design and administration to pay for

care in alternative settings that are often more appropriate and less expensive. (An exception to this general statement is the Medicare Hospice Program.) A substantial proportion of the acute care of many Medicare patients who are chronically ill could be provided in less expensive settings, that is, in nursing homes and at home.

Patients who are suffering from different diseases or groups of disease presumably have different needs. A patient with congestive heart failure requires a different service package than a patient with chronic lung disease. Specific benefits packages should be provided for different types of chronically ill Medicare patients. These packages should differ from each other as well as from the benefits available to Medicare beneficiaries who are not chronically ill. This should not only reduce hospital expenditures and provide Medicare reimbursement for services in settings where reimbursement is not presently provided, but should improve appropriateness and quality of care as well as patient satisfaction.

The ACCESS Medicaid Nursing Home Diversion Model

Most of the efforts to develop better models of financing and managing care for the elderly have focused on reducing nursing home use rather than hospital use. ACCESS Medicaid was designed in 1975 primarily to be a nursing home diversion model. In order for a nursing home diversion model to work, two things are essential. First, a mandatory pre-admission assessment is necessary. Second, one has to distinguish the few long-stayers from the many short-stayers. Otherwise, since 13% of elderly nursing home patients account for 90% of all nursing home expenditures

(Cohen, Tell, and Wallack, 1986), community services used to divert patients from nursing homes are spent on persons who would either never have entered a nursing home, or if they would have entered, would have been in residence only a short time. Either way, the additional community services are not offset by sufficiently deep reductions in nursing home use. Another factor is that home care is not inexpensive. We have found that patients who were prime candidates for admission to a nursing home also required fairly extensive home care services to remain in the community. The anticipated cost savings are not usually achievable in a nursing home diversion model because it is hard to identify long-stayers upon admission, and the expense of providing home care often equals the cost of nursing home care. We have concluded that the home care system should be expanded primarily because it provides more choices and options for long term care rather than because community care is necessarily cheaper than nursing home care.

ACCESS Hospital Diversion Models

In developing the ACCESS Medicaid program, we also wanted to reduce inappropriate use of hospitals by chronically ill Medicaid patients. There was in 1975, and continues to be, a sizeable number of acute hospital beds occupied by elderly patients who are no longer acutely ill but are severely chronically ill. During the past twenty years, this "hospital back-up" has ranged from a low of about 5% to a high of some 13% of the beds in the Monroe County hospitals. Many of these "back-up" patients have been admitted to the hospital from their homes in the community a number of times and are now awaiting admission to a nursing home. For a variety of reasons, usually related to source of payment and disability level, these chronically

ill Medicare patients remain "backed-up" in acute beds because no nursing home will admit them on a timely basis.

Since 1982 we have concentrated on the development of hospital diversion models whose focus has been to use both home care services and nursing home services as substitutes for extended hospital stays or repeated hospital admissions. Each initiative aimed at paying for expanded long term care services for the elderly (both home care and nursing home care) by reallocating Medicare and Medicaid inpatient hospital expenditures, and provided care to severely chronically ill, mostly elderly persons. Two of these initiatives involved significant changes in Medicare benefits while one used an innovative model of managing patients' care over time.

ACCESS:Medicare

The first of these special interventions was ACCESS:Medicare, a Medicare waiver demonstration program that operated from 1982 to 1986 (Berkeley Planning Associates, 1987). The purpose of ACCESS:Medicare was to substitute nursing home care and home care for hospital care among patients in need of long term care. The demonstration provided for assessments for all patients at risk of long term care, utilized a broader definition of skilled care than the Medicare definition, provided case management and Medicare reimbursement of up to 100 days per year of home care, and provided up to 100 days per year of nursing home care at a rate generally somewhat greater than the facility's Medicaid reimbursement rate, but lower than the "private pay" rate. The patients participating in ACCESS:Medicare were the highest utilizers of hospital care among the twenty-four home and community

care studies reviewed by Weissert and his colleagues (see Table 1). The Dually Eligible Group (patients eligible for both Medicare and Medicaid) used on average 60 hospital days per patient per year (adjusted) while the Medicare/Private Pay Group (those patients who were eligible for Medicare but who paid for long term care on a private pay basis) used 59 days (adjusted). The evaluation found that while the Medicare/Medicaid treatment group used only 13 days per patient per year (adjusted) (78% less), the Medicare/Private Pay treatment group used 42 days (adjusted) (29% less).

While ACCESS:Medicare was able to substantially reduce hospital use, it was cost-effective regarding public expenditures only for the dually eligible (Medicare/Medicaid) group. Although not statistically significant, public expenditures were a substantial $206 (8%) less per patient per month for the dually eligible treatment group. However, ACCESS:Medicare cost an additional $771 (49%) per patient per month for the Medicare/Private Pay group due to greatly increased use of waivered home care and nursing home services (Berkeley Planning Associates, 1987). While hospital use was reduced by a substantial 17 days per person per year, this was not enough to offset the large amount of waivered services provided.

Significantly, ACCESS:Medicare also appears to have been extremely cost-effective for dually eligible patients who died within one month of enrollment into the demonstration. Treatment group expenditures were $2,960 lower per patient per month. However, this finding should be considered with caution as the number of patients who died within one month was small.

Sudden Decline Benefit

The second intervention is what we have termed the Sudden Decline Benefit (Zimmer, Eggert, Brodows, and Treat, 1988). The purpose of the Sudden Decline Benefit was, where appropriate, to care for acutely ill nursing home patients in the nursing home rather than transfer them to the hospital. This benefit was utilized as part of ACCESS:Medicare. Nursing home patients who were becoming acutely ill and for whom transfer to a hospital seemed imminent were eligible for the Sudden Decline Benefit. ACCESS:Medicare would pay for a comprehensive assessment of the patient by nursing home staff as well as a physician work-up of the patient in the SNF. If both the physician and the nursing home agreed that the patient could be appropriately cared for in the SNF, ACCESS:Medicare would reimburse the facility a higher daily rate to enable them to provide the increased nursing care required. ACCESS:Medicare also reimbursed for physician visits to the nursing home, on a daily basis if necessary. A key benefit modification was the waiver of the 3-day hospital stay requirement.

The evaluation, a retrospective audit by a physician panel of the first 112 patients to use the benefit, found that 67 of the patients (60%) avoided a certain or likely hospital admission. Another 18 patients (16%) avoided a probable emergency room visit, while 14 (12%) required additional acute care in the SNF. Only 13 patients (12%) inappropriately received the benefit.

The pilot study estimated savings to Medicare of $3,000 per case. For patients also eligible for Medicaid, additional savings of $1,000 per case were estimated. The Medicaid savings resulted from the elimination of the

necessity to pay for vacant nursing home beds while the patients were in the hospital (Zimmer, et al. 1988).

Neighborhood Team Case Management Model

Our third special intervention was a comparison of two models of case management: the Centralized Brokerage model and the Neighborhood Team approach (Eggert, Zimmer, Hall, and Friedman, 1988). The purpose of the study was to test a new model, the Neighborhood Team, for managing the care of seriously chronically ill elderly living in the community. All patients participating in the study were qualified to be admitted to an SNF. The study population was quite ill in comparison to the majority of community care demonstration projects. This is shown by the fact that the mortality rate for the control group at the end of one year (31%) is higher than those of all but two of the 16 community care demonstrations for which this information is available. Control group patients were moderate to high users of both hospital and nursing home care, using 26 and 34 days on average per year, respectively. Each Neighborhood Team included a nurse, social worker, and case aide. Incentives were provided by (1) assigning the Team to a limited catchment area, (2) reducing the size of the caseload carried by each case manager (from 120-150 clients to 40-45), (3) getting to know the patient and family better by making home visits, and (4) allowing the case managers more autonomy and independence.

Total health care expenditures of patients managed by Neighborhood Teams were 14% lower than those case managed by the Brokerage model. This was achieved by reducing the number of hospital days (by 26%), home health aide

hours (by 17%), RN/LPN hours (by 54%), and homemaker hours (by 88%). The number of nursing home days was increased (by 45%). These presumably substituted for extended hospital care and expensive home care cases (Eggert, et al., 1988).

Lessons Learned

Over the past decade, we have learned the following lessons that have been applied or have potential applications to the Medicare program:

- The area of greatest opportunity for health care cost savings lies in the identification and improved management of high cost patients. A growing number of studies as well as our own experience indicate that a small proportion of cases accounts for a large proportion of health care utilization and expenditures. Rather than focus on a large number of individuals that account for a small amount of total expenditures, it makes sense to concentrate on that small number of patients who are responsible for the bulk of costs. One of the major reasons health care expenditures have continued to increase is that little effort has been devoted to the identification and management of high cost patients.

- The opportunity to save dollars for high cost patients lies primarily in avoiding unnecessary hospital care and better managing home health care, and only secondarily in substituting in-home and community-based services for nursing home care. While the number of patients receiving long term home care has increased greatly between 1978 and

1988, it costs more to care for many of these patients at home than in a nursing home. Although home care is being substituted for nursing home care for many of these patients, in some cases this is more expensive than caring for the patient in a nursing home. On the other hand, the cost of a day of hospital care is equal to five to ten days of skilled nursing facility care.

The ACCESS:Medicare demonstration was able to achieve significant reductions in hospital use among both the Medicare/Medicaid and Medicare/Private Pay populations even though it was designed for persons who had been hospitalized and were in need of post-hospital care rather than patients who were at risk of multiple hospitalizations. That is, even though the target was not patients at risk of multiple hospitalizations, ACCESS:Medicare was able to significantly reduce the number of hospital days used by Medicare patients requiring long term care. Presumably, targeting that focuses on those who are at highest risk of multiple hospitalizations should have greater success in reducing the number of hospital days.

The opportunity also exists to further better manage community services. In-home health care services were reduced by 23% for patients who were managed by Neighborhood Case Management Teams.

° Total health care expenditures can be reduced for certain patient groups by providing an alternative out-of-hospital benefit package coupled with case management. While we had theorized that total health care expenditures could be reduced among all Medicare patients

in need of long term care, the evaluation of the ACCESS:Medicare demonstration found that this occurred only among dually eligible patients. This may have been because a greater proportion of the Medicare/Medicaid group were over 85 years of age, had more impairments with activities of daily living, were more impaired regarding ambulation, bladder, and bowel function, and had a chronic prognosis. That is, the dually eligible group appears to have been comprised of persons meeting the traditional definition of chronically ill while the Medicare/Private Pay group most likely used ACCESS:Medicare services as a short-term post-acute hospital benefit.

° Stringent expenditure controls are needed to prevent nursing home and home care services from consuming savings even when significant hospital use reductions are achieved. Even though ACCESS:Medicare was very successful in reducing the number of hospital days of the Medicare/Private Pay Group, total public health care expenditures of the ACCESS group were significantly higher. Cost caps or tighter limits on the number of home health aide hours could substantially reduce the cost add-on.

° Specialized case management must be developed for specific groups of patients with the same or similar illnesses. The Neighborhood Team was especially effective for patients with dementia. Insurance companies and private case management organizations are increasingly using case management for specific types of patient, for example, very low weight babies, and patients with AIDS, spinal cord injuries, or head trauma, and have claimed large cost savings using this approach.

It makes sense to extend this concept further to identify homogeneous groups of patients among the Medicare population, and develop a specialized case management approach for each of these groups.

Future Directions

The opportunity exists to provide better patient care and at the same time reduce expenditures. This can best be achieved through the identification of specific groups of high cost patients and the development of specialized benefits and patient management models.

Only limited information is available about high cost patients, their characteristics and service use patterns, and the relationship between chronic diseases and service needs and use patterns over time. Almost no research has been conducted regarding the provision of special Medicare benefits packages for different types of chronically ill patients. Little testing has taken place comparing the effects of various management models on health service utilization and outcomes, including mortality, functional status, quality of care, and patient satisfaction.

In preparation for our proposed Medicare demonstration with high cost, multiple hospital admission patients, we have examined data on the hospital experience of the Monroe County Medicare population. Rather than use prior use data from only one year, however, we have utilized the research finding that 88%, 98%, and 100% of patients with 3, 4, or 5+ admissions, respectively, over a three-year period were "chronics" (Gruenberg and Tompkins, 1985). Empire Blue Cross, the Medicare Fiscal Intermediary for

Monroe County, provided us with information on all Medicare eligibles residing in Monroe County who were admitted to hospitals in New York State three or more times during the three-year period 1984-86. Using a group with three or more admissions over a three-year period should minimize the inclusion of the non-chronic users.

During that three-year period there were approximately 7,800 Monroe County residents who experienced three or more hospitalizations. Of these, about 1,200 were identified as having been alive throughout this entire period and not having been a member of a Medicare HMO. Some 800 used a hospital three or more times and died, and about 100 were alive for the three years and were members of an HMO. The vast majority (5,700) were not confirmed as either dead or alive.

We have begun examining data on age, sex, diagnoses, and Medicaid status for the 1,200 multiple admission survivors who did not join an HMO, and have reviewed the data for the 572 patients with four or more admissions (See Table 2).

Table 2
MONROE COUNTY
MULTIPLE HOSPITALIZATION PATIENTS
1984-86

No. of Hospitalizations Per Patient	No. of Patients	% of Patients on Medicaid	% of Patients < Age 65	% of Patients > Age 79
10-20	17	53%	58%	0%
8-9	29	51%	28%	17%
7	52	46%	23%	19%
6	74	31%	20%	20%
5	147	35%	13%	24%
4	253	39%	14%	24%
Total	572	39%	17%	22%

The following are the highlights of our findings:

- Seventeen patients (3%) had from 10 to 20 hospital admissions, 29 patients (5%) had 8 or 9 hospitalizations, and 126 (22%) had 6 or 7 admissions. Four hundred patients (70%) had 4 or 5 admissions.

- The greater the number of admissions, the greater the proportion of persons under age 65, and the lower the proportion age 80 and over.

- By far the most prevalent diagnostic category was "multiple cardiovascular, respiratory, renal and/or other conditions typical of old age (multiple chronic degenerative illness)", 39.1% of the 572 high utilizers being classified as such.

- The next most common predominant problems leading to multiple hospitalizations were "cardiac disease with congestive heart failure,

myocardial infarction, and ischemic heart disease" (13.9%), "chronic lung disease including asthma" (6.4%), and "psychiatric primarily" (5.4%).

- The top four diagnostic categories accounted for almost two-thirds (64.8%) of the 572 high utilizers.

- Thirty-nine per cent of the multiple admission patients and 58% of those with 10-20 admissions were Medicaid eligible.

In order to mount a substantial initiative in high cost patient care management, the public sector needs to obtain more information regarding the following:

- The hospitalization patterns of nursing home patients and, especially, long term care patients living at home.

- Whether, and if so, how, the hospitalization patterns of long term home care patients differ from those of chronically ill persons living at home not receiving home care.

- The distribution and amounts of various health care services being received by multiple hospital admission patients living at home, and how these compare to those received by non-multiple hospital admission patients.

- The types of high cost patients, the diseases and conditions they have

(many chronically ill elderly often suffer from several), and their demographic characteristics, functional status, and service needs and use.

- The use patterns of the Medicare disabled population under age 65, and how they differ from the various age groups of the over 65 population.

- How diseases and conditions, functional status, and service needs and use of high cost patients change over time, and how their care should be managed longitudinally.

- The use patterns of dually eligible (Medicare/Medicaid) multiple hospital admission patients, and how they differ from the Medicare/Private Pay multiple admission patients.

Research is needed regarding the provision of specific Medicare benefits packages designed for high cost patients.

- Benefits packages should be designed and tested not only for high cost or chronically ill patients in general, but for groups of patients with the same disease or similar diseases.

- A demonstration program should be implemented for chronically ill persons living at home that builds upon the findings of ACCESS:Medicare, and includes home care and nursing home services coupled with case management to prevent and substitute for hospital admissions.

- A randomized controlled trial should be carried out following up on the restrospective findings of the ACCESS:Medicare Sudden Decline Pilot Study to further determine the feasibility, efficacy, and cost-effectiveness of the provision of acute care in nursing home settings.

Models need to be developed, tested, and implemented for managing the care of patients over time as their diseases or conditions become more severe, their functional status worsens, and they move back-and-forth from one in-home or out-of-home setting to another. Very few comprehensive models have been developed that manage preventive, primary, acute, and long term care. Not enough attention has been focused on managing "health careers" over time as chronically ill persons move among home, hospital, and nursing home settings. This is especially important as health care utilization and expenditures are considerably higher during the last three or four years of life, and usually increase as the patient approaches death.

The effectiveness of case management needs to be tested as it relates to the care of persons at risk of multiple hospital admissions who are residing at home. The results of case management thus far are mixed. Case management appears to be cost-effective for patients who use considerable amounts of hospital care, but its effectiveness as it specifically relates to the reduction of number of hospitalizations of multiple admission patients needs to be tested.

The final recommendation is that the public sector needs to develop much

greater interest in studying the high cost, multiple hospital admission phenomenon. It is the private sector, not the public sector, that is spearheading innovations in this area of managed care (General Motors Corporation, 1984; Lenckus, 1986; Henderson and Wallack, 1987; Ricklefs, 1987). Private insurance carriers, many of them also Medicare Fiscal Intermediaries, are reporting substantial savings from new case management initiatives directed toward high cost, primarily hospitalized, cases. In 1986 Blue Shield of California averted $1.8 million in expenditures, or $4,742 per case, on only 378 cases. Metropolitan Life Insurance Company's Met-Review program saved $17 million in the first half of 1986 and AEtna Life and Casualty Company predicted its case management program would save $60 million in 1986 (Moore, 1987). These programs work almost exclusively with populations not eligible for Medicare. Medicare needs to work with its Fiscal Intermediaries to estimate what aspects of these private insurance programs are transferable to Medicare beneficiaries and where new features should be developed, since the Medicare population differs from the privately insured population.

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Representative SCHEUER. All right. Senator Pete Wilson of California.

ROLE OF PRIVATE FINANCING

Senator WILSON. Thank you, Mr. Chairman. Let me ask a question. I will direct the questions, but if any member of the panel feels inclined to respond, why I will be delighted to have them do so.

Essentially my question, though, is directed to Mr. Wiener and to Mr. Holahan. In your presentations this morning, and you, in particular, Mr. Wiener, indicated that you thought that there was a substantial untapped market for private carriers and yet you recommend long term that we go to a Federal program of some kind. That, I gather, is going to be essentially a medicare-funded program.

Mr. WIENER. Yes, medicare funded.

Senator WILSON. Medicare funded.

Mr. WIENER. That's right. I think that——

Senator WILSON. How do you see those two jibing, and what I didn't get from your testimony was how you think the private carriers could be involved in a beneficial way and what would be the sharing of that burden between the public and private sector.

Mr. WIENER. I think there's no question that there is a very great potential for growth in the private sector. We now have about 1 or 2 percent of the elderly population with any private long-term care insurance, and if our simulations were to come true, we would have many more people with private insurance than we do now.

What we didn't find in our simulations, even with some fairly optimistic assumptions was a radical change in the way in which we pay for long-term care. We didn't find that insurance would end up paying for a high percentage of long-term care expenditures. We didn't find that medicaid expenditures would——

Representative SCHEUER. You mean private insurance?

Mr. WIENER. Private insurance; right.

Representative SCHEUER. Yes.

Mr. WIENER. We didn't find that medicaid expenditures would drop significantly. So I think what we're saying is that it can do a lot more than it is doing now, but by itself, it can't be the total solution. Now within a public insurance system, there are at least three models of public-private partnership, and Ms. Moon alluded to some of them. In the bill proposed by Senator Mitchell, you have a 2-year deductible period before the public program kicks in and people absolutely have to go out and buy private insurance to fill that 2-year deductible period, because if they don't, they simply are going to impoverish themselves before that 2-year period.

A second approach is the one that Robert Ball has been talking about and Senator Kennedy, as well, and that's the sort of short-term benefit that Ms. Moon alluded to. In that scenario, private insurance could be sold to cover the long stays, the period after the 6 months or the year in the nursing home, and that would be potentially a substantial part of nursing home expenditures.

And then the third model is basically something analogous to medigap for a fairly comprehensive program where you provide fairly first dollar coverage, albeit it with coinsurance and some deductibles. The model, I think, for the third approach is some kind of medigap policy to try to fill in those deductibles in coinsurance.

Senator WILSON. Now you say you're talking about a medicare program. Someone this morning, I have forgotten who it was, indicated that they thought that a public program needed to be means tested or at least someone discussed that as a possibility, and if I understood—I don't know if that was you, Mr. Holahan or who it was. In any case, if we're talking about a medicaid program, one where we are means testing, then it would seem to me that the whole panoply of different means of private coverage very much come into play, and that there is an opportunity through this or perhaps through some kind of health IRA, or as they are sometimes referred to IMA's, for those who are not part of a group, to take a long view and be rewarded by their prudence with some kind of tax deferment.

I believe Ms. Moon made the comment that AARP had, for reasons that I will ask her to pursue, decided that tax expenditures of that kind through a health IRA were not desirable. If I misunderstood you, you correct me, but in any case, it would seem to me that we have just seen a rejection of a comprehensive effort by Congressman Pepper. Now that may be revisited, but let's just assume for the sake of argument that it becomes the decision of the Congress that that kind of a comprehensive treatment is not affordable, and that there is a need to encourage some kind of public-private sector arrangement with the private sector being encouraged through means testing to supplement or to enter that market for those that are not able to qualify for public coverage.

It would seem to me that there is still going to be a need for middle-income taxpayers, who are substantially above the poverty level, to have some incentive through something like an IMA. Or, if they are involved in a group life plan, as are the vast bulk of Federal employees, move to where they make use of risk sharing and the convertibility option to provide life coverage, they could avail themselves of the kind of private coverage that will be necessary, if we are not going to go to a thoroughly comprehensive Pepper-type coverage. Yes, Mr. Liu.

ACCESS TO LONG-TERM CARE

Mr. LIU. The debate on long-term care financing has been, in my opinion, focused on the affordability part of it. What I would like to introduce at this point is another dimension which I think is fairly fundamental in the consideration of different options, and that is the acceptability of individuals for private policies. It is particularly important as we think about the role of the private insurance market to know that certain health status characteristics of the population may make it difficult for individuals to purchase private insurance, even if they could afford it and even if they desired to. Some of our preliminary looks at the elderly population indicate, for example, that possibly 15 percent of the females who are 55 to 64 have arthritis or rheumatism with some disability, and 45

percent at that age have had the conditions. These are fairly young ages that we are talking about. But what it suggests is that a high proportion of people do have health status problems which may not allow them to screen into a private policy.

Representative SCHEUER. A high percentage of people have what?

Mr. LIU. Have a disability or medical condition that is commonly found in screens for private policies. The example I gave is fairly extreme, but it is basically to make the point that we need to consider both whether people can afford to buy insurance and whether they can get it.

Senator WILSON. I agree with that.

Representative SCHEUER. Senator, would you yield to me for one brief question for clarification?

Senator WILSON. Sure.

Representative SCHEUER. I'd like to know what percentage of folks in nursing homes after 1 year or perhaps even 2 years have spent down and have exhausted their assets, so that they are eligible for a means-tested program? Or to put it in the inverse perspective, what percentage of folks who go into a nursing home still cannot have access to a means-tested program at the end of a year and are therefore a ready target for the private market? How large is that market for private health insurance?

Mr. LIU. Well, we've just recently looked at some utilization results from a nationally representative survey. We found that 41 percent of the people who were in a community and disabled, but entered nursing homes, became medicaid eligible in 2 years. In other words, the spend-down rate was 41 percent, if you spent some time in a nursing home. The risk of becoming a medicaid-eligible person, by virtue of spending some time in a nursing home, is four to five times greater than if you did not go to a nursing home. So it happens fairly quickly, and in spite of that, there are people who also spend down in the community. We found about 7 percent of the people who were disabled in 1982 spent down in the community in the next 2 years, but it's 41 percent for those who spend some time in nursing homes. So being in a nursing home very quickly and rapidly raises the risk of becoming medicaid eligible.

Now our sense is also that many of the people who were functionally disabled were also at fairly low income levels, and that probably contributed a lot to the risk of the medicaid spend down.

Representative SCHEUER. I yield back to the Senator.

PUBLIC VERSUS PRIVATE FINANCING OF LONG-TERM CARE

Senator WILSON. Thank you, Mr. Chairman. Your point about acceptability, I think, is a very pertinent one. Under the OPM plan that I have been talking about, acceptability does not enter in, in the sense that all Federal employees can obtain long-term care coverage if they so desire. Now I think you would probably face that acceptability problem if you were looking at a different situation, where you didn't have the group enrollment, but you had, instead, individuals, assuming that Congress authorized something like a health IRA. In that case, I think part of the requirement in enacting a health IRA would be that we would have to address the question of acceptability and allow a similar treatment for those who,

as individuals, rather than as members of a group, are seeking that kind of coverage. But I agree with you, I think that is a very real question, but it seems to me that it is essentially a risk-sharing problem.

What I am really trying to get at is, there is a basic question that faces Congress, and that is, which way are we going to do this? Are we going to say that long-term care—which is a growing expectation of increasingly aging Americans—is going to be provided without means-testing, as a Federal responsibility, financed by a payroll tax, or are we going to instead say that we will provide it on a means-tested basis and give encouragement to those who cannot meet that means-test eligibility to find the sort of care that presumably does represent an untapped market?

I was also interested in Mr. Eggert's point that some of the cost savings have been pioneered by the private sector. We've got two separate questions, two separate issues. One is, are there ways to provide this kind of care at lesser cost without sacrificing quality? But the question on which I would like to focus first is this basic question, this basic choice that is to be put to Congress, and it would seem to me that at least preliminarily, the response in the House of Representatives in rejecting the Pepper bill is that they would like to look at other means which include, I think, a whole variety of private approaches, one of the most promising of which, it seems to me, is this OPM idea of convertibility of a portion of group life insurance to prepaid long-term health care.

Mr. WIENER. Well, first let me say that I am very intrigued by the OPM proposal. I think it moves in the right direction in several ways. It is a group insurance plan geared toward the under-65 population, so we can get at some of the issues of adverse selection. It establishes the principle of employers helping to pay for it, although there's no additional cost to the Government because it is a tradeoff with life insurance. I am very intrigued by that approach, and I wish you well with your bill.

My principal reservation about the OPM proposal is in the degree of inflation protection that the bill offers. The benefits and premiums basically go in step with the GS schedule, which, in recent years has not even kept up with general inflation in the economy. We would certainly expect nursing home and home care inflation like some of the rest of the medical care industry to have inflation substantially in excess of that.

So if we are talking about entering at age 50, but not using benefits till age 85, you could get a really radical reduction in the buying power of that benefit at the inflation increase level that OPM is proposing.

Now you can't get increased benefits for free, and that will substantially increase the cost, but I think that is an absolutely critical element that needs to be changed in the OPM plan, if it, in fact, is going to offer substantial beneits to people when they need them.

Representative SCHEUER. Mr. Wiener, and all of the panel. This subcommittee and this full committee, the Joint Economic Committee, does not have legislative jurisdiction. There are other committees of the Congress, the Ways and Means Committee, the various health subcommittees of the Congress, that do have legislative ju-

risdiction, and I don't wish to offend my colleagues by seeming to intrude on their turf. So I would appreciate it if you would keep your answers general, and not address any particular piece of legislation, which, frankly, is ultra vires for us. It is beyond our reach and beyond our power. As a matter of collegiality, I don't wish to have this panel get into an extended discussion of specific legislative proposals.

That doesn't mean you can't deal with the ideas, but to the extent that we can address the public policy issues that are facing our country and some of the alternative routes, of course, private versus public, that is appropriate, but let's try not to focus too much on an individual legislative proposal, which, frankly, would be inappropriate for this subcommittee. I yield back to my colleague.

Senator WILSON. Thank you, Mr. Chairman. Mr. Wiener, would not the problem which you are describing, which is obviously a real one, be an affliction of almost any plan that we are talking about?

Mr. WIENER. Well, in principle, what you want to do is prefunding, and you have to do for that either public or private insurance policy. You need to prefund for that inflation and that probably means substantially raising the initial premiums.

Senator WILSON. But I mean, is it a common problem?

Mr. WIENER. Yes, absolutely. And that clearly is something that affects acute care, retiree health benefits as well, perhaps even more dramatically. As Mr. Holahan pointed out, acute care inflation is much more rampant. So I think there are a variety of things we can do to promote the private sector, and I think the key question is, when it is all said and done, and it is all promoted, what proportion of total long-term care expenditures are you likely to be financing. And my answer is, based on my research, a lot more than the financing now, but it still won't be the dominant form of long-term care financing.

Senator WILSON. Let me just ask you about that. Why is that the case? Is this not potentially profitable?

DISINCENTIVE TO PRIVATE FINANCING

Mr. WIENER. I think there are two reasons. One is that these products are basically too expensive to be affordable by most elderly.

Senator WILSON. But doesn't that potentially change, if you have the kind of market that permits both the profit to the carrier and a relatively modest premium? In other words, the proposal that we've been discussing is one that has been the result of actuarial study, and the numbers that I used, well, they are, for purposes of example, fairly reliable. And it would seem to me that there is the potential here for a rather substantial market, to use your phrase, an untapped one, of some dimensions. I just wonder why you are not more sanguine about the eagerness of private carriers to make a profit.

Mr. WIENER. Well, I am sanguine about their desire to make a profit, but insurers also face significant risks in terms of offering private long-term care insurance. There is the potential of adverse selection, even within any working population, there are some

people who are sicker than others, and clearly they have an incentive, greater incentive to purchase the insurance. There is the potential moral hazard, that use will go up more than the insurance actuaries have estimated. Third, especially if you are selling insurance to a relatively young population, age 50 or thereabouts, there is a very long lead time between the initial payment of the premium and the use of services, maybe in this case, 30 or 40 years, and there can be an awful lot of changes, an awful lot of uncertainty in what will happen over the next 30 to 40 years, in terms of inflation of cost of home health and nursing home services, the levels of disability, mortality rates. All of those things are very uncertain over the long haul and insurance companies get very worried about uncertainty at that level.

So I think insurance companies are getting into it more than they have in the past, but I don't think market failure has gone away, and especially for employer-based plans, there is that very long lead time. I don't think employer-based plans can basically take off unless employers are willing to make a contribution. And since employers already face an unfunded liability for retiring health benefits on acute care that is at least $100 billion and probably a good deal more than that, I don't see them willing to contribute, and if they are not willing to contribute, then I just don't see it taking off.

I think we have to remember that even 20 years after the start of medicare, we only have 25 to 30 percent of the elderly with any employer-sponsored retiree health benefits. I would expect long-term care insurance, while it will grow substantially, right now it's about zero in terms of employer participation, I would never expect it to be more than a subset of that 20 to 30 percent.

TAX INCENTIVES FOR PRIVATE FINANCING

Senator WILSON. Ms. Moon, let's shift to a new approach. Maybe I misunderstood you, but I thought you said that AARP, which, by the way, I think has done an extraordinary job for its insureds, my father being one of them, but I gather that you don't favor the idea of allowing some kind of tax-deferred treatment as we did under the IRA's before the Tax Reform Act, to create a health IRA.

Ms. MOON. Like everybody else these days, AARP is struggling with how to deal with this problem, because it is a large one, and one that scares people when they think about its order of magnitude. So in many ways we haven't ruled out any option. When we look at the range of options, we are relatively skeptical about that kind of an approach. The penetration of IRA's when left unfettered before the tax changes was very modest and was——

Senator WILSON. In what respect?

Ms. MOON. The penetration of IRA's, in terms of who took advantage of them was quite small, and we wouldn't expect that an IMA type of approach, which would be more limited in terms of what you could do with it, would have even that level of penetration. IRA's were purchased largely by people with considerable means already, and it is a question of, then, whether or not you want to devote tax expenditures to the group least in need. If we are going to talk about a limited approach, we would begin to worry about

the lower and middle-income groups before we'd worry about helping subsidize an insurance program, which we believe will flourish on its own for those with higher incomes.

MEDICAID AND PRIVATE SECTOR FINANCING

We have been concentrating more and worrying about, first of all, how to cover people who are above medicaid, in many cases, or above medicaid until they've done a lot of spending down. And we are concerned that if you have the development of a strong private sector, what the seam would be between where private sector coverage ends and where medicaid coverage comes up to.

If you really want to stimulate the private sector, you can't have an overgenerous medicaid program, because people wouldn't then buy the insurance. So you will have this dilemma of pressures to hold down the generosity of a medicaid program. Thus, an older woman, the traditional person who is going to be using long-term care, say, age 80, with $15,000 of assets, is not going to have private insurance and is going to be impoverished before she'll get medicaid.

Senator WILSON. Now let me just pursue that point with you.

Ms. MOON. Yes.

Senator WILSON. You say, if you are going to stimulate the private sector to enter the market and respond to the need, you can't have an overgenerous medicaid program. Those who will be medicaid eligible will, I think, be entitled to receive quality care. Those who are not medicaid eligible, are not eligible.

Ms. MOON. Well, it's not quite that simple, because the medicaid program is a spend-down program. As was mentioned a little earlier, it's an unusual program because ultimately, over half of the population can become eligible for medicaid by spending down, although not in all States——

Senator WILSON. You mean, if they go in and go broke?

Ms. MOON. Yes. If they use up all of their assets and all of their income.

Senator WILSON. Well, but I am assuming that most people who have that choice will avoid going broke and would prefer to both buy private insurance and remain above the poverty level.

Ms. MOON. I'm sure that is right. But if your income is, say, 150 percent of the poverty level, for an older woman, about $7,500, age 65, let's say, and you have to pay $40 or $50 a month to buy long-term care insurance, it is not an option for you at this present time.

Senator WILSON. What about someone who is 50?

Ms. MOON. It certainly becomes more affordable. The issue then is that that person is going to have to pay premiums for the next 30 years, and they are going to have to be convinced at age 50 that they are not immortal or they are not going to drop dead from a heart attack. I think human nature is such that we have to be very careful before we expect people to rush out at age 50 or age 45 and begin to buy insurance when it is most affordable.

Senator WILSON. Let me ask you, how much of AARP's skepticism is based on the assumption that in the specific case of something like an IRA, that the history with IRA's was that they were

purchased by a relatively small number of relatively well-off people?

Ms. MOON. Well, that has, certainly, a considerable amount to do with it.

Senator WILSON. If that proved not to be the case, then do I take it you might have a change in attitude?

Ms. MOON. You mean if that historically proved not to be the case?

Senator WILSON. Well, I think what I ought to do is put you in touch with Professor Boskin, who will argue strenuously that you are mistaken and that the U.S. Treasury was horribly mistaken in making that assertion.

Ms. MOON. Well, I am familiar with some of his work, and I think that the coverage issue would still be important. I don't believe that it would be very easy to get penetration beyond, say, 30 or 40 percent of the population. That would be an enormous increase, and that would be an enormous contribution, but the question would remain, if you had 10 or 15 percent of the population then covered by medicaid, what about the other 40 or 50 percent? A substantial number of people would be left uncovered. I think that is our greatest concern.

Representative SCHEUER. Will the witness yield?

Isn't part of the problem that a great many people out there think that medicare covers long-term nursing home care and that they are not alerted to the fact that there is a vacuum there and that they are going to have to spend down and end up in a medicaid type of situation?

Ms. MOON. I think that has been true.

Representative SCHEUER. Isn't there a larger market out there? Wouldn't there be a larger market if people knew that long-term nursing home care was not covered by medicare?

Ms. MOON. I think that's true to a considerable extent.

Senator WILSON. Mr. Chairman, I think you're absolutely right.

Representative SCHEUER. Yes.

Senator WILSON. Absolutely right, and that's my whole point. I think there is a very substantial market, based just on the anecdotal experience I have and also talking with people who are daily in contact with the elderly and the not so elderly, who are very much concerned about providing for some kind of coverage. And the Chairman is right. Tragically, many people learn the hard way that they are not covered by medicare and, in fact, enough have now learned that, so that we've got another problem, a very serious one, that of rather unscrupulous people selling what they profess to be medigap insurance that the buyers think offers long-term care coverage when, in fact, it does not.

There is a serious problem of that kind, and every time you turn on the television and see somebody pitching medigap insurance, however they may term it, or get in your own mail some solicitation, look at it carefully, because in many cases, they imply long-term care which, in fact, is not provided. So I think the Chairman makes a very telling point.

PUBLIC SUPPORT FOR GOVERNMENT ACTION

Ms. MOON. I think that is right. The one thing that is interesting, in the last year, I believe, there has been a considerable change, partly engendered by the debate over catastrophic health insurance, when people realized what it was not going to cover. In polling that AARP has done to look at what people's attitudes are, we found a very large number of people of all ages who now recognize that long-term care is a major problem and are anxious to do something about it. Many of them are anxious to do something about it through a public sector approach, even if—and we wait till the end of the survey to ask that, but still get a very high response—if it would mean higher taxes.

There is a growing support for such activity. What the role of the private sector will be, I think, is going to be a very tough question that needs to be part of that debate, as well.

Senator WILSON. Mr. Chairman, you've been very generous. Why don't I yield to you to ask some questions. I am sure you have some.

Representative SCHEUER. Very good. Thank you very much, Senator. We are happy to have you here, and we wanted to make sure that you had a full opportunity to ask your questions.

PROPER ROLE OF PRIVATE SECTOR

Well, let me ask you, Ms. Moon, to elaborate. What do you and what do the rest of the panel feel is a proper and appropriate integrated role of the private sector in providing long-term health care? What percentage of the population is the appropriate target and how should private health care and publicly assisted health care be integrated, so that the whole is greater than the sum of the parts, so that it really makes sense?

Ms. MOON. The approach that I would favor, personally, and that certainly AARP is giving serious consideration to, would be a social insurance approach in which all people would be eligible to participate rather than a means-tested or targeted approach. It is difficult, I believe, to cover that middle group that I have been talking about, otherwise. And a means-tested approach has a lot of difficulties and problems. Successful approaches in the United States to government provision of medical care have been much more affiliated with medicare than with medicaid.

That being said, I think there still is a role for the private sector and for private insurance. The three different ways that Josh Wiener talked about integrating the private sector ought to be considered. People with means will always seek to improve their status, and they should, over time, but basic insurance of access to quality care should be there for all people who are disabled or chronically ill.

LONG-TERM CARE AFFORDABILITY AND COMPREHENSIVENESS

Mr. LIU. Mr. Chairman, I guess what drives my thinking, whether we are talking about public or public and private roles is the pattern of utilization of long-term care. While 43 percent of older Americans have a lifetime risk of entering nursing homes, the types of nursing home use does vary, and basically, what we see is

a distribution of nursing home utilization where a whole lot of people use very few days and some people use a lot of days.

Representative SCHEUER. That is what Mr. Eggert was suggesting in his testimony.

Mr. EGGERT. 13 percent of the people use 90 percent of the days.

Representative SCHEUER. It's astonishing.

Mr. EGGERT. They are the long stayers. So the question about any public or private insurance program is who ends up paying for the long stayers, because most people enter for short periods of time, and a lot of people can afford that now. Actually, private pay for 6 months is not unusual, if that is all they are there. The problem is for people who stay for 5 or 6 years, and then they absolutely spend down.

Mr. LIU. We also find that people who are in there for a short stay are discharged alive to the community. A good portion are discharged alive to private settings after 180 days. You know, from the nursing home survey, about 300,000 of the 1 million admissions returned home within 6 months.

I think the question then is, are they spending down before they return home? Was the 180 days of nursing home stay enough to wipe out their assets?

I guess I favor additional public options that protect the front end, because it affects more people and people for whom even 180 days may be sufficient to spend down. I could see a major private sector role in terms of covering the long stayers.

Mr. HOLAHAN. As I've heard the discussion today, I don't think that people were really disagreeing with the importance of the role of the private market. I think there has been a bit of a debate about how big a role that can play, and since it can't do the whole job, what the role of the public sector should be. And I think that as long-term care policy gets to be further considered, there are two sorts of things that have to be considered, whether you take the approach that Mr. Lui just mentioned of covering the short-stay nursing home resident and provide coverage for that or whether there should be catastrophic along the lines of Senator Mitchell's bill and how that should be structured, for example, how long that deductible should be before the public sector provides benefits?

At the same time, if a bill cannot be fully comprehensive, and I think that the fiscal realities will show that it probably cannot be, then there will be inevitably a residual role of the medicaid program, and I think it is very important to consider how that should be structured, in terms of issues like spousal impoverishment, the protection of assets, and what we do about nursing home quality and nursing home payment systems that ensure that while costs are contained, the sickest patients are admitted to nursing homes.

HOSPITAL, NURSING HOME, AND HOME CARE TRADEOFFS

Representative SCHEUER. Let me ask you about a seeming anomaly in our health care system for long-term care. We are told that we have an excess of hospital beds in our country and a shortage of nursing home beds, yet nursing home administrators are asserting that people come into their nursing homes sicker now than they had before in prior years, because of underutilization of hospitals,

and they are complaining about the fact that they are having to provide a more intensive quality of health care in nursing homes.

Now is this a trend that is real and, if so, what do we do about it? Can we perceive of hospital beds as easily convertible into nursing home beds, hospitals convertible into nursing homes? Why this anomaly of hospitals being underutilized and nursing homes being overutilized and nursing home administrators complaining that patients are coming in sicker with a higher level of severity of illnesses due to the underutilization of hospitals? How do we explain this anomaly?

Mr. HOLAHAN. Well, I think there is evidence that that is occurring. Because of the medicare prospective payment system for hospital care, people are leaving hospitals earlier and it appears that the average severity of the patient in nursing homes has gone up in response to that. At the same time, the way that both medicare and medicaid have paid for nursing home care, in general, hasn't really adjusted. The medicare system is based on the average costs of paying for all patients in a nursing home, and medicare patients are just much sicker than average, and there's more demand by medicare-hospitalized patients to enter nursing homes. Similarly, very few State medicaid programs adjust their payments for the severity of the care. As a result, the payments are not being adjusted upward, as the case mix of the patients is increasing.

Mr. EGGERT. What we've seen in Rochester, and in New York, is that the average disability level of people entering nursing homes has been increasing for the last 10 years, I mean, much before prospective payment. What's been happening is that the case load that nursing homes have been faced with has been getting more intense. And I think probably, unrelated to the issue about hospitals, but more related to the fact that the home health system has developed rapidly in the last 10 years, and people are staying home longer, with more disabilities. In spite of everything we talked about, people do not want to go to nursing homes. They fight to stay out as long as they can. And so the nursing home bed supply issue to me is a substitute for home health. In Rochester, we've got 60 nursing home beds per 1,000, which is—the State average is about 50, so we are over—according to the State, "overbedded," but they are all filled. They have been filled for 10 years, and they all have waiting lists.

Our response is that what we need to do is try to develop the home health system better, even though we've got a very good one, and to get more balance. Dr. Williams made a point to us earlier, for every three people we have in a nursing home, we have one person publicly supported on home health at home, but in New Zealand, the proportions are just the reverse, for every three at home, they have one in a nursing home. So it really depends on how well you develop the home health system, whether you are willing to finance it, and in some measure, it can substitute for additional nursing home beds. And that becomes a choice issue.

On the hospital issue we have a small proportion of hospital beds, 3.4 per 1,000. I guess the national average is 4 to 4.5. Ours are all filled. I mean, they are filled. Our problem is just the reverse of having low occupancy. We have 5 to 13 percent of the beds occupied by people who should be in nursing homes, but because of one

reason or another, either low payment, they are medicaid, or they represent care needs that nursing homes aren't adequately reimbursed for.

In New York, we do have a case-mix payment system in nursing homes, and it is not the high care people or the high cost people who are being excluded, but rather the ones who are chronically ill, like dementia patients, for whom, in the case-mix weightings, they are not adequately reimbursed for the indirect care, the supervision. So a person that doesn't have a lot of direct care needs does not contribute a lot to the overall facility case mix. Therefore, the people not being admitted are relatively low care people but who have a large amount of chronic disability. So it just depends on how you pay for nursing homes.

Representative SCHEUER. And who need a large volume of social services that are not recognized.

Mr. EGGERT. That are not recognized, generally.

LONG-TERM CARE ALSO INVOLVES SOCIAL SERVICES

Representative SCHEUER. To what extent, let us say, is the long-term care problem one a health problem to which we can apply the same health financing techniques as we do to acute care, and to what extent is it a social services problem that really involves different moral and ethical choices and really different public policy options?

Mr. EGGERT. I'll take a shot. I think the long-term care is really a blend of both health and social services. I mean, the principal resource in long-term care is the family. I mean, they still provide, roughly, 75 to 80 percent of the care, and a medical model doesn't address the needs of the family. We need a blend of medical and family support services. If we lose a good proportion of the family support, that is going to create a lot more demand on nursing homes, and we are not prepared for it. So it is a blend of the two.

Representative SCHEUER. Yes, Ms. Moon.

Ms. MOON. I would just add that we have spent a lot of time trying to emphasize or deemphasize the medical aspects of long-term care, so that social services are looked at seriously. On the other hand, if you look at the characteristics of people with severely limited activities of daily living, these are the same folks who also are very high users of the medical care system. This then relates to the point that Mr. Eggert made that it's really important to begin linking the acute and long-term care systems in better ways than we have done. There are considerable possibilities for cost savings when you do that.

Representative SCHEUER. Possibilities of what?

Ms. MOON. Of saving some money and having a more rational system. We need to recognize the need to marry the social service needs and the medical needs of this population of chronically ill patients.

Representative SCHEUER. Do the other OECD countries, including Australia, New Zealand, Japan, Canada, and so forth—how do they look at this mix of social service needs and pure health care needs in their long-term care for the elderly? How do they do that balancing act?

Ms. MOON. It varies enormously, I think. I know most about Canada, which provides quite a few social services, but the specifics vary by province. In many ways other countries, other European countries start out with a less medicalized view of health than we do, so they don't have quite the same reliance on medical technology or same attraction to it as we do. So from the very beginning, there's a different philosophy about health for everybody, not just the chronically ill.

IDEAL LONG-TERM CARE POLICY

Representative SCHEUER. What services would the best long-term care insurance policy available today cover? What is the prototypical superior long-term health care policy?

Ms. MOON. I would hope that any long-term care policy would specify a large number of services but not proscribe any—that is, not entitle people to any particular list. We need to be very flexible in terms of having people who can assess the needs of individuals and put together a mix of services, because the characteristics of this population——

Representative SCHEUER. They would have the whole spectrum of services available to them without limitation.

Ms. MOON. Some limitations would be imposed since the package of services would not simply be the patient's choice, but be designed to address their needs. What we do not need is an entitlement where people have a ticket to any of 15 services that they choose, but rather that they have access to a system that will help them put together a package of services.

PRIVATE LONG-TERM CARE MARKET

Mr. WIENER. If I could comment on that, I think one of the reasons that we found that the private sector policies that we looked at didn't have as much impact as they might have, is that there are a large number of restrictions in existing private long-term care insurance policies that limit the degree of financial protection that they offer.

Now policies are evolving and they are definitely getting better, but still we have a situation where the bulk of the policies have prior hospitalization requirements and the indemnity levels are not indexed for inflation, relatively little home care is covered. And we have a very confusing situation in terms of levels of nursing home care covered. When you add up all of those restrictions, people don't really get as much coverage as they may think they are buying.

Representative SCHEUER. How much do these policies cost, more or less, that offer a full range of services?

Mr. WIENER. Well, in 1986, we looked at the policies on the market then. The high end of those averaged about $700 a year if purchased at age 65. If purchased at age 79 or 80, you generally can't buy them at over age 80, they generally ran around $1,300 to $1,500 a year.

Representative SCHEUER. And what percentage of those age populations in our country can afford those charges and would find them appropriate and manageable?

Mr. WIENER. Well, we projected out into the future, and at the high end, we found that 30 years into the future, you might have somewhere between 25 and 45 percent of the elderly able to afford it. The 25 percent figure is really more the higher end of the policies, the 45 percent figure is more toward the lower end of the policies.

Representative SCHEUER. Well, that's a very substantial market, I would say, comparatively unfilled as of now?

Mr. WIENER. Well, only about 1 to 2 percent of the elderly have any private long-term care insurance now.

Representative SCHEUER. We're beginning to lose our panel, but was somebody about to say something?

Mr. EGGERT. I was going to say that raises an interesting issue. When Aetna announced their policy to their employees in Hartford, they found the biggest group that was interested was the 30- to 40-year-old group. One suggestion I might make for Senator Wilson is that maybe the age is too high. I mean, if we made this available to people in their thirties, and there was some marketing, because people in their thirties and forties are now seeing what is happening to their parents, and they are finding their parents unprotected, and we are seeing a lot more awareness among people in, you know, thirties, forties, who might be willing to trade off some life insurance or, I think Regina E. Herzlinger had two interesting articles in the Harvard Business Review, and she suggested tradeoff with acute-care benefits. Again, by taking deductibles under acute-care benefits and trading off for some long-term care coverage. And you know, it would be——

Representative SCHEUER. Deductibles that they could afford at their present earning levels.

Mr. EGGERT. Sure; right. And it wouldn't be too bad for me to pay for my own doctor visits, if, in return for that, and reduced life insurance, I could pick up long-term care insurance in my thirties, have it prefunded, have a longer time to prefund it. Then, basically, I'm pretty well protected. It seems to me that employers are not interested in any new costs, but I am not so sure that they aren't interested in trying to work around their current costs without incurring any new obligations, if people wanted a cafeteria plan model.

Senator WILSON. Mr. Chairman, in response to Mr. Eggert, I think he has put his finger on something. We are finding that there does seem to be a desire on the part of younger employees to become enrolled in something of this kind, so we are contemplating making that change, per your suggestion.

Representative SCHEUER. It makes sense. Well, as I was saying, we are beginning to lose our panel.

Senator WILSON. Mr. Chairman, I again wish to thank you and the members of the panel. I think this has been very useful. I would make a request that a statement by Ms. Horner be included in the record of hearings.

I was not aware of the rule until after I had already sent to the panel a copy of the bill and asked their response to it. But I think

we have had a very good discussion this morning, in terms of not only that concept but several competing concepts, and I find it very useful, but I would appreciate if her statement could be included.

Representative SCHEUER. There being no objection, so ordered.

[The statement of Ms. Horner follows:]

STATEMENT FOR THE RECORD BY
HONORABLE CONSTANCE HORNER
DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT

THANK YOU FOR ALLOWING ME TO SUBMIT A STATEMENT FOR THE RECORD OF YOUR SERIES OF HEARINGS ON THE FUTURE OF HEALTH CARE IN AMERICA.

I COMMEND YOU FOR YOUR EFFORT TO ASSESS OUR NATION'S FUTURE HEALTH CARE NEEDS AND CONSIDER WAYS TO DEVELOP RESOURCES TO ADEQUATELY MEET THOSE NEEDS. AS THE OFFICIAL RESPONSIBLE FOR ADMINISTRATION OF EMPLOYEE BENEFIT PROGRAMS FOR NEARLY 3 MILLION FEDERAL CIVIL SERVICE AND POSTAL EMPLOYEES, I HAVE DEVOTED CONSIDERABLE ATTENTION TO THIS ISSUE.

FOR FEDERAL EMPLOYEES, AS FOR AMERICANS IN GENERAL, LONG-TERM CARE FOR CHRONIC, DEBILITATING ILLNESS IS AN UNINSURED EVENT OF SIGNIFICANT FINANCIAL IMPACT. UNTIL RECENTLY, FEW PEOPLE REALIZED THAT NEITHER MEDICARE NOR TYPICAL HEALTH INSURANCE POLICIES WILL COVER EXPENSES ASSOCIATED WITH LONG NURSING HOME CONFINEMENTS OR SIMILAR HOME HEALTH CARE ARRANGEMENTS. THE MAJOR FINANCING MECHANISMS AVAILABLE TODAY FOR LONG-TERM CARE CONSIST OF OUT-OF-POCKET PAYMENTS BY PATIENTS AND MEDIC-AID FOR INDIVIDUALS WHO QUALIFY. CURRENT PROJECTIONS ARE THAT THE APPROXIMATE $45 BILLION COST OF PROVIDING LONG-TERM CARE FOR THE ELDERLY IN 1985 WILL NEARLY DOUBLE TO ABOUT $80 BILLION BY 1995. UNDER THE OMNIBUS RECONCILIATION ACT OF

1985, CONGRESS ACTED TO FOCUS NATIONAL ATTENTION ON THE URGENT NEED FOR LONG-TERM CARE PROTECTION BY MANDATING A FEDERAL TASK FORCE TO REPORT BY OCTOBER 1987 RECOMMENDATIONS FOR PROMOTING THE GENERAL AVAILABILITY OF LONG-TERM CARE INSURANCE. THIS PROMPTED OPM TO BEGIN STUDYING ALTERNATIVES FOR DEALING WITH THIS ISSUE AS IT AFFECTS THE FINANCIAL SECURITY OF THE FEDERAL WORKFORCE AND LED TO OUR DEVELOPMENT AND SUBMISSION OF A LEGISLATIVE PROPOSAL TO THE CONGRESS IN THE FALL OF 1987.

WE HAVE PROPOSED AMENDING THE FEDERAL EMPLOYEES' GROUP LIFE INSURANCE (FEGLI) LAW TO PROVIDE BASIC AUTHORITY FOR OPM TO ENTER INTO CONTRACTS WITH THE INSURANCE INDUSTRY FOR PURPOSES OF MAKING LONG-TERM CARE (LTC) COVERAGE AVAILABLE TO FEDERAL EMPLOYEES ON A GROUP BASIS. OUR PROPOSAL WOULD OFFER FEGLI PARTICIPANTS AN OPPORTUNITY, AS THEY APPROACH THEIR MATURE YEARS AND FAMILY RESPONSIBILITIES DECLINE, TO "TRADE IN" A PORTION OF THE FACE VALUE OF THEIR BASIC LIFE INSURANCE COVERAGE TO HELP THEM PURCHASE LTC INSURANCE. THE NEW LTC INSURANCE PROGRAM WOULD PROVIDE BENEFITS TO OFFSET EXPENSES ASSOCIATED WITH EXTENDED PERIODS OF NURSING HOME CONFINEMENT OR SIMILAR HOME HEALTH SERVICES.

THE AMENDED FEGLI LAW WOULD SET FORTH CRITERIA FOR INDIVIDUAL PARTICIPATION IN THE LTC PROGRAM, AND ALSO LTC BENEFIT CATEGORIES AND FINANCING METHODS, BUT WOULD LEAVE BROAD DISCRETION TO DEVELOP THE DETAILS OF PROGRAM OPERATION THROUGH REGULATION AND NEGOTIATION WITH PARTICIPATING INSURERS. THIS FLEXIBILITY IS, I'M SURE YOU WILL AGREE, ESPECIALLY DESIRABLE, GIVEN THE RELATIVELY SHORT SPAN OF EXPERIENCE WITH LTC INSURANCE PRODUCTS AND THE LIKELIHOOD THAT THERE WILL BE ONGOING EVOLUTION IN THE FUTURE, MAKING PROGRAM REVISION AND ADJUSTMENT DESIRABLE.

ESSENTIALLY, THE NEW PROGRAM WOULD WORK AS FOLLOWS:

- FEDERAL EMPLOYEES, AS SOON AS THEY ARE AGE 50 AND HAVE A MINIMUM OF 10 YEARS OF FEGLI PARTICIPATION, COULD ELECT TO TRADE IN A SIGNIFICANT PORTION OF BASIC GROUP LIFE INSURANCE (E.G., $25,000) FOR LTC COVERAGE. [EMPLOYEES COULD ALSO ELECT LTC COVERAGE WITH NO FEGLI PARTICIPATION OR TRADE-IN AT LESS FAVORABLE PREMIUM RATES.] SPOUSAL LTC COVERAGE WOULD ALSO BE AVAILABLE FOR AN ADDITIONAL PREMIUM CHARGE.

- THE USUAL GOVERNMENT CONTRIBUTION AND RESERVE FUNDS ASSOCIATED WITH FEGLI PARTICIPATION WOULD BE RECHANNELED TO FUND LTC COVERAGE. EMPLOYEES WITH LTC

COVERAGE WOULD PAY AN AGE-ADJUSTED LTC PREMIUM EACH PAY PERIOD (BASED ON AGE AT TIME OF ELECTION AND WHETHER OR NOT THE FEGLI TRADE-IN APPLIES) TOGETHER WITH THE EMPLOYEE CONTRIBUTION FOR EACH REMAINING $1,000 OF BASIC LIFE INSURANCE. EMPLOYEES EXERCISING THE CONVERSION OPTION WOULD ALWAYS RETAIN A MINIMUM OF $2,000 BASIC LIFE INSURANCE COVERAGE.

- AN EMPLOYEE WHO TRADES BASIC FEGLI FOR LTC PURPOSES WOULD BE ELIGIBLE TO SIMULTANEOUSLY INCREASE OPTIONAL FEGLI COVERAGE WITHOUT EVIDENCE OF INSURABILITY.

- THE LTC PROGRAM WOULD PAY INSURED INDIVIDUALS DAILY BENEFITS IN ESTABLISHED DOLLAR AMOUNTS TO OFFSET EXPENSES FOR NURSING HOME CONFINEMENTS OR ALTERNATIVE HOME CARE ARRANGEMENTS FOR A MINIMUM DURATION OF AT LEAST ONE YEAR. (MULTIPLE BENEFIT PACKAGES COULD BE OFFERED.)

- LTC PREMIUM AND BENEFIT AMOUNTS WOULD BE ESTABLISHED BY OPM AND AUTOMATICALLY ADJUSTED IN ACCORDANCE WITH THE AVERAGE PERCENT OF EACH GENERAL SCHEDULE PAY INCREASE. FURTHER AD HOC ADJUSTMENTS, BASED ON THE

EXPERIENCE OF THE GROUP AND THE NEED TO MAINTAIN REASONABLE LEVELS OF REIMBURSEMENT, COULD BE NEGOTIATED WITH INSURERS UNDER OPM'S REGULATORY AUTHORITY.

- THE PROGRAM WOULD BE ADMINISTERED THROUGH COMPETITIVE CONTRACTS WITH PRIVATE SECTOR LIFE AND/OR HEALTH INSURANCE COMPANIES.

THIS APPROACH TO FINANCING LTC FOR FEDERAL EMPLOYEES OFFERS A NUMBER OF ADVANTAGES:

- BY USING AN EXISTING PROGRAM, WE AVOID SOME OF THE COSTS AND DELAYS ASSOCIATED WITH CREATING A NEW BENEFIT PROGRAM.

- IN KEEPING WITH OPM'S TRADITIONAL POSTURE IN THE BENEFITS AREA, WE WOULD RELY ON TRUE GROUP INSURANCE SO THAT EVEN THE MOST VULNERABLE OF EMPLOYEES MAY ACQUIRE COVERAGE AT A RATE SUSTAINED BY THE GROUP AS A WHOLE.

- AN EMPLOYEE'S NEED FOR LIFE INSURANCE DIMINISHES WITH AGE AND HIS NEED FOR LONG-TERM CARE PROTECTION INCREASES, SUGGESTING THAT A TRADE-OFF IS NOT ONLY

POSSIBLE, BUT DESIRABLE FOR MANY EMPLOYEES. NINETY PERCENT OF FEDERAL EMPLOYEES PARTICIPATE IN OUR LIFE INSURANCE PROGRAM AND 655,000 WOULD BE IMMEDIATELY ELIGIBLE FOR LONG-TERM CARE UNDER OUR PROPOSAL.

- ADVANCED FUNDING, WITH PEOPLE PAYING PREMIUMS YEARS BEFORE THEY EXPECT TO NEED THE SERVICE, WOULD KEEP THE COST OF COVERAGE WITHIN THE REACH OF MOST FEDERAL EMPLOYEES.

- IT IS MORE EFFICIENT FOR THE GOVERNMENT, WHEREVER FEASIBLE, TO RELY ON EXISTING PRIVATE SECTOR SERVICES AND CAPABILITIES, RATHER THAN DUPLICATE THEM IN THE GOVERNMENT.

IN SUMMARY, OUR PROPOSAL WOULD OFFER FEDERAL EMPLOYEES AN OPPORTUNITY DURING THEIR MIDDLE YEARS TO REASSESS THE TYPES AND LEVELS OF INSURANCE PROTECTION THEY WILL NEED DURING THEIR SUBSEQUENT YEARS AND TO TRADE OFF, IF THEY SO CHOOSE, A PORTION OF THEIR BASIC LIFE INSURANCE COVERAGE FOR LONG-TERM CARE BENEFITS. IT UPDATES AN OLD PROGRAM TO ACCOMMODATE THE GROWING INTEREST IN LONG-TERM CARE INSURANCE COST AND IT ACHIEVES THIS GOAL WITHOUT INCREASING GOVERNMENT COST OR EXPANDING ANY GOVERNMENTAL ENTITY.

THE SIZE AND VISIBILITY OF THE FEDERAL WORKFORCE IS SUCH THAT ITS COVERAGE UNDER AN EMPLOYER-SPONSORED LONG-TERM CARE POLICY WOULD HAVE FAR-REACHING IMPLICATIONS. WITH 655,000 FEDERAL WORKERS IMMEDIATELY ELIGIBLE FOR ENROLLMENT, THE POTENTIAL EXISTS FOR MORE THAN DOUBLING THE NUMBER OF PEOPLE CURRENTLY COVERED BY LONG-TERM CARE INSURANCE WITH A SINGLE OFFERING. FURTHER, THE FEDERAL WORKFORCE IS SO DIVERSE IN COMPOSITION AND GEOGRAPHIC DISTRIBUTION THAT ITS EXPERIENCE COULD BE USEFUL TO MANY OTHER EMPLOYERS AND TO THE INSURANCE INDUSTRY AS A WHOLE. ACCORDINGLY, I HOPE THE CONGRESS WILL EXPEDITE CONSIDERATION OF THIS PROPOSAL.

Representative SCHEUER. And if we filled the role here of providing a marketplace for ideas and ventilating various concepts of how we approach long-term health care, that is precisely the purpose of this committee and any other nonlegislative committee.

It has been a very fruitful and very thoughtful hearing, and I very much appreciate the contributions that you have made, Senator, and your positive and thoughtful discussion of all of these public policy issues that are pressing in upon us. I very much appreciate the patience of the panel. We are now approaching 1 o'clock.

And with that, with our repeated thanks, we'll terminate this hearing.

[Whereupon, at 12:40 p.m., the subcommittee adjourned, subject to the call of the Chair.]

THE FUTURE OF HEALTH CARE IN AMERICA

THURSDAY, JUNE 16, 1988

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON EDUCATION AND HEALTH
OF THE JOINT ECONOMIC COMMITTEE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2318, Rayburn House Office Building, Hon. James H. Scheuer (chairman of the subcommittee) presiding.

Present: Representative Scheuer.

Also present: David Podoff and Dyna Hutchings, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE SCHEUER, CHAIRMAN

Representative SCHEUER. Good morning. This morning we commence the 7th day of hearings in the series of hearings held by the Joint Economic Committee on "The Future of Health Care in America."

We have considered such subjects as the increase in health care cost as a percentage of GNP. We've noted that despite these expenditures 37 million Americans are left high and dry when they become ill because they have no health insurance. We've reviewed at length the problems of a bureaucratic and cumbersome payment system that at best is much too expensive, and at worst seriously distorts the allocation of resources in our health care system.

We've considered a health care system that seems much more comfortable and at home in treating illness than insuring health and preventing sickness.

We've considered the dearth of information on the effectiveness of the whole variety of health care treatment options and alternative procedures.

We've considered the problem of health care quality and the great dearth of informaton that consumers have in selecting between the health care providers, both hospitals and doctors, who might very likely enhance their health outcomes on the basis of their proven record, and the small percentage of health care providers who on the basis of extensive records and repeated history would very likely threaten their health outcomes. How do we empower consumers with the knowledge to make decisions about health care providers?

All of these problems are real and none of them can be avoided.

Today we hope to get some very welcome relief from people who are doing very creative things, creating innovating approaches to

the delivery of health care. We are going to hear from the public agencies. We're going to hear from private institutions and foundations, and we're very much looking forward to this morning's hearing from people who can describe potential solutions to the problems of our health care system, including some research and demonstration models that are really showing the way.

This should be an uplifting morning in comparison to the many mornings we've spent just looking at problems, and they are many and they are pervasive in our health care system.

We will begin with a panel on innovations sponsored by government, foundations, and health care providers. This is a very creative group of witnesses and we thank you all for coming. We look forward to hearing from you. On this panel we will hear from the Honorable Philip W. Johnston, Secretary of the Massachusetts Department of Human Services; Mr. Ernie Sessa, executive director of the Pennsylvania Health Care Cost Containment Council; Ms. Linda Hill-Chinn, director of Community Programs for Affordable Health Care; and Mr. Stephen Somers, senior program officer of the Robert Wood Johnson Foundation.

Your testimony as prepared will be printed in full in the record, so what we suggest is that you each take 6 or 7 minutes to chat with us informally, preferably not reading, but just talking to us, as if you were in your living room, about the message you have to give us and if you're familiar with any of our other days of hearings, don't hesitate to refer to anything you may have heard or read. And then after all four of you are finished, I'm sure we will have some questions for you.

So, Secretary Johnston, please take your 6 or 7 minutes and chat with us about the great things that seem to be happening in the State of Massachusetts.

STATEMENT OF HON. PHILIP W. JOHNSTON, SECRETARY, MASSACHUSETTS DEPARTMENT OF HUMAN SERVICES, ACCOMPANIED BY KAREN SMITH, HEALTH POLICY OFFICE

Mr. JOHNSTON. Thank you, Mr. Chairman. I am joined by Karen Smith, who is sitting behind me, who is from our health policy office.

Representative SCHEUER. We would be very glad to have her come to the table and join you and perhaps answer any questions that we might have.

MASSACHUSETTS UNIVERSAL HEALTH INSURANCE

Mr. JOHNSTON. Thank you. I have prepared a statement which has been submitted which goes through the Massachusetts legislation in some detail and at your suggestion I'd like to spend a few minutes to give you some of the highlights of that and what's happened during the past year or so as Massachusetts has attempted to confront the issue of trying to deal with the fact that many of our fellow citizens are without access to high quality, affordable health care.

I think that what happened on April 21 of this year when Governor Michael Dukakis signed into law the landmark bill, which was really the first of its kind in the Nation, has implications not only

for all of us in the Commonwealth of Massachusetts, but for everyone in the other 49 States as well.

This bill, which is now law, does one very, very important thing. It provides health insurance to every single citizen of Massachusetts and now we have established in statute in our State the principle that every single person in our State has and should have access to affordable health care.

And it happened because of the partnership. This was a real partnership effort in the political sense among all of the key constituencies interested in this issue and involved in it—business, government, insurers, health care professionals, and hospitals.

When my office conducted a study about 3 years ago to try to find out how many uninsured people there were in Massachusetts and who they were, the study revealed that there were about 600,000 people, about 10 percent of the population, who were neither poor enough to be eligible for medicaid nor did they have health insurance. And in trying to get under those numbers—600,000—we found one very startling piece of information, and that was that two-thirds of the 600,000 uninsured people were working. Contrary to popular mythology, these were not folks who were sitting at home doing nothing. These were people who were out there in the work force trying to be independent, productive, self-sufficient members of society and yet, for a variety of reasons, their employers simply choose as a matter of policy not to provide them with health insurance. Nearly a third of this 600,000 are children.

Well, under this legislation, by 1992, every single one of those 600,000 will have health insurance; 90 percent roughly of Massachusetts' employers, both small businesses and large businesses, already offer health insurance, but not all of them do. Until now, employers who do offer health insurance have paid a 13-percent surcharge during the past several years on hospital bills. That surcharge has paid for acute care health services to people without insurance and what the vast majority of people in the business community concluded, Mr. Chairman, in going through this exercise, was that they felt that it was unfair and not in their interest to continue to ask them to subsidize the 10 percent or so of businesses, in our State who simply refused to offer health insurance. It's irresponsible on the part of that minority of the business community to continue to get away with having a free ride on this question of health insurance.

So for all of these reasons really, we embarked about 3 years ago on an effort to devise a plan to make sure that every single citizen in our State had affordable health insurance.

The plan has two major goals. First, affordable health security for every Massachusetts citizen by 1992. The costs of this program are going to be shared. It's not all a public responsibility by any means. The costs will be shared by the business community, by consumers, and by the Commonwealth.

In the second piece to the legislation, which has not been discussed as often as it should be and was very important to the politics of making the first piece happen, was that we're supporting a stable and equitable hospital payment system.

In order to achieve the goals that we've set out, the health bill will set out, first, a surcharge to businesses who fail to provide

workers with health insurance by 1992; second, a department of health security which will be within my umbrella of human services offices which will act as a broker to help make affordable insurance available to small businesses. It's also going to provide insurance to the uninsured to the extent that it's necessary to do that. Third, there will be continuation of the uncompensated care pool for acute hospital care for certain populations, and that uncompensated care pool will be managed vigorously by the new department of health security. Fourth, there will be health benefits made available for the physically and mentally disabled people who seek to move from public assistance to employment because we found that the single most important barrier to helping disabled people move from welfare to work was the lack of affordable health insurance. Fifth, there will be tax incentives in voluntary programs that encourage employers to offer them to their workers. Sixth, there will be a health insurance reform commission to research alternative programs for medigap coverage; and seventh, as I mentioned, there will be an improved hospital financing system with limits on charge increases so that the costs don't go out of control, help in responding to medicare cuts which have had a severe impact on the acute care side, help for underfinanced hospitals which have been hurt as a result of the revolution in health care financing during the last few years, provisions to ensure that revenue follows patients so that those hospitals which have high volume are rewarded for that and supported, encouraging closing or converting hospitals with low-patient case loads to other more appropriate we hope health care uses, if not housing or other public uses.

Representaive SCHEUER. And that might be long-term nursing home care?

Mr. JOHNSTON. Yes, it could be, although many of these buildings we found are not particularly suitable for long-term care at the moment, Mr. Chairman. We are emphasizing psychiatric care. We have a desperate need in our State and I assume in other States for psychiatric beds, trying to provide incentives to acute care facilities to get into that kind of business, and acute care and long-term care AIDS beds as well, and requiring at least 90 days' notice to employees before hospitals close or convert, an issue which is not unfamiliar to Members of Congress during the last few weeks.

Let me just conclude this by just very quickly running through it. Beginning next month, under a new program that we call common health, Massachusetts will offer health insurance to four groups of people who until now had none. Beginning on July 1, the Governor will be announcing the common health program for these four populations.

First, disabled children; second, disabled working adults; third, pregnant women and their children who are not insured at this point; and fourth, people moving off welfare rolls into jobs that offer no health insurance.

There are 37 million Americans without health insurance many of them are working people, as I mentioned. Many of them are children. We think in our administration in Massachusetts that it is a scandal that we've allowed that to continue in our country, that we've allowed doctors to ask, "How can you pay," before they

ask, "Where does it hurt?" That we've encouraged people to wait until their health problem is an emergency instead of helping them get preventive care which we all know is not only better for them from a health point of view but makes more sense from a financial point of view.

It is our hope that Massachusetts' universal health program can be the seed for a national plan that will some day offer health care not just to those who can afford it but also to the people who need it most, the disadvantaged, the disabled, the unemployed, the working poor, and their families.

Thank you very much, Mr. Chairman.

Representative SCHEUER. Thank you very much, Mr. Johnston. We will have a number of questions for you later on.

[The prepared statement of Mr. Johnston follows:]

PREPARED STATEMENT OF HON. PHILIP W. JOHNSTON

I am Philip W. Johnston, Secretary of Human Services for the Commonwealth of Massachusetts. I am pleased to be here to discuss innovations in the delivery of health care from the state government perspective. In Massachusetts we have learned a great deal about the benefits of controlling costs and improving quality of care and access to services. We learned this lesson, in part, from having an inefficient and costly system of providing charity care rather than providing health insurance. Through our new "Health Care For All" legislation, the uninsured will have access to insurance and timely, appropriate services, including preventive care.

Massachusetts has a history of supporting creative approaches to health care delivery and financing. The Health Security Act that Governor Dukakis signed on April 21, 1988 is the logical next step to the programs he has initiated and supported for years. We have one of the most comprehensive Medicaid programs in the country and strong maternal and child health programs. Our Healthy Start program for low income pregnant women has been enormously successful in improving the health of pregnant women and their babies. Our Department of Public Health's Advocacy Office has helped many elderly citizens deal with hospitals that are responding to Medicare's financial incentives to discharge the elderly "quicker and sicker". Massachusetts was the first state with a publicly funded AIDS pediatric unit, the first to do a house-to-house mailing of AIDS information, and was one of the first to fund its own research and alternative testing sites. These are a few examples of programs that succeed because they utilize good working relationships between state government and providers.

Before I describe the Health Security Act and the specific innovations we have begun implementing, I would like to stress that Massachusetts could be a model for other states, at least in terms of process. While other states have different conditions, we share some fundamental challenges in health care. Our statute points the way by improving access to health care for people who are uninsured or underinsured. The law also deals with shortages of health personnel and using health facilities more appropriately. In Massachusetts, that means converting our excess acute care beds to other health uses such as long term care beds and mental health beds. Through this law, we will continue to address an ongoing national problem -- the high cost of health care.

The Health Security Act is the most comprehensive health legislation ever passed in Massachusetts. Unlike prior bills that dealt only with the hospital payment system or a specific program, this Act recognizes that the payment system and insurance markets and indigent care are inseparable systems and must be addressed together. Fortunately, consumers, physicians, hospitals, and insurers understood this relationship and worked together to craft the Health Security Act. Despite differences among these parties, they all recognized that it was in their social and economic interest to improve access to health care by maximizing insurance coverage among Massachusetts residents and controlling the rate of increase in hospital charges.

The business community in Massachusetts has been increasingly involved in health care financing since 1982 when Massachusetts secured a waiver from Medicare's DRG system and created an all-payer system.

At that time, health costs across the nation were rising sharply and business did not understand why. Costs in Massachusetts were especially high. In the process of learning about the trends and dynamics in the health industry, business and government began to understand and worry about one particular problem; people who have no health coverage. Many of those people -- 66% in Massachusetts -- are working people or their dependents. They were uninsured because their employers provide no health coverage. Lack of insurance means little or no access to preventive or routine care. It means putting off every possible medical expense. Further, when getting care became an emergency, the uninsured could often only get care at public, municipal hospitals like Boston City Hospital. Other hospitals provided much less uncompensated care.

In 1985, a coalition consisting of business, insurers, government, and hospital worked with the legislature to enact a new hospital payment bill that contained a very significant feature - a statewide pool for hospital bad debt and free care. Every hospital increased its basic charges by the same amount, originally set close to 9%, regardless of their actual uncompensated care, and the payment system redistributed the funds paid into the pool by some hospitals, to those hospitals providing more than the average amount of uncompensated care. For the first time, the costs of caring for people with no health insurance or inadequate coverage could be isolated and identified. The most important lesson we learned was how much it cost to care for uninsured people. Hospitals now increase basic charges by 13% for the free care/bad debt pool. This is significant for other states, because even though many states do not have hospital pools, I am sure they are all incurring substantial costs for this care through taxes or through private insurance premiums. Someone pays for this care.

I believe that people in every state will demand a more equitable financing method when they understand the extent to which businesses that provide health coverage subsidize care for uninsured working people. Also, in an environment in which hospital payments are shrinking as a proportion of total health care spending, financing and delivering health care for the uninsured poor primarily through the hospital system makes even less sense than it did before. And, as I said before, the system contained perverse incentives and the uninsured poor have been encouraged to rely on expensive emergency room care, often putting off necessary services until a medical crisis called for more intensive services.

The 1985 legislation in Massachusetts created a special study commission which I co-chaired with a member of the Massachusetts business roundtable. This commission quickly came to the consensus that it made most sense in terms of cost and quality to use health insurance to encourage people to get timely, appropriate care. After many months of negotiating a way to finance that strategy and a new hospital payment system, all the parties -- business, labor, consumers, providers and state government -- arrived at the consensus reflected in the Health Security Act. The Act initially encourages and later requires employers to contribute to health insurance for their employees since two-thirds of the uninsured are working people and their dependents. Persons who are not covered by employers will be able to obtain health insurance through a number of new programs and through a new state agency at state-subsidized rates.

In addition to creating a system for financing universal health care, the Health Security Act contains several creative economic incentives for providers and consumers.

- Disabled adults who wish to return to work, but have not done so because they cannot risk losing Medicaid and all health coverage will be able to purchase primary and supplemental coverage up to the Medicaid benefit levels. We heard from many disabled people who wanted to work and become taxpayers who had to turn down jobs because they could not get private health insurance. These people can now be as productive as their health allows; I believe this is good for these individuals, good for employers, and good for the state.

- Beginning in 1990, a two year tax credit will be offered to businesses with 50 or fewer employers which have not offered health insurance in the previous three years; the credit will equal 20% in year 1 and 10% in year 2.

- The Commonwealth will begin managing the hospital pool in October 1988.

- Hospitals with low occupancy or in financial distress have incentives to close, consolidate, or convert to other uses under the supervision of a new Acute Hospital Conversion Board.

- Allowable rates will no longer protect hospitals with falling occupancy rates.

- Special protection and assistance will be offered to hospitals serving remote areas.

- Retraining and job placement assistance will be offered to displaced hospital workers.

- Excess beds will be de-licensed, with a simple process available to re-license beds when and if they are needed again.

Since universal health care will not be fully implemented until 1992, we are continuing the Healthy Start program and a program that finances uncompensated care at community health centers.

While the Health Security Act is the conerstone of improving the delivery and financing of health services, I want to point out that we are actively working on other health problems such as long-term care financing and AIDS. In these areas, the approach is still a cooperative, working relationship with providers, consumers, and payers.

I believe that Massachusetts' legislation and programs represent a model for other states -- a model for balancing the competing goals of improving access and quality of care while controlling costs. Thank you for giving me the opportunity to testify before the Committee. I will be happy to answer any questions you may have.

Representative SCHEUER. Now we will hear from Ernie Sessa, executive director of the Pennsylvania Health Care Cost Containment Council. Please take your 7 or 8 minutes, Mr. Sessa, and then I'm sure we'll have some questions later.

STATEMENT OF ERNEST J. SESSA, EXECUTIVE DIRECTOR, PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL

PENNSYLVANIA COST CONTAINMENT ACT

Mr. SESSA. Thank you, Mr. Chairman, and thank you very much for giving me the opportunity of coming to this hearing and having the opportunity to share with you what we feel is a minor miracle that's happened in the State of Pennsylvania just a couple of years ago. I refer to an effort by the decisionmakers in the State of Pennsylvania in health care to form a group that would examine the very, very important areas of health care delivery in our State and to determine the problems and to do something about the problems in the delivery of health care, such as the monumental increases in the percentages of the premium charges, the cost shifting problems, the fact that individuals who were purchasing health care were not the same people who were using the health care, therefore when patients utilized their insurance coverage many times they were not concerned consumers of health care because they weren't actually paying the bills.

Those kinds of problems were seen as an area where a major effort was really necessary to straighten out that problem. The individual employers and groups and unions had tried on their own to solve these problems through cost containment initiatives but they really had only scratched the surface and the problem with double digit inflation on medical care continued in our State.

So it was felt that the only way that we could solve the problem was through a joint State initiative using legislation to solve these particular problems that we perceived.

The basic core problems that were identified were things such as unnecessarily high increases in cost, inefficiencies in the system, lack of competition among providers, lack of cost and quality information on which to make informed decisions to purchase health care, the cost shift problem, and possible inefficiency in the delivery system to our medically indigent in our State.

Senate bill 293 was introduced to the Pennsylvania State Legislature on July 8, 1986, and it was passed by both houses with no dissenting votes whatsoever. This bill created Act 89 which in turn created the Health Care Cost Containment Council.

This council is unique in the fact that it is an independent State agency made up of citizens of the State who control the agency and who have authority in law to do certain things to help contain costs in our State. It's operated through an appropriation of the senate and it's a line item in the general budget.

The members of this council I think are important and they come from business—six business members, six members from labor, one from hospitals, one from physicians, one from insurance companies, Blue Cross-Blue Shield, HMO's, one from the consumer, and importantly the secretary of health, the secretary of welfare

and the insurance commissioner all sit on this council and make decisions as to what the council will do.

The council is governed by a sunshine law. All of our meetings are open. We conduct public hearings. So everyone has the opportunity to hear what the problems are in health care. If you will, it's a forum in our State for people to come together—large groups, small groups, and consumers—to sit down and listen and to have input as to what are these problems that we're facing and how we can solve them.

COST CONTAINMENT THROUGH COMPETITION

The council has the authority to hire staff, to carry out the administrative functions of this council. There are three basic mandates and I think this is the heart of what we're trying to do in our State. The first mandate is to contain health care costs through competition, which is kind of a unique way of getting around the problem of people and the providers of care and the purchasers of care not really knowing and caring what's going on in the field. We are trying to make the same economic factors work in the delivery of health care as they are working in other business transactions—supply and demand, value for services, prudent purchasing, and a fair marketplace.

PROVIDING CONSUMER INFORMATION

The second thing we have to do is to educate the consumers by providing them with reliable, consistent data on cost and quality of service. This doesn't sound like much, but in the State of Pennsylvania there is no usable, reliable, consistent data from which purchasers can take and make informed decisions on health care. There are data, but it's not consistent and it doesn't contain quality and it doesn't contain costs. It just contains charges.

Representative SCHEUER. Well, it may not sound like much to a lot of people, but to this subcommittee it sounds like a great deal because this has been a major concern of ours. I had an entire day of hearings in another committee on the matter of empowering health consumers with the knowledge to make intelligent decisions as between alternative health care providers. The State that can set up a system first to aggregate that knowledge, second, make it intelligible to consumers, third, make it reasonably fair to the providers—it can never be totally fair because if it were they would need to write a monograph for every hospital and every doctor that would be meaningless to consumers—and then fourth, make this information available to consumers in a convenient form and a convenient location so that consumers have day-to-day access to intelligible information that they can understand it and at a time and place where they can get access to it, a State that can manage to provide those bundles of services will be looked upon with admiration and gratitude by all of the other 49 States because I think that's an idea whose time has come. We empower consumers with all kinds of information. We flood consumers with information about cars and hair dryers and VCR's and an incredible variety of consumer services and goods. The one thing that we've virtually denied them any information about is selecting health care provid-

ers and I think that's wrong and it's unacceptable in 1988 and I think you're doing a great service by approaching the problem in the way that you've described and we will be looking at it with great hope and great interest.

Mr. SESSA. Well, we're almost there. The data are coming in at the end of this month from every hospital in the State for every discharge, 1,800,000 discharges, and we will have information on costs and we will also have the quality information using a system called medisgroups which actually was pioneered in the State of Massachusetts, which will give you a number that will determine the severity of illness upon admission and the outcome of those services by using this system, and that will be available on a regional basis by the end of September. These reports will be made available hospital and physician specific in the newspapers, specific on those issues.

Representative SCHEUER. That was my question. Hospital and physician specific?

Mr. SESSA. Specific on those issues.

Representative SCHEUER. That was a question that I had prepared after reading your information—will this information be hospital and physician specific?

Mr. SESSA. Yes. The legislation states what kind of reports we will produce and what they will look like and it indicates the data elements that we will collect and it's very specific on how this information will be available. It's also very specific, since we are getting unique patient identifiers of the patient, that this information be held in strict confidence, so there's confidentiality upon the use of the data and also empowers the council to have enforcement penalties if we are not getting the proper data.

So the teeth are in the legislation for the action to take place and I must say that the cooperation from the hospitals and the physicians is really remarkably good. They have realized that we are not the enemy, that this council is not out to bash hospitals or doctors or any provider. We're trying to make some sense out of the system with their help and they are the ones that are going to use this quality assessment as much as anyone to find out what's happening in their hospital, to find out how they stack up as physicians with other physicians in the community and in their hospital, which they really haven't been able to do in prior years.

Representative SCHEUER. Well, I have always been puzzled as to why the medical community has been so reluctant to make this information available to health consumers because, after all, the overwhelming percentage of health providers, both doctors and hospitals, are doing a perfectly competent, responsible job. And it seems to me that the health community and the legal community have failed to clean up their house. The admonition, "Physician, cure thyself" has not been followed in either the legal community or the health community. They've found it very difficult to discipline and censure their colleagues. I don't know why they should be so reluctant to just give the bare information to the public so the public can do the job for them. If the public knew which hospitals had three or four times the rate of iatrogenic or nonsocomial infections as the average hospital, or which doctors had a string of malpractice judgments against them as long as your arm, or which

doctors had been censured by a State health agency or delicensed by a health agency, those much vaunted market forces would very soon become effective and those hospitals and those doctors would soon be relegated to the showers, so to speak, and they would be exorcised out of the health care system. The cleansing job would be done by an enlightened public.

Mr. SESSA. And I think it takes the stigma away from the physician.

Representative SCHEUER. Well, of course it would, and after all, we're talking about a very small percentage and I would think that the health provider community would want to get rid of the few bad apples at the bottom of the barrel. The New England Journal of Medicine estimated that perhaps 20,000 out of 550,000 doctors shouldn't be practicing medicine; they're either drug addicted or alcoholic or mentally impaired or otherwise incapacitated and disabled to the point where they should no longer be active medical practitioners.

If the medical community itself can't or will not discipline those 20,000 or so doctors who are giving the other 530,000 a really bum rap, why shouldn't they want to let the public have the information and then be able to make informed choices?

Mr. SESSA. I think they'd rather have it that way because it's not a physician pointing to another physician saying you shouldn't be recredentialed. It's the facts that will point that out that this individual should have a problem being recredentialed because it's black and white, it's there in front of you.

Representative SCHEUER. Mr. Sessa, I apologize for breaking in, but I really was very taken by your testimony, as I was by Mr. Johnston's. Let's assume the last few minutes were taken off on my time and not on your time. So why don't you proceed and finish your testimony and then we'll hear from the other witnesses and then I'm sure we'll have some more questions for you.

COVERAGE OF MEDICALLY INDIGENT IN PENNSYLVANIA

Mr. SESSA. Thank you. I can finish up fairly quickly. I just wanted to mention one or two aspects of the legislation that does not just stop at data collection and data information. It also goes a step further realizing the competition may well limit access to care because of the very nature of competition. If you're providing free care, you may be put at a disadvantage in marketing your services. So we're doing right now what Massachusetts has done, we're conducting a study of the medically indigent in our State and we are coming up with a plan to the Governor and to the general assembly at the end of this month, by July 1, giving a recommendation to the Governor and the general assembly as to how we can best take care of the 1 million identified uninsured people in the State of Pennsylvania, similar to the numbers that have been identified in Massachusetts. Fifty percent of those people are working or low income. The employer does not provide insurance nor can they purchase insurance because of the amount of money that they make. We're grappling with that problem. How do you make it equitable? You have to get the State government involved. You have to get the employers, the consumers, the unions to try to find the best

method to do that and, believe me, we've been grappling with the method. We've come up with a framework of a plan that requires about a $300 million subsidy in a trust to have the service initiative taken care of in the medicaid sector and to provide some mechanism to have and encourage small businesses to provide insurance to their employees. We haven't gone as far as Massachusetts to say that it has to be mandated, but we are considering an offset that if you provide the insurance you will not be subject to the contribution into the trust fund, which at this point is computed at 10.7 of $14,000 which is about a $1,500 contribution. That is something that the council is debating very heavily and we hope to come up with some recommendation to the Governor very shortly.

We are also looking at another problem in health care and that's the legislature in our State coming and mandating that insurance companies provide certain types of coverage—for instance, coverage for alcohol or mental health or mammograms—be included in every company in the State who is doing business there in that arena.

We are saying that we ought to look at that information first and make a recommendation to see if it's really necessary.

SUCCESS THROUGH PARTNERSHIP

And to close, I would just like to say that if I could leave anything with the subcommittee, I would like to leave the fact that this council in Pennsylvania, although it's a part of State government, is really an independent group of citizens trying to do something about the problems of health care. It's progressive. It's far reaching. It's really an excellent example of economic development partnership in our State and it does provide a mechanism to deal with these very, very important health care delivery problems in our State. We've met all the mandates of the council in the past 2 years that the legislation has directed us to do and the best is yet to come; and that is this statewide data base which will provide information on cost and quality from which to buy health care. I thank you very much.

[The prepared statement of Mr. Sessa follows:]

PREPARED STATEMENT OF ERNEST J. SESSA

Altruistically speaking, people run for public office because they want to help and serve the general public. They want to help people. They serve citizens by proposing laws and by voting to pass the good ones and to defeat the bad ones. There are 50 senators and 203 representatives who serve the citizens of the Commonwealth. A simple majority in each body is needed to pass proposed legislation into law.

On July 1, 1986, the House voted 200 to 0 and the Senate voted 50 to 0 to pass health care cost containment legislation. The governor signed the bill into law on July 8, 1986.

The words used in the legislation were unlike any other words. The words came from the thoughts, ideas and hopes of the Commonwealth's most powerful political forces: Pennsylvania's businesses, labor unions, medical entities and government.

No other political body in the country, or in the world, for that matter, was so bold as to unanimously pass legislation seeking the containment of health care costs by collecting and disseminating information about the cost and quality of its medical componenets.

Even now, two years later later, no other state has attempted to do what Pennsylvania is doing in the same manner.

Some call it a miracle. We call it Act 89, the Pennsylvania Health Care Cost Containment Act.

Why did the General Assembly overwhelmingly approve such a measure? Obviously, it was because they thought this was an extremely vital piece of legislation that would assist the Commonwealth in solving a problem perceived as very serious.

The General Assembly and the many constituencies that were parties to the legislation saw runaway health care costs as the problem. They believed the new law, Act 89, could help solve it.

I am not going to restate the economics and statistics of health care growth over the last 10 years. Suffice it to say that the sky appeared to be the limit for rising health care costs.

Who is to blame? In my view, no single entity can be

held accountable for the rapid expansion in health costs which occurred in the past decade.

All of us who are part of the health care delivery and financing process must accept our share of complicity in this phenomenon of skyrocketing costs. This includes consumers for wanting only the best - regardless of the cost; employers for providing health care benefits that required little or no responsibility of employees to avoid unnecessary or inappropriate use of care; providers of care who gave the best health care but with little regard to the cost; and federal and state governments, who certainly took note, but did little about it.

The reality of these actions finally caught up with us and we found that although we had what we wanted - the best health care that money could buy - we no longer could afford it.

When this realization hit us we reacted like a person who suddenly realizes his depth of spending upon opening the bill from the credit card company.

It was clear that behavior had to be adjusted and attitudes changed. The problem was that since we had indulged ourselves for many years, we knew that it could take many more years to effect the necessary changes.

And so the process started. It was a slow and painful process. But as time went on, we started to make some sense of the issues. We began to exhibit new attitudes and we made adjustments. We began to define the problem, identifying where we might be able to address it, and how to do something about it.

Most experts in the area of health care delivery and financing agree that there were four main items at the root of the escalating health care costs which had to be addressed.

1. The payment mechanism had to be reformed.

2. The consumer had to be educated that there is a cause-effect relationship between services and cost, and that there is no such thing as a "free lunch."

3. There was not enough true competition in the field of health care delivery.

4. There was no available information, good information, to help consumers make informed choices as to

where, and from whom, to buy health care.

Once these issues were identified, there was a move to develop solutions. Many variations of solutions were tried. Some appeared to be successful, others did not. These efforts resulted in the development of alternative delivery systems as well as in cost shifting and cost containment.

In the beginning, alternate delivery systems were tolerated but were very rarely joined. Cost shifting was identified and challenged. Cost containment efforts, such as utilization review and purchasers' alternatives to control health care expenditures, were attempted.

Alternate delivery systems began to gather in a much higher percentage of people. Cost shifting, simply stated, requires the payors to use more than one pocket from which to get the money. This practice, understandably, usually meets with heavy resistance. The theory of cost containment, in some cases, gave way to the concept of managed care.

All of this activity may have helped momentarily to slow down and decrease the disastrous projections of the percentage of increases in health care costs. But in reality, health care costs have continued to rise. In fact, they have continued to rise more than three times the consumer price index and other measures of price in our economy. The amount of total dollars spent on health care has continued to rise. As has its proportion of the overall Gross National Product, at an unacceptable rate.

With this backdrop, it is no wonder that the bargaining tables of the large and small employers and unions became dominated by discussions about the extremely high cost of maintaining employee health care benefits.

Something had to be done, and soon.

At this point, state government and the Governors Task Force on Health Care Costs entered the arena. Over a 16-month period, a representative group of health care decision-makers re-studied the problem of health care costs.

This effort resulted in some new, and some old proposals, that were published, and presented to the governor. But the results resulted in little, if any, change.

As might be expected, business and labor were not satisfied. They decided to take the matter into their own hands. From the business community, in galloped what was called "The Race Horse Group," comprised of representatives of various payors, insurers, and providers of health care. The goal of this group was to develop legislation that would bring some relief from rising health care costs.

At the same time, the Pennsylvania AFL-CIO assembled a group of health care experts to develop legislation which would not only control the escalation of health care costs, but protect the most valued fringe benefit of its members-health care benefits.

Both of these groups labored at this process for more than two years. The resulting proposed legislation was impressive. However, as much as it was impressive, it appeared too oppressive to the providers of health care.

It became apparent to both business and labor that neither of their legislative packages would stand a chance of passage without the other's support. Consequently, they entered into negotiations aimed at a compromise and a neutral organization was brought in to assist the process. Both business and labor believed that if legislation was to be successful, ALL parties in the health care system had to be included. The hospital association, the medical society, the insurance federation, Blue Cross and Blue Shield organizations, health maintenance organizations, and state government were solicited for input and support.

Many more months of discussion, compromise and negotiations followed. The final result was a compromise proposal that everyone could support, Act 89.

The three basic mandates under the Act are:

(1) Collect and disseminate data on the cost and quality of health care delivered in the Commonwealth.

(2) Study the issue of health care for the indigent and develop a plan to address problems identified.

(3) Review and formulate recommendations on services mandated to be included in all health insurance plans.

The true purpose of the Act never varied from the first day of its inception - to provide information that could assist in educating purchasers of health care. The Act states that all citizens should have the right and the access to necessary health care services.

To ensure this, the Act mandates that the council undertake a study of the medically indigent - the poor who are uninsured or underinsured and those at risk of catastrophic health care expenses. The purpose of this study is to identify the medically indigent and to identify the fairest and most efficient method to provide services to these individuals.

The study encompasses three basic charges:

(1) Identify the medically indigent.

(2) Assess their health care needs.

(3) Conclude how we can ensure that their needs are met.

The Act also states that uniform data from the providers of health care must be submitted to the Council. The data will be used for the purpose of comparison and as a determination of provider effectiveness and quality, for use by business, employers, consumers, the general public.

Sources of "cost" data include:

*Hospitals

*Other health care facilities

*Commercial insurers

*Medicare and Medicaid

*Blue Cross and Blue Shield

Sources of "quality" data include:

*Hospitals and other health care facilities

The purposes of data collection and dissemination are to:

*Educate consumers about the health care that they are using.

*Identify efficient health care providers.

*Enable consumers to utilize and/or purchase high quality health care at reasonable prices.

*Introduce competition into the health care

marketplace.

*Reduce the increase in health care costs in the long term.

There are provisions in the Act requiring the council to review legislation which would mandate that certain health care benefits or services be included in all health insurance policies written in the Commonwealth. Before the General Assembly considers such legislation, information must be made available to the Council for review to determine the impact on consumers, providers, and the health care delivery system in general. The Act requires that this information be reviewed by experts empaneled by the Council.

The basic steps included in scrutinizing a possible mandated benefit include:

*Conduct review upon request of legislative or executive branch of the government.

*Utilize three experts - economist, biostatistician, and health researcher.

*Answer the question - Does scientific documentation exist which supports the conclusion that the medical and social impact and medical efficacy of the mandated benefit outweigh the cost of the benefit?

The Pennsylvania Health Care Cost Containment Council has a unique structure in our state government in that it is an independent state agency operate by appointed citizens who represent the decision makers in health care delivery systems. Council membership is composed of 6 representatives for the business community; 6 for labor; 1 each for the hospitals, physicians, commercial insurance carriers, Blue Cross/Shied, HMOs, consumers; 3 representatives of state agencies.

All of the mandates of Act 89 are the responsibility of the 21-member council. They are appointed by the president pro tempore of the Senate, the speaker of the House, and the governor, from names submitted by constituencies representing decision makers in the health care community. The secretaries of health and public welfare and the state insurance commissioner are ex-officio members.

The Council has accomplished a great deal in the past 17 months and will provide a most impressive data base of

information for use in health care purchasing and monitoring in the near future.

Act 89 requires quarterly reports which will be publically disclosed:

(1) Comparisons of charges, admission and incidence rates, and provider effectiveness, grouped by diagnosis and severity, identifying each provider by name and type (facility) or specialty (physician).

(2) The number of physicians by specialty on the staff of each hospital or ambulatory facility, and those physicians who accept Medicare assignment as full payment and who accept Medicaid patients.

(3) Hospital accreditation and licensure status.

These reports will be published in the Pennsylvania Bulletin and in regional newspapers. Providers will have the right to submit clarifications, dissents and explanations which are to be noted in reports.

Last December, the Independent Regulatory Review Commission gave final approval to the council regulation that requires hospitals and other health care facilities to submit data on services rendered beginning January 1, 1988.

Among the data elements being submitted to the Council include:

*Unique patient identifier/Social Security number.

*Patient sex and date of birth.

*Employment information.

*Admission and discharge dates.

*Principal and secondary procedures.

*Attending and operating physicians.

*Services received and charges for services.

In addition, health care facilities will report quarterly summary utilization and financial reports, Medicare Cost Reports, Medical Assistance Form 336, certifications, accreditation and licenses, and a listing of physicians on their medical staffs.

Physicians will report information concerning Medicare assignment and Medicaid participation to the Council.

The approval by the Independent Regulatory Review Commission was the final step in an extensive process required by law for the council to begin collecting data from health care facilities.

Another milestone was reached a few months later, in Februay, when the IRRC Commission approved a second set of regulations which proposed adoption of a severity of illness measurement system. This system, called MedisGroups, is used to determine the quality of health care provided by individual hospitals and physicians.

The regulations require that all hospitals use the MedisGroups methodology for determining patient severity upon admission and patient morbidity. Each patient is given a "score" of from 0 to 4 on admission, and for outcome. These two important "scores" will be submitted by hospitals to the Health Care Cost Containment Council to enable the Council to determine quality of care and provider service effectiveness.

The third set of regulations require that payors submit health care facility payment and physician payment information. The regulations establish the data elements to be submitted to the Council by third party payors, the time schedule for the submission of these data elements, the formats in which the data elements must be submitted and a temporary exception process. These regulations are being heard by the IRRC committee today.

This collection of data by the council will enable businesses to apply the "buy right" concept of basing health care decisions on quality and cost to practical use.

The data collection is the crux to providing a consumer's guide to health care, and I am ecstatic at having reached this plateau in implementing Act 89.

Another milestone very soon to be reached is the Indigent Care Study that, in accordance with Act 89, will be submitted to the Governor of Pennsylvania and the General Assembly by July 1.

The indigent, by the way, includes more than one million Pennsylvanians who are uninsured, and approximately 600,000 people who are underinsured.

The final indigent care plan is slated for vote by the

Pennsylvania Health Care Cost Containment Council on June 24. The plan will have incorporated recommendations submitted by Lewin and Associates Inc. a consulting firm contracted by the Council last June to conduct a study involving indigent care. The plan also will have included input from private citizens and representatives of interested parties such as hospitals, the physician community, the insurance industry, etc., who have testified at more than a dozen public hearings conducted throughout the state.

Added to that wealth of information is the information, opinion, and fact-finding that has occurred among members of the Indigent Care Committee, which falls under the purview of the Council, during its literally dozens of meetings just in the past four months, let alone during the past year. In fact, the committee met Monday, yesterday, is meeting today, and will meet again Monday to effect closure on some portions of the study that have not enjoyed full concensus.

But I am pleased to report to you that, after having been under constant pressure, what with the diverse constituencies involved in this arduous process, that we are on schedule, and we will recommend an Indigent Care Plan, including appropriate methods for delivering health care services, to the Governor and the General Assembly by July 1 of this year.

What about mandated benefits?

You are aware, I am sure, that most people do not concern themselves with the cost of health care if they can say, "my insurance pays for it."

Consequently, consumers do not purchase health care with any thought whether the service is necessary, appropriate or cost effective because the care they receive is "free."

Understandably, employers are very concerned about the possibility of any new mandate health insurance benefit because it has the potential to inappropriately increase health insurance costs.

On the other hand, mandating that certain health services be included in health insurance policies also has the potential to reduce costs in the long run, such as in benefits for prenatal care, alcoholism treatment and rehabilitation services.

That is why Act 89 created a process to differentiate between those benefits which should be mandated to be included in health insurance policies and those which should not.

To date, the Council has reviewed a benefit mandating the treatment of mental disorders and has submitted its recommendation to the General Assembly.

Moreover, the Council has been requested to review a benefit for treatment and services associated with neurological impairments. So, as you can deduce, this aspect of the council's charge is working nicely.

I hope you can grasp from what I have outlined for you today, the huge amount of work that has been done to gain the degree of progress we have achieved thus far.

I am sure you appreciate that there is an even greater amount of work to be done in the future, particularly in the area of data collection and issuing reports.

Together with the quantity of work, there is also the responsibility of ensuring that the data is accurate. We owe it to health care providers to ensure that the two major elements, the severity of illness for a patient when admitted to a health care facility, and the condition of the patient when discharged, are accurate, standardized measurements by which fair assessments and comparisons can be drawn. The Pennsylvania Health Care Cost Containment Council is committed to being fair in that regard.

All of this, of course, is of considerable import to our society and necessitates attitude changes in the ways we buy and sell health care services.

Employers will have to do their homework. It will no longer be economical, nor wise, to buy simply on the basis of cost.

Quality of care, as well as cost, must be considered.

Employers also must educate their employees. No longer can we afford to allow a cavalier approach to using health care benefits prevail.

All employees must come to realize that when someone refers to a health care benefit in their insurance coverage as "being free" - that just isn't the case.

And we must all try to develop incentives for users of health care to make educated choices - to choose the most efficient health care providers.

And, hopefully, in the end, when we as members of a society, coalesce in these efforts, Act 89 and the achievement of health care cost containment will not be a miracle any longer.

It will be a reality.

Representative SCHEUER. Thank you very much, Mr. Sessa.

Now we will hear from Ms. Linda Hill-Chinn, director of Community Programs for Affordable Health Care.

STATEMENT OF LINDA HILL-CHINN, DIRECTOR, COMMUNITY PROGRAMS FOR AFFORDABLE HEALTH CARE

Ms. HILL-CHINN. Thank you, Mr. Chairman.

COMMUNITY PROGRAMS FOR AFFORDABLE HEALTH CARE

I am here to talk about how some of the State programs get implemented at the local level in a positive way.

Community Programs for Affordable Health Care is a national program funded by the Robert Wood Johnson Foundation and cosponsored by the American Hospital Association and Blue Cross and Blue Shield Association.

When the program was first begun, a national advisory committee, chaired by John Dunlop, a professor at Harvard University and former Secretary of Labor, was formed. It is composed of national leaders in health care, business, labor, Blue Cross, and commercial insurers and makes recommendations to the Robert Wood Johnson Foundation on communities that should be funded. The Johnson Foundation very generously made available up to $1.6 million for each of the 12 communities that put together programs to control the cost of health care without adversely affecting access and quality of care.

The basic concept of the program is that there is a third force available to control health care costs—the community force. Regulatory forces and market forces are controlled for the most part at the State and Federal levels. The policy decisions made at the State and National levels, however, must be implemented at the local level and the ultimate effect of those policies is on the local health care system. Therefore, there needs to be in place community forces, community leaders who are interested in the welfare of the community, not just in their own bottom lines.

An example of an adverse effect of a competition policy would be the businesses that seek discounts from hospitals, potentially decreasing a hospital's ability to provide access to the disadvantaged.

So we were looking for leaders—the people who actually make the decisions—to get together in communities, to put together programs to address health care costs but also to not adversely affect access and quality of care.

Generally, business initiated the programs in our communities. More than half of the programs are initiated by business. But health care provider participation—really active participation—was essential to the success of the programs. Generally, the programs come under two broad headings, either delivery solutions or financing solutions, and the delivery solutions are broadly either managed care solutions or changing physician practice patterns.

Because the communities are working with managed care and changing physician practice patterns, the providers—specifically physicians—have to be intimately involved in the process.

EXAMPLES OF COMMUNITY-BASED PROGRAMS

The financing solutions took the form of HMO's and PPO's. A couple of examples of our programs—it's quite interesting to hear the Massachusetts and Pennsylvania discussion because we do have programs in both Massachusetts and Pennsylvania. We have two programs in Massachusetts that I believe are going to work toward implementing the universal health insurance plan at the local level working with State government. In Worcester, MA, the community looked at competition as a strategy, as Pennsylvania is looking at competition as a strategy for controlling health care costs. The business community was concerned that if they participated in all-out competition among providers, costs might go up because of the advertising and all of the pulling this way and that way that goes on with competition. So they made some rules.

They were going to compete—health plans would compete. They felt that consumers make decisions on how they are going to use the health system at the time they purchase the health plan rather than at the time that they are ill. So they have been publishing cost, quality, and access information on all the managed care health plans and the indemnity plans that are available to the citizens and the employers in that area. They've put together information for the medicare population, for the medicaid population, and for the employed population.

Another model, a very different model, was begun in Charlotte, NC. In this case the program was initiated by the medical society. This is one of our prime examples of enlightened self-interest. The physicians decided that costs were too high because there was too much use of acute care services. I don't think there were too many physician groups at that time in the early 1980's identifying that as the problem.

The physicians worked together to develop criteria for use of acute care services and 70 to 80 percent of the physicians participated. They cut the use of the acute services—the days per 1,000 in the general population—from about 750 per thousand in 1984 to 589 in 1985. That's in the general population. In the companies that were participating in the utilization review program they put together, the days per 1,000 were reduced by more than half, to 345.

An interesting thing happened after the second year of this program. The in-patient days per 1,000 did not go down and the physicians looked at the data and found that the mental health and substance abuse days were going up very quickly while the medical surgical days were continuing to decline. The internists and surgeons decided that they should talk with their psychiatrist friends and see if they could establish a utilization program for mental health and substance abuse. They have since put together such a program, an employee assistance program, which is combined with the benefit programs in the participating companies. Mental health and substance abuse days were reduced by about 35 percent in the first year in participating companies.

One other program that I think should be mentioned is in Tulsa, OK, where we have another good example of enlightened self-interest. The large businesses in Tulsa, most headquartered in Tulsa,

decided that uncompensated care was a major problem. They decided to develop a long-term solution, and put together and market an affordable health insurance package for small employers. They developed the list of benefits. They negotiated with managed care programs, HMO's and PPO's, to reduce the number of exclusions of different types of businesses and people with problems. And the large businesses agreed to subsidize the premium for the smaller businesses, thereby making it more affordable.

I thank you, Mr. Chairman. If there are any questions I'd be happy to answer them.

[The prepared statement of Ms. Hill-Chinn follows:]

PREPARED STATEMENT OF LINDA HILL-CHINN

SUMMARY

Community Programs for Affordable Health Care (CPAHC) was designed to demonstrate that health care providers and insurers can join with employers and employees to demonstrate cost containment strategies that protect access to and quality of care, particularly for the disadvantaged.

Federal and state governments and other purchasers establish the parameters of the healthcare financing and delivery systems through payment policies and health policy legislation that encourage varying degrees of regulation or competition.

Whatever federal or state policy may be, that policy is played out at the local level. Organized community forces are needed at the local level to assure that as the various parties at interest--business, labor, hospitals, insurers--react to changing federal or state policy or incentives, community interests, particularly the interests of the disadvantaged, are not overlooked.

Eleven community programs have been funded under the CPAHC program and more than forty projects have been implemented. Many of the communities provide a model of community forces at work organizing and overseeing changes in healthcare delivery and financing in the community. Many projects provide examples for other communities that might want to address specific local problems.

COMMUNITY PROGRAMS FOR AFFORDABLE HEALTH CARE

In the 1970s state and federal governments were attempting to control health care costs with regulatory strategies. In the late 1970s and early 1980s, business, labor and government leaders were beginning to notice health care cost increases but little response had been generated. A few business coalitions on health were forming and some academics were beginning to talk about replacing the regulatory cost containment strategy with a competition strategy. It was during this period of changing public policy that Community Programs for Affordable Health Care was developed. Community Programs for Affordable Health Care (CPAHC) is a national program funded in 1982 by the Robert Wood Johnson Foundation (RWJF) and co-sponsored by the American Hospital Association and Blue Cross and Blue Shield Association.

Key to understanding Community Programs for Affordable Health Care is the concept of "community forces." The program assumes there are three sets of forces that affect the affordability of health care in every community: marketplace forces; regulatory forces; and community forces. The program did not attempt to demonstrate that "community forces" are more important than marketplace and regulatory forces. Rather, it recognizes that all three forces exist and that solving the health care cost problem is too important and too complex to overlook any set of forces that might be useful. Solutions to health care problems in this country require the mobilization of all three sets of forces in the most

synergistic balance possible. In that way, the impact of each can be magnified by interaction with the other two sets of forces.

A community force can be any individual, agency and organization driven to some extent by concern for the well-being of all the people in some geographic community in which they are located, and who are prepared to act--at least in part--in terms of their concepts of the best interest of that community as a whole. This is in contrast to either a much broader interest, such as medical education, or a much narrower interest, such as their own "bottom line."

Community forces are essential to efficient health systems because healthcare delivery is essentially a local affair. State and federal governments set the framework for health service delivery by changing incentives, or establishing regulatory or marketplace strategies, but those strategies necessarily get played out at the community level.

Community forces also are essential because any policy or action designed to control health costs has the potential to adversely effect access to and/or quality of health care, particularly for the poor or disadvantaged, when that policy is implemented at the local level. Local community leadership is needed to assure that the adverse effects of either a competitive or regulatory strategy are avoided when that strategy is implemented at the local, delivery system level. Thus, the program encouraged community leadership--specifically local business, labor, hospital and insurer leaders--to work together as a "community force" to affect health system change locally.

The basic premises that led to the formation of the CPAHC program were: First, that health care costs would continue to escalate at an alarming rate unless community leadership emerged to meet the challenge of restructuring the way health care services are provided and paid for. Second, that unbridled competition, the solution being proposed by many at the time, could do irreparable harm to local health systems by allowing each of the parties at interest--again business, labor, hospitals and insurers-to aggressively pursue their own self interest. Some consequences of such competition have been observed in communities where the community forces have not organized to protect against it. For example, business concerned about high health insurance premium costs, raised deductibles and co-payments, thereby improving their bottom lines by shifting costs to employees but not affecting any true health system cost savings. Hospitals, concerned about filling beds and maintaining an income stream, began aggressive advertising campaigns and pursued other strategies to entice patients from other hospitals. Again, this strategy may have improved the bottom line of one hospital, but only at the expense of another. Insurers and large self-insured businesses negotiated discounts with providers, thereby reducing their costs but increasing the cost of care for others who must pay extra to make up for the discount and/or decreasing access for the uninsured as hospitals have less flexibility to shift costs. The CPAHC founders were not so idealistic as to believe that self-interest had no place. Rather, they were seeking those who understood "enlightened self-interest"--i.e., community leaders who wanted real cost savings, not the quick fix that is likely to have adverse affects on another party.

With these basic concepts in mind, a National Advisory Committee, chaired by John Dunlop (Lamont University Professor Emeritus, Harvard University), and composed of national leaders in health care delivery, health insurance, business, and labor, was formed and charged with recommending to the RWJF the communities that should be awarded up to $1.6 million each to plan and implement a program of major feasible projects. The projects were to control the cost of health care without adversely affecting the quality of care or access to care by the poor and elderly.

The lure of $1.6 million and the status of a RWJF grant led communities to submit 323 letters of interest. Eventually eleven communities were able to develop agreed on programs and projects and were awarded implementation grants for up to four years. Some exciting, potentially significant, and replicable projects have been implemented in each of these communities and a great deal has been learned about local leadership groups and the elements of success or failure of such groups and their cost containment projects.

The CPAHC funded communities provide models of both successful use of community forces and development and implementation of successful projects. The initiators of CPAHC programs are most likely to be larger businesses. Seven of the eleven CPAHC programs were initiated by either a business coalition (4), Chamber of Commerce (2) or Economic Development Organization (1). The others were initiated by a community-based planning and policy organization, a Blue Cross/Blue Shield plan, a Medical Society and a hospital.

The projects implemented have been varied with both the substance and process reflecting the uniqueness of each community. Most projects are designed to affect the delivery of care. For example, seven programs designed to change physician practice patterns have been developed -- three utilization management programs, two small area variations data dissemination and follow-up action programs, and two outpatient surgery programs. With this type of program it appears that the more physicians participate in the planning and implementation of the project the more successful it will be. Managed care is the most common solution to providing high quality, affordable health care. Twelve programs to manage care for specific populations have been developed: seven for the elderly, one for workers' compensation cases, two for mental health/substance abuse patients and two for a variety of specific diagnoses. One program to regionalize the health system is being implemented.

Other projects fall under the category of financing changes. One HMO and six PPOs were established. Five projects were designed to make affordable health plans available to smaller employers. One program was designed to change incentives throughout the community.

Three communities initially attempted projects to address excess capacity issues. To date, none has been overwhelmingly successful.

The following community programs are provided as examples of models that can be replicated. In some cases these projects already are being modified and replicated in other communities.

The Mecklenburg County (Charlotte), NC Program

The Mecklenburg County (Charlotte), NC program for affordable health care was initiated by the local medical society, whose leadership recognized the need for effective utilization review criteria to control excessive use of inpatient beds and assure quality of care. Medical society leadership brought together local leaders from business, labor, hospitals and insurers to discuss the problems of excessive use of the health system and fragmented care for the elderly. These leaders established a new not-for-profit organization, the Mecklenburg County Council on Health Costs (Council), to develop and implement a program to address the utilization and fragmentation problems.

The Council focused first on the utilization problem by developing a pre-admission review program (PAR). Unlike most utilization review programs, which rely upon financial penalties to assure compliance, the PAR program is a voluntary, cooperative effort. PAR relies on professional consensus to assure high levels of participation and results. Twenty-six medical specialty panels, including approximately 70 to 80 percent of the Mecklenburg County physicians, prepare, review and revise the clinical criteria that are the foundation of the program. The Council administers the program including performing PAR reviews and marketing PAR to local companies.

The project implementation process, including the high level of physician participation and emphasis on employee education rather than penalties, is key to the success of the project. PAR began in 1984 and has been responsible, at least in part, for reductions in inpatient hospital days

per 1000 in the general under 65 population from 750 (1984) to 589 (1985). Participating companies experienced an even greater use reduction to 345 days per 1000 in 1985. Although medical/surgical use rates dropped in participating companies from 281 per thousand in 1985 to 246 in 1986, utilization in the alcohol, drug, mental health areas (ADM) rose significantly during that year, a phenomenon noticed nationwide.

In response to the rising number of admissions and costly treatments in the area of alcohol, drug abuse and mental illness, the Council developed a program of management services for behavior related illnesses called Health Interventions. The Health Interventions case management service screens, tests, and evaluates the employee, evaluates and presents treatment alternatives to the physician, arranges services, and monitors treatment and aftercare. In addition to the case management service, Health Interventions has implemented necessary changes in the environment including: changing some corporate benefit plans to coordinate EAP services with the medical benefits; altering physician and hospital practices, assuring the availability of alternative services; and educating employees and their dependents. Since its introduction into the community January 1, 1987, Health Interventions provides services to six major community employers. While precise data are not available preliminary figures indicate that the mental health and substance abuse inpatient days /1000 for participating companies have dropped by about 35 percent.

The Council's second major priority, a program of affordable care for the elderly (PACE), includes a number of related projects designed to promote high quality, cost effective care for the elderly. The central project

of PACE is Physician-Directed Case Management (PDCM). The key ingredient of PDCM is the participation of the patient's physician in guiding the delivery of overall care. Care coordinators serve as the mechanism by which the physician ensures the patient is receiving the type of social and health-related services that are appropriate to meet the individual patient's specific needs. Currently, there are five PDCM sites: two in private physician group practices, a free standing site, and sites in two of the three major community hospitals in Charlotte.

A second project, the Retiree Health Program, was designed to incorporate the physician directed case management and pre-admission review programs into retiree benefit packages in order to assure high quality, cost effective care for retirees. Discussions with retirees indicated that they needed and wanted the type of coordinated services available through these programs. They also wanted additional services such as assistance with claims processing, and insurance coverage for services such as home health assistance. The Retiree Health Program was intended to provide employers with an avenue to regain control of their costs while responding to retirees' identified needs and wants. Unfortunately, the community has been unable to implement the Retiree Health Program due to the rigidity of HCFA rules that do not allow for such local demonstrations.

The Council currently is developing a Multiple Employee Trust to assure that an affordable health insurance product, incorporating the community's successful utilization management and case management programs, is available to smaller employers.

The Worcester, MA Program

The strategy for the Worcester, MA CPAHC program, Worcester Area Systems for Affordable Health Care (WASAHC), was developed by the major businesses in Worcester through the Central Massachusetts Business Group on Health, a business only coalition. The business group concluded that the key controllable reason for high costs was the lack of provider incentives to practice effective and efficient medicine--or market failure.

The make health care more affordable, the business group adopted a strategy of encouraging competition among managed care health plans--Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

In developing its strategy, the business leaders believed that some undesired effects could result from a competition strategy if community rules and oversight were missing. For example, if only low cost is rewarded by purchasers, then quality, service and access could suffer. To avoid this problem, quality, service, availability and cost all are monitored and the results reported to the community. Also, competition might benefit only the larger employer and penalize the disadvantaged. To avoid this problem, the business leaders' strategy encourages all health plans to serve the entire community and insists that savings be based on efficiencies rather than on discounts provided to larger employers and not to other purchasers.

After adopting its competition strategy, the business group concluded that broad community support was necessary to put it into practice. A community coalition--The Worcester Area Systems for Affordable Health Care (WASAHC)--composed of representatives of hospitals, insurers, physicians, labor, consumers, local government and small businesses was formed and charged with implementing the strategy.

WASAHC's projects address both the consumer and provider sides of the competition equation. On the provider side, WASAHC assists providers to develop and expand health plans. On the consumer side, WASAHC motivates and informs consumers to allow them to choose the most appropriate plan. Specific projects focus on each of the following population groups: employers/employees; Medicare recipients; Medicaid recipients; and, the uninsured.

WASAHC promotes informed consumer choice on two levels: 1) business and government purchasers who decide which plans will be offered to employees; and 2) individual consumers, such as employees, Medicare or Medicaid beneficiaries. Buyers' Information Campaigns have focused on both groups to stimulate purchasing decisions based not only on price but also on quality, access and service.

The Topeka, KS Program

The Topeka, KS CPAHC began by developing a more efficient, effective health care delivery system--the Regional Health Services Network. Initial activities focused on the providers of care--urban and rural physicians and hospitals--defining the interactions among those providers

in order to most effectively use the capabilities of each. Once the elements of the network are in place, the program will focus increasingly on the payment side of health care--encouraging businesses and insurers to incorporate incentives to use the regional health services network into their benefits plans.

Working with the leadership groups in each community, rural and urban physicians, and other health care providers, staff from Stormont-Vail Hospital and Blue Cross and Blue Shield of Kansas developed a strategy to make rural practice more attractive to primary care doctors, increase the efficiency of the system and improve communication between the urban and rural physician by: 1) establishing referral agreements among doctors in rural areas and specialists in urban areas; 2) establishing agreed upon diagnosis or specialty specific case management protocols between urban and rural physicians; 3) establishing specialty clinics in rural areas; 4) organizing medical conferences on rural issues such as trauma management; and 5) making state of the art tools such as a computerized utilization review program available to the rural physician and hospital.

Networking among the urban and rural hospitals has been enhanced through a computerized utilization management program available through the CPAHC program to all hospitals in the seven counties of northeast Kansas. Reports generated by this system will enable hospitals to identify areas for improvement of quality and effectiveness. The cost effectiveness of the rural/urban hospital network is being enhanced by development of a model for transfer of patients from high level acute care (urban) to lower level acute care (rural) when appropriate. The model will include appropriate payment mechanisms to ensure equitable payments for both

urban and rural facilities. Transfers from urban acute care to rural swing beds occur frequently.

The Tulsa, OK Program

In 1981, the Metropolitan Tulsa Chamber of Commerce began to study health issues, including ways of coping with the medically uninsured. Also, Tulsa's largest employers formed the Tulsa Business Health Group (TBHG) to streamline benefit plans to ease the financial burden caused by medically indigent patients. The TBHG, in cooperation with the Chamber of Commerce and area hospital and medical leaders, formed the Tulsa Program for Affordable Health Care (TPAHC) to explore solutions that serve the entire community's interest.

TPAHC developed a plan of action to help reduce the size of Tulsa's uninsured population and shift large numbers of area residents into medical plans that encourage efficient care. The plan included four major projects: (1) creating an affordable model health benefit plan to medically uninsured workers and others, (2) establishing a health awareness campaign, (3) developing a statistical picture of Tulsa's medically indigent population, and (4) establishing criteria for distributing philanthropic funds for indigent care.

The centerpiece project is the Tulsa Health Option (THO), a comprehensive medical care package marketed by TPAHC to small employers, self-employed individuals, and others previously unable to purchase a comprehensive health benefit plan at a reasonable price. TPAHC members developed the specifications, selected the providers, negotiated price and underwriting

requirements, oversee monthly utilization and revenue and expense reports, and negotiate modifications in and additions to the THO.

To help ensure acceptance, the TBHG and Chamber of Commerce endorsed the THO, which is also offered to employees by most large companies in Tulsa. To ensure affordability for small employers, Tulsa's larger businesses agreed to a "community rate."

As of November 1987, the THO had 15,000 enrollees (5,000 from smaller companies). About 75 percent are new policy holders who previously had not been able to acquire or afford health insurance.

TPAHC expects to bring Medicaid clients into the Tulsa Health Option. Medical indigents who are ineligible for any group coverage are being identified. Funding to pay for their health care will be coordinated through a local foundation established for this purpose. THO products are being modified to increase eligibility and quality standards and mental health and long-term care products are being developed.

Other Programs

Significant projects also have been implemented in other cities around the country. Briefly--in Boston, MA, a Neighborhood Health Center HMO providing efficient, high quality managed care has been established. This new HMO is being marketed to large and small employers as well as Medicare, Medicaid and, initially on a limited basis, to the uninsured. It will provide a cost-effective option for small employers who do not now offer insurance because of high premium costs. A study of small

employers has been conducted to determine their health insurance needs and ability to pay employees' health insurance premiums. The Health Action Forum (HAF) has already begun to implement the state's new universal health insurance program by offering an affordable comprehensive product to all employers. Also in Boston, hospital medical staffs and specialty societies are studying small area variations data and taking appropriate actions to reduce variations. The HAF also is working with large businesses to develop employer-based programs for employee caretakers.

The Detroit, MI program has influenced and supported projects that: 1) demonstrate cooperative approaches to reducing and redirecting the use of health care services and 2) adjust the supply of facilities and services appropriately. Projects supported by the program included outpatient surgery delivery and financing, a geriatric services PPO, social HMOs, podiatric services PPO, substance abuse identification and referral and the program for health in business.

In Pittsburgh, PA, a utilization management program, case management program and computerized service inventory have been developed. The case management program focuses on: 1) long-term care; 2) physical medicine, rehabilitation and terminal illness; and 3) psychiatric mental health. The Service Inventory will incorporate the case management protocols and services available in the community. Thus, patients can be matched with appropriate services and gaps in service will be identified.

The Atlanta, GA program includes: 1) a utilization management program; 2) development of an affordable health plan incorporating managed care and provider discounts for small employers; and 3) technical assistance to community based organizations that provide social and health service in the homes of elderly patients to assist them in developing fee for service capability.

In Iowa, the CPAHC program is demonstrating the use of small area variations data to reduce costs and has developed a workers' compensation managed care product.

The Future of CPAHC Programs

The CPAHC program, through its eleven sites, has demonstrated a variety of methods to contain costs without adversely affecting any segment of the population. These communities that have worked hard to develop and maintain the necessary community forces to effect change have discovered many win/win cost containment strategies as a result of the dialogue among leaders from all affected sectors.

Most of the CPAHC communities plan to continue well beyond the RWJF grant period to pursue universal access to high quality health care at an affordable price using the community forces in place in the community.

Many other communities recently have expressed interest in forming broad-based consortia in their communities that could develop and implement projects to control costs and increase access to appropriate health services. The focus of these groups increasingly is on access to

primary and preventive care for the uninsured. As the pressure on hospitals' ability to care for the uninsured mounts as a result of federal, state, and business reductions in payment levels, this issue will become even more critical. Those communities that have community forces in place to work toward a solution to at least part of the problem will, in the long run, experience less trauma than those that do not.

Representative SCHEUER. I'm sure there will be later and I thank you very much for your testimony.

Now for the last witness for this panel we will hear from Mr. Stephen Somers, senior program officer of the Robert Wood Johnson Foundation. Please proceed, Mr. Somers.

STATEMENT OF STEPHEN A. SOMERS, SENIOR PROGRAM OFFICER, ROBERT WOOD JOHNSON FOUNDATION

ROBERT WOOD JOHNSON FOUNDATION

Mr. SOMERS. Thank you very much, Mr. Chairman.

Robert Wood Johnson is pleased to join those here in Washington who have recognized that long-term care should be a public policy priority. The foundation is a health care foundation and I am pleased to join Linda Hill-Chinn who directs one of our programs. We spend roughly $100 million annually on health services demonstrations, research, and training programs.

In keeping with your wishes, Mr. Chairman, to have a living room chat, I will speak as an individual as opposed to as a representative of the foundation.

The foundation has been in the long-term care area for a long time. We have spent roughly $850 million since 1972 when we were established as a national foundation and roughly 30 percent of that has been for health services programming for the elderly, mostly chronic care. We have had programs such as: hospital-based initiatives in long-term care, health impaired elderly, interfaith volunteer care givers, life care, and so forth. The programs I wish to discuss are in that area as well.

I would like to do three things today: One, discuss the underlying rationale for our current long-term care programs; two, describe three of those programs; and three, talk very briefly about some future directions.

As to the underlying rationale, there are some lessons that we have learned from past programming in this area. The main one is that tinkering with the service system is not enough. We must look at the structural and financing issues in the long-term care area to develop a comprehensive system.

In addition, limited Federal resources have forced us to rethink our funding strategies. Our old strategy was to develop model programs, evaluate them and, if successful, disseminate them and hope that the public sector would replicate them lock, stock, and barrel if possible. We recognize that that is not possible today. What we now do is, one, look at the current system and build upon its strengths; two, help develop alternatives to fill the gaps that can sustain themselves financially; and three, help to target existing public dollars to the most needy populations.

Finally, in the long-term care area we believe strongly in enabling people to help themselves. Personal and financial resources are often there but the ill-conceived system saps the elderly's sense of autonomy. The medical model prevails, and the "Russian roulette of long-term care financing" robs them of their sense of control over their own destiny.

FOUNDATION'S DEMONSTRATION PROJECTS IN LONG-TERM CARE

I would like to discuss three programs. The first one is the supportive services program for older persons. This is intended to demonstrate that a private market can be developed for supportive services for older persons. The hope is that they will "vote with their pocketbooks" for the services they need most to remain independent in their homes, as opposed to being told what services they need by public agencies.

The second objective of that program is to get tradition-bound, nonprofit VNA's and home care agencies to think more entrepreneurially about developing service programs, and letting the market forces determine what services should be available.

We made 13 grants to VNA's of $750,000 each. So far we have found that the elderly are willing to buy services. The services are really quite basic. They are emergency response systems, minor home repair, housekeeping, snow shoveling, lawn mowing, and so forth. Those are the things people feel they need in order to remain independent.

Representative SCHEUER. And they purchase those—the elderly purchase those services individually?

Mr. SOMERS. Right, and they purchase them through these VNA programs because the VNA programs help: One, organize the system for the elderly so they can gain access to these types of services; and two, also give the services a "Good Housekeeping" seal of approval, so the elderly people can trust the service provider.

This program is essentially for people in their homes. We recognized that we missed a population in this program; that is, the elderly in publicly assisted senior housing projects. Therefore, we have just announced a second program, supportive services in senior housing, and we will make up to 10 grants of up to $400,000 apiece to State financing housing agencies to get them to take responsibility as well for the elderly people in their local housing projects.

The second program I would like to touch on briefly is called life care at home—LCAH. You are probably familiar with the life care community, the CCRC. LCAH is a cheaper alternative, a more reasonable alternative. It builds on the supportive services program and adds a significant dimension—long-term insurance. We hope in the long run to make this program affordable by tapping into home equity conversions and possibly public subsidies to enable people to purchase into the program. In my prepared statement I have some details about what the costs of that program are at this time. We've made four grants in that area.

The final program and perhaps the most ambitious is the long-term care insurance program. Obviously, long-term care insurance is a very hot issue here. I know that the Brookings Institution and others testified several days ago on this issue and much of the debate is over whether or not there should be a pure public system or a pure private system for financing long-term care. We do not want to get into that debate. We think that it will probably take a combination of public and private financing.

In examining our life care at home program, we found that its most appealing feature is that it enables elderly people to allay their fears of impoverishment and institutionalization. We want to do this on a broad scale in the long-term care insurance program. The five basic principles of the program are: One, to reduce anxiety about impoverization; two, to ensure quality of services; three, build home and community-based options; four, develop a case management infrastructure in which the case managers would be to some extent at risk so that you can control utilization; and five, to offer some hope for lower income people to be able to participate in the program through public subsidies.

We agree with one of the comments in the Brookings study, which we helped to fund, that the anxiety over financing of long-term care is really unfair to the elderly. The fact that only one out of eight or nine people is going to need chronic care services over a long period of time means that policy insurance risk is really an appropriate strategy.

We chose private-public partnerships at the State level because many States have demonstrated a real commitment to doing something through gubernatorial initiatives or legislative initiatives. Second, insurance and medicaid are both largely State responsibilities. Third, States are good laboratories for model design, for data analysis, and for demonstrations of infrastructure programs. So far we have made six planning grants to the States of Massachusetts, Connecticut, Wisconsin, Indiana, New York, and New Jersey, and are considering two more to California and Oregon. These are $400,000 grants of up to 2 years.

The objective of these planning grants is for these States to develop fundable demonstration programs which would be large-scale multimillion dollar, multiyear programs. No matter what the outcome of the debate here in Washington is, we feel that the results of this study will improve the knowledge base and infrastructure development, and help policymakers here make more informed decisions about the course of long-term care policy in this country.

Thank you very much.

[The prepared statement of Mr. Somers follows:]

PREPARED STATEMENT OF STEPHEN A. SOMERS

Mr. Chairman, thank you for inviting a representative of The Robert Wood Johnson Foundation to testify today on innovative programs in health and long-term care. My name is Stephen Somers. I am a Senior Program Officer at the Foundation and I have primary responsibility for programs in a wide range of areas including those I am going to discuss today: the Program to Promote Long-Term Care Insurance; the Supportive Services Program for Older Persons; and, in less detail, the Life Care at Home Program. I would like to accomplish three things in testifying today:

1) convey the rationale underlying our approach to the long-term care issue;

2) describe the three programs; and

3) outline some areas worthy of further inquiry.

Before I take up those tasks, perhaps, I should say a word or two about the Robert Wood Johnson Foundation. For the record, an Annual Report and a recent statement of the Foundation's mission from its President, Dr. Leighton E. Cluff, are available for your staff. We are a health care foundation and have since our inception as a national institution in 1972 made grants totalling more than $865 million. The majority of the grants have been for health service demonstration programs. But significant funding has also been devoted to training and health services research.

Up until the early 1980s, the rationale underlying many of our demonstration programs was to design and implement new models, evaluate them properly, and, if successful, disseminate them for broader replication by the federal government and others in the public sector. For example, we supported some early work on the hospice model, emergency medical services, and HMOs.

Today, however, it is clear that we can no longer reply solely upon public funding for the broader implementation of important social service initiatives. The federal deficit and competition from equally pressing social needs have compelled us to consider other means for beginning to address problems such as the gap in our nation's system of long-term care. Where possible, we attempt to design demonstration programs that: (a) enable individuals to help themselves; (b) build upon the current system's strengths and respond to gaps in that system; and c) assure that available public funds are more efficiently used and targeted to those most in need. The three programs I am going to discuss today all strive to meet these objectives.

In general, this nation looks for pluralistic solutions to problems. Because long-term care involves individual needs and preferences regarding living arrangements and life style, and because it calls for a much broader mix of services than does acute care, the pluralistic approach is even more appropriate. Furthermore, because maintaining personal autonomy should be a primary goal of all long-term care programs, we feel strongly about encouraging individuals to exercise choices about desired services.

The Supportive Services Program for Older Persons is an eleven (11) site national initiative seeking to demonstrate that a private market for health-related home care services can be developed. Currently, services available to the elderly are based upon what medical reimbursement programs will cover, rather than the elderly's total needs or wishes. Moreover, because of this medical emphasis, available services are focused more on reducing the impact of morbidity than on preventing illness and meeting basic needs that may enable elderly people to remain independent. Four-year grants of $750,000 each were made to non-profit home health care agencies to conduct market research, design marketable products, and make these product lines self-sufficient. A sub-objective of the program is to strengthen the entrepreneurial skills of tradition-bound VNAs struggling fiscally under tightened medical care reimbursements. After a little more than a year of operations, we have been pleased to learn that: (1) elderly people will "vote with their pocketbooks" for basic services that help them stay in their communities (e.g., emergency response systems, minor home repair, lawnmowing, snow-shoveling, housekeeping, etc.); and (2) VNAs can be entrepreneurial without losing sight of their original service mission. They are learning to "do good by doing well".

The early success of this Supportive Services Program prompted us to announce a similar initiative for elderly residents of publicly assisted senior housing projects. We are now reviewing applications for up to 10 $400,000 grants to State Housing Finance Agencies across the country. Successful applicants will be those that promise to leverage state and housing development funds and build partnerships with social service agencies.

Again the emphasis will be on delivering services that elderly residents themselves feel will enable them to remain independent.

The Life Care at Home (LCAH) concept takes the two previously described programs a significant step further -- it adds a long-term care insurance component to the development of fee-for-service, home care services. As you know, the traditional Life Care Community, now commonly referred to as a Continuing Care Retirement Community (CCRC), offers a full range of guaranteed home and institutional services to its residents, but its costs are prohibitive to all but the upper income elderly. The up-front payment (usually non-refundable after five years) ranges up to $100,000 and beyond, and monthly fees are $1,500 to $2,000. By contrast, fees under four (4) Foundation funded LCAH demonstrations across the country will be approximately $10,000 for entry and $200 per month thereafter. Thus, it will be considerably more affordable with the substantial added benefit of allowing elderly enrollees to stay in their own homes and communities. At a subsequent stage of development of the LCAH model, it is hoped that we can make this form of guaranteed care available to lower-income elderly as well by encouraging home equity conversions or by providing direct public subsidies or Medicaid waivers to supplement the costs of long-term care services.

Clearly, the most ambitious of our initiatives in this area is the Program to Promote Public/Private Partnerships in Long-Term Care Insurance. To date, we have made planning grants of up to $400,000 to six states, (Connecticut, Indiana, Massachusetts, New Jersey, New York, and Wisconsin) and are still considering two more (California and Oregon). The intent of the Program is to begin generating sound policy responses to a deepening

dilemma for our nation's elderly families -- how to plan for and cope with the often tragic consequences of our "non-system" of long-term care.

The principal appeal of the Life Care models is the long-term care guarantee that releases elderly families from the dual fear of impoverishment and institutionalization or inadequate care. Without such guarantees, the current situation is akin to "long-term care roulette", in which one out of six or eight elderly people is hit by the catastrophic costs of extended long-term care.

The principal objective of the state planning grants is to generate fundable demonstration programs that will begin to put in place the risk-pooling financing mechanisms and case management and home care infrastructures needed to rationalize the current system of paying for and delivering long-term care. Because of the federal deficit, and because the private sector will not take on the risks of constructing a comprehensive and affordable system alone, we feel that state-level public/private partnerships present the best opportunity for making progress on the problem. While one might argue that such a partnership already exists, the current system of Medicare, Medicaid, and a growing private insurance sector is really nothing more than a poorly conceived and coordinated arrangement, "a marriage of inconvenience" for all involved. It certainly is not a true partnership. We believe that the following elements could help build a more complementary relationship than currently exists:

1. A state-level financing system could respond to the needs of the state's population, build upon existing state resources, and take into account the unique nature of each state's Medicaid program, its regulatory environment, as well as the quantity and mix of

available services. Medicaid and private insurance both are already, in large part, state responsibilities. In time, the federal government might assume greater financial responsibility in order to assure equity across the country.

2. The system should use private and public insurance in tandem. For example, Medicaid or another state funding source could better limit the risk for private insurers through, for example, a reinsurance or stop-loss approach. In this way, the insurers themselves would be protected against catastrophic losses, and their products would consequently be made more available and affordable. At the same time, Medicaid, by relaxing its eligibility rules, could shed its current welfare role and make coverage available before people become impoverished.

3. Before such a system can be implemented, states and their private partners must collect and analyze data on long-term care costs and utilization. In this way, they can more accurately define risk, establish premium rates, and determine how to gain control over public expenditures for long-term care.

4. An infrastructure is needed to repair gaping holes in the current system. Very few states have anything approaching a comprehensive long-term care infrastructure. Combined private/public insurance products must cover home and community-based services. which in many areas are minimal. They must also include a strong case management component, not only to contain costs, but to

assure that the recipient can gain easy and continued access to the appropriate level and mix of services as they move from one payor to another. Only a few states have significant experience in screening and managing long-term care cases or service utilization.

Constructing a long-term care system will require considerable time, effort and resources. The Foundation, for its part, will continue to give a high priority to innovative models for financing and delivering care to chronically ill elderly people. In addition to the programs outlined above, we are now supporting efforts to develop day care for victims of Alzheimers and other dementia, as well as initiatives to improve the transition from acute hospital care back to the community (including linkages to rehabilitation and chronic care services). We are also examining the potential of service-enriched elderly housing with permanent financing for health services as well as "bricks and mortar" built into the development packages.

Each state plan under our Long-Term Care Insurance Program will look different. Nevertheless, they are all committed to building private/public partnerships, better defining and limiting exposure for private insurers, expanding the availability of such coverage to their elderly citizens and their families, creating long-term care infrastructures, and moving Medicaid from its current role as a funder of last resort to a more constructive participant in the financing of long-term care.

In the future, even if a totally public system becomes feasible, the work done under these efforts will inform policy makers about the demand and costs of long-term care services and help establish an infrastructure

for the provision of such care. Because the human problem is so real and present, we are pleased that the work at the national, state and community levels has begun in earnest.

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LONG-TERM CARE INSURANCE MARKET

Representative SCHEUER. Thank you very much, Mr. Somers.

You talked about the Brookings testimony that we received several days ago. There was some skepticism about whether there would be widespread use of private insurance and concern about whether people could afford that.

Have you ascertained whether there's a big market out there or do you think there's a big market out there?

Mr. SOMERS. Well, I think that quite a bit has been written about what the current market looks like and I think there are 400,000 or 500,000 policies and 70 or 80 companies in the arena at this time. We all agree that we would not urge our mothers or grandmothers to purchase these products at this point, because they are not comprehensive enough and do not offer a long-term guarantee. I think the maximum amount of time right now is about 6 years of coverage, and they are also not affordable. And we agree with the people at Brookings that private insurance by itself is never going to cover the people who are probably most in need of coverage—the oldest, the frailest, and the poorest.

So we are very interested in public-private partnerships in which the public sector provides some kind of premium subsidy. Currently, the public sector is providing coverage for those sectors of the population through medicaid. So there is a partnership right now, albeit not a very effective one.

Representative SCHEUER. In what way is it not effective? What are the flaws?

Mr. SOMERS. There are tremendous gaps in the system and people who have worked all their lives and have savings are always at risk of having to spend down all of their assets in order to be covered by medicaid, which is the roulette aspect of the current system.

In addition, the current system lacks home and community based services, the kind of services that the elderly people would like to have to remain in their homes.

EDUCATE CONSUMERS ABOUT LONG-TERM CARE OPTIONS

Representative SCHEUER. Do we need an education program to alert consumers to the fact that there may be gaps in the private coverage and to give them some kind of assistance in analyzing—some kind of counseling availability to help them choose between alternative programs?

It's a very complicated business and I tried myself to evaluate the various insurance programs that were available to me and I just gave up.

Mr. SOMERS. And you didn't buy any, right?

Representative SCHEUER. I gave my office manager the responsibility to advise me. It was beyond my ability to compare all those apples and oranges and apricots and prunes. And I would think it would be wildly beyond the ability of the average elderly person to make those sophisticated judgments and keep in mind all those variables. I would think you would almost need a computer capability to do it.

How do we enable elderly folk to make intelligent decisions on the wide variety of private insurance programs that are available?

Mr. SOMERS. I have three responses. It is a real issue. I think that consumer education is important. I think AARP is spending some time on that issue and I think that——

Representative SCHEUER. I guess they have their own programs. Aren't they a large provider?

Mr. SOMERS. Indeed they are.

Representative SCHEUER. So I think they perform a remarkable service to elderly people in a wide variety of ways, but they do have a vested interest.

Mr. SOMERS. There is a vested interest.

Representative SCHEUER. There is a vested interest, a perfectly respectable one, and I criticize them in no way, but there it is.

Mr. SOMERS. I do not want us to rely solely on AARP for consumer education. I think that that is a major issue that needs to be addressed.

Second, insurance companies are developing computer packages. In fact, we are funding a demonstration here in Washington—United Seniors Cooperative—in which a computer software package is being developed to help people analyze and assess what their options are in the long-term care area.

Third, I would say that an integral part of our long-term care insurance grants is to develop the kind of case management infrastructure that will assist people in making intelligent decisions about what to do about long-term care and service utilization. Confusion about the current programming I think helps explain why relatively few long-term care insurance products have been purchased. First of all people have to be convinced they need it, and that is slowly happening. Second, they need to understand what it is and right now they do not really understand because, as you said, there are apples and oranges and many other fruits.

LESSONS FROM MASSACHUSETTS

Representative SCHEUER. Let me ask Mr. Johnston and Mr. Sessa a question because they are both working on statewide models.

First, Mr. Johnston, how long do you think it's going to be before we can sort of sit back and evaluate the Massachusetts experience in providing universal health care and decide if we can lift the whole package and apply it nationally? How do we decide what elements work superbly, what works pretty well, what could use a little bit of retinkering, and what elements probably haven't worked out so well and could be replaced, substituted for? How long is it going to be before we're going to be able to really distill your experience and apply it nationally?

Mr. JOHNSTON. That's a very good question and there will be a very comprehensive evaluation component that will kick in immediately because don't forget—of course, this legislation is going to unfold over a period of—the implementation will unfold over a period of 4 years commencing on July 1 of this year, and I think what's important in this is we're not doing everything at once because we don't believe that as a practical matter that's realistic.

This is a big, big problem and nobody has ever done this before in the country and we don't want to fall on our faces. We want to succeed. So we are taking this in small chunks.

Representative SCHEUER. In other words, you're applying it incrementally, but there is a grand design.

Mr. JOHNSTON. Yes, and the grand design will be fully implemented in 1992. So that the short answer to your question is that I think we will be able to have an ongoing evaluation process which will give us immediate information regarding those pieces that we're implementing each year. But the grand design will not be able to be fully evaluated for some time after the full implementation which will be in 1992.

Representative SCHEUER. Will we have to wait until 1992 before we begin to see some form emerging and some cost effectiveness emerging and so forth?

Mr. JOHNSTON. No. I think the key to this will be the extent to which the business community responds to the mandate which really kicks in in 1990. There will be a very small surcharge which will begin to be applied in 1990.

Representative SCHEUER. And that is to firms that don't provide insurance?

Mr. JOHNSTON. For those that do provide there will be a surcharge but it will be awash because they will get a credit of the same amount. And my sense thus far is that while it remains a philosophical objection on the part of the small business community to the mandate, people are beginning to get more comfortable with the idea and our expectation is that as we head into 1990 with the various kinds of help that we're going to be providing the business community with over the next couple of years, that we will be in good shape to do this.

I think if there's any lesson that we've all learned—and I've heard it from each of the presenters this morning—in health care during the last few years, it is that no one sector can do this alone, that there really has to be a partnership, whether you're talking about this issue or long-term care or anything else, that it isn't just the Government, it isn't just the business community, it isn't just the human services department, it has to be everybody working together and that's the model that we've tried to follow in this legislation.

Are there going to be problems as we begin the implementation? Yes, I'm sure there will be. But we made it very clear that this legislation is not written in concrete and that we expect there are going to have to be some alterations and this is an experiment and the States are laboratories for change and we're going to have to learn from the experiments and make any changes that are necessary along the way and we are fully prepared to do that.

Representative SCHEUER. And when will we begin to get some gut feeling that by golly this thing is working and that all of the gears and the machinery are dovetailing and complementing each other in a positive way? When are we going to get some feeling of confidence that we're really on the right track here and that the whole of the program is greater than the sum of the parts?

Mr. JOHNSTON. I think within 2 or 3 years we will have a good sense of that.

Representative SCHEUER. Two or three years from July 1?

Mr. JOHNSTON. Yes. Again, we're doing this incrementally.

Representative SCHEUER. That's 1 or 2 years or 1½ or 2½ years into the next administration, of whatever description?

Mr. JOHNSTON. Yes. Frankly, I feel very confident that this is an approach that's going to work and I think that it now is largely a managerial issue and I'm charged with that responsibility and people within the State human services agencies are responsible for that and we're very confident we will be able to implement this legislation.

The first piece is a very major one which goes into effect on July 1. We had a very short timeframe in which to put that together. The department of public welfare did a spectacular job in putting it together and the Governor will be announcing the full implementation of that first phase on July 1. It was an extraordinary administrative achievement and I hope that that bodes well for the rest of the legislation. I think it does.

NATIONAL APPLICATION OF MASSACHUSETTS PROGRAM

Representative SCHEUER. Well, let's just assume arguendo that next January we have an administration in Washington that is basically sympathetic to the approach that's been taken in Massachusetts.

Do you think there is anything in your overall master plan that is intrinsic and relevant to the State of Massachusetts but that would not be appropriate or relevant if applied as a national model? Are we really looking here at a model that could be applied by a national administration? I say this with some particular self-interest because I'm the ranking member of the Health and the Environment Subcommittee of the Energy and Commerce Committee and I suppose a proposal might be floating before our committee before many moons have passed if we have an administration that's congenial to this approach.

Is there something so unique and special about the Massachusetts experiment that it would not be a national model or do you think we can look at it through the prism of, well, if this works, let's take it to Washington?

Mr. JOHNSTON. I think, Mr. Chairman, you can be well assured that if my boss is in charge of the next administration——

Representative SCHEUER. Let's not get down to anything politically specific.

Mr. JOHNSTON. Or anyone like him is in charge of a new national administration, that the major elements of the Massachusetts plan can be enacted nationally into national legislation. There's nothing at all here that is unique to Massachusetts. Some of the politics are unique, of course, because we have a unique political environment, but I think with the strong support of congressional majority that there's no reason in the world why this can't be done at the national level.

Representative SCHEUER. You say congressional majority, you mean bipartisan majority?

Mr. JOHNSTON. I really think so, Mr. Chairman.

MASSACHUSETTS PROGRAM: A BIPARTISAN PARTNERSHIP

Representative SCHEUER. You didn't get too embroiled in partisan politics in Massachusetts, did you?

Mr. JOHNSTON. No, it was not a partisan issue at all.

Representative SCHEUER. Tell us about that and how did you manage to avoid the partisan bickering?

Mr. JOHNSTON. Well, I think the way we did that was by demonstrating to the business community this is really a fairness issue in a political sense and in an economic sense, that 90 percent of the businesses in our State—and I think the numbers generally hold true across the country—provide health insurance to their employees and a very small minority just simply choose not to. Contrary to popular myth, these are generally not the "Mom and Pop" store owners who don't provide health insurance. These are large national chains which, for their own financial reasons, choose not to do so.

So the vast majority of the business community understood very quickly that they're subsidizing that 10 percent and to have a system which is much more equitable is going to actually benefit many people in the business community. So this became an interesting political exercise in that it was not partisan at all. There were many members of the Republican Party, many members of the Democratic Party, who were very strong supporters of the principle of providing health insurance to every single person in the State.

So we avoided the kind of—obviously, you get into some give and take always with this kind of thing in a partisan sense, but it was not and is not a partisan issue.

MANDATORY INSURANCE AND COMPETITIVENESS

Representative SCHEUER. Let's talk about your level playing field because you think you have created that in Massachusetts. Let's think about whether you are providing any kind of a competitive disadvantage to Massachusetts firms compared to firms in the other 49 States who are not required to subsidize health care. Have you done any computer modeling at Harvard or MIT that would tell you whether there's a competitive disadvantage that Massachusetts business institutions are going to be laboring under vis-a-vis their competitors in the other 49 States?

And this would be particularly relevant because if we're thinking about applying your model nationally, we have to think about the competitive posture of American business compared to all of those other businesses out there, not only in Western Europe but the Pactific Rim countries, where they are not financing health care programs through business subsidies directly. They're financing it, I assume—I think it's true—for the most part, out of their general treasuries. So the lessons that we might learn in Massachusetts about a competitive disadvantage vis-a-vis the other 49 States would give us some interesting insights on whether we can afford to go ahead with this model nationally in terms of how it would affect our global competitive posture.

Mr. JOHNSTON. Well, there are really two responses to that because that was one of the chief arguments that the opponents of the legislation made against the bill.

The first is what I have been emphasizing this morning, and that is this fairness issue for the business community in general, that it is a fact that the vast majority of businesses do provide health insurance now and we all know that if someone has an acute care crisis and they need to be hospitalized, somebody is going to pay for that. We're not going to just let people who need appendectomies lie out on the street or people who are victims of automobile accidents or heart attacks or whatever. They are going to end up in some hospital and it's usually a municipal hospital but not always and free care is going to be provided to that person. In the end, this is a tax on the business community and the fact that this 10 percent really renegade part of the business community chooses not to participate means that they're getting away and they're not paying their fair share.

Representative SCHEUER. They're getting a free ride, so to speak?

Mr. JOHNSTON. They're getting a free ride on the health care costs. So in an economic sense, to the business community in general in our State I believe in all other States, this is something that is going to help to equalize the burden in a fiscal sense for the business community.

Representative SCHEUER. In other words, you're making the point that your program doesn't add to the health care costs in the State of Massachusetts. It's simply a way of allocating health care cost more equitably. It doesn't increase the State health care costs.

Mr. JOHNSTON. It really doesn't.

Representative SCHEUER. It simply equalizes the way it's paid and it makes it a more rational and less capricious process.

Mr. JOHNSTON. And better managed.

Representative SCHEUER. And better managed, yes. Do the people in Massachusetts understand that your're not adding net costs to the total cost of health care that's being delivered to citizens of Massachusetts and that you're simply rationalizing it and redistributing it and probably managing it better?

Mr. JOHNSTON. I think that's the reason that the legislation was enacted finally by the legislature was because the majority of the people in our State did finally understand that. That's the most important principle here, that there is no free lunch in health care and these costs are going to be borne by somebody and we need to make certain that, first, those costs are shared as equally as possible among all the various players in the business and that, second, we have the capacity to manage health care costs in an as effective and in as aggressive way as possible, particularly so that the incentives are worked in such a way as to emphasize preventive care in the system and I think that we are now for the first time going to be able to do that.

MASSACHUSETTS UNCOMPENSATED CARE POOL

Let me just say parenthetically, Mr. Chairman, that in our State, as in many other States now, we have a very large uncompensated care pool amounting to about $315 million this year. That is a free

care pool which is financed entirely by the business community. That's financed by a surcharge on hospital charges and every CEO in the State is very, very concerned about this. That has been a free care pool of $315 million which has been largely unmanaged. It just sits there and if the hospital doesn't collect a bill it turns around and bills the free care pool.

Now, under this legislation, we're going to be able to really get in there and manage this $315 million which the business community has contributed and I just believe that in a very short period of time we're going to be able to demonstrate to the average business that we collectively are going to be doing a much better job of containing health care costs and making certain the incentives are as they should be.

MORE EMPLOYEE COVERAGE IN AN EXPANDING ECONOMY

But there's another economic issue here that I want to point out and that is that in New England at least—this isn't true in every region of the country certainly, but in New England we've been on an economic roll for some time and we are in the enviable position of having very severe personnel shortages. We're now importing workers from other regions of the country to work in our industries and this is particularly true in the service sector, whether it's human services or the hotel-restaurant industry or what have you.

Just as an example, the Governor was speaking to the CEO of one of the major restaurant chains the other day who pointed out that 40 to 45 percent of his available jobs in his restaurant chain are open. He can't recruit people to work there.

Representative SCHEUER. Why is that? Is it because he can't recruit people with the proper skills or because the prevailing wage rate is too high or what is it?

Mr. JOHNSTON. It's because the unemployment rate is so low in Massachusetts that we in the service sector are now competing with industries which pay a lot more money for jobs carrying with them a lot less stress. So if you're running a program for mentally retarded people or you're running a restaurant or a hotel or you're running a hospital, you're in competition with the high-tech industry or the manufacturing industry or whatever, which is paying more money.

So the interesting thing in our economy now is in order to deal with that new personnel shortage reality, business owners are now beginning to provide health insurance on their own voluntarily——

Representative SCHEUER. As a competitive factor?

Mr. JOHNSTON. Right. And this is very interesting. So the number of people who are uninsured in Massachusetts is 600,000. That's 10 percent of our population. Nationally, it's about 20 percent. So that it's an interesting twist.

Representative SCHEUER. You have about half the percentage that prevails nationally of uninsured people, and a large reason for that is that businesses find that it's a competitive factor in attracting workers to their particular firm from out of the State?

Mr. JOHNSTON. Yes. My own feeling is that the ability to manage health care costs and to make certain that they are distributed equally across the economy combines or merges very well with the

goal of having a healthy moving economy. I think they go hand in hand. And managing the economy in a macro sense is made easier by our ability now to manage health care costs much more aggressively.

So I really feel that we're going to be able to have a very positive impact on the Massachusetts economy as a result of our ability to better manage this health care economy.

Representative SCHEUER. Our opening witness was former Secretary of Health and Human Services, or HEW as it was known then, Joe Califano, and he's been actively engaged in helping to manage the health care program at the Chrysler Corp. He was not very sanguine about the ability of corporations in general, and Chrysler in specific, really to rationalize the management of health care services.

He felt there was a great deal of waste inherent in the system. In fact, he estimated that we are wasting $125 billion a year—maybe 20 or 25 percent of our total health care bill wasted—mostly from structural flaws in the system—duplication, overlapping, a health care system that is overly pluralistic and unrationalized.

I don't think we have time to get into the details of how well you're likely to manage these health care costs, especially as corporations pick them up, but Mr. Califano was not very hopeful.

COST CONTAINMENT IS PUBLIC RESPONSIBILITY

Mr. JOHNSTON. Could I just simply make this point?

Representative SCHEUER. Sure.

Mr. JOHNSTON. Prior to the enactment of this legislation. we had predecessor legislation prior to this newest bill which went into effect 5 years ago in Massachusetts and really the focus of it was on cost containment, and it was probably the most stringent cost containment legislation in the country at that time. And when Governor Dukakis came back into office in January 1983 and I went to work for him, our health care costs were rising at a rate higher than any other State in the country. We were looking at 18 percent increases annually and that was the first year of the implementation of this cost containment legislation.

Health care costs are still rising in Massachusetts, but we have reduced them to about 6 percent each year, and that's because we now have a process in the State which controls—I'm referring now to the acute care side—we have a process which gives the State the authority to set hospital charges in a way that forces hospitals to operate much more efficiently than they had operated in the past. And the business community felt that this was critical to their survival because as you pointed out they're the ones who are paying the freight on this.

And this has been successful. But I believe it's a public responsibility in the end to try to contain these health care costs. Businesses by themselves, corporations by themselves, cannot do it.

Representative SCHEUER. You think the governments have to do it, local and State governments?

Mr. JOHNSTON. I really do. I think it's largely a State responsibility. I don't think that the Federal Government can do it very effectively because you're dealing with too large a unit, and municipali-

ties can't do it very effectively either. So I think in the end it has to be a State responsibility.

Representative SCHEUER. We found in the past that one problem in including States to play a more effective role in controlling health care costs is that it's so difficult to compare the operating costs of various hospitals both within and without the State, that they use different accounting methods, different bookkeeping methods, and when we try to compare, we are looking at apples and oranges.

Have you achieved a uniform health care accounting system in Massachusetts that will enable you to keep a hands-on operating control of costs and indicate to hospitals in a comparative way where their costs are out of line with other comparable hospitals with comparable facilities and comparable patient loads?

Mr. JOHNSTON. Yes, we really have, as a result of the legislation which I referred to a minute ago. The Massachusetts Rate Setting Commission, which is an agency within our human services umbrella also, is charged with collecting that data and setting rates based on that information. And while there are always disagreements and give and take and so on, generally it's a process that has worked very well and it has resulted in a reduction in the growth of hospital costs during the last 5 years or so.

PENNSYLVANIA UNIFORM ACCOUNTING SYSTEM

Representative SCHEUER. Mr. Sessa, tell me what Pennsylvania has done in requiring all health care institutions to adopt uniform cost accounting processes and procedures so that you can compare apples with apples and not apples with oranges and grapefruits.

Mr. SESSA. We started off by mandating that a uniform data reporting system be put in place for all hospitals patterned after 21 data elements identified in the legislation and using a medicare type reporting format, so that that data from all hospitals are consistent data and the same information.

Also as part of that data we're asking for the charges that a hospital makes for particular services and at the end we intend to take the information from the insurance companies who are paying for those services, collect the payment information, put it into this same data base, and we will now have a comparison of utilization, charges and payments, which will give us consistent measurement information.

Representative SCHEUER. That's very interesting.

Now Mr. Johnston—incidentally, Ms. Smith, if you want to break in and make any remarks, please feel free to do so. Let me ask Mr. Johnston and Mr. Sessa an interesting question.

If I wanted to compare the costs of a hospital in Philadelphia with a hospital in Boston, would there be enough of the uniform accounting system for me to do that?

Mr. SESSA. I think on payments, yes.

Representative SCHEUER. I mean on every aspect of operation.

Mr. SESSA. I think we could come very close to comparing apples with apples because the rate setting information that they gather will be very similar to the type of information that we have.

NEED NATIONAL DATA BASE TO COMPARE COSTS

Representative SCHEUER. What I'm driving at—it's pretty obvious—we ought to have a national data bank on the cost effectiveness with which all kinds of health care institutions function so that we can compare a hospital in San Diego with a hospital on Cape Cod and come up with data that you can legitimately use and fairly use as a micromanagement tool in achieving maximum cost effectiveness in hospitals, and frankly, knocking a few heads together. Now can we do that? Here are two extraordinarily enlightened State administrations that are trying to achieve some rationality on a State basis. Have at least those two States achieved rationality in terms of uniform costs in a way that could be applied nationally and in a way that we could compare?

Mr. SESSA. I think the one main variable is the fact that we will have a severity adjustment factor on which to base the quality of the care.

Representative SCHEUER. You mean the severity of the illness?

Mr. SESSA. That's right.

Representative SCHEUER. But that's a basic essential of any cost control operation. You have to know how serious the patient was afflicted with illness when they came in and when they left. That's the sine qua non, isn't it?

Mr. SESSA. It's not captured currently in most data bases. There heretofore was not really a system that was available to be able to qualify through key clinical findings exactly what that severity was and to take that and then look at it and measure it against outcome.

Representative SCHEUER. Well, now, Mr. Johnston, are you doing that in Massachusetts?

Ms. SMITH. Yes. Our rate setting system includes a measure of severity for patient illness and this is an element that really was put into the system early on because particularly with the community of teaching hospitals we have they made it very clear that they could not accept cost comparisons with community hospitals that did not have the tertiary care that they were providing. So there may be some grumbling, but there's a fair amount of acceptance of that system.

Representative SCHEUER. All right. Thank you. Let me ask again, can I compare apples and apples? If I want to compare the operating costs in every respect of a tertiary teaching hospital in Philadelphia with a tertiary teaching hospital in Brookline, can we compare apples and apples and compare the operating costs and the health outcomes of those two hospitals with the data base that you have set up?

Mr. SESSA. If they are capturing a case mix severity that would be similar to ours——

Representative SCHEUER. You just heard that they are.

Mr. SESSA. Then once we get the payment data and have those available in our system, I think we could.

Representative SCHEUER. What do you think, Mr. Johnston?

Mr. JOHNSTON. What do you think, Ms. Smith?

Ms. SMITH. I think the hospitals would argue with us, but I think on some level we could make a comparison.

Representative SCHEUER. I think it would be great if Mr. Sessa and Mr. Johnston put their heads together and see if they could rationalize health care data cost collection processes and systems so that you came up with a uniform system as between your two States. Your two States are in the vanguard of rationalizing health care. I mean nationally, this whole lack of comparable data and uniform data is a disaster. It's impossible to rationalize our national health care system. This is one of the problems that Mr. Califano and many others point out. You cannot do it because we are not keeping uniform data.

If the leadership in these two extraordinarily creative State administrations were to rationalize data between their two States, I think that would be quantum leap forward.

Mr. JOHNSTON. Well, we'll work on that.

Mr. SESSA. We've been trying to work with Massachusetts and some of their people.

Representative SCHEUER. Are there any other States besides Massachusetts and Pennsylvania that are really thinking creatively about cost containment strategy, and particularly uniform cost procedures?

Mr. JOHNSTON. I think so. I think there's an increasing recognition on the part of many States that this is necessary, and obviously the quality varies from State to State and the interest varies from State to State, and that's the reason why it's so important that we have national leadership on the issue.

I might point out, not because there's a representative here, but the Robert Wood Johnson Foundation has been I think a critically important ingredient in the mix in terms of helping to spawn creativity at the State level and the local level during the last decade or so.

Representative SCHEUER. In terms of creating uniform cost accounting systems?

Mr. JOHNSTON. Well, in part, but on these innovative health care initiatives in general.

Representative SCHEUER. Well, of course, they've been superb. They are head and shoulders above the field of foundations I suppose nationally in the field of health care which is their area of expertise and specialization. Our country would be poorer today without the efforts of this great foundation.

CONVERTING EXCESS ACUTE CARE FACILITIES

Mr. Johnston, you mentioned along the way that you are interested in converting some excess acute care beds into beds for long-term care.

How do ou do that? Do you take a whole hospital and convert it? Do you take a wing and convert it? Do you take a floor and convert it?

Mr. JOHNSTON. The legislation creates a conversion board because—well, I should begin by saying that we estimate that we have between 6,000 and 8,000 too many acute care beds in Massachusetts, so there was a conversion board created. It's a three-member board—the commissioner of public health, the commissioner of the new department of medical security, and the chairman of

the rate setting commission, and this is going to be a highly sophisticated approach to this in the political sense in that those three people will not be making the decisions only by themselves. Each time a hospital is interested in converting, they will come to the conversion board and there will be an advisory committee established which will consist of people from the local community who have the interest of health care needs in that community foremost in their mind, and decisions will be made in large part based on the health care needs first of that local community.

Just to give an example, we are about to deal with the first conversion. It's a private hospital in the city of Lynn, MA, which is on the north shore of Boston, and this is a hospital which is in very serious financial difficulty. It's going to have to make some major changes or they are going to go out of business, and that will be a resource lost to the city of Lynn.

Now it just so happens that at the same time that that hospital is about to go out of providing acute care business, right down the street in the town of Danvers, we, the State, runs a major State mental health facility which is very overcrowded. We have the capital money and the operating money to put some beds on the north shore for that mental health population. So my sense is that what will come out of this conversion process—I hope at least—is an understanding or agreement with the community and with the board of that hospital that it will be converted to at least in part to deal with this other need that we have on the north shore, which is psychiatric beds.

Now that's a terrific marriage of interest between the State and local community around health care needs. Now if we didn't have this process——

Representative SCHEUER. Now I take it that the citizens of the town of Lynn, MA, would have perfectly adequate alternative possibilities of having acute care beds available when they needed them, reasonably, convenient, and close to the town.

Mr. JOHNSTON. Yes, and that's a very important point. There are certain areas of the State where there's only one acute care facility. Cape Cod, for instance, only has one; and Berkshire only has one; and if either of those were to get into financial difficulty, we would do everything we could to support it so that it wouldn't go out of business.

But if you have a situation where you have one acute care hospital on one street and you have another one on another street right in the same community, which is the case in many instances in Massachusetts, and consumers are voting with their feet—they're going to hospital B and their occupancy rate is 92 percent and the hospital A occupancy rate is—by the way, Brookline Hospital, which is in that town which is becoming well known right outside Boston, has a 15 percent—that's 15 percent occupancy rate.

Representative SCHEUER. How can they stay open for 30 days?

Mr. JOHNSTON. I haven't the slightest idea, but we will be converting them to something else.

Representative SCHEUER. Let me ask you this. Why do they have a 15 percent occupancy rate? Is it because they have a high rate of iatrogenic error?

Mr. JOHNSTON. No. I think it's because——

Representative SCHEUER. Is it because consumers are making intelligent quality care decisions about that institution?

Mr. JOHNSTON. I think it's because consumers are making intelligent decisions regarding their health care needs in general. It's not necessarily a negative statement on that particular hospital, but they can go down the street and——

Representative SCHEUER. Now wait a minute. If the occupancy rate of that hospital is down to 15 percent, that has to send up a flashing yellow light or an early warning signal that something is going on there that's out of the ordinary. Why is it 15 percent? And is this because consumers now in Massachusetts have the ability to judge the quality of care for that hospital? Are you requiring information to be made available about serious accidents, or, as I say, hospital-derived infections, open wound infections, that would give people serious pause to go into that hospital, which would explain why the occupancy rate is down way past the danger point—it's down to the point of being economically dysfunctional or moribund. How do you explain why it went down that far?

Mr. JOHNSTON. Well, Karen Smith is going to comment on the specifics of this case, but the general response I think is that this is happening in many areas across the State, that Massachusetts has a host of high quality teaching hospitals and the reality is, I believe, that when all is said and done and it's your mother or my father or my child or somebody who is a close relative and you have a choice between a local municipal hospital and a high-quality teaching hospital with an international reputation, such as Massachusetts General Hospital or the Lahey Clinic, you're going to go to the latter. It's just as simple as that.

Ms. SMITH. I think we're also finding in a number of hospitals that it's not necessarily the case that the institution has a reputation for poor quality or inadequate care, but there are some internal things that have gone on. They may have made some decisions to cut certain services and develop a certain market for themselves, get rid of certain specialties and try to be strictly a geriatric kind of institution.

Representative SCHEUER. Then at least they would presumably have a higher rate of occupancy, a high patient load of geriatric patients.

Ms. SMITH. Well, those decisions haven't always turned out to be the correct market decision, as hospitals are finding out. There are other cases where physicians may have admitting privileges at several facilities and they decide it's more convenient to do most of their admissions at one facility and so the other hospital suffers. They just aren't getting the elective admissions that their competitors are, particularly in an area where you have hospitals close together. This particular one, Brookline Hospital, is almost across the street from a teaching hospital.

Representative SCHEUER. It's probably a rational and objectively justifiable process that moved the occupancy rates for this hospital down to 15 percent—some wise judgments were being made to produce that result. They weren't irrational judgments based only on physician convenience. There were probably a lot of the legitimate reasons that you have raised.

Can we extract any lessons from the experience of that hospital, having seen its occupancy rate go down to 15 percent and then being phased into another kind of health care facility—that we could apply nationally?

Ms. SMITH. I think one lesson that many people in Massachusetts have learned from this particular hospital is it's been at a low occupancy for years and people are not happy about paying the big administrative overhead costs to keep a hospital running for a handful of patients—literally a handful of patients. And I think if we can help hospitals to see their future more clearly and move more quickly rather than have years of expensive cost without any particular health benefit, that would be a real service in terms of controlling the costs. If you give hospitals options of easier ways to make those changes, hopefully it will save us money.

Representative SCHEUER. How does the State of Massachusetts help that hospital to see the light and begin to engage in the thought processes that would lead to important decisions on the kind of health care they should be delivering?

Ms. SMITH. In the case of the acute hospital conversion board, it's very explicit. When those hospitals look for the financial relief that they need to keep them operating, we say, "You need a strategic plan," and the financial relief is contingent on some very sensible decisions about their future.

Representative SCHEUER. Another answer would be, if you have to reduce the number of hospital beds by 5,000 or 6,000 as I think somebody indicated was required in the State of Massachusetts, why don't you simply help that hospital to close?

Mr. JOHNSTON. That's an option, but again, we have to take the health care needs of the community into consideration.

Representative SCHEUER. Well, you've already told us that there are other acute care options available.

Mr. JOHNSTON. In that case there are, but there may not be in others.

Representative SCHEUER. But in that case, isn't one option simply closing that hospital?

Mr. JOHNSTON. Sure.

Representative SCHEUER. Maybe converting it into a long-term nursing facility.

Mr. JOHNSTON. Actually, my understanding is that I think one of the teaching hospitals which is overutilized is purchasing this hospital and is simply going to use it as sort of a wing of its facility.

So you are seeing much more rational decisions being made now in Massachusetts in the hospital industry.

LESSONS FROM MASSACHUSETTS EXPERIENCE

Representative SCHEUER. All right. Why are more rational decisions being made in Massachusetts? How do we institutionalize that nationally? What are the micromanagement techniques applied to specific health care institutions that enable you to rationalize your State health care system? This is what a congressional hearing is all about. What can we learn from Massachusetts—Mr. Sessa, I'm going to ask you the same question about Pennsylvania—what can we learn from you? What golden nuggets can we ex-

tract from you that will help us rationalize our national health care system the way you seem to be doing really very successfully in both of your States?

Mr. JOHNSTON. Well, I think through legislation we are forcing—if I can use that term—collaborative planning so that all parties are now required to sit at the table and not just the hospital's CEO and board but community representatives, representatives of the State, representatives of local government, the legislature and so on, to be making these decisions jointly because we believe that this is really something that is a matter for the entire community to be participating in.

So I think the joint planning and the partnership theme, the fact that we have a strong rate setting process, the fact that we now have everybody involved, including the business community, very intensely in this new legislation really gets to the heart of what you need in a State to make these kinds of things happen.

Representative SCHEUER. And to make some tough decisions.

Mr. JOHNSTON. Yes. In the legislation we really had a tradeoff with the hospitals. We said, "We will approve higher rates for hospitals in general, but in exchange for that we want you to get serious about this closing/conversion issue, that we refuse to continue to subsidize 6,000 to 8,000 beds which we don't need. So you, as an industry, are going to have to work with us to either close them down or convert them to a more appropriate use." That was the tradeoff and there was a very explicit understanding on everybody's part.

Representative SCHEUER. And the private nonprofit health care community and for profits too, if there are any, just sort of bought into that? You achieved a consensus on that?

Mr. JOHNSTON. Yes, we achieved a consensus politically.

LESSONS FROM PENNSYLVANIA EXPERIENCE

Representative SCHEUER. Tell us what happened in Pennsylvania in this regard, Mr. Sessa.

Mr. SESSA. I think what happened in Pennsylvania, Mr. Chairman, is simply the fact that people realized that in order to do something about the problems you have to buy health care on value.

Representative SCHEUER. Health care on value?

Mr. SESSA. Yes, the value of the services being provided, and that includes cost and quality, and we have a demonstration program going on in Pennsylvania now titled "Buy Right" to teach the citizens and educate them on how to buy health care right, and when you do that you must have a decent, consistent reliable data base of information from which to buy.

As competition comes forth in the State, there will be hospitals that will go out of business. That's obvious. It's happening now. And as they go out of business, as long as we can make sure that there's adequate access to care for all citizens——

Representative SCHEUER. To acute care?

Mr. SESSA. To acute care, then I think we're on the right road. We are overbedded in Pennsylvania, like everywhere else, and if a hospital, for instance, like Scranton State has an occupancy level of

less than 25 or 30 percent, it's being closed down. That's the alternative and everybody has bought into that—the hospital workers, the hospitals themselves, the medical community—people know that there is no way that we can keep the current system going if people aren't using the hospitals and those beds are not used.

CONSUMER INFORMATION

Representative SCHEUER. And what kind of information do you make available—and I'm going to ask you the same question, Mr. Johnston—what kind of information do you make available to consumers that is physician specific and hospital specific to enable them to make intelligent choices as between comparable health care providers so that market forces work in the health care industry as they seem to work very well in all other aspects of our commercial life?

Mr. SESSA. The kind of information that will be available is information relative to the services that are performed in that institution, the episode of illness, the charges for that and the cost for that service, the type of services that are performed, the results of that service, whether or not the person who goes in with a low severity comes out and ends up as a mortality, and if there are a lot of readmissions and nosocomial infections, that will all be part of the report information that will be available. We intend to make that information readable, usable type information. That's the charge of the whole council and we've been working on that very hard.

Representative SCHEUER. The information is hospital specific and physician specific and nursing home specific, I take it?

Mr. SESSA. We haven't gotten into the nursing home yet.

Representative SCHEUER. Hospital specific and physician specific information will be made available not just to State licensing boards, not just to medical censure committees and so forth, but to health consumers?

Mr. SESSA. Everyone.

Representative SCHEUER. And you are designing it in a form that is intelligible to them?

Mr. SESSA. Yes.

Representative SCHEUER. And you're making it available in a way that is convenient and accessible to them?

Mr. SESSA. Publishing it in newspapers, making it available at the State agency offices, making access into the data base available to employers on a machine-to-machine basis, at all times respecting the confidentiality and making sure that there's no way of determining the specific patient information.

Representative SCHEUER. But you are giving them specific doctor information and specific hospital information?

Mr. SESSA. Yes.

Representative SCHEUER. How do you solve the problem of privacy, the right of a physician to practice incompetently, negligibly, drug addicted, alcoholic, mentally impaired—how do you cope with his claim for privacy?

Mr. SESSA. We're just going to compare him to a standardized norm that will come out of a data base. If in fact a physician in a certain DRG is compared——

Representative SCHEUER. What is DRG, for the record? What does that stand for?

Mr. SESSA. Diagnostic related group. In that particular group and he's compared with his peers in that group for a particular number of hospital admissions and his severity is a low number, say, a zero severity, and his outcome is not very good, say, a 35- or 40-percent morbidity, which means increased illness or sickness, and his charges are high, then that individual—obviously there's something wrong there and the reports will go back to the physicians and the hospitals to allow them to attempt to find out why it's that way. If there is a good rational reason we will accept that and that will be taken care of. If not, then obviously there is a lot of room for improvement there.

Representative SCHEUER. Well, let's just talk about how you get the information out to the consumer about that hospital, about that physician. Where is it available?

Mr. SESSA. It will be available in report form. It will be published in the local newspapers, a chart of the hospitals in the entire State, hospitals in various regions and physicians, showing the information that I just described and showing how that physician compares and that hospital compares to the norms in that region.

Representative SCHEUER. OK. Now the average person doesn't keep a clipping file of that kind of thing. They don't know when they're going to get sick. They get sick. Now they have to pick a hospital and a physician for a hysterectomy, for an appendicitis, for a quadruple heart bypass. When they are faced with a medical emergency and they have to pick a hospital and a physician, what do they do? To whom do they turn?

Mr. SESSA. Hopefully, that information will have been made available and it will remain——

Representative SCHEUER. Now made available how? Where do they go? You said it was published in the newspaper. That may have been 4 months ago and this person didn't know they were going to need to avail themselves of a doctor or a hospital.

Mr. SESSA. We will make reports available in the normal community access areas in the community centers, at the regional offices of States, in any place that we feel that a person who wants to avail themselves of this type information can come in and pick up the report. We will be doing this on a quarterly basis, so that information we will be trying to disseminate so it can be used by the general public. It's going to be tough. We're going to have to learn.

Representative SCHEUER. The business of dissemination is a very complicated and challenging one. I requested the OTA, the Office of Technology Assessment, to do a study on how we could empower consumers with information that would enable them to make these intelligent decisions as between alternative health providers—doctors and hospitals and so forth—and they worked for 2 years on it and they came out with a thick report—and I will be happy to send one to each of you—just a week or two ago. What the report said in essence is, it's possible to make this information available to consumers. This is doable. It ought to be done. But we're going to have

to do a lot of research about how we prepare the information in a way that is intelligible to health consumers and how we disseminate it. There was considerable discussion about dissemination alternatives. Should it be made available in post offices, in public libraries, in shopping centers, in grocery stores, or supermarkets where people have to go all the time. Should there be computer terminals where a person can ask a question, just punch a question into a computer at post offices, libraries, schools, high schools perhaps, and hospitals themselves? Should there be some kind of counseling service available for an elderly person who may speak another language and who may not be computer literate, as most adults over the age of 40 or 50 are not, myself included? The questions of both how you prepare it and how you disseminate it are two very challenging questions on which OTA said we need to do a lot of research.

I welcome the fact that Pennsylvania is going ahead with this and I think maybe you will give us a great hands-on working research and demonstration project as to how you do it, as to how you collect the information, how you prepare the information for the health consumer, and how you disseminate it. All three of those elements are very challenging and very sophisticated.

When are you going to start distributing this information or is that ongoing now?

Mr. SESSA. Well, the first type of information that I described, on a regional basis will be available at the end of 1988 and the beginning of 1989. On a statewide basis after we build the data base will probably be available the middle or the end of 1989 when reports will start coming out.

Representative SCHEUER. Well, to the extent you can be sure of anything, you can be sure that we will be in touch with you a year from now to find out how you're doing and to find out what lessons there are for the rest of the country and how we can extrapolate what you're doing.

Mr. SESSA. We'll be happy to do that.

Representative SCHEUER. Mr. Somers, do you have any insights to give us on this business of uniform data collection, making the data intelligible to the average health consumer to help them make decisions, and then disseminating that information in a way that is convenient and accessible for the average health consumer?

Mr. SOMERS. Well, I sense a sense of frustration on your part with respect to usable data for consumers and I think that that sense of frustration is shared by many of our board members. We are considering as an institution the possibility of devoting considerable energy to just the kinds of issues that you are talking about—uniform data and making it available. But we have not had a major initiative in that area or do not have any results that I can share with you at this moment.

Representative SCHEUER. Do you think the foundation might be interested in making significant grant funds available to research these three elements—the collection of uniform data, the preparation of data so that it is intelligible to the average health consumer, and then ways of disseminating that data that are congenial and acceptable and appropriate and convenient?

Mr. SOMERS. As I said, I think that there are people on the board of the foundation who feel exactly as you do and, for that reason, the institution is likely to move in a direction which will begin to address your concerns.

Representative SCHEUER. Very good. Well, does anybody have anything else to add? This has been an exceptionally interesting panel and we've gone way, way beyond our allotted time, which is really a reflection of how fascinating we found your views. Mr. Johnston.

Mr. JOHNSTON. I have just one final point on the dissemination of information. One approach to this, because I think it should be as localized as possible, is to take the now I guess defunded HSA's, the health service agencies, within the States and within the regions of the States—we've kept them alive in Massachusetts with some State money—and change them, where they used to be responsible for health planning at the regional level, we've now identified this issue that you've focused on as the primary problem for consumers at the local level.

Representative SCHEUER. Just say specifically what you're doing for consumers.

Mr. JOHNSTON. They will now be disseminating the information within their own regions and I think that's the vehicle—at least one vehicle to use.

Representative SCHEUER. Hospital specific and physician specific information?

Mr. JOHNSTON. Yes, but they haven't started to do that yet.

Representative SCHEUER. When are they going to start?

Mr. JOHNSTON. With the implementation of the new legislation. So we'll get back with you in about a year or two.

Representative SCHEUER. I think we're going to have a terrific hearing just about a year from now, same time, same place, and same cast of characters.

Thank you very, very much for an exceptionally interesting hearing.

PRIVATE SECTOR INNOVATIONS IN HEALTH CARE

Now we will move to the second panel with our apologies for the long wait. We know we overspent on our time but it was well worth it.

The second panel will describe innovations sponsored by business and labor and again we will receive information from folks who are working on solutions to the problems in the health care system, one representing business and one representing labor. We will hear from Mr. Dick Wardrop, director of health cost management at Alcoa, the Aluminum Co. of America; and then we will hear from Mr. Lee Saunders, assistant director of research for the American Federation of State, County, and Municipal Employees.

We are delighted to have you both. Why don't each of you take 7 or 8 minutes and chat informally if you can with us without reading, tell us what you're doing, what you're thinking, and don't hesitate to refer to anything you may have heard this morning either from the witness table or from us up here. I'll start with you, Mr.

Wardrop. Please take your 7 or 8 minutes and, of course, your full prepared statement will be printed in full in the record.

STATEMENT OF RICHARD WARDROP, DIRECTOR, HEALTH COST MANAGEMENT, ALUMINUM CO. OF AMERICA

Mr. WARDROP. Thank you, Mr. Chairman. I appreciate the opportunity to appear before you this morning.

I was told not to read my prepared statement. I didn't intend to do that and I had put down what I wanted to say in the way of remarks, but in listening to what I heard this morning I think I want to change even that.

I have the opportunity to see the health care system from a number of standpoints. I serve as the chairman of the board of trustees of the Washington Business Group on Health, which is about 150 large employers. You heard this morning about the Health Care Cost Containment Council of Pennsylvania. I serve as a member of that group and as chairman of the data systems committee, and Ernie Sessa mentioned this morning the buy right program in Pennsylvania and I also serve as the chairman of the Southwestern Pennsylvania Buy Right Council and, among other things, I serve as a member of the steering committee of the Robert Wood Johnson Affordable Health Care Program in Pittsburgh. So I have my hand in a number of things that we've already talked about today.

CONTROL UTILIZATION TO CONTROL COSTS

So I thought I might just talk in summary form where business is coming from. I recently chaired a meeting of some companies in the Washington Business Group on Health simply to talk about how are we doing in the management of the health care costs. We asked them to come prepared to answer some questions around how they are doing in kind of summary form. Most large companies have a number of initiatives around the health care issue. One of those strategies is around utilization control—precertification to get into a hospital, second opinion surgery, and concurrent review.

They generally feel pretty good about that strategy, but it is a control strategy. The reasons we have this strategy is we believe that providers are putting our people in hospitals when they don't need to be there, keeping them longer than they need to be there, and doing surgery that doesn't need to be done—which says we think there's something wrong out there and the something wrong is——

Representative SCHEUER. Which is precisely the message that Joe Califano gave us in our first hearing.

Mr. WARDROP. Yes, and Mr. Califano's article that he wrote in the New York Times on March 20 was very well done, right to the point.

So we feel OK around the utilization control strategy. We don't think we're going to do much better with that strategy than we've done. And like most control strategies, left in place long enough, the providers are probably going to capture it, like most control strategies. They will find a way over or around it. It's not a bad

short-term strategy and most companies are doing it simply because they feel things are out of control.

EMPLOYEE INVOLVEMENT IN COST CONTAINMENT

Most companies are doing something about the plan design of their benefits. We found that many of us had overshot the mark on what we provided in the way of benefits and that we did not have involvement of our employees in it at all. We believe that first dollar plans that remove the employee from any consideration of cost are not as good a plan as where they have some involvement. Not to the point that they will deny themselves care, but simply that they think about what they're going to do before they get the service.

Representative SCHEUER. Mr. Wardrop, you've really gone to the central nervous system. How do you draw that fine line that will provide some deterrent to health consumers overusing the system, in really silly, irresponsible ways—providing some deterrent, providing an attention getter let us say, but not deterring a person who is living at the margin let us say economically from accessing the health care system, when a little preventive care early on could save society large amounts of dollars when that person really gets sick, when that sickness could have been avoided by a little preventive care early on? How do you draw that fine line?

Mr. WARDROP. Well, I don't know that I know how. I know how we've done it.

Representative SCHEUER. Tell us how you've done it.

Mr. WARDROP. In our nonbargained plans, we have taken a first dollar plan and provided a deductible of $100 per person, 20 percent copay with a maximum out-of-pocket expense per family of $700 a year. We don't find any evidence that with those kinds of copayments and deductibles that our employees are denying themselves or their dependents necessary medical services.

Now I'm jumping ahead to a strategy that would—another way to get at the problem would be that if we could identify the providers who provide appropriate care at fair prices, put them financially at risk to provide those services, then you don't need to have the deductibles and copayments.

Representative SCHEUER. You're talking about, for example, an HMO?

Mr. WARDROP. A managed care plan.

Representative SCHEUER. An HMO would be that, would it not?

Mr. WARDROP. Except the difference in the one I'm taking about is different than what we have today in that you have identified a group of providers that provide appropriate, efficient care at a fair price. There is no evidence today—the very thing that was talked about earlier is we don't know—we don't have the information of which providers are really better than other providers. That's the missing piece.

Let me describe some activities that are going on.

Representative SCHEUER. Before you finish, would you describe to us—maybe do this at the end of your testimony—how we get that data, how do we figure out how to produce that missing piece.

Mr. WARDROP. OK. Let me take a crack at it now. There are lots of thoughts around this and there are a lot of people working on it. The Pennsylvania legislation was a start to get some quality information. The law required us to select a methodology by which we could get severity index outcome measures. It's a piece of quality. It is measuring quality and publishing it.

Measuring quality, however, doesn't improve it necessarily, unless you do something about it. The strategy that I like is the one in which we at Alcoa—Alcoa's new chairman, Paul O'Neill, has a very good approach to this problem. He became chairman last June and he's identified quality as one of the key agenda items for our company. He takes quality not only as we're going as a company to produce quality products, but that we should expect to buy quality products from our suppliers. And he has said to us who are trying to work in the health care area, we should expect from the suppliers of health care no less than we expect the same kind of quality from other suppliers.

So we are now talking to our suppliers, which are the providers of health care, on the same basis that we talk to the provider of lift trucks. He told a very interesting story about that. As he visited one of our plants he found oil on the floor and he kept asking why is there oil on the floor in our plants, and they said, "Well, we have hydraulic lift trucks and hydraulics leak." So he said, "That doesn't make any sense. Why don't we go to the supplier and say, "We want lift trucks that don't leak." And we did, and they fixed it.

We had never demanded of them, it was just a given that hydraulics in lift trucks leak. And the same thing is true in medicine. We have never demanded of the health care anything different than what we get, and we're to blame for that. We have bought health care dumb. We give our people tickets to go out and buy health care. They spend them. Two weeks later we get a bill. We argue about the bill, whether it's reasonable or customary. We argue whether everything was done. We pay it and we knew nothing in advance about what the price was going to be and we knew nothing about quality.

So our intent is to change the way we buy that health care, to buy for value, as I said earlier—price and quality.

Representative SCHEUER. We don't even let the health care payers negotiate with the health care providers; isn't that right?

Mr. WARDROP. Well, we can.

Representative SCHEUER. Of course we can and we should. Talk about dumbness. If you don't let a large-scale purchaser of health care—a large-scale payer of health care—negotiate with the providers, you're not letting those market forces work. I mean, that is the essence of dumbness, to put it in your own words, and I don't mean to put words in your mouth, but that is just a glaring example of the economic flaws in the health care system where the large-scale

payers, the large-scale insurers, can't negotiate with the providers on rates and on payments schedules.

PROMOTE BETTER LIFESTYLES

Mr. WARDROP. Let me come back to one of the strategies that business likes as a strategy and we talked about a couple of those. The one strategy that we think holds promise of the things we've been doing is the lifestyle change. Most companies believe that 30 to 50 percent of all of our total health care costs are the result of what our people and dependents do to themselves. That is, smoking, drinking, obesity, and stress—all those good things we do to ourselves.

Representative SCHEUER. Drugs?

Mr. WARDROP. Yes, alcohol and drugs. If you believe that 30 to 50 percent of your total health care costs are the result of what we do to ourselves, then we ought to be investing in trying to get our employees and their dependents to change their lifestyle. The major companies like that strategy, recognizing it's long term, but we're going to get together—that group—again later this year and talk about that strategy because to the extent you can keep your people from getting sick in the first place, you don't have to worry about managing the cost of the health care. Incidentally, we keep calling it health care and really what we're paying for is sickness care. There's not much in what we do that really is around health care.

SYSTEMATIC PROBLEMS IN HEALTH CARE SYSTEM

So that strategy, as a long-term strategy, is one that holds promise for us. I guess the bottom line, though, when we get all through looking at the strategies, plan design changes, we've come to the point that generally the large companies don't think that what we're doing is enough to really get at the thing. There are systemic problems in the health care system and we have to get at those systemic problems that exist.

Representative SCHEUER. Are you going to describe these systemic problems for us?

Mr. WARDROP. Well, the quality problem is one. The access problem is two. Those are the systemic problems that we see in the system.

Business is not looking for a quick fix. We're not looking to just shift costs from us and solve our own problem. We realize we can't do this by ourselves and I think that came across in the early testimony, that any segment in this whole thing that thinks they can solve it by itself—we don't think we can. The business community really looks forward to working with all the interested parties and hopefully make good public policy decisions around the health care issue.

Thank you.

[The prepared statement of Mr. Wardrop, together with attachments, follows:]

PREPARED STATEMENT OF RICHARD WARDROP

Good morning, I'm Dick Wardrop, Director, Health Cost Management for Alcoa. I also serve as Chairman of the Washington Business Group on Health, Chairman of the Buy Right Council of Southwestern Pennsylvania and as a member of Pennsylvania's Health Care Cost Containment Council. Health care costs are a matter of grave concern to American industry. They are the largest uncontrolled cost of doing business, escalating at rates higher than most products or services we buy with little or no evidence of health improvement in our employees or their dependents. The health care industry has increased its share of GNP to above 11% and American industry is paying about $150 billion of the $550 billion bill. What are we going to do about it?

My testimony will be divided into two parts: what large companies are doing to manage health care costs and specific information about what Alcoa is doing.

First I'll share the results of an April 19, 1988 meeting of a group of Washington Business Group on Health Companies. The purpose of the meeting was to review the initiatives companies are using, what seems to be working, what isn't working, what will they continue using and what are they not now doing that they think they should be doing. Most companies reported that they have changed their non-bargained health care plans from first dollar plans to comprehensive plans with deductibles and co-pays. However, most companies reported that they had not been successful in negotiating to comprehensive plans from first dollar plans with their unions.

While comprehensive plans tended to decrease overall costs to the company, many felt this was not affecting utilization of health services. Others thought that comprehensive coverage positioned them toward more managed care, in that employees were becoming more aware of the costs associated with health care services and thereby partners in controlling costs.

All companies reported they are using some kind of utilization controls: pre-certification for hospitalization, concurrent review, or second opinion surgery. All agreed that while utilization reviews initially served as an effective strategy for controlling inpatient coverage, the shift to outpatient procedures has increased and little information was available on how to better control these costs. The feeling was that we should keep utilization controls in place because of the sentinel effect, but with the passage of time they will become less effective, because being a "control" strategy, the providers will find ways to go around controls.

We agreed that we needed to manage wage replacement costs during disability. Most companies pay wage continuance at full or reduced levels to employees who are unable to work because of personal sickness or injury. We agreed that leaving the return-to-work date up to the employee and his/her physician will result in high wage replacement costs. Good management should produce a 25% reduction in wage replacement costs.

The group strongly supported health promotion/lifestyle changes as a good long term strategy. To the extent we can keep our beneficiaries healthy you don't have to pay health care costs. We agreed the challenge is to get those who are leading bad lifestyles to change. Too much of what we have been doing is making it easier for those who already lead good lifestyles to continue to do so. There was some concern expressed over which health promotion activities are cost effective, but most of the group felt the opportunities in this area are so great that we must make the investment. We also agreed to have a meeting later this year on health promotion.

Prior to the meeting each company had been asked "What are your company's goals/objectives around the health care issue?" We found a hierarchy of objectives from health care cost containment to health care cost management to health management to healthy employees/healthy company.

The group expressed doubt that our present cost management activities would enable us to reach our objectives. We agreed to a next meeting to look at the market reform strategy which would involve a fundamental change in the way we purchase health care. Instead of buying retrospectively with little or no information on price and quality we would buy prospectively for value-price and quality.

The group concluded by stressing the need for employers to take a more proactive role in influencing health care policy at both the state and federal level.

Let me turn now to what Alcoa is attempting to do about health care. August 24, 1987, Fred Fetterolf, President and Chief Operating Officer wrote a letter (Attachment 1) to our management outlining the problem and what he wanted to have happen in Alcoa. Attachment #2 is a copy of Alcoa's Strategies Relating to Health Care.

Most of our health care costs occur at the plant level in our business units. We are developing a network of plant people to implement our strategies. The strength of our effort is that group of people who understand their local provider community and the needs and desires of our own employees and their dependents. They now have data (except quality). WE are working on the quality piece because we intend to purchase health care for value - price and quality.

C. F. FETTEROLF

PITTSBURGH OFFICE - 30 August 24, 1987

RE: HEALTH CARE COSTS

Alcoa's health care costs continue to escalate at unacceptable rates. A few years ago our annual costs were escalating at about the same rate as the Consumer Price Index (CPI). Our current rate of escalation is about three times CPI. While the rate of increase is somewhat lower than it was we must attack the problem more aggressively.

To help us get our arms around this problem we have asked Dick Wardrop to take on a special assignment for the next 17-18 months to implement the Company's health care strategies.

This effort has the support of the Operating Committee and I urge everyone who impacts our health care costs to work with us so we can realize the greatest possible progress.

I have asked Dick to concentrate his work at the plant level of the business units where most of our health care costs are incurred. His activities will include:

1. Train at least one person at each operating location on ways to manage local health care costs.

2. Provide location management with specific data that will identify cost and suspected quality problems.

3. Assist locations in developing techniques to use data to change the behavior of employees and providers.

4. Pursue getting local health care providers to furnish us with quality data.

5. With good price and quality data move toward a more competitive health care system by changing the way the Company and our employees purchase health care.

I'm convinced that every plant can benefit from Dick's expertise in this area.

Please give him your full support.

C. F. FETTEROLF

Company-wide distribution

ALCOA'S STRATEGIES RELATING TO HEALTH CARE

1. Utilization Controls

As a minimum, our plans should have:

- o Pre-certification for non-emergency hospital admittance.
- o Concurrent hospital review.
- o Mandatory second opinion for a limited list of surgical procedures.

Our present Pathfinder meets the minimum standard and is a good short term strategy, but is subject to "gaming" by the providers. Depending on prior in-patient utilization, we can expect the above utilization controls, properly administered, to reduce total plan costs by 4% to 6%.

2. Plan Design

The strategy is to have plan design that encourages employees to receive appropriate services in the most cost-effective setting. We believe the Comprehensive Plan (with deductible and co-payments on all coverages) is a better design than the first dollar plan, which has deductibles and co-payments only on Extended Medical expenses. Recent effective design changes include paying for out-patient alcoholism rehabilitation and paying S & A for out-patient surgery.

Our plans include provision for non-duplication of benefits. We should continue to carefully monitor our plans for design changes that will make them more effective.

3. Manage Administrative Costs

The cost to process claims, perform cost management activities and related services are about $3,500,000 per year or 3½% of claims paid. In 1978 and again in 1985, we put out an RFP to test the market to determine if our costs were in line. We believe our present self-funded arrangement with two administrators with whom we annually negotiate fees is effective. We should put out another RFP in 1989 or 1990.

4. Manage Wage Replacement Costs

In 1982, we developed a program to manage S & A costs. The results of our location's effort have been dramatic. Our annual S & A costs per employee in 1982 were $410.15. The costs/year declined to $391.89 in 1983, to $321.36 in 1984 and $298.64 in 1985. In 1986, they increased to $311.99. The cumulative direct savings over 1982 are $5,700,000. We need to review our program, renew our efforts and apply the same procedures to our salaried employees.

5. Health Promotion

This is a long term strategy directed at changing the lifestyle of our employees and dependents. About 50% of our total health care costs result from what our employees and dependents do to themselves - smoking, stress, obesity, drugs, alcohol, etc. There are programs and services available to help change behavior to lessen the impact on our costs and improve health. There is not, however, conclusive proof that these interventions are cost effective. Alcoa should continue to pursue health promotion and life style change as a strategy even though they may not be proven cost effective.

6. Become Active Purchasers of Health Care

For too long, we have been paying for health care on a retrospective reimbursement basis with little or no information on price and quality. We must be active purchasers of health. We must purchase based on price and quality - for value. To do that, we must identify the efficient providers and reward them with our business. We have good data on price, but we have virtually no data on quality. We need severity adjusted medical outcome data. This data is not readily available today. We must get providers to collect this data and provide it to us. Armed with price and quality data, we can become good purchasers. We can purchase through a variety of forms: case management, PPO's, HMO's, managed care, etc. and we can provide information directly to our employees so they can purchase in those forms or in our regular indemnity plan. The important goal is based on price and quality to purchase.

In addition to the above strategies, there are a number of activities in which locations should be involved:

- off-the-job safety efforts, such as defensive driving for employees and their dependents;
- The further use of in-house medical programs in which our physicians selectively provide appropriate and cost effective health care to our employees;
- participation in local health care coalitions;
- continue efforts that we have at our locations with our unions on health care cost containment; and
- hospital trustee education program.

The strategies and activities are a sizeable task, and while we have undertaken some, we should pursue all of the strategies with vigor.

Representative SCHEUER. Thank you very much for your testimony, Mr. Wardrop.

Now we will hear from Mr. Saunders. Take your 8 or 10 minutes. In fact if you go over the 10 minutes we'll cope with that.

Mr. SAUNDERS. I don't think I can go over my 10 minutes, Mr. Chairman. I'm on my way to Los Angeles. I have a convention out there.

Representative SCHEUER. Very good. I apologize for keeping you so late. You've been very generous and tolerant.

STATEMENT OF LEE SAUNDERS, ASSISTANT DIRECTOR OF RESEARCH, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

AFSCME APPROACH TO COST CONTAINMENT

Mr. SAUNDERS. It's always interesting for me to listen to these technical experts in this area to talk about the ways in which health care problems in this country can be resolved. I think I'm going to come at it from a different angle.

I am the assistant director of research for the American Federation of State, County, and Municipal Employees, representing approximately 1.4 million State and local government workers across the country. In negotiations all over the country I deal with the issues that impact on our members. And I think it's very safe for me to say this year and in the years to come that the costs of health care will be the No. 1 issue that the union and employer will face.

In recent negotiations, for example, in the States of Minnesota, Ohio, and New York, health care was the No. 1 issue. In those States we were faced with the employer coming to us and telling us that in fact their costs were increasing at a much higher rate than the average health care costs. As a matter of fact, in the State of Minnesota, we were faced with a 50-percent premium increase—50 percent. Obviously, we have to deal with that. Either the employer is going to have to eat that cost or the employee organization is going to have to sell a package to the members saying that your premiums are going to increase.

That's the type of climate that we're dealing with right now. We happen to think that there are a number of ways in which costs can be curtailed or contained without shifting that cost to the employee. Let me be perfectly honest with you. In negotiations across the country, the first attempt by the employer, by management, is to shift the increased costs of health care to the employee. We don't happen to think that way. Mr. Sessa from Pennsylvania will recall that when we were first presented with that problem in Pennsylvania in 1983 I believe it was, that was the employer's view—that our members would have to accept a greater burden in sharing in the cost. What was our response to that? It's the response that we have really tried to tailor all across the country and that is the formation of working labor-management committees that specifically deal with health care costs, that specifically deal with health care cost containment, and I think that we've been very very successful in doing that. The committees are normally represented equally by management and labor, individuals that are

really technically involved and know about the specific subject matter, and we hold the health care providers accountable.

NEED ACCOUNTABILITY IN COST PROJECTIONS

There has never been a checks and balances system in the health care industry in this country. Why do I say that? We have accepted projections by third parties, by the Blues, by Connecticut General, on face value. If they tell us that the cost is going to increase, we have accepted that. Either the employer or the employee has had to pay more. We aren't doing that now. We're asking for specific information which really requires them to be accountable to us as consumers, and the employer is asking for information which justifies their position.

We had a meeting with the Blue Cross-Blue Shield people a couple of months ago in Washington at our headquarters and we mentioned specific problems to them regarding the accountability question. Where are they coming up with the cost projections that will ultimately impact on our members? And they had no answers for us. They had no answers.

We have to hold the third parties accountable.

COST CONTAINMENT MEASURES AND AFSCME

Now how do we deal with some of the health care cost containment measures and what do we try to impress upon our members? Education has been talked about today. Some of the most difficult ratification meetings that I've ever been involved with have been when we have recommended changes within the health care delivery system as it impacts on the members. As a matter of fact, in many areas across the country, in the ratification meetings where I know that people are going to be a little upset about some of the changes that the union leadership is recommending—I've been looking for the nearest door to run out of because the meetings have been chaotic. People do not like change within the system.

Representative SCHEUER. I really regret interrupting. What are the kind of changes that your union members are most sensitive about?

Mr. SAUNDERS. Any change that they feel may impact on the benefit level that they have received or are currently receiving. When we propose, for example, no weekend stays, people get very upset about that. When they want to go to a hospital, they want to go to a hospital. When we propose that in fact you should go to a second doctor to determine if the first prognosis was accurate, people get very, very upset about that. They want to go to their doctor and when their doctor tells them that something is wrong they want to accept it at face value and they want it taken care of.

These are measures in which costs can be contained, but it's very, very difficult for us to impress upon our membership that in fact these changes must take place to control costs. My profession can be very dangerous at times. We've been successful at making changes through education, through our union publications; we have really placed a priority on attempting to contain health care costs. Increases in health care costs impact directly on the ability

of the employer to provide increases in wages, benefits, and so forth.

So those are the types of things that we're attempting to deal with and I think this morning we've all talked about ways in which health care costs can be contained to some measure. I'm not confident that that's going to be the total answer to the problem.

In New York State, for example, we just came out of negotiations and some of our members are going to have to accept the added burden of paying for HMO coverage which they have not done before. There were some people that were not very pleased with that, but the union had a responsibility to be realistic with the membership.

So even though we've had places where health care cost containment and labor-management committees have been in effect for a while, such as Pennsylvania, New York, and Detroit, MI, costs are still increasing. Many of our members are ending up having to pay more for health care. I think that government, politicians, unions, the employers, and the third parties are going to have to get together and fight this problem of how we can control costs in a collective manner, not on an individual basis. This is everyone's problem. Thank you, Mr. Chairman.

[The prepared statement of Mr. Saunders follows:]

PREPARED STATEMENT OF LEE SAUNDERS

HEALTH CARE COST CONTAINMENT--AFSCME'S PERSPECTIVE

Chairman Scheuer and members of the Subcommittee, I am Lee Saunders, Assistant Director of Research of the American Federation of State, County, and Municipal Employees. AFSCME is the largest public employee union affiliated with the AFL-CIO in the United States and represents 1.4 million people across the country.

While the United States health care delivery system is considered to be the most advanced and sophisticated system in the world, it is also the most expensive. In 1982, American's spent $322 billion on health care services. By 1987, this had increased to $499 billion or $2050 per person. The Department of Commerce forecasts that 1988 expenditures will increase to $544 billion or over 11 percent of the total U.S. Gross National Product.

While total U.S. health care expenditures are projected to increase by 9 percent in 1988, the costs of health care premiums confronted by employers, with whom we bargain, will continue to increase at a much greater rate. We are witnessing a trend in which premium costs are now increasing 20 percent to 40 percent a year. Within the last 12 months several state plans have had increases of over 50 percent.

These premium increases have begun to erode the hard earned health benefits workers have struggled so long to secure. Rather than addressing the causes of health care costs,

employers have often responded to the problem by trying to shift the increased costs to the workers.

Shifting the burden is not a solution. While the task of controlling health care is a difficult one, it is a problem that readily lends itself to labor and management working together to find a solution. Managers are looking to reduce costs, yet also recognize the importance of good medical care for their employees. Unions find that increased costs for medical care are beginning to affect bargaining on wages, salaries, and other benefits. Recognizing this shared interest, AFSCME urges public employers to join in forming labor-management committees to work on reducing health care costs without cutting benefits or reducing the quality or the access to care.

Generally joint labor-management committees are established during the course of negotiating a contract. For example, during 1983-1985 contract negotiations, the Commonwealth of Pennsylvania facing a 22 percent increase in premium costs confronted AFSCME Council 13 with a proposal that employees begin to pay a portion of the monthly cost of their health insurance. As an alternative, AFSCME proposed and the Commonwealth accepted the creation of a Joint Health Care Committee with the single purpose of reducing the state's cost of health coverage.

Due in part to a committee-developed, union-based education program focusing on the problem of increasing costs and techniques for members to become smart shoppers for health care, the overall cost of health care dropped almost $50 million in the first year. This joint effort preserved the level of benefits without shifting costs or requiring further employee out of pocket medical care expenditures. Recently this joint effort expanded beyond cost containment to joint labor-management administration of the entire program.

Another example involves the State of New York where AFSCME represents over 130,000 state employees. Confronted with escalating health costs, AFSCME and the state created in 1985, and reconfirmed this year, a Joint Committee on Health and Dental Benefits. The work of the committee is supported financially by the state.

Under the current contracts, the state must receive the approval of the committee in order to change insurance carriers. In addition, HMOs must be approved by the committee before they can participate in the program. With the goal of seeking new ways to reduce costs while maintaining quality care, the committee is directed by the contract

"to conduct an extensive and thorough review and analysis of current plan administration, benefit plan design and utilization. Recommendations on ways to improve the effectiveness of either area will be solicited from appropriate state agencies and external sources. Their findings and

recommendations shall be submitted to the Joint Committee for their consideration. A major focus of the study will be hospital, physician, and other provider practice patterns which effect utilization levels and subsequently impact employer and employee costs."

The committee is charged with reviewing and overseeing the operation, utilization, hospital precertification and cost containment provisions of the health plan.

In addition to working with individual employers, AFSCME joined with the U.S. Conference of Mayors and the National Public Employer Labor Relations Association to publish, with the financial support of the Federal Mediation and Conciliation Service, The Labor-Management Guide to Health Care Cost Containment. The guide offers detailed advice to labor leaders and managers attempting to achieve health care cost containment.

While I will not summarize the entire guide here, I will highlight the major cost containment strategies we have identified:

Plan Redesign

Since inpatient hospital care accounts for more than one-half of all health care expenditures, efforts directed at encouraging the use of less expensive alternatives to inpatient hospital services and limiting the length of necessary hospital stays offer a real opportunity to control costs. Strategies and techniques to achieve these goals include:

1. **Mandatory Pre-admission Testing:** Not all tests related to non-emergency hospital confinements need be completed in a hospital on an inpatient basis. By completing tests in a physician's office, clinic, laboratory, or outpatient department of a hospital, the patient's hospital stay may often be reduced by one or more days.

2. **Mandatory Second Surgical Opinions:** Most patients ask more questions when buying a car than they ask before facing surgery. The U.S. Department of Health and Human Services estimates that 2 to 4 million unnecessary operations are preformed each year. Patients should be able to find out if the recommended surgery is the best treatment for them without incurring additional out of pocket cost.

3. **Mandatory Outpatient Surgery:** Many non-emergency surgeries qualify for an outpatient program. Most require local anesthesia or short exposure to general anesthesia, or do not require overnight monitoring of the patient. They include such procedures as taking tissue samples, removing tonsils, setting broken bones, and removing cataracts.

4. **Utilization Review Programs:** Over-utilization is primarily a problem with hospital care, where the patient is held longer than medically necessary or where identical medical

treatment could have been provided less expensively on an out-patient basis. A utilization program directs the patient to less costly out-patient benefits, such as out-patient surgery, home health care, pre-admission testing, and out-patient diagnostic services (including second surgical opinions), or eliminates medically unnecessary admissions and pre-operative and non-acute care days.

There are three times to review -- before a patient goes in the hospital (pre-certification), while the patient is there (concurrent), and after the patient leaves (retrospective).

Precertification generally calls for a review of planned hospital services. All patients must receive prior certification to enter the hospital in non-emergency situations. In the recent AFSCME-New York State agreement precertification has been expanded to include all surgical procedures except those performed in the doctor's office.

Concurrent Review involves an analysis of each hospitalization to determine whether the patient can be released or needs to stay in the hospital. This review could be very effective in limiting the number of non-necessary days a patient stays in the hospital.

Finally, a Retrospective Review involves a determination if the care received by the patient was appropriate and, therefore, reimbursable. If problems arise from this review, there will be discussions with the hospital to correct the problem.

5. **Increased Emphasis on Home Health Care:** While this coverage is included in most health plans, it is used by few employees. It is less expensive and often a more effective alternative for individuals who need professional medical care but who do not require the constant supervision and sophisticated medical equipment of a hospital.

6. **Restrictions on Friday and Saturday Admissions:** Few elective surgeries are performed on weekends. Weekend hospital care tends to be more custodial than acute. Plans should not be subsidizing a hospital's goal of full occupancy over the weekend. Emergency admissions, including maternity admissions and emergency room admissions would be exempted from the restrictions.

7. **Maternity Incentive Plan:** One approach to lowering the cost of maternity care is to reduce the number of days the mother stays in the hospital for a normal or uncomplicated delivery. Cash payments and free follow-up services are being offered to mothers who return home within one day of uncomplicated delivery.

8. Hospice Care: As an alternative to inpatient hospital care for terminally ill patients, hospices provide medical services to make the patient's remaining days as comfortable as possible and counseling services for both patient and family.

Claims Control

In many cases, health care plans can save money by reinforcing administrative and claims controls. Techniques which might be considered include:

1. Claims Audits: In many plans, the claims administrator reviews or audits only major hospital bills. Since overcharges and charges for services occur as frequently in moderate size bills as they do in larger ones, consideration should be given to reducing the audit threshold.

2. Patient Hospital Claim Audit Incentive: Under this audit approach the patient reviews the hospital bill and receives a percentage of any overcharges that they are able to identify.

3. Workers' Compensation: Frequently treatments for job related injuries and illnesses are charged to the workers medical benefits plan instead of workers' compensation. Many employees do not understand workers' compensation, and many employers and plan administrators do not effectively follow up on work related injuries or illnesses.

4. Other Administrative Strategies: Controls on administrative charges and the reduction of double billing through better efforts of coordinating benefits from different plans can also reduce costs.

Not all plans are able to or should incorporate all of these plan redesigns and administrative changes. A careful and thorough analysis of the particular plan, the utilization by its participants, and the health care delivery system servicing the area are necessary before an effective plan redesign effort can be initiated.

Health Maintenance Organizations

In some areas, HMOs have achieved significant savings by emphasizing preventive care and avoiding unnecessary hospitalization costs.

Medical Case Management Programs

Medical case management involves third-party health professionals, frequently registered nurses, working with seriously ill or catastrophically injured patients, their families and doctors to evaluate the patient's continuing medical needs. Using this information, these medical case managers

coordinate with the treating physicians and the insurer in the implementation of the most medically appropriate and cost effective treatment plan.

Wellness Programs

Ultimately, the answer to health care cost containment is just what labor unions promote--the improved health and well-being of workers. To work on the prevention of illness and disease some public and private sector employers have also developed health promotion or wellness programs. These programs encourage healthy lifestyles and try to identify health problems at early stages. Organizations with long-standing established wellness programs have found that the employer also benefits with improvements in morale, employee recruitment and retention, and community relations. Examples of activities include:

Health Education: A health education program can teach participants not only how to use their health plan (e.g., Commonwealth of Pennsylvania), but how to identify symptoms and to select the appropriate level of care.

Early Detection Programs: Early detection programs identify illnesses or diseases in the early stages through health screening and health assessment programs. Health testing might be done to detect problems with high blood pressure, glaucoma, diabetes, or sickle cell anemia.

Fitness Programs: Fitness programs can be offered to employees in a variety of ways. Some employers offer fitness memberships to health clubs, present programs and workshops on diet, smoking cessation, and managing stress. The State of Illinois offers partial payment under the health insurance plan for employees who successfully complete a stop smoking plan.

As shown by experience, cost containment efforts can address the real causes of rising health care costs and in fact have been effective. Cost can be contained without shifting cost to employees, without reducing benefits, and without reducing the quality and access to health care.

AFSCME has been actively working to contain run-away health care costs since 1979. We have led the way in plan improvements and will continue to work with public employers to guarantee that our members' gold cards, their health insurance cards, retain their value.

HEALTH PROMOTION INCENTIVES

Representative SCHEUER. You say the members don't like paying more. Is there any way we can hook additional payments to them as an incentive for them to make the changes in their personal behavior that are going to reduce health care costs? Is there any way we can sort of extend a quid pro quo to them, if you'll take off 30 pounds, if you'll stop smoking, if you'll reduce your alcohol consumption, if you'll get off drugs, if you'll adjust your diet, if you'll exercise regularly, we're going to make thus and such concessions because you're helping us to not only improve your own health but also helping to reduce the health care costs burden on this company.

How do we work with a carrot as well as the stick to induce them to change their own behavior?

Mr. SAUNDERS. In a number of areas we've been successful in developing wellness programs. For example, in the city of Indianapolis where I was involved in negotiations 2 years ago, there is an incentive for employees to participate in wellness programs. Employees who participate pay no health premiums, those who do not must pay a certain amount toward coverage. Now that was not received well by the membership, but what we attempted to do in that area was to educate our members saying, "Look, health care costs are escalating. If you take care of yourself, if there are alcohol and drug programs, if there are employee assistance programs, things of that nature, which may keep you out of having to go to the hospital, then you have to take advantage of that." So we have been successful in dong that.

Representative SCHEUER. How was that received in practice?

Mr. SAUNDERS. It was a rough sell initially. I would expect that it would be an easier sell or it would not be as difficult in those areas where established health care cost containment programs are in effect. It's my understanding that in Indianapolis it's an accepted practice now. There's no discussion about it. I don't think you will hear a member talk badly of the program, but initially when we had to make that first change, it was a rough sell for the union. But it's in practice now and it works.

Representative SCHEUER. Well, that's very interesting. Do you think that concept is capable of being extended, extrapolated? Is that a possible answer? Giving a real incentive to people who go into a wellness program and think about changing their own personal behavior and a disincentive for those who refuse to do that?

Mr. SAUNDERS. I think that's a part of the answer and I think that can be done. But again, I'm not convinced that that's the total answer to deal with the problem of the increasing costs.

Representative SCHEUER. There isn't any one total answer. We're all knowledgeable enough in this room to know that there is no simplistic single answer. It's a whole bunch of incremental things that add up and produce real change. I'm impressed with this story that you've just told us about the wellness programs in providing a disincentive for a worker refusing to engage in it and providing an incentive for those workers who do go in it.

Is there an incentive for those who do go in?

Mr. SAUNDERS. Yes. The employer picks up the total health care premium. If the employee decides against participation, they must pay a certain amount toward coverage.

Representative SCHEUER. Well, that sounds like a great idea.

Mr. SAUNDERS. Now that worked in Indianapolis. I'm not saying that it can work everywhere.

Representative SCHEUER. What is there so unique about Indianapolis that if it worked there it isn't susceptible of being tried elsewhere?

Mr. SAUNDERS. Let me say, Mr. Chairman, that I don't know if I would be alive today if I tried to sell that program in every area where I negotiate contracts.

Representative SCHEUER. Why?

Mr. SAUNDERS. Because of the problems I think that people have with changing their health care system. That's a dramatic change for an individual who has relied on the health system in the past.

Representative SCHEUER. But you say it's working in Indianapolis and they grew to accept it and perhaps even to value the benefit to them of being engaged in a wellness program that they aren't paying for.

Mr. SAUNDERS. I think there are a numb of ways that you can control costs. That is one of the ways. Establishing labor-management committees and reviewing the utilization patterns and redesigning programs are other ways, and we've been successful in implementing those types of practices all over the country.

Representative SCHEUER. How do you react, Mr. Wardrop, to the experience in Indianapolis, a requirement to participate in a wellness program and a disincentive if you don't?

Mr. WARDROP. We have not tried either of those two things. I guess we look at the lifestyle thing as a win-win situation. It's largely an education job. The challenge that we have is to get the people who lead bad lifestyles to change. Too much of what we've done up until now is make it easy for people who lead bad lifestyles to do it. We find the exercise programs that we have used, that 90 percent of the people in one location use the facility that we provided, but the 90 percent of them were going to exercise anyway. The challenge is to convince those people who lead bad lifestyles and I'm not sure that either a penalty or a reward is right. You have to teach those people that they are winners if they can improve their health. We have a tremendous education job to do. It was mentioned this morning. We have a tremendous education job in this country around this issue. We start with the problem that most of the people in this country believe that they should have access to all the health care that they think they need and somebody else ought to pay for it. It's engrained in us that we ought to have all we want and somebody else ought to pay for it. We have an education job around that and it's a significant one and it's going to take a lot of people and it's going to take companies and government to change that.

Representative SCHEUER. I totally agree with you and I totally agree with your estimate of 30 to 50 percent of our health care costs involve mismanagement of our own personal behavior in just the areas you mentioned—alcohol, tobacco, drugs, lack of exercise, lack of diet control—we've met the enemy and he is us. But Mr.

Saunders seems to have come up—at least in Indianapolis, with what he says has been an accepted program with pretty rough going in the first few years perhaps but now it's very well accepted that either you get into a wellness program and benefit from it or it's going to cost you. He had some rough times in the early years but now it's accepted.

Mr. SAUNDERS. Let me just add something else too. I think the problem that's staring us in the face right now is this. Whenever I'm involved in negotiations and I'm dealing with the employer and they're telling me that your members are going to have to accept a premium increase of 50 percent or 60 percent, we have to react to that and we have to deal with that. That's not pie in the sky. That's reality. And we have to be I think creative enough to deal with those types of issues and develop measures in which the members will not be penalized. That's what AFSCME is all about, not penalizing the members. We represent those members.

Representative SCHEUER. But do you feel that you don't have the mandate or you don't have the mission of requiring the members to make a nonfinancial contribution to their own health? Do you have the moral right to tell them, "Look, you have to get your act together. You have to readjust your personal behavior to improve your own health and reduce the cost of health care to society."

Mr. SAUNDERS. That's a responsibility that we must share with the employer and other organizations. There's no question about that. If we don't accept that responsibility, then we're going to have some serious problems. We have serious problems right now with the escalating costs that we're faced with.

Representative SCHEUER. So you don't hesitate to at least jawbone your members about improving their health behavior?

Mr. SAUNDERS. Not at all.

Representative SCHEUER. Well, that's very encouraging. And you've institutionalized one way of doing it—these wellness programs. I think that's very, very promising and I don't understand why that Indianapolis experience can't be extrapolated across the country.

Mr. SAUNDERS. Well, as I said, we are attempting to deal with it on a number of fronts in a number of different ways and see how successful the different types of programs that we've negotiated will be.

Representative SCHEUER. Then tell us what some of the alternatives are.

COST CONTAINMENT MEASURES

Mr. SAUNDERS. Well, as I said, through labor-management committees, through looking at the redesign of the program, through recommending that members go to another doctor for a second opinion, a smaller usage of weekend stays in hospitals and things of that nature, hospice care, home health care—all of those will decrease costs, but it's about us educating our members about what is available to them under the current plan.

Representative SCHEUER. Well, I think all of the above would be helpful approaches. As I said before, there's no simplistic one single answer. All of the things that you just mentioned it seems to

me should be very helpful and productive of achieving not only economies in health care expenditures, but improvements in health care outputs, which is what the ball game is all about.

Do you agree, Mr. Wardrop, that the various approaches that Mr. Saunders just ticked off are the directions in which corporations and unions ought to be working together toward?

ASSESS APPROPRIATENESS OF PROCEDURES

Mr. WARDROP. Yes, and they are. But we still have the very systemic problem and that is that something in the order of 25 or more percent of everything the providers do is inappropriate.

Representative SCHEUER. This is the Califano message that you're echoing?

Mr. WARDROP. Yes. We have to find out which 25 to 50 percent it is.

Representative SCHEUER. Of course. The President of the American Tobacco Co. once said we spend $80 billion a year in advertising and 50 percent of it is in newspapers and magazines and 50 percent of it is in radio and television and we know that we're wasting 50 percent of that total expenditure, but we don't know which 50 percent. This is what you're saying.

Mr. WARDROP. Exactly.

Representative SCHEUER. Twenty-five percent of medical procedures and operations are unnecessary. How do we micromanage our health care system to identify the procedures and the surgery that are recommended by doctors but which aren't appropriate and from which the patient ought to be protected, as well as society that has to pick up the bill.

Do you have any thoughts on how we make progress on micromanaging the delivery of these procedures and these various kinds of surgeries that do turn out to be unnecessary and sometimes harmful?

Mr. WARDROP. Well, there are some people that have looked at it. Mr. Eddy at Duke University has made some suggestions about what we ought to do. Mr. John Wennberg at Harvard has made some suggestions, as has Mr. Bob Brooks at the Rand Corp. The feeling is that we need as a country to invest in some research because we have never looked at many of the procedures that are done to find out what the outcomes of those procedures are.

The Hartford Foundation, another foundation that does some things—Dick Sharp at the Hartford Foundation floated a paper in the last year to some people—not that he intended or the Hartford Foundation intended to sponsor all of this, but raised the question of do we as a country need to invest in finding out what of all the things we do out there really are appropriate, which ones are producing any change in health status, which ones are not? Because the physicians are the ones that tell us. This isn't coming from business. We wouldn't have known. But they have told us that a lot of what we do is not producing any change in health outcome. We just don't know which ones it is.

So I think at some point we're going to have to decide to make some investment and Bob Brook, for example, would say let's identify the 10 most costly procedures and do the research on those to

find out which of those are producing improved health outcomes and which ones aren't, what are the indicators that ought to be present before you do a bypass operation?

Representative SCHEUER. Well, what you're instructing us is that we have had 7 scheduled days of hearings and we'd better extend this series of hearings by 1 day and have a hearing solely devoted to the kind of research we need in order to be able to screen out of the system unnecessary procedures and unnecessary surgery and perhaps unnecessary drugs. We ought to really focus on that as a major means of rationalizing the health care system and also preventing negative health outcomes. Is that what you're telling us?

Mr. WARDROP. I would urge you to do that.

Representative SCHEUER. Well, I think that suggestion of yours, Mr. Wardrop, is a hell of a good one and we'll consider adding another hearing if our schedule permits.

Do you have any suggestions, Mr. Saunders, as to areas of research that would produce data that would make it easier for you to convince your members that such an action is necessary and justifiable and make it easier for you to negotiate with management on a particular question? In other words, have you been in bargaining procedures with management and have you been in discussions with membership where you said to yourself under your breath, "Why the hell don't I have hard, factual information on this so I can convince them of the rightness of my cause? I know I'm right but I don't have the data to support my position."

Mr. SAUNDERS. I think that having data and having information would be very useful. The data are not available, unfortunately, right now for negotiators, as I see it. The information you were talking about with the first panel, for example, about the cost that different doctors apply to different services. That would be very helpful. The experience of hospitals in local areas, that would be helpful for the membership to steer them in areas and directions which they may get the same quality service but for a better price.

Representative SCHEUER. Or maybe better service for the same price.

Mr. SAUNDERS. The impact the wellness program has on decreasing costs in the health care industry—all of that information I think would supply us with ammunition in sitting down with our members and educating them about how we can control costs. And if we don't take these measures, don't utilize these measures, how the costs will continue to increase.

UNION HEALTH PROMOTION EXPERIMENTS

Representative SCHEUER. Well, that's very interesting. How many of these wellness programs that you describe as being so successful and now apparently well accepted in Indianapolis exist in other parts of the country so that we could use them as laboratories in looking into this very question?

Mr. SAUNDERS. Well, off the top of my head I cannot think of one which rewards individuals that are involved with getting the physicals, with the wellness programs, and really penalizes those that are not involved in those programs. Indianapolis is one which I was directly involved with. I can provide you with more information on

that. I'm sure that we probably have that in other areas across the country. We have been promoting wellness programs. The international union has been promoting these programs all over the country as a way to decrease or to get a hold on the costs. That is just one actual experience that I'm familiar with.

[The following information was subsequently supplied for the record:]

AFSCME.
JANUARY-FEBRUARY, 1986 NUMBER 31

Collective Bargaining REPORTER

AN APPLE A DAY: WELLNESS PROGRAMS

Americans spend about $1 billion every day for health care—not to stay healthy, but to treat medical problems. Health plan coverage has historically focused on medical care, rather than preventive medicine. AFSCME has been involved in health care cost containment in many jurisdictions. Most activities have focused on altering how services are delivered, while maintaining the quality of care, under the basic health insurance plan. The health plans may have been revised to require second opinions for surgery, pre-certification for hospital admissions, or preadmission testing. Some jurisdictions have encouraged participation in health maintenance organizations (HMOs), which have financial incentives to stress maintenance of good health for the participants.

To work on the prevention of illness and disease, some public and private sector employers have also developed health promotion or wellness programs. These programs encourage healthy lifestyles and try to identify health problems at early stages. While some employers may feel that each individual worker should assume responsibility for his or her own lifestyle, the workplace is a good place to start. Participation time can be scheduled on a regular basis before or after work, or during the lunch hour. Attitudes and lifestyles are to some extent molded and reinforced at the workplace with support from coworkers. Employers with long established programs to keep their employees healthy have found that they also benefit from improvements in employee morale, employee retention, and community relations, as well as reduced health care costs. One study showed that 26 million working days are lost each year due to heart disease and hypertension, and 93 million working days are lost to back problems. In a hypertension program sponsored by one company, the hospital stays among program participants were reduced by 10%.

WHAT THE UNION SHOULD LOOK FOR

A total health promotion program seeks to work on certain health risks through nutrition training, smoking cessation, fitness activities, seminars on stress reduction, or other programs. While a structured program may be offered, the individual's success in the program depends on the individual. All proposed wellness programs should include the following safeguards:

1. Participation in any program must be voluntary.
2. The results of participation in a program such as health screening or health assessment must be kept confidential.
3. Participation incentives must be positive rather than negative.
4. A participant cannot be penalized for having participated in a program. For example, an employee who fails to successfully complete a stop smoking program cannot later be restricted in assignments because she continues to smoke.

HEALTH EDUCATION

A health education program can teach participants not only how to use their health plan, but how to identify symptoms and select the appropritae level of care. A program sponsored by Blue Cross of Northern California attracted 7200 (about 45%) eligible employees of various public and private sector employers, and offered self-help books and advice on

(continued on page 2)

A newsletter from AFSCME Research and Collective Bargaining Services to assist AFSCME negotiators in securing better contracts.

(from page 1)

when professional medical care was needed. Participants were encouraged to find and use a personal family physician. The self-help books identified common symptoms of health problems and gave advice ranging from seeing a physician immediately to using a home treatment. After the instruction, office and emergency room visits were reduced by 8% to 17%—a significant savings for the health plans.

EARLY DETECTION PROGRAMS

Early detection programs identify illnesses or diseases in the early stages through health screening and health assessment programs. Health testing might be done to detect problems with high blood pressure, glaucoma, diabetes or sickle cell anemia. For example, AFSCME's DC 37 has an active hypertension screening and treatment program at four different sites in New York City. The City provides free use of space and the union provides the medical personnel to perform the screening.

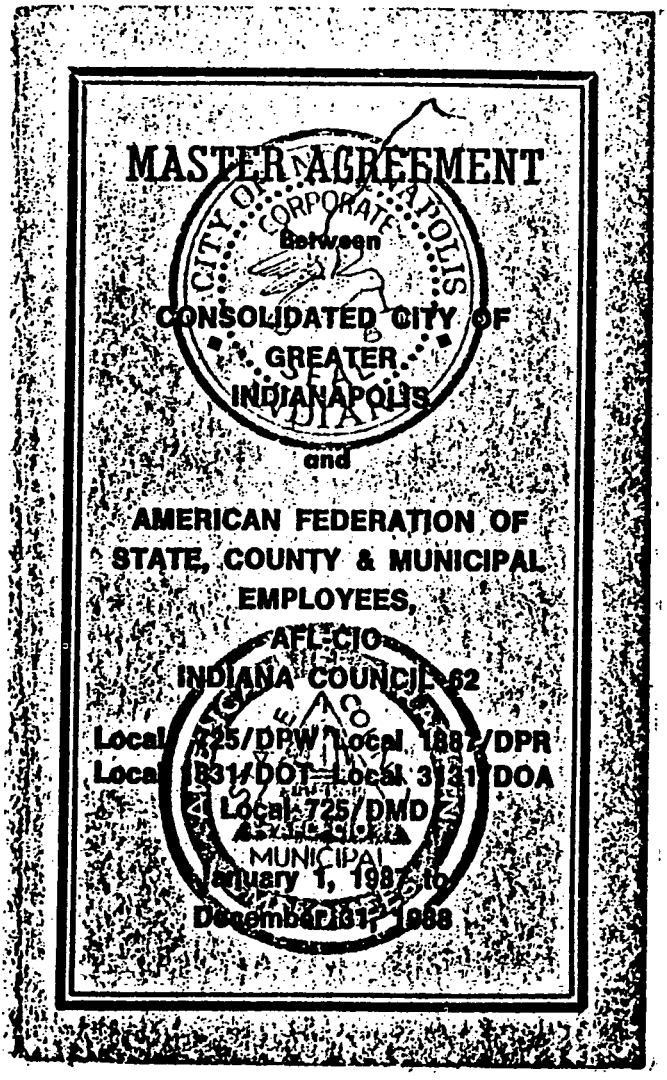
Another approach is to help employees and their families learn more about their health and health risks through a health assessment, where an individual's potential health risks based on age, sex, race, lifestyle, and family medical history are identified. The participants complete questionnaires that are analyzed by a computer. Based on the results, each participant is given recommendations to improve his/her own health status and minimize potential health risks.

FITNESS PROGRAMS

Fitness programs can be offered to employees in a variety of ways. The City of Des Moines, Iowa, started a jogging program during the lunch hour and sponsored a Fun Run competitive meet for its employees. It also offered group memberships at the local YMCA/YWCA. Multnomah County, Oregon, offers workshops and demonstrations on how to kick bad habits, manage stress and diet. The State of Illinois now offers partial payment under the health insurance plan for employees who successfully complete a stop smoking program. Other employers are offering aerobic exercise programs and use of gymnasium facilities.

HOW TO GET STARTED

The Union might propose that the employer set aside a certain level of funding for a pilot program, with a labor-management committee designated to determine how the funds will be spent. Some programs can be started with very few financial resources. Examples of these include offering healthy foods in the cafeteria, distribution of materials for breast and testicular self-examination, classes on lifting techniques, and sponsoring a smoking cessation class. The Office of Disease Prevention and Health Promotion of the Department of Health and Human Services published a list of suggested options to consider for a health promotion program. A copy of the list is reprinted on pages 81-85 of the AFSCME Health Care Benefits Handbook. Additional copies are available from the Research Department. ■



MASTER AGREEMENT

Between

CONSOLIDATED CITY OF GREATER INDIANAPOLIS

and

AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES, AFL-CIO INDIANA COUNCIL 62

Local 725/DPW Local 1882/DPR
Local 1331/DOT Local 3131/DOA
Local 725/DMD

January 1, 1987 to December 31, 1988

Section 3. Insurance. A. Group Life Insurance. The Employer shall make available group life insurance coverage for all full-time permanent employees in the amount of Eight Thousand Dollars ($8,000.00) plus accidental death and dismemberment coverage in the amount of Eight Thousand Dollars ($8,000.00) in 1987 and shall increase the coverage to Ten Thousand Dollars ($10,000.00) in 1988, subject to such waiting periods and standard terms and conditions as may be set forth in any master insurance policy providing such coverage.

B. Hospitalization — Medical Insurance and Wellness Program 1. 1987. The Employer shall make available to employees covered by this Agreement, a group hospitalization and medical insurance plan, subject to such waiting periods and standard terms and conditions as may be set forth in the master insurance policy. The Employer, Union and employees must engage in mutual efforts to control the cost of health care. Accordingly, the Employer shall maintain a Wellness Program for hourly paid employees covered by the Agreement effective January 1, 1987, to help reduce health care costs in the future and reward those hourly paid employees voluntarily participating and completing all phases of the Wellness Program in 1987 by paying all of the increase in premium through December 31, 1987. (See Exhibit C).

To be eligible for the Wellness Program, an employee must (a) have been employed with the City for six (6) months and (b) have participated in an insurance program, health or life, for at least six (6) months.

2. 1988. For 1988 and subsequent years, only those hourly rated employees participating and completing all phases of the Wellness Program, as determined by the provider, shall

be eligible for the increased contributions. Effective January 1, 1988, for those hourly rated employees participating and completing all phases of the Wellness Program, as determined by the provider, the Employer will increase its contribution in a dollar amount equivalent to seventy percent (70%) of the average premiums for family health insurance premiums of the insurance programs offered by the Employer in 1988 and employees with single coverage shall only pay a minimum set forth in Exhibit C.

3. Failure to Complete the Wellness Programs. For those hourly rated employees who decline to participate in the Wellness Program during 1987, or thereafter, or who fail to complete all phases of the Wellness Program, as determined by the provider, by December 31, 1987, the contribution level by the Employer shall be Fifty Dollars ($50.00) per month for single coverage and One Hundred Dollars ($100.00) per month for family coverage. This same eligibility requirement for increased insurance contribution shall continue into 1988. (See Exhibit C).

4. Employees Hired After January 1, 1987. Hourly rated employees who are hired after January 1, 1987, and who desire to enroll in a health insurance plan may do so and the Employer shall pay the monthly contribution

levels of Fifty Dollars ($50.00) per month for single coverage and One Hundred Dollars ($100.00) per month for family coverage.

After such employee has been with the City and enrolled in an insurance program for six months and completed all phases of the Wellness Program, as determined by the provider, such employee is eligible for the additional Employer contributions as set forth above.

An employee is considered enrolled for participation in the Wellness Program when an enrollment form is completed, however, after January 1, 1988, the employee will not receive the additional contribution until after completion of all phases of the Wellness Program.

It is understood that as a condition of the Employer making higher insurance contributions, the employee must complete all phases of the Wellness Program each year. If an employee fails to complete all phases of the Program, the additional contribution will be terminated and the contribution by the Employer reverts to the non-wellness level. If an employee does not complete all phases and his/her insurance premiums revert to levels paid by individuals who are not members of the Wellness Program, employees are still welcome to participate in the Program and the additional

contribution by the Employer will be reinstated as soon as the employee has satisfactorily completed all of the phases.

5. An advisory committee shall be created to assist in developing the standards and in communicating the standards to the Union. Two (2) members from each Union Local shall be designated to serve on the advisory commiittee.

The Director of Administration or his/her designee shall serve as the chairperson of the advisory committee. The recommendations of the advisory committee shall be made jointly to the Director of Administration, or his/her disignee, and to the provider of the Wellness Program.

Section 4. Public Employees' Retirement Fund. The City will continue to elect to participate in the Public Employees' Retirement Fund of Indiana, established by Acts of 1945, Chaper 340 and all Acts amendatory thereof and supplemental thereto.

Contributions, allocation of contributions and benefits will be established in accordance with State Law governing the Public Employees' Retirement Fund. Effective with the first full pay period after execution of this Master Agreement, the City will begin paying the employees' contribution to PERF. This affects

all full-time union eligible employees and represents an across-the-board increase of three percent (3%). Pursuant to State law, City-funded PERF contributions are refundable to the employee when a non-vested employee is terminated or resigns. Such contributions made as compensation become the property of the employee and as such are non-refundable to the City even if the employee in question is non-vested.

I.C. 5-10.2-1-1 states:

> As used in this article, "member's contributions includes contributions paid by: (1) the employer for member of a public employee's retirement fund: . . ."

I.C. 5-10.2-3-2(c) states that:

> "A member's contribution and interest credits belong to the member and do not belong to the state or political subdivision."

Therefore, once the City pays into the fund for any employee per this Agreement, that payment becomes, by definition, a member's contribution and must be treated as are all other member's contributions.

Representative SCHEUER. Well, I feel we have learned a very valuable lesson this morning from hearing you describe the Indianapolis experience, especially your description of how rough it was in the early days and how it came to be accepted and sort of taken for granted, if I'm quoting you correctly.

Mr. SAUNDERS. That's right.

Representative SCHEUER. I think that's a terrific lesson for us all and I'd like to know—and maybe you can get in touch with us—if you can let us know where other experiments along this line have been undertaken. I mean this gets right to the heart of Mr. Wardrop's statement in which I wholeheartedly concur, that 30 to 50 percent of our national health care costs derive from inappropriate and harmful human behavior. We know that 350,000 die each year of smoking who would not be dying of cancer of the lungs if they weren't smoking and the cost of that to our country is in the neighborhood of $65 billion a year and that's just one example. We know that 125,000 people die of alcoholism every year and that maybe 11 or 12 million people are crippled and disabled in carrying on their normal lives, both in the workplace and at home and in their families from alcoholism, and you go on to drugs—drugs are probably the greatest education spoiler, certainly among minority communities in the country, and are more destructive of education prospects, job prospects, marital prospects, life prospects, than any other single phenomena.

Now it's true that most of these people who are involved in drugs in the minority community aren't in the work force, and the fact that they are involved in drugs is probably one very significant reason why they aren't involved in the work force, but I think this has been a very valuable panel to have zeroed in on behavior as a key element in our health care costs, irresponsible human behavior, as far as health is concerned, and ways that we can institutionalize changes in behavior. And you have outlined, Mr. Saunders, a very, very useful experience out there in Indianapolis.

Mr. SAUNDERS. Well, let me just say that it was a very useful experience in Indianapolis and I think it served its purpose in Indianapolis and it could probably serve its purpose in other areas. I think that I would be less than truthful with you to say that that program could sell in every area where we conduct negotiations because it would be very difficult, especially in a large area—for example, in New York State—I would say that if we attempted to incorporate a program such as that, it would be very difficult to sell to the membership without preparing them properly first.

Representative SCHEUER. But that's your job. That's what you're paid for.

Mr. SAUNDERS. Sure.

Representative SCHEUER. That's the function of an enlightened union membership and an enlightened union leadership that you are part of. I don't take any risk in saying that and I think your union is fully capable of meeting that need and I happen to know the leaders of your union in New York State and they are terrific and I don't see what would be the problem in having AFSCME undertake selling to their members in New York State the requirement of a wellness program.

Mr. SAUNDERS. Well, we have no hesitancy about talking about the need to incorporate wellness programs, the need for members to be concerned about that. Obviously, the final vote does not come from us; it comes from the members. Again, I think it depends upon education, but we have a rely upon how the employee feels about their health insurance coverage and their health care needs. Their concerns must be represented by the union in negotiations.

NEED CONSENSUS IN ENCOURAGING HEALTH PROMOTION

Representative SCHEUER. I understand that. There is a triad of responsibility here. There's unions and there's corporations and there's government, and you have a jawboning responsibility on selling these wellness programs to your union membership. Do you think it would help you in selling it to the membership if corporations just as a matter of public policy said, "We are not going to continue to pay for uncontrolled health care costs if people aren't willing to at least think about and listen to other people tell them about their own health outcomes and how their own personal behavior impinges demonstrably and provably and verifiably on their own health outcomes. And we're just going to require them to think about their own health outcomes and think about altering behavior." Now supposing corporations, as a systematic matter, said, "This is it. We are not going to continue insuring health and picking up the tab for health if people aren't willing to think about doing their share, which is engaging in more responsible behavior affecting their health."

Now supposing corporations took that point of view and maybe there was a government incentive—and I can't tell you what right now—an incentive that we would establish, both to help the corporations and perhaps even more to help the unions convince their own membership that this is something that they simply cannot avoid doing.

Mr. SAUNDERS. Well, let me honestly say that I think that you would be walking on very, very thin ice.

Representative SCHEUER. But that's what I'm paid to do, too.

Mr. SAUNDERS. Yes, but I think that the relationship is strained enough between the employer and the employee. The employer making a unilateral change in health benefits, regardless of whether it is considered to be beneficial is a bad move. It could completely destroy the bargaining relationship. I think there are probably better ways in which we can make changes and that's through education, through union and management working together, but not having the employer come down on the employee and say, "This is what we're going to do for your best interest," because that's just not going to work.

Representative SCHEUER. Do you think that has to come out of consensus building?

Mr. SAUNDERS. Sure.

Representative SCHEUER. Well, you're probably right. Is there anything that government can do, the Federal Government, the State government, to encourage this process of consensus building to encourage individual union members to say; "Well, I didn't like this idea but I thought about it and why the heck shouldn't I join

this wellness class? Why shouldn't I ask my wife to come along? She's 40 pounds overweight and she's feeding me all this great food at night and I'm 50 pounds overweight. Maybe the two of us should attend that wellness class."

Mr. SAUNDERS. I think there's a role for government and there's a role for the unions in getting that message across. I think that government can do a number of things in putting physical facilities within offices which may entail a cost immediately but in the long run it may be cheaper because the employee will utilize those facilities and the health care premiums may go down. I don't have any proof that would happen.

Representative SCHEUER. I dare to suggest that many large corporations around the country are already doing that for their executive talent pool. Probably there's been less availability of those facilities for their blue collar or even white collar staff, but they've bitten the bullet that these preventive health care programs make sense for their executives. They're all over the place, are they not, Mr. Wardrop?

Mr. WARDROP. That's true. In fact, Honeywell, as a company, has budgeted 2 percent of their total health care—their sick care bill for preventive activities. They simply said we're going to spend that much money. So they have a dedication around this.

Representative SCHEUER. Of 2 percent of their sickness care bill for wellness?

Mr. WARDROP. Right.

Representative SCHEUER. Terrific. Well, do either of you have anything further to add? I've kept you over 3 hours.

Mr. WARDROP. Could I just suggest perhaps to help you and your staff along, there is a speech that was made by Dr. Henry Simmons. He is president of the National Leadership Commission on Health Care. That may be of help to you in terms of this quality assessment issue. If I could just submit it to you for your review.

Representative SCHEUER. By all means.

Mr. WARDROP. I have a copy of it.

Representative SCHEUER. How many pages is it?

Mr. WARDROP. The full speech is 16 pages, but there are only about 4 or 5 pages that are pertinent to this.

Representative SCHEUER. All right. We will accept those 16 pages and place them in the official record of this hearing.

[The speech follows:]

SPEECH PRESENTED TO THE BUSINESS ROUNDTABLE EMPLOYEE RELATIONS COMMITTEE

HENRY E. SIMMONS, M.D., M.P.H., F.A.C.P.
PRESIDENT, NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE

WESTIN HOTEL
WASHINGTON, D.C.
APRIL 14, 1988

On behalf of the National Leadership Commission on Health Care, I appreciate the opportunity to meet with you today to discuss an issue important to every American -- the state of our health care system. As the nation's largest single payer and as enlightened employers, you in American industry have a critical interest in how this vital system operates and how your $140 billion share of a $500 billion health care bill is spent.

Health care costs have become your largest uncontrolled cost of doing business. Given your massive expenditure, you have a right to expect quality care which is efficiently rendered. The questions you deserve answers to are: Is the care you pay for of high quality, appropriate to the need, and efficiently rendered? Is the yield in health improvement of your beneficiaries commensurate with your large and rapidly growing investment?

For the past year, our Commission has been examining these questions on behalf of all Americans. I have been asked to share with you what we have learned.

First, we have found that, in many respects, the health care system has done and is doing a remarkable job. Access has been improved for many and there have been important advances in medical science. These have brought measurable improvements in the length and quality of life. Medicine has much to offer those in need, but with those advances have come problems. We have identified three that we consider major and overriding. They are interrelated; they are systemic; they are growing worse. Without systemic solutions it is unlikely we will solve them.

The first problem is the rapid and massive escalation of costs. Despite fifteen years of vigorous cost containment efforts by government and the private sector, health costs have

quadrupled and now consume 11% of the GNP, or $500 billion. With present trends these costs will triple in just 12 years to 15% of GNP or $1.5 trillion. At that point, the average American's yearly share of the total health care bill will be almost $6,000, and industry's costs will have doubled or tripled. The Medicare program faces the largest increase in physician premiums in its history. The Medicare trust fund faces bankruptcy in the 1990's, and Medicaid (designed to be the nation's health care safety net) now covers less than one-half of those in need. Thus, the three major pillars of current health care financing -- American industry, Medicare, and Medicaid -- are all in deep trouble, and there is no end in sight.

The second problem is diminishing access for millions. The cruel paradox is that as health care expenditures are rising, more and more people are being excluded or underserved. Although some big city hospitals are full, on any one day over 40% of the nation's total hospital beds are empty. Despite an excess of physicians and hospital beds, and while operating the most expensive health care system in the world, many today face limited access to health care. We have the least equity of access of any major industrial nation. Thirty-seven million Americans lack any health insurance, at least at some point during the year, and about thirty million others have seriously inadequate coverage. Therefore, one in four Americans is either uninsured or underinsured. About eleven million of those uncovered are children. Such inequity constitutes a ticking social time bomb.

The third problem area, and the one you may know least about, relates to serious problems in the quality and appropriateness of much of the medical care being rendered. The uncertainty which pervades current clinical practice is far greater than most people realize, and it does not have to be.

Although each of these problems is critical, possibly the most central, and the one most in need of attention, is in the quality and appropriateness of medical care. Problems in the area of quality and appropriateness impact heavily on costs. Until we come to agreement on the definition of quality and appropriate medical care, it will be difficult to know what is worth providing access to and what is worth paying for. In light of this, you have asked me to concentrate on the issues of quality and appropriateness.

Assuring quality and appropriateness requires answers to some central questions. They are as follows: what are the medical practice standards guiding the care which your employees receive and for which you pay? How are these standards being set? Are they based on solid science? Are they adhered to and, if not, why not? Are there adequate systems in place which continually monitor adherence and, when necessary, cause timely corrective action? How effectively are the medical resources for which you pay being utilized and how is such use affecting the health of your employees and their families?

In a paper developed for the Commission, Dr. David Eddy of Duke University points out that quality care depends on making rational decisions about medical practices. This involves three main steps. First, there must be good information on what the practice does and how it affects patient outcomes. Second, this information must be processed into recommendations about the appropriate use of the practice. And, third; the recommendations must be applied to serve the individual needs of the patient, or in your case your employees.

Problems have been identified in each of these three steps. I'll go through just a few. First, there are serious flaws in much of our scientific literature. Much of it is of poor

quality. One study suggested that approximately half the articles published in medical journals that use statistical methods use them incorrectly. Dr. Alvin Feinstein, Professor of Medicine at Yale, in his book, *Clinical Judgments*, states the following: "Doctors are still uncertain about the best means of treatment for even routine medical problems. ...The exact effects of many therapeutic procedures are dubious and shrouded in dissension, often documented by either the unquantified data of experience or by grandiose statistics whose mathematical formulations are so clinically naive that any significance is purely numerical rather than biologic." The National Academy of Sciences, which recently examined this issue, concluded that much of the medical literature is inadequate to allow us to judge the effectiveness of much of our widely used technology.

The problem relating to the quality of evidence and recommendations based upon it is that for many widely used practices -- in fact, for many of the most commonly used practices which your employees receive and for which you pay -- we simply do not have the evidence needed to determine what the outcomes of the medical practice are or to determine what the appropriate recommendations for its use should be.

Even when we have sound evidence, it can only be useful if it is properly converted into actions which actually improve health. A very important means to accomplish this is the development of recommendations for appropriate practices. Given the important role of practice recommendations, it is instructive to examine their rationale. How are they set?

Dr. Eddy uses glaucoma as an example. Glaucoma affects approximately 1.5 million people in the United States. It is one of the major causes of visual loss and blindness. For decades it has been the universal practice to treat glaucoma patients first with drugs; then, if the drugs fail, to treat with laser therapy or surgery.

When deciding on treatment, it is important to know how such treatment is expected to reduce chances that the patient with glaucoma will suffer visual loss or go blind. A search of the literature reveals dozens of trials, many controlled and randomized (which are scientifically the most valid), that compare medical treatments. They show that no one treatment is better than any other in stopping progression of disease. The main difference is in their side effects, which may be severe.

This raises the question of how applying these treatments compares with doing nothing at all? There are only four trials that could be considered in any way controlled. None were randomized, all involved few subjects, and three of the four indicated that treated patients are more likely to have their disease progress compared to those who receive no treatment at all.

In addition to these studies, there are a large number of uncontrolled studies. All these studies show is that in a large proportion of patients, the disease progresses despite treatment. For these studies, there is no comparison to untreated patients to indicate whether the patients would have fared better or worse without any treatment at all.

To summarize, for this common condition there is virtually no usable evidence about the effectiveness of medical treatment. Yet practice recommendations in the medical literature, developed by experts in some of our best academic health centers, are recommending that millions of Americans be screened and possibly treated for a disease for which we do not know answers to even the most basic questions. Unfortunately, many similar examples exist.

Then there is the problem of observer variation which has been reported in virtually every aspect of the diagnostic process, from taking a history to doing a physical exam, from reading a lab test to performing a pathologic diagnosis. In general, the errors range from 10 to 50%. In other words, the percentage of times doctors looking at the same thing will disagree with each other or even themselves ranges from 10 to 50%. Yet much of the time this known phenomenon is not adequately controlled in studies or taken into account in actual medical practice.

What do we know about our technology? Here we define technology as all the procedures, tools, and instruments we doctors use to prevent, diagnose, and treat disease. The National Academy of Sciences recently spent two years studying the adequacy of technology assessment in this country. What they found is troubling.

They reported that many technologies, old and new alike, have never been adequately evaluated for either safety or effectiveness prior to their widespread dissemination. Almost no technology has been evaluated under average conditions of use -- which, after all, is how it is usually used. Little research has been done on outcomes of care, (i.e., yes the technology works, but does it make a difference in the end result?).

In 1970 the drug Diethylstilbestrol (D.E.S.) was shown to be ineffective for threatened abortion. It remained in widespread use for years thereafter, and in some instances resulted in vaginal cancer in young women exposed in utero (in their mothers). In early 1970, studies demonstrated that in the absence of neurologic signs, the use of skull x-rays in trauma is unnecessary. Despite this evidence, last year we did 2.5 million skull films unnecessarily, and you paid for many of them.

Carotid endarterectomy, one of the more commonly performed major surgical procedures in this country, serves as another example of a widely used but inadequately evaluated technology. An editorial in the *New England Journal of Medicine* recently concluded, "What is painfully clear for endarterectomy is that we do not know which patients, with what lesions, detected by which tests, should be treated and with what therapies." Despite that, we have seen a six-fold increase in the use of the procedure. Last year over 100 thousand endarterectomies were performed and we are just beginning the randomized controlled trials which, in three to five years, will tell us what, if any, utility they have, and on whom, if any, they are useful.

Dr. Arnold Relman, the editor of the *Journal* (and a member of our Advisory Group) comments as follows:

> "A major problem is the rampant proliferation of inadequately evaluated new technology and a general ignorance of the relative costs and benefits of many of the tests and procedures now being employed in the practice of medicine. The sad fact is that much of the technology employed in practice has never been adequately evaluated. As a result, we physicians are woefully ignorant about much of what we do and are influenced at least as much by custom, opinion, advertising, personal clinical experience and economic self interest as by hard objective published data."

It is reasonable to ask, what is going on? What is there about our system that takes so long to pose the appropriate questions and to monitor what is going on?

Because of these basic system flaws, many current practice standards lack adequate scientific evidence to back them. Some lack evidence at all. In many instances we lack the data necessary to justify the norms of clinical practice. Gaps in our knowledge add to uncertainty, and too much uncertainty leads to major variations in clinical practice. Dr. John Wennberg of Dartmouth, a pioneer in recognizing these variations, notes the following:

> "Most people view the medical care they receive as a necessity provided by doctors who adhere to scientific norms, based on previously-tested and proven therapies. What we have instead is major gaps in our knowledge which contribute to highly variable use rates for most medical, therapeutic and diagnostic tests...with major cost differences but no discernible differences in outcomes."

I would like to share with you several examples cited by Drs. Eddy and Wennberg. One is a classic study demonstrating variation and disagreement among physicians on the need for tonsillectomy. This study was published in 1934. In that study, 1,000 eleven-year-olds in New York City public schools were surveyed; 611 previously had had their tonsils removed. The remaining 389 children were examined by a group of physicians and 174 were recommended for surgery. The remaining 215 children were then examined by a second group of physicians and 99 were recommended for surgery. The remaining 116 were evaluated by a third group of physicians; 51 were recommended for surgery. The remaining 65 out of 1,000 children were not evaluated further because there were not enough physicians left.

More than 50 years later, 11-fold differences have been observed in the rates of tonsillectomies in small areas in Vermont, often between adjacent counties or between hospitals in the same city. Furthermore, after feedback of this information to pediatricians, the rate of tonsillectomies in the area with the highest rate dropped dramatically, showing that better information can make an important difference and will cause physicians to do the correct thing.

Unfortunately, there are many other current examples of similar patterns and problems. Regardless of what is examined -- ordering diagnostic tests, recommending surgery, use of intensive care units, admitting patients to the hospital -- the results are always the same. Substantial variations are found: two to ten-fold variations that cannot be explained by differences in disease or in the patients. Thus, people are asking, how scientific is our practice? How can we account and allow for these kinds of practice variations?

Despite the shortcomings which have been noted, none of us should lose sight of the fact that this nation leads in the science of technology assessment. We know how to examine technology effectively and have done some excellent assessments. Many of the corporations represented here today deserve major credit for these. Unfortunately, even when technology is evaluated properly, we find growing evidence that otherwise useful technologies are often used inappropriately or not used when they should be. Cancer under- and-overtreatment is a recently publicized example; there are many others. One in 500 Americans has a permanent heart pacemaker. Over 120,000 new pacemakers are implanted annually at a cost of $2 billion. A recent study concluded only 44% were definitely indicated and 20% were not indicated; the rest were equivocal. This has been

editorially described as "pacemaker mania." Twenty to twenty-five percent of coronary angiography is used inappropriately. Blue Cross and the American College of Physicians recently concluded that 20-60% of the $30 billion spent annually for routine laboratory testing is unnecessary.

The American College of Obstetrics and Gynecology feels that as many as half of all cesarean sections are unnecessary. Yet the frequency of the procedure, already over 25% of all pregnancies, is rising, and our fetal mortality rates are no better than other nations with far lower cesarean rates. In fact, the U.S. ranks 17th in infant mortality. Remember, the chance of dying during a cesarean is 2 to 4 times greater than during a vaginal delivery, and complication rates are higher.

It has been estimated that one-fourth to one-third of the 200,000 coronary artery bypass operations done annually are unnecessary. We do many more such operations on a per capita basis than any other nation, and this with little evidence that our results are superior to theirs. There are many other examples. We are talking about huge amounts of waste. The editor of the *New England Journal of Medicine* has estimated to the Commission that 20-30% of all things done by well-meaning physicians in good hospitals is useless. Other estimates are even higher. An article in the *Journal of the American Medical Association* by Dr. Marcia Angell, the deputy editor of the *New England Journal of Medicine*, addressed this question: Is more medical care better? She concludes that "Far from being beneficial, much of the medical care in this country is unnecessary, is of no demonstrated value to those who receive it, and some of it is harmful."

Errors in medical practice, while often unavoidable, are much more common than is generally realized. Despite the use of our most sophisticated technologies we often miss

important diagnoses. You have seen the recent reports of very high (40-50%) error rates in reading of pap smears for cancer and cholesterol testing. There are many other examples. A study done in one of the world's most advanced hospitals pointed out that we doctors wrongly diagnosed disease in one-fourth of patients who died in the hospital. About 10% of autopsies uncover a major problem which, if known before death, might have led to a change in therapy and prolonged survival. At the same time, we are seeing the most precipitous drop in our autopsy rate in history. Our autopsy rate has fallen to only 15% of all deaths. This means that our final quality control procedure is falling into disuse.

Unfortunately, waste is not the only problem. Misuse of technology is also associated with substantial harm. Iatrogenic disease (i.e., disease caused by care rendered) is a serious problem. For example, carotid endarterectomy is done on 50,000 patients without symptoms each year at a cost of about 1/4 billion dollars. Yet, this procedure is of no known benefit in asymptomatic patients, and it is thought to carry an operative risk of death or stroke of 7 - 10%. That exceeds by several fold the death or stroke rate associated with the untreated disease.

Infection rates in hospitalized patients are in the range of 5-6%. In 1985, the Center for Disease Control (CDC) attributed $2.5 billion in medical costs and 20,000 deaths to infections occurring in hospitals which were not present on admission. The CDC feels this rate will increase substantially as we increase ambulatory care. Again, much of this is unavoidable, but CDC estimates that one-third to one-half of these deaths are preventable by presently available surveillance and quality control systems. Unfortunately, many of our institutions have not installed such systems.

Human error is inevitable in a process as complex as health care and in which physicians must deal with many complex diseases. It is therefore mandatory to have in place adequate quality control and assurance systems. Unfortunately, health care has remained largely insulated from modern methods of quality control. Inspection remains the main form of quality assurance, and there is little evidence of appreciation of the importance of designing quality into the front end of our services.

The sad fact is that in regard to inpatient care, our quality control systems are at best rudimentary. They are even less developed in the office setting, where more and more care is being delivered. Most errors and quality problems in health care are due to faulty systems design or inadequate information and not to wilfull neglect. Yet, out of a $500 billion annual health care expenditure, we have invested virtually nothing in the tools for designing quality into our services. We have invested pitifully inadequate amounts into determining whether much of what we are doing is done well, or worth doing in the first place, or in developing standards for care which can be monitored.

Our hysterectomy rate is six times that of Sweden, a nation with the best health indices in the world, and twice that of Canada, with no evidence of better health outcome of our population. Such statistics cry out for explanation, yet it has been about 40 years since a substantial study was done on this issue. The question is why? Why have we not allocated dollars to these and many similar vital questions?

It is difficult to conceive of a more short-sighted investment strategy. No successful corporation could function for even a short time with such inadequate investment in research, standard setting, and quality control.

In summary, what we find is a system under great stress with serious cost, access and quality problems which are inextricably intertwined. Our problem is not due to a few bad apples; our problems are large and systemic. How did we get to this troublesome state? Who is to blame? First, we must recognize there is no one culprit, and we certainly cannot place all the blame on the health care system. We all share blame: government, industry, unions, insurerers, consumers, and providers of care. Through well meaning but often short-sighted actions and often in attempts to shift the problem elsewhere, we have all helped create a system (or non-system) with which no one is very happy. Unfortunately we have too often rewarded the system to do the wrong thing and never laid out before hand what we wanted it to accomplish in the first place. Exagerrated public expectation of what medical care can accomplish is also a problem.

At this point, finger pointing and diatribes are neither useful nor in the public interest. We, all of us, have a problem. It is time we all get on with the solution.

Fortunately, there is reason for optimism, for despite its problems, there is much that is good in the health care system and on which we can build. We do have some excellent technologies. We have learned a great deal in the last 25 years; we have much better ideas of what needs to be done, what pitfalls to avoid, and where we are likely to succeed. We have much better tools with which to work. We believe the medical profession is ready to step forward to help us use these tools to assure that quality is defined and delivered. It has never been more difficult to practice medicine. We must provide the medical profession the support necessary to do a very tough job. We must provide relief from the malpractice problem. We know we have underinvested in preventive services. We know better clinical research and quality control can favorably affect our costs. We know we need better informed consumers and buyers, and better integrated systems of care by which to

meet their needs. And we know how to begin to do these things. We can also learn from other nations who are providing their citizens universal access to a broad range of health care services at far lower cost than ours.

There are major opportunities to improve both our system and the results obtained. We know we can and must do better. The task now is to come together and put our knowledge to use. Our problems are soluble, although the solutions will not be pain free. We first have to recognize the systemic nature of our problems and acknowledge that applying band-aids, or short-term and piecemeal solutions will not only fail but even aggravate our problems for the long-term.

> The following slide illustrates the end result of 15 years of piecemeal attempts of <u>each</u> of the major parties to each solve its share of the cost problem. No nation in the world, including ours, can any longer afford such a strategy. Furthermore, even if we could, the return in health benefit would not be commensurate with the investment.

Our present strategies have not worked. Competition alone will not solve our problems. We need a new investment strategy. We must develop a common vision of the future, and a long-term systemic strategy and plan on how to get there.

You in industry have already begun some of the steps necessary, and there is much more you can and I'm sure will do. You can take steps to control your costs. But you must recognize that cost and quality are inextricably intertwined. Therefore, you will have to focus much more of your attention on quality and move, as you are, from being a payer to being a prudent purchaser of health services. As in every other aspect of your business

HEALTH CARE IN THE AGE OF "SHRINKING RESOURCES":

you will find that over the long-term, quality is the best buy. Each of the major parties, including industry, can solve a piece of the problem, or try to shift the problem and cost to someone else, but it is increasingly clear that no single group -- industry, unions, providers, insurers, or even government -- can do it alone. Ultimately there are distinct limits in what any corporation can accomplish alone in cost control through the benefit package. Such a strategy will not solve the long-term care problem, it will not build a long-term care system, or an adequate science base, or necessary quality assurance systems. It will not cure the problems of the uninsured or an aging population or deal with the burden of a retiree population which will soon be spending more years in retirement than in employment.

Solutions to these interrelated problems will require a broader, integrated and long-term strategy, and no matter what strategies are ultimately decided on, business somehow will be called on to pay a major portion of the bill. It is therefore incumbent on you to become deeply involved in developing solutions. This will require your leadership, working with other important parties at interest, and ultimately industry's involvement in a new public-private sector partnership.

That process has already begun through the establishment of the National Leadership Commission on Health Care. This effort was born with strong corporate support including IBM, AT&T, W.R. Grace, General Motors, General Electric, Upjohn, USX, the AFL-CIO, private foundations, and subsequently many others.

This Commission represents a first and is notable for several reasons. First, it represents an example of private sector leadership stepping forward at a critical juncture and on a vital public issue to act in the public interest. Second, it includes distinguished individu-

als from all the groups necessary to effect change -- providers (physicians, nurses, and hospitals), insurers, corporations, labor unions, consumers, and public policy leaders. Third, it recognizes the problems are systemic and will need systemic solutions. We are not interested in assigning blame, we are interested in solutions. Fourth, the Commission is bipartisan in nature, including former policy makers who served both at the national and state levels. Former Presidents Carter, Ford, and Nixon are Honorary Co-chairmen. Former Iowa Governor Bob Ray and Congressman Paul Rogers are Co-chairmen. The Commission and its Advisory Group is composed of individuals with the leadership, knowledge, and interest necessary to carry its recommendations forward to implementation. No group such as ours has come together for the last thirty-five years for a broad inquiry into the health care system and development of proposals for needed change.

We intend to create no less than a national debate on these issues and proceed from there to development of a shared vision for our health care system and a systemic strategy (involving government and the private sector) that can take us there. We plan to have our recommendations ready by year-end in time to serve the needs of a new Administration, a new Congress, and leaders in the private sector.

Recognizing the Business Roundtable's interest in public issues that have impact on the economic and social well-being of the nation, we have a clear convergence of interest on this important subject. We appreciate your interest, we welcome your support, and we urge you to step forward and help us provide the leadership necessary to serve the public interest. We are confident this effort can make a difference. With your help our confidence is even greater.

Representative SCHEUER. Well, you have been two extremely useful and productive witnesses and I'm very grateful to you both. I apologize for the late hour. You've been very patient and very kind and I express my appreciation to you and we may very well be back to you. This has been a most useful panel. I thank you.

The hearing is adjourned.

[Whereupon, at 12:35 p.m., the subcommittee adjourned, subject to the call of the Chair.]

THE FUTURE OF HEALTH CARE IN AMERICA

TUESDAY, JUNE 21, 1988

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON EDUCATION AND HEALTH
OF THE JOINT ECONOMIC COMMITTEE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:10 a.m., in room 2359, Rayburn House Office Building, Hon. James H. Scheuer (chairman of the subcommittee) presiding.

Present: Representative Scheuer.

Also present: David Podoff, Dale Jahr, and Dayna Hutchings, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE SCHEUER, CHAIRMAN

Representative SCHEUER. Good morning. The Subcommittee on Education and Health of the Joint Economic Committee will come to order. Today we will continue with the 8th day of hearings in the series we are having on "The Future of Health Care in America."

Today we will consider two very complex and emotionally laden problems, the ethical and moral problems associated with various aspects of health care delivery and the whole tension-ridden area of medical malpractice.

It is frequently said that fools will rush in where angels fear to tread, and perhaps that may explain why this hearing is almost the first, if not the first, congressional hearing—one of the very few hearings where Congress has taken on the extremely sensitive mission of investigating these two areas. We are truly walking on eggs.

At this point in time before proceeding further, I want to thank, Dr. Joanne Lynn, sitting in the front row here, who is acting director of the Division of Geriatric Medicine at George Washington University, for having guided us through these treacherous shoals and being of indispensable assistance to us in structuring today's hearings. We are very grateful to you, Dr. Lynn.

We will be hearing from Dr. Lynn in the first panel, but I wanted to—not share the blame—but give credit to her for having helped craft or organize what I hope will be a very instructive hearing. And if we fall short of our potential, it is our fault and our blame and not hers.

In this morning's session, witnesses will address ethical and moral questions which Congress and society as a whole find very difficult to ask, let alone to answer. Some of these questions include:

What rights do patients have in determining the course of their treatment?

What role should family members and physicians play when patients cannot make treatment decisions for themselves?

How and when and under what circumstances do we play triage, the game of deciding who shall live and who should die, especially when one looks at the field of organ transplants and the very large number of potential donees and very small number of donors?

Do we continue to provide very expensive high-technology services to prolong the lives of a very few, at a time in their lives for many of them when the quality of life which you are extending is very questionable, and tragically at a seemingly low level of satisfaction, while we allow millions of Americans, especially in their younger years to go without access to the most basic health care services which could add very significantly to the quality of their lives?

These are just a few of the extraordinarily difficult, complicated, agonizingly sensitive questions which society really should face up to. We don't expect to reach a consensus on them by any means. What we do hope to accomplish is to stimulate a reasoned and scholarly debate on these issues, because they have a very significant impact on the access to and the quality and cost of health care for every American.

We also need to ask some fundamental questions about the objectives of our health care system—a system which cannot keep expending an ever-increasing percentage of our gross national product on health. There are competing goals which society holds forth, which are equally important as health.

Daniel Callahan, in his book "Setting Limits," argues that our goal should be a better life, not necessarily a longer life. A leading medical ethicist and perhaps one of the great medical ethicists in our Nation at this time and director of the Hastings Society, Callahan points out the contradictions in our health care system. Through medicare, we pay for very expensive care for a heart attack in an intensive care unit, but will not, unless you are impoverished, fund long-term care that may be necessary as a consequence of that heart attack.

And questions should be raised about the priorities in a health system that spends, for a medicare patient in the last year of life, six times the average annual expenditures for all medicare patients. Yet that same health care system is not able to provide emergency room treatment to patients, many of them children, who do not have adequate personal financial resources.

To address this anomaly, at least in part, the Department of Health and Human Services only last week proposed regulations which would require hospitals to examine and treat patients in their emergency rooms irrespective of their ability to pay.

It should be emphasized that many of these ethical questions that need to be aired are not economic questions, are not about competition for scarce health care dollars. Discussing the rights of terminally ill patients to decide the type of care they will receive is an ethical and moral and not an economic question. As Alexander Capron, the former Executive Director of a Presidential Commission on Medical Ethics has observed, we should recognize that pro-

viding comfort and compassion for terminally ill patients may be as important or more important than trying to extend the lives of those patients.

This afternoon's session will deal with the problems of medical malpractice. I am sure that everybody in this room is aware of the so-called "malpractice crisis" that has been with us in varying degrees for a decade or more.

This high cost of malpractice insurance and the threat of lawsuits are causing obstetricians to stop delivering babies and many other physicians are opting for early retirement.

While it is difficult to produce reliable estimates of the cost and the effects of medical malpractice, we will hear important testimony on this subject this afternoon, with some statistics giving an indication of the magnitude of the problem. We will have more to say about malpractice this afternoon.

We will begin this morning's hearing on the ethical and moral questions that keep cropping up in many parts of the health care system by hearing from Mr. Morris Abram, who served as Chairman of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. This was the Commission for which Mr. Capron, whom I just quoted, served as Executive Director. Isn't that right, Morris?

Mr. ABRAM. Yes.

Representative SCHEUER. Mr. Abram is currently with the law firm of Paul, Weiss, Rifkind, Wharton & Garrison in New York. He served as Chairman of the Presidential Commission, as I said, from 1979 to 1983, and he's had such an awesome record of public service over the past generation, in which I have had the pleasure and honor of calling him friend, that it would probably take up the rest of this morning's session to cite his enormous contribution to the public good and public welfare in a wide variety of civic concerns.

Morris, I don't know what kind of ethical and moral questions my first suggestion is going to raise, but I think we ought to clone you and have an infinity of Morris Abrams around to fill the need for an enlightened citizen leadership: to man important positions in government and out of government, and to make the enormous changes in our society so that it will be a fair and just society. However, until we arrive at this cloning process and solve all the medical and ethical problems that would entail, we are going to have to get along somehow or other with just one Morris B. Abram.

So with that in mind, let me ask you to take such time as you may need, hopefully to chat with us informally, as if you were in our living room. The full text of your prepared statement will be printed in the record, and let me just say personally how delighted and honored we are to have you with us this morning.

STATEMENT OF MORRIS B. ABRAM, ATTORNEY, PAUL, WEISS, RIFKIND, WHARTON & GARRISON, AND MEMBER, NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE

CONFRONTING ETHICAL ISSUES IN THE MEDICAL PROFESSION

Mr. ABRAM. Thank you, Mr. Chairman, it is a great pleasure for me to be here, not only because of the work of this committee which will, I hope, chart a path for medicine into the 21st century,

it is an important contribution to public life. But you, as chairman, have demonstrated those qualities and your length of service has given you that experience, I think, to separate the wheat from the chaff, and I think, come up with some solution that might be practical and also very beneficial to a system which, must vaunted, and rightly so, has some very grave imperfections.

I am also glad that today you will be hearing from Joanne Lynn, who is perhaps one of the really great experts in the field in which I am sure she will testify and who served on the President's Commission, invaluable particularly in that section of our report that deals with the decisions to forego medical treatment. And also, there is another former associate of mine, Susan Wolf, who is one of the experts in the Hastings Center, a premier institution dealing with the critical problems of medicine. I am sure you will have an extremely interesting and informative session today.

Now I am going to speak from my experience as the Chairman of the President's Commission, which published 13 volumes, these are three of them, and at the beginning of its work, it was composed entirely of members of the Carter administration, appointed by President Carter. When it ended its massive works, it was composed of three members of the Carter appointment and eight from this administration, which is currently in office. And I am glad to say that when we concluded our work, we could say that all 13 volumes in some of the most tendentious fields have been adopted in toto without any dissent, with the exception of one technical dissent in one volume.

Representative SCHEUER. That is a remarkable achievement.

Mr. ABRAM. It is an achievement, I think to the American spirit, that when people of diverse political and social viewpoints are presented with the facts, they come up with—under proper staff guidance, I would say, because Alex Capron was superb—with the right result.

I also want to speak as a member of the National Leadership Commission on Health Care, which is a bipartisan voluntary group which is now in its second year and will conclude its work this year. We had a 2 year limitation on our mandate.

The importance of this body is illustrated by the fact, I think, that three former Presidents of the United States have accepted positions as honorary chairs of this commission. This commission will report on cost, quality and access, which is the broad spectrum of issues that face American medicine and include, I am sure, and embrace every issue that you will be considering.

I want to say, when I speak with respect to the Leadership Commission, I am not speaking authoritatively, because the reports are not finished and the consensus has not jelled on all the concerns and the issues that we will discuss and report upon.

Finally, I would like to speak as a beneficiary, Mr. Chairman, of the vaunted American health care system, because I am now 15 years in remission from a dread disease, which was thought to be fatal and which I have no doubt would have been fatal, that is acute myelocytic leukemia, had it not been for the care received in a system which I am now going to criticize in some detail. But I want to acknowledge the fact that, at its highest, it presents an enormous success story in many, many cases.

Now you spoke, Mr. Chairman, of the mandate to deal with some of the ethical issues in modern medicine. I think if you were to look at the final volume of the President's Commission, you will find that the Commission's analysis in the ethical field found that there were three basic principles which predominated. One being that the wellbeing of the people be promoted; two, that the people's values and preferences and choices be respected; and three, that people be treated equitably. And it is in that framework that I would like to first address the ethical concerns in their broad overall context.

I suppose if you were to ask me to try to sum up the basic ethical principles, the overarching ethical principles, there will be details which Dr. Lynn and Ms. Wolf will not doubt flesh out in great detail, using examples and anecdotes which are very telling. But the general overall, overarching principles, as I see them, are the tensions that are produced between the American desire for human autonomy, the respect of the human preferences and another public concern, which is the utilitarian principle of the greatest good for the greatest number.

The principle of autonomy, of course, derives in some respects from Immanuel Kant, and if you want to put it in the context that Will Gaylin, the president of the Hastings Center, sometimes speaks of it, it is the greed for life, and the fact that doctors are challenged and taught to respect the greed for life and to do everything possible to achieve and to fructify and greed for life and also to have everything done for the patient that can possibly be done that could conceivably be of any help, and that the individual should have the determination, after, I might add, full explanation of the alternatives, of what is to be done and what is not to be done.

It is a matter of choice and, of course, with respect to the greed for life, to have everything done, no one would want physicians to have a greed for death. So, you can obviously see that there are very severe limits, if one wanted to chain the greed for life, as was suggested, as you said a moment ago, by Dr. Callahan.

The second principle, the utilitarian principle of the greatest good for the greatest number, is illustrated in stark reality by the former practice amongst the Eskimos, when the oldest members of the society, those who were no longer reproductive or productive, were thought to be an impediment to the others eating, they were placed upon ice floes. And that is a very cruel form of what you yourself mentioned a moment ago as always an ever-looming possibility in any system, of triage.

Now in earlier times—in fact, not so early, I had a rather milestone birthday the other day—when I was growing up in Fitzgerald, GA, a litle country town in south Georgia—and my grandfather was a doctor there—the tensions between autonomy, having everything done that you wanted done and what the society could afford, did not exist. Grandpa, who had graduated from Jefferson Medical College up the road here in 1881, and indeed, my great aunt, who had graduated from the Women's Medical College in 1879, their armamentarium consisted of a little black bag, which I

saw very frequently. It was all they had. So consequently if they gave all they had to a patient willing to receive all they suggested, it would not have drained society's resources. And as a matter of fact, I never knew a baby born in the hospital, and I knew very few people who died in the hospital.

So the demands of the most medicine, and the most choice, and the greatest preference, both of the doctor and the patient, could not have affected the society's national income statistics or expenditure statistics. But now, of course, that is no longer true, the available diagnostic and therapeutic devices and inventions are increasing and are increasingly expensive.

I just noticed yesterday, it was handed to me by the president of the Leadership Commission, an article that is appearing—and I wish you would look at it—in the April issue of the Journal of the American Medical Association, "Cascades, Collusions, and Conflicts in Cardiology," which indicates that every time we have a new procedure, it produces a new set of factors and a new set of results, which have to be further examined and further disposed of. So from one intervention follows other interventions, to the point that there is an almost endless chain to know everything, however important it may be or unimportant it may be.

Representative SCHEUER. We will include that article in the record following your prepared statement.

Mr. ABRAM. The expense, therefore, grows, and here we are dealing eventually with some of these issues such as triage, at least in terms of rationing, which always looms, but we hope never occurs. But the reason, the commonsense reason for the fact that American medicine is becoming so expensive, is that you can't expect people not to opt for that which may help, doesn't hurt too much and doesn't cost them. You can also expect doctors and providers to go to the limits, particularly where financial incentives are built in and malpractice lurks.

NEED RATIONAL COMPREHENSIVE SYSTEM

Now I am firmly of the opinion, and I am sure that my colleagues who have come out of the same tradition will agree, that whenever there is a conflict between autonomy, that is, the preference, and going as far as you can to be effective, and society's needs to limit, I am sure that wherever there is a tilt, if there is a tilt, it should be in favor of autonomy. But to prevent that dark and evil day of rationing, we have got to rationalize the American medical system.

I don't know how many people are aware of the fact that in England which has a comprehensive health system that kidney dialysis, a lifesaving device, of course, is not given in certain regions after the age of 65.

Representative SCHEUER. I believe the age is 55.

Mr. ABRAM. Is it? Has it been——

Representative SCHEUER. And 65 for CAT scans, for open heart surgery and other sophisticated medical treatments.

Mr. ABRAM. Thank you, Mr. Chairman. I might add that on the kidney dialysis, when I knew that it was 65, when it was there, I

thought it was a fine rule until June 19, 1978, when I changed my mind drastically.

Now my personal beliefs, and I will now go into the concrete things that I believe from my own experience, are that we have got to have a comprehensive medical system in this country, that that system should provide a basic package of medical care to everybody, and that the government or third party payers of such a system should pay for only cost effective diagnostic or therapeutic procedures. And I would like to detail why I think that should be the rule.

NEED ASSESSMENT OF EFFECTIVENESS OF MEDICAL PROCEDURES

One of the things the staff work in the National Leadership Commission on Health Care has uncovered is the enormous number of unnecessary procedures, costly procedures.

Representative SCHEUER. In our first day of hearings, former HEW Secretary Califano testified, and he indicated that we were wasting approximately $125 billion a year in our health care system, a large part of it due to unnecessary and unwarranted treatments, procedures, surgery and the like.

Mr. ABRAM. Joe would certainly be an expert on that, but I wanted just to give you a couple of examples which are just outrageous. You take a very commonly used procedure—this comes from the work of the staff based on the reading of the literature. A cartoid endarterectomy has never been adequately evaluated. There are 100,000 performed a year now, just as randomized trials are beginning. The results of those trials are 3 to 5 years off; 50,000 such procedures are done each year on patients without symptoms at a cost of a quarter of a billion dollars. And from that procedure, death or strokes occur several times more often than they do in the disease untreated.

Now there is an example of something that is very expensive and very dangerous.

Dr. Relman, the editor of the "New England Journal" says—he is an adviser to our commission—that 20 to 30 percent of all things done by well-meaning physicians in good hospitals are either inappropriate, ineffective, or unnecessary.

Representative SCHEUER. He also adds that there are probably 20,000 doctors or more out of the Nation's 550,000 doctors who are drug-addicted, alcoholic, mentally impaired, or otherwise demonstrably unfit for carrying on an active medical practice.

Mr. ABRAM. It really is a national problem. You know, as early as 1983, Mr. Chairman, when the Commission did its report on access, the figures showed that there were 75 million chest X rays done in 1980 at a cost of $2 billion; one-third were unnecessary. One-fourth of all patients in hospitals, one out of every four, get respiratory care, oxygen and the like, and the Commission said that one in four, one in four didn't need it. The total bill is $5 billion a year. So you are wasting $1 billion a year and probably hurting some people.

What I am trying to suggest is the need for a careful study, and technical evaluation of the most common operations and proce-

dures, because if the country and industry invests in the scientific method, in everything else, why shouldn't it do so in medicine?

REFORM COMPENSATION TO REDUCE UNNECESSARY SERVICES

The next suggestion, and I won't dwell on it, is that the incentive system for compensation is perverse. I have had some rather interesting examples of it myself. I won't go into it, but it is perfectly obvious that so many procedures are done simply in order that they be done. There may be some reason for it, but there is no good reason.

Now I turn to something, and I'm——

Representative SCHEUER. What is the engine that drives the decisionmaking?

Mr. ABRAM. Economic gain.

Representative SCHEUER. On whose part?

Mr. ABRAM. On the provider's part. We all are human, and if something is questionable, and there is a profit to do it, and if there is some possible scintilla of excuse for doing it, and particularly if malpractice is the major cost of not doing it, if you make a mistake, the engine is driven in the wrong direction.

IMPROVE PHYSICIAN-PATIENT RELATIONSHIP

Now I'd like to turn to something I think is terribly important, and that is the necessity to improve the doctor-patient relationship in this country. The President's Commission found that the proper ethical relationship between the doctor and the patient is a shared relationship. That is the one in authority and having supposedly the knowledge, should share that knowledge to the degree that the patient is willing to receive it and the patient should be encouraged and invited to receive. And the choices should be explained of the alternative procedures and the probabilities explained of doing nothing. It ought to be the patient's decision as to whether or not a particular procedure is used. Where that doctor-patient relationship is at its best, the Commission said, and I do not know of anyone who disputes it, there are shorter stays in hospital, less analgesics are required, there is less morbidity and the patients are benefited therapeutically as well as financially.

Now Mr. Chairman, I now turn to a personal experience and that is the difficulty in achieving a proper doctor-patient relationship in an evironment with so many specialties and specializations.

When I lay ill at a great hospital with acute myelocytomas leukemia, I had the following people in attendance: a pathologist; a hematologist; an internist; an oncologist; an immunotherapist; and a cardiologist. I had three attacks of hepatitis, so I had a hepatolotist. I had a renalogist; and a psychiatrist. And each—except the psychiatrist, bless his heart—wanted blood every day. [Laughter].

It got to the point that I had no limb veins left, and they were about to use the veins in the head.

As my veins were giving out. I called all the doctors together, and I said, "Look. All of you are great, and you're doing great. I'm alive, and I'm not supposed to be. But I want to say something. I'm tired of specialists; I want a doctor." And I turned to a 50-some-odd-year-old woman, and I said, "You're it. You run the team. Some-

thing else, all of you who want blood, get together every morning or every night and decide who wants what. And pool your requests, and unless there's an emergency, nobody gets any more. Finally, nobody is going to draw blood except the intravenous nurse team, because they know how to find a vein." You have no idea how my life improved.

And that one doctor became so invested in me, I can recall the thrill and joy and the communication when she danced into my room one day, when I thought she was about to do another bone marrow, but she says, "No, bone marrow." She says instead, "the megalocaryocytes are back." I said, "What does that mean?" She said, "It means you're in remission."

And that bonding between that patient and that doctor was like a rope being extended down into a dark well, with the doctor standing on the rim and offering that rope and telling you when to pull and when to tug. That it is part of the healing process. There is no doubt about it. And it also slows the cascade effect, that is, the multiple gyrations to find the most minute and perhaps irrelevant feature of an illness.

Now I turn to health care coverage. I think it is a national disgrace.

Representative SCHEUER. Mr. Abram.

Mr. ABRAM. Yes.

Representative SCHEUER. When you describe that bonding effect, aren't you saying that the personal relationship between the doctor and the patient, this bonding effect that you described, the compassion, the caring, the moral support, all of that, that I am sure your grandfather excelled in a half a century or more ago, isn't that—I won't say as important, but isn't that significantly important in the recovery of the patient, in the patient's sense of well-being, be they terminal or be they in remission, as the application of all kinds of high technology treatments and procedures? Isn't that bonding an actual form of health care treatment itself——

Mr. ABRAM. I think so.

Representative SCHEUER [continuing]. Perhaps we are neglecting, with our enormously increased armamentarium of high technology treatments and procedures, the armamentarium that your grandfather had in a little black bag? Wasn't this kind of bonding effect that the old-time family doctor had and excelled at, isn't that—perhaps don't we underemphasize that and underfund that in today's health care delivery system, compared to how we fund, perhaps to excess, the application of high technology?

Mr. ABRAM. Mr. Chairman, I am not a doctor, but within the limits of my competence, I would say, yes, and with my experience, I would say yes, triple squared. I think that bonding—and the Commission found that where that relationship exists, malpractice suits were greatly reduced. And it stands to reason. If you have that bonding, you are not going to sue somebody for a simple mistake.

You know, I wish that I might add, and you might see fit to put in the record a piece from the New York Reviewer of Books, review of a book "Becoming a Doctor: The Journey of Initiation in Medical School," by Melvin J. Connor, M.D. That is not as significant as the fact that it was reviewed by the distinguished Lewis Thomas. And I don't know whether you have seen it, but my grandfather, whom

you mentioned, I was thinking of him when I read this. He cites the plaque that appears to the memory of Sir Richard Bright, the discoverer of Bright's disease who practiced from 1789 to 1852, and this is what the tablet says:

Scared to the memory of Sir Richard Bright, M.D., D.C.L., physician extraordinary to the Queen. He contributed to medical science many scientific discoveries and works of great value and died while in the full practice of his profession after a life of warm affection, unsullied purity and great usefulness.

And then Dr. Thomas says this is what 19th century people expected their doctors to be and believed that most of them were in real life. The expectation survives to this day, but reality seems to have undergone a change in the public mind, anyway. And I think he summed it up very, very well. And I think it is one of the big missing ingredients.

NEED NATIONAL HEALTH CARE SYSTEM

Now, sir, to conclude, I think this country has to have a health care system. We don't have a system. We have a crazy patchwork quilt instead. At the best, it is superb, but its coverage, you've heard before, it's sadly lacking. There are 37 million people really out of the system in terms of a third party payment. And in terms of the ethics of whether or not medical care should be available to everybody, I would like to simply say that the President's Commission, I thought, summed up, beautifully, why medical care is different than clothing. Everybody needs clothing, but clothing and medical care are different in the following respects:

First, the absence of medical care can cause intense suffering.

Second, without adequate medical care to preserve health so that a person can work, an independent person may be a dependent person.

Third, poor health is more frequently than not the result of serendipity. It is sometimes your own fault for smoking, but actually, it is something that cannot be forecast.

And finally, medical care costs can be catastrophic and can wipe out anybody except the very wealthy.

So therefore, the President's Commission said that there is an ethical responsibility on the part of society to provide adequate care for everybody without excessive burden to any.

Now we get confused sometimes. People speak of medical care as a right. I, as a lawyer, and I am sure you, Mr. Chairman, as a lawyer, know that the basic rights in this country to free speech, free press, free elections, and all of the other vaunted rights we have as American citizens are in a very preferred category, and the right to a house and the right to medicine is not a right of that type; however, the system of which you are now a key, that is the democratic system is the way we acquire certain benefits, and this country needs a benefit, and it needs a rational health care system.

It should provide coverage of everybody; it should give many, many choices in provision or the discharge of that obligation, and it should provide a diversity of delivery.

And I wrote it down here, exactly what I think it should be. It should provide without charge for those who cannot pay, except for a peppercorn, for everyone should pay something, to let him know

that he is getting something, with just copayments for everyone else, a basic package, adequate, demonstrated to be therapeutically cost effective. The cost of it should be determined, that is, the provider should be paid as a result of fees established by collective bargaining between groups that are matched in power with extra services provided for those who are willing and able to pay for it.

And I think we badly need such a system, and I think, Mr. Chairman, you cannot do it on a State-by-State basis. If you try to do it on a State basis, you will put some States at tremendous disadvantage, economically. And anyway, it is a national problem.

A TIME TO DIE

I want to close, Mr. Chairman, by picking up on your suggestion about Dan Callahan's statement about death.

You know, Governor Lamb, he got in hot water——

Representative SCHEUER. He's testified before our committee.

Mr. ABRAM. Yes. He got in hot water sometime ago, I'm sure, before he testified before you. He said there was a duty to die. Well, I always thought that Governor Lamb was pointing out something very important, but I thought he might have been more biblical and gotten away, if he'd said there's a time to be born, and a time to go to school, and a time to live and a time to die, he would have been better off.

But the truth is, we in this country have gotten to the point that we feel that death must be avoided, even if it means cardiac resuscitation to somebody with cancer, 85 years old.

Representative SCHEUER. Perhaps you mean deferred rather than avoided.

Mr. ABRAM. Yes, exactly. Well, I wrote down what I believe about that, and I said this:

From time to time, I reflect that death is a frame around the painting of life. A painting on a canvas of infinite size, worked on eternally, would be without focus, meaning and probably without any beauty. A painting, as life, needs limits. While I, speaking personally, have an almost insatiable craving for knowledge, I believe death to be the final and perhaps the greatest teacher—the one that provides the key to the ultimate questions of life that have never been answered. In my darkest hours, I was consoled by the thought that death at least is a payment for the answer to life's most haunting secrets.

And we must learn to accept that in this country, because otherwise I think we become a society that is contrary to nature. Thank you, Mr. Chairman.

[The prepared statement of Mr. Abram, together with the article referred to, follows:]

PREPARED STATEMENT OF MORRIS B. ABRAM

Mr. Chairman, Members of the Committee: It is a privilege to be invited to testify before the Joint Economic Committee. I applaud your foresight in calling this series of hearings on the future of health care in America. I believe, as you do, that it is time for us to stop and reassess our health care system and thoughtfully put in place the changes that will permit our vaunted health care system to provide high quality, cost-effective care for all our people into the twenty-first century.

I would like to start, from my background as chairman of the President's Commission for the Study of Ethical Problems in Medicine, to sketch out what I believe and the Commission found to be the basic ethical conflict in medicine. It can be described as a contest between two principles. The first is the principle of human autonomy, the Kantian principle on which much of our public ethic is built. This concept of freedom of choice speaks to the "freedom of each member of society as a man" and the "autonomy of each member of a commonwealth as a citizen." This has great resonance in American medicine as doctors are commanded to do everything possible for the patient, and the patient has the urge to live and to forestall death. Doctors try to satisfy that need. And who, after all, would want that turned around?

Standing alone, this principle is a good, but it needs to be balanced with another principle, the concept of the public interest which also permeates our political philosophy. John Stuart Mill, the chief apostle of this utilitarian creed, called for the "greatest happiness for the greatest number." Eskimos represent one example of an earlier society that in the past acted on the tenet of the greatest good for the greatest number: In times of scarcity, they put older

people on ice floes to preserve the younger people who could have children and thus represent the future of their society.

Fortunately, we don't live in such a society, and we're not even approaching it. But these two principles must be kept in balance. For many years we did not need to be concerned about balancing the two concepts. When my grandfather graduated from Jefferson Medical College in 1881 and my great-aunt graduated in 1879 from the Women's Medical College of Pennsylvania, they could do so little to help people that the maximum they were able to do took few societal resources. The little black bags they carried around were their entire armatorium. So their use of resources to provide medical care didn't impinge on the general good.

We can't say that today. We now spend over half a trillion dollars a year on health care, more than 11 percent of our Gross National Product. No other country in the world spends as much on health care. And the cost is soaring at several times the rate of general inflation. Of course, we can also do far more for patients today. A little black bag would be hopelessly inadequate to a doctor who is prescribing antibiotics that were unknown a hundred years ago and routinely saving lives that would have been lost. Doctors are now transplanting organs and keeping tiny premature babies alive.

Our medical research and delivery system is helping people live healthy, productive lives into their eighth decade and beyond. Years ago, many would have died at a younger age. Eliminating many acute conditions that used to kill millions means that more people are suffering from chronic conditions and long, lingering illnesses. The costs have always been, and always will be, highest at the end of life. But today, with all of the extraordinary measures now possible, an even larger chunk of our health care dollar is consumed. Almost 30 percent of the Medicare outlays go to the 6 percent of the Medicare population who die each year. Much of this is spent in the last few months of life.

So we have come face-to-face with the need to balance: the demands of the individual, of autonomy, versus the demands of the public interest, or the greatest good for the greatest number. Always, the balance should be tilted to autonomy. There comes a time of constrained resources when you cannot tilt that way, but that time is extended far into the future when the American health care system is operating properly. The problem in the United States today is that our health care system isn't operating properly, so we will have to make choices. We can postpone making those unpleasant choices only if we make fundamental changes in our health care system.

It was to begin to make some of those choices in a private, bipartisan setting that the National Leadership Commission on Health Care was formed in 1986 with a self-imposed two-year timetable to examine carefully the problems in the cost, quality, and access to care and report to the nation on its findings. This group of private citizens is now examining what changes in the current system it would like to propose. Although the Commission's deliberations are not complete, I have personally spent the better part of a decade considering what I believe is needed in our health care system.

I believe that changes should take several forms:

First and foremost, government or private third-party payers should only pay for cost-effective diagnostic or therapeutic procedures. As the National Leadership Commission on Health Care pointed out in its interim statement explaining the problems it found in the health care system, there are many common procedures for which we have inadequate evidence of appropriate and effective use.

I believe there are today egregious examples of common procedures which have not been carefully evaluated prior to their use in the general population. For example, carotid

endarterectomy, one of the more common major surgical procedures in this country, has never been adequately evaluated. An editorial in the New England Journal of Medicine recently concluded that "What is painfully clear for endarterectomy is that we do not know which patients, with what lesions, detected by which tests, should be treated and with what therapies."

Despite that, we have seen a six-fold increase in the use of the procedure. In recent years, over 100,000 endarterectomies have been performed a year, and we are just now beginning the randomized controlled trials which, in three to five years, will tell us what, if any, utility they have, and on whom, if any, they are useful.

Endarterectomies are done on 50,000 patients without symptoms each year, at a cost of a quarter of a billion dollars. Yet this procedure is of no known benefit to asymptomatic patients. Beyond that, there is the risk of the danger of the operation itself. Endarterectomy is thought to carry an operative risk of death or stroke of 7 to 10 percent. That exceeds by several fold the death or stroke rate associated with the untreated disease.

This is but one illustration of the fact that for many of our most common operations, we have insufficient scientific evidence about the appropriateness and effectiveness of medical treatment. Most people probably assume that all the major procedures and operations in use today have been carefully examined for effectiveness and that there are guidelines for their appropriate use, much as there are for drugs. That is not true. In fact, the editor of The New England Journal of Medicine, Dr. Arnold Relman, an advisor to the National Leadership Commission, has said he believes as much as twenty or thirty percent of all things done by well-meaning physicians in good hospitals is either inappropriate, ineffective, or unnecessary.

We must start as soon as possible to do careful studies of the most common operations, with a view to doing only those that are appropriate and effective. If we were to take this course, a relatively small investment in the near term would yield large long-range savings by cutting back on the number of expensive operations and procedures now being done which would be determined to be inappropriate and would not be conducted after solid scientific research leads to new guidelines.

A second major problem is that we have built perverse incentives into the health care system. We pay doctors only for doing something to us. Since doctors are paid for procedures, they conduct many procedures. Our litigious society fuels this problem, placing physicians under pressure to do everything possible.

These inappropriate incentives could become even more of a problem in large urban areas with a preponderance of doctors. In a popular city like San Francisco, there is now one doctor for every 180 people, far more than is needed. This is one reason we are sent to see one specialist after another. For a persistent condition that has previously been treated with one office visit, a New York specialist recently suggested I return to him three times. Appalled, I checked with my internist, who told me that was not necessary. If we change the incentives in our health care system, we will forestall the evil day when we have to ration.

Third, I believe that we must improve the doctor-patient relationship. Ethically, the doctor-patient experience should occur in a shared relationship. That goal has not only ethical but therapeutic value. The President's Commission on Bioethics pointed out that this type of relationship serves to "reduce anxiety and complications during convalescence" and results in the need for shorter hospital stays and fewer analgesic medications. Patients have to convince doctors to tell the full story, to treat them fully as

autonomous, rational individuals. You can't have a fair system when all the information is on one side, the doctor's side.

The proper doctor-patient relationship is central to the practice of the art and science of medicine. This relationship must be one in which information is shared, including the alternative modes of treatment and the probable advantages and risks known. It is the responsibility of the profession to extend to the patient the full knowledge of the outcomes of various modes. This body of knowledge can be easily expanded through outcomes research which we already know how to conduct, both for existing procedures and for new technology as it is introduced.

Fourth, we need to invest in our future. New and often expensive technology in medicine is part of the output of our sophisticated scientific establishment. Research, development, and assessment are part of our tradition in all fields of science, and there is no reason why medicine should be different. Extraordinary research is being done in the health care field, without a comparable investment in assessment. No other major part of the American economy fails to make that crucial investment in assessing what they do.

Fifth, we must begin to make people understand the costs and benefits of the health care they receive. We must learn to be better patients, to ask our doctors the right questions. To do this, we must all start paying our proper share for what we receive. Adequate co-payment is a very important element of a changed system in which everyone would understand both the appropriateness and benefit of the care received and the cost of that care.

In today's insurance system, which often offers many very generous coverage but few deductibles or co-payments, there is little or no incentive for people to economize on either

side, patient or provider. We realize there are people who can pay little, but even a peppercorn should be charged those who are able to pay no more. To change the current system to one where the individual understands the cost of care is the beginning of a crucial cultural change process that must take place if we are ever individually and collectively to get control of our runaway health care costs.

Finally, providing health care for everyone should be seen as a social good and part of what any humane society should do for its people. Health care is not a constitutional right, such as free press or free speech. But it is also not like housing or rest and leisure or other social goods, because the lack of it causes suffering. Lack of health care causes dependency, even inability to work, and may be serendipitous, since it may come about through no fault of the individual's. Lack of it can also be catastrophic. So it is unlike the lack of something that we regard as a rather ordinary good.

We could provide systematic coverage for basic human need without any loss of diversity and initiative, which are absolutely essential to a good system. The new system should provide, without charge to those in need and with just co-payments for everyone else, a basic medical package representing an adequate level of care. The system would have to control costs by collective bargaining for the price of benefits between reasonably matched and knowledgeable groups. This would assure freedom of choice of identified providers who could work in settings of their own preference. Such a comprehensive system would leave to individual initiative a higher level of care at personal expense.

We should, in other words, preserve the best of the freedoms and private initiative that we enjoy today, and at the same time cover basic human needs which we must not allow to go unmet forever. A new system would have the advantage of not placing one state which may have low Medicaid payments or another, such as Massachusetts, which will have a costly medical coverage system, at a disadvantage.

One final point: America is a frontier society, and Americans like to live their lives without limits. Many of us believe we must marshal our resources for as long as possible to fight off our inevitable death. We seem to have lost sight of the concept, once a goal of all of us for our loved ones, of death with dignity. We must begin to understand that death is not always to be fended off.

I have begun to understand that because I have lived with acute myelocytic leukemia for fifteen years. From time to time I reflect that death is the frame around the painting of life. A painting on a canvas of infinite size, worked on eternally, would be without focus, meaning, and probably without beauty. A painting, as life, needs limits. While I have an almost insatiable craving for knowledge, I believe death to be the final and perhaps greatest teacher -- the one that provides the key to the ultimate questions life has never answered. In my darkest hours I have been consoled by the thought that death at least is a payment for the answer to life's haunting secrets.

Cascades, Collusions, and Conflicts in Cardiology

For many valid reasons, no physician today can afford to ignore the question of cost of health care. One of the more compelling reasons why this is true is that such costs have soared so rapidly that they have understandably become a target for control by the government, industry, and all others who primarily pay the bill. During this period of growing concern and increasing efforts to control the cost of medical care, it is crucially important that the quality of care not be eroded and that access to care not be limited unfairly.

See also p 2419.

In this issue of THE JOURNAL, Sawitz et al[1] of San Francisco report that during a decade when hospitalization time for patients with acute myocardial infarction decreased significantly, physician services tripled. They properly concluded that it was not possible to determine whether those services and the diagnostic information obtained may have been responsible for the decrease in hospitalization time. They did document, however, that the increase in cost for these physician services was due principally to the use of complex diagnostic technology and to surgery performed for coronary disease.

Provocative findings of this nature lead one to ask whether such costs are justified. For example, one recent study from Europe[2] has concluded that neither immediate coronary arteriography nor coronary angioplasty (there was no surgery) offered superior advantages over prompt thrombolysis with tissue plasminogen activator in patients with acute myocardial infarction. If those findings and conclusions are supported by future studies, we may anticipate that less complex and less costly treatment of acute myocardial infarction will emerge. At least two factors may impede such a trend in the United States. These are the widespread practice of "defensive medicine" due to fear of legal jeopardy, a phenomenon preponderantly or almost exclusively American, and the entrenched habits of diagnosis and treatment that exist here, including the investment by hospitals and clinics in equipment that yet needs to be amortized.

How often are the fascinating new diagnostic techniques as helpful as we all hope? Some unquestionably have advanced the capabilities of physicians to make a more accurate diagnosis and choose wisely among therapeutic options. Yet, with this astonishing assortment of diagnostic bells and whistles, one often gets the feeling of watching the sorcerer's apprentice at work. The thinking physician's dilemma is sometimes solved by a "collusion of anonymity" defined by Balint[3] as the consequence of actions evolving from the abdication of primary responsibility by some physicians when faced with a perplexing medical case, vital decisions being taken by multiple physicians without anybody feeling fully responsible. This in turn too often leads to the "cascade effect" in the clinical care of patients,[4,5] surely one of the more regrettable causes for soaring costs of diagnosis and treatment.

Cascades in cardiology, as in other disciplines in medicine, are a process that, when once triggered, becomes almost impossible to stop. Too often one test leads to another and then another, with too little pause to think in between. One medicine leads to a side effect that requires some other medicine to counteract it, and so on. Instead of delving more carefully into the history when a patient presents with unusual chest pain, someone may order an exercise test that shows suspicious changes, leading to an isotope study with suggestive defects in a shadowy image, followed by arteriograms that, predictably, in most cases show some coronary disease, and so on down the cascade, sometimes with disastrous complications that no one wanted or anticipated.

Compounding the collusions of anonymity and cascades in cardiology is the ugly specter of conflicts of interest. For example, the same physician who decides whether a diagnostic or therapeutic procedure is to be done is too often also the one who does the procedure, interprets the findings (and decides whether additional procedures are indicated), and is paid for each step of the way. This is not to say that such physicians are unskillful or that their decisions are necessarily made on the basis of personal gain, but the temptation is inescapably there. It would be helpful to know how often certain costly diagnostic or therapeutic procedures would be done if all elements of financial advantage were removed not only for the physician who does the procedure but also for his clinic or institution, for the latter can bring great pressure to bear on decision making. Unless answers to such questions can be obtained, it is predictable that an eventual unbearable level of costs from cascades, collusions, and conflicts will spell catastrophe for cardiology.

Philosophers distinguish between knowledge and wisdom (or common sense), a distinction from which we can draw many valuable lessons. In cardiology, knowledge permits us to choose and use new technology. Common sense warns us how often it may be better not to use it. Knowledge furnishes us the pride of a correct diagnosis. Common sense makes us understand the pain and anguish that the diagnosis may bring to the patient. Knowledge is content to deal with murmurs, ejection fractions, and multiple gated acquisition scans. Common sense forces us to think of jobs lost, families distressed, and grief to face.

E. B. White once warned, "We can't afford to look nostalgically at the past and backwards to the future." But I do not wish to. If our future were one of science and technology alone, no matter how brilliant, it would be a cold and gloomy world. The contribution any thoughtful and compassionate physician can bring to a patient's well-being by thinking carefully and being kind is no less now than in years past. We do have the advantage today of choosing from many forms of technologically derived information, but we must be more selective in deciding when it would be genuinely important to have such knowledge.

Thomas N. James, MD
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2. Simoons ML, Betriu A, Col J, et al: Thrombolysis with tissue plasminogen activator in acute myocardial infarction: No additional benefit from immediate percutaneous coronary angioplasty. *Lancet* 1988;1:197-203.
3. Balint M: *The Doctor, His Patient and the Illness*, ed 2. New York, International Universities Press, 1963.
4. Moïd JW, Stein JF: The cascade effect in the clinical care of patients. *N Engl J Med* 1986;314:512-514.
5. Carmichael JK: The cascade effect in the clinical care of patients. *N Engl J Med* 1986;315:319.

Representative SCHEUER. Well, thank you, for a most touching and deeply moving statement, Mr. Abram. We expected a superb statement from you, and we certainly received it.

BASIC HEALTH COVERAGE

In your remarks just 2 or 3 minutes ago, when you stated your credo, you talked about the health services that each of us should be able to look forward to, and then you said, with additional services to be available for those who want them and can afford them.

Mr. ABRAM. Right.

Representative SCHEUER. What is the cutoff line?

Mr. ABRAM. I'm sorry. What is the what?

Representative SCHEUER. What is the dividing line between the services each of us are entitled to and the services that each of us may want but are only available to those of us who can afford them?

Mr. ABRAM. Well, Mr. Chairman, I suppose if——

Representative SCHEUER. And here you are obviously talking about health rationing.

Mr. ABRAM. Well, not really. I am saying that the basic package, the adequate care, the cost-effective care, should be provided on some kind of an overall coverage that is available to everyone.

Representative SCHEUER. How do you define "cost effective"?

Mr. ABRAM. Well, that——

Representative SCHEUER. Well, let me read to you a paragraph that will help us focus on the question of cost effective, because you have to consider cost effective, but compared to what? Compared to what other health needs and what other societal needs.

I am going to quote a paragraph from the guidelines on the termination of life-sustaining treatment and the care of the dying, which is a report by the Hastings Center.

Mr. ABRAM. You have the author here. Ms. Wolf.

Representative SCHEUER. It's a brilliant piece of work, and I'm quoting from page 8 of the printed copy.

> Justice demands that individuals have an oportunity to obtain the health care they need on an equitable basis. At the same time justice places ethical limits on the patient's liberty to demand rather than forego scarce medical resources. Justice tempers patient autonomy in those cases, where complying with the patient's directives would unfairly deprive others of equitable access to an adequate level of scarce medical resources. Considerations of justice or equity enter into decisions concerning these use of life-sustaining treatment—especially at an institutional or policy level—because those treatments can be extremely costly. Providing them can tie up scarce resources—such as beds in the intensive care unit—which must therefore be denied to others.

How do you define "cost effective"?

Mr. ABRAM. All right. Let me—it is a very difficult thing, and I am not a physician, but let me just give you an example of what I am trying to say. First of all, I don't think that the basic package should include carotid endarterectomy for asymptomatic patients. It hasn't been evaluated, and it may be actually dangerous. And I don't think the package should require it.

So I would say, first of all, with respect to new procedures that are costly and untested, I think the package should not include them unless they have been properly evaluated by some kind of a technical evaluation process, technical assessment, any more than

drugs should be used until they have passed through the FDA. We don't make these other requirements with respect to certain procedures and technology.

Now Mr. Chairman, let me give you a personal example. The other day I go in for a general examination by a wonderful internist, and he says to me, "You've got a heart murmur." Well, I'm 70 years old; I'm supposed to have a heart murmur, I should think. And I said, "What should I do that I shouldn't be doing?" He said, "Do whatever you want." I said, "What should I stop doing?" "Don't stop doing anything you want to," he said, "but come back in 2 weeks. I'd like to do an echogram." And then he says to me, "What's that thing on your ear, that brown spot?" I said, "I don't know." he says, "Do you have a dermatologist?" I said, "Yes." He says, "Has he seen it?" I said, "He looks at me all the time." He says, "Go back."

So at the end of a week, I was getting tied up in courts and other obligations, and I kind—I said, "Listen," called him up. I said, "I don't care what this costs." I said, "I'm not going to pay for it." The echogram. But "What are you going to do or not going to do as a result of that echogram?" He says, "Nothing." I said, "Well, then, I'm not going to have it." He said, "Okay."

That ought not to be in the package under those circumstances, but if I want to pay for it, let me pay for it. And the inhibition will be the paying and the time spent.

Now similarly, the thing on my ear, I go see the dermatologist. He looks at it and he says, "I've seen it for years." He says, "It's an angioma, burst blood vessel." But he said, "But oh, if this doctor says"—he starts getting out his knives; he's going to do a biopsy. I said, "Now wait a minute. You tell me that you think it is an angioma, and you are about to do a little surgical procedure." I said, "Wouldn't the blood come out if you stuck the needle in?" He said, "Yes." I said, "Well, do it." He stuck the needle in, and the thing was gone.

Now you see, what I am saying is that these—the system is built so that we demand everything. If we are going to have a national system, we can't demand it, and every headache cannot be examined by NMR or CAT scan. If somebody wants the NMR or the CAT scan, let them pay for it and let them pay dearly. That's all I mean.

Representative SCHEUER. The tough question comes, and what is the difference between everything and anything? Where is that line? What are we entitled to? And then what is in that whole other arena, that everything arena that each of us can't demand? How do we draw that line in the dust?

Mr. ABRAM. I think it very difficult, and I wouldn't sit here to try to give you a generalized set of principles, certainly not in the presence of the author of the guidelines and Dr. Lynn, who is a specialist in this field.

Representative SCHEUER. Well Dr. Lynn and Ms. Susan Wolf will be testifying in the next panel. We will have a chance to ask questions of them then.

Mr. ABRAM. And I will listen with great interest.

REASONS FOR LACK OF MEDICAL PROCEDURES

Representative SCHEUER. Mr. Abram, you say we shouldn't permit people to demand procedures whose appropriateness and effectiveness have not been tested and validated. Why do you think we have been so lax in doing careful studies and analysis of the appropriateness and effectiveness of so many of these procedures that have come under such critical scrutiny by you and Joe Califano and a whole host of other critics of the system.

Mr. ABRAM. Mr. Chairman, we have lived in, first a very rich society, and second, we have lived in an age of terrific explosion of medical technology and great hope. So having very few limits, after all, we are now at 11 percent of our gross national product, and I suppose that is not the ultimate limit, but we have not felt that it was inhibiting housing, education, and defense even. So I think there has been the proclivity to spend if it would yield any result.

And the second thing is that there has been no national control over expenditures whatsoever even for those whose benefits are paid for by outside authorities. And when there is no control, there is a desire to use every development that hits the market, and there are people who, of course, advance the cause of the new-fangled idea. They've got an investment in it, and there is a trained cadre of people who would like to try it, and then, of course, I think malpractice has an effect. Obviously, it would if I were a doctor.

Representative SCHEUER. Well, before we exercise control as a society on these things and say that if you can afford it, you can have it, but if you can't afford it, you can't have it, wouldn't we have to define its effectiveness, and wouldn't we have to define the circumstances under which it could be effective and the circumstances under which its effectiveness in enhancing patient outcomes would be very dubious?

Mr. ABRAM. Well, I had a discussion——

Representative SCHEUER. Before we control it, don't we have to know more about it?

Mr. ABRAM. Yes.

Representative SCHEUER. And my question to you is why haven't we engaged in this effort more intensively?

Mr. ABRAM. Well, I think in certain instances, we have assumed certain things are effective, and we know they are effective from long experience. For example, we don't need any further tests on digitalis. We don't need any further tests on quinine. We don't need any further tests on certain aspects of aspirin. I gather we need some tests with respect to the cardiovascular effects. But I think we do sometimes test those things—we need not test those things which are so obviously beneficial, but new, expensive technology, such as NMR and the use of carotid endarterectomies and the use of certain operations, particularly prostate operations—I noticed in some studies that were recently done, that in one Maine community, the number of prostatectomies declined by one-fourth, when there was a regional publication that showed that the bad effects of the operation were much greater than the doctors themselves knew.

I do feel that there is a great need to test an awful lot of procedures that are being done. I am not competent to say exactly what they are, but I do know that from all the evidence that the National Commission has and the President's Commission, there ought to be some better system of assessment.

Representative SCHEUER. And then after we make the assessment——

Mr. ABRAM. Yes.

ALLOCATING RESOURCES

Representative SCHEUER [continuing]. Where do we go from there, as a society, in saying that this very expensive life-extending technology that can extend the life of a person who is in their eighties or nineties and may be suffering from various levels of dementia; this very expensive technology that could prolong that life or defer the process of dying; how do we evaluate providing that very high-cost technology against other competing unmet needs in the health care system for people at the very beginning of their lives, with their whole lives ahead of them and, as you said, other competing needs of society outside of health care—education, job training, enhancement of our science and technology, more National Science Foundation postdoctoral fellowships? How do we do that balancing act?

Mr. ABRAM. Your question is very well-posed, and I would say that to begin with, you do it by controlling third-party payments, and you establish standards for what third-party payments will pay. Until you do that, Mr. Chairman, it is now, as it should be, I might add, in the hands of the doctor and the patient. A patient able to make a rational choice says that I want this done to them. The doctor has the obligation to do it now, as long as the patient is able to exercise autonomy. When the patient is not able to exercise autonomy, then the proper surrogate operates for the patient with the aid of the physician, and they make a decision on the basis of the exchange of information with such third-party consultation—priest, rabbi, or preacher, as they wish, or any other family member. But we are now in the hands of those who can pay of absolute exercise of autonomy. And the ethical way it is done is on the basis of a full exchange of knowledge and the patient's choice.

I am saying, and this may be offensive to some, I am saying that at some point, at least in respect of those who have third-party dependents, some of these things that are technically assessed properly or that are simply absurd, have got to be stopped.

Dr. Lynn is perhaps as well informed and deeply conscientious on these principles as anybody that could possibly testify, and I think you really should address this in detail with her.

Representative SCHEUER. Well, Mr. Abrams, you have given us very thoughtful, very moving, and touching testimony, and we have gone way beyond our allotted time for your testimony.

Mr. ABRAM. I know we have. I must apologize for that sir.

Representative SCHEUER. No, no. You have nothing to apologize for. If you hadn't been thoughtful and stimulating and provocative, this part of the hearing would have been terminated quite a few minutes ago. We want to thank you very much for your testimony.

Mr. ABRAM. Thank you, Mr. Chairman.
Representative SCHEUER. Thank you for your testimony.
Mr. ABRAM. Thank you for the privilege.

OVERVIEW OF MAJOR ISSUES

Representative SCHEUER. OK. Now we will hear from the first panel on an overview of the major ethical issues. Ms. Susan Wolf, associate for law at the Hastings Center and the author of the report from which I just read a brief quote, and a very brilliant job.

Ms. Wolf is a director at the Hastings Center of the project that developed the set of guidelines on the termination of life-sustaining treatment and the care of the dying. Mr. Giles Scofield, staff counsel for Concern for Dying; Ms. Ann Neale, vice president, Bon Secours Health System; and Dr. Joanne Lynn, acting director, Center for Aging Studies and Services, George Washington University. Again, I want to thank Dr. Lynn for her prodigious efforts in helping us structure and organize this hearing. We are looking forward to this panel very much. Why don't each of you take 7 or 8 minutes, chat with us informally, and be free to comment on any aspect of the hearing this morning, either Mr. Abram's remarks or anything you may have heard from the Chair, and give us your informal thoughts and widsom on this incredibly perplexing and soul-challenging set of issues, and then I am sure after the four of you have had a chance to brief us, we will have some questions for you. We will start off with Ms. Wolf.

STATEMENT OF SUSAN M. WOLF, ASSOCIATE FOR LAW, HASTINGS CENTER

Ms. WOLF. Congressman Scheuer, I am delighted to be here today to talk about a problem of tremendous significance: the substantial obstacles that unfortunately still block good and ethical clinical decisionmaking in medicine. The very fact that we are still talking and worrying about this is remarkable. It is remarkable because I think 10 or 15 years ago, people thought these problems would be solved by now. We would recognize that patients have a basic legal and moral right to say "yea" or "nay" about invasive medical treatment. We would agree that when the patient no longer has decisionmaking capacity, somebody else—a surrogate—can take over decisionmaking for them. And we would put in place some kind of statutory recognition of what are commonly called "living wills," ways that people can say while they are still competent what kind of treatment they do and do not want when they lose capacity.

Unfortunately, these problems, these obstacles to ethical decisionmaking have not gone away. In some ways, they seem more intractable and more difficult then ever. I want to talk about why. I want to talk about what it is that seems to be blocking the substantial efforts we are making, both on the ethics front and the legal front, to put in place good decisionmaking practices. And to do that, I want to focus on one set of treatment decisions in particular, decisions about life-sustaining treatment. I am talking about cardiopulmonary resuscitation for the patient who is having a cardiac or respiratory arrest, the ventilator, dialysis, the full gamut of interventions that keep people alive.

I want to choose this focus for three main reasons.

First of all, it involves a lot of people. Of course, everybody eventually faces death. Many of us, increasingly, also face decisions about life-sustaining treatment as we approach death. Also, unfortunately, the AIDS crisis has confronted many people, often younger people with decisions about life-sustaining treatment and the need to plan for death.

Second of all, we are talking about big ticket items, a lot of money. As you yourself were pointing out in questioning Mr. Abram, life-sustaining treatment and care in the last year of life turns out to be expensive. That is provoking more and more calls for rationing and for more deliberate allocation decisions, even though it is very unclear how to go about formulating principles that we might agree upon and find fair.

Third, in some ways most importantly, I think decisions about life-sustaining treatment are the perfect test case for looking at obstacles to ethical decisionmaking in medicine generally. They are the perfect test case for a couple of reasons. One is, that how you care for people who are facing death is really the oldest concern of biomedical ethics. In fact, it is one of the oldest concerns of medicine. There is, at this point, a lot of consensus—not complete consensus, but a great deal—on how this kind of decisionmaking should happen. That makes the gap between theory and clinical reality all the more perplexing. I mean, if we agree, what is the problem? Why can't we get doctors to talk to patients? Why can't they share decisionmaking authority and honor the right of patients, the moral and the legal right, to decide about their medical treatment? Why does this gap remain very wide?

Because there is so much agreement, and so much reason to expect we would have solved these problems by now, the fact that we haven't is enormously interesting. This makes it a good test case for looking at the obstacles to good decisionmaking in all of medicine. The persistence of this gap means that this hearing comes at a very critical time. It comes at a particular evolutionary moment, I think, in the world of biomedical ethics. Biomedical ethics has come of age. You know, it is no longer the fringe pursuit of a few. It is very well accepted. It exists in the curriculum of many medical schools. There's probably not a medical student in the entire country that doesn't know at least the phrase: "informed consent." But we still have these tremendous problems in clinical practice.

I think the time has come to face the fact that the words and the theory and the models and the books and the articles, which are by now plentiful, are not enough to do the trick. They are very important. They lay the foundations. They have occasioned an enormously important scholarly and public debate. But they have not solved the problem. The clinical problems remain, and recognizing that has forced the atttention of bioethicists back to the clinic and the doctor-patient relationship, to do some hard factfinding. We need data on what is really going wrong, and new strategies to fix it.

ROLE OF GOVERNMENT IN ETHICAL DECISIONMAKING

Representative SCHEUER. Ms. Wolf, I hope by the time you finish, you will tell us what you think the role of the Federal Government should be in getting the research ideas on these ethical and moral issues into the stream of commerce, let us say, into the practical hands-on realities of doctors dealing with patients.

Is there a Federal role. It may be that there isn't a Federal role. It may be that this process should continue in a comparatively uncoordinated way—and I don't say that critically—at the State level, because medicine is licensed and coordinated by State legislatures and State health commissioners, and leadership comes from State Governors. And maybe that is the way this process should have envolved on an uncoordinated but in nevertheless a productive fashion. Or it may be that there is a role for the Federal Government for a President, for a Secretary of HHS and for the Congress.

If there is, and I really address this to the whole panel—if there is, maybe you can advise us what our role should be in the months and years ahead. We don't want to rush in where angels fear to tread. We have avoided and deferred any sense of involvement in the process of rationalizing our health care system on these very provocative and challenging and sensitive moral and ethical questions.

If we erred, it is on the side of inaction and noninvolvement. If there is no legitimate role for the Federal Government at this point in time, tell us. If there is a possible role, either for the Congress or for the executive branch, and probably working together, then tell us that in the course of your testimony. And I refer to all four of you. Excuse me. Please proceed.

Ms. WOLF. Well, I would be happy to address that immediately. I think it is a very important question for all of us to deal with. I think the Federal Government does have a role, but it has a limited role. As you point out, traditionally these have been state concerns. And I would not favor Federal preemption in some wholesale fashion of the regulation of medicine. Moreover, we really still are evolving a sense of where to go with some of the tough ethical questions. As much consensus as there is, there is still debate on matters such as the withdrawal of artificial nutrition and hydration. That remains very controversial.

Representative SCHEUER. That means food and water, as I interpret it.

Ms. WOLF. Well, I think it is necessary to be a little more precise than that in this debate. Many of those who oppose the patient's right to refuse artificial nutrition and hydration talk about the matter as if we are talking about food and water. But technically, we are talking about the right of a patient to refuse tubes and catheters, invasive conduits for nutrition and hydration. That is the key—that patients, as a legal matter and a moral matter, have a right to refuse unwanted bodily invasion.

So there remains a lot of controversy. There is an adage in the law that we should allow the States to be laboratories for experimentation. That has bite in this area, particularly where the consensus has not yet jelled. However, we do need research on what is going on in the clinic and how we can improve decisionmaking.

The Federal Government can play an important role in funding that research and encouraging it.

Second, the debate about economics cannot occur simply in a "patchwork" fashion, to borrow the word from Mr. Abram. We need a coordinated national debate about access to health care, about the kind of coverage that we are going to provide, and the like. Also, the Federal Government is funding an enormous amount of health care. So the Government is a major or perhaps the major player, when you are talking about economics and coverage.

Finally, I think the Federal Government has a significant role to play in education, doing things like holding this hearing, and certainly constituting a body like the President's Commission on Biomedical Ethics. The Congressional Bioethics Panel is the latest incarnation of Federal concern about biomedical ethics. I think such groups are enormously important. If the President's Commission on Biomedical Ethics had not existed and had not turned out its many volumes, we would be at an earlier stage in this debate nationally. The Federal Government has played an important leadership role.

PROVIDING REIMBURSEMENT FOR COUNSELING

Representative SCHEUER. Let me just ask a question here, and you can answer it now or later.

Would it help move things on a bit, if the Federal Government changed its medicare and medicaid reimbursement schedules to provide compensation for communication between doctor and patient for talk, for hand holding, for the function that Morris Abram's grandfather excelled in? He may have had a limited armamentarium in that little black—what do you call it—the little black bag of his, but he had a whole further level of contribution in consoling and encouraging and supporting the patient that many of us feel has suffered in the current preoccupation with high technology and the economic fact that doctors' time is driven by financial concerns of providing services and procedures that are compensated under medicare and medicaid.

And this would be, if it were advisable—and I would like to get the advice of all four of you on this question too, in addition to the first question I asked—would it make sense for us to make specific provision for compensating consulting time under medicare and medicaid?

Ms. WOLF. I think it would be a tremendous step forward to do that. Whenever you tie increased compensation to the high-tech character of the physician's intervention, you create a disincentive for the low-tech type of interaction—conversation, the establishment of rapport, and the like. You provide an incentive for the physician simply to abstain from conversation and go ahead and perform a procedure.

Representative SCHEUER. With somebody else. Just leave the room and go to the next patient.

Ms. WOLF. Sure. And go to the next.

Representative SCHEUER. One question that will inevitably be raised and should be raised revolves around the fact that whenever you create a funding process for something, a lot of sharpshooters

out there will sort of be poking around to see how that can be exploited and taken advantage of. How would you prevent overuse of such a consultation provision? Fraudulent claims for consultation and charging the Federal Government through medicare and medicaid for consultations which never, in fact, took place? Is there any way that this could be policed? And I don't suggest that you answer that now, but in thinking about possible changes in the reimbursement schedule, how would the Federal Government protect itself against this provision being unfairly exploited and the service perhaps not rendered or rendered very cursorily or inadequately?

Ms. WOLF. I think it is important to take a historical view and realize where we stand in a process of historical development. Right now the problem is insufficient conversation with patients, insufficient planning ahead. So we need to provide incentives to swing that pendulum in the direction of conversation. Then patients, particularly those facing decisions about life-sustaining treatment, can begin dealing with these tough questions way in advance—not at a crisis, when they are having an arrest, when they are going into the ICU or to the hospital and traumatized, but in the doctor's office before they ever enter the hospital.

The more incentives we can provide for that, the better. Now sure, we are going to have to worry then about abuses. But that is a generic concern that we already have to worry about in all kinds of spheres. Perhaps by simply approaching the problem you raise as one species of the broader genus of fraud, we can employ the normal mechanisms to deal with that problem.

I would suspect that this would not be a grave problem anyway, because as things stand we really need more talk.

OBSTACLES TO GOOD MEDICAL DECISIONMAKING

That was one of the obstacles to good decisionmaking that I was going to highlight, that there really is not enough planning ahead, with doctors and patients sitting down together. One of the obstacles to this, and it brings up your State-Federal question again, is the poor legislation that exists in some States on advance directives. Advance directives, of which living wills are one type, are very helpful documents. Patients can use them to state in advance what they want to happen to them medically if they should lose decisional capacity, and who should take over decisionmaking for them, a member of the family or somebody else.

Unfortunately, not all States formally recognize these in statute, and second——

Representative SCHEUER. Excuse me, in the list that you provided in this remarkable article from which I quoted a paragraph, I noticed New York was missing. New York was not on that list. Can it be possible that New York doesn't recognize a living will?

Ms. WOLF. Yes—their is no legislation. My colleague, Giles Scofield, may address this in greater depth. But I am afraid that New York is not on that list, although Governor Cuomo's Task Force on Life and the Law has suggested legislation that would allow people to designate a proxy in advance. Now having said that, there is case law recognition in New York for the use of advance directives. In statute, however, there is not yet recognition.

What I was suggesting before, however, is that our States should be doing a much better job in making advance directives easy—not complicated, not encumbered with a lot of restrictions, but easy.

I would like to highlight, in closing, a couple of other obstacles to good decisionmaking.

One is that institutions themselves, health care institutions, need to undertake a process of debate and developing guidelines on how to make decisions. You referred to the Hastings Center Guidelines, which is one effort to spur institutions on to this process. I do want to clarify that that was a consensus document, the work of a 20-person group at the Hasting Center of which, indeed, Joanne Lynn was an important part.

Representative SCHEUER. You were the author of this document?

Ms. WOLF. I was the director of the project that produced the book. The book itself is the result of 20 people sitting down to work out guidelines.

Another important obstacle to good decisionmaking is the lack of medical education. By that I mean not only education within medical schools but also later efforts, continuing medical education and other strategies for getting practitioners to work on their decisionmaking practices.

There are two final obstacles I would like to highlight. One is the rampant mythology about the law within health care institutions. I largely blame lawyers for this. The quality of legal advice being given is often not good. When I go around and give grand rounds or whatever in different hospitals, I am often shocked at the questions I get about the law. It leads me to believe that the in-house or outside counsel for these health care institutions are not doing their job. They are not going into these health care institutions and affirmatively educating providers. Providers then feel they have to practice law as well as medicine, in order to protect themselves from real and imagined legal threats.

Perhaps you will get into that some this afternoon in addressing malpractice. There is a real malpractice crisis, but there is also a perceived crisis, which figures large in providers' minds and deters them from candor with their patients and from good decisionmaking practices.

Finally, the last obstacles I would like to highlight has to do with economics. It is the specter of what I am going to call, and others have, bedside rationing. It has to do with the perception of economic problems that the doctor takes into the doctor-patient encounter with him. Health care professionals are well aware that there is an economic problem and calls for rationing, but no agreement on how to do it. The debate is very undeveloped and inchoate. So there is a risk of health care providers in the one-on-one doctor-patient relationship deciding to deprive a patient of some care, because it is too expensive or because that doctor feels he has to do his bit to help with the economic crisis. That leads to silent, covert, undisciplined rationing. We can't tolerate that. We've got to make sure that the level at which rationing occurs, if it is going to occur, is not that bedsidel level. If rationing is going to occur, it's got to occur at the institutional level or at the governmental level. Those are the levels at which we've got to formulate our principles, not with the individual health care professional winging it at the bedside. We

have to have explicit discussion, public debate, and scrutiny of the principles we develop.

In conclusion, biomedical ethics and the law have at this point done a lot of work articulating the necessary foundation. We've achieved a lot of agreement. The task now is to move into the clinic. We have to do some very hard-nosed investigation and research on the obstacles to good decisionmaking, and we have to proceed with determination to knock these obstacles down. I commend this subcommittee for undertaking that important process. Thank you.

[The prepared statement of Ms. Wolf follows:]

PREPARED STATEMENT OF SUSAN M. WOLF

The Obstacles to Ethical Decisions in Medicine: The Case of Life-Sustaining Treatment

I am honored to be here today to testify before this Committee on a problem of great significance: the obstacles to ethical treatment decisions for patients coping with illness, disability, and impending death. This has been a focus of my own work for quite some time. I am an attorney and the Associate for Law on the staff of The Hastings Center. The Center is an independent research institute in Briarcliff Manor, New York, specializing in medical ethics. I served as director of the Center's Project on the Termination of Life-Sustaining Treatment. That project recently produced the first comprehensive set of guidelines on how to make decisions about such treatment. In addition to my work at the Center, I have recently served on the Office of Technology Assessment's Panel on Institutional Protocols for Decisions about Life-Sustaining Treatment. I also sit on the Ethics Committee at Memorial Sloan-Kettering Cancer Center in New York, and teach on law and medicine at New York University School of Law.

The very fact that we are here today to discuss the obstacles to ethical medical treatment is remarkable -- remarkable because ten or fifteen years ago, people thought these problems would be solved by now. We would recognize the basic right of patients to control their treatment through informed consent or refusal, and the authority of a surrogate decisionmaker to decide for a patient without decisional capacity. We would enact "living will" legislation allowing people to state their treatment preferences in advance, and the problems would go away.

The problems have not gone away. Twelve years after the Karen Ann Quinlan decision recognized the right of patients to refuse treatment even if the expected consequence is death, it is clear that for many people that right remains more fiction than reality. Many patients still receive inadequate information about their options and never really become partners in the clinical decisionmaking process.

It is apparent that there are substantial obstacles to ethical decisions about medical care. I would like to concentrate in my testimony on the obstacles blocking good decisions about life-sustaining treatment in particular. I choose this focus, and would like to suggest that it is an important focus for this Committee's work, for three main reasons.

First, these problems touch an enormous number of people. We will all face death, of course, and because of the technological capacities of modern medicine, many of us already have or will confront decisions about the use of life-sustaining treatments -- the ventilator, cardiopulmonary resuscitation, dialysis, artificial nutrition, and the like. The AIDS crisis gives this a terrible urgency -- we tragically now have a whole new population of younger people who must face their own deterioration and death.

Second, life-sustaining treatment and care in the last year of life is expensive. Increasingly there is talk of rationing, and how to produce more deliberate decisions about the proper allocation of health care resources. Any sort of allocation decision, particularly when the life-and-death consequences are so direct, raises fundamental concerns about justice and nondiscrimination.

Finally, decisions about life-sustaining treatment are the perfect arena in which to examine the obstacles to ethical decisionmaking in medicine generally. Death and dying is one of the very oldest concerns of biomedical ethics. In no other sphere is there so much consensus, and such a well articulated model of what clinical decisionmaking should be. This is the fruit of more than a decade of litigation, a huge interdisciplinary literature, and a number of governmental reports -- the most important of which remains the 1983 report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, entitled Deciding to Forego Life-Sustaining Treatment. Yet despite all of this, the gap between rhetoric and clinical reality remains wide. It turns out to be much easier to change the way people talk than their actual clinical behavior. There is probably no medical student in this country who does not know the phrase "informed consent," but translating that into effective conversation with patients and support for their authority, is a much more difficult task. This would give no surprise to any sociologist, but it has come as a rude and rather recent awakening to those concerned with the quality of patient care.

This hearing thus comes at a critical time. It has finally become clear that the talk, the analysis, and the models have not done the trick. Surely they have been important. They have laid the foundations and given us a common understanding. But that is not enough. The ultimate concern is what sort of care patients are getting; how decisions about that care are actually being made; and how doctors, nurses, patients, and families are really handling these weighty problems. This is a sobering time for those who have been studying and attempting to change clinical decisionmaking. We are chastened by the limits of our success. Bioethics, in my view, is

consequently moving into the trenches. Clinical ethics is more important than ever -- ethical analysis on the ward, in the emergency room, the intensive care unit, the nursing home, and the hospice. Bioethics has always concerned itself with cases, but there is new impetus to turn to the clinic for answers, searching for the real obstacles to good care and for the possible solutions.

A number of obstacles to good clinical decisionmaking have already become apparent. I would like to suggest five that I think are particularly significant -- the need for institutional discussion and guidelines on clinical decisionmaking; the lack of good medical education on these issues, poor state legislation on advance directives, rampant mythology about the law, and risk of covert rationing by caregivers.

First, there is a need for health care institutions to undertake a deliberate process of self-scrutiny and debate, in order to formulate explicit guidelines on how clinical decisions should be made. This has already begun. Many institutions now have policy on "Do Not Resuscitate" orders. These are orders by a physician directed to all health care personnel to refrain from administering cardiopulmonary resuscitation in the event that the patient has a cardiac or respiratory arrest. This permits the patient to die without medical intervention. When the practice of refraining from resuscitation first came to light, it was beset with scandal. Patients were given DNR orders without consulting them, there was sloppy or no recordation, and there was no physician accountability. Institutions began to formulate DNR policies to cure these problems. These policies by and large mandated a patient's or surrogate's decision on the acceptability of the order and formal documentation. Now the Joint Commission on the Accreditation of Healthcare

Organizations mandates DNR policy as a condition of institutional accreditation.

Recently, there has been an effort to go beyond DNR orders and adopt institutional guidelines about other forms of life-sustaining treatment. Indeed, The Hastings Center produced a book last fall entitled Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying, the first truly comprehensive guidelines covering all the major treatment modalities. We found that in formulating guidelines it is necessary not only to recommend a basic decisionmaking process, but also to take up the special considerations raised by each of the key treatments. It is also critical to address the affirmative side of caring for the dying: palliative care, pain relief, and supportive care. Beyond that there are systemic issues: what procedures to follow in declaring death, how to structure ethics committees and other mechanisms for ethics consultation within an institution, the role -- or the limits of the role -- of economic considerations in these decisions, and how to get a grip on the currently chaotic way in which patients move between different health care settings.

Getting institutions to formulate guidelines is a promising way to help bridge the divide between rhetoric and clinical reality. But the point is not simply to have these institutions put together good-looking documents. The point is to have them use the challenge of writing guidelines to scrutinize their practice, debate the issues, and try to come to some agreement then memorialized in the policy. Even after the policy is drawn, the work is not over; the most artfully drawn policy is no guarantee of behavioral change. Policies must be accompanied by a process of education, revision, and monitoring to see whether clinical behavior is successfully altered.

A second needed strategy, beyond the institutional guidelines process, is improved medical education at all levels, including Continuing Medical Education courses for established practitioners. There is a serious lack of training in how to work with patients to make decisions about life-sustaining treatment. That training may take many forms -- from formal courses, to presentations in the hospital at Grand Rounds, to informal lunches to discuss difficult problems. A fruitful tack is to create an institutional ethics committees or hire an individual able to consult on ethical problems. Either can lead education efforts. They can also work with individual practitioners on particularly troublesome cases.

My third recommendation, turning to the patients' side of the ledger, is that we need to educate patients about their health care options and help them exercise control. Proper education requires time; ideally it should begin well before a medical crisis. The worst place to make a decision about life-sustaining treatment is in the emergency room or the intensive care unit, when the patient is debilitated and the family traumatized. Planning ahead is essential. A very useful tool for planning is advance directives. Advance directives are documents that people can use to specify, while they still have decisional capacity, what their treatment preferences are and who should take over decisionmaking in the event they should loose capacity. Two common examples are the "living will" and the durable power of attorney for health care decisions. Advance directives are governed by state law. Unfortunately, these tools are not recognized by statute in all states. Even where they are recognized, some statutes impose unnecessarily complex requirements or restrict the circumstances in which advance directives can be used. A common restriction, for instance, is that the patient must be terminally ill

for the directive to be given effect. Yet if "terminally ill" means expected to die within a certain period of time -- say, six months or a year -- that is often difficult to predict. Limiting statutory coverage to the terminally ill will exclude many whose directives should be honored. Another type of restriction beginning to appear in some state statutes is that there are some types of treatment, notably artificial nutrition and hydration, that the patient cannot effectively refuse through the directive. Yet patients have fundamental constitutional and common law rights to refuse unwanted bodily invasion. Advance directives merely help patients exercise those rights if they so wish, and in a timely fashion. All of these restrictions are counter-productive. Advance directives legislation should be simple and straightforward, not complex, discouraging, and restrictive.

A fourth obstacle to good clinical decisionmaking is mythology about the law. Misconceptions and outright error about the law are shockingly common in health care institutions: ungrounded fear of prosecution, misunderstanding of the law on the termination of treatment, and the like. This deters good decisionmaking practices. It makes physicians fearful of candor with their patients, misleads them into thinking that they cannot honor patients' treatment refusals, and discourages proper recordation of treatment decisions. Lawyers themselves are much to blame for this. Attorneys who work in medical settings have an affirmative obligation to inform themselves fully and then work with health care professionals to dispel the unwarranted fears that can obstruct good decisionmaking.

Fifth and finally, economic pressures loom large. Others coming before this Committee will undoubtedly address the direct economic disincentives to good decisionmaking; I would like to focus instead on the way in which

caregivers' subjective perceptions of the need for rationing and allocation can thwart good decisionmaking practices. Health care professionals are well aware of economic pressures and the call for rationing. Yet the public debate on rationing and allocation is at a much earlier stage than the debate about what constitutes ethical decisionmaking practices. There is far less consensus about the economic issues. In this atmosphere, where the pressures are real but the debate undeveloped and the answers still out of reach, there is a genuine risk of what has been called "bedside rationing." By this I mean the health care professional taking matters into his or her own hands and rationing or cutting costs in an ad hoc, undisciplined way in caring for individual patients. If we are going to engage in rationing care, that must be accompanied by a full and public debate and be conducted through explicit policy at the institutional or governmental level. We cannot leave individual practitioners to engage in silent rationing according to principles that may be utterly misinformed and never exposed to public scrutiny.

I believe that fulfilling these five needs -- for institutional discussion and guidelines, improved caregiver education, greater information for patients and ease in using advance directives, better understanding of the law, and a firm rejection of bedside rationing -- will go a long way toward removing the obstacles to good clinical decisionmaking.

Biomedical ethics and the law have articulated a necessary foundation for good medical decisionmaking. Yet after years of work developing a picture of what clinical decisions should look like, one thing is clear: words alone are not going to do the job. It will take hard-nosed investigation of what is really going on in the clinic, and a resolve to tear down the obstacles to good decisionmaking. I commend this Committee for undertaking that process.

ROLE OF GOVERNMENT IN RESEARCH, EDUCATION, AND DISSEMINATION

Representative SCHEUER. Well, thank you for your very direct and thoughtful statement, Ms. Wolf.

I am going to ask all of you at the end, is there a Federal role here? It seems to me that there are a few things that the Federal Government can do that are widely accepted, and one is financing research, and another is stimulating the distribution of information, and if doctors aren't really well informed, if hospitals and doctors in those hospitals aren't really well informed about the current status of the law, it seems to me that this is a fairly uncontroversial and comparatively not very sensitive or emotionally laden function that the Federal Government could provide research and dissemination of cold, hard, factual information on what the law is and what the law is not.

Think about that, and then I am going to ask all of you: Is there a Federal role here, and if so, what? And I say this with a great deference to the fact that we have 535 ethicists here in Washington——

[Laughter.]

Representative SCHEUER [continuing]. And probably this may not be the right forum to consider some of these very emotionally charged questions. But these ethicists, as they are, may agree that in some areas the Federal Government would provide a constructive intervention—the Congress and the executive branch—could help States and help doctors and community leaders in these States meet head on some of these very perplexing problems. Is there a research function? Is there an information dissemination function? And I will ask all of you that later.

Now we will hear from Mr. Giles Scofield, staff counsel for Concern for Dying. And I note, Mr. Scofield that in a memo—I don't know exactly what it is—under your imprimatur, Concern for Dying, that it lists States with specific living wills legislation, and it does not include New York. Does New York come aboard?

Mr. SCOFIELD. Well, New York has come aboard through court action. New York is like New Jersey in the sense that the courts have given affirmation or recognition of the living wills. So the Governor's task force did not perceive a need to pass legislation. In New York, the need really, as it is, I think, throughout the Nation, is for more education and how to care for patients who are terminally ill.

Representative SCHEUER. Let me add a third possible role for the Federal Government, and that is, general education. Research, education, and dissemination are three comparatively noncontrovesial roles that we play, and I think we have to make sure that the kind of education we would engage in would be consensus education. It probably would not permit the Federal Government to take a role right at the cutting edge of some of these extremely emotionally laden and controversial questions, but where there is a considerable degree of consensus, probably we could do some education, and we certainly could encourage information dissemination, and it seems to me we could do the kind of research that you folks thought was appropriate.

I apologize for the intervention, Mr. Scofield. This was on my time, not on yours. Please proceed with your presentation.

STATEMENT OF GILES R. SCOFIELD, STAFF COUNSEL, CONCERN FOR DYING

GAP BETWEEN LAW AND CLINICAL REALITY

Mr. SCOFIELD. Thanks very much, Mr. Chairman. First of all, I want to thank you for inviting us to come here and speak before you today and for the invitation to deal with these issues, if I could take Mr. Abram's remarks as a model, in a sensitive and compassionate manner. And I say that because when I was in law school the Karen Quinlan case was decided, and I don't think there is a person in the United States who hasn't heard of that case, but based on what we see on a daily basis at my office, you would think that a lot of doctors and a lot of lawyers don't know what that case stands for and aren't aware of all the developments that have taken place since that case was decided.

Numerous decisions in New Jersey, the fact that 39 States now have some form of living will legislation, the Hastings Center Report. There is so much work out there that in the cases decided most recently in New Jersey and California in the last year, the courts have begun to say, we are grown up now. There is enough law out there. There are enough studies. There are enough reports. These matters should not be in court. Physicians and patients ought to be able to decide these matters and discuss these matters on their own.

I bring that to your attention because even though the courts recognize that right, it is not reality, there is such an immense gap that exists between what the law permits and what actually goes on at the clinical level.

There was a study just published this week in Colorado from the Graduate School of Public Affairs regarding the familiarity Colorado physicians have with their State's living will statute and the living will document in general. They concluded that a sizable number of physicians, even though Colorado has had a living will for a number of years and has actually had case law on it, are in fact unfamiliar with the document. And an even greater number of physicians are unfamiliar with the uses of the durable power of attorney which permits you to have someone else make decisions on your behalf when you can't on your own.

An even larger number of physicians said that discussions about either of these types of advance directives constitutes a negligible portion of their practice.

EDUCATE PROVIDERS AND CONSUMERS ON LEGAL ISSUES

Education is one thing I am glad you mentioned because education is the one thing that Concern for Dying is all about and has been about for 20 years, educating patients as to their rights through dissemination of the living will, but also providing training and seminars to physicians, nurses, anyone on the health care side who gets involved in making these decisions.

I am going to follow on Susan Wolf's remarks and say that hospital lawyers need to be educated here as well, although I don't know exactly quite what the Federal role would be for that. When I was in private practice, I represented doctors on malpractice suits and lawyers on malpractice suits, so I am more than a little bit familiar with the extent to which lawyers fall short of the obligations owed to their clients.

Hospital lawyers, by and large, tend to know an awful lot about certificates of need, malpractice suits, zoning matters, and reimbursement matters, but when they get the call from a doctor saying I have a patient, in whatever wing, who wants to refuse treatment, the reaction is often a knee-jerk one of simply going to court instead of going to the case books and finding out what the patient's rights really are.

How you are going to educate lawyers, I don't know. I certainly would not want to have the Federal Government start paying for it, although it might make my job a lot easier.

COSTS OF LAW CLINIC REALITY GAP

The one thing I did want to bring to your attention today, because they can't be here themselves today, would be the enormous personal cost that the present gap between what the law permits and what goes on at the personal level imposes on patients and their families. There are presently at least six cases pending in States around the Nation regarding matters of treatment refusal that have been disposed of elsewhere, and there is really no substantial reason why these cases have to be in court.

When people end up going to court, it can cost an awful lot of money. It can cost $20,000 just to get the initial court order to have treatment stopped. In a case in California last year, they awarded the patient's family $160,000 for the legal expenses incurred in going to court under circumstances in which the court concluded there was no basis for anyone to be there. In the meantime, families can spend down their own resources, receiving care that they don't want.

In Michigan last year, there was a case involving a patient named Clifford Cullum who was diagnosed with Lou Gehrig's disease back in 1983. In 1985 or 1986, he and his wife had to sell their house because they had used up all their other assets to pay for their medical expenses. The $67,000 that they got from that sale was eventually used up in paying for the remainder of his medical expenses, and he ended up having to go to court to have treatment stopped. Lou Gehrig's disease is one of the worst diseases there are, and this is the case of a competent patient who clearly should not have to be in court. It is someone who could communicate.

In North Dakota last year, there was a woman named Iona Bayer, a 61-year-old patient who had suffered a heart attack and gone without oxygen for 25 minutes. I think anyone who is familiar with oxygen deprivation and its effects on the human brain could tell you that after 25 minutes, Iona Bayer's chances of recovery were pretty slim. In fact, she was left in a persistent vegetative state, the same kind of condition that Karen Quinlan had 12 years

ago. She was being maintained with an artificial breathing device and with a nasogastric tube.

Her family went to court because they believed that she would not want to be kept alive this way. The judge agreed with them and ordered the feeding to stop. What happened then is that the doctors devised another way for feeding Ms. Bayer. What they did was, they would take a large syringe and they would treat her throat in such a way so that the food they put in her mouth would not go into her lungs. They would take the syringe, load it up with about 20 ounces of food and water, and put it in a cheek on one side of her mouth. And because she still had some sort of swallowing reflex, as the nurse explained to the court, what would happen is either some of this would run out the side of her mouth or some of it would be swallowed. And they did this to her four times a day, until they went back to court.

Now, I don't know what the doctor testified to in court. I mean obviously this was not artificial feeding in the sense of there being a nasogastric tube. I have always called this artificial eating. I think that is what he invented.

But the court ruled that this is what the family didn't want when they had been there earlier in February and this had to stop as well. Well, eventually it did stop, but the problems of the Bayer family didn't. They are now being sued for medical treatment, medical care, services that were provided seemingly in one instance in violation of a court order, but absolutely regardless of what the patient's wishes were.

Representative SCHEUER. In defiance of what the patient's wishes were.

Mr. SCOFIELD. Absolutely. And they filed a counterclaim, saying if anybody is going to pay for the medical expenses, it is going to be the people who provided them to us against our mother's will, and also for the legal expenses that they incurred.

That is one of the cases that is out there, and you sit back and you say why is this happening?

ROLE OF GOVERNMENT IN LEGAL ISSUES

I think that the role that the Federal Government could play here would be if you can't educate lawyers, I guess you could probably try to educate the doctors. If they are going to be using the technology, then they have to start thinking about how they are going to use it. I don't know the best way to do it. Maybe you need to put a set of instructions on the side of every respirator saying, by the way, if you turn this on, you should be aware that there is a law in this State that under these circumstances says that you should turn it off if the patient establishes the following elements.

Perhaps through residency training programs, which I know receive some Federal support, perhaps at the nursing home level, through regulations that would give recognition to such documents as the living will, the durable power of attorney, would say that nursing homes have to act in a manner that is consistent with State law, you would start getting doctors to start thinking about these things; because I think what is going to happen is that eventually a patient is going to sue a doctor for being treated against

his or her wishes, and the patient is going to win, and the patient is going to get a lot of money.

I don't think that that is really going to solve the problem because patients don't want to be in court, doctors don't want to be in court, patients don't really want those money awards. What they want at the very beginning is the type of physician-patient relationship that is conducive to discussing these matters and planning for them ahead of time.

I don't know if reimbursement for having that conversation is the way to go. I think that any doctor who takes a sound clinical history of a patient, which always involves a personal history, should as a matter of simple sense for patients who are chronically ill say, do you have an advance directive? If something happens to you, as it might, when I have to make a decision and I can't talk to you, who should I talk to? There is no reason why that can't happen, because doctors know in their heads that it is a possibility, but sometimes they leave it there.

The Federal role can be, in getting doctors to talk and to think about these, as I mentioned, either through residency training programs or a change in regulations or something like that. I think you could provide a leadership role and a role of guidance that wouldn't preempt the States, but would give the Federal Government a chance to take the first step in getting doctors to start thinking about technology instead of just using it. Thank you.

[The prepared statement of Mr. Scofield follows:]

PREPARED STATEMENT OF GILES R. SCOFIELD

Good morning. On behalf of the Board and supporters of Concern for Dying, I want to thank the Committee for inviting us to discuss the ethical and legal issues facing the medical profession. We welcome the opportunity to assist the Committee in its efforts to explore and resolve these important social questions.

For those of you who may be unfamiliar with us, let me provide a little background about Concern for Dying. Concern is a charitable, educational organization founded in 1967 to increase public awareness of the isssues of death and dying, especially in light of the choices afforded patients by modern medical technology. It is the only educational organization devoted solely to the ethical, medical and legal issues relating to the care and treatment of terminally ill patients. We are dedicated to insuring that dying patients receive proper care, which includes respecting their right to refuse treatment.

Concern's early members drafted the first Living Will, by which individuals may express their specific directions regarding treatment or refusal of treatment during a terminal illness, thereby insuring that the patient's wishes are given the pre-eminence the law requires and relieving family, physician and others from the agony of a substituted decision made in a vacuum.

Since 1968 concern has distributed over eight million Living Wills.

Society and medical technology have come a long way in 20 years, and yet we are facing many of the same questions that surfaced prominently in 1968. That was when we heard of the first successful heart transplant, the Harvard criteria for determining brain death, and the Living Will. Although the technology has changed and introduced us to other new marvels, it has simultaneously created new types of problems and a steady stream of vexing moral and, unfortunately, legal questions. These include:

How do we decide what care to provide dying patients, and how that care is to be paid for?

How should the medical professions respond to the patient who wishes to refuse any further treatment?

At Concern we seek to address these issues from the patient's perspective, taking into consideration the concerns of those whose job it is to provide that care.

Although it has had to accommodate all the many changes medicine has brought us, the thinking that led to the Living Will's development has remained fundamentally unaltered. It is based on a simple principle, as old as the common law: you may not treat a patient against his or her wishes. Treatment that is neither desired nor invited is unwelcome. This belief, grounded in the doctrine of informed consent and, in some states ,in the

right of privacy, protects a patient's right of medical self-determination.

Related to that principle is the belief that the decision to apply, withhold or withdraw medical treatment of whatever sort is ultimately a matter of human judgment. That technology gives us options, but doesn't dictate what should be done. That though we may have an artificial heart, an artificial kidney and even something called artificial intelligence, there is no such thing as artificial judgment. Personal choices must be made by the people who will be affected by them. That means by the patients. No matter how marvelous medicine becomes, decisions about its use must always focus on the personal desires of the patient and the realities of modern medicine. Which is to say that sometimes we can postpone or delay death, but we're not going to conquer it.

Judgment involves responsibility, and in the realm of the critically or terminally ill patient that responsibility is awesome. But we assume that responsibility, willingly or not, by developing and using the technology that has become so familiar to us. Unless we wish to discard that technology we may not shirk the responsibility it imposes on us.

Applying these principles provides substantial guidance to resolving many of the issues we face. Competent patients have the right to refuse treatment, even life-sustaining treatment, and may express that preference verbally, through a living will, some other form of advance directive (such as a durable power of

attorney), or in any other reliable mode of communication. This is recognized in the 39 jurisdictions whose legislatures have passed living will legislation and wherever courts have upheld this fundamental principle.

A legally authorized representative, such as a guardian, conservator or the holder of a durable power of attorney, may make such decisions on the basis of this type of evidence or, in its absence, on the basis of what would be consistent with the patient's personal values and beliefs, or, failing either of these, by a determination of what would be in the patient's best interests.

In the twelve years that have followed the famous Quinlan decision, these principles have been endorsed and elaborated on by numerous court decisions, professional organizations such as the American Medical Association, the Presidential Commission Report, Deciding to Forego Life-sustaining Treatment, and most recently, the Hastings Center's Guildelines on the Termination of Life-sustaining Treatment and the Care of the Dying. Despite these achievements, patients and their families suffer from the immense gap that separates what the law permits from what doctors do.

We receive about 50 phone calls each day from people who are worried about the prospect of being maintained unnessarily by an array of tubes they don't want. These calls frequently come from a family facing the ordeal of a loved one who has already been hooked up to one of these devices despite evidence that it wasn't

wanted and the doctor's acknowledgment that the patient is not going to recover. And yet the family can do nothing because of the doctor's belief that what the family wants constitutes murder, or might result in a malpractice claim, or requires a court order. In fact, a colleague of mine recently encountered a hospital that has a "policy" of requiring court orders. None of these concerns is realistic, and patients end up bearing the burden of someone else's misperception of what the law permits.

It can easily cost up to $20,000 for a family to initiate and complete the process required for getting a court order. The process can be lengthy, especially if a hospital or doctor elects to appeal an adverse decision. The New Jersey Supreme Court, in the trilogy of cases decided last summer, said that in most instances there is no need to be in court and that no purpose is served when a doctor appeals an adverse trial court ruling. Two recent California cases went so far as to award counsel fees to patients who were unnecessarily forced to seek court orders. In one case those fees were $160,000; in the second it will likely be an even larger amount. These courts basically are saying that there are enough cases, reports, and studies on these matters for physicians to make the decisions without going to court. And yet, from the daily phone calls we receive, it is clear that many requests go unheeded, and that still patients fear they will be trapped by medical technology they do not want and cannot stop.

What is equally clear from these cases, reports and our experience is that many people do not want to be sustained

indefinitely on life-sustaining treatment, or even receive cardio-pulmonary resuscitation in the event of a foreseeable cardiac arrest. With advance planning, through a Living Will, these choices may be made and human tragedy avoided. Yet we have also found that the Living Will, while a legally valid document, is no substitute for a compassionate and candid relationship with one's physician. Patients want doctors to listen to them. In order for this to happen more physicians, nurses, hospital administrators (and the lawyers who represent them) need to know that when a patient says "enough" it is not time to call the risk manager or the district attorney or the local judge. It is time to resolve this matter where it began, in the context of the physician-patient relationship. For this reason, we believe that improved professional education will enable patients to refuse treatment they do not want and receive the care they deserve.

If we lived in a world where life went on forever we might not have to make these types of decisions. There is no magic bullet that can make this profoundly difficult problem go away. Especially in this age of cost consciousness treating patients who don't want it makes little sense. It would certainly help if we could persuade doctors to stop forcing treatment on people who don't want it.

The ultimate question, therefore, is whether we want to live in a society where medical care is applied with or without regard to a patient's wishes. Most patients and most doctors do

not want to be in court. As a judge who handled one of these cases recently said, "When a doctor calls a judge, he's no longer practicing medicine." Unless doctors are willing to practice medicine in a responsible and compassionate manner these principles will remain meaningless to patients. It requires effort, but it can be done. It involves, especially in an age of budgetary constraints, facing the limits of our society and its resources, just as facing death necessitates facing the limits of our existence.

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Representative SCHEUER. That was provocative and thoughtful testimony.

The Federal Government does have a means of encouraging the States to take all kinds of action without forcing them to do it, by use of the carrot rather than the stick, and provide Federal moneys for such and such an activity, so long as the States do thus and so.

What the two of you, I guess, are suggesting is that at a certain point in a patient's life, a hospital is a dangerous place to be because a patient, once he enters those portals, or is carried into that place on a stretcher, loses all autonomy, loses all control over his or her own life.

Is the answer for an individual to stay at home, to die at home, where at least he has control? For some individuals that is a practical alternative; for many others it would not be a practical alternative.

Is there any other kind of a place where a patient could go and get whatever care they would deem appropriate for them in their stage of living or dying from a terminal disease perhaps, that would be designed to ease their suffering, ease their pain, and let them die a death of dignity? Is there a place where they wouldn't lose control, where they would be capable of limiting the kind of health care they receive to avoidance of pain and suffering?

Is there a possible role for the Federal Government in saying to all hospitals that receive Federal moneys of any kind—and that presumably includes 99.99 percent of all hospitals—yes, you do receive Federal funds and we are going to establish a condition of receiving Federal funds. That condition is that in some way that I can't define at this moment, you must recognize the patient's right to make key decisions over their life and death, so long as they are competent, and you must recognize the right of a patient surrogate and/or family and/or doctor to make those decisions in the event that the patient is no longer capable of making those decisions. Is there some way that could be done?

MEDICAL ETHICAL DECISIONMAKING

I am very happy to recognize Ms. Ann Neale, vice president of Bon Secours Health System. We are very happy to have you Ms. Neale.

Please proceed as have the first two witnesses in chatting with us informally, and then I am sure we will have some questions.

STATEMENT OF ANN NEALE, VICE PRESIDENT, BON SECOURS HEALTH SYSTEM, INC.

Ms. NEALE. I would like to add my voice, commending you and your committee for holding these hearings and thank you for the opportunity to participate.

When Mr. Podoff invited me, he suggested that the panel would be addressing decisions around the treatment of terminally ill persons, neonates, elderly persons, and he also expressed your interest in the issue of organ transplantations.

Having to narrow this because of time limitations, for both speaking and preparing the text, I, too, concentrated on life-saving technologies from two different perspectives: the clinical decision-

making perspective where the major players are the patient, family, and care giver—prominent among them, the physician—and I would concur with my colleagues who very much assert and insist that the patient is the primary decisionmaker; and then also from the perspective of allocation and rationing, where it is generally agreed that the locus of authority rests with regulatory and legislative bodies at the regional, State, and Federal levels, I want to move on to discuss life-saving technologies from the perspective of allocation and rationing.

I entitled my own remarks "Limits and Balance in Clinical Decisions Concerning and Policy Decisions Allocating Health Care Resources," so my theme is going to be limits and balances. I am cognizant that this is a subcommittee of the Joint Economic Committee. I can imagine that a good deal of your interest has to do with the fact that we spend more money in our country than any other country in the world on health care, both in absolute dollars and as a percentage of gross national product.

We do that, despite the fact that our outcomes, our statistics, are not better than and often are worse than other countries with much less spending.

Representative SCHEUER. As an information matter, we spend just under 12 percent of GNP for health. The average that the OECD countries spend, the developed countries of Europe, Australia, New Zealand, Canada, Japan, the average is about 8 percent, so we are spending almost 50 percent more than the average and, as you say, with little or no indication that they are suffering inferior health outcomes to us.

Ms. NEALE. I don't mean to diminish the economic implications of all of this, but I suggest that the issues that we are grappling with are really fundamentally philosophical and political issues. Other countries can and have solved the economics, and persons much better equipped than I have laid out various ways that we can cap and contain costs.

So I suggest that what is lacking is not an economic solution as it is the moral understanding and conviction, conversion perhaps, and a political will then to act on that which needs attention in these matters.

COSTS IN PROLONGING LIFE

What I have done in my section of testimony concerning clinical ethical decisionmaking is talk about life, its purposes, its value, its meaning. I have given a very cursory outline, a sketch of an argument that concludes that although life is intrinsically valuable, it is not an absolute value. We are generally obliged to preserve and to prolong it, but up to a point, a reasonable point.

My starting point is that life is a fundamental good, that it has intrinsic value no matter its quality, and that a basic ethical assumption, it seems to me, of medicine is that we would protect and preserve and often, if not usually, prolong life.

I think, however, it is important to note that quality of life is a relevant factor, as is cost, in determining our obligation to prolong life. The reason we prolong life, it seems to me, is because physical life enables us to pursue other human goods such as knowing, re-

lating, loving others, pursuing truth, beauty, good, playing, all those good kinds of things.

If the life that we experience is so minimal, if the quality is so diminished that there is no prospect, virtually no, or very little, prospect of engaging in any other of life's human goods, although the poor quality doesn't affect the value of that life, that life is still valuable—it makes moral claims on us—it may affect our obligation to preserve it. And in fact I suggest that it does. And cost entailed in the preserving of life is also morally relevant.

Representative SCHEUER. You have said something very important when you said that the costs of preserving that quality of life and of deferring death are morally relevant. You said something very important there.

Either you can pursue it now or I will ask you some specific questions later on.

Ms. NEALE. I will pursue it to this extent. I think that there is nothing in a sound ethic, nothing in a sound Christian ethic, nothing in a sound Roman Catholic ethic, that would suggest we have to prolong life at all costs. The Roman Catholic Church, is noted for its strong prolife position yet years ago the Holy Father said, in making the distinction between ordinary and extraordinary means, that you don't have to move to Arizona if that would improve your asthmatic condition. You don't have to take on burdens that impinge on other of life's value. We need to preserve and prolong life up to a reasonable extent, and there is some legitimate leeway within that.

So I am pointing out for the 535 enthicists in Congress that there is nothing in the Roman Catholic ethic, and I would say in any sound human ethic——

Representative SCHEUER. Excuse me, Ms. Neale. I never said they were in Congress. I just said there were 535 distinguished ethicists in Washington.

Ms. NEALE. Excuse me. I jumped to a big conclusion. I don't want them to think that a religious tradition as strong as ours in the area of life and the obligation to prolong it would stand in the way of an individual clinician suggesting to a patient who has the right to decide—the locus of decisionmaking is there—that perhaps it is reasonable to cease with aggressive measures and to intensify our comfort measures.

There are other important values for the individual and society, it seems to me, which ought to take precedence. A well-known moral theologian in our tradition, Dick McCormick, cites what he thinks are two misguided positions with regard to our obligation to prolong life. One he calls medical moral pessimism. Persons coming from this perspective find life of absolutely no value unless it is totally robust, and they would be inclined to drop life-prolonging treatments if the infant couldn't go to Harvard, or if there was any diminishment of potential. That is a midguided position, a pessimistic position.

Likewise is a medical moral optimism misguided. These are vitalists. They believe that life is the only and the highest and the best good, and that we must do everything we can to prolong it at all costs.

Well, Dick McCormick suggests that we follow a middle ground, one that values life, that sees intrinsic value in all of life, but which suggests that we have a limited obligation to preserve it.

Now, I haven't said exactly what those limits are, but I would be willing to venture in a question and answer period what some of the limits quite obviously are. But my testimony then goes on to the issue of allocation of resources, and I suggest that limits and balance are required here.

BIAS TOWARD HIGH-TECHNOLOGY CARE VERSUS OTHER NEEDS

The imbalance I am speaking of is the emphasis in our health system, which has already been alluded to by previous speakers, on acute inpatient, high-cost, high-tech care. That bias was shown even in the recently touted medicare overhaul. The immediate health benefit to medicare individuals is going to be significantly reduced liability for unlimited inpatient hospital care.

So what we are doing is, the immediate payoff for that, which every medicare beneficiary is paying for, is inpatient, probably high-tech care, which very few medicare beneficiaries draw on.

But I think two more obvious examples of this in our health system, and Mr. Scofield particularly alluded to it, are the intensive-care efforts we make—I will cite the example of neonates. Neonatal intensive care units seem to have elastic walls and we don't always, it seems to me, although it is harder in the case of infants and children to be sure about prognosis, but we don't always look at prognosis, the ability to pursue life's good as carefully as we ought to, so that we have neonatal intensive care units spending thousands, tens of thousands, perhaps hundreds of thousands of dollars on children whose prognosis is very grim, if at all hopeful.

That happens at the same time, in the same city, perhaps in the shadow of that same neonatal intensive care unit, where scores, perhaps hundreds of children are not getting routine care—immunizations against childhood diseases.

I work for an organization that has numerous hospitals and nursing homes. I am aware that in our hospitals we have played out—and I know that this is true probably in almost every hospital in the country—the tragic and, in fact, I would say sometimes the absurd drama of elderly people, end stage numerous diseases, no longer going to regain any cognitive or affective function, who may even have expressed prior wishes, but if that is not the case their loved ones are expressing them for them, asking not to receive care, not being totally informed about what "everything" means, and spending thousands of their dollars or the public's dollars on care that really, it seems, we don't need a professional ethicist to decide is not proportionate to the benefit.

REALITY OF LIMITED RESOURCES

What I am suggesting then is that we have to be ready to make some hard choices, and I think policymakers have to be ready to make them. It seems to me that in light of the potential unlimited technological interventions and the limited public funds, we have got to make explicit the choices we are making.

HCFA, for instance. It must be very difficult for those officials to decide not to reimburse for a spectacular, potentially life-saving technology. Doing that makes it less possible for them to reimburse for other more appropriate technologies.

My State, Maryland, chose to mandate an insurance benefit for childless couples. I know that I don't fully appreciate their tragedy—because I am not part of a couple wishing to have a child and unable to do so—but that sad fact itself is not, it seems to me, sufficient reason to go ahead and mandate in vitro fertilization as a benefit that must be offered by every insurer who comes into the State.

There are costs far beyond the economic costs of that, and I am not even speaking to some of the Roman Catholic concerns about reproductive ethics. There are justice issues. There is the matter of employers going to self-insurance, and in that case they are not covered by ERISA and can have much less adequate packages for their employees than the law permits.

There is a remarkable instance, I think, or responsible policymaking that happened within the last year at the State level. I am alluding to the decision by the medicaid program of Oregon to not cover organ transplantations other than corneas or kidneys which had been covered. What led up to that was a very thorough education process in the State of Oregon, called Oregon Decision, where through town hall meetings, church gatherings, living room forums, persons were educated about health care financing, the tradeoffs that had to be made, so that when the medicaid program found that it had $48 million worth of health service enhancements vying for $15 million of funds, organ transplantation and other matters did not make the final cut.

Now, people in Oregon are able to accept that with some equanimity and they understand the rationale. That is not true, it seems to me, as that news hit the fan. The media that I have seen have really called into question the sincerity and the goodness and the reasonableness of that kind of a decision.

I think policymakers have to bite the bullet and make that rationale clear.

Representative SCHEUER. Apparently that decision was made after considerable public introspection, as you say, through church groups, religious meetings, local meetings of all kinds.

Does that indicate to you that this is the proper way for these agonizing decisions to be made by a community, by a State, and that we are less able to engage in a national debate in the churches and synagogues and whatnot than we are on a State level, and that perhaps the way we should make progress in the future, the near term, is to follow the Oregon example and let the States mobilize their religious leadership and their spiritual resources in the kind of fashion that apparently Oregon did?

GOVERNMENT ROLE IN ALLOCATION OF RESOURCES

Ms. NEALE. I don't think it is an either/or decision, Congressman. I believe that those things should happen, those local intitiatives should happen. But I believe that policymakers at the Federal level and even at the State level, absent that kind of thorough-

going education, have all sorts of opportunities to make principled decisions, for instance with regard to what you are going to fund or not fund, what kind of benefits will be included in the medicare-medicaid package, what the income eligibility levels will be.

One thing that the Federal Government could do right away would be to make medicaid a Federal program from the perspective of income eligibility and benefits packages, and they are moving towards that. But the fact that it is a State-Federal program, and that States can set the income eligibility level—and some of them don't do it totally out of miserliness, they don't have adequate resources—I think is a disgrace, and that is why we have so many poor persons who are not covered by medicaid.

So I would like to see action happening at both levels and not let Federal lawmakers off the hook.

What I am suggesting then is the fact that there are childless couples who might be benefited by in vitro fertilization, but cannot afford it, or a 7-year-old boy who needed a bone marrow transplant in Oregon but did not receive it, those may be unfortunate realities, and they surely are unfortunate realities, but they are not necessarily and I suggest they clearly are not unfair, given the health system that we have now.

We should not be saving a few hundred thousand dollar lives and not acknowledging that we are not serving well thousands of lives that could be saved at much lesser costs.

CHRISTIAN ETHIC DOESN'T PRECLUDE ALLOCATING HEALTH RESOURCES

My message then in my testimony is that a sound ethic, surely a Catholic-Christian ethic, concerning our obligation to preserve life or to provide health resources does not preclude, in fact it may require acknowledging and setting limits, both at the clinical decisionmaking level at the given institution, and surely at the level of allocation where policymakers and regulatory bodies are making the decisions; because physical life is only one value. Justice is not necessarily served by providing extraordinary benefits to a few at the expense of ordinary benefits for many more.

I recognize that setting limits is not popular, at least in the short run, and I do recognize that the political challenge is formidable, but I think that the moral imperative to right our system leaves us no option. Thank you.

[The prepared statement of Ms. Neale follows:]

PREPARED STATEMENT OF ANN NEALE

LIMITS/BALANCE IN CLINICAL DECISIONS CONCERNING AND POLICY DECISIONS ALLOCATING HEALTH CARE RESOURCES

Introduction

I commend this subcommittee on these hearings concerning The Future of Healthcare in America and am pleased to be able to address some major ethical issues.

The ethical issues this panel was asked to address -- decision making about treatment of severely compromised newborns, terminally ill adults, organ transplantation -- can be approached from a variety of angles.

I will first attempt to shed some light on the principles and values which should guide clinical decision making about these matters. It seems to me that primary responsibility for medically, morally and socially responsible decisions at this

level rests with the patient, family, and caregivers. The health care facility can promote sound clinical decision making through education, providing forums such as ethics committees to institutionalize ethical decision making, establish pertinent policies and hold physicians, especially, accountable to them.

Next I will comment about these matters from the perspective of resource allocation, justice and the common good. The health care community must, of course, contribute to this debate as well, but the locus of authority and policy making for these decisions seems to be the body politic, more specifically, state and federal regulatory and legislative bodies.

Problems at the level of clinical decision making have to do with the technological imperative -- an uncritical inclination to apply life-saving technology even when it is not wanted by the patient, provides no benefit proportionate to the economic and human costs and is, therefore, medically contraindicated.

Allocation problems which I have described as being the responsibility of the political realm, occur because we tend to develop and fund health services which are technologically sophisticated at the expense of needed, less expensive, more appropriate health services. This results in serious access and economic problems.

I will try not to lose sight of the fact that this is a subcommittee of the Joint Economic Committee. I suspect that the fact that the U.S. spends more on medical care than any other country in the world (both in absolute terms, and as a percentage of its gross national product) has a great deal to do with your committee's interest in these issues. I assure you it is as disconcerting to me, an ethicist, as to yourselves that recent cost containment programs have had little effect on overall expenditures -- especially since our outlays are greater than, and our health statistics often worse than, those of most other industrialized nations. I hope also to assure you that nothing in the values and principles that should inform clinical ethical decision making should stand in the way of policy makers' trying to rationalize the system. Allocation, indeed, rationing of services, even if that results in some individuals not receiving life prolonging technologies they "need" to live, is necessary to making ours a morally defensible health care system.

In other words, limits and balance are required at the macro level of determining availability and distribution of health care resources.

Although the precipitating factor bringing these issues to your committee may be economics, I suggest that the problems which you as legislators face in improving the economics and financing of health services are not fundamentally economic problems, they are philosophical and ethical problems.

Who as a nation are we? How do we value health services? Do we really believe everyone should have access to a decent minimum of health care? If so, what should we do about it?

Clinical Decisions Concerning Life Prolonging Treatment

Let me turn, then, to the matter of decision making about prolonging life which goes to the heart of patients' rights and the medical profession's responsibilities and which calls into question some of our most seriously held beliefs and values.

Decisions about whether or how aggressively to treat seriously ill newborns or terminally ill elderly are never easy. There are no answers or formulae which can be given in advance. There are some values and principles which should inform all such decisions, however.

The crux of the issue, it seems to me, is whether there are limits on our obligation to prolong life, and if so, how we can discern them. That is, the significant ethical question in a particular preservation of life dilemma is, "Is there an ethical obligation to prolong life?" -- Not, "Are we able to prolong life?"

In grappling with that question we need to be clear on what we think about the value of life, what assumptions or biases we have in that regard.

I will lay out, in summary fashion, an argument about the meaning and value of human life which goes some way towards helping us know what we should do in these difficult circumstances. This position is one that is consonant with the Catholic, indeed, the Christian moral tradition.

My starting point is that life is a fundamental human good or value. It is intrinsically valuable, no matter its condition or quality.

Furthermore, the basic ethical assumption upon which medicine and health care are based is that life should be prolonged because living enables us to pursue the purposes of life. I take the purposes of life to be things which require at least a minimum level of cognitive and affective functioning such as knowing, relating to and loving others, pursuing knowledge, beauty, truth, playing. In other words, mere physical life is not an end in itself -- rather it is a necessary condition for pursuing other human goods.

Medical ethical decision making is shaped not only by our value/view of life but also by our understanding of death. A basic Christian understanding of death regards it as a physical evil, something usually to be avoided, but ultimately accepted as inevitable. Indeed, it is a necessary transition to a fuller life in Christ. The ethical corollary, is then, that we generally have an obligation to prevent death, but not at all costs.

Finally, it should be noted that quality of life is a morally relevant factor in decisions about whether one ought to prolong life. The quality of life does not affect its value. All human life is intrinsically valuable and makes moral claims on us. One's quality of life may, however, affect the ability to pursue the purpose of life (the purposes of life, you recall, require some degree of cognitive-affective functioning) and may, therefore, affect our obligation to preserve that life.

If efforts to prolong life are useless or result in a severe burden for the patient insofar as pursuing the purposes of life is concerned, then the obligation to prolong life is no longer present.

Physiological function, when it can be prolonged after cognitive-affective function ceases irreparably, is not a sufficient reason for prolonging life.

This is because physiological function, bereft of the potential for cognitive-affective functioning, does not benefit the patient and does not contribute to pursuing the purposes of life.

The usual ethical obligation to prolong the life of another person ceases once it can be determined that the person will never recover or initially develop, cognitive-affective function.

The foregoing, if persuasive, only allows that it is acceptable in some circumstances to forego or withdraw life saving treatment. It does not settle the matter of who should be involved in that decision and how to reach that determination in specific circumstances. For the purposes of this testimony, however, it seems sufficient to emphasize that decisions about management of the critically ill are not merely medical decisions. They also have ethical, economic and legal implications and the responsibility for contributing to those decisions is shared by many.

Reverend Richard McCormick, S.J., claims that there are two misguided positions about our obligation to preserve life. One he labels medical moral pessimism, that is, the view that life has no value unless it is totally robust. Someone with this bias would refuse life saving treatment just because the life is of diminished quality, no matter how slight. An equally misguided position is medical moral optimism, or vitalism, which regards life as the highest and best good. Death, from this perspective is an unmitigated evil to be avoided at all costs. Therefore, maximal treatment is always thought by vitalists to be optimal treatment.

McCormick advises us to strive for a middle ground which does not view life as an absolute good, which values all life regardless of quality, but which recognizes a limited obligation to preserve life.

Allocation of Health Resources

Having put forth a position on the appropriateness of selectively allowing to die, withholding life-saving treatment, or treating dying persons with comfort rather than aggressive measures, I would like to turn to the matter of distribution of resources and show that limits or balance are called for in this arena, too.

I have already referred to the very high and rising costs of American medical care. I do not wish to criticize the technological sophistication of American medicine, though I do take serious exception to our emphases and priorities. We have in this country, through a series of technical, professional, political and economic decisions, chosen to create a health care delivery system which is skewed towards high technology, in patient, emergency, expensive care. This bias is clearly evident in the recently enacted Medicare overhaul. The immediate, major benefit enhancement is a greatly reduced liability for unlimited, inpatient hospital services covered by Medicare. Although all Medicare beneficiaries will pay higher premiums, only a small percentage of elderly actually have long and expensive hospital stays.

There are numerous other examples of the imbalance in U.S. health services. In the same city where an affluent suburban, perhaps even an indigent inner city, neonate with minimum brain stem activity, and grim prognosis receives hundreds of thousands of dollars of high tech interventions in the struggle to maintain his or her vital functions, scores of infants -- perhaps living in the shadow of that very neonatal intensive care unit -- do not receive their immunizations against serious childhood illnesses such as polio, measles, mumps and diphtheria.

In most every U.S. hospital there is regularly played out the tragic, often times absurd, drama of an elderly, terminally ill, or perhaps permanently vegetative (unconscious), individual being aggressively treated with highly sophisticated, very expensive life (or death?) prolonging technology. Eight months earlier the spouse of this same individual would probably not have been able to receive the health services support she needed to appropriately care for her husband in their own home or the reimbursement to pay for their necessary prescriptions.

Policy makers are loathe to make explicit the hard choices that need to be faced in light of potentially unlimited medical technological interventions and limited public resources. It is not easy for HCFA to refuse to reimburse for a spectacular, potentially effective life saving technology which would benefit a few, because it would mean that many more would fail to receive less spectacular, but much needed, health services. The tendency is to appropriate money for high tech research and services despite the fact that many worthy, but more pedestrian, low level technologies are insufficiently funded. Nevertheless, choices -- and therefore tradeoffs -- are constantly being made, and we are less well served than we might have been if the implications of those tradeoffs were identified and comprehensively assessed.

For example, childlessness is a great cross to many infertile couples. That reality itself is not sufficient reason to mandate insurance coverage for in vitro fertilization in a given state. Problems, in addition to cost, are generated by numerous mandated benefits. Reason and fairness, rather than emotion, should prevail.

Frequently, the spotlight in these dilemmas focuses on the medically indigent. They become the focus of our attempts to "rationalize" the health care system. A recent decision in Oregon concerning organ transplants illustrates this well.

In July Oregon's Medicaid program made permanent a policy to limit organ transplants to kidneys and corneas. They came to this decision because they had $48 million worth of human service program enhancements vying for only $15 million in extra general fund revenues for the FY '87-'89 biennium budget. The legislature decided to invest in prenatal care services instead of organ transplants.

State Health Notes (#79, January/February 1988, p. 7) reports that, "The final budget allowed the Oregon Medicaid program to expand medically needy income levels, increase reimbursement to obstetricians by 50%, cover low-income pregnant women and infants and add case management for high risk pregnant women. By adopting this prenatal care package, the legislators made explicit their preference for investing in preventive services for greater numbers of people, rather than paying large sums of money to pay for "high-tech" procedures that would only benefit a few."

The fact that a seven year old Medicaid beneficiary "needed" a bone marrow transplant which he would not receive because of this policy is unfortunate -- but not necessarily unfair. Nevertheless, the rationale for this responsible action on the part of Oregon legislators has not been well explained in the media I have seen. The moral probity of this policy does not seem to be understood, at least by the public outside Oregon. Unfortunately, other state and federal legislators may be reluctant to take similar responsible action in the public policy arena.

It is easier, now, while the trade-offs are still implicit, to deny thousands of beneficiaries necessary preventive and primary care benefits, than it is to deny a few identified individuals a very expensive, often dubiously effective, extraordinary benefit.

I contend, however, that it is much less reasonable and quite clearly unfair.

Such inequities are not isolated anomalies in the U.S. health care system. Rather, they characterize it and can be traced to competing values and interests well detailed in an essay by Daniel Callahan in the April/May 1988 Hastings Center Report.

Furthermore, although the poor bear the brunt of such inequities and enjoy the fewest of our health system's benefits, everyone of us, no matter how affluent or well insured, is inadequately served by a system which is tempted by sophisticated technology and the lure of profit to pursue primarily emergent services, usually for the well insured, at the expense of primary and preventive services for all.

I suggested at the beginning of this statement that these issues were fundamentally philosophical and ethical, and not economic, in nature. They have to do with who we say we are. Actions, we know, speak louder than words. An analysis of the adequacy and fairness of our health system will tell us more about the sorts of people we are than will pious protestations about our concern for the health and welfare of all our citizens.

Presently, our unjust health non-system, shows that we are not a people who value access to basic health services for all. We are a people who value (because we pay for and provide) costly health care for some, and who leave many outside the system altogether.

To the extent we do so under the rubric of a Christian ethic concerning the need to preserve life I submit that we need to reexamine that ethic to better understand the meaning and value of life. Indeed we need to supplement it with a better notion of community, interdependence, and the common good.

Life is not an absolute value. Quality of life and cost (both human and economic costs) are morally relevant factors both in determining our obligation to prolong life and to allocate and ration health care services.

Shaping reasonable health care policy, particularly when it entails defining limits and achieving balance, may not be popular in the short run. The political challenge is formidable. But the moral imperative to do so, it seems to me, leaves us no option.

Representative SCHEUER. That is an extraordinarily courageous statement and a forthright statement, and I congratulate you for having made it.

I am going to ask the entire panel, when Dr. Lynn is finished speaking, how do we bite the bullet and establish up to this point, yes, beyond that point, no. That is the process of triage that you are saying we must engage in, in a more rational way than we are doing it now. And I am going to ask all of you how.

MUST RATIONALIZE ALLOCATION OF HEALTH RESOURCES

Dr. Joanne Lynn, is acting director, Center for Aging Studies and Services, George Washington University. Now you are living with the "we must reap what we have planted." You have planted the seeds for this hearing, you are now the home-run batter on this remarkable panel, and we thank you for your help and we look forward to your testimony. Please take such time as you may need.

STATEMENT OF JOANNE LYNN, M.D., ACTING DIRECTOR, CENTER FOR AGING STUDIES AND SERVICES, GEORGE WASHINGTON UNIVERSITY, AND MEDICAL DIRECTOR, THE WASHINGTON HOME

Dr. LYNN. Thank you. I am honored to have been asked to be part of the planning, as well as giving testimony, and pleased that the Congress is taking some note of the fact that it isn't just the ways and means that shape the health care, but also the rules under which we operate.

Let me take your earlier invitation seriously—you keep saying that we should chat with you—and I will pretty much abandon my prepared statement in the hope that their organization and clarity will be read by someone some day, and embark on trying to answer some of the questions you have raised during the hearing and that others have raised, or at least give some thoughts on the matters raised.

I find it troubling to be a practitioner in the setting in which I practice. I am a physician who works almost entirely with the very old or people who are close to dying. It is not an area of medicine that is highly, funded, highly visible. It is not the area of medicine that we have designed our health care system to serve. And yet it is an area of medicine that virtually everyone in this room will confront.

Most of us in this room will die while old, we will mostly die of chronic illnesses, we will die of illnesses that we know more than a year prior to our death will take our lives. We will have a chance to plan. We will have a chance at good care. We will have a chance at living well during that time, and if our current care system persists into my old age, I am very unlikely to get that care. I am very likely to be essentially abandoned, to be largely requiring the services of my family. That family will largely get no support from anyone in providing those services, and this leads to a demonstrably bad system of care.

There is a comfortable vision of our problems and I think that as we get into the hard nuts and bolts realities of the political possibilities of resolution, we all retreat to that comfortable vision. That

comfortable vision would go something like this: that we are a large and wealthy nation, we have very creative and innovative minds; that those problems for which we can't find technological solutions can be solved by eliminating waste, by promoting health, preventing illness, being kind, encouraging kindness, and all will be well; that we can find ways of getting rid of those wasteful things that Morris Abram outlined and that others have mentioned; that if we can just find ways of getting people healthier and healthier, that somehow this whole problem will go away.

I think that is a sham, that it will not happen, although we can eliminate waste to a certain extent. A certain amount of demonstrable waste is present in every system. We can eliminate a certain amount of the waste in health care and it will be absorbed immediately by the black hole of yawning needs

There are needs within 10 blocks of this place that would consume all of the conceivable cutouts of waste of all of the medical institutions in the city. There are people in this city who cannot get prenatal care. There are people in this city who cannot get meals on wheels because the neighborhoods that they live in are too dangerous to deliver meals in. There are people in this city who will wait their lifetime, waiting for drug abuse treatment that they want to have.

There are such enormous needs that we can cut out waste and we can promote health and we can be clean living, and we will still have more needs than we can meet.

Someone said earlier today that there was a specter of rationing or a grim visage of rationing. Rationing is now happening. It is already here. It is just not terribly clear. It is the way that we design the system, the reimbursements that we put in place, the incentives that we provide, the way we train people, the way we make them capable of functioning that provides the rationing now.

There is no explicit decision that there won't be good drug treatment programs in D.C.

Representative SCHEUER. So what you are saying is that it is not a question of should we have rationing such as they have in England or should we not have rationing. The question is: What kind of rationing should we have?

Dr. LYNN. Exactly. We cannot live without rationing. It is not a conceivable state of affairs. The only question is, can we do it better?

Representative SCHEUER. Than we are doing it now.

Dr. LYNN. Yes. And I think that we have to come to terms as a nation with the failure of our comfortable vision. We are not big enough, we are not wealthy enough, we are not strong enough, and we are not bright enough to solve all the problems. Instead, we must figure out which ones are the problems that we will seek to solve, which are our priorites, and acknowledge that there are going to be needs that will go unmet, and that we will live with, and we won't make them stories on Nightline.

I see one of the big barriers to allocation—it must be a big problem in political life generally—is that any reasonable health care allocation scheme that one would want to put in place and articulate can be destroyed by finding a poster child, putting that poster child on "Nightline," and no politician can bear the public re-

sponse by morning. We have to learn not to make poster children of reasonable allocation decisions.

There are going to be people who do not get the services that they in fact want and could use, and we have to learn to live with that. I think the real lesson of England is not that they find ways of failing to make certain services available, but that they do that without there ever having been an articulated policy. You cannot find, written down, that you can't get dialysis over 55. It just is not made available. And it is not seen as a scandal. It is not on the BBC at night that someone at 58 who could have lived for 12 years and done well didn't get dialysis.

We may have to learn to live with that, after two decades of feeling like we could slay any dragon that came our way. I remember in 1970 when I was a medical student in a large hospital in Boston, you could not die there without resuscitation. There was no way to die without an effort at resuscitation.

Now, that sounds barbaric, but resuscitation had just been developed 5 years earlier and people were in fact alive and walking around who, 5 to 10 years earlier, would have been dead. And we didn't know the limits of our capabilities. We have learned a lot, even in the years since 1970, but we haven't learned enough to confront the fact that we are all going to die, we are all going to be sick, we are almost all going to have multiple chronic illnesses, and that is the challenge of the next 20 years.

By the year 2030, 20 percent of the population will be over 65. Something like 3 percent will be over 85. We are going to have to learn how to deal with the fact that the dominant illnesses in American medicine are going to be either preventable or chronic, and we are not going to have very much of our care system devoted to curative medicine because those are going to be so simple. The broken arm gets fixed and is gone, and the damaged heart, the damaged liver, the damaged brain, live with us forever.

Most of our successes in modern medicine have been the conversion of acute killers into chronic illnesses. We have not in fact had very many successes since the advent of antibiotics that are true cures. When you give somebody a coronary artery bypass graft and thereby grant them some years of pain-free existence, you have substituted a different illness for the one they come in with, and that person will be under a doctor's care for the rest of his days, and his days will be longer and they will be costly.

The advent of larger numbers of people with Alzheimer's disease buries the importance of any other illness. A large proportion of us will have dementing illness in our old age. Something like about half of the women and about a quarter of the men will spend some time in a nursing home, and yet chronic care and the problems of chronic illness have not been center stage in our policymaking.

MEDICARE DOES NOT ADDRESS NEEDS OF VERY OLD

If you look at the medicare system, it was a system designed for the fears of 55-year-old men. You can get anything fixed that can be fixed with surgery or with an emergency trip to the hospital.

Representative SCHEUER. You can get anything fixed with what?

Dr. LYNN. That can be fixed with surgery.

Representative SCHEUER. With surgery.

Dr. LYNN. Yes.

But if you go and ask 85-year-old people what they are scared of, they are scared of not having a place to live, they are scared of no one being available if they fall and break a hip, they are scared of not having enough food, not having anyone to prepare the food, of beginning to forget how to get the food. They are scared of those daily living activities being unavailable to them, and yet medicare does not pay for those. In a systematic way, medicare does not pay for those.

It is a system designed for acute care, and it does that well, and there is good evidence that medicare has done wonderful things for acute care needs. But that is not the fear of the population it serves. It is an excellent shoe designed for the wrong foot.

ROLE OF GOVERNMENT IN HEALTH CARE

You had asked for us to give some responses about the role of the Federal Government, and that is not in my testimony at all because I thought we were to be laying out the problems, but I think that the role of the Federal Government is limited only by two things. One is the creativity and inventiveness of the minds that we put to it, and second the limitation that there are some things that are prudent to leave to the innovation and the control of the States.

In some areas, probably especially the issues of criminal law, it is probably better for most of those issues right now to be left to the States, since it is an area of great ferment. When should a doctor be charged with homicide for assisting in the death of a patient is something that there has just been so little comment on, so little in the law, that it may be well that the States get to test those cases. Furthermore, the Federal Government has never had a role in criminal issues.

In the malpractice issues, the Federal Government is beginning to get dragged in because they have to pay the bill. Somehow, someone pays for these enormous costs runups; and since the Federal Government is now paying for a large proportion of health care, they end up, through various mechanisms, paying the bill. So the Federal Government will be dragged into the largest civil law arena.

But the Federal Government has an enormous hand in regulatory law and in shaping the system by the reimbursement incentives. I have outlined some of these while others were talking. The things I would highlight here are a very partial list, but maybe some things that you might want to think about.

NEED EQUITABLE SYSTEM

The first and foremost is that we must shape a health care system that is and is perceived to be fair. I will game the system for the benefit of my patients and, for that matter, for the benefit of my institution whenever I perceive that the system that I am stuck into is a gaming system, is one in which you play the system so as to benefit those who you know are doing good deeds, because who knows where the rest of the system is going.

In that system, a doctor can undercut any regulation that you put forward because we know more about our patient and we can highlight one area and underplay another so as to see that the patient qualifies for the benefit at issue.

If, however, I have a system that is perceived to be fair, then I am at least somewhat called upon to be fair. I think that most of my confreres are decent people, and that most doctors and nurses and hospital administrators would be willing to say to patients, individually and generally, that certain things are not available because this Nation can't afford them or because it is more important that we do other things.

That is the strength of the Oregon initiative that Ann was talking about earlier, where providers were willing to say, this has been discussed, we have talked about it, the community has spoken, and the community has decided that this whole range of things will not be made available.

Now, that doesn't mean that everybody complies, and in fact there was a poster child made out of a child dying in Oregon and it had the Nightline effect. But if we do that repeatedly, we will gradually learn to live with our limits. But we cannot learn to live with limits that are perceived as being unfair.

So when I have a patient who is stuck in a system that is just grinding him and his family to shreds in a thoroughly unfair fashion, that I cannot imagine a civilized community intended to have happen, then I and all the people like me are going to game the system so as to benefit that patient.

So the first and foremost thing is that the system must be and must be perceived to be fair in how it allocates the benefits.

MANDATE ETHICS EDUCATION

Then there are a lot of other little things that came to mind. We could provide loans only to medical students in schools that teach medical ethics in decisionmaking, that have a serious impact on outcomes teaching. Overnight, the next generation of physicians would learn that. We could do the same thing with nursing schools that are becoming increasingly reliant upon Federal aid.

Now, you can't very well get down to the social work and nursing aide level yet, but if you get the leaders you will get most everyone else within a generation. That is a generational change.

You can mandate ethics teaching in VA and Defense Department institutions. Something on the order of nearly half of all physicians trained are at some point trained in a VA or Defense Department institution, and that you have direct control over. You could mandate that they simply have someone on their staff who is expert in these issues and you would wreak a major change.

You could mandate ethics teaching in residency programs that are supported in part by medicare, and overnight you would get every residency program in the county. We could have research on health care delivery as a higher priority so that we would shift some things from the traditional functions of the National Institutes of Health, which focus mainly on curative endeavors, and direct it toward health care delivery, researching outcomes.

NEED CARE ASSESSMENT

Do you know that right now, I cannot tell you what is the expected outcome of an elderly person with a gangrenous leg that isn't amputated? No one has ever collected those figures. And the National Institutes of Health are never going to research that unless someone starts pushing them to do that. We don't know what the outcomes are.

Representative SCHEUER. Why is that?

Dr. LYNN. Because we have been taking them all off. We have been amputating them since the Civil War. So now when I have a patient who says, I don't want that leg off, I can't tell them what the likely outcome will be. I can imagine what it might be, but I can't tell them accurately.

I now actually have enough experience to be able to tell them on the basis of my five or six cases, but there is not an initiative out of the National Institutes of Health to study that kind of mundane treatment.

What is the expected outcome of certain kinds of strokes in terms of the person's disability, in terms of their functioning, in terms of their impact on the family? Those are not things we have studied. We have studied survival and we have studied progression of tumors, we have studied correction of physiologic abnormality, but we have not studied how people live as the outcomes of our medical care. That is what is called health care services delivery, research, and right now it is exceedingly underfunded.

INCOMPETENT PATIENTS AND TREATMENT DECISIONS

We could work a great deal on research and policy development with incompetent patients. A major calamity facing health care is that there is increasing pressure to take incompetent patients who do not have durable powers of attorney through a court process to make any substantial treatment decision.

This will double health care costs at least because of the inefficiency involved in going to court but, in addition, it will run up the court costs, all for very little evidence of any improvement. Nevertheless, there are States inching toward requiring that people who have not spoken to the issue themselves will have to go through a court process.

New York State, in fact, is one of the closest States requiring that. Under certain court rulings, if a person has not spoken to the issue themselves, they will have their life sustained to the maximum possible. And a judge and certainly a physician has no authority to do anything else. So New York is actually in some ways the farthest along on this, what I would see as a calamitous path.

ENCOURAGE COUNSELING AND ADVANCE CARE PLANNING

We could, as you were pointing out earlier, fund caregiving, not just interventions. We could try to make sure that there is a reasonable reimbursement incentive to make sure that people get talked to, that there is this counseling function. I agree there are problems of fraud and abuse, but even just making it possible would be helpful.

Right now in my nursing home practice, we are under an automatic audit if we see a patient more often than every 60 days under the current HCFA rules. So if I see a patient every 2 weeks because they are very sick and I am trying to manage them in the nursing home, I not only don't get paid my $8 a visit, which certainly doen't cover my costs, but I also face a virtually automatic audit. That is a substantial disincentive for taking care of that patient in their appropriate environment.

There are regulations that HCFA could put in place to encourage durable powers of attorney. For example, when a person first signs up for social security, when a person first signs up for medicare or first uses a medicare benefit, information could be sent as to how one could designate a surrogate.

For that matter, the medicare system could even keep that information and make it available to whoever the provider is so that we know who to turn to to make decisions. We could have as part of the overhead and indirect costs in hospitals and nursing homes, ethics committees and ethics consultants.

We have regulations that do not allow care plans which acknowledge that people die. Right now I have these bizarre circumlocutions for medicare care plans that say that I am going to retard the expected rate of decline of this patient and count that as an improvement over where they would eventually be. Why can't I say this is a person who is dying and I am going to make their dying as comfortable as possible? Why can't I? Because that would not be reimbursable.

Only improvements in the person's situation are funded, so I have to word what I do as an improvement over their expected state, which leads to a thoroughgoing head-over-heels. It is just a crazy gymnastics that is terribly inefficient. I mean I can only give physical therapy if the person is going to get better, not just to make them slower at getting worse. That is a very bad system.

We could refuse to pay for hospital care under medicare when the care is delayed by hospitals seeking court orders in these circumstances that Giles alluded to, where the court ruling is already clear, but the hospital spends 2 weeks waiting for the court order.

We could require a clear decision on "do not resuscitate" orders by the 7th day of any patient in the hospital under medicare. It can be any decision you wish, but you are going to have to have it on the chart by the 7th day.

These are just the things that come to mind in the last hour. I think if you mandated HCFA, the people at NIH, the people in the health services research and health technology areas, and OTA, to give you some thoughts on these issues, there would be an abundance of possibilities, many of which would save money, a few of which would cost money, but all of which would enhance the possibility of doing a good job in the case of patients.

We are at an important time of ferment. Increasingly we notice that health care has changed. The average age at death in 1900 was 46. The average cause of death was childbirth, fever, and industrial accident. Now the average age at death is in the eighties for people who survive infancy. The average cause of death is a chronic disease.

We have a few years here in which we can reshape health care so that it really serves the needs of the people that we are in fact having to serve. I think that is wonderful that this committee and that the Congress has interest in taking the lead in reshaping things so that they will fit our populace, and many of those issues will be ethical and legal issues, not issues solely of cost-benefit and economic allocation. Thank you.

[The prepared statement of Dr. Lynn follows:]

PREPARED STATEMENT OF JOANNE LYNN, M.D.

Legal and Ethical Issues in Contemporary Health Care

I am honored to have been asked to speak with this panel this morning. I am pleased to find that the Congress has taken note of the serious legal and ethical problems besetting American health care. In the past, the Federal policy has been largely to leave these issues to states and localities, thereby ignoring an enormous potential for good that rests in the fact that the Federal government is now largely responsible for funding and organizing health care.

In current health care delivery, there are only two issues which commonly raise serious and troubling ethical and legal issues:

First, what options should be made available?
Second, how should decisions be made among them?

THE OPTIONS

A patient can be viewed as being in a situation which has various possible outcomes, depending upon the health care interventions used to affect the patient's course. In other words, the choices that are made affect how the patient will live and for how long. There are only four kinds of choices that cannot be made available:

1. those that are not yet discovered
2. those that are made illegal as homicide or suicide
3. those that are made illegal as public health measures, and
4. those that are unavailable because of costs

The first issue raises few substantial legal or ethical issues, since a citizen does not have a right for there to be research on any one problem, and researchers are under no recognized moral duty to pursue, much less succeed with, any particular problem. However, each of the other three raise common, serious, and persistent legal and ethical problems.

Homicide and Suicide

The barring of homicide and suicide is currently under assault by a substantial minority of Americans who feel that each person has a right to decide whether to live or not, especially when that person's dying does not particularly harm others and when the person is suffering from an illness that is likely soon to be fatal. Advocates of this position point out that dying

people often suffer terribly and contend that the suffering person should be able to enlist a physician's help in ending the life.

To allow this course would be exceedingly imprudent, though I acknowledge that retaining the present bar does cause suffering to be prolonged for some people. For dying patients, physical suffering can always be relieved with vigorous enough treatment; however, the treatment needed is often not available because of deficiencies in how the health care system is funded and structured. Mental, spiritual, and emotional suffering is not so reliably relieved by treatment but is also not seen as being sufficient justification for killing a person. In fact, the sufferings of a dying patient would seem to call for a marshalling of the resources of the community to help. In our society, unfortunately, this is not the case.

The needs of dying patients are largely not covered by health insurance, including Medicare, except for the privileged few who qualify for hospice. Relief of the physical symptoms is often unavailable because the needed services are not reimbursable and because so few caregivers know the techniques needed. Supportive services to relieve the emotional anguish is rarely even a part of the potential interventions. This is a situation that cries out for better services and a redesign of the incentives and structures in the health care system. Possibly, good care for dying people is no more expensive than is our current fragmented and often inappropriate care system.

If we were to accept physician-assisted suicide, or mercy as a defense for homicide, we would be encouraging dying persons in our society to remove themselves (or to be removed) in a timely way. Rather than encourage endurance, insight, and forbearance, we would encourage economic efficiency and denial. If good care options were available, perhaps then the claims of those who would still rather be dead would bear close consideration. However, in our present care environment, where good care of dying persons is routinely unavailable, allowing the deliberate taking of life could only be seen as an abdication of the responsibility of the community for the continued support of these people in their search for a meaningful way to live with a terminal illness and to die.

Public Health

Some courses of care are barred because they would endanger the health of other people, but this is rarely a serious detriment to the patient whose options are limited. A person with active tuberculosis can be required to take treatment and held prisoner until the risk of infecting others is past. A child with AIDS can be barred from living in a home for mentally retarded children. However, most such situations have resolutions that already are carefully considered, the pathways for any litigation or regulatory involvement are clear, and the need for coercive treatment or placement refusal engenders little controversy.

Resource Limitations

Barring good options because they are costly or not readily made available within the current health care structure is the most common and the most troubling ethical problem for health care providers today. Examples abound. Persons who need housing and supervision cannot get such simple remedies, though they can and will get intensive care and surgery for their frozen limbs when found on the streets. Persons with AIDS who probably could live longer with certain drug regimens cannot afford that. Mothers with little education and extreme stress are expected to take home infants with major handicaps that require nearly constant skilled attendance.

In my practice with the elderly, the most common calamity is that of long-term disability. Very often, competent care to supplement the family's efforts could probably be found. Most of the time, however, it cannot be afforded and the way that it can be arranged is not optimal. What the person needs might be as simple as someone to help get him in and out of bed, but that help only comes in four-hour shifts, and the person will be bankrupted quickly by paying for eight hours of help each day. Even worse, the patient will have to watch his or her spouse becoming impoverished.

I have had patients who could live for some time with relatively modest technological support -- perhaps a feeding tube -- but whose continued care cannot be paid for without devastating effects upon the family. Sometimes the patient and family prefer to accept the patient's dying rather than to lose all their assets, all their dreams for their children, and all their savings for the surviving spouse. Every care provider in the health care system ends up providing support for some such patients, but some face disproportionate demand and all face increasingly limited options for subsidizing this care by increasing the rates that others pay.

I would argue that some restrictions on access to care are necessary and acceptable, and not particularly tragic. However, I would contend that those restrictions on access to care must be reasonable, public, thoughtful, and responsive to people's real needs. If the real needs of most people at eighty-five center around a secure and comfortable place to stay, assistance with activities of daily living, supportive caregivers, and symptom control, as I believe them to do, then why are these exactly the elements that are not provided under Medicare? I can get a cataract operation paid by Medicare for my most demented, dependent, and unresponsive patient. But, my most capable, active, and responsive patient cannot get a second pair of glasses under Medicare if the first set is destroyed. None of my patients have insurance that covers homemaker services. None has a way of protecting their ability to live in their apartments.

In this system, physicians are increasingly called upon to be the gatekeepers, to keep people from getting services of "marginal" utility. It is not clear that physicians can do this. It is, for example, not a defense to a charge of malpractice to have failed to provide a service because doing so would be disproportionately expensive for Medicare. Also, most physicians are not well-situated to arbitrate the differential impact of treatments upon how their patients will live.

Rather than hoping that physicians can manage this allocation issue, policy makers must take a broader view and begin thinking about the wisest combination of entitlements and discretionary services that would serve the population best. Certainly, care for long-term disability in old age would garner a larger proportion of the public investment, as would basic housing and nutrition. Most likely, we cannot avoid these issues by hoping to prevent disease and promote health. Our successes in prevention, except with infectious diseases, are slim. And most of us now adult will live to a very old age, mostly with multiple physical problems. It is not clear that the degree of disability can be expected to decline.

While waiting for wise public policy, it is not clear how we serve our patients best when certain advantageous options are not really available. Should we inform patients and families, hoping in the long run to motivate them to become advocates for change, but making them uncomfortable, angry, or feeling abused in the present? Or, should physicians generally not tell people of treatment options that they really cannot have, thereby protecting the patient and family from the pain of that knowledge and reducing the pressures that might force changes upon the health care system.

DECISION-MAKING

Competent Patients

Once a patient's situation is understood to have various possible treatment possibilities, how should the choice among them be made? If the patient is competent, understands his or her options, and can and will make the choice, then the patient's view is decisive. More often now than in the recent past, the patient who does not have a definable mental illness and who has a strong desire to stop a treatment is allowed to do so, even if that means an early death. Also, competent patients have broad authority to decide among available treatments and have legally enforced rights to know about the options and their effects.

Unfortunately, often the effects of treatments are very incompletely known. While physicians may well know the survival rates with various treatment options, they very rarely know the kind of life that the patient will likely lead. Very little research is available that documents such outcomes of alternative

treatments as ability to care for oneself, seriousness of long-term pain, family stress, or financial effects. Yet, these are what the patient often most needs to know. Directing some research funds to these areas would be important.

A person may realize that he or she is likely to have a period of incompetence and may well plan for that by advising family and physician as to what should be done. This advice might be formalized in a "Living Will" or a durable power of attorney. The former is a limited purpose document that is fairly well-known and honored. The durable power of attorney is much less well-known but much more powerful. It allows a person to state who should make decisions if the person ever is incapable of doing so and also gives instructions as to the decisions that should be made. These documents have now been used extensively in some areas and seem to be so valuable that they should be encouraged in education and in regulation of health care providers.

Incompetent Patients and Deciding Competence

Much more serious problems are arising in the very common case of a person who may be incompetent to make his or her own decisions but who has left no explicit instructions. In no state is the decision-making for this group entirely clear. Generally, family have been authorized to make the choices, but this rests on uncertain legal grounds. Some have advocated that all such cases really need the protections of full due process in a court proceeding. Court appointed surrogates which would result from many such hearings would need to be paid, trained, and supervised. Thus, the alternative models for dealing with patients who cannot decide for themselves have very large cost and efficiency implications.

The controversy over how decisions should be made for those who are now incompetent and who have not given their directions in advance is just now erupting. Federal rules and practices have a substantial actual and potential role in these issues. Who has authority to cash a Social Security check, to place a person in a Medicare-approved nursing home, or to consent to admission to a hospice are all issues with a substantial federal government involvement. If the federal government would take the opportunity to see that comprehensive and reliable research is done on this group of issues and if the various agencies involved were to take a reasonable and prudent stand in regard to the best resolution, this issue could possibly be resolved over the next few years. If not, it could cause serious inefficiencies in health care delivery, raise costs, prolong suffering, and generally complicate health care delivery within the next few years.

CLOSING

There are other legal and ethical issues that arise in health care: artificial reproduction, use of fetal tissues, and confidentiality, to name a few. However, the recurrent and

painful issues are those of which treatment options can be made available and how one should be chosen. Especially pressing are the issues of providing good supportive care for those who are disabled or dying and making choices for those who cannot make their own. On these issues, the Federal government, the largest purchaser and provider of health care, could play an important role.

Representative SCHEUER. Thank you, Dr. Lynn, for your marvelous testimony.

I must say in my over 20 years as a Congressman, I have never heard a hearing that was superior to this one, and very, very few that were the equal of this one in the thoughtfulness and the broad-ranging intellectual quality of the testimony.

We have gone way over our time for this panel, but as you notice, I just felt it was inappropriate to limit you to 7 or 8 minutes, or even 10 minutes. It was marvelous testimony.

IMPROVING QUALITY OF LIFE

Ms. Neale, you mentioned "up to a point." How do you define that point and how does society decide when we have reached that point and how does society achieve some kind of a consensus that the point is fair and equitable and appropriate and is reflective of our resources and the moral and ethical values that we put on living at a given quality of life?

Ms. NEALE. Let me take a stab at that from two perspectives. I think I said that we generally have an obligation to preserve life, but up to a point. The reason I outlined that little argument about life, it is an intrinsically valuable thing no matter what its quality, but its quality does make a difference for what our obligation is to preserve it.

Then I sorted out how I can have an indication of whether I ought to preserve a life. If this life can realize no other of life's goods, other than just mere vital functioning, then if I could have certainty that there was only—please, my medical colleagues, assist me here—minimal brain stem activity, with no reticular system activity, meaning that the person has some vital functions but there is no even consciousness, and we can get this in all sorts of clinical measures, then I would say it is quite clear that we do not have an obligation to preserve that life with even nutrition and hydration, because at that point they can be viewed as, and I think probably ought to be viewed as, cumbersome medical and technological interventions that in no way benefit this patient, save to maintain the minimal vital function that he has. Now, I think that is a pretty clear case, but we are continuing to preserve such lives.

That is easy for me to say. It would be easy for me to say if there were a similar situation with a neonate, but it is my understanding that it is harder to be firm on the diagnosis and prognosis of neonates; that even brain death criteria have to be more stringent and more clearly defined than they are presently.

But if you know that the individual can enjoy no other of life's human goods, I will say categorically there is no moral obligation to preserve it. And from a just societal perspective, there is probably a moral obligation to cease aggressive measures and to, because this is an intrinsically valuable individual, to continue then with intense comfort measures but to withdraw life support if it has been initiated.

Then there are judgments that reasonable people are going to disagree with, and this is where I think it is important to leave the decisionmaking and the discretion, to the extent that it is possible and that they are not making unreasonable demands on society's

resources, to the individuals themselves, if they are able to participate or to follow their advance directives if they have given them, or to the loved ones who would know the best interests of these people.

TECHNOLOGY AND RESOURCE ALLOCATION

Now, from the point of view of allocation of resources, I think it is reasonable to say a nation as wealthy as ours ought to provide health care resources to its people. It doesn't seem to me that it is reasonable, however, to provide exotic, life-saving technologies to a few when we have so many persons of equally deserving health care situations who aren't getting basic care.

So it is unfortunate that we can't meet everybody's needs. But I would fall back to the utilitarian principle. Should we save these three people who need liver transplants, whose quality of life even with the liver transplant is quite questionable, who will need a lifetime of cyclosporin and have other kinds of effects, or should we—and then I don't know what the alternative is. I know that when I served on Governor Hughes' Organ Transplantation Committee. the then director of medicaid was reluctant to tell us the tradeoffs, but I happened to know them, so under questioning he would explain them.

We transplanted a liver in a young man by virtue of a joint resolution of our houses down in Annapolis, and the money spent on that exceeded the money that we gave in medical services to all of Allegheny County in Maryland.

Now, we can't identify the people who did not get the services, but identifying organ transplantations as something that was now going to be paid out of the limited medicaid pot is clearly going to mean other basic care is not going to be given to many more people.

So it seems to me that we can make some decisions about reasonableness, at what point we are willing to fund things and at what point we say we won't. I am not so sure, though, that even though we don't pay it out of medicaid, we might not find other general funds. I hate to start our rationing on the backs of poor persons.

ABORTION

Representative SCHEUER. Ms. Neale, you discussed the neonatal intensive care unit. Let me ask you, what do you think ought to happen when we discover, through the various prenatal tests that can be taken, that there is a severely damaged fetus that is incapable of living a cognitive life, who will always be institutionalized at enormous expense to the public and, as I say, will never be able to lead a cognitive life as we know it?

Would you consider that abortion is a viable option under those circumstances?

Ms. NEALE. First of all, I would say that a lot of neonates who are born and have very limited potential have that limited potential for a number of reasons. Sometimes it is just because they haven't gotten good prenatal care. Their mothers are very young and very poor, and there are solutions that ought to be applied prior to pregnancy.

Representative SCHEUER. You will find no disagreement from this panel on that question.

Ms. NEALE. I would never want my remarks to be interpreted that any fetus that we can determine, prebirth, is not as I said before, going to go to Harvard ought to be eliminated.

I can give you a clear clinical example of the kind of individual you are speaking of, and that is a child with anencephaly, a neural tube defect that is so great that there is virtually no brain, or little neurological development.

If such an individual was detected prenatally, I believe that the situation we have right now with regard to legal options is acceptable; that a woman could, if she chose, take that child to term and the child would be born, and if it is a true anencephalic child, it could be allowed to die.

I personally—I am not saying that this is necessarily the stand of my tradition, although I know that there are people within my tradition who would believe that—feel that a decision to terminate a pregnancy like that, since there is no human potential—in fact, there would be people within our tradition who would say because there is not even the neurological substrate necessary for that individual to be a person, that termination of pregnancy would be acceptable.

Representative SCHEUER. Is that a position that the Catholic Church would accept?

Ms. NEALE. Probably not.

Is that a position that a good many Catholic philosophers and theologians would accept? Quite clearly, yes.

Now, I am talking about the anencephalic child. This is at this end of the spectrum.

Representative SCHEUER. I understand that. That is exactly the question that I am asking you.

Ms. NEALE. Also our tradition, which isn't well known it is a pretty well-kept secret, many of us can live with the present *Roe* v. *Wade* decision, not because it is ideal from a legal perspective or that every decision made within the leeway of the first 3 and 6 months which it provides is a morally acceptable decision—I wouldn't know which ones are and which ones aren't, but undoubtedly some may not be—but I don't believe that legal coercion is the way to solve a moral problem. And if we do have a moral problem in terms of more persons opting for abortion than ought to, I don't think the way to address that problem is legal coercion, making women outside the law, penalizing them from a criminal perspective.

I think it would be far better if we improved our health economic education and made women who have difficult or unwanted pregnancies, made them see that there are other options. But when there are clearly seriously identifiable clinical problems, then I think that persons in our country should have the leeway of adopting their own responsible options. For some of those, it may mean termination of pregnancy.

The Roman Catholic tradition does not believe that law is the final or best answer to every single national problem.

Representative SCHEUER. I take it that—and I don't know this for a fact—but might it not be true that abroad, in England, France,

the low countries, Netherlands, the Scandinavian countries, that the Roman Catholic Church might be closer to validating the position you have just expressed than perhaps the Vatican or the Roman Catholic——

Ms. NEALE. Well, I am not sure. I am pretty sure that in Ireland and in Spain, the Roman Catholic Church led very strong campaigns against easing up on abortion regulations.

Representative SCHEUER. Well, abortion is not legal in Spain.

Ms. NEALE. Yes. And the church campaigned to not liberalize the law.

Representative SCHEUER. Yes.

Ms. NEALE. So if you are asking if the local churches in those countries have a somewhat different view than our more hard-lined view, I can't affirm that. It may be the case in some instances.

Now, having said what I said, I still think to the extent we have an abortifacient culture, that is a regrettable thing. But I don't think necessarily the solution is, because I don't think the problem is, the women with their individual pregnancies that may have bad outcomes. I think the problem is much more deep seated.

BIAS TOWARD HIGH TECHNOLOGY VERSUS COMFORTING THE ELDERLY

Representative SCHEUER. Thank you very much, Ms. Neale. Let me ask the entire panel, are we allocating health care dollars unwisely for very expensive high-technology efforts to extend life at a point where life of the very elderly, where there is dementia present and other crippling and disabling factors, mentally as well as physically, is not very satisfying? And are we spending too little attention on caring for the ill and the elderly frail, the elderly weak, who are in possession of their faculties and who have the ability to relate?

I don't remember which one of you described caring, loving, communicating. Was that you, Ms. Neale?

Ms. NEALE. I identified those as the purposes of life. And if persons can enjoy those, there is an obligation to preserve it.

Representative SCHEUER. You did it beautifully. Are we spending too much, applying high technology and very expensive means of extending life and deferring death when death appears inevitable, and spending too little on making elderly ill people and elderly frail people comfortable, and are we spending too little in giving them the kind of caring relationships with health care delivery personnel—counseling, comforting, communicating—that would make the lives of these people who are not suffering from dementia and who have the ability to reach out and communicate and care and love, to make them much more comfortable and add significantly to the extent to which they can enjoy life at comparatively little cost?

Ms. NEALE. I think the imbalance that I referred to in the health system is evidenced through the illustration you just gave.

I would even return to what I understand to be one of the to be phased in benefits of our overhauled medicare program. We will extend the care that we give in a long-term facility to something like 6 months—I am not sure, but it is considerably longer than

what we had before—but it has to be acute skilled care. So fewer people than you would like qualify for that.

So I think the kinds of reimbursement that we give is usually attached to the level of care, and the level of care is usually inpatient, high-cost, high-tech, emergent care. Because we give that, we tend to have less inclination to give it for the kinds of care that many more people need, that they cannot obtain sometimes in their homes, or they could if it was reimbursable, and so they are cared for in inappropriate settings or they are doing doubletalk and imaginative diagnostic kinds of things, as Joanne is speaking to, to get needed care covered.

Representative SCHEUER. Yes, Ms. Wolf.

Ms. WOLF. When we were doing the work that led up to the Hastings Center Guidelines, I think one thing we concluded is that the affirmative side of caring for the dying—that is the term we use—is neglected generally. This is what you were referring to, attention to a person's social needs, their spiritual needs. It also includes things like palliative care, symptom relief, pain relief, making people happier, more comfortable, more able to function, even if they are going to die in a short period of time. It is not just that there is not enough money. It is that there is not enough education about it, nobody thinks about, and it is poorly done. There is too much emphasis on the acute high-tech intervention.

I think that is true for all patients, whether they are on a ventilator, or other high-tech life supports, or whether they are not. We just aren't doing enough on the affirmative side of caring for patients in this more social way.

It is a little tempting to see it as an either/or: either the money goes into high tech or the money goes into this kind of supportive care. But we absolutely need such supportive care for all patients, whether they are also getting high-tech care or not. Then when we turn to the high-tech side of the ledger, we need to become more discriminating and more precise about which patients get that, on the basis of their individual preferences but also some of these allocation principles that we have been debating.

Representative SCHEUER. Yes, Mr. Scofield.

Mr. SCOFIELD. My only remark would be that it certainly doesn't make sense to pay for care that patients don't want to get, and that when you put a patient on a ventilator you have probably increased the costs, increased the discomfort to the patient, decreased the patient's quality of life, and obtained only a marginal difference in the length of that patient's life.

I think in particular of a nursing home patient in upstate New York who last year was told that she would have to go on a feeding tube. She was in a nursing home. And I wish for the life of me I could remember her name right now. She refused. And the nursing home ended up going to court to get an order. And the judge said basically, this woman is competent, she is communicative, she doesn't want to be on a feeding tube, you can't put her on a feeding tube.

What happened after her ruling came down is the other residents in the nursing home wondered what was going on with her, and they started to come by and visit her more often. She is still alive. She is not on a feeding tube. And I think that the notion that

giving people a tube is a quick fix lets us treat patients with indifference.

For her, her quality of life I think was improved and her length of life—well, who will know—but she is still alive, and eating, and happy.

PROMOTE ADVANCE CARE PLANNING

Representative SCHEUER. Let's get to the question of living wills. We all know that many people do not write wills, even as to how their personal property should be distributed.

How do we encourage people to write living wills on this much more sensitive and perhaps frustrating and bothersome question if people would naturally prefer to delay and ignore, far more than deciding who gets the piano, who gets the tapestry, and so forth?

Don't we have a very inequitable situation that people get very different health outcomes because, just as you say, Mr. Scofield, some people are able to express themselves in a living will that perhaps is binding in an increasing number of States, and other people who don't have living wills, don't have the option, when they approach incompetence, of having their clearly expressed feelings while they were competent carried out?

Isn't there a basic unfairness here and isn't the answer really to encourage people to prepare living wills? And the question is, how do we do that? What should be the institution, or who should be the person to explain to people the tremendous importance to their lives of having a living will and perhaps appointing a durable power of attorney?

You would think massive numbers of people would wish that they had done that, and if they had their lives would be enhanced. How do we get them to do it?

Mr. SCOFIELD. Certainly that is a question that we have been addressing over the years. We have distributed 8 million living wills since 1968. I don't know what number the Society for the Right to Die has distributed, but I am certain that they have also distributed a large number.

I think that this type of advanced planning is something that ought to be encouraged. It is encouraged through community groups. It ought to be encouraged in the hospital and nursing home setting, and it ought to be a part of the regular practice of any physician who is involved in caring for a patient, either geriatric or someone with a chronic illness, who may end up on life support technology.

A lot of doctors sort of refuse that suggestion. I am not saying all, because I know that there are some who do. But making that type of advance planning is no different than saying to a patient after back surgery, by the way, you can't pick up bricks anymore. I mean doctors customarily talk about things that aren't related to the clinical setting, aren't taking place right there, but are part of a patient's life.

One of those would be to plan ahead for the time when you either become incompetent or a choice will have to be made. I think it tends to occur more often with patients who are chronic because they tend to be more informed about what is likely to

happen to them, because they talk to other patients, or they know the experience of friends.

But too often, I think, physicians are simply unfamiliar with or unwilling to discuss this. How do yo get them to talk? I don't know. I sometimes think that the only way to do it would be to incubate them for a few months. I really think that sometimes because then they would know what the experience would be like and they would be more likely to bring it up with their patients.

Representative SCHEUER. Should we at least make sure that the new generation of physicians emerging from the medical schools have this kind of training as well as a whole variety of training in subjects that you have discussed this morning?

Mr. SCOFIELD. I think that is absolutely essential, and also that lawyers who do, for example, estate practice or represent hospitals—I don't know what you can do about law schools—but they should also have training in this type of document.

Representative SCHEUER. I would think law schools also ought to have classes of this kind. They certainly didn't when I went to law school.

Mr. SCOFIELD. They didn't when I was there either.

Representative SCHEUER. Ms. Wolf.

Ms. WOLF. Mr. Chairman, if I could also suggest, as I did in my testimony: I really think a number of State statutes on living wills require revision. They are very cumbersome and they obstruct the use of these documents. They make it very tough for patients to simply write down what they want. So I think we need statutory revision as well in this area.

Representative SCHEUER. At the State level?

Ms. WOLF. Yes, at the State level.

Representative SCHEUER. Is there a model State law that is available to states?

Mr. SCOFIELD. There is one that the Uniform Law Commissioners put out a few years ago and Concern for Dying has also put out a Right To Refuse Treatment statute.

But I would also say that as far as getting doctors to talk about this, if you go into a hospital, I often tell people going into a hospital is like a hotel except no one gives you a book about who runs the place and what to get once you are in there. But if you ever talk to a hospital lawyer or a hospital administrator, they have a book of forms up in the office someplace, and one of these forms in that book is always either a treatment refusal form or a living will.

So they have the information, but the question is just getting it to the patient and getting people to talk about it.

Representative SCHEUER. Yes, Ms. Neale.

Ms. NEALE. I would say some hospitals—and you are probably aware of this, Giles—actually have pamphlets about living wills, your right, whom to call, what to do, the fact that there is an institutional ethics committee. That is helpful.

But I am not sanguine about physician education, to tell you the truth. I try to do a lot of that in the organization that I am in, and I just think it is going to be a slow incremental process.

Some of the suggestions Joanne made about getting it into the educational curriculum of physicians is important, but I think, too, that there is a modeling and a role and thousands of years of tradi-

tion of autonomy on the part of physicians that we have yet to overcome.

Dr. LYNN. Let me add an observation to the living will, durable power of attorney discussion. I very much encourage advance planning and I think most of my patients have advance plans, but not in the form of durable powers of attorney, but in the form of informal writing, writing in the chart, that sort of thing.

So there is a plan and it is clear, but it is not in the form of a durable power of attorney. I think they are perfectly adequate and should be relied upon, and are more possible than getting everybody to write a durable power of attorney.

There is, as you noted in starting this line of questioning, a tremendous reluctance on the part of most people to even get around to ever writing an updated will. I dare say if we asked for a show of hands in the room as to who has a will that they would be happy to have probated if they died today, probably less than a quarter of us do. Probably all of us in the room would want our organs to be donated if we were brain dead, and yet I will bet less than a quarter of us carry a donor card.

I think we have to not only attend to a mechanism for people who have a view to say it, but also for those who never got around to saying a view, to end up getting treated reasonably well. The background presumption, the "intestacy presumption," which operates if someone didn't get around to writing their own will, should be reasonable. If I fail to quite ever get around to writing this out, I should not end up getting brutalized by medical care that will require that I be treated with everything possible to keep me alive, which is the current background assumption if I end up in court.

Ms. NEALE. Which is one of the arguments for some persons suggesting that maybe statutes with regard to living wills were not well advised, because we have that right as individuals. I am speaking as a philsopher, not as an attorney. But I should be able to say, even in New York State, which doesn't have a living will, to my physician, I choose this kind of treatment at the end stages and I reject this kind.

And unless I have retracted that statement, that statement should be honored even though the State doesn't have a living will.

This is just an aside, Joanne, but I don't want my organs donated, not until we have a more just health system. I resent the tremendous media and other kind of play of this issue which only further entrenches a high-cost, high-tech emergency kind of health system. So I have tattooed on my chest, no organ donation, not until we have access to care for everybody.

Mr. SCOFIELD. Let me just follow up on what Joanne said, because she is right. One of the problems with living will legislation is it creates the impression that if you don't use the State document, that you haven't done it the right way. In fact, that is not the case. Most of those statutes say it is not the exclusive method for expressing your preferences about life-sustaining treatment, but the problem still remains, though, of getting that on the record in whatever form would be reliable, so that people can act accordingly.

Representative SCHEUER. Mr. Scofield, you mentioned that you have distributed 8 million living wills. Does that mean that they

have been executed, there are 8 million folks out there who have executed living wills?

Mr. SCOFIELD. We have a registry of people who send back living wills only when they don't have someone else that they can turn to, a relative, family member, someone like that, to say these are my wishes if something happens to me. That certainly is not 8 million people. I would say the number of people who have executed living wills exceeds 8 million because a lot of people we send them to make photocopies, and you can get these out of a lot of books that have made the living will available. And, as I say, the Society also publishes them.

There isn't any firm count on who has and who hasn't executed a living will. It is certainly more than 8 million people.

Representative SCHEUER. We have a very distinguished individual in the room who is the director of the New York City Public Library. I would like to have him come up to the witness stand.

This an individual who is egregious in the field of public libraries and the leadership he has given the public library in New York City is absolutely outstanding. Would you please introduce yourself for the record?

Mr. GREGORIAN. I am Vartan Gregorian, president of the New York Public Library.

Representative SCHEUER. Mr. Gregorian, I hate to have dragooned you into this panel, but I think you might have a contribution at this point.

Can the public library system in our country play a useful role in getting out the information to people at any age in their life about what they should do to assure their own integrity as living, sapient human beings when they end up in a hospital? Can libraries show them how they can maintain autonomy, how they can maintain decisionmaking over what happens to them?

The public library is a very different place today than what it was when I was a kid. It has extended itself into information dissemination in a thousand different ways that you know far better than I.

Do the public libraries of America have a role in getting out the kind of information about how people can ensure that their last days are serene, that they are able to live with dignity and die with dignity, and avoid any life-extending high technology tubes, whatnot, that they find offensive, unnecessary, and simply suffering prolonging? What role would you say public libraries have?

Mr. GREGORIAN. Congressman Scheuer, I came to pay my respects to you, but if I knew I would have to work in order to pay my respects to you—I will be delighted to answer the question.

Number one, the libraries of America are unique institutions. Nothing comparable exists anywhere in the world. Their mission is to provide information, all kinds of information to the public, because information is source of knowledge, and source of knowledge is source of power, and power is source of self-determination and autonomy of individuals, individual choices.

As a result, the New York Public Library, for example, provides some 21 million transactions every year, and we deal from job application forms, tax information, publications of how ex-inmates can reenter society with dignity and so forth.

We have most of the information that you have been talking about in various journals, handouts, and so forth because ours is to provide all kinds of information, pro and con as well. You have heard me before saying that the libraries are the only tolerant institution and nonpartisan institution in this country because we reflect society's needs and aspirations. So we do provide all information including, by the way, tax forms and all kinds of information, doing service therefore to the Federal Government.

One of the things, whether we are in the position to pass forms of one without requiring a competing position, that is a problem. I think to provide one set of information, we have to be sure that we have provided others because otherwise we become unilateral advocates of one position or another, which libraries have not done in the past.

But we do provide all kinds of avenues, including information to nursing homes in the form of books, tapes, cassettes, performing a kind of both social, cultural and educational role, a continuing educational role.

Hospitals are a different situation, because I am not familiar what we provide to actually the patients and so forth. We do not have that kind of service. Some hospitals have some small libraries, but they do not have the same kind of facilities.

Representative SCHEUER. What I was asking was, could you provide or would libraries; as a generic group of institutions distributing information of all kinds, be an appropriate locus for providing information to people about their right to control their lives, to control their death, to control the degree to which high technology, tubes and whatnot are forced on them?

Mr. GREGORIAN. Absolutely. We do have any kind of information possible. Anything demanded of us we can provide, and the libraries of this country will be one of the best ways to disseminate the information.

PROVIDING CONSUMER INFORMATION

Representative SCHEUER. There are some of us in Congress who feel the time has come when people should have information not only about their right to live with dignity, but also about their right to die with dignity, their right to determine the course of action that takes place as to people's health outcomes when they are in the final stages of life.

There is also a feeling among some of us that people should have information about the quality of health care providers, doctors, hospitals, and their history, so that when we come to make these all-important decisions on doctors and hospitals, we can examine the track record of the particular health care providers and avoid those who might threaten our health outcomes and embrace those who would be likely to enhance our health outcomes on the basis of the proven record.

The New England Journal of Medicine has published figures that about 20,000 of the Nation's 550,000 doctors are drug addicted, are alcoholic, are mentally impaired, or are otherwise totally incapable of practicing competent medicine.

Should there be a way of informing people who are about to pick a hospital or a doctor, whether the one that they are picking is one of these 20,000 or whether they are one of the 530,000 who will quite likely give them excellent care?

We know that State licensing boards and hospitals dc exercise discipline over physicians. They get censured. They sometimes get delicensed. They get fired from a hospital. They may have a record of malpractice judgments as long as your arm, but people don't know about this.

There may be hospitals that have two or three times the rate of nosocomial infections as comparable hospitals. That means hospitals that have a very high rate of delivering, free of charge, infectious diseases to patients who come into that hospital who are well, for an appendicitis, or for childbirth. And if they go into surgery, that hospital has a very high rate of open wound infections, far more than a comparable hospital.

There are hospitals that have a rate of iatrogenesis, which means physician error, far higher than comparable hospitals.

Should there be a place where people can conveniently access this kind of information about a particular doctor, about a particular hospital, in ways that are intelligible to them, understandable by them, and fair to the health care deliverer?

If you think that is likely to be true, are libraries a place where people can go and access that information? Should there be a computer terminal in major libraries where people can ask the computer how about Dr. X, how about hospital Y?

Should there be a counseling service? Should there be a listing that the government and the private health care community would put out that would be available, perhaps a bulletin of some kind that would be brought current every few months?

Can you see a library as an appropriate place for the dissemination of that kind of hospital-specific and physician-specific information for health consumers, which includes all of us?

Mr. GREGORIAN. I think maybe in 2001, medical libraries will have that kind of facility, and since libraries are computerizing, and from any source of computerized data base, one can have access to this information—but you will need several local major libraries to have that, so everyone does not have to verify their legal statutes as well as their other problems. Each one will be liable otherwise for providing false information resulting in lawsuits and so forth.

So you have the New England Journal, if it publishes a list, you already have access to that. But if it is centralized in a national medical library or somewhere, entire medical information, then anybody can have access to it.

Representative SCHEUER. Mr. Gregorian, I thank you very much for this unscheduled and spontaneous appearance of yours. You have enriched us.

Let me say again to this panel that this has been one of the most remarkable and productive and throughtful hearings that I have ever participated in my more than two decades of service in this great institution. I am proud to have presided over this hearing, and I think that the ripple effect may be greater than any of us anticipates. I am very grateful to you. Thank you very much.

I will now go to answer this rollcall vote and we will call the second panel in about 10 minutes.

[A brief recess was taken.]

PATIENT AUTONOMY IN CARE

Representative SCHEUER. The second panel today of our consideration of ethical and moral issues in health care includes two lawyers who have addressed the issues raised in this morning's discussion. This panel will look at the problem both from the theoretical and practical perspectives.

Our panel includes Ms. Nancy Coleman, director of the Commission on Legal Problems of the Elderly, of the American Bar Association, and Mr. Allan Bogutz of Bogutz & Gordon.

We are very happy to have you here. We appreciate your patience and we look forward to your testimony. What we would suggest is that you address us informally, chat with us for 8 or 10 minutes as if we were all together in a living room someplace, and refer to anything you may have heard this morning, if you were here, that intrigues you. Then, after that, I am sure we will have some questions for you.

So, Ms. Coleman, why don't you start out and take such time as you may need.

STATEMENT OF NANCY COLEMAN, DIRECTOR, COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, AMERICAN BAR ASSOCIATION

Ms. COLEMAN. Thank you, Congressman Scheuer. I would ask that my prepared statement be included in the printed record. It is very difficult to follow the last panel since many of the issues which I had hoped to raise were already raised.

Let me approach the topic, as you asked, in an informal way. I think that we are moving in our society and have moved to a position where older people as well as the rest of us are looking to be able to make our own decisions. We are looking for our own autonomy having to do with health care decisionmaking.

In looking at this, the ABA has seen the development in the health care system, such as in hospitals, nursing homes, or even home care agencies, of an elucidation of what resident's or patients' rights are. And amongst these rights we find consent or informed consent for health care decisionmaking.

I am speaking today on behalf of the ABA, on behalf of the president of the ABA from New York City, Bob McCrate, and John Pickering who is the chairman of our commission. The way in which we look at the question of autonomy and how it is exercised, I think, is the major issue on which I would like to focus.

First we have the movement toward the patients' rights and then we have to look at the way in which we exercise those rights, that is informed consent. The work of Morris Abram, Joanne Lynn, and Susan Wolf, as well as the Office of Technology Assessment's Study on Life-Sustaining Technologies, gives us a sense of what are the ways in which residents or patients can make their own decisions.

We have, I think, an increasing number of people who we are concerned about, who may lack the capacity at certain times in their lives or at certain times of the stages of their lives to give adequate informed consent, and then we look for a substituted judgment of some sort. In a minute I will talk about living wills and durable powers of attorney.

But as we begin to look at the notion of the autonomous individual making decisions, we have to look at how much they know. That is the issue which I think we talked about: how much does the medical profession, how much does the hospital and/or the nursing home tell somebody about what is going on? This is a basic problem. I don't think that people are told what the options are, in terms of decisionmaking, and I think that we need to look further into the way in which people are asked to make decisions.

It is partially out of ignorance, but it is partially out of what I call a paternalistic view of the elderly's ability to make decisions. And for the most part, society has looked to physicians as well as lawyers in many cases to make decisions for us.

We go into a doctor's office and, as Morris Abram expressed this morning, we don't ask why we take a test, but we take the test. We don't ask what the outcome is. For a learned man such as himself to be able to make those decisions, I think is honorable, but for most of us, those kinds of decisions are not made or that range of choice is not given.

We talked a little this morning about the fact that there are 39 States who have what is known as a living will statute. On the other hand, we also have 15 States where family members may give consent for certain kinds of health care decisions. I think that the efficacy of families making decisions needs to be looked at in terms of the law in using substituted judgment or surrogate decisionmaking. One also has to be wary that family members often are not the appropriate or necessary spokespersons for people.

We need to also look at the issue of capacity. That is, how does somebody lose their capacity? Unless you or I are adjudicated to be incompetent, then we have the right to decide to use or not to use a life-sustaining treatment, to have or not to have a leg amputated, or to take or not to take that pill that is offered to us by that cute nurse that is wandering around the hall. We have a range of choices to make. That range should be the same for everyone whether it is the life-sustaining technology or the medication. For someone who has to take several types of medication daily, the decision not to take that individual pill must be available.

ADVANTAGES TO DURABLE POWERS OF ATTORNEY

Now, in addition to the 39 States which have living will statutes and the 15 States which allow family decisionmaking, we also have another tool. Giles Scofield referred to it and Joanne referred to it to a limited extent—the durable power of attorney for health care.

It is the opinion of my commission, the opinion of many lawyers, that the durable power for health care gives a great many more options to an individual than does the living will. The reason that I say that is that if I have a living will, I have signed it, and if I become incapacitated, then it can kick in or terminate life-sustain-

ing technologies. It does not necessarily allow for other kinds of medical treatment either to be ceased or to be given.

If, however, I delegate to a surrogate the right to make decisions for me at the time when I no longer have capacity to do so, then there is a much broader sense of decisionmaking capacity because of that delegation. There is a greater sense that one's care can be taken care of. The living will is really a much more limited document than the durable power for health care, although it is good, and certainly should be signed by people.

In 12 States now, there are statutory provisions for durable powers for health care. In all 50 States, plus the District of Columbia, there are statutes recognizing durable powers of attorney. There is widespread belief among attorneys, although not by courts at this point, that one can use a statutory durable power of attorney specifically for health care decisionmaking. Thus, we have the ability in all 50 States to be able to use such a document for that purpose.

Representative SCHEUER. Is a durable power of health care preferable to a simple power of attorney?

Ms. COLEMAN. I think there are two answers to that. A durable power of attorney could be used for health care decisionmaking. I believe that a durable power written specifically for health care decisions allows a little more flexibility, rather than tying it to financial matters and other kinds of issues.

The interpretation that some attorneys are making right now is that if you have a durable power at all, that it can be used for health care decisionmaking, just as it can be for banking transactions or anything else. But I think you are better off having it specifically written for health care decisions.

The more that somebody expresses, the more that is written out, the more conversation that takes place between individuals who delegate the power and those who are the designated surrogates, the greater the ability of third parties to interpret what the signer intended to have the document used for. The more specific direction given in the written document, the better off you are.

As we move in the direction of using durable powers or using other kinds of substitute documents or surrogate decisionmaking or advance directives, we need to begin to think about the issue of standards. If we have a plain durable power form that I have picked up at Ginns store down the street and signed, the standard and the question of how it is used, I think, is going to come up. I think that the question needs to be raised.

For instance, if one is in the State of Virginia, in order to use a power of attorney for a real estate transaction, one has to register it with the county court. That is a standard established in the statutory provision in Virginia.

That kind of standard setting, or those kinds of statutory requirements, need to be looked at as we begin to use powers of attorney for health care decisionmaking. I don't think we should just throw them out and say, "everybody use them." I think we need to begin to address how they are going to be used.

PROMOTING DURABLE POWERS OF ATTORNEY

But let me stand back a second and try to answer one of the questions which you raised earlier, Congressman. That is, how do we get people to use or to sign such kinds of documents? I think that the greatest impetus to doing that is—and I hate to be "cliche-ish"—is when it reaches a lot of people through the media.

When Ann Landers ran columns on two occasions that talked about the Concern for Dying and the Society for the Right to Die and their brochures and their forms, the total number of people who wrote for those was 60,000 in one case and 100,000 in another. Now a column in a newspaper that says that an organization has such a form is really good impetus for an individual to act. Films in the popular media that talk about the right to die and the fact that individuals should talk to their doctors about it really adds to that impetus for folks to go out and do it.

It doesn't mean that every single person is going to do it, but it means that there is a greater impetus to at least begin the discussion.

In the court cases in the last few years where there have not been written documents but there have been conversations within the family, and among doctors and the patient, those conversations have been viewed as indications of people's feelings about termination of treatment.

TECHNOLOGY VERSUS CHRONIC CARE

Now, a question that you raised earlier which I think is a very important one is whether we are going to fund chronic care services and provide for people in supportive settings, versus whether we are going to provide dollars for high-tech kinds of services?

It seems to me that we have to look at both areas. Ten or 15 years ago, it was not common to have renal dialysis, but now renal dialysis is almost chronic care. It can be considered chronic care. You can go to a center, you can have your dialysis three times a week, and you can live as a regular human being.

At the time that Congress foresaw paying for it through the medicare program, renal dialysis was looked at as a high-tech service. So if we decide that we are not going to fund something that currently is a high-tech method of providing treatment, is that action going to preclude later use of that treatment method for chronic conditions, where it will allow people to live normal kinds of lives?

There are methods, for instance, whereby one can get nutrition supplements at home through machines that allow people to have normal kinds of lives. Well, how then, do we define what is a high-tech methodology, given to somebody to keep them alive? If you go to the definition of somebody who is near death, who is kept living by the technology, that is one thing; but to deny high-tech kinds of things to people who are not on the brink of death but who could go on living productive lives with the aid of new technology would be wrong, it seems to me.

The other question, and this was borne out to me half a dozen year ago when I heard Bob Butler talk about the issue, is: Do you deny older people, by virtue of age, access to new medical technologies? This is not the rationing question which I think Dr. Calla-

han would give us, but the question of access to care which they, if they had been a younger person, might get. I think that one needs to look at the issue of what is chronic age.

You know, Congressman Pepper is 87 years old and I know that he, in fact, talks about the issue that he was a crazy man when his wife Mildred was dying. He went around and he tried laetrile and he tried every other kind of methodology that he could to save her, but he did it, as he said, out of his own pocket. He wasn't denied the service.

Not allowing a dollar amount to be paid for by the Federal Government may in fact make it impossible for businesses or for high-tech companies to offer a service, period. That has been the argument in terms of new drugs in the area. But I will stop and answer questions.

[The prepared statement of Ms. Coleman follows:]

PREPARED STATEMENT OF NANCY COLEMAN

Mr. Chairman, Members of the Subcommittee, my name is Nancy Coleman. I am the Staff Director of the American Bar Association's Commission on Legal Problems of the Elderly.

I am here at the request of the President of the American Bar Association, Robert McCrate, to express the Association's views on the legal and ethical aspects of health care in the future.

The Commission on Legal Problems of the Elderly was created in 1978 by the ABA Board of Governors to analyze and respond to law related needs of older Americans, one of which is assuring that there is respect for legal and ethical standards in providing health care to the nation's elderly.

The American Bar Association has taken a variety of positions that relate to the issues that the Committee is considering today. Among these are support of the Model Act on the Rights of the Terminally Ill, a second Model Act on Health Care Consent, support of the Uniform Guardianship and Protective Proceedings Act as well as a previous Guardianship Model Act, and policies relating to nursing home and home care regulation with particular interests in patients' rights or residents' rights. These policies give us a basis for looking at the issues that I would like to discuss today.

The legal and ethical issues in the delivery of health care are vast. What I would like to do today is to focus on what I believe are the legal issues which older people will face in attempting to make health care decisions. These issues include the right to make health care decisions about oneself and, when one is no longer able to make decisions, the options for making necessary decisions either through courts, family members, or other surrogates who might be designated. The Model Health Care Consent Act and the underlying doctrine of informed consent assume that the patient understands the available treatment options and the implications of choosing one option rather than another, and that the patient is able to make and communicate a choice. In recent years the growing awareness of patients' rights, both in acute care and long-term care settings, has functioned to encourage this kind of patient decision-making. Most hospitals have developed patients' rights standards, either through the requirements of the Joint Commission on Accreditation of Healthcare Facilities, through state licensure or at their own initiation. In the long-term care field, federal and state regulation have led to the development of patients' rights regulations in nursing homes and, more recently, in home care. These patients' bills of rights assume that patients are able to and want to participate in health care decisions. These decisions might include whether or not to take particular medications, whether or not to have surgery, and whether or not to enter or remain in an acute care setting or long-term care facility.

We heartily endorse the trend in health care decision-making toward encouraging as much patient autonomy as possible. The Model Health Care Consent Act as well as the Rights of The Terminally Ill Act attempt to give patients more control over their own health care decisions. It is our belief that whenever possible an older person, like any of the rest of us, should make decisions about what health care treatments to undergo, who should provide services, and where those services should be delivered.

There are increasingly large numbers of people who may not be able to make health care decisions. In legal terms, a person continues to have the right to make all of his or her health care decisions until a court in a proceeding such as a Guardianship or Conservatorship hearing, finds that the person can no longer do so and a surrogate is appointed. An individual through a Power of Attorney or a Living Will may also delegate this kind of decision-making to another person without resorting to the courts.

In everyday medical practice, traditionally, when a patient is unable to make a decision or the ability to make a health care decision is questionable, there have been three kinds of approaches: (1) the physician has made the decision, perhaps discussing it with the family; (2) family members have made the decision, usually in consultation with the physician, or (3) family members or the health care facility have petitioned the court for appointment of a guardian or conservator to make the decision. The first approach -- i.e., physician as decision-maker -- still appears to be fairly common in our society, even though the health care provider has no independent legal authority to make health care decisions for a patient. The exception to this, of course, is in emergency cases. Generally, physicians have the authority to administer care necessary to preserve life and limb without the express consent of the patient or legal representative. Instead, implied consent is presumed.

Those individuals who have not been adjudicated to be incompetent to make specific health care decisions retain the right to make all health care decisions. Here it is important to emphasize that the mere appointment of a guardian or conservator does not mean that the ward is incompetent to make health care decisions. Decisional capacity is situation-specific and needs to be determined separately from generic judgments of competency. A not uncommon bias against decisional capacity arises when a patient's decisions are not the ones physicians or families would make. Just because a patient chooses a treatment or decides not to have a particular procedure does not make that individual incompetent.

There has been a great deal written about the issue of determining the decision-making capacity of patients with cognitive impairment. The issue arises around a patient's ability to give consent for medical treatment. Assessing a particular patient's decision-making ability in the context of a particular decision is often difficult. The President's Commission for the Study of Ethical Problems in Medicine, in its Chapters 8 and 9 in Making Health Care Decisions, gives three standards in order to help us understand the capacity for health care decision-making. To be competent to make health care decisions, the patient must be able: (1) to understand the nature of the treatment choice presented; (2) to appreciate the implication of various alternatives; and (3) to make and communicate a reasoned choice. When a patient is not able to meet these standards or where competency or capacity to consent is questioned, the President's Commission endorses the traditional method outlined above, by which a patient's decision-making capacity should be determined. The Office of Technology Assessment in its report Life Sustaining Technologies and the Elderly also turns to the President's Commission when asking what the basis is for having an alternative to a patient making a choice. OTA supports the notion that the patient's decision-making capacity is determined by the attending physician in consultation with relatives close friends, or care givers. Court intervention should only be necessary when uncertainty or conflict about the patient's decision-making capacity cannot be resolved at the institutional level.

The court system is not always the best arbiter of health care decision-making. The courts generally are not conducive to quick or efficient decision-making, especially when they are asked to make decisions about a particular type of medical procedure. But when there are no other decision-makers or where there is an intense conflict among decision-makers, the courts are an appropriate forum for this kind of decision-making. During the last few years the courts have increasingly become the arbiters of a variety of health care decisions, including whether to terminate life support or whether to amputate a limb. The courts suffer from the same problem that other types of surrogate decision-makers also share. That short-coming is a lack of agreed upon standards for: (1) determining capacity; (2) determining the nature and extent of the surrogate's role in making decisions; (3) defining a process for making decisions; and (4) reviewing such decisions.

There are other methods for health care decision-making which we believe can be extremely useful for the elderly. These involve two kinds of alternatives. There are about 15 states which authorize family members to make health-care decisions on behalf of incapacitated adults. Some of these state laws allow the family member to make decisions only under certain kinds of circumstances. The state laws which allow such authority do so sometimes for terminally ill patients and sometimes only about withholding life prolonging treatment. The Model Health Care Consent Act suggests that family members such as a spouse, or adult child, or adult sibling, be able to make decisions if a guardian has not been appointed and if no other written designation has been made. The Model Health Care Consent Act emphasizes making decisions that the incapacitated person might have made, based on his or her expressed preferences or values to the extent that these are known or can be determined.

This notion of using a "substituted judgment" standard rather than a "best interest" standard has been a fairly recent trend in the law that has been emerging in the law. It emphasizes having the surrogate decision-makers act as the patient would have acted if capable rather than having the decision-maker decide what he or she thinks is best for the patient. Court decisions throughout the country considering the termination of life support, the Model Health Care Consent Act and many of the family consent statutes all utilize this notion of substituted judgment.

The most recent developments in surrogate decision-making have involved in the use of advance directives. These generally are referred to as Living Wills and Health Care Powers of Attorney. The ABA endorses these instruments because they enhance the degree of control elderly people can maintain over their lives. The Uniform Rights of the Terminally Ill Act is one of the models for state legislation regarding so-called Living Wills. State Natural Death Acts, depending upon the state, give legal recognition to living wills, documents allowing a person to exercise a right of self-determination over life extension or life termination when the individual is no longer capable of making or expressing his or her own choice. Living Wills generally spell out the patient's instructions in the event of terminal illness or irreversible condition or any other treatment decision the patient identifies.

Statutes in 39 states, including the District of Columbia expressly recognized Living Wills. Court decisions in several other states have affirmed their use.

A more useful and versatile tool for delegating authority for health care decision-making is now gaining in popularity. About a dozen states expressly recognize by statute the use of Durable Powers of Attorney for Health Care decisions generally, another eight states recognize their use in the context of their Living Will statute for purposes of forgoing life-sustaining treatment. A Durable Power of Attorney is a document designating another individual to act on behalf of the signor. It is durable because it remains operative even when the signor becomes incapacitated or incompetent. A Durable Power of Attorney for Health Care, or simply Health Care Power of Attorney, is more flexible and applies to more situations than does a Living Will. It permits the individual to specify who should make decisions on his or her behalf in the event of incapacity. In addition, the use of Living Wills is typically limited to times when someone is terminally ill, while a Durable Power for Health Care may be used for other kinds of health care decisions when the issue of terminal illness is not present. A Durable Power for Health Care may be written as broadly or narrowly as the individual wants it to be written.

Ordinary Durable Powers of Attorney are recognized in all of the states and jurisdictions. It is the opinion of most legal commentators that Durable Powers of Attorney may be used for health care decision-making, even though neither the Uniform Durable Power of Attorney Act of 1979 nor the Uniform Probate Code provisions on powers of attorney specifically talk about health care decision making. Statutory Health Care Powers of Attorney can be used to delegate decision-making power to another person, generally not the physician or the health care facility, but rather to an independent person such as a spouse or another relative. The President's Commission in its 1982 work endorsed the use of Durable Powers for Health Care decision-making. To date, there have been no court cases to test the validity of Health Care Powers of Attorneys where there is no state statute recognizing such documents. However, because Durable Powers of Attorney are intended to enhance the autonomy of incapacitated persons, courts, as well, as state legislatures, are likely to approve and encourage their use in the health care context.

A book, A Matter of Choice: Planning Ahead for Health Care Decisions, written by Barbara Mishkin for the Senate Special Committee on Aging and distributed through the American Association of Retired Persons, outlines many of the issues which have been set forth above. There is however, a remaining issue which needs to be discussed. Standards for decision-making should be developed. These would include what role the

surrogate has, whether there is any review, for example, (either by a court or an ethics committee) or whether there should be any intervention when conflicts arise. Current studies in New Mexico, Florida, and New York are looking at health care decision-making through the use of guardianships or special court decision-making. I am hopeful that these studies as well as future ones will begin to address the question of standard setting.

I would like to thank you for allowing me to testify today and hope that the issues which have been raised here will be useful to the efforts of the Committee.

Thank you very much.

Representative SCHEUER. I am taken by the point you make, that kidney dialysis can help an otherwise well person in their middle years lead happy, productive lives. And I am a little bit puzzled by the British practice of not providing kidney dialysis for anybody 55 or over when they would have perhaps 20, 25, maybe 30 years of really happy, productive, enriched life with the aid of kidney dialysis.

I can understand the pressure to ration and to restrict high-tech health care where the quality of life has ebbed to a very dim level or to really no level at all. But for an otherwise well person of 55, who could continue an active life professionally, businesswise, socially, and whatnot, to deny them health care through kidney dialysis I find very un-British.

I wonder just why a consensus has apparently developed in Britain that that is acceptable.

Ms. COLEMAN. I asked that question—I was recently at an international conference and met some folks who are not as familiar with medical ethics as you are today—about that issue, and was told that it is actually not as common a cutoff period as we in America play it up to be; that in fact, one, it still is available in the private market, so that somebody out of the health service can buy it. Number two, in fact, it is only regionally where it is decided what the age limit is; that in other regions within other health services within Britain, you might be lucky if you lived in those areas to be able to have it at an older age.

I bring up the issue simply because 10 years ago we believed it to be a high-tech thing, and if in fact we are going to cut off high tech, are we cutting off high tech when it can be used for people who, in my analysis, need it due to a chronic condition rather than as a high-tech intervention to save a life. I mean at some point, we in this country thought of it as a high-tech intervention to save lives, whereas it is now used for a chronic condition, and I guess that is the distinction I was trying to make.

Representative SCHEUER. Thank you very much, Ms. Coleman.

DURABLE POWERS OF ATTORNEY

Now we will hear from Allan Bogutz of Bogutz & Gordon. We are happy to have you here, Mr. Bogutz.

STATEMENT OF ALLAN D. BOGUTZ, ATTORNEY, BOGUTZ & GORDON

Mr. BOGUTZ. Thank you, Mr. Chairman. It is a pleasure to be here. I will also take you up on the opportunity to speak informally.

Representative SCHEUER. Indeed, I hope you will.

Mr. BOGUTZ. The prepared statement that I have provided to staff I think fairly clearly sets out some of the issues and technicalities with regard to living wills, durable powers of attorney, and durable medical powers of attorney, along with trusts, guardianships, and conservatorships.

I speak to you from a very practical level today because I am a practitioner in Tucson, who also has been a public fiduciary, a public guardian for his county. From 1975 until 1981, I managed an

office that served as guardian and conservator for people in our community who had nobody else who was willing or qualified to serve. That was not just the indigent; that was also people who found themselves with adequate assets but no one prepared to assist them.

As I am sitting here, I am about 2,500 miles from home, and if something were to happen to me medically, I have taken some steps to prepare for that. If I were to have a stroke, not completely improbable——

Representative SCHEUER. God forbid.

Mr. BOGUTZ [continuing]. Yes; and find myself in a DC hospital, or be visting in Virginia or Maryland—I don't know how many States there are around here, but every time I move I am crossing a State line—my wife has a document that is called a durable medical power of attorney, and that document says in the event that I am unable to express my own wishes, I designate my wife, with full authority as my agent, to grant or withhold any consents that may be necessary to obtain or refuse any medical care, counsel, treatment or service.

Second, that document says in the event that my wife exercises these responsibilities, any physician, health care provider, institution, or other person honoring my wife's directives shall be released from any liability.

And, third, it says in the event that any health care facility, physician, or other provider fails to honor the power of attorney, my wife shall sue them for actual and punitive damages. So it gets their attention.

Now, the opportunity to exercise that would be presented immediately because while steps would be taken to protect my health, there would also be contact made with my wife, and she would be the decisionmaker as to how far that care went. Without that document, it is likely she would have to go to court in DC or in Virginia or in Maryland, or wherever she found me, in order to establish a guardianship.

Now, that is very different from a living will, because I am not terminally ill as a result of that stroke. A living will only applies with regard to a terminal illness. the power of attorney applies to any medical situation at all in which I am not able to express my own opinion.

So do I have such a document? The answer is yes. And when do I provide it to my clients? Almost always. As an initial part of any initial client interview, my clients are asked whether they have made arrangements in the event of their own disability to have decisions made for them.

What do I find? I find they haven't. And when I present them with the option of the durable power of attorney, the discussions are generally, "I didn't know that I had such control over my destiny. I wasn't sure these were my own decisions."

And I find very frequently that my clients' concerns are fear of loss of control. The durable power of attorney in a broad sense, and a living will in a limited sense, permit people to retain that control over their own destiny and their own medical care, because I have discussed with my wife what my care will be in the event of termi-

nal illness or in the event of major illness. I have discussed with her all kinds of things.

PORTABILITY AND UNIFORMITY OF DURABLE POWERS

I have had discussions with my personal physician, but he is not here while I am traveling. He is not in Europe when I visit there. The durable power of attorney presents one problem, and that is one that ought to be addressed: the question of portability. Can I use my Arizona power of attorney in DC, Virginia, Hawaii, or wherever I may be?

There are problems with that, and that is one of the problems with presenting a form power of attorney because it may not necessarily address those portability issues. Portability has been addressed by the Commissioners on Uniform Laws.

Representative SCHEUER. Do you think that limited problem would be a proper focus for Federal attention, congressional attention? Should Congress legislate somehow or other that durable powers of attorney for health care, with some standard accepted form, be accepted by all States?

Mr. BOGUTZ. I believe that that is appropriate.

Representative SCHEUER. You know, we are very leery about intruding on the jurisdiction of the State to be in charge of health. Traditionally States have covered all of the circumstances delivering health care within their jurisdiction. But this is almost a matter of human rights, the integrity of the individual, to state what he wants to happen to him and to have that recognized wherever he or she may be within our 50 states.

So it is a matter of recognizing an individual's legal right to say once and for all how he wants his health care to be determined in the event of his incapacity. It seems to me that maybe the congressional writ would extend to affirming that right and requiring all States to recognize that right when, at the same time, we have a great deference and a great reluctance to interfere unnecessarily in the right of States to conduct the oversight and to determine the parameters under which health care shall be delivered in their States.

Mr. BOGUTZ. Mr. Chairman, I believe that is completely appropriate. It approaches a full faith and credit issue as among the States.

The consequences of a will, a last will and testament drawn in one State and moving to another State, generally most States will determine that a will that is valid in the State in which it is executed is valid in any State unless there is something contrary to public policy contained in the document.

I believe that exactly the same kind of interpretation can be given to the durable powers of attorney. That is, if it was valid where it was executed, it has to be a valid expression of a person's wishes, it should be honored wherever it is presented within the United States.

Representative SCHEUER. One would think so. Is there a standard uniform durable power of attorney for health care?

Mr. BOGUTZ. There is not at the present time. There are proposals.

Representative SCHEUER. What would be the process by which such a uniform durable power of attorney for health care would be developed?

Ms. COLEMAN. The two methods which have generally been used are that Uniform State Law Commissioners have developed forms. They have one for a statutory power of attorney and they are then emanated through what is known as the Uniform Probate Code, and then adopted within States.

There are several statutorily mandated State durable powers of attorney. California has one of those. In the last year or so we have seen four more States adopt statutory forms of health care powers of attorney.

Representative SCHEUER. Are they uniform?

Ms. COLEMAN. They are not uniform. Again, the uniformity and the portability question are difficult.

Representative SCHEUER. I think you can solve the portability problem more easily if they were uniform.

Ms. COLEMAN. I absolutely agree with you. The other problem which exists is that, when you have groups like the Society for the Right To Die who distribute forms, there is a tendency for people—and this is not a full employment of lawyers argument now—but there is a tendency for people to make them out without having a lot of discussion with other folks around them or with another party like a lawyer.

I think that is another issue which one needs to look at when one distributes en masse kinds of forms.

Representative SCHEUER. Mr. Bogutz, I didn't mean to interrupt your testimony. Please proceed.

Mr. BOGUTZ. Thank You.

PATIENTS' RIGHTS

I have a couple of proposals for Federal action that I would like to get to in just a moment if I could. First of all, one observation and then a couple of premises that I think need to be acknowledged.

The first observation is that in every situation where I have been able to present a physician or other health care provider with a durable power of attorney, a living will, or a guardianship, it has been welcomed with open arms because it is apparent, in many cases it has to be explained, but once it is explained, it is apparent that the issue of liability for actions taken or not taken is going to be resolved by having a surrogate decisionmaker with official power to make those decisions, whether it is delegated power or court-appointed power. It is welcomed broadly. In our practice, we deal with it a on a day-to-day basis.

I serve as guardian for perhaps 100 individuals still, even in private practice, in my community. Four premises that I wanted to address.

First, everyone has the right to make their own decisions, everybody has a right to cut his own throat in his own way as long as he understands the implications of what is going to happen if he does so.

John Stuart Mill said that the only time society has a right to intervene in the actions of another is for the protection of itself. Now, part of our actions today, or part of our proposals today involve protecting ourselves as a society financially, economically, in terms of distribution of care. But otherwise, we really have to respect that individual's wishes.

The second premise is that those wishes have to be honored if a person has expressed them. As far as I know, every court in the country that has addressed the issue has said that if a person has expressed wishes in advance, again provided they are not contrary to public policy, those wishes must be honored.

The third premise is that people should be able to plan for disability, whether it is a terminal illness or just a disability that would be debilitating if you will, and those disability planning tools are discussed in my prepared statement, and those are the durable power of attorney for medical care, the living will, the general durable power of attorney which is for financial management, and the guardianship and conservatorship as a last resort can be done on a voluntary basis.

GOVERNMENT ROLE IN CARE CONDITIONS

Finally, the fourth premise is that the options for decisions made by a surrogate have to be created and they have to be supported, and I think these are the areas in which the Federal Government can really take a role.

One of the premises that we have adopted in our geographical area with regard to care of the elderly is that that care has to be addressed as a continuum. It can't be addressed as isolated specialties. That is, social workers need to know what hospitals are doing and have available.

Meals on Wheels personnel need to be able to know that other social services are available, and somehow they have to be coordinated to the extent that Mr. Abram's blood doesn't have to be drawn 10 times during the course of a day, or that the person doesn't have to fill out 200 forms. And so we have arranged for long-term planning and coordinated planning.

Probably one of the best areas for the Federal Government is in that coordination role, stressing that there needs to be, within the States, created some types of public agencies or mutual support groups or family responsibility acts—which have been adopted in a couple of states—or encouraging the use of private agencies that will provide case management and care coordination.

Representative SCHEUER. What kind of management?

Mr. BOGUTZ. Case management, where an individual who is not aware of how the system or the health care system or the social services system operates can have someone who is familiar with the overall picture of care assisting him in obtaining the care. That is not just medical care, but it is support services as well.

I think the role of the Federal Government needs to encourage these particular types of options.

Second, this morning you heard information concerning whether a physician should be paid or reimbursed for sitting down and talking with a patient. Absolutely. There is no questin but that—a

term that is becoming more popular in alternative health care systems is holistic care—you must treat patients; you cannot just treat symptoms.

Alleviating the symptom may not eliminate the problem if the problem is an unhealthy home situation that the physician has never seen or heard of for failure to discuss it with the patient. That has to be provided.

Now, it may be that physicians are becoming so technically involved with the patients that we may have to provide for an alternative such as a case manager, which is evolving in hospitals as a way of cutting costs, to determine ways to keep people out of hospitals and move them out more quickly. That needs to be a reimbursable expense as well.

Representative SCHEUER. Is a case manager in a hospital typically a paraprofessional? Is it somebody with a university degree?

Mr. BOGUTZ. Mr. Chairman, it can be a paraprofessional. It can be a master's in social work. It can be a nurse practitioner. It can be anyone who is trained, with reasonable skills, to determine what the overall needs of the patient are and what is going to happen when this patient leaves the hospital, what kind of care or assistance will we provide to prevent the person from coming back in 2 months with the same problem again?

That addresses not only the issues of death and dying, but it addresses issues of continuing care and the expenses of long-term health care.

Representative SCHEUER. Are there any other phrases that have been applied to describe that role? "Case manager" is not a very salubrious expression.

Mr. BOGUTZ. Well, if it is well done, a discharge planner arranges for services in the community to support the patient upon discharge. Discharge planning is generally a hospital function.

Case management and care coordination are terms that are used within the professions as the persons who provide social services on a continuing basis to provide assistance to prevent future health problems.

Representative SCHEUER. Well, it is not only providing social services, but providing counseling on a holistic basis about the patient's total psychological and physical health status and degree of comfort and support and emotional outreach.

Mr. BOGUTZ. Absolutely.

Representative SCHEUER. There has to be a better way of describing this function than "case manager."

Mr. BOGUTZ. I am afraid I am limited in the terms that we are using in our community. "Case manager" and "care coordination" are the terms that are becoming, I think, generally accepted among the profession.

I am not a social service provider. I am an attorney, although much of my practice appears to be providing social services at this point.

Representative SCHEUER. I would say that is clear. That is very clear from your testimony.

Mr. BOGUTZ. The third area where I think Federal assistance is really required, as Dr. Lynn suggested, is in the education of physicians. I find that a good deal of my practice is not only educating

my clients as to the options that are available and assisting them in taking the steps that are necessary to plan for their care, but then having to enforce those issues with regard to the physicians and the care providers.

For example, a woman I had was 87 years old and a social service worker, and she had a terrible stroke. She found herself in a fetal position in a nursing home, in a persistent vegetative state, and the health care provider, the nursing home, and the physician would not honor an order from her guardian to cease nutrition and hydration.

The law was clear. Unfortunately, the health care providers didn't know what the law was and had no inkling that it was anyone's decision other than the facility's. And yet we were able to educate them without going to court and were able to have these services stopped for her and allowed her to die with the little dignity as she had left.

Representative SCHEUER. With as much dignity as she had left.

Mr. BOGUTZ. Well, she had very little left, I am afraid, at the stage at which this occurred.

Representative SCHEUER. You enabled her to conserve and protect whatever level of dignity she had.

Mr. BOGUTZ. We did. Yes. We are assisting with physicians and medical schools and attempting to provide assistance to faculties to train physicians as to what some of the options are. Again, it is met with a sense of relief, understanding that they can practice medicine as opposed to making as many life and death decisions.

There is a group that has been formed of attorneys who practice predominantly with the elderly in the United States. That is the National Academy of Elder Law Attorneys. As a group, they are attempting to address issues that focus on health care as well as other issues facing the elderly.

But again, I have to go back to my primary concern. That is, that if we are able to make these options more well knwon among the public, we will find a great deal of relief for people who are concerned about how well they are retaining control over their own density. My clients are more grateful generally for the durable powers of attorney and living wills than they are for their last wills and testament, because they can see a real practical effect on their own lives from these individual documents.

So my concerns are that these options be made more well known. And I would like to reiterate something Nancy and I spoke to during the break. That was that we are both very impressed, as are the other panelists, with the depth of this proceeding, and welcome the opportunity to participate.

[The prepared statement of Mr. Bogutz follows:]

PREPARED STATEMENT OF ALLAN D. BOGUTZ

PLANNING FOR DISABILITY: OPTIONS FOR SURROGATE DECISION-MAKING

During much of the history of the United States, families had regular multi-generational contact. Frequently, three or four generations would reside within the same building or within walking distance of each other. In the event of the illness or chronic disability of one member of the family, the other members of the family were in a position to provide support services that would meet all of the basic needs of the dependent family member. A family physician often knew his patients personally, resided in the same community and was able to communicate with the family effectively to reach decisions concerning the nature and quantity of care that would be given to the patient. Furthermore, medical science and medical technology really allowed the physician to do no more in many cases than make a patient as comfortable as possible during the final stages of life.

The last fifty years particularly have seen substantial changes in all of these areas. First, the family structure has changed; the family home is often empty during the day as all the adults go off to work and the children go to school or day care. There is no one staying at home to provide for the elderly or infirm family member. Secondly, families are geographically diverse; family members may live thousands of miles and even continents apart without having the ability to provide the type of hands-on support that historically has been the role of the family. Finally, medical technology has helped to change the demographics of our country so that many people are living longer lives and many people are surviving illnesses that historically would have been fatal. Such survivors are frequently in a debilitated state of health including a mental state of inability to make or communicate responsible decisions concerning their own care, housing or personal needs.

As a result of these changes, decisions frequently have to be made for people by persons who are unacquainted with the patient's desires as to the amount and type of care, housing and treatment that the person might prefer and often decisions are made which do not necessarily reflect the wishes of the individual patient. Physicians often find themselves treating patients in a social vacuum, patients that are personally unknown to them and for whom close family are not readily available to provide consultation.

Under these circumstances, it becomes more important for persons to take whatever steps they can to preserve their own autonomy and to assure that their own wishes concerning such matters will be honored at a time when they may be individually unable to communicate them on their own behalf. There are several alternatives available today that are readily accessible to individuals that permit them to make their wishes known, assure that they are carried out to the extent possible and, indeed, appoint a surrogate decision-maker on their own behalf. Failure to take some of these steps may result in difficult situations in which family members are left at sea as to what steps they should take and which family members are appropriate to make decisions, physicians and other health care providers may find themselves forced to act in a decision-making capacity with regard to the care and denial of care to certain patients and, perhaps most unfortunate, individuals may receive care of a type and quantity which is very much against the patient's principals.

The options that will be discussed are:

THE LIVING WILL
(HEALTH CARE DECLARATION)
TRUSTS
DURABLE POWERS OF ATTORNEY
MEDICAL DURABLE POWERS OF ATTORNEY
GUARDIANSHIPS AND CONSERVATORSHIPS
BY COURT APPOINTMENT

PERSONAL CARE

The right to die is now fairly well recognized in most states although clarifications are still being required to decide the circumstances under which decisions can be made to allow a patient to die, who is responsible for making such decisions, under what circumstances the decisions will be made, when such decisions will be made and what types of care may be withheld or terminated. Unless the patient, however, has given some type of advance directive, however, those in the position of responsibility, whoever they are, can only speculate as to what the patient would have wanted were the patient able to participate.

The best approach, therefore, is advance planning. There are, in fact, numerous opportunities for appropriate discussion of these issues. These are issues that are most frequently faced or at least addressed by the elderly and one appropriate time for such discussion is at the time of the preparation of a Last Will and Testament or an estate plan for the client of a lawyer. Many lawyers are now addressing such questions and providing clients with the alternatives. An additional time that is now being utilized is in the medical counseling process during which a physician or other health care provider advises the patient that it is possible for such advance directives to be made. Nursing homes and hospitals are addressing the questions at the time of

admission to a facility or as part of the social services that are available. Protective service agencies are discussing alternatives now to imposed care and many persons who have been at risk in the community are given the options of making self-determination by use of the tools that are presently available. A discussion of each of the options is appropriate.

LIVING WILL

The **LIVING WILL** or **HEALTH CARE DECLARATION** is a document that has become relatively well known over the past several years. In essence, the Living Will is a statement signed by an individual which states that, in the event of a terminal illness, artificial life-sustaining measures either shall not be employed or may be disconnected and that the patient be allowed to die a natural death without further intervention. Living Wills are a state statutory issue and the states have addressed the question in different ways. For the most part, however, the individual statutes provide that such a document, if executed, must be honored. There are numerous limitations and drawbacks to the Living Will. First, the Living Will attempts to anticipate situations in which the patient may find himself and give directives as to how such situations should be handled; rarely does reality meet our prediction. Secondly, the Living Will only applies in situations of terminal illness and does not provide for direction as to what type of care should be provided in the event of a chronic non-terminal illness during which the patient is unable to communicate for himself. Third, the Living Will does not appoint a decision-maker; it merely gives a directive as to the type of care that should be provided. In failing to appoint a decision-maker, the patient has to rely solely upon the document at a time when the patient himself is unable to communicate. On the positive side, the Living Will is a readily available document, relatively simple to understand, governed by a statute in most cases and subject to wide acceptance.

DURABLE MEDICAL POWER OF ATTORNEY

A second alternative, one that is probably preferable to the Living Will, is the execution of a **DURABLE MEDICAL POWER OF ATTORNEY**. This document in essence provides that "In the event of my disability and inability to communicate my own wishes, I designate [Name of Agent] as my Agent to grant or withhold any consents that may be required to obtain or refuse any type of medical care, counseling, treatment or service." The validity of such a document is now acknowledged in nearly all states and uniform laws are being proposed. The benefits of this document are that it allows for a surrogate decision-maker, acquainted with the patient and his wishes, the authority to such a surrogate to make decisions based upon the circumstances existing at the time of the illness so that one need not anticipate every contingency in drafting such a document. In addition, the Power of Attorney can limit the authority of the Agent to only make certain types of decisions to provide or refuse certain types of

care (such as "My Agent shall not have the authority to place me in any long-term care facility without Court order" or "My Agent shall have the authority to use non-conventional means of treatment such as acupuncture, biofeedback, imagery, . . ."") and can also provide for releases of liability for any person or facility honoring the directives of the Agent which further eases the process of having the Power of Attorney honored. Finally, the Durable Power of Attorney provides authority for such decision-making in the event of any illness or period of disability, not just in the circumstances of a terminal illness. On the negative side, however, the Durable Power of Attorney is in essence a "blank check" which permits the Agent absolute authority with regard to decision-making at a time when the grantor of the Power of Attorney is not able to object. Furthermore, the Durable Power of Attorney is not necessarily widely recognized among health care professionals because of lack of exposure to the document and because of occasionally vague statutory language. The Power of Attorney may have portability problems, i.e., a Power of Attorney drafted in one state may not necessarily follow the requirements or be acknowledged as acceptable in another state in which a patient may find himself hospitalized or in need of care while traveling or after having changed residences.

In many cases, the execution of both a Living Will and a Durable Medical Power of Attorney is advisable to provide clarity and assurance with regard to wishes for future care and decision-making.

FINANCIAL MANAGEMENT

While the Living Will and the Durable Medical Power of Attorney address issues concerning health care and personal care, a period of disability or illness may also require management of financial affairs. Two simple options are available for a person concerned with the continuity of the management of his business and financial affairs in the event of disability; these are the Living Trust or Stand-By Trust and the Durable Power of Attorney.

TRUSTS

TRUSTS are generally well known and incorrectly presumed by most to be a planning tool only of the wealthy. Very modest estates can be managed under a Trust arrangement. While banks and other financial institutions generally require substantial assets before they will serve as Trustee, it is possible for an individual, by means of a Living Trust, to become his or her own Trustee with an alternate Trustee available to serve in the event of disability. Such a person would presumably be one who is versed in the financial affairs of the individual and who understands the individual's wishes with regard to the management of those matters in the event of disability. A "Stand-By Trust" is a mechanism whereby a Trust is established and not "activated" until such time as the person becomes disabled. At that time,

assets are transferred into the Trust by someone designated to do so and the Trust assumes responsibility for the management of the assets and income. Such Trusts can be revocable or irrevocable or can become irrevocable upon disability. These Trusts are relatively inexpensive to establish, provide assurance that assets will be marshalled and managed appropriately and provide for the appointment of a fiduciary who can be bonded if necessary as the Successor Trustee. Other Trust arrangements are of course available and can be used for other goals such as avoidance of probate, tax considerations, etc. Such routine Trusts can, of course, include language that will permit the contingency of disability to be addressed as well.

DURABLE POWER OF ATTORNEY (FINANCIAL)

An alternative to the Trust for financial management is the granting of a DURABLE POWER OF ATTORNEY FOR FINANCIAL AFFAIRS. Historically, Powers of Attorney have been for such financial management (as opposed to the Durable Medical Power of Attorney). Common law, however, has always provided that a Power of Attorney is invalidated by the disability of the grantor of the Power (the Principal). Thus, without statutory change on a state level, a Power of Attorney to handle financial affairs would be extinguished by the disability or inability of the Principal to communicate. All states and the District of Columbia have now enacted legislation to permit for "durability" of Powers of Attorney. (This durability provision is what has allowed the Durable Medical Power of Attorney to be utilized as set forth above.) Durability may take two forms: It may be a "Springing" Power of Attorney or a "Surviving" Power of Attorney. A "Springing" Power of Attorney contains language which, in essence, states "This Power of Attorney shall take effect upon my disability." A "Surviving" Power of Attorney, on the other hand, takes effect upon execution but contains language that states "This Power of Attorney shall not be affected by my disability." In either case, the Power of Attorney provides for management of financial affairs in the event of the disability of the Principal. The extent to which such financial affairs can be managed and the way in which they can be managed can be specifically set forth within the framework of the Power of Attorney document. Thus, one Power of Attorney may provide that "My Principal may invest only in United States Treasury Bills," while another Power of Attorney may provide that "My Agent may invest in any types of investments which the Agent deems appropriate without regard to risk, tax implications or other considerations." The Power of Attorney can be as broad or narrow as the Principal wishes. The benefit of such a Power of Attorney is, of course, that the Principal determines who will manage his or her financial affairs as well as how they will be managed and provides for great flexibility and prior direction by the Principal. The risk involved in granting such a Power of Attorney should also be obvious, viz., one truly gives up substantial control at the time of disability without any meaningful supervision of the Agent. Such Powers of Attorney are

routinely accepted although they still face the problems of having interstate portability and having a lack of recognition in some types of financial transactions. Generally, a custom-drafted Power of Attorney can overcome these limitations by specifically addressing the needs of the individual such as by specifically permitting inspection and removal of safe deposit contents, management of brokerage accounts, transfer of securities, etc.

Frequently the Durable Medical Power of Attorney and the Durable Power of Attorney for Financial Affairs will be combined in the same document. This is not necessary but is a matter of convenience if the same Agent is to be appointed under both documents.

JUDICIAL OPTIONS

Unless these tools are provided, in the event of a serious disability or extended illness which requires the appointment of a surrogate decision-maker, those responsible for the care and management of the affairs of such a person will have no choice but to resort to the judicial system for appointment of a surrogate decision-maker. While the terminology may vary from state to state, in most states such needs are met by the appointment of a guardian of the person and/or a conservator of the estate. Other terms in use are "guardian of the estate" or "committee."

GUARDIANSHIP AND CONSERVATORSHIP

A **GUARDIAN** is appointed, generally speaking, when a person lacks sufficient capacity to make or communicate responsible decisions concerning his own person. Once appointed, a guardian generally has the same rights, powers, duties and responsibilities that a parent has for a minor child except that a guardian is not obligated to contribute financially to the support of the ward. Appointment of a guardian for an individual generally acts to remove most of the person's rights of self-determination, often eliminates the right to vote and essentially places the individual in a "disabled" legal stance, unable to make his or her own decisions.

The appointment of a **CONSERVATOR**, on the other hand, appoints an individual to manage financial affairs when a person is proven satisfactorily to the Court to have assets which will be wasted or dissipated unless proper management is provided and that the individual is unable to provide such management himself or herself as a result of some type of disability, incapacity or disappearance.

As to both the appointment of a guardian and conservator, most states provide for substantial judicial controls for the protection of the person to become protected, usually the appointment of a physician to examine the proposed ward, the

appointment of an attorney to represent the individual and due process protections with regard to a right to hearing, notice of such hearing and the right to put on such evidence as the person may believe is appropriate in his or her defense. The extent to which these protections are afforded in fact varies from state to state and jurisdiction to jurisdiction.

There is limited ability on the part of the person to be protected to determine who will become guardian or conservator. Statutory priorities exist but these are not always honored and can be ignored under certain circumstances. The appointee as guardian or conservator is usually given unlimited authority and this has severe impact on persons who may be less than fully disabled or incapacitated. The protections that are afforded by Court appointment are usually valuable but, again, from jurisdiction to jurisdiction the enforcement of these may vary.

The Court will appoint any individual who comes forward seeking such appointment in most circumstances provided that the individual is able to demonstrate reasonable qualifications to serve. Under some circumstances, there is no one available to provide such services and many states now have public guardians available to fulfill such a role. These public guardians are for the most part over-worked, under-staffed, in greater demand than they can meet and have limited ability to provide anything but basic, impersonal services. Private guardianship agencies are available in many communities but these may serve on a for-profit basis and the expenses may be beyond the reach of most individuals.

Very often, however, there will no nobody able to serve on behalf of an individual, the costs of appointment may exceed the ability of the estate to pay and no option may exist other than for the health care provider to make whatever decisions may in the individual's "best interests" with many other factors affecting the decisions. Many people who could live in the community or in relatively unrestrictive group situations are unnecessarily institutionalized as a result of a surrogate care giver being unavailable to supervise and arrange for such alternative care.

Thus, it would appear that given the alternative and the availability of the tools to permit direction of an individual's future care by that individual, these options should be made more available, become more widely known and be utilized more frequently.

INFORM PUBLIC OF LEGAL OPTIONS

Representative SCHEUER. Thank you very much. Is there a greater need today than in the past for setting forth decisions about care in legal documents?

Mr. BOGUTZ. There are changes in demographics. We have many more older people today than we have had in the past. People are surviving, as Dr. Lynn said, illnesses that had previously been fatal, and families are no longer living three and four generations to the household, or living within walking distance of each other.

In my community in Arizona, we don't only have retired people who have left their families back here; we also have young people who have left their parents and grandparents back here when they have moved out to find work. And that geographic diversity today prevents us from having the family unit make these decisions.

So it needs to be addressed. It needs to be addressed with constitutents. Give them the opportunity to think about the questions and see someone for the type of assistance that might be available.

I urge, however, that a form for a durable power of attorney is not necessarily the document that we want to provide, because it is a document that requires individual consultation to make these decisions. We don't want a form to just say, "I don't want any health care services provided if I am terminal." We want the form to say what that individual person wants it to say for him or for her.

It is going to be difficult to structure a general form. For example, I have one client who says, I do not want nutrition; I do want hydration. That is not going to be a form document. That is going to be something that is going to have to be drafted specifically for her, but she has reasons for it.

Representative SCHEUER. So she is willing to have water artificially introduced into her system, but not food?

Mr. BOGUTZ. She is. This is a nurse who says she has seen a number of terminal cancer patients who have had food and water withheld and has seen suffering in those patients that she feels would be prevented by the artificial introduction of fluids, which can be done without great intrusion.

Representative SCHEUER. But would permit death with dignity earlier than if they had provided both food and water.

Mr. BOGUTZ. That is correct. These are such personal decisions that we can't just provide a form. We have to discuss these on an individual level. Even without a document, and this I think is an important thing, if you were to send out that type of information to your clients, even if there is not the health care power of attorney executed, even if there is not a living will, then if the matters had been discussed, most States are now recognizing that if wishes were expressed, even if not in writing, even without a delegation, most States are saying those wishes must be honored when they are brought to the attention of the provider.

So I think you do a great service to your constituents.

Representative SCHEUER. You don't think any appreciable number of them would consider that an offensive intrusion on their privacy?

Mr. BOGUTZ. I would be very surprised if that were to happen, based on my experience with my clients who come from all backgrounds and are a very diverse group of people.

DURABLE POWERS OF ATTORNEY

Represetnative SCHEUER. Are durable powers of attorney freely revocable in all States?

Ms. COLEMAN. Yes.

Mr. BOGUTZ. Yes. A durable power of attorney is nothing more, really, than an agreement between the principal and the agent, and it can be revoked at any time that the principal has the capacity to do so.

Representative SCHEUER. What happens when an older person who may be slightly disoriented decides to change or revoke a durable power of attorney for health care?

Mr. BOGUTZ. We have a judgmental decision at that time, Mr. Chairman. We have a question as to whether the person really has the capacity.

It is not an insurmountable problem because if there is concern, then it is time for a judicial determination of capacity. If the person is incapacitated, the court is likely to establish a guardianship.

Representative SCHEUER. In my congressional district, people do live close to each other and there are communities where parents and kids live within a few blocks of grandparents.

How would that reflect itself in the kind of appropriate living wills or durable powers of attorney for health care that would be appropriate for them?

Mr. BOGUTZ. That, Mr. Chairman, makes it much simpler because then your constituents know whom to give the power to. One of the biggest issues is the individual who is somewhat dissociated from all of his personal and family support systems. He or she really has no one to designate as a decisionmaker, and there are few other options that can be presented.

But where there is a close-knit family, you save a great deal of expense in preventing judicial action, but in addition you save a great deal of heartache by making your own wishes known to the family members who have to make the decisions, rather than have them try to second guess what you might have wanted had you discussed it beforehand.

Ms. COLEMAN. There is only one proviso that I make with that. That is, I think Allan is absolutely correct, except when there is family conflict. Among a group of relatives who are close, it behooves the person making the power to decide whose wishes they think are closest to their own to follow and to make that designation because if in fact you decide, well, I will give it to a collection of nieces to make, then they may not be able to sort it out.

When there are conflicts and the conflicts rise to the point where there is disagreement and there is a siding, for instance, with a health care provider and some relatives are opposed to the position taken by others, that is when we end up in court most often, whether there had been a designation before or not. But those are the ways to resolve that so you don't get to that conflict.

Representative SCHEUER. All right. Unfortunately, I have to go vote now.

This has been a most thoughtful and productive and touching panel. I very much appreciate your excellent, really outstanding testimony.

[Whereupon, at 1:25 p.m., the subcommittee recessed, to reconvene at 1:55 p.m., the same day.]

AFTERNOON SESSION

OPENING STATEMENT OF REPRESENTATIVE SCHEUER, CHAIRMAN

MALPRACTICE

Representative SCHEUER. Good afternoon, I apologize to those of you on these two panels who have been waiting.

This afternoon's session will deal with medical malpractice. I am sure everybody in this room is aware of concern over the so-called malpractice crisis that has been with us in varying degrees since the middle 1970's. The high cost of medical malpractice insurance and the threat of lawsuits are causing major disruption in the practice of medicine in our country. Neurosurgeons are retiring or are ceasing to practice, and obstetricians have stopped delivering babies, and other physicians are opting for early retirement.

While it is difficult to produce reliable estimates of the costs and the effects of medical malpractice—and we will hear some important testimony that may quantify these costs and effects this afternoon—some of the statistics which are available give an indication of the problem and its magnitude.

The General Accounting Office, which is the investigatory arm of the Congress, the GAO, estimates that malpractice insurance for physicians and hospitals cost $4.7 billion in 1985, up from $2.5 billion in 1983. It almost doubled in the space of 2 years.

In addition to the direct cost of malpractice insurance, the American Medical Association—AMA—estimates that indirect costs attributed to defensive medicine, powered by the fear of malpractice suits, exceeds $12 billion.

Now, all of these costs, both the malpractice insurance fees and the costs of defensive medicine, are eventually passed on to the consumer in the guise of higher prices for medical service. And as these costs get passed on to the Government, so we as taxpayers pay for them, because 40 percent of all health care costs are payed for by the Government.

But these statistics only tell part of the story. In some regions, the problem is much more severe than this, and the effects even more traumatic. In south Florida, for example, malpractice insurance rates climbed so high that doctors curtailed services, while the insurance companies threatened to stop providing coverage even after premiums had been increased by 43 percent. These rate increases have resulted in annual malpractice insurance premiums for south Florida of $89,300 for anesthesiologists, $100,200 for general surgeons, $165,300 for obstetricians, and $209,000 for neurosurgeons. According to the AMA, 12 percent of the obstetricians in the country have stopped delivering babies.

In addition to being so costly, the present malpractice insurance system treats injured parties capriciously and unequally. People suffering similar injuries can and do receive vastly different awards. One party might even be denied compensation altogether when a person similarly situated, with virtually identical facts surrounding his or her case, would achieve a significant settlement.

The only certainties about the current system are that injured parties will wait months or years to recover damages and that they will incur significant legal costs as they do so which will, in a major way, impact on the amount of the recovery that is left for them.

The dilemma we find ourselves in with respect to malpractice, however, is that despite its flaws, the current system is the only effective way we now have to punish poor providers of medical care. State licensing boards discipline very few physicians annually, even though we are experiencing what one witness, in this set of hearings, has described as "an epidemic of iatrogenicity." Iatrogenicity means physician error.

The only deterrent remaining to incompetent and negligent and clearly substandard medical care is that provided by the tort system. We know that there are, by the estimate of the New England Journal of Medicine, about 20,000 doctors out of the 550,000 practicing in our country, who are drug-addicted, who are alcoholic, who are mentally disturbed, and who are incapable of delivering satisfactory health care by anybody's standards.

If we are serious about dealing with health care costs, we must deal with medical malpractice and we must find rational solutions to medical malpractice that are not as expensive and not as time consuming as relying on the tort system.

We must remember that while we are doing this, we cannot undercut the safety of the public in the process of finding a better solution.

This afternoon we will hear from two panels of witnesses. The first panel will present testimony on the costs and effects of malpractice litigation, and the second panel will present alternatives to the current litigation system which might strike a better balance between the need to compensate injured parties, the rights of the providers and the interest of deterring incompetent medical practitioners and ultimately screening them out of the practice of medicine.

We will start with a discussion of the costs and effects of malpractice suits. We have a very distinguished panel of lawyers and scholars appearing today. In the first presentation we will hear joint testimony from two scholars from the Institute of Medicine of the National Academy of Sciences, Dr. Roger Bulger, chairman of the Medical Professional Liability Study and Ms. Victoria Rostow, study director. Also on this panel is Mr. Carter Phillips of the firm of Sidley & Austin.

We are very happy to have you with us and we apologize for the late hour. If you have been in the room for the last couple of hours, you will know how exceptionally productive the hearings that preceded you have been, and we know that yours will be equally stimulating, equally useful.

Why don't each of you take 7 or 8 minutes? Your prepared statements will be printed in full in the record. And please feel free to advert to anything you may have heard today either from the witness table or from up here. Even though the two sessions, this morning's and this afternoon's, have a somewhat different focus, still there is a very clear interface between these two panels. So feel free to refer to anything that has intrigued you that you have heard today.

Why don't you start out, Dr. Bulger? Take 7 or 8 minutes and then, after we have heard from Ms. Rostow and Mr. Phillips, I am sure we will have some questions for you.

JOINT STATEMENT OF ROGER J. BULGER, M.D., CHAIRMAN, AND VICTORIA P. ROSTOW, DIRECTOR, MEDICAL PROFESSIONAL LIABILITY STUDY, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES

Dr. BULGER. I may do better than that and go down to 2 or 3 minutes because we have worked it out so we can do our thing in a brief period of time.

In order that you not have inappropriate expectations of me, when you referred to lawyers and scholars from the Institute of Medicine, I am neither one. I am just a little old country doctor that happened to be brought in to try to work on this committee, and my function here would be to truncate some of the written material that you have and simply point out that our study, which we are getting increasingly enthusiastic about has the possibility of being able to make a real contribution.

We are not able to share with you recommendations of the committee because it hasn't got any yet in terms of its cogitations, but it has had a chance to review a lot of the evidence and we can share with you a lot of that preliminary stuff.

I think the other main comment that I would make at the outset is that it is an interesting process in which we have, we think for the first time, almost equal numbers of lawyers, doctors, and people from the insurance and finance world as well as some patient-oriented scholars really in health services, all around the table together, trying to address an issue that is very complicated.

With that, why don't I turn the microphone over to Ms. Rostow for the substantive?

MALPRACTICE AND OBSTETRICS

Ms. ROSTOW. At the Institute of Medicine we are approximately halfway through our 24-month study of the effects of medical professional liability on the delivery of maternal and child health care.

As you have our prepared statement, I thought I would just briefly tell you a little bit about this study and summarize some of our very preliminary findings which I think you will find interesting.

Early in its deliberations, our committee decided to focus on obstetrical care as a microcosm of the whole medical malpractice problem, in part because it is an area that has been disproportionately impacted.

For convenience today in summarizing my prepared statement, I thought I would briefly set forth some of our preliminary findings in three areas: the effect of professional liability on access to obstetrical care; the effect of medical professional liability on the actual practice of obstetrics, which are two areas of indirect costs of the medical professional liability problem; and then finally some brief remarks on the actual effect of the medical professional liability problem on the cost of malpractice insurance.

One of the committee's chief concerns is whether the medical malpractice problem is actually affecting access to care. While we are still very much in the fact-finding stage, we see preliminary indications that the medical professional liability problem is in fact impairing access to obstetrical care to poor women and women whose care is financed by medicaid.

Some of the evidence that is available to the committee thus far makes the following points which were highlighted yesterday at a large symposium we held at the Institute of Medicine where Secretary Bowen of HHS gave the keynote address.

First, we would like to highlight for you that we believe that when we talk about the provision of obstetrical care, we are concerned not only with obstetricians, but with family physicians and nurse midwives, because all three are very important providers of obstetrical care.

Yesterday we found that obstetricians and family physicians are increasingly reporting that because of professional liability concerns, they are either abandoning obstetrical practice or very much curtailing their practices, they are limiting their medicaid participation, avoiding high-risk patients who are very often socioeconomically disadvantaged women, poor women, women on medicaid, according to a number of State surveys.

The National Governors' Association surveyed State medicaid and maternal and child health agencies and found that most medicaid programs and most MCH programs reported significant problems in provider participation for reasons that physicians claim are related to medical liability concerns.

We also commissioned a survey of community health centers which was presented yesterday at our symposium. That survey found a majority of centers reporting that unease about medical malpractice had reduced their ability to provide maternity care to low-income women.

Medical malpractice concerns are creating significant access problems in rural areas according to other research conducted at our request. The problem is particularly acute in those areas served mainly by family physicians.

Recent data from the American Academy of Family Physicians indicate that as many as 23 percent of family physicians reported that they have recently abandoned obstetrical practice because of either the high cost or lack of availability of malpractice insurance for obstetrics. Another 10 percent reported that they have limited their practices because of professional liability concerns.

According to research that was done for us, approximately two-thirds of the providers of obstetrical services in rural areas are family physicians.

Representative SCHEUER. Excuse me. In other words, you are saying that obstetricians have gotten out of the delivery of obstetrical services in rural areas to a large extent, and that they are being replaced in the delivery of obstetrical services by family physicians?

Ms. ROSTOW. No. Actually, traditionally, family physicians have—it is both problems, but traditionally family physicians have been strong providers of obstetrical care in rural areas.

Representative SCHEUER. So there is no change involved.

Ms. ROSTOW. There is no change involved, except that now the family physicians want to get out of providing obstetrical care, leaving no providers of obstetrical care. So it is quite a problem.

Finally, the same problem is affecting the practice of nurse midwives. It appears that the cost and availability of malpractice coverage for nurse midwives is very much impairing their ability to provide care. And, once again, traditionally in this country, nurse midwives have been very important providers of obstetrical care to indigent women, minority women, women on medicaid.

Representative SCHEUER. And, in years gone by, middle class women.

Ms. ROSTOW. Absolutely.

Representative SCHEUER. I am a birth product of a nurse midwife.

Dr. BULGER. And still some middle class. I mean they are not solely for the——

Ms. ROSTOW. Oh, absolutely. I wouldn't want to convey otherwise.

Our findings related to the effects of medical malpractice on the actual practice of obstetrics are similarly preliminary, but again some of our early findings are very notable. The IOM conducted an informal survey of heads of obstetrics departments at academic health centers. We didn't attempt to quantify our findings, but our survey results strongly indicated that the current legal climate is making it difficult to provide obstetrical residents with appropriate training responsibility and, further, that the cost of medical malpractice insurance for obstetricians is impeding the ability of academic medical centers to hire adequate obstetrical faculty.

There is also concern in many quarters that too many babies are being delivered by cesarean section. Our committee has been studying this problem and has tentatively concluded that among the very many factors affecting the C-section rate in this country are concerns about medical liability and excessive reliance on the electronic fetal monitor, which itself is a byproduct of medical malpractice concerns.

The IOM committee has also heard much testimony to suggest that the medical professional liability problem in obstetrics had adversely affected the physician-patient relationship, has created a crisis of confidence among obstetricians and other obstetrical providers, has increased the practice of defense medicine and, in the minds of many physicians, devalued their relationship with their patients.

Finally, the committee is still studying both the direct and indirect costs of obstetrical malpractice insurance. There is no question, as you well know, that costs are rising, but the implications of

these escalating costs are still being evaluated by our committee. It is not yet clear what proportions of these costs are being passed on to consumers and to third-party payers.

We continue to study the problem but it is apparent that there really are not enough data existing to be able to document the effects of rising malpractice premiums on physicians' incomes or on the costs of obstetrical services with any degree of precision.

Finally, we wish to advise you that our committee is studying varying proposals for the legal system for health care providers and for insurers. We believe that this problem in obstetrics is multifaceted and will require not only legal reforms, but also changes in the way that care is provided and the way that it is insured.

We are heartened to know that you are concerned with this problem and very pleased to have this opportunity to discuss our study and our preliminary findings. We hope that when our committee's recommendations are ready, we will have a similar opportunity to discuss them with you.

[The joint prepared statement of Dr. Bulger and Ms. Rostow follows:]

JOINT PREPARED STATEMENT OF ROGER J. BULGER, M.D., AND VICTORIA P. ROSTOW

Good afternoon. We are very pleased to be asked to speak to the Joint Economic Committee this afternoon. My name is Roger J. Bulger. I am the president of the American Association of Academic Health Centers and the Chairman of the Institute of Medicine's Committee on the Effects of Medical Professional Liability on the Delivery of Maternal and Child Health Care. I am accompanied by Victoria P. Rostow, the staff director for this study, and an adjunct professor of law at the Georgetown University Law Center.

I. Background of the IOM Study

The Institute of Medicine (IOM) is approximately halfway through a 24-month study of the effects of medical professional liability problems on access to and delivery of maternal and child health care. This study began with an inquiry by the American Academy of Pediatrics (AAP) in 1984. The AAP encouraged the IOM to examine the implications of a disturbing trend that they were observing: an increasing number of physicians reporting that they were discontinuing practice because of professional liability concerns, and a large number of physicians reporting that they were making significant alterations in their practice patterns because they feared medical malpractice liability.

Although the Institute found this inquiry to be of interest, it also wished to examine larger questions associated with the effects of medical professional liability. Thus, in October 1985, the Institute organized a preliminary meeting of staff and external advisors to discuss the general features of the malpractice issue and its relationship to health care. That meeting was followed by a detailed planning meeting on April 1, 1986, the outcome of which was a recommendation for a study of the effects of medical professional liability on the delivery of maternal and child health care. To conduct this privately funded study, the IOM assembled an interdisciplinary committee of 15 individuals with expertise in obstetrics, pediatrics, general medicine, diverse areas of law, medical ethics, health services research, insurance, economics, nursing, and public policy. The committee met for the first time on October 1 and 2, 1987 and expects to complete its report early in 1989.

Because our committee's work is not completed, we cannot discuss its findings or conclusions with you. However, we believe that it is important for you to know the direction that the study is going, the scope of the endeavor, the data that are available, and more important, the nature of the information that does not exist but is sorely needed.

Early in its deliberations, the committee decided to focus its inquiry on access to and delivery of obstetrical care, and on an analysis of various proposed solutions to the medical malpractice problem. The committee found that much attention has been directed to the

causes of medical malpractice surges, the effects of rising malpractice premiums on physician incomes, and the difficulties that have occurred in certain states when medical malpractice insurance became unavailable. However, there has been very little analysis of how the current medical professional liability climate has affected the delivery of health care and access to it. Accordingly, the committee chose obstetrical care as a microcosm of the malpractice liability problem as a whole, in part because it is a practice generally believed to be disproportionately impacted. The committee has set out to evaluate how the medical professional liability problem has affected practice patterns, who is served and ill-served by the health care system, and who ultimately receives care.

The committee is currently investigating diverse questions related to medical professional liability and obstetrics. Are poor women disproportionately impacted? Are high-risk women underserved? Are community health centers and maternity centers experiencing liability problems? Are obstetrical services waning in rural areas? Are family physicians being adversely affected? Are medical professional liability concerns affecting the development and dissemination of new technologies for the delivery of maternal and child health care?

As part of its inquiry, the committee held an interdisciplinary research symposium on Monday, June 20, 1988, on "The Effects of Medical Professional Liability on the Delivery of Maternal and Child

Health Care." Secretary of Health and Human Services, Otis R. Bowen, M.D., gave the keynote address. Scholars and policy analysts from such diverse fields as obstetrics, epidemiology, law, economics, and public health set forth their most recent research findings on the effects of the medical malpractice problem in obstetrics. These papers will be published by the National Academy Press as a companion volume to the Institute of Medicine committee's final report early in 1989.

II. Questions of Access

One of the committee's chief concerns is whether the medical malpractice problem is affecting access to care. Although we are still very much at the fact-finding stage, we see preliminary indications that the medical professional liability problem is impairing access to obstetrics for poor women and women whose care is financed by Medicaid. There are identifiable pockets of diminished access in some rural areas and certain urban ghettos. However, much of the evidence to support this view is indirect or based on physicians' self-reported changes in practice. There are many changes currently taking place in the medical profession that are causing discontent among physicians. Any conclusion about the effects of professional liability on physician behavior should be understood in this context. The evidence available to the committee thus far makes the following points.

o Physicians are reporting that because of professional liability concerns they are curtailing their practices, limiting their Medicaid participation, and avoiding "high risk" patients who are very often socioeconomically disadvantaged women, poor women, and Medicaid women, according to state surveys.

o An evaluation of approximately 40 state surveys specially prepared for the IOM committee revealed that in the median state, 25 percent of the obstetrical providers contacted had stopped practicing obstetrics--the range was from 7 to 70 percent.

o The National Governors' Association surveyed state Medicaid and Maternal and Child Health (MCH) agencies and found that 60 percent of Medicaid programs and almost 90 percent of MCH programs reported significant problems in provider participation. Three-fifths of the MCH and Medicaid agencies surveyed reported that physicians have stopped providing obstetrical care to their clients because of malpractice concerns. Seven out of ten agencies stated that physician participation levels were being reduced for that reason.

o An IOM-commissioned survey of community health centers found a majority reporting that unease about medical malpractice had reduced their ability to provide maternity care to low-income women.

o Medical malpractice concerns are creating significant access problems in rural areas, according to other research conducted at the request of the IOM. The problem is particularly acute in those areas mainly served by family physicians. Recent data from the American Academy of Family Physicians indicate that as many as 23 percent of family physicians reported that they have recently abandoned obstetrical practice because of the high cost or lack of availability of malpractice insurance for obstetrics; another 10 percent reported that they have limited their practices because of professional liability concerns. Two-thirds of the providers of obstetrical services in non-metropolitan areas are family physicians.

o It appears that the medical professional liability problem has increased the cost and availability of malpractice coverage for nurse midwives to the point of impairing their ability to provide care. The IOM committee regards this as a potentially significant problem, because traditionally nurse midwives have been important providers of care to indigent women, minority women, and women on Medicaid.

III. The Effects of Medical Professional Liability on the Practice of Obstetrics

Our findings relating to the effects of the medical malpractice problem on the practice of obstetrics are still preliminary. However, some of our early findings are notable. First, we wish to emphasize that

not all of the changes in obstetrical practice that have been brought about by the medical malpractice problem have been bad. Some have benefited patient care. Some physicians have reported that because of medical malpractice concerns they have improved their record keeping, have increased appropriate diagnostic testing, have increased discussions with patients, have increased their use of informed consent documentation, and have given greater attention to their relationship with their patients.

Other reported changes in obstetrical practice have been more disturbing to our committee. Some examples follow.

o The IOM conducted an informal survey of heads of obstetrics departments at academic health centers. Many department heads reported that medical professional liability concerns are having an adverse effect on the training of new obstetrical residents. They reported that the current legal climate makes it difficult to provide residents with appropriate training responsibility, and that the cost of medical malpractice insurance for obstetricians is impeding the ability of academic medical centers to hire adequate obstetrical faculty. However, the committee has noted that, although overall applications to medical schools have declined in recent years, the percentage of medical students choosing obstetrical residencies appears unchanged.

o There is concern in many quarters that too many babies are being delivered by cesarean section. The committee has studied this phenomenon,

and has tentatively concluded that among the many factors affecting the cesarean section rate in this country are concerns about medical professional liability and excessive reliance upon the electronic fetal moniter--itself a by-product of medical malpractice concerns.

o A study commissioned for the IOM committee suggests that medical malpractice concerns may lead to excessive and inappropriate use of new genetic testing and screening technologies, and may ultimately distort research in this area.

o The IOM committee has heard much testimony to suggest that the medical professional liability problem in obstetrics has adversely affected the physician-patient relationship, has created a "crisis of confidence" among obstetricians and other obstetrical providers, has increased the practice of defensive medicine, and in the minds of many physicians, has devalued their relationship with their patients.

IV. The Costs of Medical Professional Liability Concerns

The committee is still studying both the direct and indirect costs of obstetrical malpractice insurance. According to a survey by the American College of Obstetricians and Gynecologists, the average obstetrician-gynecologist paid $30,500 in 1986 for insurance--an increase of almost 47 percent since 1984. By 1987, premiums had risen another 21 percent--

to almost $37,000. Obstetricians in major urban areas paid much more than these national averages. At the end of 1987, medical malpractice insurance for obstetricians with coverage providing $1 million per plaintiff and $3 million per occurrence—the standard amount—exceeded $65,000 a year in Anchorage, Alaska, Dade and Broward Counties in Florida, Baltimore City and County in Maryland, Nassau & Suffolk Counties in New York and in the greater metropolitan area of New York City. It should be noted that in Dade and Broward Counties, Florida, a mature claims-made policy providing $1 million of coverage per person/$3 million per occurrence will cost $152,900 in 1988.

The implications of these escalating costs are still being evaluated by the IOM committee. It is not clear what proportions of these costs are being passed on to consumers and third-party payers. The data on this question are not good. Certain aggregate national data sources suggest that the proportion of obstetricians' average gross income used to pay malpractice premiums has increased from five percent of average gross income to eight percent between 1982 and 1984. Although this is not a dramatic change, these highly aggregated national data may not convey the real economic burden of malpractice premiums on certain younger obstetricians, obstetricians wishing to relocate their practice, or to retire. Although we continue to study the problem, it is apparent that there are not enough data existing to be able to document the effects of rising malpractice premiums on physicians' incomes, or on the cost of obstetrical services, with any degree of precision.

IV. An Evaluation of Proposed Solutions to the Problem of Medical Professional Liability in Obstetrics

The IOM committee is evaluating various proposed solutions to the problems caused by the medical professional liability problem in obstetrics. It is, therefore, premature for us to discuss specific policy recommendations. The committee is studying proposals for the legal system, for health care providers, and for insurers. The committee believes that the professional liability problem in obstetrics is multifaceted and will require not only legal reforms, but also changes in the way that care is provided, and the way it is insured. We are heartened to know that Congress is concerned with this problem and very pleased to have this opportunity to discuss our study and our preliminary findings. We hope that when our committee's recommendations are ready we will have a similar opportunity to discuss them with you. Thank you.

Representative SCHEUER. Thank you very much, Ms. Rostow. Now we will hear from Mr. Carter Phillips.

STATEMENT OF CARTER G. PHILLIPS, ATTORNEY, SIDLEY & AUSTIN

Mr. PHILLIPS. Thank you, Mr. Chairman.

AMA SPECIALITY SOCIETY MEDICAL LIABILITY PROJECT

I should identify myself as more than simply a partner in the Washington office of Sidley & Austin. I am also the outside legal consultant to a project called the AMA Specialty Society Medical Liability Project.

That is a consortium of the American Medical Association and 31 medical speciality organizations, including the Council of State Medical Specialty Societies. That organization I think probably best reflects that there is a malpractice crisis.

The very notion that the American Medical Association could come together with all of the medical specialty societies, organizations that were originally created because of discomfort or dissatisfaction with the way the AMA has itself handled specific matters of particular interest to those specialty societies, that those organizations could come together 2½ years ago, contribute common funds and common intellectual effort in order to try to find a solution to the problems that physicians face, I submit to you is probably the best evidence that we are in fact facing a serious problem.

The project in the last 2½ years has put together an important alternative to the tort system and I would like to talk about that later. In some ways I suppose I am either improperly placed in this panel or serve as a useful bridge to the next panel.

MAJOR CONCERNS WITH MALPRACTICE

But I think it is important to realize that the predicate for the proposal that we put forward was based on essentially four findings that the group made in response to the medical problems.

The first is that it is quite clear to us that, as medical malpractice exists today, there is now and there will be for some time a serious concern about access to medical care. I think it is important to just explain how that access problem operates.

If you are an ordinary physician practicing medicine in this country, you are going to make a decent living. That much is fairly clear. Historically, if you were a specialist, you could increase your living, obviously, by providing specialized skills and reasonably asking for additional money in order to provide those skills.

Today, if you are a specialist in certain areas, what that really means is that your insurance rating goes up and when your insurance rating goes up, the cost of your insurance also goes up significantly, so that the family physicians who provides obstetrical care is placed in a different insurance category, making it virtually economically infeasible for him to continue in that practice. He simply cannot get back enough money through obstetrical care to justify the increase in insurance that he has to pay, and that is true across the range of specialties.

That is the economic reason why people who entered into the profession with the hope that they would be providing certain types of services suddenly find themselves unable to perform these services and make that judgment, even though I think it runs across deep-seated feelings about how they would prefer to practice their medicine.

Representative SCHEUER. And may do what? Just repeat that last sentence.

Mr. PHILLIPS. They walk away from activities that brought them to the profession that they wanted to perform, and those are difficult judgments to have to make. I don't think most physicians like to make judgments on strictly economic bases.

In addition, by performing specialized functions along those lines, of course, you create greater potential for litigation. Obstetrics is one of those areas where things happen that may or may not have been malpractice. It is a maloccurrence, but it is not necessarily malpractice. That is something that physicians understand, that may be something that their attorneys understand, but that is all too often something that juries have a very difficult time understanding.

Before you are going to assume that kind of a burden, you have to give very long, hard thought as to whether it is worth it, and over time as this crisis has increased, more and more physicians have made that judgment. Neurosurgeons walk away from that kind of specialized surgery. Obstetricians obviously walk away from that kind of specialized treatment, and that is a trend that is not going to stop as long as the current system remains operating the way it has.

The second dominant concern that the project worried over is the basic problem of defensive medicine. Estimates vary with respect to how much both the Federal Government and everyone else have to pay with respect to defensive medicine. They range from the most recent AMA study of about $10 billion, to the earlier study by the same organization of around $13 billion.

Part of the problem is how you define "defensive medicine," and even more difficult is if you could reach common agreement as to the appropriate definition, trying to measure those costs. There are obviously always going to be some gains to the patient by the provision of certain treatments, by certain consultations. There is always a 1 in 1,000 chance that that is going to lead you to uncover something that you might not otherwise have uncovered.

The problem is, is that worth it? Over the course of society, can we afford to pay for each one of those consultations for each one of those screening tests? I think at this stage, if the price tag is in the multibillion dollar range, which we think it is, it seems quite clear that we cannot justify that.

It is important to try to find some kind of mechanism to provide greater guidance to physicians, to allow them to make judgments as to whether this is a particular procedure or a particular consultation that is worth making. Unfortunately, the jury system as it has developed today, doesn't provide physicians with any guidance. You never know what a jury, post hoc, will conclude would have been a reasonable undertaking by a physician faced with a situa-

tion of a plaintiff who has been injured as a consequence of medical care or lack of care provided by a physician.

The third basic finding of the project is that the system as it exists today is flawed. The flaw is not simply one that disadvantages physicians. I think that is important and I think that is an important advance of the project's proposal over other proposals that have come forward from the medical profession historically.

First of all, far too few patients are compensated for injuries that they suffer at the hands of health care providers today. Estimates range from 1 in 10 to 1 in 25 patients who are injured are ever able to obtain any kind of recovery in the jury system. That is because plaintiffs' lawyers require a certain amount of money in damages to be available to the plaintiff before they can go forward with the lawsuit. Therefore, there is a barrier to access that patients have to suffer and face every day.

Second, the basic means of decisionmaking, the jury, is hardly the optimal method for deciding whether or not intricate technical medical technology and efforts were appropriately exercised in a particular instance. Juries do not have the opportunity to question physicians directly. The most that they can glean is what skilled attorneys can bring before them, which may or may not help those jurors find the truth at the end of the judicial process.

Representative SCHEUER. They can ask judges to clarify the judge's directions to them.

Mr. PHILLIPS. They can clarify on the law. Unfortunately, they cannot clarify on the facts. They go back and say, did so and so testify to something, and does this mean X? The judge can say, I can send you back the transcript of what he testified to, but he can't tell you what it meant. And if they don't know what that means, there is no chance to ask those kinds of questions.

Third, the current system is a truly inefficient and ineffective method of compensating patients who have been injured. Somewhere between 40 and 60 cents on the dollar is spent for plaintiffs' lawyers, defense lawyers, court costs, and only around 40 cents is actually spent on the patient who has been injured as a consequence of malpractice.

This all tells us, then, that there has to be some better way to try to resolve this problem, the problems I have identified earlier about the costs to the system, than the one we have now.

I think the fourth finding that the project came forward with in devising its alternative is that the solution to this problem in general cannot reside solely in changing the liability system. Any answer to this problem has to take into account the need to change the liability system and the need to change the monitoring and disciplining of physicians.

And we have to examine that half of it, because if you are going to change how the tort system acts as a deterrent, to the extent that it fairly does act as a deterrent, then you are going to have to supply some additional mechanism to ensure that physicians continue to maintain high-quality practices. You have to find instances where those practices have fallen below acceptable minimum standards.

AMA SPECIALTY SOCIETY MALPRACTICE PROPOSAL

The proposal by the AMA Specialty Society, which is set out in my prepared statement, addresses all of those concerns. We propose an administrative fault-based system which is basically designed to use an agency akin to the National Labor Relations Board, at the State level, to attempt to adjudicate liability claims. That agency would also have authority to discipline and monitor physician practices, our assumption being that the integration of those two functions in an administrative agency will more effectively respond to the problems that I have identified already in my testimony.

The last point I would like to make in connection with this, I suggested to you that this is a State-oriented proposal. I think most proposals with respect to malpractice are going to be oriented to the States, because that is a more effective way of trying to take a solution and adapt to the particular needs in a particular locality.

That does not mean that there is not a role for Congress to play in this setting. As States consider alternatives, and they are going to begin to consider alternatives, the first problem they are going to face is the notion that those alternatives are expensive by nature. If you are going to create an administrative agency like ours, you are going to have to expend substantial resources in order to put that agency into place.

States are going to be reluctant to do that when they are already going to be asked to assume the risk of an entire new scheme for resolving malpractice cases. It seems to me it is fair to ask the States to assume the latter risk, quite reasonable to ask the Federal Government to support demonstration projects by providing the States with the money so that they are not out of pocket the exact costs of developing those alternatives in the first place.

I would urge this committee to make that kind of recommendation in terms of how Congress can respond to the particular problem at the State level. Thank you, Mr. Chairman.

[The prepared statement of Mr. Phillips, together with an attachment, follows:]

PREPARED STATEMENT OF CARTER G. PHILLIPS

I am a partner in the Washington, D.C. office of the law firm of Sidley & Austin, and in that capacity I have served as an outside legal consultant to the "AMA/Specialty Society Medical Liability Project." The Project is sponsored by the American Medical Association and a consortium of 32 other medical specialty societies and organizations. A list of all of the medical organizations involved with the Project is attached to this Statement as Appendix A.

The purposes of the Project are: 1) to design and test an alternative system for resolving medical liability claims, 2) to provide responses, when appropriate, to the assertions of trial lawyers and other critics of tort reform, 3) to evaluate programs for risk management, peer review and physician discipline and recommend improvements that will

enhance the quality of medical care and 4) to provide information to the public about the nature of the malpractice problem.

In furtherance of these purposes, the Project has collected information concerning the dimensions and effects of the liability crisis in medicine and, based on that information, the Project has designed a fault-based, administrative system to adjudicate medical negligence claims and to improve the monitoring of physician practices. Before describing the proposed administrative system, I would like to review the information collected by the Project concerning the current crisis in medical liability.

I. The Cost and Effects of Medical Malpractice Suits

Increasing number of claims. The last decade has seen a dramatic increase in the number of malpractice claims filed. Through physician surveys, the AMA's Socioeconomic Monitoring System found that from 1981 to 1985 the number of claims filed against physicians tripled, increasing from 3.2 per 100 physicians to 10.1 per 100 physicians. St. Paul Fire & Marine Insurance Company, the nation's largest medical liability insurer, reported a 70 percent increase in claims against its 50,000 insured physicians from 1980 to 1985 -- from 10.5 per 100 physicians to 17.6 per 100. This trend in claims filed has been confirmed by the RAND Corporation's

Institute on Civil Justice study on trends in tort litigation. In its November 1987 report, the ICJ characterized medical malpractice as a type of "high stakes" personal injury litigation where the increase in suits has been much sharper than in routine personal injury litigation and the increase far outpaces population growth.

Increase in claims costs. Not only has the number of malpractice claims continued to increase, but so has the severity or magnitude of the claims. RAND's 1987 report on trends in tort litigation found that mean or average tort awards in high stakes suits such as product liability and medical malpractice showed increases ranging from 200 percent to more than 1,000 percent over the 25 years (1960 through 1984) for which data exist. RAND research also showed that juries tend to award substantially greater amounts -- 200 to 400 percent more -- in malpractice cases than in cases which concern identical injuries not involving physicians as defendants. The St. Paul Company reports that the average paid loss (exclusive of defense costs) increased by 60 percent between 1982 and 1986 -- from $45,421 in 1982 to $72,703 in 1986.

Most of the indemnity dollars now paid out by the system are awarded in a very small percentage of the total cases. The General Accounting Office in its 1984 closed claims study found that 61 percent of the total money paid out in that

year went to claims closed with an indemnity of $250,000 or more. These large claims represented only nine percent of the total number of claims closed.

Moreover, for these larger claims, which are the source of the insurance industry's greatest problem in assessing risk, non-economic injury is often the largest component of the award. Patricia Danzon, a noted expert in this area, has documented in Florida that only 2.7 percent of all injury claims receive compensation for pain and suffering in excess of $100,000, but the pain and suffering portion of those awards accounts for 80 percent of the total verdict in such cases. Similarly, the GAO found that 62 percent of the total non-economic damages paid out were awarded in 2 percent of the cases.

High cost of processing claims. The cost of processing medical liability claims through the current civil jury system is also very high, in terms of both time and money. Taking into account plaintiff and defendant costs, the RAND Corporation estimates that only 43 cents of every dollar spent in medical liability litigation reaches an injured patient. The remaining 57 percent is spent on attorney fees, insurance claims processing, court expenditures and the cost of plaintiffs' and defendants' time. Most of the claims --57 percent by GAO estimates -- are dismissed without a verdict, settlement or any compensation going to the claimant.

Nevertheless, the cost of defending even unsuccessful claims is very significant. Of the $807 million spent on malpractice defense costs in 1984, the GAO estimates that $349 million, or 43 percent, was spent in defending claims where there was no compensation paid to a claimant. Whether or not the claim is successful, it will take a substantial period of time to be resolved. According to a survey released by the American College of Obstetricians and Gynecologists (ACOG) in March 1988, in 55 percent of obstetrician/gynecologist cases, it took three or more years to close the claim. In New York, more than 75 percent took that long to resolve. The steady rise in the magnitude of awards and the transaction costs of processing claims through the court system is directly reflected in the total losses (payouts and expenses) for professional liability claims reported by the A.M. Best Company. According to Best, payouts and expenses rose by more than 500 percent in the decade from 1977 to 1986, from $817 million to $4.1 billion.

Increase in physician premium costs. Both the average premium and the premium rate have continued to increase substantially in excess of inflation throughout the 1980s. Average premiums paid by self-employed physicians for professional liability insurance have risen from $5,800 in 1982 to $12,800 in 1986. These average figures mask the

enormous variation by geographic region and specialty -- according to a study by the federal Tort Policy Working Group, the average obstetrician in Florida would have seen his malpractice premiums increase by 395 percent between 1980 and 1985. The 1988 American College of Obstetricians and Gynecologists survey revealed that the average Florida obstetrician paid $52,000 for insurance in 1987. There is no indication that these increases in premium rates will decline anytime in the foreseeable future. Physician-owned companies (which hold over 50 percent of the market for self-employed physicians) reported a rate increase of 29.9 percent in the 18-month period from January 1986 through July 1987. AMA data indicate that the cost of liability insurance premiums increased an average of 21.9 percent annually between 1982 and 1985, compared to a general inflation rate that averaged 3.2 percent annually in that period.

Increase in hospital insurance premium costs. Hospitals, often the "deep pocket" in medical negligence cases, have also continued to experience a dramatic increase in the cost of insurance premiums in the 1980s. The GAO found that on an inpatient day basis, average malpractice insurance costs increased nearly 85 percent from 1983 to 1985 at a time when total hospital expenses increased only 12 percent.

Increase in cost of medical care. The increase in professional liability premiums for physicians has been a significant factor contributing to the growth in patient medical bills in recent years. When adjusted for inflation, 16.4 percent of the average increase in the cost of physician services can be attributed to increased liability premiums, based on an assessment of data from 1983 to 1985. Physician and hospital professional liability insurance costs as a percentage of the national health care budget have risen from 0.9 percent in 1983 to 1.22 percent in 1985 -- a 33 percent increase. Looking only at the total aggregate annual costs of professional liability for physicians, $15.4 billion was spent in 1985. This represents 18.7 percent of total expenditures for physician services in 1985. That additional cost is borne in part by patients and in part by taxpayers, the latter because the government is the largest consumer of medical services.

Increase in costs due to defensive medicine. The impact of the increases in the frequency and severity of claims and in the amount paid for premiums can be seen in the increase in "defensive medicine," i.e., medical care that is provided primarily to protect against future liability claims for less than perfect outcomes. Additional laboratory tests, X-rays and outside consultations done for the primary purpose of establishing a record that will be defensible in court all contribute to the cost of medical care. According to surveys

done by the AMA, the practice of defensive medicine is extensive and increasing -- 70 percent of the physicians surveyed said that they engaged in defensive medicine and 41.8 percent said they had increased their defensive medical practices above past levels. Total costs of defensive medicine have been estimated by the AMA to be in the range of $10.6 billion annually. While this estimate is necessarily speculative, it cannot be doubted that society pays a hefty price for medical tests designed to uncover problems that are very unlikely to exist.

Damage to physician-patient relationship. Although harder to measure than other costs, the damage to the physician-patient relationship caused by the current liability crisis is no less real. In an era in which over 70 percent of obstetrician/gynecologists have been sued at least once in their careers and 36.5 percent of all physicians have been sued, it is not surprising that physicians would feel that their relationships with patients have become more adversarial. A Wall Street Journal article last fall illustrates the consequences -- a Dallas plastic surgeon, having been sued for malpractice, began to videotape all his discussions with and treatments of his 2,000 patients each year. Pleased with the results, the surgeon has licensed his program to other doctors in the area.

The human toll created by the deterioration of the trusting relationship between physician and patient is an aspect of the medical malpractice crisis that is all too often ignored, an aspect which distinguishes medical liability from other forms of tort liability. Professor Paul Weiler of Harvard Law School has conducted an extensive analysis of the malpractice situation and concluded:

> "[T]here is a personal and emotional cast to a lawsuit between a patient and a doctor which gives this branch of tort law an entirely different edge than is felt in suits filed against the large and remote manufacturers of defective products. Surely few of us want the therapeutic relationship between sick person and physician to require the kind of unimpeachable documentation which might be felt desirable in the adversarial atmosphere of a police officer interrogating a prisoner in custody."

Decreasing availability of and access to medical care. One of the most disturbing consequences of the current liability crisis is the decreasing availability of medical care. The problem has become most serious in the area of obstetrics and gynecology. In its recently released study, ACOG found that almost one out of every eight obstetrician/gynecologists has stopped delivering babies because of the threat of malpractice suits. Of those, two-thirds dropped obstetrics before the age of 55, with close to 30 percent quitting before age 45. The result is a dramatic decrease in the availability of obstetrical care in many regions of the country, particularly non-urban areas. For example, 44 percent of the counties in Georgia, 42 percent of the

counties in Alabama and 30 percent of the counties in Colorado no longer have any physician (obstetrician or family practitioner) providing obstetrical services. Even in areas where obstetrical services are still available, many physicians are restricting the percentage of their practice that is devoted to high-risk pregnancies. The number who have restricted their practices has grown from 18 percent in 1983 to 23 percent in 1985 to 27 percent in 1987.

The problem is not confined to obstetrician/ gynecologists. The experience during the past year in Florida underscores the need for change -- faced with insurance premiums of more than $100,000 a year, medical specialists in Miami began avoiding high risk treatment procedures and emergency rooms refused to admit some patients.

Those most likely to suffer when access to care is restricted due to the unavailability or unaffordability of medical liability insurance are patients who are poor. In its August 1987 report, HHS cited 150 examples from 26 states of instances in which patients had suffered from impaired access to adequate medical care. Most of those examples involved low-income patients, including Medicaid recipients and state and local public health department patients.

II. The AMA/Specialty Society Proposal

In response to the problems with the existing system for resolving medical liability, the Medical Liability Project has proposed a comprehensive alternative. A copy of that proposal is included as Appendix B. Unlike prior tort reform proposals, the new alternative is designed to be fair to all relevant parties affected by the malpractice problem -- patients, physicians and society.

The proposal calls for the abolition of the common law tort of medical malpractice. In its place would be substituted a fault-based administrative system for resolving medical liability disputes. To implement the system, the proposal recommends the creation of a Medical Practices Review Board at the state level, which would decide medical liability disputes in roughly the same way that the National Labor Relations Board decides unfair labor practice charges. Members of the Board would be appointed by the governor from nominees submitted by a blue ribbon panel and no interest group would constitute a majority of the Board.

A patient who believed he was injured by medical negligence would file a claim with the Medical Practices Review Board. The filing process would be simple and no assistance from an attorney would be required to initiate a claim. A claims reviewer at the Board would then evaluate

the claim, submit it to peer review, and if it has merit, offer the patient the opportunity to be represented at no charge by a Board attorney.

Hearings would be conducted before hearing examiners or administrative law judges whose decisions on liability and damages would be subject to review by the Board. Judicial review would be available, but strictly limited to the issues whether the Board acted outside its statutory authority or whether the Board acted arbitrarily.

In addition, the proposal includes a series of specific changes designed to improve the quality of medical care, including:

1. creation of a centralized state clearinghouse of information concerning physician performance;
2. reporting of all settled claims, findings of liability and disciplinary sanctions to the Board;
3. reporting of all adverse credentialing and all non-class-based adverse insurance actions to the Board;
4. use of professional staff to investigate disciplinary allegations and use of the Board's administrative system to resolve disciplinary matters fairly and expeditiously;
5. required continuing medical education tailored to the physician's field of practice;

6. periodic reviews of each physician's performance file and use of on-site review of physician practices, when warranted; and

7. required risk management programs for hospitals and insurers.

Finally, the proposal recommends specific changes in the standards for imposing liability, including use of a pure comparative fault basis for allocating damages, use of a "prudent and competent" practitioner standard for the standard of care, application of a "contributing factor" rule for causation and a reasonable patient standard for informed consent. The proposal also includes some traditional tort reform modifications of the damages rules, such as elimination of joint and several liability, elimination of the collateral source rule, and a graduated cap on non-economic damages, correlated to the age of the injured party and the average state wage.

The AMA/Specialty Society proposal is designed to be enacted at the state level. After much consideration of the problems of medical liability, the members of the Project determined that variations from state to state make implementation of this unique proposal on a federal basis inappropriate.

Nevertheless, there is a vital place for federal government support of state efforts to respond to the malpractice problem. The extensive administrative apparatus

needed to evaluate and adjudicate a large number of claims as well as to improve significantly the oversight of physician practices will not be inexpensive. States that have a serious malpractice crisis and are interested in trying a daring new proposal, such as the AMA/Specialty Society's, may nevertheless be reluctant to bear not only the financial and political risk of implementing a proposal that may lead to many more claims of liability, but also the sizeable initial cost of establishing and operating an entirely new administrative system. Federal financial assistance, through demonstration grants from HHS, would do much to promote creative state solutions to the malpractice crisis. Both the General Accounting Office and the Department of Health and Human Services have called for federal government involvement in and support for such experimentation in the states. I urge the members of this Committee to heed this call by authorizing HHS to fund demonstration projects to implement alternative methods of resolving medical liability claims outside of the civil justice system.

APPENDIX A

AMA/SPECIALTY SOCIETY MEDICAL LIABILITY PROJECT MEMBERS

American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology - Head and Neck Surgery
American Academy of Pediatrics
American Association of Thoracic Surgery
American Association of Neurological Surgeons
American Association of Plastic Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiology
American College of Surgeons
American Medical Association
American Psychiatric Association
American Society of Anesthesiologists
American Society of Clinical Pathologists
American Society of Cytology
American Society of Internal Medicine
American Society of Plastic and Reconstructive Surgeons
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
International Society for Cardiovascular Surgery
Society of Vascular Surgery
Society of Nuclear Medicine
Society of Thoracic Surgeons

A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES:

A FAULT-BASED, ADMINISTRATIVE SYSTEM

JANUARY 1988

EXECUTIVE SUMMARY

The American Medical Association ("AMA"), 31 national medical specialty societies and the Council of Medical Specialty Societies have joined together to create the Medical Liability Project to propose a fair and efficient system of resolving medical liability disputes. Specifically, we propose a system in which such disputes would be adjudicated by an expert administrative agency. This agency can be either a modification of the current state licensing board or a new agency. This Medical Board would also have the power to take appropriate action to identify and rehabilitate or discipline physicians whose practice patterns pose a threat to patients. Because of the radical nature of our proposal, we recommend that it be tried as an experiment in one or more states.

We have endeavored to create a system that is fair and equitable to patients and physicians alike. Medical liability is only a part of the much larger and more important issues concerning the quality of medical care being provided by physicians. Accordingly, in addition to changes in the legal standards for determining medical liability, the proposal includes specific provisions designed to enhance the state medical board's credentialing and disciplinary functions. The administrative scheme proposed in this Report recognizes that physicians, patients and the public have distinct interests which must be respected and evenly balanced in any reasonable attempt to solve the medical liability crisis.

Part I: The Administrative Alternative To The Current Medical Liability System And Improved Credentialing and Disciplinary Processes

A. Rationale for the Alternative

Our proposal arises out of two basic facts. First, the current judicial system for determining professional liability does not compensate a significant number of patients who have been injured by medical negligence. Individuals who have claims which do not involve a substantial potential recovery have difficulty enlisting the services of private attorneys. Thus, the existing system imposes barriers to the courts which preclude plaintiffs from receiving any compensation for injuries caused by medical negligence.

Second, the current tort system, which relies heavily upon juries, is not optimally suited for resolving medical negligence issues. Under the current system, there have been consistent increases in the size of damage awards,

especially for non-economic damages. By their magnitude, these awards are threatening the availability and affordability of insurance coverage and health care in many geographic areas in the United States and in many medical specialties. Moreover, juries have tended to award plaintiffs significantly greater amounts in malpractice cases than in cases which concern identical injuries not involving physicians. In addition, the use of juries can be a time-consuming and inefficient way to resolve medical liability disputes. Currently, less than half of the total dollars spent on malpractice insurance ever reach the injured patient.

Because the existing judicial system is not entirely fair either to patients or physicians and is not an effective or efficient method of medical liability dispute resolution, it is reasonable to consider whether an alternative could be developed which would be fairer and more efficient. However, the system of trial by jury has strong historical roots in this country and there are significant constitutional and political limitations on the range of alternatives to the civil justice system that can be implemented even on a limited basis. In particular, there must be a meaningful quid pro quo provided to patients in order to justify withdrawing their claims from the jury system -- as there is in no-fault automobile and workers compensation systems.

The Medical Liability Project does not suggest a general rejection of the tort system, nor does it advocate the abandonment of traditional tort reform. However, the Project has concluded that a persuasive case can be made for employing on an experimental basis an administrative alternative to the tort system for resolving medical liability disputes. The Medical Liability Project therefore proposes that in one or more states broad authority to handle medical liability disputes be granted to an existing medical disciplinary board or to a new agency so that an administrative system of medical liability compensation can be established. This Medical Board would provide several advantages to patients. The most important of these is that the system should permit more injured parties to be compensated than does the current system. At the same time, windfall damage awards would be eliminated, medical liability disputes would be resolved more quickly and efficiently, and certainty and predictability of compensation for medical liability would be increased.

B. The Claims Resolution Function

The administrative system for adjudicating medical liability can be divided into three parts: (1) the pre-hearing and initial hearing stage; (2) the final decision of the Board; and (3) judicial review. The proposed system would provide a significant benefit to patients by making available to any patient who has a claim of reasonable merit

an experienced attorney from the Medical Board's general counsel's office who will litigate the claim on behalf of the patient free of charge.

Under proposed pre-hearing procedures, claims reviewers from the Medical Board will quickly evaluate claims and dismiss those without merit. For claims with merit, the claims reviewers will submit the matter to an expert in the same field as the health care provider. The expert will review the claim and make a judgment as to whether it has merit. The claims reviewer also will assist the patient in evaluating the claim and any settlement offers.

If the claim is not settled, it will be assigned to one of the Medical Board's hearing examiners. In order to encourage reasonable and timely settlements, blind settlement offers by the parties will be required prior to a hearing. A party would be subject to sanctions if the outcome of the case is not an improvement over a settlement offer that the party has rejected. The hearing examiner also will oversee expedited discovery and ensure that the parties have valid expert evidence available to support their case. At the hearing itself, the examiner will have broad authority to conduct the proceedings, including authority to call an independent expert to provide assistance in deciding the case. The hearing examiner will be required to render a written decision within 90 days of the hearing. In that decision, the hearing examiner will determine whether the health care provider is liable for the claimant's injury and, if so, will determine the size of the damage award.

The hearing examiner's decision will be subject to review by the Medical Board. The Board will have discretion to award fees and costs incurred in an appeal if the appeal presented no substantial question. The Medical Board will hear these cases as an appellate body in panels of three members. The Medical Board will make a full independent determination whether the health care provider's conduct was inadequate and caused the claimant's injury. Appeal from the Medical Board's decision will be to the intermediate appellate court of the state, where the review will be limited to whether the Board acted contrary to statute or the Board's own rules.

This proposed scheme will provide experienced and expert personnel at every level in the decision-making process. Over time, they should be better able than a jury to evaluate medical negligence claims. In addition, the involvement of the Board will increase the ability of the decision-making process to be consistent in both liability determinations and the size of damage awards. The proposed administrative system also should be able to resolve disputes more quickly than the current system and thereby save both

plaintiffs and defendants the substantial expense incurred in litigating cases for years in court.

In addition to acting as an adjudicator of medical liability claims, the Medical Board also will develop rules and substantive guidelines to complement the statutory standards. The Board will have administrative authority to initiate rulemaking and to solicit public comments. A rule promulgated by the Board will have the force of law and will be subject to judicial review by an appellate court to determine if it is arbitrary, capricious or in excess of the Medical Board's authority.

C. The Performance Monitoring Function

1. In conjunction with its expanded authority to handle medical liability claims, the Board's performance monitoring function will be strengthened. Specifically, all settlements and awards based on medical liability will be reported to the Board's investigative branch. This does not mean that every or even many liability determinations will lead to disciplinary actions. What it means is that every liability determination will give rise to an initial screening of the physician's practices as reported to the Medical Board. The primary purpose of this endeavor, as with all performance monitoring, will be education and rehabilitation. Thus, our proposal is intended to enhance the Board's ability to discover physicians who are impaired, lacking appropriate medical skills or otherwise unable to provide acceptable medical care.

2. In conjunction with the proposals for monitoring physician performance by the Medical Board, our proposal calls for enactment of three categories of changes designed to further strengthen physician credentialing. First, reporting requirements will be increased by requiring hospitals and other health care institutions to conduct periodic physician performance reviews (a modified version of those required by the Joint Commission on the Accreditation of Healthcare Organizations) and to report to the Medical Board any conclusion that a physician's performance has been substandard. Insurers will be required to report cancellations and failures to renew for reasons that are not class based. All physicians will be required to report instances of suspected incompetence, impairment, or drug or alcohol dependence to the hospital credentials committee or other credentialing entity. In order to facilitate physician reporting, the state will provide immunity to physicians who report suspected problems in good faith. All of these reporting requirements are designed to increase substantially the amount of information available on physician performance.

Second, this information must be maintained in a form that is accessible to those who conduct professional review activities under the proposed system. To facilitate this process, the Medical Board will create and maintain a clearinghouse (or utilize the one established pursuant to the Health Care Quality Improvement Act of 1986) for reports from insurers, reports from hospitals and other entities and disciplinary actions taken by other states. Much of the information that will be collected under this proposal overlaps with the required reporting under current federal law. The licensing board will review this information, on a routine basis, every two years. Immediate review is required in the event of certain negative reports. The Board will also have authority to conduct an on-site review of the medical practices of all physicians against whom a medical liability determination (or settlement) has been made where there is reason to believe that the physician's practices pose a threat to patient health. In addition, certain credentialing entities, such as hospitals, will be required to check with the clearinghouse in connection with credentialing and privilege reviews.

Finally, the Project calls for the furtherance of quality assurance/risk prevention goals by requiring all physicians to complete a number of continuing medical education "credit hours" per year. A certain percentage of these hours must be directly relevant to clinical practice. In addition, all physicians will be required to participate in a risk management program. This change is designed to ensure that physicians maintain and enhance their professional skills.

In addition to the settlements and awards that are automatically reported, performance complaints -- from hospitals, physicians, the public or employees of the Medical Board -- will be sent to a claims reviewer at the Board for investigation. As with claims of medical liability, the claims reviewer will evaluate these complaints and, if appropriate, make a recommendation to the Board's general counsel's office to pursue complaints that appear meritorious. A member of the general counsel's office will then make a decision whether to initiate a disciplinary charge. Once a disciplinary charge is initiated, a member of the general counsel's office will prosecute the charge before a hearing examiner who, after an appropriate due process proceeding, will make a decision as to what, if any, action is appropriate. The examiner's action is subject to review by the Board, which is required to provide notice of any discipiinary action to credentialing entities, insurers and other state Medical Boards.

D. The Structure of the Board

In order to perform the complex and sensitive functions outlined above, the existing Medical Boards will be restructured or a new agency will be created. Membership on the Board will have to become full time, probably for a five year term. Members will be selected by the governor -- from a list of nominees selected by a nominating committee -- and approved by the legislature. The Project recommends a seven person Board, of which at least two but no more than three members are physicians. It is also crucial that the Medical Board members be widely recognized as experienced and neutral, and that they be committed to attempting a bold new approach to the problems of medical negligence. To ensure the Board's quality, all of its employees, from claims reviewers to hearing examiners, must be selected and retained on the basis of their ability and commitment to resolving claims efficiently and fairly.

Proper implementation of the administrative model also will require that substantial issues of funding be addressed. With respect to the increased funding requirements of the Board itself, because of the substantial benefits to the public and expected lower overall costs, use of general revenues will be necessary and appropriate. In addition, the state could make an initial assessment against insurance companies, which provide medical liability insurance within the state, or physicians and other health care providers.

Part II: The Legal Elements of Medical Liability

In order to ensure that the administrative model of medical liability passes constitutional muster, it will be necessary to codify the liability rules to be applied by the Medical Board under the administrative system. It will not be enough simply to incorporate by reference existing common law standards. The statute establishing the Medical Board will have to define specifically the standards under which a claim for medical liability is established, although as noted previously, the Board will be expected to exercise its rulemaking authority to fill in the interstices of the statute. The need for codification of the rules governing medical liability provides an opportunity to revise existing rules in a way that furthers the patient's interests in fair compensation, the physician's interest in predictable awards and the public's interest in standards of liability and damages that can be consistently and efficiently applied. Set forth below is a summary of the most important proposed rules of medical liability.

The rules governing standard of care based on custom and locality would be abolished in favor of a standard that focuses on whether the challenged actions fall within a range of reasonableness, to be determined by reference to the standards of a prudent and competent practitioner in the same or similar circumstances. The hearing examiner would be required to consider a variety of factors in determining the range of reasonableness, including the expertise of and means available to the health care provider, the state of medical knowledge, the availability of facilities and access to transportation and communications facilities. With respect to proof of liability, the statute also would set standards for evidentiary matters such as the qualifications of experts, the use of manufacturer's instructions on drugs and medical devices and the use of medical literature.

A significant modification in the causation standard is also proposed. Traditionally, recovery has been denied unless the physician was at least 50% responsible for the patient's loss. The causation standard would be modified to allow recovery if the physician's negligence was a "contributing factor" in causing the injury. Damages under this standard would be apportioned according to the physician's degree of fault.

The informed consent doctrine would be codified under the current "minority" rule which requires that the adequacy of the disclosure should be measured from the perspective of the reasonable patient. The privilege to withhold information (for therapeutic reasons) and standards for determining individual responsibility for disclosure also would be included in the statutory "informed consent" doctrine.

In the area of damages, non-economic damages (and punitive damages) would be capped at an amount that is tied to a percentage of the average annual wage in the state. Special damages would be awarded under a series of guidelines designed to ensure that those damages represent a realistic "replacement cost." For example, in determining the "lost income" of an unemployed minor, the hearing examiner would be required to award damages based on the average annual income in the state multiplied by the average work life expectancy, absent clear and convincing proof that the loss would be greater or smaller.

The rule of joint and several liability would be abolished so that defendants would be liable for damages only in proportion to their actual liability. In addition, any award of future damages, where the present value of such damages exceeds $250,000, would be made in accordance with a periodic payment schedule. Finally, damages generally would be reduced by collateral source payments.

Representative SCHEUER. Do you feel that we ought to have Federal funding for States that want to develop an alternative system to the current malpractice tort system?

Mr. PHILLIPS. Absolutely. This is fully consistent with what HHS has already said in its most recent task force report, and also with the GSA's recommendation that the Federal Government has to promote alternatives, and the only effective way to promote alternatives at the State level is to provide funding for those alternatives.

Representative SCHEUER. Is there a uniform State code that would govern a new formula or a new procedure or practice for settling malpractice claims out of court?

Mr. PHILLIPS. I think the answer to that is yes and no. The "yes" part of it is that our project has in fact codified the particular proposal that we have put forward, and it could be enacted in any State.

The reason why the answer is really no is that I don't think any State should, I don't think all 50 States should try to enact the same alternative method of deciding tort cases. I think what is important is for each State to take a look at alternative ways of resolving malpractice problems and decide which of those solutions makes the most sense for their State.

I just don't think New York needs the same method of resolving liability issues that Utah needs or that New Mexico requires. I think each of those States has to look at the problem as it relates to that State.

Representative SCHEUER. I am no expert on this subject, but I wonder whether it is sort of cost efficient on a national basis to have 50 different formulas for dealing with malpractice claims.

Can you tell me what are the geographic or demographic or regional differences that would militate that New York would have a significantly different kind of settlement system for malpractice claims than Colorado or New Mexico?

Mr. PHILLIPS. We know, at least in terms of how the current system operates, there are significant differences between urban and rural communities in their response to malpractice issues.

Obviously, States that are predominantly rural are going to follow the sort of rural mode as it exists today. Urban States are going to go differently. There are significant differences across those that are demographic in nature.

Representative SCHEUER. What is the rural mode? Can you describe it?

Mr. PHILLIPS. Sure. In terms of how medical malpractice cases are decided today?

Representative SCHEUER. Yes.

Mr. PHILLIPS. Everyone, of course, uses a jury system because that is essentially required as a constitutional matter. How juries respond, however, differs significantly depending on where you are. In urban settings, they tend to be more proplaintiff and they tend to give higher jury recovery verdicts. In rural areas, juries tend to be more sympathetic to the physician and they tend to give lower recoveries than urban settings.

I suspect there are also differences, frankly, in urban and rural settings in terms of the willingness of a patient to come forward

and sue his physician. In urban settings you tend to have operations that are larger, less personal. In that kind of a setting, you tend to get more litigation.

In the situation where you have a family physician who has been treating you and your father and your grandfather, willingness to sue that individual is much less. So there obviously are demographic differences.

But I don't think that is the reason why you can realistically expect different States to respond differently.

Representative SCHEUER. What is the reason?

Mr. PHILLIPS. It depends largely on what is the current crisis in that State. Some States are suffering more seriously than other States.

For instance, California, having now come through essentially a two-decade-long fight to bring certain types of tort reforms into place, would prefer to allow those tort reforms to operate and determine whether they are going to effectively resolve the cost problems we have identified already and whether we can still monitor physician practices in that setting.

I see no reason why anyone should step in and say to California, sure, you went through all that effort; now we are going to make you abandon that and try something else.

Other States, however, have not followed that pattern and are much more willing to consider alternatives, and I think that is a much more sensible approach to this problem. I don't think that there is much sentiment in this country for a single uniform malpractice statute. I certainly am not in favor of it and I doubt seriously that the AMA Special Society Project members, any of them, would be inclined in that direction.

STATE REFORM EXPERIMENTS

Representative SCHEUER. Do you think that Congress might want to exercise some influence to produce a result so that there would be a few different varying formulas that States would adopt, rather than 50 different approaches? Would that be a productive kind of leadership for Congress to play, or do you think that Congress ought to just probably get out of the way and let the 50 States handle this matter in ways that are acceptable to them?

Mr. PHILLIPS. I think if Congress could convince itself that there are three or four alternative ways of resolving the malpractice crisis, that makes a lot of sense.

Representative SCHEUER. What do you think? What is your judgment on that?

Mr. PHILLIPS. I don't think we have had enough of an opportunity with any experimentation at the State level to make any kind of judgments like that.

The sad part of it is, as I sit here today, that we have one alternative; HHS has another alternative that it has put forward, encouraging arbitration as the primary mechanism. There are other alternatives being bandied about, but no one has really pushed far enough in this direction that we have States that have tried to become laboratories that would provide Congress or anyone else

with a substantial basis for making a judgment about what is the best way to resolve the problem.

Representative SCHEUER. Is there enough of a knowledge base out there, a data base that is built on experience so that research could be done, perhaps funded by Congress, on what has actually happened out there in the various States and try to distill that experience to come up with some observations and recommendations, conclusions, that would be helpful to the States in crafting their own approach to solving this problem?

Mr. PHILLIPS. I don't think there is enough data out there that you could reasonably go that way. If you look at what States have tried innovative, creative solutions—and now I am talking about methods of resolving the problem distinct from the traditional tort reform damage limitation efforts that are made in States like California—I am talking about essentially Virginia and Florida—basically what you are talking about are impaired infant statutes where no fault has been attempted.

The truth is, though, you couldn't begin to collect any data there because Virginia hasn't had a single claim made yet and Florida's just went into effect. So there are no data on those alternatives. There is simply not in place enough information about alternative ways, because we have always used the tort system; it has always been accepted. It is only now that we begin to seriously be concerned about whether that method is so fatally flawed that it needs to be reconsidered at its foundation, that we can even begin this process.

I think what Congress can do in this area, the kind of help it can supply, is to fund efforts by the States to experiment because those are the risks, the States have to take those risks. The question is, do they have to assume a significant fiscal problem by undertaking that risk, or will Congress assist them as they go ahead and try to provide the raw data that you are talking about, 10 years from now, might allow Congress to make some kinds of recommendations about the better way to proceed?

Representative SCHEUER. You are suggesting that Congress might carry on the research that, after a half a decade or a decade, might provide a fact base from which States could develop their own individual approaches.

Mr. PHILLIPS. Absolutely.

I would certainly hope that if we had enough alternative methods out there being experimented with, that HHS and other organizations, the Institute of Medicine, would be racing to those States to collect as much information as possible to provide this body with a realistic assessment of whether these alternatives make sense.

Representative SCHEUER. Mr. Phillips, you are talking about two different things as I get it. Correct me if I am misunderstanding you.

Should Congress fund States in undertaking new approaches to the problem of medical malpractice and actually support new initiatives by the States in facing up to the problem of medical malpractice? Or should Congress simply do research on the new initiatives that the States are carrying on now and try after some period of years, as soon as they can, to report to the various States as to

what is going on, as to what kinds of programs the States with their own initiatives and their own funding are carrying out?

Mr. PHILLIPS. The answer is that today Congress should be funding the States to initiate alternative dispute resolution methods, because the second form of funding isn't going to be effective at this point. There are simply not enough alternatives out there to allow any systematic data collection that would be useful.

Ten years from now, then Congress should start funding those kinds of efforts, I think, or maybe 5 years from now, when you have enough States that have undertaken it.

Representative SCHEUER. But you say that without congressional support of some kind, not enough States are going to try and craft creative new approaches to the whole problem of malpractice.

Mr. PHILLIPS. They are going to be very reluctant because it is a significant risk that they have to incur in order to pursue alternatives. No one has alternatives to say we know this is going to work. I cannot say to you with confidence that an administrative system is going to function any better than the current system. I can argue with you as a matter of logic that I think it will, but until it is implemented there is no way to answer those questions.

Representative SCHEUER. If Congress were to fund individual initiatives by the various States that would include a creative approach, an innovative approach to medical malpractice, what kind of accountability do you think the Federal Government should require as it funds these new, creative, and innovative approaches?

What kind of oversight should the Federal Government maintain?

Mr. PHILLIPS. I don't see any reason for the Federal Government to maintain any oversight except to ensure that the funds aren't fraudulently expended.

Representative SCHEUER. That they are expended for the purposes for which they were designed.

Mr. PHILLIPS. Sure. But, beyond that for the Federal Government to interfere with how the State tries to implement the particular proposal is, to me, completely counterproductive.

Representative SCHEUER. You certainly would recommend, would you not, that where the Federal Government funds a State in trying an innovative experimental program, that they would require the State to keep adequate records?

Mr. PHILLIPS. Sure. But the State would do that anyway, I suspect.

Representative SCHEUER. Well, some would and some wouldn't. We have lots of State programs and lots of Federal programs where adequate records were not kept.

But as I understand you, you would say that Congress has a role here in funding a few individual State programs in order for us to collect a data base so that all of the 50 States could scrutinize the experience and see whether some approaches worked in the States where they were tried and would be replicable and applicable to a particular State.

So you would want to make sure, wouldn't you, that you had a pretty clear record of what actually was happening?

Mr. PHILLIPS. Absolutely. My answer was obviously too flip to what you are saying. I thought you were leading down to the ques-

tion of whether Congress should begin to tell the States how to spend its money in terms of what alternatives make sense to Congress. On that, I want to say no, I don't think that is an appropriate action.

Representative SCHEUER. I quite agree with you, Mr. Phillips. If Congress had that kind of experience and that kind of judgment, we could pass a law right now. We wouldn't need the States if we knew enough to tell them what to do.

What I am suggesting, and I think what you are suggesting is that it would be useful to have a period of State experimentation, of States probing new approaches to the medical malpractice problem, and that we should fund perhaps part of the expenses in setting it up, and that part of the expenses associated with creating a uniform data base. Don't you think, if there are several States doing this, we ought to have a uniform data base so that at the end of 5 or 10 years we could compare apples with apples and oranges with oranges to see, on a comparative basis, which States seem to have produced the most acceptable, congenial, and cost-effective means of dealing with the problem?

Mr. PHILLIPS. I agree with that, because I think it would be very important that you sit down and try to carefully construct the criteria by which you are going to measure or judge the effectiveness of any of these proposals.

It has got to be not simply on whether you have reduced the costs of the malpractice system, but whether you have enhanced physician monitoring techniques, whether the quality of medical care is increased and in what ways. There is no doubt that that is an important endeavor and one that Congress can play a significant role in helping, by funding those people who want to examine the problem with that kind of care, and to do that at the beginning of the process of experimentation.

Representative SCHEUER. To do what? I didn't get that.

Mr. PHILLIPS. To begin—I mean obviously if you are going to go with a series of alternatives in various States, you are going to want to begin the evaluation process right at the beginning.

Representative SCHEUER. The evaluation of how the process is working.

Mr. PHILLIPS. Right.

DISSEMINATION OF INFORMATION TO CONSUMERS

Representative SCHEUER. I presume that part of that process would be evaluation of doctors and hospitals that get caught up in the medical malpractice phenomenon, so to speak.

Supposing a State developed a system that was working where they could identify a small number, a small percentage of their licensed physicians who were engaging in what could be described as systematically inferior medical practice. As you may have heard me mention before, the New England Journal of Medicine has published figures that perhaps 20,000 of the 550,000 doctors in this country are drug addicted or mentally impaired or alcoholic or otherwise clearly incapable of delivering standard adequate health care.

That is a small percentage, there is no question. That is less than 5 percent of the health care practitioners, of the doctors in our country. Unfortunately, they are responsible for a wholly disproportionate percentage of the iatrogenesis, the physician errors that take place and, to some extent, they are damaging the credibility of the entire profession, of the 95 percent of health practitioners who are delivering superb health care.

Do you think that it would be appropriate for Congress to require, as a condition of funding alternative, creative, innovative systems to be carried out by the State to meet the medical malpractice problem head on, that an indispensable element in such a process would be for the State to make known to the public, to the health care purchasers of our country, the individual health care consumers let us say, ratings of doctors and hospitals who States feel, after proper due process, are practicing inferior medicine, and publishing the results of the findings in a way that is comprehensible and intelligible to health consumers, and in a way that is accessible to them?

Do you think we have reached the time when part of the disciplining of doctors and hospitals should come from health care consumers who have been empowered by knowledge of the track record of health care providers, that small percentage of them who have been proven by due process to be providing inferior medical care, and who are involved in serious cases of physician error, iatrogenicity?

Should one element in any such innovative State program be required; namely, to develop a way of letting consumers know about the results after due process, of their investigations, of their delicensing procedures, of their censure procedures affecting the small number of physicians in their State who were practicing demonstrably inferior medicine?

Mr. PHILLIPS. I don't speak here as a representative of the American Medical Association or directly for the AMA, but what I can tell you is that a process not significantly different from that is precisely what is embodied in the PRO sanction process as part of medicare, and the AMA does not oppose the publication of the names of individuals who have been sanctioned, after full due process.

Representative SCHEUER. That is a given. Full due process is a given.

Mr. PHILLIPS. Sure, there is a role for that.

Representative SCHEUER. I don't think up to now, and correct me if I'm wrong, I don't think the Department of Health and Human Services or HCFA make that information public now.

Mr. PHILLIPS. It is published.

Representative SCHEUER. It is published?

Mr. PHILLIPS. Yes. There are local newspaper accounts that read things like, "Six Dead, Doc Sanctioned" that are published. The sad part about that, frankly, is that it was all too often publicized before actual hearings before administrative law judges, but now if you go through a full sanctioning process and are sanctioned after a hearing before an administrative law judge, that fact is published in the local newspaper and is required to be so by Congress.

I don't think with all the problems the AMA may have had with various elements of how the PRO process has been implemented, I don't believe that one of their criticisms has been to that last portion, the fact of the publication. I think we have asked, as an alternative, that the physician be allowed to try to explain it to his patients directly, to the extent that that can be monitored, and HHS has taken a look at that alternative way. I am not sure that headlines in the local newspaper is the best way to try to communicate these kinds of issues to the public.

Representative SCHEUER. I quite agree. I suppose that part of the process of experimentation and research would be on the subject of what is the fairest and most effective way of communicating the records of these physicians who, after due process, are found to have been practicing substandard medicine.

Is it through libraries? Is it through post offices? Is it through hospitals, universities, high schools? And how should the information be prepared and delivered? Is it in pamphlets? Is it a computer terminal that is hospital specific and physician specific?

I think we have to do research on how you prepare the information so that it is intelligible to the average health consumer of average education and intelligence, and research on how you disseminate that information.

Would these two things, research on how you prepared it and research on how you disseminate this information, be an appropriate part of a program where a State is being funded by the Federal Government to try and create an innovative approach to medical malpractice?

Would it be reasonable for us to require that States have to provide some means of passing on the information to patients that is intelligible to them, and some means of disseminating it, a means of preparing it and a means of disseminating it? Should we will leave the particular methodology to the States and see what comes out of this process, assuming half a dozen or a dozen States exercise their own creativity and initiative with the help of the various State and county health organizations that we hope would play a very useful and constructive role, would that be a legitimate approach of the Federal Government?

Mr. PHILLIPS. Let me just say one thing at the outset of that. I think it is more important probably to try to make sure that the alternative that is developed is a more sensitive and effective way of uncovering those physicians who require some kind of disciplinary action.

REHABILITATE PHYSICIAN BEFORE DISCIPLINING

I think it is also important to keep in mind as you go through this sort of due process proceeding before you get to the final sanction, it is I think much more cost effective and a more efficient system to try to rehabilitate physicians, bring their medical practices up to standards rather than simply disciplining them.

But with those caveats, and if you understand that the way we would proceed is to try to uncover those physicians whose practices are below, and those you can bring up you try the best you can; those you cannot bring up should be disciplined. And I don't be-

lieve there is any problem, frankly, if Congress wants to condition receipt of money on the need to publicize disciplinary action, final disciplinary action. Most States do that now. They don't publicize it as broadly as I suspect you are suggesting, but that information is public at this point.

It seems to me that if a State wanted to receive money, that would be a reasonable condition to impose, and the State can make its own judgment whether it wants to go down that road or not. Personally, I don't have any problem with that.

Representative SCHEUER. Just to eliminate any possibility of misunderstanding, I think this committee would be totally in favor of efforts to rehabilitate doctors who had departed from proper standards of health care. If they were drug addicted or alcoholic, the avenue is clear: to help them get off that addiction.

If they were mentally incompetent, that might be more difficult. But whatever could be possible in terms of counseling, in terms of some medical reeducation, obviously to save a medical professional's career and return him to the fold of excellence in the practice of medicine, seems to be totally desirable from everybody's point of view.

After all, society has a lot invested in that doctor. Very few doctors pay for the full costs of their medical education. Not only does society have an investment in their education, society has an investment in their experience that they have learned. If we can just cut out with a surgeon's scalpel these crippling and disabling characteristics that they seem to have picked up along the way that are solvable, it seems to me that would be a tremendously cost-effective process.

Perhaps the Federal Government should help States in that process of perhaps reeducating and counseling the 3, 4, or 5 percent of our doctors who are practicing substandard health care.

Mr. PHILLIPS. I have no doubt that the States would welcome that kind of funding. There is no question that one of the problems with the disciplinary process as it exists today is inadequate money and resources and staff. If the Federal Government could provide that kind of money, I have no doubt that the States would relish it, frankly.

AFFECT OF MALPRACTICE ON ACCESS TO CARE

Representative SCHEUER. Dr. Bulger, did you have a comment?

Dr. BULGER. Yes. I am kind of disturbed that we are getting off one of the main points that I see about this whole issue. That is, that because of the malpractice situation, people who used to get care are not. Larger and larger pockets of people are being kept out of the system.

Representative SCHEUER. You mean they are being denied health care when and where they need it.

Dr. BULGER. Yes. And the doctors might as well be alcoholic and debilitated. They are just not taking care of those patients.

I am obviously no lawyer and no constitutional expert, but if that is true, I guess my response to 10 years of study is frustration. I think there is a problem. We are going in the wrong direction, and that if it is a national problem, that the central government

ought to take some steps to facilitate the States doing something about it and making sure that the access questions are reversed; that whatever they do or whatever gets done actually begins to solve those access problems.

Example: When you take care of somebody who is poor or is on medicaid, you get $300 to deliver a baby, but it costs you $500 to pay your malpractice insurance. So you lost $200 each time.

Just last year, I guess, the private physicians who were delivering services on the Indian reservations were included in that Federal act that gave them coverage when they went on the reservation. So that it might be possible at a Federal level to take an action that would address this issue.

I think later today you will hear of studies that are going on now, not so much—and I agree with Mr. Phillips—not so much of alternate methods, but of the costs and of sort of modeling alternate methods on the basis of past experience and projecting what they might be. There are some studies going on. There is data being collected.

I guess I am kind of arguing against the trend of the conversation that I have just been hearing which is, well, we can kind of let it go and we will work on some of the doctors who aren't doing so well. I think there are things that really should be, one at a time but certainly in the foreseeable near-term future, we ought to be able to make some decisions that could address the access problems that are clearly there.

Representative SCHEUER. Do you have some specific suggestions?

Dr. BULGER. I just made one. I think that that is one that we need to address, and I am speaking sort of out of turn as a member of a committee that is going to address some of these things and try to make those suggestions.

I think we need to try to figure out or take a position that the current system is simply not workable. If we can take that position, then maybe the Federal approach to encouraging people to change to some other system might be worth it. As I am digesting our experiences with this now, we are the only country that does it through a jury trial, that does it this way. We are the only country that has such an unequal distribution as a result of the malpractice situation.

In part, other nations provide health care to everybody, so it takes away the issue of future health care costs and leaves you strictly with the pain and injury side of the malpractice equation. It may well be that the reason in Canada and England you don't have quite so much is that already everybody knows their care is being taken care of.

Let me give you one other example to get you into another area. Recently we heard of an expatriate, I guess, to this country, at a university who had a child that was defective and severely damaged. They just had to go home to West Germany, leave the University of California. The reason was that there was no way that they would ever be able to take care of that child in this country the same way that the child would be cared for back there.

I think you can go around the Western democracies and find out that that would be true. So we are in a much more complex situation, but it seems to me that if we make the value judgment that

access to care is important and at least important to those people who have entitlements to the Federal Government, medicare and medicaid, then there are some specific things that could emerge.

QUALITY MAINTENANCE IN OECD COUNTRIES

Representative SCHEUER. How do developed countries abroad, the OECD countries in Europe, how do these advanced developed countries deal with the problem of iatrogenicity, or physician error and, for particular physicians, repeated physician error?

Dr. BULGER. I probably can't answer that adequately.

Representative SCHEUER. Can anyone answer that?

Mr. PHILLIPS. Sure. Most of them use judges as opposed to juries. They are not bound by the same restrictions of the jury system. With respect to the disciplining of physicians, on that it is much more difficult to judge. I think they have State-operated systems so there are built-in mechanisms for reviewing the physician's practices more effectively than in a private market system such as ours.

At least for the most part, my understanding is that since they don't have juries, that is protects——

Representative SCHEUER. I suppose most of them have national health systems rather than State health systems.

Ms. ROSTOW. I was going to bring up that point, that it is a very large distinction between having a neurologically impaired infant born in this country where people look to either third-party payers, or in some cases the State, or in some cases their own pocket for the millions of dollars that that infant will cost in the course of his life, and having such an infant born in England, for example, where his medical care would be covered by the national health system. It changes the entire quality of the way someone looks at an iatrogenic injury.

Representative SCHEUER. I suggested that probably most health care systems abroad are national health care systems, not really State health care systems as we have here, and that would make it simpler for their national governments to regulate and control the system and perhaps to identify the doctors who are rendering systematic and continuous inadequate health care, negligent health care.

Dr. BULGER. I am not so sure that that actually is true. In other words, it takes a certain kind of data to make the kind of judgments—and, in fact, over here we may and I think we will end up leading the way in terms of identifying doctors because of the enormous amount of data and the computerized data that we will have.

In England, you know, when you get your phone bill in England, it is not the same as our phone bill. You can't read all the calls that your kids made all through the day and how long the calls were. They don't get that kind of bill. They get a number, they are supposed to pay it, and they haven't any idea.

I haven't walked through all the halls over there, but they simply don't have as much data as we do. And the reason is, a lot of people say, because they provided the money and said, here's the money, go and spend it, deliver the care as best you can, the society in general has not had to impose these various elements to qual-

ity control. In many ways, it is a lot harder to practice medicine here with all these different reports and elements going on.

Representative SCHEUER. You think we have refined the question of quality control examination and measurement to a further point that most other developed countries have?

Dr. BULGER. Yes. Well, I do think that, for example, now people are feeling they are getting their arms around the hospital data. HCFA has that and the mortality rates, and now they will be able to put doctors' billing numbers together with the same kinds of things so that you will have access to sort of outcome data that is very unusual.

Representative SCHEUER. That the European countries, to your knowledge, don't have?

Dr. BULGER. I don't think so. They are concerned with the same problems of technology assessment as we are, but when it gets to a malpractice case, that is when I would agree with Mr. Phillips, that you get an administrative judge, and I think there is a more equitable distribution among patients.

DATA ON ERROR RATES IN ALTERNATIVE DELIVERY SYSTEMS

Representative SCHEUER. Let me ask, are there any providers of health care such as HMO's, for example, who have perhaps lower levels of physician error, iatrogenesis, than others? Can we look at the broad schema of health care deliverers and say, this type of deliverer seems to have a propensity for a high rate of physician error? This type of health care deliverer, for reasons that we may not know, or for reasons that are obvious, has a much lower rate.

Can we learn from looking at the broad spectrum of health care delivery systems, hospitals, HMO's, nursing homes, so forth, which ones are likely to do a better job at exercising some kind of oversight and scrutiny over physician practices and physician quality?

What is there to learn from the variety, enormous variety of health care delivery systems we have out there?

Mr. PHILLIPS. Part of the problem, Mr. Chairman, is that no one has collected the kind of data you are talking about that just indicates the full magnitude of iatrogenic injuries. As we speak, in New York, Harvard is doing an extensive study to try to ascertain, I think, the kind of information you are looking for. I don't know even whether the Harvard people are going to look at those injuries that have existed in various settings to try to make the kind of sensitive judgment you are asking for there.

But to show you how far we are away from what you are talking about, other than a relatively old study by Mills, no one has ever even begun to collect the kind of data from which you could infer how broad the problem is to begin with. So the answer is, I don't think there are any data that would help us make that kind of judgment.

Ms. ROSTOW. I will say, though, that you are asking the right question and there are several efforts currently in place to gather that kind of data. Not only is that Harvard study going on at the request of David Axelrod in New York, but a number of large hospital systems and medical care systems are currently engaged in

risk management programs that are attempting to collect some of that data.

The Harvard University Hospital Health Care System is self-insured and collects data on various practice settings within their system. That is of somewhat limited value because it certainly doesn't represent any kind of geographic diversity, but those types of efforts are in progress currently. We don't have data on which we could base judgments at this point.

Dr. BULGER. Let me respectfully disagree from a different standpoint. I think speaking from a legal standpoint, there is a lot of data, if I heard you correctly, to help people decide are there ways to get information? Can we learn from certain setups to improve practice and to watch the quality of it?

There is no doubt that in group practices with lots of information coming back, or in practice situations where data about how people practice is fed back to them against a standard, that people in fact change their behavior. For example, you could go out to the Columbia Health Care Plan out there, and if a doctor gives penicillin more frequently than is the norm, he gets asked about it by some colleagues.

Now, that wouldn't happen if he was practicing alone. Therefore, there are ways in which patterns of practice are altered. It is clear, too, that in recent studies where you have side-by-side cities, and up in New England with double the rate of tonsillectomy in one city and the next city has half, when the doctors are informed of that, the rate comes down and they begin to ask questions.

PHYSICIAN RESPONSE TO MALPRACTICE THREAT

So I think, if I heard you right, there are information loops, there are ways, there are enough studies to help us deal with things. And doctors are very sensitive to those numbers. The problem I think we get into when the lawsuit is the number you are being measured by is that you say that is what I want to avoid at all costs. So I am going to get out of that lawsuit, no matter what I do nor what it costs. That is part of the tragedy that we are into. We have doctors avoiding those lawsuits.

Representative SCHEUER. You mean avoiding the lawsuits by avoiding the practice?

Dr. BULGER. Sometimes avoiding the practice completely.

Representative SCHEUER. How else do they avoid lawsuits except by practicing superior medicine? If they are going to be practicing in obstetrics or neurosurgery, how are they going to avoid lawsuits other than by practicing superb medicine?

Dr. BULGER. What you are saying, and I would agree that lawsuits are an element of quality control and there have been many good things about it, but I would also say that we can, in our own study, tell you that there seems to be, I would say there is little doubt that people are doing cesarean sections more often in delivering babies because of the threat of a lawsuit than they would if there were no threat of a lawsuit in terms of doing good practice.

Now, in Massachusetts, as we heard yesterday, no one has ever been sued for doing a cesarean section. All the people who have

been sued have been sued for not having done a cesarean section at the right time.

Representative SCHEUER. So do you think a considerable number, an appreciable number of cesarean sections are the result of defensive medicine?

Dr. BULGER. Yes.

Ms. ROSTOW. Yes. And there are other practice changes as well. Sadly, if physicians' responses to the threat of malpractice was simply to be better doctors, we would be certainly less concerned about it. But we have observed a number of practice changes: physicians selecting their patients with an eye to them being potential plaintiffs; avoiding patients that they regard as high risk. And their predictive ability may not be very accurate because we are finding that the patients that they may be avoiding may be medically high risk and very much in need of care, may be socioeconomically disadvantaged, may be women who most need care. And the cesarean problem is another indication, but an overuse of very expensive medical technology, a potential overuse of diagnostic testing, these are things that are adding to the health care budgets.

We are spending too much on malpractice already, so to add to it the cost of defensive medicine is really quite tragic.

IMPROVE PATIENT-PHYSICIAN RELATIONSHIP

Representative SCHEUER. It is sometimes said that the existence of malpractice as a major phenomenon in medical care is destructive of doctor-patient relationships.

Are there any approaches to solving the malpractice problem that any of the three of you think would improve doctor-patient relationships? Are there models, any creative new initiatives being thought about that would sort of defuse the malpractice problem of the impairment, the sad impairment of doctor-patient relationships?

Ms. ROSTOW. It is a very, very complicated problem and I can't think of any single solution that would work toward building a better doctor-patient relationship.

I can only emphasize that the current system is very destructive to that relationship, and I think any solution to this problem that would allow a physician to look at a patient not as a potential plaintiff, but as a patient, would be a very large step toward solving that problem.

I think the other thing is that I think the physicians feel very much under siege. I am very, very concerned by the reports that we have had of the disillusionment of young physicians in training, physicians who are not selecting certain areas of specialty, who are disillusioned with primary practice before they even begin. I think when it is reaching that level, it is an extremely serious problem.

So I think the answer is anything that would defuse these very strong feelings would be a very large step toward solving this problem.

Dr. BULGER. No fault would be the best from that point of view, so that every patient who came in, the doctor and the patient would both understand that if there is a maloccurrence, the patient would get some compensation.

Let me just say one quick thing because I sense you are getting near the end here. That is, that often this doctor-patient relationship business is presented as a somewhat romantic thing, and it is too bad we don't have it, and so forth, and it gets kind of soft. But I think it is important to note that if you are my doctor and you and I believe that I have got a problem, I go to you, and you and I both believe that what you are going to do for me is helpful, and I trust you, there is a 60 percent chance that I will be helped by it, even if it is just a glass of water.

Then when you don't believe, as the doctor, in what you are giving me, but I believe as the patient, that tends to go down to 30 percent. It is called the "placebo effect." It is the effect of trust.

Well, if we are talking about high technology, we are very often talking about the last third. I mean we are talking about effective, important things that frequently save lives, but what I think we are throwing out with this when we lose the doctor-patient relationship or the health profesionals, the trust in the institution is part of it. When we lose that, we are simply throwing out more than half of the effectiveness of the various treatments we have.

And that is what I think personally is the most destructive thing, pervasive, where every patient intersects with every doctor now in the current environment, the doctor sees an adversary coming through the door and the patient sees that, and I don't know what the percentage is down to, but a lot of the placebo effect is gone.

Representative SCHEUER. I couldn't agree with you more, and I think it is very much in our national interest to make our health care system more productive of positive health outcomes to restore the doctor-patient trusting relationship. I think it is a positive element in producing a positive outcome. I don't think there is any question about it, especially when the doctor helps create that feeling by spending a little time with the patient, by counseling with the patient, by evincing a caring attitude, a compassionate caring attitude about the patient, sensitive to whatever the patient's anxieties may be.

I think when the doctor is willing to spend the time and invest enough of himself or herself in reaching out a hand of support and compassion to the patient, that contributes to a positive health outcome. I mean this is the old mind-body problem, this is the psychosomatic health problem, and I think it is demonstrable that we have a very vested interest in restoring doctor-patient trust for purely health outcomes. I think that is quite clear.

ISSUES IN MALPRACTICE SYSTEM REFORM

Let me ask just one question. The malpractice system now serves two functions: the first, to compensate victims for harm that happens to them; and the second is to identify those health care providers who are delivering inadequate, negligent, substandard health care.

Do you think it is reasonable and acceptable for us to continue fulfilling both of those functions in one system, or do you think we ought to separate out those two functions and perhaps address them differentially? Does it work in some sort of rough and ready

way, to have the malpractice system both compensate the victim and identify the purveyors of substandard health care?

Is that a reasonable way of proceeding to perform both of those important functions? Or would we have a whole that is greater than the sum of the parts if we did them separately and in perhaps in some way enhanced our ability to identify substandard health care purveyors, perhaps improve the patient-doctor relationship, and perhaps expedite the whole question of compensating victims?

Mr. PHILLIPS. If you are going to maintain the current system, there is a lot to be said for seeking deterrence outside of the current tort remedies. That is a system and designed and probably most effective, if at all, in compensating victims of malpractice.

So I think if you were going to keep the current system, you ought to beef up the disciplinary side, wholly apart from the way torts operate.

On the other hand, if you were going to try an alternative system, you might very well try to integrate the two in a way that would allow you to perform both of those functions more effectively. In fact, the project's proposal, by integrating disciplinary and the monitoring function, is designed to do both of those more effectively than the current system by allowing you to identify more readily instances of substandard care in a way that would allow you to respond to that through the disciplinary and rehabilitation process.

So I think in some instances, you could certainly use compensation mechanisms, to let you learn more about the quality of care approach. The problem with the current system is that the tort system does not tell you very much about the quality of medical care. Physicians who perform quite well get sued; physicians who perform quite poorly don't get sued; and there is just simply no mesh between the two and, therefore, no way to effectively be a very good deterrent.

Representative SCHEUER. Of course, one source of that inconsistency which you point out, that good doctors get sued a lot and poor doctors perhaps aren't brought to task by the tort system as frequently as they should, one problem that you have is that health consumers have somehow or other acquired the attitude that if their childbirth or their neurousurgery doesn't result in a perfect health outcome, by golly, you go to the courts.

They don't seem to understand that health is an inexact science and that health outcomes cannot be predicted and that even the most brilliant and technically qualified and scrupulously careful neurosurgeon or obstetrician can be involved in a happening between a doctor and a patient where the outcome is less than perfect. But yet too many of our health consumers operate on the assumption that if it isn't a perfect outcome, sue. How do we get around that problem?

Ms. ROSTOW. That is a societal problem. We have explosions of litigation in other areas besides malpractice, so we seem to be living in a very litigious age.

But there are specific things that we can do about some of those. Some States have experimented with bills to provide compensation for neurologically impaired infants who are born, which is a very tragic outcome of the obstetrical process. Often the exact fault,

whether it is genetic or whether it is obstetrically caused, cannot be determined. It is extremely traumatic for an obstetrician to go through this type of litigation.

Representative SCHEUER. Let alone the parents.

Ms. ROSTOW. Let alone the parents. Absolutely. So that is one possible solution, but it raises a host of other ethical and legal questions. Why compensate this particular type of iatrogenic outcome and not others? It may be in fact a bright line a legislature can work with; it may not.

But it seems that that is a political decision that a State legislature would have to make as to whether it chooses to compensate that type of incident.

Representative SCHEUER. Well, we have had a roll call vote that I am going to have to answer, and I think we have pretty much squeezed the last drop of wisdom out of this panel. Does anybody have any final observations?

Thank you very much. It has been an excellent panel and we are very grateful to you for coming here and giving us your views. Thank you. The next panel will be about 20 to 25 minutes from now.

[A brief recess was taken.]

Representative SCHEUER. I apologize for the late hour of this hearing. We conclude today's hearing with a consideration of several alternatives to the current litigation system. We have before us a very distinguished panel of lawyers and scholars who have devoted a great deal of time to formulating and analyzing alternatives to the current tort system. Our panel includes: Mr. Randall Bovbjerg, senior research associate at the Urban Institute; Professor Thomas B. Metzloff of Duke University Law School; Dr. Laurence Tancredi of the University of Texas Health Science Center; and Mr. John Hoff, legal counsel to the National Council of Community Hospitals.

I don't know if you have attended any of the prior panels, but let me suggest that each of you take 8 or 10 minutes, perhaps chatting with us informally about this very challenging and perplexing subject, hopefully not reading from your text. Your prepared statements will be printed in full in the record, and then I am sure after you have all finished testifying we will have some questions for you.

Again, I apologize for the lateness of this hour, and we very much appreciate your forbearance and patience. Mr. Bovbjerg.

STATEMENT OF RANDALL R. BOVBJERG, ATTORNEY AND SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE

Mr. BOVBJERG. Thank you, Congressman Scheuer. I am very pleased to be here. I was told that as a lead-off witness, I should try to bridge the previous session and this one. As I understand it, the previous session dealt with certain problems in malpractice, medicine, insurance, and law, and this one deals with reform. So I will try to bridge the two quickly.

While I was waiting during our little recess, I counted that I have a baker's dozen points to make. I am not sure how many that gives me per minute. But first come two background points: No. 1,

what is it that we know or think we know about this whole situation? I am afraid that we know less than we think we know; evidence runs way behind emotions in this area.

There is no dearth of problems or documentation of problems at the level of anecdotes, and there is some objective information. Still, we know rather less than we would like.

I think that GAO had it right in their report titled "No Agreement on Problems or Solutions," and that runs beyond simple differences of viewpoint between trial lawyers and doctors and so forth. There are simple facts we don't know. Exactly how many claims are there, et cetera, et cetera? Things that you would think would be simple aren't so simple.

Worse than that, we don't know enough about the dynamics of the whole situation. We may know a lot of descriptive information, but what makes things tick? What would happen if you made certain changes? That is another level of ignorance.

Finally, there is some evidence about past reforms. But I think a lot of what you are going to hear about today is rather new, a kind of second generation of reform, and not much is known about their likely effects. So a lot of times people will ask me, what do you know about this? I feel the way my 2-year-old son must feel when I come into the room and there are blocks and toys scattered all over. When I say, "Well, what happened here?" He always says, "I don't know."

The second point is, what do we want? A lot of times that is also a little harder than we think it is. Congressman, you alluded to making choices in the colloquy you just had with the last panel. That is, if you had to choose between compensation of claimants and deterrences, or getting rid of bad doctors as you put it, which would you choose? That is a choice. You can do both under certain circumstances, but how important are the two?

Representative SCHEUER. I suppose we have to meet both of those challenges of identifying the negligent doctors and compensating victims. The question is: Do we do it in the same system, or do we try and establish discrete systems to perform those two functions separately?

Mr. BOVBJERG. Precisely. But you have to identify what it is you want to accomplish with each. This gets down to such nitty-gritty things as, do you want more claimants or fewer? Hot disputes rage on that.

We also haven't really decided whether we think we have a malpractice problem or a tort problem—we probably have both—or whether we have a local, State, regional, national, or maybe even international problem in certain insurance respects. Or whether we mainly worry about law, insurance, or medicine. There is lots of finger pointing among those fields. Past reforms have addressed all three areas, and their general sweep is pretty well known. There is no reason to belabor which addressed what.

In general, most reforms have taken the point of view that what we want is fewer claims and lower recoveries, with the goal of having lower malpractice insurance premiums and lower disincentives to physician practice in certain areas. The empirical results on some early reforms are fairly well in, although not completely nailed down.

Some of the reforms, one might say, were only placebos or cosmetic surgery. On the other hand, some did get down to the level of major surgery. But heart-lung transplants are yet to come as far as legal operations are concerned.

The big reforms that constitute strong medicine are the caps on damages, offsets for collateral-source recovery, reduced statutes of limitations, and structured settlements, although the last is more recent.

MALPRACTICE REFORM PROPOSALS

What are the new ideas that haven't been tried so much? Let me just mention some quickly. Perhaps the best thing of all, although I am not sure that it is lawyers who know about it, is to avoid injuries in the first place. How you do that depends upon how you think these injuries occur. It is appropriate to get into the question of whether you think that most injuries are the results of bad doctors—or perhaps also bad medical procedures—or whether you think it is a more general problem of basically good practitioners who make occasional mistakes just like all the rest of us.

A number of new reforms go past what was tried in the mid-1970's. Many of the 1970 reforms are still with us in States where they weren't enacted to begin with, or even at the Federal level to give guidance to States.

But there are some new ones. I was encouraged to read the recent HHS report, which focuses rather more than earlier efforts on basic matters of administration. If justice is not working so well, why not worry about whether juries are getting clear instructions, whether they understand what they are doing and can respond to special interrogatories or special verdicts, and whether judges and juries have before them information that can allow them to make good judgments about the appropriate level of damages? All those things have to do with day-to-day administration, really, rather than large reforms.

A number of reforms that are in my prepared statement I will skip over. One notion that fits with cutting back in an administrative way is what Tom Metzloff will talk about: alternative, private dispute resolution. What is particularly exciting about this is that you are almost guaranteed a winner. If the alternative works, people will choose it. If it doesn't, they won't. And there is no way that anyone could be made worse off.

That basic insight is what prompts one of the two really large proposals for reform that I know about. One is the notion of so-called private contracting, associated with law professors Epstein and Havighurst. It would encourage agreements between individuals, medical providers on one side, patients and their employers or unions on the other side, to create their own system by private contract. They could say to the courts, we are not going to use the courts, we will handle injuries however we want. We can set our own rules for both substance and process.

This is a very thoroughgoing brand of reform. Anything could happen. Is it a good idea or bad idea? That gets into a lot of detail. I have listed a few pros and cons in the prepared statement.

The other really thoroughgoing proposal that would completely replace the tort system is the AMA proposal that Carter Phillips has described to you. Again, there are pros and cons. One thing that I find very encouraging——

Representative SCHEUER. Describe the AMA system. I didn't get that.

Mr. BOVBJERG. We cannot really cover all the details, it is a very thoroughgoing reform in the sense that it is meant to completely substitute an administrative process for the current court system. It would create an entire set of procedural and substantive rules.

The other approaches to reform tend to carve out particular areas and say, for example, we should handle bad baby cases this way, as in Virginia or Florida. Or, we should handle certain bad results through a no-fault system. Larry Tancredi and John Hoff will talk about that.

I am involved in two other, smaller reforms. They are experience rating for physicians and hospitals, to try to get better information into the insurance premiums and other practices, and scheduling damages, to try to make awards more predictable and, therefore, send better signals both to insurance ratemakers and to the people who pay the premium.

Finally, it bears emphasizing that big reforms are very enticing and we all like to think of ourselves as reformers, but there is an awful lot to be said for day-to-day administration. One thing that you have to give to the medical profession is that, whereas in the early 1970's they complained a lot about insurance and law, since then they have been running their own insurance companies and really making an effort to do peer review and come up with workable legal alternatives.

The legal profession and patient advocates have an obligation to do the same, to get into the trenches for the long term, to do the day-to-day administration and not seek one magic bullet as a permanent solution. Malpractice crises seem to recur. There is an insurance cycle out there. And opinions are always changing about how these matters should be handled. It would certainly be nice, come the next crisis, to feel that we were a little ahead of the curve rater than behind it. Thank you.

[The prepared statement of Mr. Bovbjerg, together with attachments, follows:]

PREPARED STATEMENT OF RANDALL R. BOVBJERG

REFORMS IN MEDICAL MALPRACTICE: Alternatives to the Current System of Litigation

As the kickoff witness in this session, I have been asked to help bridge the gap between the immediately preceding session on some problems posed by the current malpractice system and our session on reforms. I will try to do so by briefly covering what we think we know about malpractice and what we want before describing a number of potential reforms or improvements in administration, especially two on which I am working.

WHAT DO WE KNOW?

The point of departure for any policy change should be a clear understanding of current problems: We need to know "what's broke", and how it's broke, before we can think productively about what might fix it. Many have diagnosed the ills of the current system, for instance that:

- o Claims and awards are "too high," overinflating insurance premiums, causing periodic problems of availability or affordability, and driving some physicians out of some types of care.
- o Conversely, claims can be seen as too low, relative to the true number of medically caused injuries.
- o The entire system is too slow, cumbersome, uncertain, and costly to provide good justice and economical insurance rate-making.

But there's considerable disagreement about these points, disagreement that goes beyond the understandable differences between plaintiffs' lawyers and

physicians in how they see the world. At bottom, we know much less than we think about malpractice. Even about basic facts.

Evidence lags well behind emotion in discussions of malpractice. How often do doctors and hospitals make consequential mistakes? How many malpractice claims were brought last year? How much truly defensive medicine is there? To these and many other basic questions of fact, the true answer is "we don't really know."

Perhaps worse, we know still less about the dynamics of behavior that underlie these facts. How often do juries bend the facts out of sympathy for a claimant? How free of legal worries would doctors have to be to cut back on defensiveness? To what extent could rural obstetricians' liability fears be calmed by higher fees? Again, we don't know.

The policy debate could benefit from more objective information on the extent and nature of all of these phenomena, about what drives behavior of various actors, and just how particular efforts at reform aim to change things. It would be good to be able to target problems with more precison. In fairness, it should be noted that much more information is available now than in the past, particularly about insurance claims, less about medical and legal behavior. More ambitious efforts to develop data and analyze behavior are under way; for instance, my colleague Frank Sloan of Vanderbilt and I are analyzing the industrial organization of the malpractice insurance industry, and effects of past tort reform, under a two-year grant from the National Center for Health Statistics for Health Services Research.

WHAT DO WE WANT?

It would also be constructive to consider better just what we want from reforms by way of changing the current situation. In particular:

- o Is achieving compensation for victims more important than deterring unduly risky medical practice or vice versa?
- o Do we want more claimants or fewer? More or less generous payment rules?
- o Do we want to fix malpractice problems or tort problems? How different is medicine from other areas that affect human health and safety? A number of state courts have objected most vehemently to singling out of malpractice defendants for special protections.
- o Are the primary difficulties inherent in law, insurance, medicine, or society at large? By law is meant that complex of legal doctrine, the plaintiffs bar, juries, and judges. Insurance problems include alleged collusion, excessive profits, unfair practices, failure to maintain good incentives, imperfect competition, inadequate regulation. Medical failures may include individual "bad doctors," systems' failures rather than individual problems, and simple errors by normally careful, good doctors. Societal issues may include high patient expectations, a supposed "jackpot mentality" of claimants, and jurors swayed by sympathy rather than by the law and facts before them. Different information and different policy tools are surely needed for each area.
- o What level of government should act? What problems are located at a local, state, regional, national or even international levels?

Basic, if limited background information is widely available. I recommend some materials from the National Conference on State Legislatures (NCSL) and a symposium issue of Law & Contemporary Problems (L&CP) as a start. (See attachments) Nonetheless, the GAO had it right when they titled one report "Medical Malpractice: No Agreement on the Problems or Solutions."

PAST REFORMS

The mid-1970s state reforms arose from that era's insurance "crisis," so they naturally gave top priority to insurance and its availability. But they also reformed tort law and practice to a degree, and tried to shore up state medical discipline on the quality side. Interestingly, although federal involvement is new in the 80s, it too first addressed insurance availabily—through the Risk Retention Act—and more recently turned to medical quality—through the Quality Improvement Act, while tort reforms have only been discussed (by executive task forces and legislative proposals). The 1980s developments give a definite sense of déja vu. Most of the 70s reforms have been considered anew. The number of wholly new ideas thus far enacted in the 80s is relatively small—notably including modifications of joint and several liability and the very recent approach in Virginia and Florida to cases of severe birth impairment.

The general sweep of past reforms is widely familiar from previous hearings, reports, and publications. Most reforms to date have tinkered with the current legal-insurance system for malpractice rather than offering sweeping alternatives. Most have simply sought to cut back plaintiffs' remedies with the intent of reducing claims, claims payments, and premiums.

Seen from this perspective, the evidence of success is instructive but not overwhelming. Some reforms seem mere placebos, others might qualify as cosmetic surgery, and a few as more radical surgery. Legal operations have yet to advance to the stage of heart-lung transplants. The pioneering work of Patricia Danzon (see, e.g., L&CP) and some actuarial projections seem to agree that relatively few reforms have had major impacts; however, a good deal more work in this area remains to be done. Again, some is already under way, including by my colleague Frank Sloan and myself and others under grants from The Robert Wood Johnson Foundation (RWJF) (see attached press release). The

strong medicine currently being dispensed includes caps on damages (either total damage, as classically in Indiana, or on noneconomic damages, as exemplified by California), offsets for collateral source recovery (to foreclose "windfall" double recovery by insurance claimants), and reductions in the statute of limitations.

Structured awards or periodic payments in lieu of lump-sum payments also have their adherents. Although strong empirical evidence needs to be further accumulated, many observers are convinced that the relative stability in insurance prices observed in Indiana and California for example is proof enough. Nonetheless, claims and premiums apparently continue to rise. And many of the reforms have had problems in state supreme courts, on constitutional grounds (which is relevant to the issue of federal versus state roles). Moreover, not everything is known about the reforms' effects. What type of damages and claimants are cutback by the caps? How are obstetricians faring? Eleanor Kinney is studying that in Indiana with a grant from RWJF. An aside: it is unclear what the effects of limiting recovery against medical providers have been on tangentially related defendants, such as manufacturers of drugs, anesthesia, and other medical devices.

NEW REFORMS FROM WITHIN THE SYSTEM

The assignment for this session is to consider additional reforms that might be alternatives to current practice in litigation and dispute settlement. Space permits only selective discussion. I start with reforms that work "within the system," those that accept its basic premises, but seek to make improvements.

It is worth briefly emphasizing at the start that some medical-legal innovations have the potential to keep injuries (and hence claims and disputes) from arising in the first place. Directly reducing injuries is better than

dealing better with those that do occur. Most quality-oriented statutory reforms so far relate to medical discipline. They seem to accept the "bad apple" view of medicine--that most bad results come from bad doctors, who themselves need reform. (Sometimes, it is also asserted that the best doctors attract suits because they take high-risk patients.) My own suspicion is that there are for more "peaches" than bad apples, but that all produce can be blemished or bruised on occasion. So I'm encouraged by reports of advances in risk management, peer review, and incentives for better performance. Consider just one relatively new idea:

Developing Better Standards of Medical Practice

This medical-legal approach deserves highlighting. The basic idea is for professionals to set better standards for customary practices, so as to improve care and reduce legal liability for failure to follow customary practice. Such an approach is said to have helped anesthesiologists improve their malpractice premiums from the 70s to the 80s, at least relative to other specialities. The approach is certainly worth trying for particular areas, such as emergency room practice, radiology, and obstetrics. One RWJF grant addresses such ideas.

Pros	Cons
o Theoretically could help improve outcomes both in medicine and law	o Unclear feasibility o Unproven impact on medical practice, legal liability

Similar ideas in legal medicine call for better early warning of malpractice claims, studying warning factors among early training of physicians, improving peer review, better risk management, and the like. The relationship between quality of care generally and medical malpractice certainly deserves much more investigation. One good incentive for better medical performance would be a

reliable legal-insurance system that generates good information on past experience and future improvements.

Consider other relevant reforms of law and insurance. Far more ideas exist than have yet been seriously proposed or enacted at the state or federal level. One little-mentioned possibility is to seek change in legal doctrine through the normal evolution of case-by-case tort decisionmaking and change in legal process through improved judicial administration. If today's system works poorly, courts should theoretically be willing to reform themselves as a result of scholarship and advocacy. Many blame court-initiated change for bad malpractice outcomes and high premiums, but it need not be a one-way street; statutory reform is not the only possibility.

Several listings exist that suggest modifications of current rules and practice. The recent HHS report and model legislation are instructive, including such little-heard ideas as figuring claimants' income loss net of taxation, improving jury instructions, relying more on jury interrogatories, requiring unanimous, twelve-person jury verdicts, and creating new data banks on the amounts of damages paid in particular cases to guide juries and judges in settling awards. Going further in this direction is the idea of "scheduling" awards.

"Scheduling" of Damages

Here the idea is to cut down on the degree of variation of awards for similar cases by using a computational algorithm or other method to simplify the setting of damages, at least in certain cases. In a way, imposing a flat cap in noneconomic damages of a quarter of a million dollars is one form of scheduling. And, when people buy coverage to protect themselves from personal injury--health insurance, disability coverage, or auto medical payments--they accept limited

payment levels and do not seek restitution for intangible damages, as Patricia Danzon has pointed out. Adopting other approaches to assessing injury could bring more predictability and consistency to liability damage awards, thus making insurance losses easier to predict and ending apparent discrepancies of results in similar cases, which some view as unfair.

Under an RWJF grant (see attached project description), Frank Sloan and I are exploring various approaches to making awards more predictable, by no means limited to "schedules" as such. A structured approach to intangible damages (in lieu of arbitrary caps), information feedback, and Workers Compensation-like practice are three possibilities. They could be used in any type of reform, from legislative enactment to private agreement and even administrative changes by courts themselves.

Pros	Cons
o Might indeed bring predictability and consistency	o Unclear feasibility, certainly for simple "schedule"
o Could cut transaction costs	o Will still get considerable variation in damages because of compromises on liability, other factors
o Could cut risk premium charged by insurers because of uncertainties	o Unproven effectiveness

Experience Rating

Insurance practice could better translate legal findings into incentives for improved quality by physicians and other practitioners. The same RWJF grant just mentioned is also considering ways to do more experience rating of physician premiums. Two basic approaches are (1) to induce different groups of physicians to pool their experience within pre-existing business enterprises, such as hospitals or group practices, so as to promote peer review; and (2)to develop better individual predictors of experience, charging variable premiums accordingly.

Pros	Cons
o Theoretically good quality incentive, if basic information on faulty outcomes is correct	o Might exacerbate defensive medicine or mutual silence about bad results
o Theoretically improves incentives to be careful on one's own and in monitoring fellow insureds	o Not a new idea, unclear if can be done better
	o Might lead to avoidance of high-risk patients

Improving dispute resolution through alternative mechanisms

One last particularly intriguing possibility deserves mention for working within the system. These hearings are shortly going to hear from Tom Metzoff of Duke University School of Law on alternative dispute resolution. A very exciting thing about such "ADR" is that these private alternatives can only help all parties. No one need seek out or accept alternatives unless they are convinced that they would be better off than under conventional court procedures.

Pros	Cons
o May hold lessons for administration of public courts	o Addresses only procedural problems
o Competition of ADR may prompt improved court administration	o Not yet widely available
o Wholly voluntary	

REFORMS AS ALTERNATIVES TO THE CURRENT SYSTEM

Beyond simple modifications of current practice come more elaborate changes that would replace all or part of the fault-based litigation-insurance system. Only two complete replacements seem to be receiving much serious attention--the idea of private agreements and the AMA proposal.

Private agreements on tort rules and processes

Private contracting is the first major reform, one most clearly associated with law professors Richard Epstein and Clark Havighurst. Like private dispute resolution, private contracts are a "do-it-yourself" reform, but could be more thoroughgoing. Proponents would allow patients and providers to agree in advance to the rules and processes for handling any or all medical injuries that might later occur.

Any number of particular reforms, substantive or procedural, could result from various agreements. At a minimum, any of the public reforms ever suggested could be adopted by contract between patients and medical providers, either individually or in organized groups. Substantive changes in rules might include different standards of care or measures of damages, for example. Or agreements could change the process by which the rules are applied—arbitration, mediation, prescreening, other alternatives. Although voluntary dispute resolution is already possible after an injury occurs, the advocates of contract want to encourage agreements before injuries and disputes arise.

Pros	Cons
o Clearly set out private agreements, knowingly entered, cannot make parties worse off	o Courts are very hostile to limits on "right to sue"; might require change in legal doctrine
o Allows various legal regimes to exist within a state, as they now exist across states	o Seems most feasible only in organized context, and with respect to appropriate level of care not carefulness with which procedures are undertaken
o May allow small claimants and non-litigious patients to receive benefits for injuries	o In point of fact, consumers may want more care taken, not less, as many reformers assume
o No need to legislate particular reforms	

The AMA Proposal

The other major alternative is the recent AMA proposal. I understand that Carter Phillips has addressed the Committee on this topic. Briefly summarized, it would retain liability based on fault but would completely replace the current fault-based litigation-insurance system with an administrative scheme. It would resemble Workers Compensation but seems to draw many procedures from the National Labor Relations Board.

The AMA would create a new state administrative tribunal (or add new responsibilities to current state boards of medical discipline) that would operate under new processes. It would recieve complaints of medical injuries, investigate, make determinations, and consider appeals. Substantive standards would largely follow existing law, but care would be judged by a new national standard of reasonable medical practice (rather than local or national customary practice). The general intent seems to be to replace laymen with experts as decisionmakers and to reduce the influence of the plaintiffs bar. Regardless of how one weighs the proposal's precise pros and cons, the medical profession deserves commendation for seeking constructive change.

Pros	Cons
o New idea worthy of serious consideration	o Patient and claimant point of view not clearly represented
o Arguably will allow smaller and less certain cases to be heard	o No guarantee that more injuries will be found and compensated
o Attempts to limit legal expense of the system	o A very complex administrative structure
o Should satisfy medical profession of fairness	

Most other reform options carve out a particular area for superceding today's system. A few can be mentioned.

The Virginia/Florida Approach to Obstetrics

Here the idea is to take certain cases of very sympathetic, severely injured newborns out of the fault system. Their cases are to be settled by something more like a Workers Compensation system, offering relatively easy recovery, but limited damages. The financing of premiums is also different, with contributions drawn from a much larger base than merely obstetric practitioners.

Pros	Cons
o Attacks the most visible and sympathetic malpractice problem of the mid-80s	o Relatively few claimants likely to be helped because of restrictive definitions
o Wholly new idea, worth attention	o Unknown effect on premiums
o Appears to offer relatively low costs of operation	o Not clear why costs of obstetrics care should be spread further, even to liability insurers generally

"No-Fault" Methods

Two main versions of "no fault" for medical care bear mentioning here. The name is a little misleading but has stuck. Real "no-fault" usually means covering any injury causally related to the covered activity and paying without regard to fault, often through first-party insurance. Workers Compensation and auto no-fault are the prime examples. For those activities, it's clear that virtually any observed damage results from the covered activity, namely, being on the job or operating a motor vehicle. Of course there remain boundary disputes, but by and large the responsibility for payment is clear cut. Moreover, the clear ex ante expectation about causation is that any injury occurring in the workplace or on the highways occurred because of working or driving and is thus worthy of compensation.

In medical care this expectation about causation is not at all clear. All of us, almost by definition, are under medical care when we die and when we are very sick. So it is very difficult to separate problems that result from the natural progression of illness or injury from those that result from medical care. It is thus unrealistic to cover all adverse outcomes under medical care through liability insurance. Two different approaches deal with how to select a subset of injuries to pay on a "no-fault" basis.

"Designated Compensable Events" No-Fault. Larry Tancredi will explain more about this. He is one of the fathers of DCEs for adverse medical outcomes. In short, the notion is to deal with these problems of causation by listing events that will automatically be compensated. The system is not wholly no-fault because in choosing the list of events to be compensated, the likelihood that these outcomes could happen in the absence of fault is highly relevant, as is whether they're relatively avoidable. A different measure of damages is also usually contemplated. Larry is continuing to work on DCEs under a RWJF grant, along with Phil Held and myself (see project description with his testimony).

Pros	Cons
o Eliminates costly fact finding and acrimony of litigation	o Unclear how many cases can be covered on this basis
o Not inconsistent with incentives for quality if experience rated	o A major part of the fault-based system would survive
o Would cover more injured people than the current system	o Already under fault system many easy cases are settled without lengthy process or elaborate fact finding

"Neo-No-Fault". John Hoff will discuss this here today. Two main versions have been described by law professor Jeffrey O'Connell, one to be introduced through legislation, the other through voluntary private contracts. I describe

the former here. O'Connell argues that listing DCEs is impractical, so that fault should remain the basic criterion for payment. Under the legislative scheme, medical providers would decide who should be compensated without litigation. Providers are encouraged to settle claims by being given new rewards for doing so: By promptly offering to pay net economic losses (as they occur) to an injured patient, they foreclose that patient's right to sue in court for higher damages. Discretion to make the offer would lie entirely with the provider. Any disputes about what damages actually occurred would be arbitrated.

The theory is that many offers will be made because providers badly want to avoid the uncertainty and expense of litigation. The increased number of patients compensated, the promptness of payment, and the full coverage of economic losses (net of other sources) are thought to balance the loss of litigation's potential for higher recovery that in any case occurs more slowly and is subject to high lawyers' fees.

Pros	Cons
o The scheme is simple; it remains fault-based and there is no new "system" created	o The statutory version is a clear "take-away" from claimants, who lose claim to noneconomic damages
o It relies on existing rules of liability	o The actual impact on provider behavior is quite unclear in terms of incentives to settle
o It changes only rules of damages (in the statutory scheme) and incentives to settle	o Impact on claims and premiums is unknown

CONCLUSION

Many possible malpractice reforms exist. I offer three final suggestions for policymakers who must ponder changes: (1) Given that there's little consensus

on problems or solutions, it makes sense to continue to experiment--which in turn suggests accepting state-by-state variation in practice, and perhaps also some private alternatives. (2) Although it is not glamorous, day-to-day administration of the litigation system and its medical-legal and insurance-legal aspects may best achieve change. There is probably no "magic bullet" in any "one-shot," global reform. (3) Problems of medical quality and legal performance will never disappear, and many insurance-market phenomena seem to run in cycles: So concerned policymakers need to continue their exertions over the long haul. Then, we might all be better prepared for the next crisis when before it occurs.

Thank you very much for your attention.

Prepared for Joint Economic Committee hearings on "The Future of Health Care in America: Ethical and Legal Issues in the Medical Profession; Alternatives to the Current Litigation System." Preparation of these materials was covered by Institute funds, whose support is gratefully acknowledged. Funders of past and current work on malpractice include the HCA Foundation, the National Center for Health Services Research, and the Robert Wood Johnson Foundation. Naturally, these remarks should not be assumed to represent the views of anyone but the author.

ATTACHMENTS

Testimony of Randall R. Bovbjerg

1. GAO, listing of malpractice reports
2. National Conference of State Legislatures, malpractice materials
3. Law & Contemporary Problems, symposium issue on malpractice and reform
4. Robert Wood Johnson Foundation, press release on malpractice grants
5. Project description on "scheduling" and experience rating

ATTACHMENT 1

GAO Reports Related to Medical Malpractice

Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50)

Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112)

Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21)

Medical Malpractice: Case Study on Arkansas (GAO/HRD-87-21S-1)

Medical Malpractice: Case Study on California (GAO/HRD-87-21S-2)

Medical Malpractice: Case Study on Florida (GAO/HRD-87-21S-3)

Medical Malpractice: Case Study on Indiana (GAO/HRD-87-21S-4)

Medical Malpractice: Case Study on New York (GAO/HRD-87-21S-5)

Medical Malpractice: Case Study on North Carolina (GAO/HRD-87-21S-6)

Medical Malpractice: Characteristics of Claims Closed in 1984 (GAO/HRD-87-55)

Medicare: Reviews of Quality of Care at Participating Hospitals (GAO/HRD-86-139)

Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients from Health Practitioners Who Lose Their Licenses (GAO/HRD-84-53)

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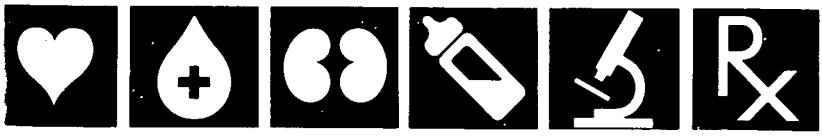
ATTACHMENT 2

What Legislators Need to Know About Medical Malpractice

National Conference of State Legislatures

Foundation for State Legislatures



Attachment 2

National Conference of State Legislatures

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ATTACHMENT 3

LAW AND CONTEMPORARY PROBLEMS

DURHAM, NORTH CAROLINA

VOLUME 49 | SPRING 1986 | NUMBER 2

MEDICAL MALPRACTICE: CAN THE PRIVATE SECTOR FIND RELIEF?

RANDALL R. BOVBJERG & CLARK C. HAVIGHURST
Special Editors for this Symposium

Attachment 3

Attachment 3

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ATTACHMENT 4

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News Release

FOR FURTHER INFORMATION, CONTACT:
Linda S. Orgain, (609) 452-8701
Extension 287

FOR IMMEDIATE RELEASE

FIRST ROUND OF GRANTS ANNOUNCED UNDER
MEDICAL MALPRACTICE PROGRAM

PRINCETON, N.J., June 29, 1987 — In an effort to alleviate problems related to medical malpractice, The Robert Wood Johnson Foundation today announced $3.2 million in grants to 14 projects* whose efforts will advance knowledge about what constitutes malpractice, what causes it, and how it can be prevented.

Selected from nearly 300 responses to the request for proposals, the projects announced today will each receive up to $300,000 for a one-to-three-year period. A second round of grants will bring the total funding for both rounds to as much as $6 million.

The projects funded under the Foundation's Medical Malpractice Program aim to: (1) determine whether there are identifiable factors in medical practice or among medical practitioners that can help predict malpractice; (2) improve risk management; (3) assess alternative methods of setting malpractice insurance premiums, including both experience-rating systems and no-fault systems; and (4) evaluate the effectiveness of efforts to reform state tort law.

*See attached list of grantees.

Attachment 4

According to Leighton E. Cluff, M.D., president of The Robert Wood Johnson Foundation, "The high costs of insuring physicians against medical malpractice liability causes several problems for the public. First, it may deprive patients of access to care by some specialists. Second, it contributes to increasing health care costs as physicians raise their fees to cover insurance premiums. And third, it may detract from the quality of care provided, because physicians and hospitals often subject patients to excessive tests or deny them high technology diagnostic or treatment procedures, in order to protect themselves from potential malpractice charges.

"While the Foundation is not prescribing or endorsing any particular solution; we hope that these research projects will offer alternative approaches to handling this serious national problem."

The deadline for submission of proposal letters for the second and final set of grants under the Medical Malpractice Program is December 1987. Completed applications are due in May 1988, and the grants will be announced in November 1988. For more information about the Program, contact: Phyllis L. Kane, The Robert Wood Johnson Foundation, P.O. Box 2316, Princeton, NJ 08543-2316, (609)452-8701.

Direction for the Program is being provided by Walter Wadlington, LL.B., James Madison Professor of Law and professor of legal medicine at the University of Virginia.

The Robert Wood Johnson Foundation became a national philanthropy in 1972. Since then, grants in excess of $750 million have been made to improve health care in the United States.

ATTACHMENT 5

PROJECT DESCRIPTION: RWJF

SCHEDULING DAMAGES AND EXPERIENCE RATING:

THE NEXT MEDICAL MALPRACTICE INSURANCE REFORM

We are assessing the desirability and feasibility of two major malpractice insurance reforms: scheduling of damages and experience rating of insurance premiums.

Past insurance and legal reforms have made relatively minor adjustments to the basic system of tort law and insurance. The intermediate goals have been to keep liability coverage available and affordable for providers, yet fair to injured claimants. Scheduling and experience rating constitute the next level of reform--more fundamental changes to today's rules and incentives, yet still within the traditional system. Indeed, these are probably the two major existing insurance reform possibilities, short of a wholly new system.

Scheduling primarily addresses the first main goal of the malpractice system--fair compensation to the injured. Experience rating mainly addresses the second basic goal--deterrence of substandard medical practice. This project is considering both reforms jointly for several reasons. They are parallel, intermediate insurance reforms that together address the most fundamental goals. They are consistent with other reforms, under a fault-based, no-fault or part-fault regime. And, they overlap considerably in the data bases and expertise needed to develop and evaluate possible reform models, empirically and otherwise.

We have reviewed existing knowledge, canvassed similar insurance practices in other lines through an extensive literature search, held one-day panel meetings with academicians and practitioners, and surveyed insurance companies to learn what, if any, experience rating programs have been tried or considered. We have begun to develop working models, considering both the theoretical and the political pros and cons of each. As work progresses, our goal is to empirically test first-order results of the models and to assess their policy importance. Scheduling constitutes the bulk of the project effort; work on experience rating builds on work funded by the National Center for Health Services Research. Special emphasis has been placed upon dissemination, with five publications planned.

Our data sources are rich and varied. For experience rating, we have obtained a data file on all Florida closed malpractice claims from 1975 through the present. The claim form includes information on the physician insured, defense costs and the total indemnity paid. We have added the allegation(s) which led to each claim for 1980 through the present and merged the closed claims with AMA data on all M.D.s practicing in Florida between 1972 and 1987. The new data set allows us to calculate the claims per exposure year for each physician. This data set allows us to perform a "bad apple" analysis and to test proposed experience rating models.

For scheduling, we are supplementing the Florida closed claims with the Rand jury verdict data for Cook County and California, 1980-84; information coded from jury verdict reporters for Kansas City and Florida, 1976-87; and, the NAIC (1975-78) and the GAO (1984) closed claim data.

It is our goal to both advance the state of knowledge about existing issues related to the scheduling of damages and experience rating and to assess potential reforms.

Frank A. Sloan
Vanderbilt University

Randall R. Bovbjerg
The Urban Institute

April 1988

Representative SCHEUER. Thank you very much. Mr. Metzloff, please proceed.

STATEMENT OF THOMAS B. METZLOFF, ASSOCIATE PROFESSOR, DUKE UNIVERSITY SCHOOL OF LAW

EXAMINING THE LITIGATION PROCESS

Mr. METZLOFF. I want to speak to perhaps a more specific issue than has been raised either by Mr. Bovbjerg or in the other panels. I think what I might have some insight into is the litigation process itself for medical malpractice cases. I am presently working on a study of litigation procedures in medical malpractice cases, trying to analyze and answer some of the questions that you have been asking about how these cases are litigated, and then consider what forms of alternative dispute resolution or ADR might be useful in handling malpractice cases.

Sometimes the line between procedure and substance is a difficult one. The AMA proposal, for example, has procedural reform elements and yet also it is clear to me that there are substantive aspects to the AMA plan.

My ideas, which is not a hard proposal that I will be giving you today, but what I think are some insights into the problem, relate to purely procedural change, and I want to try to limit my comments to that.

Certainly if you look at the anecdotal evidence out there, there is a problem with the litigation procedures in medical malpractice cases. Putting together different criticisms you can come up with a picture which truly is a bad one. Only 1 out of every 20 people who may be suffering an injury is ever in a position of asserting a claim. They can't find the lawyers. They don't know how to access the legal system.

We know that many of the claims in which an attorney is found are dismissed or the case is dropped without payment being made. Now, some doctors conclude that these cases are then frivolous. It may be that some of them are. We really don't have any information as to whether or not these cases should have been in the system or how they were handled.

Even those claims that succeed, in the sense that some payment is made, we know that it happens at great expense, as high as 70 percent of the amount involved goes to the attorneys, not in the hands of the people who suffered the injury. And, again, we have no real confidence that those people who do win are those who are deserving. Indeed, some people have gone so far as to label the system a "lottery."

What, in fact, do we know about the system? Mr. Bovbjerg said not very much, and certainly some of the work he has done has proved that point. We don't know very much about the litigation system. You asked earlier, in the prior panel, about what ADR programs, what alternatives are being tried in the States, and I agree with Mr. Phillips that there isn't much going on right now. There are some efforts. We had the screening panels and some efforts at arbitration attempted in the 1970's, and there are beginning to be some reports now as to whether or not those systems have worked.

There is still a shortage of information, even on those systems. But with respect to some of the new alternatives, such as using mediation, or some of the more advanced forms of alternative dispute resolution, there are very few projects underway and little empirical research.

CHARACTERISTICS OF GOOD MALPRACTICE SYSTEM

Indeed, I think we need to stop and ask some questions about what we think the procedural system should do in a medical malpractice case, and I would suggest that there are perhaps six factors that need to be analyzed.

First, you need a procedural system that operates at an appropriate level of expense. And there is some question as to whether our system in fact operates at an appropriate level of expense.

Second, you need a procedural system that operates in a timely fashion, and certainly there is criticism about how long it takes to handle medical malpractice cases.

Third, you need a procedural system where the adversarial tendencies of the opposing attorneys operate to sharpen the dispute and to resolve it, not to drive the parties further apart and impede the resolution of the case.

Fourth, I think a procedural system must seek quality information from witnesses, both lay witnesses and expert witnesses. We should have a system that has as one of its goals obtaining quality information.

Fifth, the procedural system must use an appropriate decisionmaker, be that the jury or, if an alternative system, some different sort of decisionmaker.

Finally, a procedural system must have an ability to short-circuit the process and handle frivolous litigation. In a traditional litigation posture, that is the process known as a summary judgment.

PROSPECTS FOR ALTERNATIVE DISPUTE RESOLUTION

In looking at the existing system, I am not so much interested in the role of the jury—for the jury decides the issue in perhaps 5 to 10 percent of the cases—but rather how do the rest of the cases, the 90 percent of the cases that never get to a jury, get resolved? For those cases that are settled, or those cases that are dismissed or dropped by the plaintiff's attorney for some reason or another, why are those cases handled the way they are? And where do we find successes in those procedural systems and where do we find procedural problems? In identifying the problems with the bulk of those cases, the 90 percent of the cases, is where we find the opportunity for alternative dispute resolution techniques to improve and sharpen the process.

I have mentioned before the Private Adjudication Center at Duke is conducting a study with precisely that focus. We are attempting to look at the settlement dynamics in medical malpractice cases. We are attempting to look at how the procedural system operates in terms of handling frivolous cases to try to find those procedural opportunities that exist for improving the method by which these cases are litigated.

The Private Adjudication Center—I just want to say a quick word on this—is a nonprofit affiliate of the law school and it is dedicated to the development of alternative dispute resolution. In a sense it is a research and development institute associated with the law school. Our specific project is being funded by the Robert Wood Johnson Foundation.

Let me conclude and just say a few words about the prospects and opportunities for procedural reform. ADR, which has become a well known acronym within the legal profession, has undergone a tremendous growth in terms of both acceptance within the legal profession and its understanding by both the profession and policymakers.

In the last 15 years the Federal courts, in part spurred by Congress, have developed a number of alternative techniques such as the summary jury trial, court-annexed arbitration, and the use of special masters to assist in handling complex litigation. It is precisely in this development of a second generation of alternative dispute resolution, using techniques a little bit different than arbitration, but which also offers us some understanding of the arbitration system, that has possible applications to medical malpractice cases.

Last week, we attended a summary jury trial in a medical malpractice case in the Federal courts in North Carolina. What would normally have been a 3-week trial was presented to a jury in 1 day.

Representative SCHEUER. Can you tell us how that works? The summary jury trial.

Mr. METZLOFF. Yes. A summary jury trial relies on the attorneys to a greater extent that in a traditional trial. So instead of calling a witness to the stand and going through their whole background and having them explain every part of the case, the attorney will talk to the jury and simply say, the evidence which we have already collected through the discovery process shows this, and summaries of the evidence are provided.

Now, in this particular summary jury trial, the expert witnesses were presented through a videotape, with some cross examination. Yet, what normally would have been perhaps a full day of testimony was shortened to 20 or 25 minutes.

Now, the question whether this is an appropriate way to present a medical malpractice case is a difficult one and you would have to work through an empirical test, and we are certainly attempting to do that. But this technique which was developed in the Federal courts is potentially useful for handling medical malpractice cases. And we think there are a number of others.

The choices that exist include the procedural reform aspects of the AMA plan, but there are a host of others. Wisconsin now is experimenting with a program in mediation of medical malpractice cases which is being tested by the Wisconsin litigation project and subject to some evaluation.

We are hopeful that through voluntary reference of cases, we can obtain some insight into the use of alternative dispute resolution in these fields. This will never be a total solution to the medical malpractice project. Concerns with avoiding malpractice initially, risk prevention techniques, are needed as well.

But I think the AMA has, in a sense, thrown down a gauntlet to the legal profession to try to justify the procedures that we are

using in malpractice cases and perhaps, where we find problems, seek creative and useful ways within the context of due process to improve the workings of the system. Thank you.

[The prepared statement of Mr. Metzloff follows:]

PREPARED STATEMENT OF THOMAS B. METZLOFF

ALTERNATIVES TO THE CURRENT LITIGATION SYSTEM: PERSPECTIVES ON ALTERNATIVE DISPUTE RESOLUTION IN MEDICAL MALPRACTICE CASES

I. Procedural Perspectives on the Malpractice Problem.

Perhaps no other area of litigation has generated as much controversy as that of medical malpractice. For at least the past fifteen years, a debate has been raging in many areas about the efficacy and fairness of the litigation system in resolving disputes between clients and their physicians. While the amount of hard evidence that we have is somewhat skimpy given the importance of the issue, most would agree that malpractice litigation is expensive and frequently cumbersome. Many would go much further in criticizing the procedural system.

Most notable in the range of opinion concerning the procedural system is the widespread conviction of many of its critics that the process for handling malpractice cases is expensive, slow, and unreliable. Of course, these particular attacks do not necessarily serve to distinguish malpractice cases from other areas of litigation---people have been complaining for a long time that litigation generally is expensive, slow, and unreliable. Yet, the discussion in the medical malpractice context rings with a sincerity and a severeness that makes it an appropriate context for scrutiny. Perhaps most noticeable about the attack is its stringency--many critics go so far as to conclude the the present system is nothing short of a "lottery."

The "procedural critique" involves a series of concerns about the litigation system in medical malpractice cases including: (1) its inability to handle frivolous litigation; (2) its expense; (3) the delay involved; (4) concern with the role of plaintiffs' attorneys; (5) the perceived problems with the reliance on "hired gun" expert witnesses; and (5) the role of the jury.

The medical profession's frontal assault on the present litigation system is most clearly directed to the quality of the decision-making process. This is to be expected; more specific procedural shortcomings would be unlikely to be the focus of their concern as non-legal observers of the system. In the public debates, the question frequently centers on the role of

the jury. The recent American Medical Association's proposal for abolishing the present litigation system in favor of a fault-based administrative system is indicative. The basic point is easily stated: juries of laymen are not well suited to resolving complex issues of causation or assessing the appropriate standard of medical care. Malpractice cases require expert testimony which jurors cannot effectively evaluate. Juries, so the argument goes, are biased in favor of plaintiffs and tend to make excessive awards. The result, according to the critics, is a litigation system out of control.

Of course, the issues relating to the cost efficiency and fairness of the litigation system runs much deeper than the impact of juries on the system. Like most areas of litigation practice, the vast majority of cases are settled without trial, or dismissed for a variety of other reasons including lack of merit or inadequate resources available to the plaintiffs to pursue the claim. Yet, even for these cases, the critics point out the high transaction costs for processing the disputes.

Given the widely shared concern with the present operation of the procedural system, it is not surprising that many are considering the use of alternative dispute resolution (ADR) in malpractice cases. Indeed, in the mid-1970s, many states reacted to the first "malpractice crisis" by enacting a series of procedurally-based reforms. Several states moved to make arbitration of malpractice claims easier. Over 30 states enacted a device known as the "screening panel" to look over malpractice claims early in the dispute to make a preliminary determination about the potential merits of the disputes. It was hoped that such a preliminary review would help weed out frivolous cases or encourage the parties to settle meritorious cases. To date, the evidence on the efficacy of these screening panels suggests that they have not succeeded in implementing these goals.

While the promotion of arbitration and the development of screening panels perhaps constitutes a form of "alternative dispute resolution" or "ADR", there has been little systematic attempt to date to apply many of the newer ADR techniques----such as mediation, summary jury trials, mini-trials, court-annexed arbitration, or early neutral evaluation---to malpractice cases. Just as importantly, there has been little comprehensive analysis of the litigation process itself in malpractice cases. Such review is necessary before we can analyze whether ADR techniques could be usefully applied in the malpractice context, and what forms of ADR would be best used.

II. Empirical Insights in the Existing Procedural Process.

It is useful in analyzing the potential benefits of ADR in medical malpractice cases to first canvass what information is presently known about the litigation system. Regrettably, little empirical work has been done relating to the litigation process in medical malpractice cases in part owing to the significant expense involved in gathering representative data.

A true understanding of the litigation process should focus on settlement dynamics and the role of the legal profession as in resolving malpractice cases. On these issues, there is a dearth of empirically based studies. Apart from anecdotal evidence, there is presently no clear understanding of the litigation dynamics in medical malpractice cases.

Of course, an important attribute of the system is the role of the jury, and on this point a few studies exist, although there has not been a major empirical study of the jury's performance assessing its overall competence specifically in the medical malpractice context. On one point, the evidence is clear. As with other types of litigation, only a small fraction of malpractice disputes---fewer than 10%---are resolved by a jury. Nevertheless, it is suggested that the jury's influence significantly exceeds the numerical proportion of jury trials. Verdicts arguably provide "the going rates" for settlements so that the spectre of its perceived pro-plaintiff proclivities and its perceived bent towards awarding excessive damages color the entire litigation process.

What evidence exists, then, as to whether the juries are biased towards plaintiffs or are awarding "excessive" damages? Jury Verdict Research publishes national statistics on verdicts over $1 million. Its 1982 report noted a steadily upward trend in awards in medical malpractice cases between 1973 and 1982, culminating in an average jury verdict in the rather astonishing amount of $962,258. Such reports are cited to show that juries have run amok.

These reports suffer from a series of methodological or interpretative concerns. Perhaps most importantly, by covering cases in which there are jury awards, which by definition are in favor of the plaintiff, the data necessarily exclude consideration of findings for the defendant, as well as the large number of cases that are settled. Without knowing how often juries find for defendants, it is not possible to assess juries' potential bias.

Other studies have attempted to be more empirically based. Using data from a closed claims study prepared by insurers, Danzon and Lillard examined a large number of malpractice claims closed in 1974 and 1976. The examination revealed that only about seven percent were resolved by a jury. In those cases

actually tried, the jury found for the defendant in almost three out of four cases. Danzon and Lillard, Settlement Out of Court: The Disposition of Medical Malpractice Claims, 12 **J. Legal Studies** 345 (1983). Significantly, Danzon and Lillard found a strong correlation between the amounts of damages awarded and the economic loss suffered. From the same data, Danzon subsequently concluded that the extreme charge that juries compensate without regard to fault was not substantiated; damage awards are strongly related to economic loss and by the law defining compensable damages.

Steven Daniels and his colleagues at the American Bar Foundation have also gathered data on malpractice cases from verdict reporters. One important aspect of this research is its breadth of coverage: 43 counties in 10 different states between 1980 and 1984. These locations do not constitute a representative sample in the statistical sense, but they do reflect data collected from an array of diverse states. A significant finding from the data set is that it demonstrates significant variations in medical malpractice verdicts both between and within states.

Perhaps the one solid conclusion that can be drawn from these various studies of jury verdicts is that there is much variability in jury outcomes, between and within jurisdictions. A reasonable second conclusion is that the extreme claim of a runaway jury system in medical malpractice cases has not been substantiated.

Even if it were established that some juries were reaching "incorrect" decisions or were awarding unjustified sums to plaintiffs, it would not follow that the litigation system was necessarily deficient. The jury's decision does not terminate the litigation process. Several opportunities exist for the defendant to obtain a reduction in the amount awarded by the jury. Taken collectively, this array of post-verdict adjusting mechanisms potentially constitutes a significant limitation on aberrant juries.

Until recently, this post-trial period was one of the least studied aspects of the procedural system. Two recent reports, however---both of which collected data on medical malpractice verdicts---have at least begun a serious consideration of post-trial adjustments. See Broder, Characteristics of Million Dollar Awards: Jury Verdicts and Final Disbursements, 11 **Justice Sys. J.** 349 (1986) (reporting reductions of 27% as a result of post-trial adjustment processes); M. Shanley and M. Petersen, **Posttrial Adjustments to Jury Awards** (Rand 1987) (for medical malpractice cases, the average reduction for jury verdict awards was 33%). If these results are confirmed, they tend to suggest that the public's concern with "out of control" juries can be effectively handled by the existing system.

Apart from this evidence relating to juries, there are

certain insights into the litigation system from other empirical studies. For example, there is a fairly rich series of empirically reports relating to medical malpractice cases known as "closed claims" studies. The most recent closed claims study was completed last year by the General Accounting Office (GAO). **U.S. Gen. Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984** (1987).

The purpose of any study is to collect data on a significant number of claims---not just litigated cases--which were terminated during a given period. Since many claims are settled or dropped prior to suit being filed, the universe of claims is significantly broader than litigated cases. Typically, data is obtained exclusively from insurance company files.

The GAO's stated purposes for its work did not include an analysis of the litigation system's performance, except indirectly as set forth below. Rather, its primary purposes, consistent with other closed claims studies, is simply to determine how many malpractice claims there were in a given period and the amount paid out by insurers in compensation. This non-litigation data is analyzed to describe claim frequency and severity (amount of payments). The claim data is then cross-tabulated against plaintiff characteristics, defendant characteristics, and the injury itself. With respect to these primary variables, no effort is made to det mine whether medical negligence in fact occurred in a particular case, or whether the dispute was efficiently handled.

Closed claims studies do attempt to collect some data that relates to litigation/process variables. Regrettably, the insights into the litigation process learned from the GAO's analysis of these "litigation variables" is neither extensive nor profound. Closed claims studies do document the importance of settlement. Almost half of the claims were closed without a lawsuit being filed at all. This cohort clearly includes many anticipated claims where nothing was ever heard from the potential plaintiff, but it also includes a large number of claims where a settlement was reached with the plaintiff without suit being filed. In the slight majority of cases, suit was filed. Even where suit was filed, however, virtually all of the closed cases were settled or dropped short of trial. In the total sample of closed claims, only 5% went to trial.

To be sure, the GAO study confirms that settlement is the most significant means of dispute resolution in medical malpractice cases. By a slight massaging of the reported results, approximately 93% of the claims that were closed involving a payment to the plaintiff were settled prior to trial or arbitration. But the mere fact of settlement is not descriptive of the settlement process itself. For example, on the question of when settlements occur, the GAO study, like all closed claims studies, provides minimal guidance. According to the results reported, approximately one-third of all cases settle

before suit is filed.

The existence of such a large amount of pre-litigation settlement is potentially quite significant. What is the character of these claims? Two differing visions suggest themselves. First, insurance companies may simply be settling the smallest of cases---those where a few thousand dollars will placate the plaintiff without involving defense attorneys at all. Secondly, it may be that insurance companies are in fact settling some of the most serious disputes prior to litigation in an effort to avoid the tremendous expense for experts and defense counsel that would necessarily be required to defend in a complex case. Thus, it may be the high level of pre-litigation settlement demonstrates that the insurance companies are working hard to identify the most serious malpractice disputes and are willing to settlement them early in the process. In this alternative vision, litigation is reserved for the close cases or the minor cases where the insurance company can "afford" to contest liability. Trying to characterize which of these two diametrically opposed descriptions is more accurate is critical to understanding the settlement process, and thereafter considering the use of ADR procedures.

The same basic concern continues for the two-thirds of the settled cases that settle after suit is filed. Here, the GAO report, like other closed claims studies, is content to lump all settlements together--the GAO has a single category for settlements prior to trial. To obtain a deeper understanding of settlement dynamics in malpractice litigation, however, one must relate the timing of settlement to the discovery process (do cases settle only after significant discovery or do a significant percentages settle after certain specific discovery has occurred?), particularly its relationship to the expert witness concern.

In sum, the existing data on medical malpractice litigation is not well suited to obtaining an understanding of the procedural forces at work. As such, it is difficult to predict what forms of litigation alternatives would be best suited to the malpractice context to improve the existing system's performance given the lack of information on the existng system.

III. Duke's Private Adjudication Center's Medical Malpractice Research Project.

The Duke University School of Law, through its non-profit affiliate the Private Adjudication Center, recently embarked on a major three-year research project to analyze litigation procedures in malpractice cases and then to develop ADR procedures specifically designed for malpractice cases. Funding for the project was received from the Robert Wood Johnson Foundation. The major purpose of the research study is to improve our understanding of the litigation process.

The three-year project is divided into two stages. Phase One, scheduled for completion by the end of 1988, consists of an in-depth examination of the present litigation system as applied to malpractice cases. Project personnel are reviewing court records and other files in all malpractice cases litigated in North Carolina over the past three years. From this review---estimated to involve over 850 cases---the Project's researchers will be in a position to document specific problem areas under the current litigation regime as well as identify procedural opportunities that might exist.

In addition to reviewing records in all litigated cases, the researchers will select approximately 50 cases in which to do an in-depth review consisting of detailed interviews with the relevant parties---plaintiffs, defendants, their attorneys, insurance claims managers, judges, witnesses, and even jurors. This more impressionistic data will provide the anecdotal richness needed to help understand and interpret the data gathered from the court records.

The study focuses upon four primary issues: (1) developing greater understanding of the settlement dynamics in malpractice cases; (2) analyzing the ability of the existing system to dispose of nonmeritorious cases; (3) the jury's impact; and (4) the role of the expert witness in malpractice cases.

After the first year, the Project will enter Phase Two. During this two-year phase, the Private Adjudication Center will first design a series of specific ADR mechanisms for handling malpractice cases. The actual design will be a function of the litigation problems and opportunities revealed during Phase One. The researchers will specifically address the potential use of summary jury trials, mini-trials, early neutral evaluation, mediation, and other specific ADR techniques.

The designed ADR procedures will then be applied to a significant number of actual malpractice disputes. These cases will largely come from voluntary referrals of cases as well as from existing government-sponsored ADR programs in North Carolina. These cases will be analyzed in order to test the utility and fairness of the new ADR procedures used. A final report will assess the designed procedures and make recommendations concerning the use of ADR.

While the Medical Malpractice Research Project is initially focusing on North Carolina malpractice cases, it is hoped that our findings will have national impact. Given the widespread interest in procedural reform, Duke expects that the insights into the process will act as a catalyst for the use of efficient ADR techniques throughout the nation.

IV. The American Medical Association's Plan for Reforming the Litigation System.

The Duke research program is one of a number of initiatives currently underway involving possible reform of the litigation system in malpractice cases. Recently, the American Medical Association ("AMA") put forward a controversial proposal that would substitute an administrative system for the current court-based method. Given its importance, it is appropriate to comment upon the AMA's initiative.

The proposal itself is complex. In short, the plan anticipates that claimants can assert their medical negligence claim in an administrative forum. This litigation alternative does not utilize judges or juries, and indeed, the role of attorneys, especially plaintiff's attorneys, is greatly reduced. Rather, claims evaluation is performed by staff members of the administrative board.

The AMA's approach, not surprisingly, is totally consistent with the medical profession's perception of the causes of the malpractice crisis. Without attempting a rank ordering, the medical profession has long been critical of the roles of (1) plaintiffs' attorneys; (2) juries; and (3) partisan medical experts. The AMA proposal maintains the essential legal structure of the malpractice dispute, while the designed procedure serves to exclude almost completely these three groups from the process.

The AMA's proposal is truly innovative and controversial. Without question, the AMA has raised important questions concerning such items as the need (1) to improve compensation among the class of injured victims; and (2) to improve the speed and efficiency of the process. This is not the appropriate forum for analyzing in depth all of its strengths and/or weaknesses. Instead, however, it is useful to put the plan in context within the world of ADR. In doing so, there are three significant observations that can be made about the proposed system:

(1) The Unified ADR Theory in a Mandatory Setting. The AMA approach adopts a "one-size fits all" approach to procedure. Thus, just like the present litigation system, there is but one track a malpractice dispute can follow. The track is certainly different than the present one, but within its own confines is quite rigid.

(2) The Ethics of Representation and Advocacy. The AMA's approach breaks away from the lawyer/client adversarial process in several important respects. The administrative agency provides assistance to claimants, but at key points in the process, the assistant is asked to make an independent assessment of the merits of the claim. Should the assistant advise against continuing, the claimant is left without an official spokesman

and required to search for help elsewhere.

(3) Settlement Dynamics. The AMA plan has an elaborate system for promoting settlements in cases. The various options and requirements are triggered throughout the administrative procedures. Prior to the final hearing, for example, a refusal to accept a settlement offer places the parties at risk should they not improve on their positions after the hearing. Some of these changes resemble in a limited fashion the proposed amendments to Rule 68 of the Federal Rules of Civil Procedure that were considered, and subsequently rejected, by the Rules Advisory Committee.

Whether these observations should be considered criticisms is open to discussion. In my view, at least the first two observations constitute criticisms. ADR's greatest potential contribution in the medical malpractice context relates to taking advantage of the flexbility of ADR techniques. The AMA proposal has many innovative and potentially useful ideas, but by requiring that all cases go through the identical procedures, we may be trying to ignore what ADR theory is telling us---namely, that no one procedure is ideal for all cases or even for all types of cases. Medical malpractice cases come in different shapes and sizes, and some of these differences are relevant in terms of determining the "best" procedure for resolving them.

Similarly, I am skeptical about the ethical role played by the administrative body's "examiners." Over the course of the proceeding, the same person goes from neutral evaluator, to advocate, to mediator. To be sure, one of ADR's central attributes is its openness to non-adversarial mechanisms to assist in dispute-resolution. The prospects for mediation-based techniques is a major component of the movement. Indeed, Wisconsin recently enacted legislation requiring all medical malpractice disputes to go through a mediation-based process prior to litigation. Early results under that procedure are inconclusive although a research project was recently begun to analyze that effort. Yet it is far from clear whether the AMA model is a mediation model at all; it is the ambiguity that is troubling, not the possibilities for reducing adversarial conduct.

V. Conclusion.

There currently exists wide-ranging support for creative thinking about the litigation process from a procedural standpoint. Initiatives in the field of alternative dispute resolution are recent. For example, the federal courts have only in the past decade begun experimenting with several forms of ADR such as the summary jury trial and court-annexed arbitration. Similarly, the advent of a service industry of private dispute resolution providers remains in its infancy.

To be sure, we have already had some experience in

alternative procedures for deciding malpractice cases. The opportunity exists however for a "second generation" of proposals that are more finely tuned to alleviate specific problems that exist in malpractice cases. It is an appropriate time to enter into a period of experimentation whereby existing and developing forms of ADR are applied to medical malpractice disputes. Ideally, true experiments can be performed in order to assess whether procedural changes offer any realistic hope of improving the current state of affairs.

Representative SCHEUER. Thank you very much, Mr. Metzloff. Now we will hear from Dr. Tancredi.

STATEMENT OF LAURENCE R. TANCREDI, M.D., DIRECTOR, HEALTH LAW PROGRAM, UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON

Dr. TANCREDI. Thank you, Congressman Scheuer.

ADVANTAGE OF NO-FAULT COMPENSATION

I am here to discuss a little bit about no-fault medical injury compensation. I would like to make some general statements first. That is, that the assumptions underlying the benefits of no-fault over the existing fault system rest first on the belief that there will be potential savings in legal and administrative costs from a no-fault system.

Second, that such a system, if put into place—and I will describe one subsequently—will result in savings in doctors' time, time that is now being used in defense of legal actions.

Third, that it will bring about a decrease in the existing distrust in the doctor-patient relationship, will eliminate some of the unwarranted stigma that is now currently attached to claims and the bitter adversarialness that we see in medical malpractice actions.

Finally, it will bring about prompter and more widespread compensation for medical injuries, as well as having, I think, a greater impact upon the avoidance of injuries, a much greater impact than we now see with the current tort system.

A no-fault system has the potentiality of integrating the day-to-day activities of the health care provider with a means for injury avoidance. It will link compensation to the outcomes of medical practice.

The tort system fails to really bring about this kind of deterrence, deterrence of injury avoidance. First of all, there are not always consistent results on similar kinds of cases. Second, it depends a good deal on the ability of the plaintiff or the patient to successfully prove their case. Third, the tort system has been thus far relying on community-related ratings through insurance providers, whereas a no-fault system has the potentiality of being experience rated, where one could focus on those providers or those particular physicians who are engaging in medical practices that result in significantly higher adverse outcomes than would be expected in similar kinds of practice settings.

In addition, a no-fault system has the possibility of bringing about good feedback to the profession that doesn't currently exist. It would allow for the kind of statistical development of medical injuries that occur in hospitals or other provider facilities that could begin to systematize these adverse outcomes in a way that could feed back to the profession and bring about certain kinds of behavioral changes. And, as I indicated already, it has the potentiality of strengthening the physician-patient relationship.

DESIGNATED COMPENSABLE EVENTS SYSTEM

The specific plan that I have been particularly interested in is one that requires the presence of designated compensable events

rather than simply compensating patients for injuries that occur in the health care system generally, which would be compensating them even for adverse outcomes where the therapy could even be beneficial to them.

Such a system based on designated compensable events would essentially cull out of the adverse outcomes that now occur, certain numbers of them that are economically prominent or else epidemiologically prevalent—high incidence and high prevalence—such that a good deal of what now comes under the tort system could be dealt with in an automatic compensation system. The rest of the adverse outcomes would be left to the tort system or the regular fault system.

The criteria for developing a listing of designated compensable events includes, most importantly, the medical avoidability of the event. That, is, if an adverse outcome occurs, for example, a physician treats a patient, puts a cast on for a broken bone and we discover that the patient ends up with serious ischemic effects or even necrosis, and one could say that is an adverse outcome that is relatively avoidable, maybe not in any individual case which would be necessary if we went through a court to actually establish fault, but avoidable in a high enough percentage of cases that it could be considered a designated compensable event, especially if the medical profession would agree that such an outcome should be automatically compensated.

So we would look at medical avoidability as how preventable was the adverse outcome and how treatable would it be if it occurred and one would want to avoid the long-term consequences, medical care expenses and otherwise.

The second issue would be the medical detectability. It would have to be an event that could be easily detectable so that one would't get into dispute that would require litigation on whether or not an adverse outcome did or did not fit into this designated listing.

Third, we would be concerned about the impact of designating an adverse outcome as in this DCE in terms of professional behavior. We would not want to, for example, designate hepatitis from blood transfusions if that would mean that doctors would then avoid blood transfusions where they would be the most appropriate care that should be given to a patient.

The American Bar Association, back in the late 1970's, engaged in a pilot study of the feasibility of designated compensable events based on data from the National Association of Insurance Commissioners study around 1975 and data that came from the Mills study out in California. Listing of potential designated compensable events was constructed, and panels of orthopedic surgeons and surgeons—and those were the two specialties that were examined—were brought in. They agreed that a certain number of these adverse outcomes met the criteria that I have already delineated, such that they could be included on a listing for compensability.

That study, certainly to the satisfaction of the Commission on Medical Professional Liability of the ABA, established the feasibility of designating compensable events.

The benefit of a DCE system is that it would be quite flexible. You could include events that would be consistent with new tech-

nological events in medicine, or you could remove some events if the system got too costly or too expensive.

Second, it would have important implications on quality assurance. There is this big emphasis now on quality assurance. As you may know, there is a focus either on inputs, on the process, or potentially on outcomes of the medical care system, and a DCE system would focus on the outcomes and would create feedback and would begin to actually have some kind of leverage on physician behavior and provider behavior such as to bring about some avoidance of injuries in the future.

We are currently in the middle of a no-fault research project that is being supported by the Robert Wood Johnson Foundation. None of the data has been totally collected, but we are in the process now, and the project will be finished by next July.

Representative SCHEUER. July 1988?

Dr. TANCREDI. July 1989. I am sorry. We are still collecting the data. And what we are attempting to do is to look at some of the important elements that would be necesary for actually developing a feasible system. We are examining hospital records, insurance claim records, and looking at the contrasts of them. We are also looking at the economic effects, the potential economic impacts that would occur if a DCE or a similar kind of system were actually implemented.

Thank you very much for giving me this opportunity to talk about this program.

[The prepared statement of Dr. Tancredi, together with an attachment, follows:]

PREPARED STATEMENT OF LAURENCE R. TANCREDI, M.D.

THE DCE APPROACH TO NO-FAULT MEDICAL INJURY COMPENSATION

A no-fault compensation scheme should rank at the top of long-range solutions to the crisis in medical malpractice. The system that I will describe in this testimony is one that provides automatic compensation for a well defined set of "designated compensable events." It closely integrates with the day to day activities of health care providers--individual practitioners or health care institutions--and links compensation closely to the outcomes of medical intervention. This system not only provides quick and equitable compensation for a wide range of medically caused injuries, but also supplies strong incentives for modifying provider behavior to improve the quality of health care.

There are several reasons why the prospects for a no-fault alternative to the existing tort system of medical injury compensation are very good. A no-fault compensation mechanism would be far more effective than the fault system in achieving the primary goals that the tort system is suppose to serve--fair compensation and deterrence. A no-fault system would effectively and fairly compensate those whose injuries fall within its scope. The tort system is arguably inequitable in that its decision

making processes do not always yield consistent results on similar facts. In addition, whether similar injuries will or will not be compensated depends upon the fortuitousness of the victim's ability to prove provider fault. Although a no-fault scheme based on designated compensable events would not undertake to compensate all patients whose encounters with the health care system produced a regrettable result, its coverage would be more extensive and more systematic than that of the present system.

A properly designed no-fault system would also be more successful than the tort system in preventing injuries through deterrence. The tort system in its present form leaves many avoidable injuries uncompensated. Without fairly systematic compensation, it is likely that injuries are suboptimally deterred, confirming the views of many that the tort system fails to deter even those injuries that would be compensable under its own restrictive rules. Also, because liability insurance is priced on the basis of community experience, it insulates each physician against the true financial cost of his detected negligence. This reinforces the impression that the tort system creates inadequate incentives for accident avoidance. Unlike the tort system which relies on stigma and publicity to induce better provider performance, a no-fault approach would be designed with appropriate financial incentives--experience rating of providers--for the prevention of injuries. Systematic data would also be generated about adverse events in a form that would permit statistical analysis and comparison with results at other

treatment centers. This information would be fed back to the responsible practitioners who could modify their behavior to decrease the accident rate in their facility.

Another attraction of a no-fault system is that it could function more efficiently than the current tort system. The tort system's transaction costs are very high, well over fifty cents on each premium dollar. By eliminating the need to evaluate fault in every case and to litigate the issue exhaustively in many of them, a no-fault system would save resources that could be better applied to compensating patients.

The no-fault system would also bring about a minimization of undesirable medical practices falling under the label of "defensive medicine." Estimates of the cost of defensive medicine are at best speculative as there have been no good studies to determine the precise range and impact of defensive practices. However, many groups including the American Medical Association have suggested that it is widespread and costly. To the extent that costs are incurred without benefit to the patient, or patients are exposed to unnecessary and risky diagnostic procedures, defensive practices create burdens on the public. By avoiding public accusations of malpractice and the stigma attached to them, a no-fault system would neutralize the motivational factors responsible for defensive medical practices that provide no net benefit to patients.

The changing patterns of medical practice also point up the logic of a no-fault system. The development of HMO's and large

hospital conglomerates and the increasing involvement of employers in controlling the cost of their employees' health care have brought about profound changes in the structure of health care delivery. The diversity resulting from HMO's and competitive medical plans of other kinds is inevitably offering consumers new options and opportunities to economize on the amount and quality of health care obtained and to seek the best financial protection and quality of care attainable at reasonable cost. In this new climate, concern about the costs generated by the malpractice situation and about the alignment of the compensation system with quality of care objectives should make a no-fault alternative increasingly attractive.

A no-fault insurance plan also offers an opportunity to strengthen physician/patient bonds and to shore up the values of honesty and trust that are essential to a healthy and beneficial therapeutic relationship. Clinicians and others have observed that the current adversary system discourages the physician from revealing to the patient his doubts and full truth about the outcomes of his management because such disclosures may trigger a malpractice suit. A no-fault scheme, by which a provider acknowledges risks and undertakes to protect patients against specific harms, should strengthen and improve both the subjective and the objective quality of care.

A NO-FAULT PLAN

An ideal no-fault program would guarantee adequate compensation for all medically induced injuries. Upon the occurrence of these events, a patient would automatically receive compensation for economic losses (medical care expenses and loss of wages) without the necessity of proving negligence through a tort claim. In order to maintain provider responsibility for adverse outcomes, the payment would come from a provider-purchased insurance policy under which premiums and other features preserve provider incentives to prevent or minimize the cost of injuries.

The most obvious problem with this ideal no-fault system is the high cost of making health care providers insurers of good medical results for all their patients. Moreover, such extensive coverage is not indicated on policy or any other grounds. For one thing, it would duplicate financial protection that most patients already have against medical expenses, death and disability. In addition, there would be great difficulty in distinguishing harms brought about by treatment--iatrogenic injuries--from the natural consequences of the patient's underlying disease or condition. Moreover, many of the compensated harms would be unavoidable side effects of therapy, the net effect of which was decidedly beneficial, perhaps the best that could be expected. For these and other reasons, a practical no-fault scheme would be confined to covering a limited set of adverse outcomes that were specified in advance--

"designated compensable events" (DCE's). Patients suffering adverse outcomes not appearing on the predefined list would remain free to bring tort actions under traditional principles. Obviously, the extent to which the problems of the existing tort system would be obviated by substituting no-fault compensation would depend upon the scope of the DCE list.

The criteria for listing adverse medical outcomes as DCE's are crucial. The list should be developed by medical experts who are concerned about protecting consumer interests and creating desirable quality-of-care incentives as well as about letting providers avoid tort actions (and large recoveries) for obvious negligence. The major criterion for the identification of DCE's is the relative avoidability of the outcome under good medical practice. The idea is not to list only outcomes that are always avoidable or that occur only under negligent management: instead, if the statistical incidence of an outcome is reduced by good practice, it is a candidate for listing even if the risk of harm cannot be eliminated altogether. This test focuses not only on the extent to which the outcome is preventable, but also on whether it is treatable once it occurs, so that the economic loss to the patient could be minimized.

An equally important criterion is the medical detectability of the event. The individual DCE must be so clearly defined that it would be readily identifiable and distinguishable without litigation from non-compensable events. The third criterion in judging DCE's is the impact that compensating for a particular

adverse outcome has on the overall quality of health care. In addition to the incentive created to prevent the outcome, there is also a risk that physicians would be induced to make inappropriate therapeutic choices, avoiding risks that it would be in the patient's interest to take. Thus, the selection of an adverse outcome as a DCE requires a multifactorial analysis going beyond strict medical notions of causation and relative avoidability.

In 1977, the American Bar Association's Commission on Medical Professional Liability conducted a study to determine the feasibility of a DCE system. (See ABA Comm'n on Medical Prof. Liab., Designed Compensable Event System: A Feasibility Study, 1979.) This project involved data from studies by the National Association of Insurance Commissioners of tort claims in two specialties, general surgery and orthopedic surgery. Panels of specialists, convened to evaluate the economically prominent adverse events emerging from the data, agreed that several of these untoward outcomes would be appropriate DCE's. Despite the complexities of differentiating those risks associated with the care itself from those associated with patients' underlying medical conditions, the ABA Commission concluded that this study had demonstrated the feasibility of developing such a listing from the universe of treatment-related injuries.

In addition to making no-fault concepts potentially practical in the health care field, the DCE approach has several other advantages. One is its flexibility. The DCE list can be

updated periodically as panels of specialists accept new adverse outcomes as deserving of compensation. The ease with which adverse outcomes can be added to (or removed from) the list is essential in a health care system in which new diagnostic and treatment technologies are constantly being introduced, creating opportunities for a wide range of mishaps. The list can also be expanded or contracted in light of financial considerations and the relative attractiveness or unattractiveness of the tort system.

Predefinition of compensable events also links compensation to quality assurance efforts and prevention. Providers of health care are on notice concerning adverse outcomes that are likely to occur and are implicitly advised that such outcomes are avoidable through careful monitoring of the treatment process. Whereas most quality assurance mechanisms operating in the health care field focus on the quality of input employed (personnel licensure is one example) or on the processes employed (evaluation by peer review bodies, for example), the DCE approach focuses the attention primarily on outcomes--the only matter of concern to the patient.

That the DCE system focuses on avoidable outcomes and maintains provider responsibility through experience rating suggests that it is not in fact a major departure from the fault system. Indeed it is not. It is a conceptually sound middle ground between a fault system and one that, like no-fault auto insurance, would exonerate providers from responsibility. It

differs from the fault system, however, in dispensing with a case-by-case determination of negligence and the specific attribution of provider fault. It would seem, in short, to offer the best of both worlds--wider compensation and better deterrence of poor practice.

Aside from the problem of designing a workable DCE list, the implementation problems seem relatively straightforward. Decisions regarding the level and character of compensation would have to be made. For example, should minimum or maximum payments for loss of wages be provided? Should any allowance by made for pain and suffering? More complex issues might be encountered in trying to align the details of the system with incentives that would appropriately influence provider behavior to promote the quality of care. An especially troublesome issue would be whether to allow patients compensated by collateral sources to enjoy a windfall so that incentives for avoiding DCE's would not be diluted. One suggestion is that collateral sources should be identified under the providers' insurance policy. Another feature that has been proposed is an obligation on the part of providers to disclose the occurrence of a DCE, discouraging coverups and ensuring that those who are injured receive compensation.

STATUS OF NO-FAULT RESEARCH

Under the sponsorship of the Robert Wood Johnson Foundation, research on no-fault medical injury compensation is currently

being conducted as a joint effort of the University of Texas Health Science Center at Houston and The Urban Institute. This project, "No-fault" for Medical Malpractice: Moving to the Third Generation of Development, is in the data collection phase. It represents the third generation of inquiry since it follows the first generation which was concerned with the conceptualizing of no-fault systems, and the second generation which focused on developing lists of designated compensable events (DCEs).

This project's third generation of activity is revisiting the development of compensable events in two new ways. First, it is comparing and contrasting information about medical injuries in medical records with subsequent information about the same incidents contained in closed insurance claims files (or incident reports). This inquiry is establishing to what extent medical records as currently maintained are useful for finding and categorizing injuries. It may be necessary to make modifications of the medical record so they can be useful in a new system of compensation and quality assurance. Some specific components of this part of the study include assessing the relationship between the hospital record and the insurance or risk-management record; determining the nature of systems in hospitals for early signalling of adverse outcomes; examining how decisions are made to settle claims and the characteristics of these claims; finding the extent to which injuries are discovered on later hospital admissions; and deciding the validity of current lists of DCEs, including expansion where medically advisable.

The second phase of the project involves an examination of a broad spectrum of medical records suspected to have or known to have quality problems or injuries. This research will determine the frequency distributions of various types of injuries and obtain detailed information on some of them. The basic inquiry in this second part of the project is the economic feasibility of no-fault and its place in overall quality assurance.

Essentially this project is addressing the two main criticisms of opponents of no-fault who insist that the concept cannot be made operational. First, the proposition that it is possible to separate out compensable injuries from ordinary and necessary risks of living and of necessarily non-omnipotent medical care is being tested. Second, the hypothesis that a no-fault alternative is in fact affordable, because the number of injuries involved--especially serious injuries--is not vastly greater than the number of current and projected malpractice claims and lawsuits (as is commonly believed), is being examined.

This project constitutes a major advance in feasibility testing of "no-fault" because it is the first to use both medical and insurance data, including national data on injuries, to address the two key issues and many sub-issues. The product will be a proposed no-fault feasibility report for at least some major areas of medical practice. The research will be completed by July, 1989.

designated compensable event system

a feasibility study

Sponsored by
the
Commission on Medical Professional Liability
of
the
American Bar Association

PART I*

A. Introduction

This is a report on a study of the feasibility of an innovative method for providing reparations to patients who have incurred medical treatment-related injuries. The system, which is known as the "designated compensable event" system, would provide prompt compensation for certain predefined occurrences without imposing on the patient the time-consuming task of instituting a tort liability claim and proving negligence on the part of the health care provider.

This study was conducted under the sponsorship of the American Bar Association Commission on Medical Professional Liability. It was carried out by retained consultants and was funded in large measure by the Department of Health, Education and Welfare pursuant to a contract (No. 282-76-0321) between DHEW and the ABA Fund for Public Education. Supplemental funding was received from the American Insurance Association and Blue Cross-Blue Shield of Greater New York.

The Commission's overall charge was to examine the causes of the crisis and seek to develop solutions both short and long term. The Commission decided early in its deliberations to investigate fundamentally different approaches to compensating injured patients as well as ways to make the present tort law system fairer and more efficient.

In considering fundamental ways to improve the medical professional liability system, the Commission decided that any system for compensating injured persons should ideally:

1. Encourage the prompt availability of remedial medical services to injured persons;
2. Compensate all persons deemed compensable under the mechanism;
3. Pay a victim of a compensable medical incident at least the net economic loss occasioned by the incident;
4. Provide for the prompt resolution of claims;
5. Charge a minimum of administrative costs (including attorneys' fees) and make a maximum amount available for the injured person;
6. Insure maximum predictability of outcome as an aid to planning by health care providers and insurers;
7. Discourage the bringing of baseless or contrived claims and provide for their prompt elimination if brought;

*An Appendix to the Report describes the composition and work of the Commission.

8. Contribute to the prevention of malpractice incidents by introducing incentives for improving health care and improving the supervision and discipline of health care personnel;
9. Distribute losses through insurance or otherwise in a way which does not leave an unfair burden on any segment of the health care systems; and
10. Disrupt to the least possible degree the relationships of trust and confidence between health care providers and patients.

To meet the need for a fair and reasonably permanent solution, the Commission explored a number of innovative alternatives. Among these were a plan to compensate patients for all medically-caused injuries which occur in a hospital, a workers' compensation type of mechanism providing scheduled benefits to patients injured as the result of negligence, and two proposals which would define specifically the circumstances under which compensation would be paid.

The Commission concluded that the most promising alternative of those considered is a designated compensable event (DCE) system which would predefine compensable outcomes according to established criteria. Such a DCE approach would largely but not solely predicate the payment of compensation on the conclusion of a respresentative group of clinicians that an injury probably would have been avoidable by adherence to accepted medical practice. Thus if a medical mishap resulting in injury is an occurrence which has been predefined, the patient would receive reparation without the necessity of bringing a tort liability claim and proving negligence. Mishaps not covered by the list of designated compensable events would remain under the tort liability system.

The Commission cited the following reasons in its 1977 Report for selecting the DCE approach for study (at pages 94-95):

1. The DCE approach offers a conceptually sound "middle ground" between retaining negligence as the basis for compensation and compensating all who are medically injured. It offers an opportunity to retain a general relationship between avoidable conduct and compensation while not restricting the system to a "fault" label or to a costly case-by-case determination of negligence.
2. DCE is a flexible tool. It permits a modest start on the enumeration of compensable events and the periodic expansion and updating of any such list. Such an incremental approach permits program costs to be taken into account in deciding whether to expand the number of covered events.
3. DCE offers the possibility of creating links between quality of care efforts, malpractice prevention, and compensation. The health care and tort systems now relate only in jarring, discordant ways. By predefining compensable events and by relating those events to general quality of care efforts (particularly in the hospital setting), a strong impetus can be given to prevention efforts.
4. DCE might improve the predictability of outcomes by setting forth in detail the outcomes which would give rise to compen-

sation. To the extent that predictability of outcomes increases, the practice of defensive medicine should decrease.

5. If the decision to compensate or not follows fairly automatically when there has been an injury, based upon enumerated outcomes, then transaction costs should be considerably reduced and claims closed out much more quickly than under the present system.

The study methodology consisted of five basic tasks. The first task was a data analysis of treatment-related injuries in order to develop lists of candidate compensable events, each to be identified by as many of the following variables as possible: frequency; degree of disability; amount of indemnity paid; expense; procedure involved; and medical specialty. The second task was to refine the criteria for determining DCEs and to select two medical specialties for intensive efforts to develop and validate DCE lists. The third task envisaged a review of available literature on the relative efficacy of particular treatments and procedures and attendant risks. The fourth task was to discuss, modify and augment the tentative DCE lists through review panels consisting principally of practicing physicians in the selected specialties. The fifth task was an analysis of the implementation of a DCE system in terms of elements of damages, benefit systems, dispute resolution mechanisms, pros and cons of statutory vis-a-vis voluntary systems and constitutional basis.

The Commission considered a number of ways of pursuing the study and finally decided that the most effective operational method would be to retain individual consultants with special expertise, rather than to assign the whole study to an independent research organization.

The two consultants who jointly undertook a major phase of the study (Part III of this Report) are Dr. John S. Boyden, Jr. and Dr. Laurence R. Tancredi. Each has both a medical and a law degree. Dr. Boyden is a practicing lawyer with the Salt Lake City firm of Boyden, Kennedy, Romney and Howard. Dr. Boyden prepared a report, "Medical Injuries Described in Hospital Patient Records," for the DHEW Secretary's Commission on Medical Malpractice (1973). A recent past president of the American College of Legal Medicine, he was one of three principal investigators in the Medical Insurance Feasibility Study (1977) jointly sponsored by the California Hospital Association and the California Medical Association.

Dr. Tancredi is on the faculties of the New York University Schools of Medicine and Law. He co-authored with Clark C. Havighurst, professor of law at Duke University School of Law, several pioneering articles on a reparations system similar to the DCE concept. Dr. Tancredi has served on a number of study groups concerned with the effect of medical professional liability on health care delivery.

It should be emphasized that Drs. Boyden and Tancredi had joint responsibility for the important work outlined in Part III of this report. Dr. Boyden had primary responsibility for the management of the data bases. Dr. Tancredi had primary responsibility for convening the two

panels of medical specialists and for preparing the tentative lists of DCEs.

The study also dealt in a preliminary way with a number of problems which must be addressed before a DCE system can be instituted. Among such issues are whether the system should be elective or compulsory; whether enabling legislation is required for an effective elective system; which elements of damages are to be included; how damages will be measured; how the risk of loss should be spread; what methods of dispute resolution should be employed; and what constitutional questions might be presented. Professor James A. Henderson, Jr., a professor of law at Boston University School of Law, was retained to carry out this phase of the study. In addition, at the request of the Commission, Professor Henderson considered the possible unintended use of designated compensable event lists outside a DCE system. See Part IV of the Report. The main part of Prof. Henderson's work is set forth in Part V where he outlines the problems which must be considered and alternative approaches. In Part VI Professor Henderson examines the constitutional issues which might arise under a DCE system.

"Historical Antecedents of the DCE Concept" set forth in Part II is also the work of Professor Henderson.

Part III refers to three data sources which were made available to the Commission. The Commission is deeply grateful to those who made these data sources available.

Utah Biomedical Test Laboratory of the University of Utah Research Institute was retained by the Commission to assemble the data and prepare various exhibits referred to in Part III.

The Commission is indebted to the general and orthopedic surgeons (listed in Part III) who volunteered to serve on the two panels. Their service on the panels should not be interpreted as indicating their personal views of the DCE concept.

The Commission expresses its appreciation to Ralph S. Martini, the DHEW project officer under the DHEW contract. His interest and support were most helpful. Dr. James K. Cooper, now a DHEW consultant and formerly a member of the Commission, also provided valuable assistance.

This study could not have been undertaken without a grant from the Department of Health, Education and Welfare. The Commission is also indebted to the American Insurance Association and to Blue Cross-Blue Shield of Greater New York for their financial contributions. Support from these sources should not be interpreted as an endorsement of the DCE concept.

B. Commission Commentary and Recommendations

The Commission believes that the work product of the consultants should stand on its own merits. The consultants were given complete

freedom in developing their views, and it is appropriate that this report directly express the findings and views of the respective consultants. The Commission believes, however, that it has a responsibility to state its views and highlight some of the issues.

1. Continued Development of the DCE Concept

It is the consensus of the Commission that the feasibility of developing lists of designated compensable events has been established by this study. The Commission recognizes that the study has not proved the feasibility of a DCE compensation system. This will only be established after a DCE-based compensation system has been constructed and tested. Nonetheless, the Commission is encouraged by the work which has been done and strongly recommends that those who are involved with medical professional liability—such as the organized bar, health care providers, consumers and insurers—proceed with the further work which must be done before a DCE system can be designed and tested.

The important point is that this study has shown that DCE lists can be developed from universes of treatment-related injuries. In fact, starting from the real world of treatment-related injuries appears to be the most practical and effective methodology for developing DCE lists.

Many informed observers predict that another crisis will occur in the near future. It may not be as severe and damaging as the 1975-76 crisis but it is likely to raise again the basic question of the present system's capacity to serve patients and health care providers in a fair and equitable manner. Now is the time to act, since it would be most unfortunate if no properly tested alternative were available at that time.

a. Tasks Which Must Be Accomplished

In general, a new compensation system must be *fully delineated* and *operationally tested* before it can be considered for permanent adoption, either as a voluntary or a mandatory system. A number of related tasks must be completed. The most significant of these are:

Comprehensive Definition of Compensable Events—Dr. Boyden and Dr. Tancredi point out* that it will be necessary to derive an economically significant series of procedures and outcomes. Therefore, a wider spectrum of events must be constructed not only from further work with medical specialties but also from a broader review of injuries which occur in hospitals, whether physician-caused or not.

Reparations—Options for the measurement and payment of compensation are extensively discussed by Professor Henderson**. Whether, for example, there should be recompense for "pain and suffering," or whether special damages should be issues in which adequacy of payment in the individual case must be balanced against cost considerations. The cost of a DCE system will reflect the reparations system selected. The

*See pages 31-32.

**See pages 61-69.

basic choices are: (i) the present tort system modified to let the DCE system determine in part who gets paid; (ii) a scheduled benefit system similar to a workers' compensation system but expanded to include persons with no earned income; and (iii) an expansion of health insurance to include loss of income and disability payments.

Whatever the costs turn out to be, they will ultimately be passed on to consumers through direct payments, health insurance and taxes.

The Commission recommended the wide use of periodic payments settlements and judgments in its 1977 Report and more recently endorsed in principle the Uniform Periodic Payments Act drafted by a committee of the National Conference of Commissioners on Uniform State Laws. Periodic payment concepts are discussed by Professor Henderson.*

Responsibility for Losses—Once an event is deemed compensable and issues of the measurement of compensation are settled, rules must be adopted to determine how the economic burden of compensating injured patients is to be allocated. There appear to be three ways to allocate losses:

—Responsibility for each compensable event could be pre-defined. Under this option, every compensable event would include a statement of primary responsibility which places the burden on the individual or institution which is in the best position to avoid a recurrence.

—Responsibility could be allocated after the fact among those who share responsibility for the medical care sequence during which the injury occurred. As a practical matter, this will usually involve allocating responsibility among one or more attending physicians and the hospital.

—The hospital could be designated as the responsible entity in all situations.

Risk Distribution Mechanisms—Whatever individual or institution the burden of loss is placed upon, there is need for a risk distribution system if socially necessary activity is not to be impeded or stopped along with undesirable activity. Thus, a prime planning task will be to design an insurance mechanism which strikes an appropriate balance between deterrence on the one hand and unacceptable losses on the other.

Dispute Resolution Mechanisms—Although a prime objective of a DCE system is to reduce time-consuming and costly arguments over entitlement to compensation, disputes will arise at a minimum over the applicability of a listed event to a specific occurrence and over damages. Unless responsibility for injuries is predetermined, there will also be a need for a mechanism to determine responsibility on a case-by-case basis. In fashioning a dispute resolution mechanism, primary emphasis should be given to assuring prompt payment of compensation to the injured patient. Once this is done, the allocation of responsibility for payments can be worked out among the health care providers.

Financial Feasibility—Only actual experience will accurately determine the cost of a DCE system. Nevertheless, once the parameters of

*See page 69.

one or more proposed systems have been determined, it is possible through actuarial and financial analysis to predict with some degree of accuracy the expected costs. Among the elements which would be taken into account in such a projection would be claims frequency (including assumptions as to increased claim activity due to simplification of the system), claim severity, and claims management and other administrative costs.

Pilot Testing—If a DCE system is to win approval on a permanent basis in any jurisdiction, it must first be proved in a realistic test (whether under actual operating conditions or on a prospective "pro forma" basis) so that its workability can be demonstrated and its costs measured. While the Commission agrees with Professor Henderson that a general elective DCE system should be buttressed by enabling legislation, it strongly urges that ways be found to test one or more systems by contract. The Commission agrees with Professor Henderson's conclusion* that the most desirable parties for the purposes of such pilot tests would be an organized group of patients (presumably with the aid of an authorized bargaining agent) and a Health Maintenance Organization (HMO) or a similar entity which provides medical services under contract.

b. Funding for the Development of a DCE System

The tasks summarized above are time-consuming and expensive. The Commission's working assumption has been that a minimum of three years and substantial funds will be required to complete development through a pilot test phase. There are three sources of the funds which will be required: (1) interest groups, especially organizations representing lawyers and health care providers and the insurance industry; (2) the Federal government, especially the Department of Health, Education and Welfare; and (3) major foundations. It would significantly increase the chances of success if substantial support could be drawn from each category.

c. Project Leadership

Any support of the magnitude described above requires that an organization, or a small consortium of organizations, take the lead. Indeed, a project of this sort usually involves the leadership of a small cadre of far-sighted persons who are in a position to influence organizations. In the Commission's judgment, leadership in this instance must come from one or more of the groups that are most concerned with medical malpractice issues; that is, organizations representing hospitals, physicians, lawyers and insurance companies. The Commission owes its existence to a statesman-like act of the American Bar Association's House of Delegates in 1975. The Commission strongly urges the American Bar Association to exert its leadership again to help form a task force to design an operating DCE system.

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*See pages 58-59.

2. Medical Injury Code

Dr. Boyden and Dr. Tancredi emphasize the difficulties encountered by claims specialists in trying to translate information in claims files about patient injury into the coding categories utilized by health care professionals for totally different purposes. They urge that a coding system be developed which is specifically oriented towards medical injuries. The Commission endorses this position and recommends that HEW work with the major medical organizations to explore the initiation of such a project.

3. Collateral Sources

The Commission notes the recommendation of Professor Henderson that sources of collateral benefits be reimbursed from DCE benefits. This treatment of collateral sources contrasts with the recommendation of the Commission that collateral sources be deducted from damages awarded to patients injured as the result of negligent medical treatments.* A windfall recovery, the Commission believes, runs counter to tort law, the purpose of which is to make the plaintiff whole. The Commission believes that the deduction of collateral sources and the negation of subrogation rights on the part of collateral sources are equally appropriate in a DCE system. If collateral sources were to be reimbursed by the DCE insurer, the Commission believes that the settlement process would become onerous and costly.

4. Experience Rating

Professor Henderson stresses the role of experience rating in a DCE system in order to provide incentives for high quality medical care. The Commission has recognized experience rating in certain situations but notes that actuaries believe experience rating cannot operate efficiently when rating individual doctors. On the other hand, experience rating can be applied to hospitals. If a DCE system were to be pilot tested in a group setting, conceivably experience rating would be appropriate.

C. Conclusion

The Commission reiterates its strong conviction that the DCE concept, on the basis of this study, warrants further exploration and development leading to pilot testing. Leadership in this regard must be provided by the major organizations representing health care providers, lawyers and insurers.

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*See pages 146-148, 1977 Report of the Commission.

Representative SCHEUER. Thank you. Now we will hear from Mr. Hoff.

STATEMENT OF JOHN S. HOFF, LEGAL COUNSEL, NATIONAL COUNCIL OF COMMUNITY HOSPITALS

Mr. HOFF. Thank you, Mr. Chairman. This panel has been cleverly put together. It seems to work in a nice progression.

PROPOSAL FOR RAPID AND FAIR COMPENSATION

Our proposal is to reduce the incidence of litigation to the maximum extent possible without going to a no-fault system, without attempting to define what is a compensable event.

The proposal that we advocate is based upon several fundamental premises. The first is that most people, in fact probably all plaintiffs, want to avoid bringing a tort case. They want to be compensated for their injuries and they want to be compensated fairly and quickly. They have no desire to engage in the hand-to-hand combat of tort litigation.

Neither do defendants have any such interest. And if both the plaintiffs and the defendants have a mutuality of interests, it ought to be possible in most cases to work it out so that they get what they both want. There is also a societal interest in avoiding the waste of resources spent on litigation.

Our proposal is simply to facilitate settlement by providing the plaintiff what he wants; namely, rapid and fair compensation. The proposal works very simply. If a defendant or a hospital or doctor who is not yet a defendant believes that an untoward event has occurred that might lead to tort liability, he is permitted but not required to make an offer, a commitment, to the patient, to pay that patient's net economic loss as it accrues over time. That gives the patient the compensation that he or she is looking for.

Once he makes that commitment, once the doctor or hospital makes that commitment, the patient would be precluded from bringing a tort case.

Representative SCHEUER. Does the doctor make that offer to the patient before the patient knows there is a designated compensable event?

Mr. HOFF. It is not tied to the DCE concept. It is made, it is required to be made before the patient even knows he has been injured in many cases.

Representative SCHEUER. That is what I am asking. It is before the patient has picked up the fact that has been grievously wounded or hurt or whatever.

Mr. HOFF. It provides an incentive for the physician and the hospital to find where they have made mistakes.

Representative SCHEUER. And to confess fast.

Mr. HOFF. Correct. Without using the word "confess," because you can make this offer without having to confess.

Representative SCHEUER. Right.

Mr. HOFF. There are some cases where you can't do that; namely, a birth injury which doesn't manifest itself for 17 years, or a misdiagnosis which may not manifest itself. But leaving out those exceptions, your characterization is correct.

Once that commitment has been made, the patient is precluded from bringing a tort case. Now, the patient loses nothing by not being able to bring a tort case, except the "right" in quotation marks, under existing law, to enter the lottery for recovery of large windfall noneconomic loss. That is what the patient gives up.

Representative SCHEUER. Punitive damages.

Mr. HOFF. Punitive damages and pain and suffering. So in exchange for an assurance of quick payment, he gives up a chance to go for a big hit which only a few get and much of which in any event goes to pay the legal fees of the lawyer who no longer is necessary if you have made a settlement offer.

That is the proposal. The hospital and physician would not be required to make the offer because it is not a no-fault system. It is tied to their concept of when fault might be proven.

The only down side, the only criticism, the only persons whose oxes are gored, are trial lawyers for obvious reasons and those few plaintiffs who have small economic injury and large noneconomic injury.

Representative SCHEUER. Large pain and suffering.

Mr. HOFF. A piano player who loses a hand——

Representative SCHEUER. Well, that is an economic injury.

Mr. HOFF [continuing]. Who is not a professional. A lawyer, who is a piano player, who loses a hand.

And that is the judgment the proposal raises: whether or not to save the litigation system for everybody, with its expense and trauma, to provide windfall recovery for a few. Is the litigation system worth continuing as a few people get something that one can opine they are not entitled to? Is it worth running the system to give them the right to make an effort in a few cases to win that recovery?

[The prepared statement of Mr. Hoff follows:]

PREPARED STATEMENT OF JOHN S. HOFF

My name is John Hoff. I appear today on behalf of my client the National Council of Community Hospitals (NCCH). Its members operate approximately 150 not-for-profit hospitals in 30 states around the country, providing approximately 40,000 acute-care beds.

NCCH and its members are committed to the development of new ideas to improve the efficiency and quality of the health care delivery and financing system. They have devoted particular attention to developing reforms to alleviate the malpractice crisis.

Hospitals are acutely concerned about this issue for two reasons. First, and most importantly, because they are dedicated to the well-being of their patients, they seek to prevent malpractice from occurring. At the same time, they face increasing costs when untoward events do occur in a hospital. A generation ago not-for-profit hospitals were immune from tort suits under the doctrine of charitable immunity. With that doctrine effectively eliminated, hospitals now pay for tort

recoveries and must purchase malpractice insurance. Suits and judgments have consistently increased. Premiums for malpractice insurance have continually increased. And hospitals increasingly have been forced to become self-insurers as the cost of insurance has escalated, and in many instances realistic coverage has become unavailable.

There are two components of the malpractice problem: reducing its occurrence and improving the system by which malpractice is identified and its victims compensated.

Hospitals are dedicated to quality care for their patients. That is their mission. As part of their effort to improve quality, they monitor and evaluate the professional competence and conduct of physicians performing services at the hospital.

Physicians practicing in hospitals are subject to more quality control than the members of perhaps any other profession. They are licensed by the state, and subject to review and discipline by medical societies. Most importantly, hospitals and their medical staffs review the qualifications of each physician seeking to provide services at the hospital through the credentialing process. By on-going peer review activities, they identify physicians with problems and educate and counsel them to improve their performance. Where that is not sufficient, the hospitals discipline the physician and where necessary bar him or

her from providing services at the hospital. This process is conducted by the volunteer activities of physicians on the medical staff and members of the boards of trustees of the hospital.

NCCH was a strong supporter of legislation passed by the Congress in 1986 known as the Health Care Quality Improvement Act of 1986 (Title IV of P.L. 99-660). This legislation is designed to strengthen the peer review process in two ways:

First, it provides a limited immunity to physicians, members of boards of trustees and others engaged in the peer review process against payment of damages to physicians who are disciplined. The Act will encourage physicians and members of boards of trustees to vigorously pursue their peer review responsibilities.

Second, the legislation provides for a national Data Bank of information about peer review actions taken with respect to physicians. At the present time a physician who is disciplined in one state can apply for privileges at a hospital in another state and that hospital does not have any systematic way of knowing about the adverse action that had been taken. When the Data Bank becomes operational (it currently is awaiting funding)

hospitals will be able to learn of adverse actions which have been taken against a physician anywhere in the country. This will enhance their peer review activities.

Despite strong peer review and despite the best efforts of physicians, nurses, and hospitals, however, there will be adverse results from medical intervention. Some of these bad events will be the result of malpractice. Many others will not. The fundamental question this Committee is dealing with is what system should be used to determine which patients will be compensated for an adverse outcome, and how much.

It is possible, of course, to have a program of social insurance by which everyone suffering an adverse outcome in the course of health care would be compensated, irrespective of whether the provider was at fault. This, however, would be a very expensive social insurance program.

On the premise that there is no support for the Federal Government's instituting such a massive social insurance scheme, the issue is which bad outcomes will be compensated. That is the role of the tort system: patients are supposed to be compensated when a provider causes the bad outcome by negligence or other wrongful act, and the tort system exists to determine in an individual case whether the requisite causation and fault have occurred.

There can be little doubt, however, that the current system is a disaster. It is a cumbersome, expensive, and inefficient method of determining and paying compensation. It is harmful to all who participate in it, and to society at large.

The system holds out the promise of very large recoveries, far in excess of real economic loss for a few plaintiffs, but denies fair payment for most victims. Plaintiffs can in some instances collect twice for the same damage -- from the tortfeasor and from collateral sources (insurance policies, the employer who pays wages, etc.). Recovery is allowed not only to compensate the injured patient for his economic loss, but also to pay him for his "pain and suffering," and various other theories of noneconomic loss, and to extract punitive damages from the defendant. These elements of damages are entirely subjective, and the amount of verdicts awarded is thus matters largely within the discretion of the jury. The emotional appeal of the plaintiff to the jury is a critical element in determining which patients recover, and how much they can recover.

Plaintiffs thus are encouraged to go for the big win. But in actuality very few collect on the promise. And those who do typically must litigate for five to seven years, a process which not only delays receipt of compensation but is often traumatic to the patient who must undergo it.

And the litigation process is expensive -- to plaintiffs, defendants, and to society as a whole.

Fear of large recoveries and attendant publicity forces physicians to engage in defensive medicine, which the American Medical Association estimates costs $15 billion a year in added physician costs alone, as well as subjecting patients to added risks and inconvenience.

The fear of malpractice and the cost of increased malpractice insurance premiums forces physicians to abandon high risk areas of practice. Access to care today is being adversely affected by the litigation system. Doctors who are sued can become depressive, impeding their ability to provide care.

The system, finally, is unacceptably expensive in straight financial terms.

Recovery depends upon proof of negligence -- a concept difficult to establish in as inexact an activity as medical care. Juries do not have personal experience in diagnosing disease or performing surgery. The reasonable man, therefore, must be guided by expert witnesses. The result is trial by phalanxes of experts who evaluate a physician's decision with the wisdom

provided by hindsight. And the ring masters of the process are the lawyers, who must be paid. The system operates mainly for the benefit of those who run it.

Most of the money spent for insurance to compensate victims goes to running the system rather than for paying compensation. There is one statistic that demonstrates the true nature of the system: of the average premium dollar spent on malpractice insurance a mere 28 cents goes to the plaintiff; only 12.5 cents goes to the plaintiff for economic damages not compensated by other sources.1/ Almost three-quarters of the money is used up in the cost of running the system; an additional 16% is spent on duplicate compensation and on compensation for noneconomic loss.

We are as a society spending vast amounts of money to fuel a non-productive system.

The traditional tort reforms make marginal changes in the litigation system. They shorten the statute of limitations; limit the fees lawyers can charge; change the collateral source rule, so that the plaintiff cannot be paid twice; change the forum in which the litigation occurs (by promoting arbitration); or cap the amount the plaintiff can recover.

1/ O'Connell, "An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries," 60 Minn. L. Rev. 501, 509 (1976).

These proposals only change the rules of litigation; they do little to reduce the amount of litigation. Caps on recovery, like price controls, obviously reduce pay-outs to some extent, but they do not avoid litigation except to the extent that a reduction in the lottery prize dissuades some litigants from suing.

Since most of the expense, trauma, and delay of the current system is the result of litigation itself, the better approach is to reduce the incidence of litigation as much as possible. The challenge is to create a mechanism by which victims are paid a fair amount quickly and without litigation but without abandoning the principle that patients should be compensated for untoward events only if the provider is at fault.

Working with Professor Jeffrey O'Connell of the University of Virginia Law School, former Congressman Henson Moore and Congressman Richard Gephardt developed a legislative proposal to reduce litigation and pay victims quickly and fairly.2/ NCCH supports that proposal. The proposal would work this way:

2/ This bill was introduced in the last Congress as the Medical Offer and Recovery Act, H.R. 3084. It was introduced as model legislation for the states to consider. It encourages states to develop their own mechanism for providing prompt payment without litigation. If a state does not do so, H.R. 3084 would become effective in that state for patients whose health care is financed by the Federal Governemnt.

If a patient is harmed, a hospital or physician could within a certain number of days make a commitment to pay the patient's net economic loss as it accrued over time. The deadline for making that commitment would not be tied to a claim from the patient but to the event. Providers therefore would have an incentive to discover and to inform patients of untoward events and not simply wait for a claim to occur. This benefits the individual patient and also fosters quality assurance mechanisms that benefit all patients. (For some incidents, such as misdiagnosis or birth injury, where the provider is likely not to know of the occurrence, the time to make a commitment would be triggered by a claim.)

The provider would not be required to make a commitment to pay economic loss (since this is not a scheme of social insurance), but if it decided to do so, the patient would be foreclosed from bringing a tort suit. Since the patient would receive compensation for economic loss, the foreclosure of tort suit would merely bar the plaintiff from seeking noneconomic damages (a large percentage of which in any event goes to pay the plaintiff's attorney for conducting the litigation that would be avoided by the provider's prompt commitment to pay economic loss).

Noneconomic loss is what it sounds like. It is economic injury: wage loss, the cost of medical care, the cost of fixing up the house or car to adapt to handicaps caused by the adverse outcome, psychiatric counseling, the wages of a housekeeper, etc., net of any collateral sources that may also be available to the patient for the loss.

The commitment is a formula; if the provider does not make a commitment that meets the statutory requirements, it does not qualify and does not bar a tort suit by the claimant.

Third parties (equipment manufacturers, drug manufacturers, other doctors) may be joined in a commitment. The participants would either agree on the relative participation or their share would be resolved in arbitration. Because it would be arbitrated among insurance companies or between participants who frequently deal with each other, settlements are likely to occur in most cases.

The proposal is premised on the fault principles of current tort law. A provider who did not believe it was at fault or did not believe that a jury would find that it was at fault would not have to make a commitment. However, if the provider wished to make a commitment, it could do so (depending on the terms of any insurance contract).

If the provider does not make a commitment to pay economic loss, the patient could demand arbitration (in lieu of litigation); the arbitration would be on the basis of fault with the recovery being the net economic loss the plaintiff would have received if the provider had made a commitment.

The proposal is based on a fundamental calculus: money now wasted on running the litigation system can better be used to compensate more victims fairly and quickly and to alleviate the insurance burden on providers. If litigation can be avoided and compensation limited to actual damages, enough money can be saved to permit more injured patients to be compensated and compensated more quickly for their real economic loss; the increase in malpractice premiums can be retarded; and the trauma of litigation can be substantially reduced.

The proposal in its initial form provides that the commitment to pay net economic loss bars litigation. The quid pro quo for the prompt assurance of payment is the plaintiff's foregoing the chance to participate in the lottery to recover non-economic loss (which may well be unsuccessful). There will be some cases in which a plaintiff has suffered serious injury, but little economic loss (for instance a lawyer who loses an arm or a recreational piano player who loses a hand). The proposal is premised on the assumption that although in a few cases a particular plaintiff may be denied the opportunity to seek (but

probably not successfully) noneconomic loss, this is justified by the benefit provided to the numerous other plaintiffs who receive economic compensation quickly and when they most need it and to society as a whole by reducing litigation and paying more claimants more quickly. If, however, a judgment were made that this is too stringent a result and that each plaintiff should be offered the opportunity to decide whether to accept or reject a provider's commitment of net economic loss in lieu of tort, this could be accommodated by the proposal.

Under current law -- which by hypothesis has proved to be unsatisfactory -- a plaintiff is free either to refuse or to accept an offer of settlement, or to negotiate different terms. If the proposal merely gave the plaintiff the same option, it would not improve upon existing law. If the patient is to be given the option to reject an offer of net economic loss, therefore, there must be incentives for him to accept such an offer that do not know exist. Otherwise no improvement will have been effected.

Such incentives could include, for instance, imposing a cap on recovery if the plaintiff turned down the offer, sued, and was successful. This would be fairer to the patient than the traditional cap on recovery, since the plaintiff would have had

the option to avoid litigation entirely and the cap would apply only after he or she had made a decision to reject prompt payment of economic loss.

Other adjustments to the tort system could also be used to encourage a claimant to accept an offer, if it is decided that there should be a choice. The details are not important here. What is important is that emphasis be put on developing measures to avoid litigation rather than merely changing the rules of litigation. It is by reducing litigation that the emotional and financial burden that is overwhelming all participants in the health care system can be lifted.

INCREASED COMPENSATION FROM LEGAL REFORM

Representative SCHEUER. Thank you, Mr. Hoff.

Mr. Metzloff, you mentioned that only 1 victim in 20 victims of malpractice actually recover under our current tort systems; right?

Mr. METZLOFF. Yes. Actually, my point is probably twofold, but——

Representative SCHEUER. Let me just ask a question based on that.

Mr. METZLOFF. Certainly.

Representative SCHEUER. If we went to one of these alternate dispute mechanisms, whether the type that Dr. Tancredi described or the kind that Mr. Hoff described just now where the doctor initiates some kind of process on his own, and let's say 80 or 90 percent of the people who suffer from a compensable event or medical practice, what have you, will the total cost of the malpractice in an alternative system go off the chart—80 or 90 percent recover rather than 20 percent recover, even though the actual recoveries may be much more modest and may only go to economic loss, not go to pain and suffering, not go to punitive damages, still in all, since four or five times the number of recoveries will be had, even if they average less, the total bill to society could be a lot more.

Now that might be a lot fairer. Rather than having a few extraordinary large recoveries, based on pain and suffering and punitive damages, maybe it is fair to compensate everybody according to their economic loss, but still one factor that you would have to consider would be that the bill to society could be significantly larger.

Mr. METZLOFF. I think there are a couple of responses to that. One is, yes, that may very well be true, and I think Dr. Tancredi should speak to that, because in a sense that is what his research is trying to analyze—the cost of moving to a system that would attempt to compensate all those who suffered some sort of an injury. My point is really twofold. We know there are more people who are injured through the malpractice of their doctors than whoever even get into the litigation system to begin with. There's a large gap there.

Representative SCHEUER. Well, there's five times as many.

Mr. METZLOFF. Yes. There are a lot of people who don't ever want to sue their doctor, some who cannot find an attorney—who don't know how to access the system. We also know that because of the cost of the system, many plaintiff's attorneys will not take a case unless the provable damages exceed $100,000. That is the ballpark figure that many plaintiff's attorneys give, and I believe that to be true. The cost of finding an expert is very high.

Representative SCHEUER. I've seen them advertise on television, attorneys for significant tort claims.

Mr. METZLOFF. Right. The $10,000 claim, where the plaintiff had to spend another week in the hospital is simply not economically feasible to pursue. I think the alternatives that I am discussing are really trying to deal with the larger cases that are costing that much more money, but certainly an argument that has been made is that if we ever got a system that really was efficient in terms of processing claims, we would see more claims and the overall cost

might increase. At this point, though, I believe the opportunity exists for improving the system, in terms of how it processes claims and realizing a cost reduction in terms of lowering the transaction costs. The overall impact of how efficient the system would become, or how many people would then decide to assert a claim is a very difficult question.

Representative SCHEUER. It would be fairer, would it not?

Mr. METZLOFF. I think it would be fairer. I have never been as troubled as some people who suggest, oh, it would be terrible. Lots of people would be compensated. I think that is what the system is supposed to do.

Representative SCHEUER. It wouldn't compensate people who didn't deserve being compensated.

Mr. METZLOFF. No. And it might reduce the compensation level of some of these big recoveries.

Representative SCHEUER. You could limit it to economic losses.

Mr. METZLOFF. You could.

Representative SCHEUER. So pain and suffering would be out of it and punitive damages would be out of it.

Mr. METZLOFF. I don't know—the pain and suffering issue is one that is difficult for me. I think sometimes that's a very appropriate type of damage.

Representative SCHEUER. It is appropriate, but it is awfully hard to quantify, and it is awfully hard to remove the exaggeration, a little bit of fraud, fraudulent misrepresentation. You know, life itself is a risk, and there are some things that the legal system—and no organized system of society can equalize. Some people are smarter than others. Some people are prettier than others, handsomer than others, more talented than others. There's no way that we can equalize this, and if somebody has an accident with a lot of pain and suffering, I'm just not sure that society can cope with that very well without a lot of abuse of the system.

Mr. METZLOFF. Yes. Of course, one of the advantages of alternative dispute resolution is that you can think of some decisionmaker other than the jury who only sees one case at a time. Instead, you could think about someone who could structure the decision on pain and suffering and perhaps make it more consistent over time, but I would agree with most of your comments.

Representative SCHEUER. Dr. Tancredi.

ADVANTAGE OF NO-FAULT COMPENSATION

Dr. TANCREDI. I would like to make a couple of comments. One is, a system of automatic compensation avoids to some extent some of the incredible amounts of money that now go into the legal expenses and administration of the present tort system, and also, I think one has to be aware of the fact that these costs are being absorbed somewhere; if somebody is injured, social costs are being absorbed maybe through disability insurance or third party payment or somehow——

Representative SCHEUER. The taxpayers are picking them up.

Dr. TANCREDI. Somebody is paying for this already, so the difference would be that a no-fault system might channel those expenses into a program that begins to create a kind of economic incentive

for the providers to improve their care and to actually do research to assure that——

Representative SCHEUER. Well, not only that, they would reduce a lot of the expense, the litigation expense, the pain and suffering recovery and the punitive damages recovery. So there would be some significant savings, particularly in administration and in the legal expense.

Dr. TANCREDI. Also the program that we had constructed on designated compensable events would allow for calibration. For example, one could conceive of taking the economically most prominent injuries that now occur, as we get statistical data and start to study those kinds of injuries and maybe allow those to be automatically compensated and then get a feeling as to how expensive, what kind of an impact that is having economically on the system, and if it is too expensive, then some of those events maybe will have to be removed and put back into the existing fault system. But it offers an opportunity to experiment with either large numbers or small numbers of DCE's in a way that you can begin to kind of test out the economic effects.

Representative SCHEUER. That acronym of yours, that is designated compensable events?

Dr. TANCREDI. I'm sorry, designated compensable events. And in addition now, our study with the Robert Wood Johnson Foundations is going to give us some information on this, once we delineate the listing of adverse outcomes and then begin to study the statistical frequency and get some sense of the cost impact of this by looking at a large—a national data base to sort of test out how frequent these outcomes are, so we can really get a feeling as to what would happen if a no-fault system went into effect. But we are—

Representative SCHEUER. If the no-fault system went into effect.

Dr. TANCREDI. Well, similar to this DCE program or something of that nature.

Representative SCHEUER. Yes. And you are going to have that information in about a year?

Dr. TANCREDI. Certainly, as a pilot study, as a preliminary data base.

Representative SCHEUER. Let me ask this. Why should consumers agree to a system that limits awards, eliminates pain and suffering, eliminates punitive damages, and in many cases only substitutes for payments they would have received in any event from disability, various disability policies, health insurance policies, in general? In other words, they would have received these from other insurance policies that they have. And I take it that pain and suffering and punitive damages might be included in the insurance policies. Why should they trade one for the other?

Dr. TANCREDI. Well, first of all, I don't know what percentage of people would have received some kind of compensation. I mean, there's a large number of uninsured individuals in this country, so it is hard to really assess what percentage of people actually are getting some compensation. But our system as constructed, would include medical care expenses and loss of wages, as well as some factor for pain and suffering.

Representative SCHEUER. And there would be certainty of recovery.

Dr. TANCREDI. There would be certainty of widespread compensation, prompter compensation.

Representative SCHEUER. Pardon?

Dr. TANCREDI. Prompter compensation. And it would also begin to, I think, start to ameliorate the real tensions that are occurring between providers, physicians, and the patients, which are coming to the detriment of both parties. Physicians are being affected by this, but so are patients, in terms of patient care.

Representative SCHEUER. Yes. The whole physician-patient relationship is threatened. It is coming under a lot of strain. Physicians and patients begin to view each other as a possible enemy rather than as colleagues in producing together a positive health outcome. And that is not good for society. That is awful.

DEFINING DESIGNATED COMPENSABLE EVENTS

Let me just come back to you. I just want to get this out for the record. Can you give us a laundry list of these designated compensable events? What are you talking about? How many of them are there?

Dr. TANCREDI. When we did the study, we did only two specialties: general surgery and orthopedic surgery, looking at the claims data from the NAIC study, the National Association for Insurance Commissioners, and then we came out with an agreed-upon listing. I think that in orthopedic surgery we came out with something like 15 or 16 adverse outcomes that were among the most economically prominent and prevalent outcomes that the doctors agreed they would conceive of these as being DCE's.

Representative SCHEUER. And that they were clearly definable and came along with a reasonable amount of frequency?

Dr. TANCREDI. And cost effects; right. And we came out with about 18, I think, is general surgery.

Representative SCHEUER. Give us a couple of examples.

Dr. TANCREDI. I will read some of them. In general surgery, obviously one that one would expect would be foreign bodies that are unintentionally left in an operation site. That would be the most egregious.

Representative SCHEUER. What kind of foreign bodies? A glove?

Dr. TANCREDI. A sponge or something like that.

Representative SCHEUER. Does that happen with any amount of frequency?

Dr. TANCREDI. It happens even in the best of circumstances where everybody thinks they are on top of it. It happens. Some of that may be—I mean it could even be unavoidable in some circumstances.

Representative SCHEUER. In what circumstances would something like that be unavoidable?

Dr. TANCREDI. Well, I would think it would not be unavoidable, but there are cases where, in the operating room, somebody has cut a sponge and then a half of it ended up inside. Yet when they did the counting of the sponge, it came out with the right count. And

the question as to who is responsible at that point was somewhat debatable.

Representative SCHEUER. It is hard to see how they wouldn't see a sponge visually before they closed up the wound.

Dr. TANCREDI. If you have an operation site where there is a lot of blood and a lot of debris, it might not be so easy, especially if you have a situation where there are tremendous structural problems with the patient from infection or other kinds of things. It is not inconceivable that that would happen. I would still consider that to be probably negligent because it should never have gotten in there, but for whatever reasons happened in the process.

But in any case, some other ones: we include serum hepatitis following blood transfusion as part of surgical procedure, removal of a wrong paired organ, complications of common duct surgery, immediate, early, and delayed complications. These were some of the kinds of listings that were included.

In general surgery and orthopedic surgery, it was agreed that nerve injury following orthopedic procedures, like peripheral nerve impairment, motor nerve impairment, is considered to be highly avoidable, even though in any one case it may not have been avoidable. We are looking at this statistically. We are saying relative avoidability as a statistical concept.

ENCOURAGE PHYSICIAN ADMISSION OF MALPRACTICE

Representative SCHEUER. Mr. Hoff, under the system you described, where a doctor would initiate an offer for some type of recovery, isn't it quite possible that he or she might do that when there was an egregious example of negligence with an identifiable, quantifiable, negative result and that they would make the offer in those cases where they were likely to be caught up in a tort action anyway, and leave the smaller cases or the fuzzier cases to the tort system, so you might have the result that in the most serious cases, they get a limited judgment, with no punitive damages and no pain and suffering, but with some degree of predictability, but some of the people who suffered lesser injuries, if they went through the tort system, they might get far larger recoveries?

Is that an anomalous situation that we ought to worry about?

Mr. HOFF. I think that to make sure it is not too expensive, they and the insurance companies will not dish out the dollars to an extent that it would be more than the present system.

Of course, the incentive would be to do it in the "worst cases" where the plaintiff obtains most benefits by getting the offer. In the worst cases, you don't want to make the plaintiff wait for 7 years of litigation to be compensated. In the worst cases where the offer is made, the plaintiff gets his or her money immediately, or at least the assurance of the money immediately. More importantly, they will also make the commitment in the marginal cases. I think that where they think that they are not going to be found liable, they will not make an offer, and that is part of basing the system on the present notions of fault, and we don't want them to make offers in those cases, or we are just spitting out money——

Representative SCHEUER. Where there isn't fault.

Mr. HOFF. Where they believe that there isn't fault or where they believe the jury isn't going to find fault.

Representative SCHEUER. Right.

IDENTIFYING SUBSTANTIAL HEALTH PROVIDERS

All right. Now we have been addressing mostly recovery, compensation of victims. How about an equally important goal, surely, from society's point of view, of identifying doctors and hospitals that deliver grossly inadequate, negligent, incompetent health care? Which combinations of factors have we been talking about, which system will more readily identify for society those folks who probably shouldn't be delivering health care and those institutions that probably shouldn't be delivering health care, at least without retraining, reeducation, attempts to rehabilitate doctors who are mentally impaired, drug addicted, alcoholic, and so forth?

Mr. HOFF. Could I respond to that question?

Representative SCHEUER. Please do.

Mr. HOFF. All of the proposals would do better than the present system in reaching that result.

Representative SCHEUER. In identifying substandard health providers.

Mr. HOFF. Depending on how you use the system. How you used the systems that we are talking about. Any of them can be data-collecting or data-creating devices. In our solution, for instance, if any physician made an offer, that offer could go to the licensing board or to the hospital peer review committee for further examination of the physician's competence. The DCE, any physician who invoked DCE and made a payment under DCE would be triggered, would be identified, if not triggered.

Representative SCHEUER. Yes, Dr. Tancredi.

Dr. TANCREDI. I have a sense that a DCE approach, because it is more of a systematic approach, and if, in fact, these events were constructed by specialists through their medical societies would be applicable to all people who are practicing general surgery, gives you some kind of an epidemiological basis to do some comparisons among various provider groups, treatment groups, hospitals and doctors.

As I understand Mr. Hoff's proposal, it is more individualized. It is based on what that person feels about that specific outcome in that specific circumstance, and consequently, isn't quite as potentially generalizable as a system to really look at a whole range of providers and situations.

Representative SCHEUER. I suppose that even under Mr. Hoff's situation, the doctor would have to identify what he thinks is a probable medical flaw, fault, whatever. In the kind of generic list that you have, if it is orthopedic surgery, you would have to pick one of your 16 problem areas and say it was this. Wouldn't you need to identify what went wrong?

Dr. TANCREDI. I don't know. I'll defer to him on that.

Mr. HOFF. Well, you have an orthopedic surgery and something goes wrong, and it may not—it may fit within 1 of the 16 or it may not fit within 1 of the 16. It may be one of those more rare occur-

rences that the great arbitrators have not decided should be a DCE. He would then make a judgment as to whether he thinks something occurred that might appear to be fault, and he would then make the offer. You've than got an identifying event that somebody else can look and see whether, in fact, fault did occur in a noncompensatory proceeding.

NEED UNIFORM DATA ON QUALITY OF CARE

Representative SCHEUER. Yes. Well, one would certainly hope that no matter what system was picked of the alternatives that you have described very ably and very interestingly, that at least we would have uniform recordkeeping and uniform identification of what these DCE's are, so that we would have some national standards, we would know which health care providers seem to be having higher error rates on these particular DCE's. Is this a regional problem; is it a problem between tertiary hospitals, little 300-bed community hospitals? You would want to have a data base where you could, as I said before, compare apples with apples and oranges with oranges.

Wouldn't that be desirable under any system that you pick out, of identifying DCE's, by whatever name?

Mr. HOFF. Yes, but you have to remember that you're not always dealing with apples and apples, that patients differ, and that you may be much more likely to have a DCE-3—we are going from DRG's to DCE's—may be more likely to have a DCE-3, if you are a very sick patient who also has diabetes. And it is often the case that the specialist ends up with the trouble.

Representative SCHEUER. Yes. Patients who have diabetes are not very hopeful candidates for surgery involving loss of blood.

Mr. HOFF. There are all sorts of other complicating factors that go into any surgery, including age, but also, just the severity of the particular illness that you are dealing with.

Representative SCHEUER. Yes.

Mr. HOFF. And that is why some of the best physicians and some of the specialists are often the most sued.

Representative SCHEUER. Often the most what?

Mr. HOFF. Sued.

Representative SCHEUER. Sued; sure. I suppose that a surgeon that takes on high-risk neurosurgery or high-risk obstetrical cases runs a very high-risk legal life, in addition to the high-risk medical life.

I happen to have a relative, a cousin, who was born and lives in Strasbourg, where my ancestors come from, and she is a specialist in obstetrics. She only consults on problem cases. She doesn't have any practice of her own. She only consults with doctors and hospitals that have really significant problem cases, and she travels around all over France and Germany too, just dealing with real problem cases. Well, in our country, that kind of a practice would be almost impossible to conceive of an obstetrician or of a gynecologist carrying out the kind of practice. The insurance factor would absolutely be prohibitive, if a person specialized in nothing but very high risk cases. You couldn't conceive of that kind of a practice in this country.

PROVIDING CONSUMER INFORMATION

Mr. METZLOFF. I think it makes a point of publicizing malpractice cases to consumers, because an individual who has experienced a claim and has a judgment against him or her may or may not be worthy of any moral blame. I think this is where the medical profession has some real concerns, because I have heard you ask that question several times: How do we tie together the disciplinary system with a system to help consumers? And I think it is a tremendous challenge to think about it. As I look at it from the malpractice standpoint——

Representative SCHEUER. How do you produce the data that comes out of the disciplinary system, and how do you massage it, so that it is fair to the providers, intelligible to consumers, and then propagate it and distribute it in such a way that it is conveniently available to consumers?

Mr. METZLOFF. I think it is very difficult, because when you take an individual malpractice claim, you may very well have a doctor who made a mistake on that day and is appropriately found negligent. You know, the doctors always refer to that as being found guilty, which, of course, it is not. It simply means that you made a mistake on that day. I am not sure that until you have three, four, or five of those over a career that the doctor deserves any adverse publicity among the consumers.

Representative SCHEUER. I am inclined to agree with you. If there isn't a systematic showing——

Mr. METZLOFF. A way of thinking about it, right.

Representative SCHEUER [continuing]. That this happened time and time and time again. If this guy was just a deliverer of high-risk health services, I don't think you would want to pin a practicing physician to the wall for one untoward effect.

Mr. METZLOFF. I think that is right. And some of the proposals are moving toward doing that.

Mr. HOFF. There is new legislation which requires reporting of every payment made in settlement of a malpractice claim of any amount and any adverse peer review action taken against a physician, reporting to a national data bank, which information will then be available to hospitals, medical societies, and others to engage in peer review, but presumably, not the public, in order to have that evaluative process that you are mentioning.

Representative SCHEUER. Yes, That is a tough one. I have the feeling that we have erred too long in sort of looking at the medical fraternity as a medieval guild with a mystique all of its own and exaggerated ideas of privacy. This is the year of 1988, and I think the time has come where there is a feeling abroad that patients have a right to know about facts and histories that are of legitimate concern to them in selecting a health provider, doctor or hospital.

Now if a guy has been in practice for 20 years, and he has one untoward event—and I suppose it could happen to anybody, even Congressmen. And I suppose that is a tough question, as to whether you would want to make available to the public one unfortunate medical happening and whether it is fair to blemish a long and successful and presumably professionally competent career. Once it

got beyond one and I suppose you need the wisdom of a Solomon to make these decisions, I would err on the part of making it public and also assure the practitioner that he would have the right to append to the statement of the case, whatever explanation was there, whatever ameliorating circumstance were present, the statement he had done 1,735 of these operations and this is the first time there was ever an untoward event. But I think, certainly, after one, it probably should become public, but this is really an area in which people far wiser than I have to grapple with what the public's right to know really should be.

We have a Government agency called NHTSA, the National Highway Traffic Safety Agency, that is really mainly involved in testing cars and making public information about cars, and we have the Consumer Product Safety Commission, devoted entirely to testing all kinds of consumer products, from hair dryers to television sets to toys, to God knows what, and publicizing that for the benefit of consumers. And this goes on and on and on in society for the principle that people have the right to know about the things that affect their lives. And if we do it for these sort of inconsequential consumer purchases, why can't we do it for the doctor that is going to put a knife to them, a scalpel to them and to the hospitals that are going to be in charge of their health for a period in time when they are very vulnerable, where they are very subject to nosocomial infections, and they are defenseless, and their defenses are down emotionally, physicially, in every way.

It seems to me that this is an idea whose time has come, and I think that it is probably overdue for the best minds in the medical community to be putting together plans and systems to make that system available to consumers. The barely rebuttable presumption—you who are lawyers know what I am talking about—should be to make it available. It can be rebutted in specific limited circumstances, where the balance should be tipped toward privacy, but the assumption should be, a fairly rebuttable presumption should be, it is public, the future patient, the putative patient has a right to know.

I hope that the medical community will begin the function with that assumption and devise ways that do protect the honest practitioner, do protect perhaps the chap who had one untoward medical happening in a perfectly creditable career, but also have as its main goal giving health consumers the information they need to make those tremedously important decisions.

Mr. Bovbjerg, I know you have been waiting to speak.

Mr. BOVBJERG. I wanted to point out, Congressman, how your two concerns interrelated. One was, if we went to some alternative system of whatever type, would there not be a lot more cases, and would that be affordable? And the other is, how about deterrents in finding these things? I think that, in fact, one of the things we need more than anything, for the purpose of finding, not just bad practitioners, but bad practice or problematic procedures or whatever, is a lot more cases through the system, whatever the system is, as long as we are dealing with something that is like 1 in 20, 100, whatever number you like, of not finding very many of these, you are going to have a system that is perceived as somewhat

random, somewhat of a lottery, and therefore, there would be a lot of resistance to what you are proposing.

If you go to a system which deemphasizes a lot of the tensions, a lot of the big dollar, a lot of the all or nothing, and you run a lot more of those through the system, you won't have the same types of problems that you identified, be able to find a lot more of these problem physicians, problem practices, problem days of the week. Who knows what you might find?

Representative SCHEUER. Any other thoughts?

[No response.]

Representative SCHEUER. Well, it is almost 5:30. We've all had a long day. You have been very, very patient. Your testimony has been extremely helpful, very thoughtful, and we thank you very much. I thank you again for your great contribution. The hearing is adjourned.

[Whereupon, at 5:20 p.m., the subcommittee adjourned, subject to the call of the Chair.]

THE FUTURE OF HEALTH CARE IN AMERICA

THURSDAY, JUNE 23, 1988

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON EDUCATION AND HEALTH
OF THE JOINT ECONOMIC COMMITTEE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2359, Rayburn House Office Building, Hon. James H. Scheuer (chairman of the subcommittee) presiding.

Present: Representative Scheuer.

Also present: David Podoff and Dayna Hutchings, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE SCHEUER, CHAIRMAN

Representative SCHEUER. Today's hearing is the ninth and final hearing in this series of hearings on "The Future of Health Care in America."

We have a remarkably talented list of experts who are going to review a broad range of important health care issues that will conclude our set of hearings on America's future health care system.

Today, we'll hope that the witnesses will put into sharper focus some of the things we've learned during the 2 months of hearings of this subcommittee. And with the aid of the distinguished and experienced group of witnesses, we will peer into the future and see how we can use what we know about our current health care system as a means of promoting a more effective, more rationalized, more compassionate, more caring and more egalitarian and fair health care system in the 21st century.

Before turning to our witnesses, let me review what we've learned in this truly remarkable set of hearings.

In the past 2 months, we've heard testimony from about 70 witnesses representing a broad spectrum of professionals including physicians and lawyers, demographers, economists, ethicists, psychologists, sociologists, and other professionals in the health care system.

And several themes seem to be repeated consistently throughout our deliberations.

First, numerous witnesses, starting out with former Secretary of Health, Education, and Welfare, Joe Califano, noted that the United States spends 50 percent more of its GNP in health care compared to the average of the OECD countries, the developed countries of Western Europe, Japan, Australia, New Zealand, Canada, and the like. We're at 12 percent. OECD averages about 8

percent. Yet none of the witnesses testified that we have 50 percent better health outcomes than the OECD countries, or indeed any percent better outcomes.

Some witnesses like Secretary Califano and Professor Uwe Reinhardt of Princeton University indicated that perhaps 20 to 25 percent of our total health care bill of about $500 billion—$125 billion—was wasted for an extraordinarily chaotic and disorganized health care system that was full of duplications, overlappings, on the one hand, and gaps and vacuums on the other hand. A high administrative overhead and a vast degree of unnecessary procedures, unnecessary surgery that not only added to our health care bill, but added to patient discomfort and poor health outcomes.

Other representatives like the American Medical Association and the American Hospital Association, attempted to explain those expenditures by noting that we have a very diverse and pluralistic health care system that offers many choices to health care consumers and it is worth the price tag.

Whether it is worth $125 billion is a very arguable point.

Nobody mentioned that our health care system is 50 percent better or produces health outcomes 50 percent better than our fellow developed countries of Europe and the rest of the world which seems to get along with a vastly lower percentage of GNP applied to health.

There also are a number of anomalies in our health care system.

How come the United States, which developed the production line 50 or 60 years ago, and that over the generations has the most rationalized industry in the world, has such a chaotic and disorganized and cost ineffective, irrational health care system?

How come in a country that's worried about galloping escalation of health care costs that are going up at twice the rate of the consumer price index, we spend so much on developing new procedures, new surgery, new products at the cutting edge of high technology, but we spend so little on teaching ourselves that we have met the enemy and he is us, that we are in charge of our health outcomes and that when we get control of our malbehavior, of consumption of alcohol, consumption of tobacco, consumption of drugs, poor diet, lack of exercise, obesity, when we get control of our behavior, we'll have a vast increase in health outcomes and a vast reduction of hundreds of billions of dollars.

We have 350,000 deaths a year from cigarette consumption, at a total cost to the public of about $65 billion. No person has been more eloquent and articulate on this matter than the Surgeon General, who is going to be our first witness.

Yet, what have we done in this country in terms of organized public education programs on preventive health to get people to stop smoking, to get people to stop indulging in alcohol to excess, to reduce the 125,000 deaths that we have every year from alcohol, to reduce the toll, the terrible price our country is paying for drug addiction, not only in dollars but in urban destabilization, almost to the point of disintegration.

How come we have such a predilection on spending our dollars in high-tech development of new products and new procedures, but we don't have any reimbursement for doctors who simply want to counsel patients?

How come we have such a predilection for high tech but yet there are 37 million people who are falling through the cracks in our country and have no regular organized access to the health care system?

How come we're so concerned with high tech, and I think we should be, that we provide all kinds of open-heart surgery and sophisticated devices and treatments and systems for the elderly, but when it comes time for them to recuperate and they need long-term care, we have no way of giving them long-term care unless they spend themselves down to insolvency.

Well, these are just some of the anomalies in our health care system that I hope we will address.

Dr. Koop wrote in his prepared statement that the American people are getting mad at some of the outrages of personal behavior in health that are costing them so dearly. And he's right. How come we have done so little to provide both incentives to good personal behavior as far as health is concerned, and disincentives to carrying on these harmful patterns of personal behavior that Dr. Koop has so eloquently described and which he accurately described as a phenomenon that's making the American people mad?

Let's now turn to our first witness, Dr. Everett Koop, the Surgeon General of the United States.

I felt like apologizing to Dr. Koop because, with his very busy schedule and his being tugged and hauled in so many directions, there was some question on his part and his staff's part as to whether he ought to testify here this morning. I badgered him unmercifully and unabashedly. I felt a little bit ashamed at having done that, although I was very happy he consented to appear. But when I read his prepared statement last night, I realized how right I was, and I now have no sense of shame at having badgered you and prodded you.

Dr. Koop, your prepared statement was so excellent, so remarkable in its wise, avuncular quality. I felt I was being lectured by the famous artist who did the Saturday Evening Post covers and that I was being lectured by a wise, avuncular family physician on the wisdom and the verities of health care, of health behavior.

So I welcome you, Dr. Koop. There were some among us when you became Surgeon General some years ago who had some reservations about some of your views, some of your positions. But I must say that over the years, you have transcended all of those hesitations that some of us had and you have established yourself as a Surgeon General who is larger than life, who is everything to everybody.

You embody and inculcate in your courage and your forthrightness and in the direct and simple, understandable way in which you've expressed yourself on such a wide variety of sensitive issues so constructively, such persuasiveness, that you will go down in the history books as one of the giants of American medicine in this century.

I don't think I'm engaging in hyperbole and exaggeration. Such is the extraordinary order of magnitude, of credibility and respect and affection in which you are held by the entire spectrum of public officials and citizens, from liberal to conservative.

The view is unanimous on the remarkable quality of the service you have rendered and the leadership that you have rendered.

And I'm very happy and very proud that you should have found time in your schedule to appear before us today.

So, at this point, why don't I give you such time, as you may need, and suggest to you that your prepared statement will be printed in full in the record and hopefully, you'll chat with us informally and then I'm sure we'll have some questions for you.

STATEMENT OF C. EVERETT KOOP, M.D., SURGEON GENERAL, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. KOOP. Thank you very much, sir. I do appreciate those kind words.

I hope you realize that after such an embarrassing introduction, it's hard to perform as well as one might. But I will proceed with my remarks. And knowing that you've had so much good advice and will be hearing from excellent witnesses today, I would like to touch on three overarching issues in my prepared statement and then answer questions for the remainder of my time.

TECHNOLOGY'S ROLE IN HEALTH CARE

The first issue that I want to raise and to which you have already referred, is the future relationship between technology and health care to which you have already referred. Technology has had a very pervasive influence so far, but will it always be so? For many years, we've assumed that the health status of our people would constantly improve as long as we continued to push against the frontiers of biomedical technology. The American people have supported that assumption in a way that counts; that is, through taxes and through donations willingly given.

However, in recent years, I've begun to detect a countertrend in which the public, and even some members of the medical profession itself, question the high cost and limited results of new medical technologies.

There is, for example, a lively public debate over the use of so-called extraordinary measures to save or prolong the lives of the terminally ill. I have been involved in that debate for many years, both before and since becoming Surgeon General.

Recently, much public sentiment has been raised against the use of such measures. I wouldn't say that most people feel this way, but certainly a substantial and vocal minority does not want their physicians to prolong their lives if there is any chance at all that the kind of life being prolonged will be qualitatively less than the life that they have known.

In other words, while the American people welcome the expectation of longer life, they don't want longevity at any cost and they see technology, in a sense, perpetrating longevity upon a dubious and, at times, even unwilling public.

In other areas, there is also growing skepticism as to the adequacy of technology to solve the major contemporary health problems of our people. In fact, the keystone of public health for the past decade, and certainly for the future as well, has been the idea that

each person makes the key decisions day by day that affect his or her own health. Decisions, for example, which you've already alluded to—eat sensibly and exercise regularly, stop smoking and stop using dangerous drugs, ensure that one's workplace is safe and healthful, and live at home and at play in a manner that will enhance and not imperil one's health status.

In fact, as more and more people make and benefit from these kinds of personal decisions, I think we may find that fewer and fewer people will retain such complete and uncritical faith in high-tech medicine, as was the case, say, in the 1950's and 1960's.

Also, the new technologies tend to respond to conditions that are rare in the patient population or they require the kind of difficult ethical and moral choices that most people would rather not have to make.

For example, I would not minimize the significance of the esoteric technologies that reverse infertility. However, the popular preferences for dealing with this medical problem still seem to be adoption, routine drug therapies, and resignation.

During the years when technology was considered the sine qua non of medical practice, the pressures of the marketplace tended to skew support for research away from the basic sciences and toward research applications and product development. This is clear from the annual reports of the National Science Foundation for the past two decades.

But what if, as I've indicated, that market pressure begins to ease? Then we might see basic research successfully compete for more resources, more bench scientists, additional academic facilities, and more Government and private funds as well.

Concurrently, I believe we will also see an increasingly important role for the field of so-called low-tech applications to health care and health administration.

In one of his plays, George Bernard Shaw asked why we pay doctors to take a leg off, but we don't pay them to keep a leg on. Now, almost 80 years have passed and we still haven't come up with a good answer. In fact, our technology-driven reimbursement system, whether that of the Government or out of pocket, is predicated on taking the leg off.

That's today. But I do not think the system will remain that way tomorrow because of the shift in the public's own perception of what it really needs. I think we're beginning to hear the public say that it needs and wants the kind of hardware and systems that promote healthful living or that help older people and people with disabilities or chronic illnesses to live safely, healthfully, and independently in their own homes.

I think we should try to understand how and why that may be happening and what it could mean for the future of biomedical research and for health care in general.

RELATIONSHIP BETWEEN PUBLIC AND HEALTH SYSTEM

The second issue I'd like to discuss is the changing relationship between the public and the health care system. Many factors are bringing about this change. One is the increased mobility of the American people. This phenomenon makes it less likely that the

average patient will be known and served by the same physician and same hospital staff for a lifetime. Yet, that had been our norm for almost three centuries.

Another factor is the rise in prepaid practices of one kind or another. These, while more cost efficient, also tend to automize patient care. I'm not saying the change is either good or bad. I'm saying it's different and the difference is significant for the long-term relationship between health care and the public.

The third factor is the well-advertised and well-discussed shift in the demography of our country, the so-called graying of America. Already, the specialty of geriatrics is responding to newly recognized health needs of the aged. This specialty now joins two others, pediatrics and family medicine, to divide primary care and, again, change all of our traditional ideas about the continuity of care.

I'm afraid that many of the assumptions upon which we base much of our health planning and financing may still reflect a patient-to-system relationship that for many individuals and many institutions no longer exists.

Let me illustrate this with a little anecdote. Last winter, I convened the Surgeon General's workshop on self-help. My purpose was to gain a better sense of what was going on in this new area and what the Federal Government's role might be, if any. I discovered that an estimated 15 million Americans are involved in the self-help movement, that they represent all social, racial, ethnic, geographic, and economic groups, and that they are fiercely independent.

I also discovered that they are providing leadership in three health areas in which traditional medicine and public health are still searching for meaningful roles. These are health promotion, disease prevention, and the counseling function called cognitive medicine by some physicians.

The self-help movement embraces Alcoholics Anonymous and a number of allied organizations, smoking cessation groups and programs, and counseling and treatment groups for drug addicts. There's also an ever-expanding assortment of support groups for persons with family, personality, sexuality, or infectious disease problems. For persons who've just kicked a habit of some kind, or persons returning home after a major health ordeal, such as a heart attack, cancer treatment, a stroke, and so on.

You'll note, Mr. Chairman, that these diseases and disorders are among the most serious public health problems we face today—substance abuse, including cigarettes, the epidemics of sexually transmitted diseases (STD's) and acquired immune deficiency syndrome (AIDS), and the three persistent major killers of our people—heart disease, cancer, and stroke.

Traditional fee-for-service medicine or tax-supported public health programs generally do not respond to the intensely personal aspects of these perceived health problems. Also, since the individual decides when such assistance is no longer needed, there is no generally recognized end point. Therefore, there is no specific point at which expenditures must end or reimbursement must begin.

I honestly marvel at the extraordinary degree to which average Americans are engaged in these do-it-yourself health programs and also the degree to which they are truly helped by them. My only

concern, and it's a major one, is that some people who need the help of experts with medical training, aren't getting it or are avoiding it. Thus their health, and possibly their lives, may be in peril as a consequence.

I would like to see more physicians, nurses, and allied health professionals become involved in what is now called self-help or do-it-yourself health care. My instincts tell me it would be very useful if this kind of partnership did develop.

But whether traditional medicine and the public health sectors do or do not get involved, I believe this movement will continue to grow and become not merely an alternative system of health care, but, in fact, our other national system of health maintenance, health promotion, and disease and disability prevention.

HEALTH COMMUNITY VALUES

That leads me to the third and final issue I want to touch on this morning, Mr. Chairman. It's the related issue of community health values and public support.

I mention it because in the course of my involvement with the AIDS epidemic, I have seen the outlines of this issue already forming. Also, it is a kind of corollary of the issues I've discussed so far.

Let me begin by saying that the American people are generous to a fault. Through taxes and through personal out-of-pocket donations, they do want to help everyone in our society achieve good health and the good life that comes with good health.

But they also can become impatient. For example, most Americans disapprove of smoking and would like to see all smokers stop. And through the self-help movement, many smokers are indeed quitting the habit. But it's happening very slowly.

Hence, the nonsmoking public is asking for new and stronger State and local laws to curb cigarette smoking in the workplace and in all public, governmental, and commercial buildings.

Most health and life insurance companies now have a separate and higher premium for smokers based on the theory that a person who smokes ought to pay a larger share for the consequences of that unhealthy behavior.

New laws, higher premiums, and segregation at the worksite are examples of public retribution directed against smokers. It is being exercised against others as well—drunk drivers, drug addicts, promiscuous and pregnant teenagers, and others who are perceived as deviating from the community standard of normative behavior.

But the American people are still very generous and very forgiving and they do honestly believe in and will continue to support public health programs that promise redemption.

But they are not pushovers, either. It is possible that the American people, already traveling the road of retribution, may begin to exercise their retributive powers more and more. The object will continue to be the individual who willfully behaves in a high-risk manner—alcoholics, drug addicts, cigarette smokers, sexually promiscuous people of all ages, dangerous drivers, wifebeaters, childbeaters, and others.

At the top of that list right now is the person with AIDS, someone who contracted that lingering, but fatal, disease through what

the community regards as an unsavory act, sodomy or intravenous drug abuse. It is possible that a reaction of retribution toward people with AIDS may come about in the 1990's when the annual cost of AIDS-related research and patient care are expected to reach and then exceed $5 billion.

The 1990's is also that point in time when new cases of AIDS will be reported among people who most likely became infected sometime after, and maybe long after, the human immunodeficiency virus, or HIV, was identified and the nationwide AIDS prevention program was well underway.

Such a public response would be a tragic development, but not unexpected. It would be consistent with the other retributive trends I mentioned earlier.

Our challenge, then, would be to recognize, if and when it comes, this reaction by the general public against high-risk individuals and try to channel it into some more positive, more tolerant responses.

At stake is the very basis of the American approach to public health itself; that is, the majority of the American people who live their lives in a generally healthful, low-risk manner have been willing to support, sometimes enthusiastically and sometimes grudgingly, the services that take care of the minority of people who live in a generally unhealthy and high-risk manner.

In many respects, this is the most important issue of all. We know that health care costs are taking a larger and larger share of the gross national product. It stands to reason, then, that more and more Americans will begin to look with greater critical interest not only at our system of health care, but also at the people directly benefiting from that system.

That could be a very welcome development because it is rooted in our system of participatory democracy. But it could also be a painful development for many of our citizens and we ought to be prepared to deal with that.

Let me close, then, Mr. Chairman, by saying that I anticipate certain major changes in American health care over the next several decades. Some will be easier to experience than others. But, on balance, I see them as contributing to a stronger, more responsive, more contemporary system of health care for the next generation and for succeeding generations of Americans.

Thank you, sir, and I will be glad to answer your questions.

[The prepared statement of Dr. Koop follows:]

PREPARED STATEMENT OF C. EVERETT KOOP, M.D.

THANK YOU, MR. CHAIRMAN.

I AM PLEASED TO JOIN YOU THIS MORNING AND TO CONTRIBUTE TO THE RECORD BEING BUILT BY THIS COMMITTEE IN REGARD TO "THE FUTURE OF HEALTH CARE IN AMERICA."

I KNOW YOU'VE COVERED A GREAT MANY TOPICS IN MEDICINE AND PUBLIC HEALTH IN YOUR PREVIOUS COMMITTEE HEARINGS, AND, OF COURSE, A NUMBER OF EXCELLENT WITNESSES FOLLOW MY APPEARANCE THIS MORNING. WHAT I WOULD LIKE TO DO, THEN, IS TO TOUCH UPON THREE OVER-ARCHING ISSUES IN THIS BRIEF OPENING STATEMENT AND THEN ANSWER QUESTIONS FOR THE REMAINDER OF MY TIME.

THE FIRST ISSUE I WANT TO RAISE IS THE FUTURE RELATIONSHIP BETWEEN TECHNOLOGY AND HEALTH CARE. TECHNOLOGY HAS HAD A VERY PERVASIVE INFLUENCE SO FAR. BUT WILL IT ALWAYS BE SO?

FOR MANY YEARS WE'VE ASSUMED THAT THE HEALTH STATUS OF OUR PEOPLE WOULD CONSTANTLY IMPROVE, AS LONG AS WE CONTINUED TO PUSH AGAINST THE FRONTIERS OF BIOMEDICAL TECHNOLOGY. AND THE AMERICAN PEOPLE HAVE SUPPORTED THAT ASSUMPTION IN A WAY THAT COUNTS: THAT IS, THROUGH TAXES AND DONATIONS WILLINGLY GIVEN.

HOWEVER, IN RECENT YEARS, I'VE BEGUN TO DETECT A COUNTER-TREND, IN WHICH THE PUBLIC -- AND EVEN SOME MEMBERS OF THE MEDICAL PROFESSION ITSELF -- QUESTION THE HIGH COST AND LIMITED RESULTS OF NEW MEDICAL TECHNOLOGIES.

THERE IS, FOR EXAMPLE, A LIVELY PUBLIC DEBATE OVER THE USE OF SO-CALLED "EXTRAORDINARY" MEASURES TO SAVE OR PROLONG THE LIVES OF THE TERMINALLY ILL. I'VE BEEN INVOLVED IN THAT DEBATE FOR MANY YEARS, BOTH BEFORE AND SINCE BECOMING SURGEON GENERAL.

RECENTLY, HOWEVER, MUCH PUBLIC SENTIMENT HAS BEEN RAISED AGAINST THE USE OF SUCH MEASURES. I WOULDN'T SAY THAT MOST PEOPLE FEEL THIS WAY, BUT CERTAINLY A SUBSTANTIAL AND VOCAL MINORITY DOES NOT WANT THEIR PHYSICIANS TO PROLONG THEIR LIVES, IF THERE'S ANY CHANCE AT ALL THAT THE KIND OF LIFE BEING PROLONGED WILL BE QUALITATIVELY LESS THAN THE LIFE THEY'VE KNOWN.

IN OTHER WORDS, WHILE THE AMERICAN PEOPLE WELCOME THE EXPECTATION OF LONGER LIFE, THEY DON'T WANT LONGEVITY AT ANY COST AND THEY SEE TECHNOLOGY, IN A SENSE, "PERPETRATING" LONGEVITY UPON A DUBIOUS AND EVEN UNWILLING PUBLIC.

IN OTHER AREAS THERE IS ALSO GROWING SKEPTICISM AS TO THE ADEQUACY OF TECHNOLOGY TO SOLVE THE MAJOR CONTEMPORARY HEALTH PROBLEMS OF OUR PEOPLE. IN FACT, THE KEYSTONE OF PUBLIC HEALTH FOR THE PAST DECADE -- AND CERTAINLY FOR THE FUTURE AS WELL -- HAS BEEN THE IDEA THAT EACH PERSON MAKES THE KEY DECISIONS, DAY-BY-DAY,
THAT AFFECT HIS OR HER OWN HEALTH ... DECISIONS, FOR EXAMPLE ...

* TO EAT SENSIBLY AND EXERCISE REGULARLY ...
* TO STOP SMOKING AND STOP USING DANGEROUS DRUGS ...
* TO ENSURE THAT ONE'S WORKPLACE IS SAFE AND HEALTHFUL ...
* AND TO LIVE AT HOME OR AT PLAY IN A MANNER THAT WILL ENHANCE AND NOT IMPERIL ONE'S HEALTH STATUS.

IN FACT, AS MORE AND MORE PEOPLE MAKE -- AND BENEFIT FROM -- THESE KINDS OF PERSONAL DECISIONS, I THINK WE MAY FIND THAT FEWER AND FEWER PEOPLE WILL RETAIN SUCH COMPLETE AND UNCRITICAL FAITH IN HIGH-TECH MEDICINE AS WAS THE CASE, SAY, IN THE 1950s AND 60s.

ALSO, THE NEW TECHNOLOGIES TEND TO RESPOND TO CONDITIONS THAT ARE RARE IN THE PATIENT POPULATION OR THEY REQUIRE THE KIND OF DIFFICULT ETHICAL AND MORAL CHOICES THAT MOST PEOPLE WOULD RATHER NOT MAKE.

FOR EXAMPLE, I WOULD NOT MINIMIZE THE SIGNIFICANCE OF THE ESOTERIC TECHNOLOGIES THAT REVERSE INFERTILITY. HOWEVER, THE POPULAR PREFERENCES FOR DEALING WITH THIS MEDICAL PROBLEM STILL SEEM TO BE ADOPTION, ROUTINE DRUG THERAPIES ... AND RESIGNATION.

DURING THE YEARS WHEN TECHNOLOGY WAS CONSIDERED THE SINE QUA NON OF MEDICAL PRACTICE, THE PRESSURES OF THE MARKETPLACE TENDED TO SKEW SUPPORT FOR RESEARCH AWAY FROM THE BASIC SCIENCES AND TOWARD RESEARCH APPLICATIONS AND PRODUCT DEVELOPMENT. THIS IS CLEAR FROM THE ANNUAL REPORTS OF THE NATIONAL SCIENCE FOUNDATION FOR THE PAST TWO DECADES.

BUT WHAT IF, AS I'VE INDICATED, THAT MARKET PRESSURE BEGINS TO EASE? THEN WE MIGHT SEE BASIC RESEARCH SUCCESSFULLY COMPETE FOR MORE RESOURCES: MORE BENCH SCIENTISTS, ADDITIONAL ACADEMIC FACILITIES, AND MORE GOVERNMENT AND PRIVATE FUNDS AS WELL.

CONCURRENTLY, I BELIEVE WE'LL ALSO SEE AN INCREASINGLY IMPORTANT ROLE FOR THE FIELD OF SO-CALLED "LOW-TECH" APPLICATIONS TO HEALTH CARE AND HEALTH ADMINISTRATION.

IN ONE OF HIS PLAYS, GEORGE BERNARD SHAW ASKED WHY WE PAY DOCTORS TO TAKE A LEG OFF BUT WE DON'T PAY THEM TO KEEP A LEG ON. NOW, ALMOST 80 YEARS HAVE PASSED AND WE STILL HAVEN'T COME UP WITH A GOOD ANSWER. IN FACT, OUR TECHNOLOGY-DRIVEN REIMBURSEMENT SYSTEM -- WHETHER BY GOVERNMENT OR OUT-OF-POCKET -- IS PREDICATED ON TAKING THE LEG OFF.

THAT'S TODAY. BUT I DON'T THINK THE SYSTEM WILL REMAIN THAT WAY TOMORROW BECAUSE OF THE SHIFT IN THE PUBLIC'S OWN PERCEPTION OF WHAT IT REALLY NEEDS. AND I THINK WE'RE BEGINNING TO HEAR THE PUBLIC SAY THAT IT NEEDS AND WANTS THE KIND OF HARDWARE AND SYSTEMS THAT PROMOTE HEALTHFUL LIVING OR THAT HELP OLDER PEOPLE AND PEOPLE WITH DISABILITIES OR CHRONIC ILLNESSES TO LIVE SAFELY, HEALTHFULLY, AND INDEPENDENTLY IN THEIR OWN HOMES.

I THINK WE SHOULD TRY TO UNDERSTAND HOW AND WHY THAT MAY BE HAPPENING AND WHAT IT COULD MEAN FOR THE FUTURE OF BIOMEDICAL RESEARCH AND OF HEALTH CARE IN GENERAL.

A SECOND ISSUE IS THE CHANGING RELATIONSHIP BETWEEN THE PUBLIC AND THE HEALTH CARE SYSTEM.

MANY FACTORS ARE BRINGING ABOUT THIS CHANGE. ONE IS THE INCREASED MOBILITY OF THE AMERICAN PEOPLE. THIS PHENOMENON MAKES IT LESS LIKELY THAT THE AVERAGE PATIENT WILL BE KNOWN AND SERVED BY THE SAME PHYSICIAN AND SAME HOSPITAL STAFF FOR A LIFETIME. YET, THAT HAS BEEN OUR NORM FOR ALMOST THREE CENTURIES.

ANOTHER FACTOR IS THE RISE IN PRE-PAID PRACTICES OF ONE KIND OR ANOTHER. THESE, WHILE MORE COST-EFFICIENT, ALSO TEND TO ATOMIZE PATIENT CARE. I'M NOT SAYING THE CHANGE IS GOOD OR BAD. I'M SAYING IT'S DIFFERENT AND THE DIFFERENCE IS SIGNIFICANT FOR THE LONG-TERM RELATIONSHIP BETWEEN HEALTH CARE AND THE PUBLIC.

A THIRD FACTOR IS THE WELL-ADVERTISED AND WELL-DISCUSSED SHIFT IN THE DEMOGRAPHY OF OUR COUNTRY, THE SO-CALLED "GRAYING OF AMERICA."

ALREADY THE SPECIALTY OF GERIATRICS IS RESPONDING TO NEWLY RECOGNIZED HEALTH NEEDS OF THE AGED. NOW THIS SPECIALTY JOINS TWO OTHERS -- PEDIATRICS AND FAMILY MEDICINE -- TO DIVIDE UP PRIMARY CARE AND, AGAIN, CHANGE ALL OUR TRADITIONAL IDEAS ABOUT CONTINUITY OF CARE.

I'M AFRAID THAT MANY OF THE ASSUMPTIONS UPON WHICH WE BASE MUCH OF OUR HEALTH PLANNING -- AND FINANCING, I MIGHT ADD -- MAY STILL REFLECT A PATIENT-TO-SYSTEM RELATIONSHIP THAT, FOR MANY INDIVIDUALS AND MANY INSTITUTIONS, NO LONGER EXISTS.

LET ME ILLUSTRATE THIS WITH A LITTLE ANECDOTE. LAST WINTER I CONVENED A "SURGEON GENERAL'S WORKSHOP ON SELF-HELP." MY PURPOSE WAS TO GAIN A BETTER SENSE OF WHAT WAS GOING ON IN THIS NEW AREA AND WHAT THE GOVERNMENT'S ROLE MIGHT BE -- IF ANY.

I DISCOVERED THAT AN ESTIMATED 15 MILLION AMERICANS ARE INVOLVED IN THE SELF-HELP MOVEMENT ... THAT THEY REPRESENT ALL SOCIAL, RACIAL, ETHNIC, GEOGRAPHIC, AND ECONOMIC GROUPS ... AND THAT THEY ARE FIERCELY INDEPENDENT.

I ALSO DISCOVERED THAT THEY ARE PROVIDING LEADERSHIP IN THREE HEALTH AREAS IN WHICH TRADITIONAL MEDICINE AND PUBLIC HEALTH ARE STILL SEARCHING FOR MEANINGFUL ROLES: HEALTH PROMOTION, DISEASE PREVENTION, AND THE COUNSELING FUNCTION, CALLED "COGNITIVE MEDICINE" BY SOME PHYSICIANS.

THE SELF-HELP MOVEMENT EMBRACES ALCOHOLICS ANONYMOUS AND A NUMBER OF ALLIED ORGANIZATIONS ... SMOKING CESSATION GROUPS AND PROGRAMS ... AND COUNSELING AND TREATMENT GROUPS FOR DRUG ADDICTS.

THERE'S ALSO AN EVER-EXPANDING ASSORTMENT OF "SUPPORT GROUPS" FOR PERSONS WITH FAMILY, PERSONALITY, SEXUALITY, OR INFECTIOUS DISEASE PROBLEMS; PERSONS WHO'VE JUST "KICKED A HABIT" OF SOME KIND; OR PERSONS RETURNING HOME AFTER A MAJOR HEALTH ORDEAL, SUCH AS A HEART ATTACK, CANCER TREATMENT DIAGNOSIS, A STROKE, AND SO ON.

YOU'LL NOTICE, MR. CHAIRMAN, THAT THESE DISEASES AND DISORDERS ARE ALSO AMONG THE MOST SERIOUS PUBLIC HEALTH PROBLEMS WE FACE TODAY: SUBSTANCE ABUSE, INCLUDING CIGARETTES ... THE EPIDEMICS OF SYPHILIS, HERPES, GONORRHEA, AND AIDS ... AND THE THREE PERSISTENT MAJOR KILLERS OF OUR PEOPLE: HEART DISEASE, CANCER, AND STROKE.

TRADITIONAL FEE-FOR-SERVICE MEDICINE OR TAX-SUPPORTED PUBLIC HEALTH PROGRAMS GENERALLY DO NOT RESPOND TO THIS INTENSELY PERSONAL ASPECT OF THESE PERCEIVED HEALTH PROBLEMS. ALSO, SINCE THE INDIVIDUAL DECIDES WHEN SUCH ASSISTANCE IS NO LONGER NEEDED, THERE IS NO GENERALLY RECOGNIZED END-POINT; THEREFORE, THERE IS NO SPECIFIC POINT AT WHICH EXPENDITURES MUST END OR REIMBURSEMENTS MUST BEGIN.

I HONESTLY MARVEL AT THE EXTRAORDINARY DEGREE TO WHICH AVERAGE AMERICANS ARE ENGAGED IN THESE "DO-IT-YOURSELF" HEALTH PROGRAMS AND ALSO THE DEGREE TO WHICH THEY ARE TRULY HELPED BY THEM.

MY ONLY CONCERN -- AND IT'S A MAJOR CONCERN -- IS THAT SOME PEOPLE WHO NEED THE HELP OF EXPERTS WITH MEDICAL TRAINING AREN'T GETTING IT OR ARE AVOIDING IT ... AND THEIR HEALTH AND POSSIBLY THEIR LIVES MAY BE IN PERIL AS A CONSEQUENCE.

I'D LIKE TO SEE MORE PHYSICIANS, NURSES, AND ALLIED HEALTH PROFESSIONALS BECOME INVOLVED IN WHAT IS NOW CALLED "SELF-HELP" OR "DO-IT-YOURSELF" HEALTH CARE. MY INSTINCTS TELL ME IT WOULD BE VERY USEFUL IF THEY DID.

BUT WHETHER TRADITIONAL MEDICINE AND PUBLIC HEALTH DO OR DO NOT GET INVOLVED, I BELIEVE THIS MOVEMENT WILL CONTINUE TO GROW AND BECOME NOT MERELY AN "ALTERNATIVE" SYSTEM OF HEALTH CARE BUT IN FACT OUR OTHER NATIONAL SYSTEM OF HEALTH MAINTENANCE, HEALTH PROMOTION, AND DISEASE AND DISABILITY PREVENTION.

AND THAT LEADS ME TO THE THIRD AND FINAL ISSUE I WANT TO TOUCH ON THIS MORNING, MR. CHAIRMAN. IT IS THE RELATED ISSUE OF HEALTH, COMMUNITY VALUES, AND PUBLIC SUPPORT.

I MENTION IT BECAUSE, IN THE COURSE OF MY INVOLVEMENT WITH THE AIDS EPIDEMIC, I'VE SEEN THE OUTLINES OF THIS ISSUE ALREADY FORMING. ALSO, IT IS A KIND OF COROLLARY OF THE ISSUES I'VE DISCUSSED SO FAR.

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LET ME BEGIN BY SAYING THAT THE AMERICAN PEOPLE ARE GENEROUS TO A FAULT. THROUGH TAXES AND THROUGH PERSONAL, OUT-OF-POCKET DONATIONS THEY WANT TO HELP EVERYONE IN OUR SOCIETY ACHIEVE GOOD HEALTH AND THE GOOD LIFE THAT COMES WITH GOOD HEALTH.

BUT THEY CAN ALSO BECOME IMPATIENT. FOR EXAMPLE, MOST AMERICANS DISAPPROVE OF SMOKING AND WOULD LIKE TO SEE ALL SMOKERS STOP. AND, THROUGH THE SELF-HELP MOVEMENT, MANY SMOKERS ARE INDEED QUITTING THE HABIT. BUT IT'S HAPPENING VERY SLOWLY.

HENCE, THE NON-SMOKING PUBLIC IS ASKING FOR NEW AND STRONGER STATE AND LOCAL LAWS TO CURB CIGARETTE SMOKING IN THE WORKPLACE AND IN ALL PUBLIC GOVERNMENTAL AND COMMERCIAL BUILDINGS.

MOST HEALTH AND LIFE INSURANCE COMPANIES NOW HAVE A SEPARATE -- AND HIGHER -- PREMIUM FOR SMOKERS, ALSO, ON THE THEORY THAT A PERSON WHO SMOKES OUGHT TO PAY A LARGER SHARE FOR THE CONSEQUENCES OF THAT UNHEALTHY BEHAVIOR.

NEW LAWS, HIGHER PREMIUMS, AND SEGREGATION AT THE WORKSITE ARE EXAMPLES OF PUBLIC RETRIBUTION DIRECTED AGAINST SMOKERS. BUT IT IS BEING EXERCISED AGAINST OTHERS AS WELL: DRUNK DRIVERS, DRUG ADDICTS, PROMISCUOUS AND PREGNANT TEEN-AGERS, AND OTHERS WHO ARE PERCEIVED AS DEVIATING FROM THE COMMUNITY'S STANDARD OF NORMATIVE BEHAVIOR;

BUT THE AMERICAN PEOPLE ARE STILL VERY GENEROUS AND VERY FORGIVING. THEY DO HONESTLY BELIEVE IN -- AND WILL CONTINUE TO SUPPORT -- PUBLIC HEALTH PROGRAMS THAT PROMISE REDEMPTION.

BUT THEY AREN'T PUSH-OVERS. AND IT'S POSSIBLE THAT THE AMERICAN PEOPLE -- ALREADY TRAVELING THE ROAD OF RETRIBUTION -- MAY BEGIN TO EXERCISE THEIR RETRIBUTIVE POWERS MORE AND MORE.

THE OBJECT WILL CONTINUE TO BE THE INDIVIDUAL WHO WILFULLY BEHAVES IN A HIGH-RISK MANNER: DRUNKS, DRUG ADDICTS, CIGARETTE SMOKERS, SEXUALLY PROMISCUOUS PEOPLE OF ALL AGES, DANGEROUS DRIVERS, CHILD BEATERS, AND OTHERS.

AND AT THE TOP OF THAT LIST RIGHT NOW IS THE PERSON WITH AIDS ... SOMEONE WHO CONTRACTED THAT LINGERING BUT FATAL DISEASE THROUGH WHAT THE COMMUNITY REGARDS AS AN UNSAVORY ACT: SODOMY OR INTRAVENOUS DRUG ABUSE.

IT'S POSSIBLE THAT A PUBLIC REACTION OF RETRIBUTION TOWARD PEOPLE WITH AIDS MAY COME ABOUT IN THE 1990s, WHEN THE ANNUAL COSTS OF AIDS-RELATED RESEARCH AND PATIENT CARE ARE EXPECTED TO REACH OR EXCEED $5 BILLION.

THE 1990s IS ALSO WHEN NEW CASES OF AIDS WILL BE REPORTED AMONG PEOPLE WHO MOST LIKELY BECAME INFECTED SOMETIME AFTER -- AND MAYBE LONG AFTER -- THE HUMAN IMMUNODEFICIENCY VIRUS, OR H.I.V., WAS IDENTIFIED AND THE NATIONWIDE AIDS EDUCATION PROGRAM WAS WELL UNDER WAY.

SUCH A PUBLIC RESPONSE WOULD BE A TRAGIC DEVELOPMENT -- BUT NOT UNEXPECTED. IT WOULD BE CONSISTENT WITH THE OTHER RETRIBUTIVE TRENDS I MENTIONED EARLIER.

OUR CHALLENGE, THEN, WOULD BE TO RECOGNIZE -- IF AND WHEN IT COMES -- THIS REACTION BY THE GENERAL PUBLIC AGAINST HIGH-RISK INDIVIDUALS AND TO TRY TO CHANNEL IT INTO MORE POSITIVE, MORE TOLERANT RESPONSES.

AT STAKE IS THE VERY BASIS OF THE AMERICAN APPROACH TO PUBLIC HEALTH ITSELF: THAT IS, THE MAJORITY OF THE AMERICAN PEOPLE WHO LIVE THEIR LIVES IN A GENERALLY HEALTHFUL, LOW-RISK MANNER HAVE BEEN WILLING TO SUPPORT -- SOMETIMES WILLINGLY AND SOMETIMES GRUDGINGLY -- THE SERVICES THAT TAKE CARE OF A MINORITY OF PEOPLE WHO LIVE IN A GENERALLY UNHEALTHFUL, HIGH-RISK MANNER.

IN MANY RESPECTS, THIS IS THE MOST IMPORTANT ISSUE OF ALL. WE KNOW THAT HEALTH COSTS ARE TAKING A LARGER AND LARGER SHARE OF THE GROSS NATIONAL PRODUCT. IT STANDS TO REASON, THEN, THAT MORE AND MORE AMERICANS WILL BEGIN TO LOOK WITH GREATER CRITICAL INTEREST NOT ONLY AT OUR SYSTEM OF HEALTH CARE BUT ALSO AT THE PEOPLE DIRECTLY BENEFITING FROM THAT SYSTEM.

THAT WOULD BE A VERY WELCOME DEVELOPMENT BECAUSE IT IS ROOTED IN OUR SYSTEM OF PARTICIPATORY DEMOCRACY. BUT IT CAN BE A PAINFUL DEVELOPMENT FOR MANY OF OUR CITIZENS, AND WE OUGHT TO BE PREPARED FOR THAT..

LET ME CLOSE, THEN, BY SAYING THAT I ANTICIPATE CERTAIN MAJOR CHANGES IN AMERICAN HEALTH CARE OVER THE NEXT SEVERAL DECADES. SOME WILL BE EASIER TO EXPERIENCE THAN OTHERS. BUT, ON BALANCE, I SEE THEM AS CONTRIBUTING TO A STRONGER, MORE RESPONSIVE, MORE CONTEMPORARY SYSTEM OF HEALTH CARE FOR THE NEXT AND FOR SUCCEEDING GENERATIONS OF AMERICANS.

THANK YOU. AND NOW, IF YOU WISH, I'D BE PLEASED TO ANSWER QUESTIONS.

Representative SCHEUER. Well, thank you very much, Dr. Koop, for this eloquent and touching statement.

INCENTIVES TO HEALTH PROMOTION

Dr. Koop, a key phrase that stuck in my mind as I read your testimony last night was the phrase where you talked about new laws, higher premiums, and segregation at the worksite as examples of public retribution; the way our society expresses its frustration. And sometimes approaching anger at the expensive and antisocial results of high-risk behavior.

And we have addressed that in a few nominal ways. But we really haven't done a systematic job of attaching incentives to proper, positive health behavior and disincentives to negative health behavior systematically across the board. And adopting the policy, well, if you're going to smoke, you're going to die of cancer of the lungs, that can be directly attributable to your habit, your smoking addiction. If you're going to be an alcoholic that cripples you and disables you in the conduct of your everyday affairs, impacts on your family, your friends, your job, and so forth, society is going to express its disapproval very strongly.

We don't want you to do this. We want you to do that. We want you to engage in positive health behavior.

What kind of specific, let us say, financial incentives and/or disincentives could we attach to this egregiously expensive and clearly unproductive human behavior resulting from cigarette consumption, alcohol consumption, drug consumption, obesity, and lack of exercise?

I don't suppose any of us want a Federal nanny that is reaching into the bedroom and tapping us on the shoulder and telling us not to have that slice of pie or to get on the exercise bicycle.

But short of going to that extreme, do we have to sit at the other extreme where we're doing virtually nothing to attach incentives to good health behavior and disincentives to clearly bad and very costly health behavior, both to the individual and to society?

What can you give us in the way of specific recommendations as to what Congress or what the Governors, mayors, what society should do to be a little bit more specific with these folks whose bad behavior is costing them so dearly, and also costing society very dearly?

How do we focus this feeling of public retribution that you feel is welling up in constructive ways?

Dr. KOOP. I think the first thing to say is that there's a strange paradox in our health care system. We recognize that the promotion of good health and the prevention of disease is the way to go. We recognize that it's very effective and that it's very cheap. But we tend not to pay for it.

I think that, for starters, one thing that we could do is to make available to the average individual in our country those preventive programs that would aid him to stop smoking, to stop drinking, and to stop using drugs. In general, those services are not paid for by insurance companies. They are also not paid for by Medicaid. Yet, the amount of money it would cost for such services would be a fraction of the end result of not doing it, which is the repairative

and rehabilitative types of medicine and surgery that have driven up medical costs to where they are today.

Representative SCHEUER. And I take it that you would favor compensating physicians for the time they spend in counseling with patients, perhaps the most important function, I believe, that they can play.

Dr. KOOP. I think that that is absolutely true. What we have done, you see, is to mount very large public and private partnerships in that direction mounting educational campaigns against these things. But when the individual patient says, yes, I heard you, and he goes to get that kind of care from a physician, he finds his insurance plan doesn't cover it and he can't afford to pay out of pocket. It think that is what has to be corrected.

Representative SCHEUER. We had excellent testimony a few days ago from a union, the American Federation of State, County, and Municipal Employees, known as AFSCME, where they described to us some negotiations they had successfully completed, particularly in Indianpolis, IN, where they had negotiated with companies—rather, companies had insisted that in the union contract there would be a requirement for members to participate in wellness programs, that the company would carry on as part of its broad scale of extracurricular activities, let us say.

And the representatives of AFSCME indicate that they bargained hard against that and felt that it would be an invasion of the personal rights of privacy and so forth of the union members. But they finally struck some kind of acceptable compromise with the company, the corporation, and agreed to do that.

And at the end of a year or two, all hesitations, all their reservations of the union had disappeared into the morning mist and they were absolutely enthusiastically supporting these wellness programs and workers were responding very positively to them. The employees paid reduced insurance premiums, if they completed these programs.

Is that the kind of pattern that you would like to see enlarged upon and extrapolated around the country in various ways, encouraging employees to engage in a wellness type of program, be it at the school, be it at the workplace, be it at the church, the synogogue, at the community hall, the labor union hall, whatever?

Dr. KOOP. I certainly would support it, sir. I do and I have.

I have focusd my attention on education at the worksite by companies primarily in reference to smoking and to AIDS, but I also have supported it in reference to exercise, diet and changes in the type of food that's served in a cafeteria.

SMOKE-FREE WORKSITE

I think that the experience you just described has been sort of the rule across the board in reference to smoking. I have been watching this in terms of unions versus management. Five years ago when management wanted to do things with unions about having a smoke-free worksite, there was union resistance. But now they've come to realize that when it comes to health, the goals of both management and unions are the same. One of the most gratifying things I've seen in the past year is that when a union sits

down with management to negotiate, it is the union that asks for the smoke-free worksite.

So I think we're making progress in that area. But that kind of partnership, I think, should be developed to address other health areas and can do a tremendous amount of good for the future.

Representative SCHEUER. Well, those words are music to my ears. I'm the congressional sponsor of legislation that would require a smoke-free workplace in all Federal buildings, with perhaps some designated smoking areas.

The GSA has already put that into effect, but since their reach only extends to about 30 percent of all Federal buildings, there are 70 percent of the Federal buildings, including the one in which we're sitting now that are not covered and can't be covered by GSA. About 41 States have legislated in this area, and hundreds and hundreds of municipalities, but, of course, they can't reach the Federal workplace.

I think it's about time that Congress did that in buildings like this one, like the Defense Department buildings, the Post Office buildings, and all of the others that aren't run by GSA.

And I think that this is an idea whose time has come. Most of the Fortune 500 companies are already doing this.

Do you think we ought to give some kind of financial incentives, tax incentives or some kind of subsidy, to corporations? Should we provide some kind of incentives to business and unions to proliferate, to encourage the proliferation of these wellness programs, either by tax incentives or government subsidy of the cost of these programs?

DO NOT NEED FEDERAL INCENTIVES FOR HEALTH PROMOTION

Dr. KOOP. No, I would not support that, Mr. Chairman. I don't think you have to. Any company that has tried, for example, a smoke-free worksite, recognizes the benefits. They have less absenteeism. Their pension plan is not taxed as heavily. They have fewer accidents. Their insurance premiums go down for fire, for maintenance, and so forth. Every company that has tried such a program has agreed that although they may have had purely altruistic reasons in terms of health benefits for their employees in mind when they started, it also produced additional black ink on their ledgers.

Representative SCHEUER. And increases in the productivity of workers.

Dr. KOOP. Without any question. The reason that most of the Fortune 500 companies have some kind of a program is that their chief executive officers talk to each other and they say, it worked for us, it will work for you.

So I don't think it requires a Federal incentive.

Representative SCHEUER. Do you believe that Federal reimbursement programs should cover the kind of self-help programs that you describe, including physician counseling, to encourage this alternative medicine that you describe?

PHYSICIAN COUNSELING AND SELF-HELP

Dr. KOOP. I think there are two separate issues. I certainly think that cognitive medicine, as I called it, the ability for a patient to sit

down for one-on-one counseling and have that consultation paid for by the insurance company or whoever, I think that that is absolutely essential.

However, I have different thoughts about the self-help groups. The self-help programs are actually very inexpensive. They are generated at grassroots level and they function largely on small donations, but with a tremendous amount of energy from those who participate in them.

So I think the two issues are separate. What I would like to see, and have implied, is a little more cooperation between organized medicine and the self-help groups. One of the problems that I mentioned is that they are fiercely independent. The self-help groups came into being because they sensed that there was a lack of ability to have one-on-one cognitive medicine with the physician. Therefore, they have withdrawn from that arena.

I'd like to see them get back together again because, as I said, there are dangers of being too do-it-yourself oriented. I am working with a nonprofit corporation now and a clearinghouse which will be federally supported to bring about some kind of rapproachement between these two groups.

Representative SCHEUER. In the whole generic field of self-help, counseling, wellness programs and so forth, do you think to make the cost of this less burdensome, we could develop systems whereby much of the self-help counseling and support are rendered by paraprofessionals, physician assistants, physician extenders, self-help aides, wellness aides?

Dr. KOOP. It will take a while to come about.

Representative SCHEUER. But we have such a desperate shortage of nurses in this country and doctors, whether they're in shortage or not, seem to be so preoccupied with delivering specific health services and procedures, that there seems to be very little give there, very little opportunity by nurses or doctors to participate in this informal colloquy and improved communication, relaxed communication that you're talking about.

Would it be a good idea to try and design paraprofessional roles so that nonprofessionals, nondoctors, nonnurses, perhaps physician assistants, physician extenders, licensed practical nurses, could get special training in wellness counseling and relieve the burden on doctors and nurses of what we hope will be a lot, millions and millions of more hours spent in this alternative, as you've described it, cognitive medicine?

Dr. KOOP. Many groups practices, either of internists or of pediatricians or family practitioners, already utilize a person who functions as a wellness counselor. They don't necessarily identify the person by that name, but it is the person to whom, after the doctor has done those things that are essential to his profession, they turn over the patient for nutritional advice, vaccination advice, and all of those things which are necessary as adjuncts to the problem that was raised by the professional consultation.

I think that one of the things that you always run into——

Representative SCHEUER. And they get reimbursed, I take it.

Dr. KOOP. Oh, yes. Absolutely. The self-help groups have volunteers who do this, but, again, they are separated from organized medicine.

One of the problems that I run into all the time as I talk about this issue because I, too, see the shortage of manpower to do certain jobs, is that you always get into concerns about turf.

The American Medical Association, for example, right now has raised the issue of a new kind of care specialist that would supplement nursing care. Of course, the practical nurses and the registered nurses oppose this because they see it as an intrusion on their turf.

Representative SCHEUER. Even though they don't have the time to perform those services themselves?

Dr. KOOP. That's right. I think what it will take is a lot more dialog to understand that we all have the same goal and we can reach it by different means.

UNHEALTHY BEHAVIOR AND RETRIBUTION OF PUBLIC

Representative SCHEUER. Dr. Koop, when you mentioned retribution, I think the American people have the right to be mad. They're paying too much for health care and not receiving health outcomes consistent with the cost of that system.

But this concept of retribution, and it's probably a valid one, does raise the specter at the extreme that one of these days, our society may actually favor denying health care or largely cutting down health care to the elderly ill in the last stages of their illness and to people whose egregiously bad health behavior, is really the cause of their illnesses, which are very expensive to society.

And I'm talking about people who may be seriously ill from alcoholism, from drug addiction, from tobacco, from obesity, from bad diet, poor exercise, and the like.

Do you see the possibility that this proper and understandable sense of retribution could be carried to what you would consider unethical and immoral extremes so as to deny health care and cause these people unnecesarily to suffer, even though their own bad behavior may be at the root of their illness and their suffering?

Is that something that we have to watch out for?

Dr. KOOP. Yes, I do see that as a danger, and in my closing remarks, I said we have to look out for it, try to blunt it, and try to turn such a response into something more constructive.

The reason that I raise this issue is because it has borne in on me so heavily as I travel around the country in carrying out our AIDS efforts. There are many people who already feel that because most people get AIDS by doing things that other people don't do and don't approve of, that the public should not have to foster the care of these individuals.

I think I must have given at least a hundred public speeches thus far warning against this kind of response and pointing out the fact that we have to treat the people who have AIDS as the persons they are—individuals sick with a very serious illiness—and not deprive them of standard medical care.

I would hope that we could blunt these things that I believe are real problems. I would not have raised them if it were not that my sense of the pulse of the country is that people feel this way.

Representative SCHEUER. I think your sense is entirely right.

Dr. KOOP. My mail would certainly support it. Also, there's no doubt about the fact that as I travel around, the questions that I get asked after lectures on AIDS are headed in that direction.

PREFERENCE FOR HIGH-TECH CARE

Representative SCHEUER. Dr. Koop, we promised you you'd be out at 10:15. It's now 10:15. I'm going to burden you with one more question.

Why do decisionmakers have such a predilection for high-tech solutions, almost exclusively—tertiary hospital illness care, CAT scan, open-heart surgery, organ transplants, high-tech procedures, high-tech products—when there could be such a greater payoff dollar for dollar in terms of improving health outcomes from counseling, from health education, from wellness programs, from the kind of self-health programs that you've described, more neighborhood clinics, more rationing of high-tech facilities, and engines of high technology so that they're used more cost effectively?

Why has there been such a predilection in our health care community for very expensive, high-tech facilities, and systems and procedures and products, many of which benefit only a few, while we're so obviously neglecting very much less expensive, very much more cost effective, very much lower tech, perhaps what you'd call appropriate technology means of improving our health and promoting proper health, rather than waiting to cure illness at a very, very high cost?

Why is this predilection so endemic in our entire health care system?

Dr. KOOP. Well, I think the answer is simple, and I think the answer is also changing.

The simple reason is that Americans are tremendously preoccupied with health. They love to read about it. The things you've mentioned—the high-tech things—are glamorous. The things that we mentioned before, such as the prevention of disease, the promotion of health, good counseling, that is very effective, very cheap, but it has no glamour whatsoever.

HEALTH CARE RATIONING

I think that we have to face the fact that you can have glamour as long as it's cheap, but when glamour gets as expensive as it is, you have to sort of trim your sails.

The State of Oregon did this last December. They looked at their budget and they said, we have a choice of providing 30 major organ transplants or giving good prenatal care to 1,500 women and getting babies that are not premature of low-birth weight—the mothers won.

I think that is the kind of change in attitude you're going to see more and more. It will produce a kind of rationing which will, unfortunately, end in kind of a two-tier system of care.

The first victim of that Oregon situation was a little boy who needed a bone marrow transplant that cost $100,000. Now, nobody today thinks that a bone marrow transplant is extraordinary or heroic. But Oregon felt that the economics were extraordinary and heroic. They decided he couldn't have it—he died. Had his parents

had $100,000, he would have had the transplant. That is a two-tier system.

Representative SCHEUER. Well, that's a kind of health rationing. There isn't a country in the world beside us that doesn't have some kind of health care rationing. And we've come to it late.

In England, as you know, if you're over 55, you don't get kidney dialysis. There's nothing in their law that says that, but it just doesn't happen. And if you're over 65, you don't get organ transplant, you don't have complicated heart surgery, you don't have access to CAT scans.

There's nothing in the law that says that, but in the British health care system, it just doesn't happen.

I think a Congressman who advocated anything like that would be a candidate for instant retirement in our country. But, yet, these are problems that we're going to have to grapple with.

Dr. KOOP. Well, let me say in defense of our system, and in closing, that at the age of 70, I need a lot of those things that you just mentioned. I got those services in this country and I'm here talking to you. Had I needed them in many places in the world, I'd be dead.

Representative SCHEUER. You're absolutely right, and thank God you did have them. And I hope you'll be around for many, many years, Dr. Koop, to give us the kind of wise, informed, compassionate, utterly civilized advice that you gave us here this morning and that you've been giving so freely throughout your career.

We're very grateful to you for testifying.

Dr. KOOP. Thank you.

Representative SCHEUER. Is Dr. David Axelrod here

Dr. AXELROD. Here, Congressman [indicating].

Representative SCHEUER. Oh, there you are, David. I'm sorry. I didn't see you. Would you please come to the witness table.

Our next witness will be Dr. David Axelrod, who is commissioner of the New York State Department of Health, and has been since 1979.

Dr. Axelrod is a nationally recognized research scientist and a renowned authority of environmental toxicology. But above and beyond that, he is an egregious member of the New York State cabinet. He stands out head and shoulders in the top governing body of New York State. He is relied on for his wisdom and his sagacity in many areas, some of them outside of the health care system. And he is nationally recognized as one of the finest, if not the preeminent State health care commissioner in our country.

I would also say I pressured David Axelrod unmercifully to come down here this morning. He, too, was busy and pulled and shoved from many points of the compass. He, too, finally agreed to come down and I'm very happy that he did.

I think he and Dr. Koop are going to give this last day of hearings on this subject the wisdom and the authority that the subject deserves.

Dr. Axelrod, we're very grateful to you for coming here this morning. I know how hard pressed you are. I felt it was important that you be here. Your presence and your words of advice to us would be very hard to substitute for.

So I want to express my personal appreciation that you're here and our Congress and the public will be the better off for it.

So, with those words, please let me yield to you as much time as you may need. Your full prepared statement——

Dr. AXELROD. I'm afraid it hasn't arrived, Congressman. I assured your assistant that I would not rely heavily upon a prepared statement.

Representative SCHEUER. There's absolutely no problem.

Dr. AXELROD. I would rather address some of the pressing issues which you have identified.

Representative SCHEUER. Please chat with us. Don't hesitate to avert to some of the issues which you have heard me discuss with Dr. Koop. In fact, I would encourage you to face up to some of these very perplexing problems and give us the benefit of your wisdom.

Please proceed.

STATEMENT OF HON. DAVID AXELROD, M.D., COMMISSIONER, NEW YORK STATE DEPARTMENT OF HEALTH

JUSTIFYING PUBLIC HEALTH PROGRAMS

Dr. AXELROD. Thank you very much, Mr. Chairman. I'm delighted to have this opportunity and I am indeed grateful to you for your holding these series of hearings to address what I think are some of the critical issues of our time.

I think it's also appropriate that I take this opportunity to publicly acknowledge the personal leadership that you have demonstrated in addressing these issues, and also to address and acknowledge fully the role that the Surgeon General has played. The two of you, I think, have played a very profound role in focusing upon some of the elements of promotion and health prevention that must be an integral part of the future of our health care system.

I think that many of the statements that were made by Dr. Koop I would heartily endorse and, if I might, I would like to at least pick up and initiate my testimony with a response to the question you asked as it relates to high technology and the fascination with high technology.

One of the constant difficulties that I face as a public health official is justifying public health programs to legislators, whether they be State or Federal legislators. The distinction that is made between public health programs and high technology is that there are bodies that one can count. One can count an individual saved by organ transplantation. One can count an individual saved by renal dialysis.

I can't count the bodies that I save by virtue of prevention, by promotion of public health. There is an inability for me to prove the negative, that had I not done something, these people would have died. How many people? What is the responsibility of public health officials to the community in terms of the allocation of resources as opposed to the individual, as Dr. Koop has pointed out?

The issue is not necessarily with respect to longevity. It is, rather, with the quality of life that can be provided through prevention, through promotion of health care services. And our responsibility is to exert a form of budgetary ethics that have been

described by the former Director of the Centers of Disease Control, Dr. Foege. The whole issue is one of budgetary ethics. The ethics are that we are required as public health officials to constantly justify each and every preventive and promotional program on the basis of numbers of individuals saved and we are required to identify them, not by name, but necessarily by number.

When the introduction of coronary artery bypass surgery took place, no one asked the kinds of critical questions that needed to be asked with respect to the nature of the procedure—how efficient it would be, how effective it would be, and the cost and the benefits that were associated with that procedure.

Those kinds of questions are constantly being asked of public health procedures and not being asked of the kinds of high-technology introductions; as a result, the dissemination of those high-technology features are part of our society without adequate evaluation.

ADDRESS INEQUITIES IN HEALTH CARE SYSTEM

I believe that the time has come, as you have suggested, to determine what the societal obligations are in the provision of health care services, to look at some of the inequities that exist in the distribution of our services, and to determine, as you have discussed with Dr. Koop—are they morally acceptable? Are there decisions that are being made with respect to limits to provide an autonomy, and individual liberties of patients in the distribution of health care?

Who decides who ought to get what? Can we introduce the kinds of subjects that you suggested might be introduced as a form of retribution in the allocation of resources?

Does distributive justice require us to make the kinds of determinations with respect to the nature of the lifestyle of individuals? Who is innocent and who is guilty?

Is that a responsibility of the health care system? Is that a responsibility of our society in terms of designing a health care system that is equitable with respect to the distribution of resources?

The just design of a health care system, which you have sought to address in these hearings, must be a national objective and I applaud you for having taken this initiative.

There are major inequalities in our society in terms of the risk of getting sick and in the ability to obtain medical services. There are inequalities with respect to programs such as medicare itself, where many of our lower socioeconomic classes contribute at the same level to medicare programs, and yet, do not live sufficiently long to adequately benefit from programs like medicare.

There are similar benefits that they achieve through the medicaid program in some circumstances, but that was never meant to be the same as the medicare program. The medicare program was meant to be a program in which the elderly were going to have certain benefits and it was to be equitably applied across the whole of society.

It is not, by virtue of the way in which we've taxed those individuals, many of whom will not have the same lifespan, life expectancy, as will their white counterparts in particular instances.

So we do have a series of inequalities. We do have inequities with respect to the way in which taxation is carried out, the way in which health care services are provided.

Without agreement on a framework, policy discussions are difficult. What I think you have done is to provide the opportunity to develop a framework and to examine in a principled way the very difficult conflicting claims that are advanced by different groups with respect to the reorganization of the health care system.

In many instances, there is no entitlement. And we talk about access. The access really has to be addressed more specifically. We cannot deal with it simply as rhetoric, in talking about access for health care services to all of our society.

Access for whom? To what? Under what circumstances?

You have already touched upon one of, I think, the most critical elements in our health care society in your discussion with Dr. Koop. And that is that the leading causes of death are illnesses that are significantly affected by behavioral and social factors such as cigarette smoking, excessive drinking, illicit drug use, bad dietary habits, violence, stress, and refusal or inability to maintain recommended medical regimens.

Of the 2 million deaths in the United States every year, about 1½ million are due to heart disease, cancer, stroke, or fatal injuries and overdoses. For all of them, behavioral and social causes are known to be the major risk factors.

I believe the time has come for us to recognize the importance of those elements in our health care system, and to take perhaps some very dramatic actions with respect to allocation of resources.

KEY ELEMENTS OF A BASIC HEALTH SYSTEM

We talk very glibly about basics. We talk very glibly about basic health care services for which all members of our society should be eligible. But the principles upon which everyone might agree have never been clearly articulated. They're societal. They relate to communal responsibility for the assurance of conditions that are going to provide and promote, preserve and protect health. They also imply that there will be equal risks imposed on all aspects of society, equal risk with respect to those conditions.

What are some of the elements that should be part of a basic health structure if we are indeed going to assume that there is some framework that we can develop?

We all would recognize that emergency care must be available to all of our society. There should be no limitations. It should not differentiate between those who are innocent and those who are not innocent. If someone is injured, he should have access to emergency care.

There must be preventive health care services available for everyone. They must be part of an educational system. They must be part of our social system. They must be part of our work structure. They must be part of everything in our society if we are to be effective in dealing with the kinds of behavior modifications, the kinds

of behavior formulations that are going to provide a higher quality of life for all of our society.

I'm not here to suggest that it's going to be cost effective. It may be. It certainly may be. But we also have to recognize that we are going to keep people alive longer and some of the illnesses that they otherwise might have had in earlier age may eventually come back to haunt us in terms of additional costs.

But that's not the issue. The issue is what do we owe our society in terms of quality of life that can be manifest in the greater availability of preventive health services?

We also must provide protection against the devastation, the economic devastation by catastrophic illness. And I think that the Secretary of Health and Human Services has recognized that and is attempting to extend medicare. I believe that if he had his druthers, he would extend it far more than he has.

But I think he recognizes that the protection against economic devastation caused by catastrophic illness must be part of any societal response to providing equity of health care.

There must be a good, basic system of primary care for everyone, for the poor, the handicapped, primary care for all citizens that includes not just hospital care, but community care programs that provide for an integration of the prevention services—prenatal care services, all of those things at every stage of our existence that can provide for a higher quality of life.

They don't exist. In many instances, there are inequities with respect to their availability. And many of these inequities are derivative of socioeconomic circumstances in which individuals have lived or which they have fallen into.

We also have a responsibility for assuring that there are services for those who are losing their independence. The loss of independence for many individuals is progressive and we need to structure a system that provides a sensitivity to the level of independence.

In some instances, it may be day-care centers. In others, it may be custodial situations. But we also have to recognize that comprehensive care for the elderly alone is not nursing homes. We have to make certain that we use home care and day care not necessarily because they are less expensive, because they may be more humane, they may provide for a greater independence for those individuals and certainly, a greater feeling of worth.

We must not make the mistake that we made in the 19th century when Dorothea Dix, by virture of her well-intentioned efforts, ended up with an institutional warehousing program for mentally ill individuals in this country.

There is no quality in health care unless there is assurance that all individuals can benefit from health care services. Quality of health care relates not simply to the quality of health care of an individual, but to the quality of health care within the community.

Without a recognition that quality extends to an assurance that all those in our society can benefit at least equally from a basic minimum of services, there is no quality.

There is also no quality if there is no egalitarianism with respect to those who are in training. We recognize that those who have been excluded from the health care system, minorities, are also

those same populations who have lacked access, adequate access to health care.

Quality is going to come only when we recognize that there has to be egalitarianism with respect to our admissions policies, our training of health care professions.

NEED PRINCIPLES AND OBJECTIVES TO PROMOTE EQUITY

We have an opportunity to make a choice. If we don't make a choice, I'm afraid that chaos and new inequities will result. We have an opportunity to structure a more beneficial society with respect to the availability of health care services.

I think that there are a series of principles which we must strive to attain. We all must recognize also that there is no magic number for the percentage of the gross national product that must be devoted to health.

I don't know what the right number is. I don't know whether it's 12 or 13 percent or 14 percent, but I know this. We are going to spend more money than we are currently. We are going to spend a higher percentage of the gross national product on health care and we are going to spend it without a series of principles, without a series of objectives, without a clear series of choices that are going to provide for a better health care system than we currently have. Indeed, if we have a health care system.

We have a potpourri of services that are disorganized in many instances, that do not provide equity, that do not provide the kind of egalitarianism that I believe a democratic society wishes.

We have an obligation to provide an adequate level of health care for everyone, those who can pay, those who cannot pay.

We should do what it takes to fulfill the obligations of a democratic society. For those individuals who receive benefits entirely from public funds, the amount of health care that has to be made available can be less than the maximum.

I don't mean to suggest to you that there should not be the opportunity for those who have independent funds to purchase, as in the case of the United Kingdom, health care services they desire.

But we need to define what it is we mean by adequate. What is it that we have an obligation to provide, beyond which we are going to permit individuals by virtue of their economic circumstances to add to the availability of health care services.

NEED BETTER CARE ASSESSMENT

To make decisions about what constitutes essential health care, we will have to make explicit decisions concerning the magnitude of the health outcomes that can be achieved with different health practices. We are not going to indulge, nor can we afford to embark upon the dissemination of technologies without fully understanding their impact, without fully understanding the benefits, the deficits, the costs associated with those health care services.

There must be a better mechanism for evaluating technologies as they are introduced, much as the Food and Drug Administration evaluates drugs before they become part of the drug armamentarium.

If we are going to make decisions about essential health care, we must explictly estimate the economic costs of different health care practices, the value of continuing practices that do not contribute to the welfare of our society, that do not contribute to the longevity, that do not contribute to the feeling of well-being that we owe all of our citizens.

DEFINING ESSENTIAL HEALTH CARE

We are going to have to make some very difficult decisions that are going to require weighing of benefits, harms and costs. And to the extent possible, as you have already indicated, consumers need to be involved in the value judgments that ultimately are going to determine what is going to be disseminated, when, and how much.

I'm not suggesting to you that the professional organizations and the professionals should not be an integral part of that determination. But there is a need for greater public participation, the kind of participation that your recent committee hearings have provided.

If we are going to define essential health care, we are going to need the participation of the professional organizations, business, labor, and consumers.

Everyone has responsibility, everyone should have an opportunity to make input into what we are going to define, as our responsibility in a democratic society, as a community, to provide for everyone, whether they be the disabled, whether they be the poor.

INTEGRATED HEALTH CARE SYSTEM

Providing an equitable response to the need for the poor may require a significant restructuring of the current system. That's not to say that everything needs restructuring. That is not to say that a national health care system, in the mode of those of the other industrialized nations, is precisely the mode that we need to bring to the United States, or that the mode that exists in Canada is the mode that we need to bring to the United States.

But the current fragmented process by which we provide for care for the poor, the disabled, the fragmentation and the confusion that results from multiple programs, of medicaid, bad debt, and charity care, cost shifting, the whole variety of subsidies that we have developed, cannot provide for the equitable distribution of health care resources.

And we need to have a system that is going to provide essential care, however, we define it, that everyone can avail himself of without discrimination. And it needs to be integrated into a system that provides care for the nonpoor as well. We cannot have two systems.

We must have a single system of health care, in terms of prevention, in terms of primary care services within the community, and in terms of hospital emergency services.

Whether or not we permit and how we permit the purchase of care beyond that is another issue. But we cannot have two systems, a poor and nonpoor system.

I believe these are the essential elements that we will have to consider if we are indeed going to have an equitable system, if we

are indeed going to deal with the enormity of the problems that are associated with the future of health care in the United States. If we are to deal with the problems that you've already identified in terms of the services for the elderly, at what stage and how? Who is going to make the decision about specific services for the elderly population?

I think those decisions should be based upon a structure which we can define now, rather than face the increasing chaos that is likely to occur if we do not make those decisions.

FOCUS ON HEALTH PROMOTIONAL DISEASE PREVENTION

And I would add one other comment which derives from Dr. Koop's observations. And that relates to the future of the physician practice in the United States.

He made a number of points with respect to the cognitive functions of physicians and the future capabilities of physicians and payment for the services they render.

I am becoming increasingly convinced that future physician care will necessarily focus to a greater extent on health promotion and sickness prevention.

In the not too distant future, a child leaving the hospital will be accompanied, not by a footprint, but by a DNA print, in which the parents, the physician, will have the opportunity to intervene and to develop behavior that will prevent disease, much as we have been able to prevent disease with vaccines.

The new armamentarium that will be provided to the physician will relate to our knowledge about genetic characteristics, genetic propensities in which there are opportunities for intervention that we would not have dreamed of years ago.

What this information will represent to heart disease and to many other similar diseases will be what the polio vaccine meant to those who were susceptible to polio.

We are going to replace an iron lung with the same kind of effective intervention, indeed, that we were able to achieve with polio. And in many respects, we will look back at organ transplantation, we will look back at coronary artery bypass surgery, much as we look at the iron lung at the present time as it relates to polio.

Mr. Chairman, the development of a framework upon which we can build and develop a structure that will provide for a better, more efficient, and certainly more egalitarian system is one that I hope will come from these hearings.

Thank you very much.

[The prepared statement of Dr. Axelrod follows:]

PREPARED STATEMENT OF HON. DAVID AXELROD, M.D.

Thank you Mr. Chairman and members of the committee. I appreciate this opportunity to appear before you, and address some of the issues confounding us most in New York...and, I suspect, the nation as a whole.

The overall issue ... or question ... might best be defined with a single word: ACCESS. Access to health care. And what I would like to offer for your consideration are some thoughts on what we mean by access to health care.

How does, and how should, the United States define access to health care at the close of the 20th Century? We can argue that we have the finest transplant technology in the world. Who is it that rushes to Moscow to perform bone transplants in the wake of Chernobyl?

But there are any number of other countries that do much better than we do in providing basic primary care for low income pregnant mothers. And this is reflected in their infant mortality statistics.

A study of health care spending in the Organization for Economic Cooperation and Development nations shows that we rank 15th among 22 nations when it comes to infant mortality. Yet, we spend 2.2 times as much per capita for health care as the average for the other 21 countries.

More about infant mortality and pre-natal care later.

First, let me frame the issues somewhat by asking that you consider the question of how different sectors should contribute to improving access. What roles must we ask of the government, the professional--voluntary sector, and the employers or the private sector. I submit the answer lies in the type of intervention necessary to promote access, and the actual goal in mind. This analysis should guide overall social investment.

Look, for example, at the wonderful news just this week about tooth decay.

A dramatic decline has been achieved...to the point where we have a federal government health official saying, and I quote..."this is no longer a public health problem." Did this result from an increase in the number of dentists and the development of higher technology. No, absolutely not. This improvement resulted from the simple use of floride in public water supplies, and in some topical applications.

I would submit the same lesson is applicable to other areas. In AIDS...we need hospital beds, yes. But we also need to attack the root cause of our problems, primarily drug abuse, if we expect to do anything except build hospital beds on every empty corner in the South Bronx...for decades to come.

Rationing. Rationing is now an implicit process in our society. Society is surprised when we have to wait for a hospital bed. But we have not demonstrated the leadership to confront the issue directly, and help the public share in the explicit rationing decisions increasingly necessary.

Some of you may be familiar with Oregon's decision to eliminate Medicaid payment for transplantation procedures. The State of Oregon decided that it was more important to provide prenatal care to a large number of individuals than to provide a procedure that would benefit a small number of individuals. I do not believe that Oregon's position is politically sustainable. I don't think government can take the position that as a State or a nation we are not going to take advantage of advances in technology, even though they may benefit a relatively few people. We cannot eliminate some of the important changes in technology from our ethical allocation of resources.

We have a process in New York State by which we limit the number of heart transplant centers, liver transplant centers, bone marrow transplant centers to what we believe is the required number, based upon the availability of organs and based upon the estimated numbers of people who can benefit from this technology. What we have done is gradually increase the number of centers with respect to the need that exists as well as the availability of organs. There is a liver transplant consortium in New York City made up of all of the major hospital centers which have the requisite scientific interest and skills in this area. The purpose of the consortium is to provide for a greater stimulus for some of the research that may be more important than the actual surgical techniques themselves.

I would urge you to consider transplantation procedures very much as the iron lung was to polio. Like the iron lung, transplantation is a crude and ineffective way of dealing with the problems associated with heart disease or liver disease. The ultimate solution involves our understanding of DNA and our ability to develop techniques that will prevent the diseases from occurring, such as motivating behavioral changes. I expect that within ten years advances in genetic medicine will replace the newborn infant's footprint with a DNA printout describing the genetic propensities of that individual child so that the physician's responsibility will be to provide for early intervention and to motivate changes with respect to both the parents' behavior and the child's behavior to prevent the occurrence of heart disease or liver disease much later in life. Other responsibilities as physicians will be very different from those that we have today and I am concerned about spending large quantities of money for the support of what is a halfway technology. At the same time, I recognize the need to provide existing technologies to those who truly need them.

This applies to preventive technologies, as well. We are releasing today on Long Island, the first thorough population based breast cancer study undertaken in New York. And it identifies the fact that with the more intelligent use of existing technology ... mainly assuring use and access, we can save thousands of lives.

In Nassau and Suffolk counties, the data show a large percentage of women visited a physician one or more times in the previous year. A high percentage had learned how to examine their breasts for physical changes; about 1/3 practiced it monthly, comparable to levels in statewide surveys. Forty-one percent of Nassau county respondents and 38% of Suffolk county women age 50 to 70 had received at least one mammogram during their lifetime. However, only 10% of Nassau County women and 5% of Suffolk County women age 50 to 70 reported that they receive the recommended annual screening mammogram.

The data from the Long Island breast cancer study indicate that the breast cancer screening practices of Nassau and Suffolk county women are similar to those reported in national and New York State surveys. These data suggest that a major effort is required in these two counties to achieve the screening levels recommended by the National Cancer Institute for the year 2000, i.e. 80% participation in clinical examination and mammography. With such screening, estimates of the number of breast cancer deaths that might be prevented from 1988 to 2010 range from 1,155 to 1,430 in Nassau County and from 944 to 1,153 in Suffolk County depending on the number of years to reach screening objectives.

MATERNAL AND CHILD HEALTH. A 1985 Institute of Medicine report, Preventing Low Birthweight, stated that although many different factors

contribute to the problem of inadequate access to prenatal care, an underlying cause is the patchwork, nonsystematic approach to making prenatal services available. "Without a structure of accountability, gaps in care will remain, and efforts to expand prenatal services will continue to face major organizational and administrative difficulties."

The value of prenatal care is well-documented. First, and foremost, effective and timely prenatal care can promote healthy pregnancies, which will save thousands of infant lives and prevent needless birth defects. If current trends are permitted to continue in New York State, nearly 1,100 babies will die between now and 1990, primarily because they were born too small to survive. At least one in nine or 86 infant deaths can be prevented simply by ensuring that their mothers receive early and comprehensive prenatal care. Moreover, prenatal care can help prevent thousands of infants from being born handicapped for life.

According to the Institute of Medicine study cited earlier, there is overwhelming evidence that prenatal care reduces low birthweight and its associated complications of neurodevelopmental handicaps, learning disorders and respiratory tract conditions. By preventing low birthweight, therefore, prenatal care can result in cost savings. The report estimated that for every additional dollar spent for prenatal care within a high risk target group, there is a savings of $3.38 in the cost of care for low birthweight infants who require expensive medical care.

However, it would be a mistake to focus on prenatal care exclusively and ignore the larger concept of maternal care. Maternal care begins with pregnancy testing, continues with the clinical management of the pregnancy until labor begins, extends through labor and delivery and includes a postpartum examination. Improved access to prenatal care will have a constrained effect on pregnancy outcomes unless the other components of the materrrnal care delivery system are well coordinated and accessible. The importance of examining the full maternal care system is underscored by research suggesting that the reduction in infant mortality rates over the past decade can be largely attributed to improvements in neonatal intensive care units and not in prenatal care.

The current system for ensuring maternal and newborn health lacks comprehensiveness, efficiency and does not guarantee accessibility to all components of maternjty care for low income women. There are an estimated 47,000 low income, pregnant women in New York State each year who have limited or no prenatal coverage under the existing system.

The current structure for providing access to maternal services consists of a variety of programs whose efforts are largely uncoordinated, and offer varying program characteristics in terms of client eligibility, service components, outreach and payment structures. The largest are Medicaid, an assortment of private insurance plans, the Prenatal Care and Nutrition Program (PC/NP), and the Bad Debt and Charity Care Pool. While PC/NP ensures high quality, comprehensive prenatal care, it does not include inpatient delivery or maternal and newborn follow-up. As a result, PC/NP clients can deliver in any hospital, even if there are no linkage arrangements and pre-filled prenatal records. The result is uncoordinated treatment and duplicative testing, unnecessary risk and expense.

The weakness of the currenŧ Medicaid program for providing maternal

services include a poor rate of participation by private physicians in the program; fluctuating Medicaid status determined before, during or after pregnancy; a fee-for-service approach which does not encourage prenatal care providers to be efficient; an inpatient per diem reimbursement mechanism which provides incentives for hospitals to keep the routine maternal admissions for as long as possible in order to maximize revenue; and, a complex eligibility process.

The private health insurance industry also contributes to the weakness of the current system by marketing plans with inadequate prenatal coverage. Since 1977, New York State has required that every health insurance policy or contract include inpatient maternal coverage. However, only two payments for prenatal care are currently required under law. Consequently, many women are underinsured for prenatal care despite coverage for other health benefits. An estimated 13,000 women in the state with incomes at or below 185 percent of poverty fall into this category. New York should further explore requiring every health insurance policy or contract to include an increased amount of coverage for prenatal and postpartum care. In keeping with current private-public joint efforts, coverage for comprehensive prenatal/postpartum services should be a shared responsibility between the public and private sector; the government should not bear the entire responsibility and cost for adequate coverage.

The cost of providing what we call Universal Access is not a financial risk to a state like New York. Based on expenditure expectations, the goals could achieved at a cost similar to or perhaps even lower than what is already being expended for maternal and newborn care from the combination of private insurance, Medicaid, out-of-pocket payments, the Prenatal Care/Nutrition Program, the Bad Debt and Charity Care Pool, and the Block Grant programs. Nearly all hospitals costs for maternity care are currently covered for low income women, which accounts for more than 80 percent of the cost of a universal insurance plan.

Research on the cost effectiveness of prenatal care strongly demonstrates that these programs pay for themselves even in the short run. In the long run the savings are substantial -- a modest 10 percent reduction in extended hospitalization due to complication could result in an annual savings of $20 million.

New York State is already making a substantial commitment to funding maternal and newborn services for the target population. Total current expenditures are estimated at $546 million. This figure includes some of the following: $$302 million from Medicaid, $123 million from private insurance funds, and $92 million from bad debt and charity care. Free care is also provided to the target population by diagnostic and treatment centers, but data are not available to assess the dollar value of that care.

Extended care deliveries account for 40 percent of all obstetrical discharges, patient days and expenditures, and require a hospitalization 2.5 days longer with a per capita expenditure $1,000 more than for a normal delivery. A 10 percent reduction in deliveries requiring extended care for mothers will result in 900 fewer extended care days and an annual savings of

$800,000.

A 10 percent reduction of antepartum and postpartum complicated discharges of mothers will result in 2,000 fewer nondelivery discharges for a savings of $2.5 million.

The largest potential source of savings is in the reduction of patient days for newborns with complications; such a savings can occur with the provision of better prenatal care. Births requiring extended care for newborns who would be served by UAP currently account for 42 percent of all newborn discharges but 68 percent of total newborn days and 86 percent of newborn expenditures. A 10 percent reduction in births requiring extended care will result in a savings of nearly $18 million from 4,000 fewer extended care births and 31,000 fewer extended care days.

In a December 18, 1986, editorial in The New England Journal of Medicine, the country's most influential medical publication, its editor, Dr. Arnold Relman, wrote: "We seem to be too involved in our present romance with the "market" to consider other approaches seriously. But the cost of our present system may prove to be so high and the inequities so onerous, that universal tax-supported health insurance may become a far more attractive political option than many now suspect. Perhaps even the medical profession, disenchanted with the private corporations and the competitive market, will some day be leading the campaign."

Representative SCHEUER. Well, thank you for your predictably brilliant and eloquent statement, Dr. Axelrod.

Do you have a few minutes for questions?

Dr. AXELROD. Yes, I do sir.

NEED TECHNOLOGY ASSESSMENT AGENCY

Representative SCHEUER. You said, and quite properly, that we are not evaluating the effectiveness of new technology, new procedures and processes, and so forth in anything like the detail and scrutiny that we give to drugs through the Food and Drug Administration, where a drug has to be proven to be safe and effective. We apply none of this scrutiny to very expensive high-tech procedures, practices, products, surgery, and the like.

Now, shortly after this administration came to power in 1981, they abolished the National Center for Health Care Technology, an agency that was responsible for assessing major medical technologies. That function is now part of another agency.

Do you believe that this technology scrutiny office, the National Center for Health Care Technology, ought to be reestablished as a separate entity, or in a format something like that?

Do you think it should be left where it is? How and where do you believe that a capability, a very much greater capability for assessing the effectiveness of technologies, procedures, systems, operations, surgery, and the like, should be carried out?

Dr. AXELROD. Mr. Chairman, I don't believe it's where the organization is in terms of the role it is meant to fulfill. The importance is that it be financed, that it receive the support, and that it be in a position to make binding recommendations with respect to financing that affect virtually every area of our society.

If one looks at the allocation system, one cannot help but be struck by the fact that third-party payers, whether they be Blue Cross, medicare or medicaid, or other commercial payers, are all part of the same system.

And it would seem to me that if they are to be effective in carrying out the evaluation there must be ways in which they can extend the limitations of that technology to other payers beyond those that are fully federally reimbursed, such as medicare.

It should be extended to medicaid. It should be extended to commercial payers and the Blue Cross if we are indeed to have the kind of impact that we are attempting to achieve with respect to averting the dissemination of useless techniques. Some 25 or 30 percent of all premiums are paid by Blue Cross or similar, not-for-profit organizations. Something like 40 percent are paid for by medicare. And an additional 25 percent, perhaps, by medicaid.

It would seem to me that we have the opportunity by virtue of the power of the purse to limit the dissemination of techniques that are not proven, that, indeed, may be harmful, and provide for inefficiencies within the health care system.

The issue is to accomplish our goal, to have a clearly defined mission, rather than what the organization is. But it must be financed and it must have the ability to enforce its determinations with respect to the dissemination within the institutional systems.

Representative SCHEUER. Dr. Axelrod, you mentioned that we ought to have this information and that the health care payers should be able to use it.

At the present time, we don't have the information, we don't have the research. And even if we did, health care payers are not currently in a position where they can negotiate many of these things. Certainly, they can't negotiate fees with the health care providers because of the application of the antitrust laws, as I'm informed.

FEE NEGOTIATIONS WITH LIMITATIONS

I'm going to talk to you about the research in just a moment. But wouldn't you say that the health care payers, the Government in the case of medicare and medicaid and the private insurers like Blue Cross & Blue Shield, ought to be in the position of using their economic clout and their expertise in negotiating fee structures with health care providers?

Dr. AXELROD. Yes, I do. I think that there should be greater opportunity for the use of that power. I have advocated that there should be the opportunity for virtually all elements of our society, all elements of the payer groups, at least, to be able to negotiate within reason and not create—again, it is possible, as I'm sure you recognize, to create chaos if there is unlimited negotiation on virtually all elements.

But there should be the opportunity to negotiate within some limitations that would provide for a more efficient system, as in the case of the preferred provider organizations, that in some instances have proven to be cost effective and efficient.

LACK OF TECHNOLOGY ASSESSMENT AND GERIATRIC RESEARCH

Representative SCHEUER. Now, let me ask you a question about research.

In a country that historically has valued knowledge and valued research, and has used knowledge and research to jump to a preeminent place in the commercial and industrial world, at least preeminent up until recent years, doesn't it strike you as anomalous, to say the least, that we haven't done the research on what works and what doesn't work when it comes to all these new high-tech procedures, processes, objects, products, surgery, treatment modalities, and so forth?

We really don't know what works and what doesn't work. And that is expensive and costly to society, as you have mentioned, besides causing great harm to patients where these things, these procedures and practices and products are applied where they are inappropriate, and sometimes unhealthful and sometimes truly damaging.

The whole question of unnecessary and inappropriate and unhealthful application of processes, systems, products, surgeries, and whatnot, accounts for an enormous percentage of the waste inherent in our system that Secretary Califano talked about, the $125 billion that seems to evaporate in the morning mist while producing no positive health outcomes.

Isn't it long overdue that we do this?

And let me mention two other kinds of research that it seems to many of us are long overdue. We seem concerned about, and rightly concerned about, the rapidly escalating costs of long-term health care for the elderly. We just turned down a bill in the House last week, Senator Pepper's bill, because it cost too much.

Yet, we've been told in these hearings that there are perhaps three avenues of research that would be comparatively inexpensive and that would very substantially cut down the period of dependence in an elderly person's life, delay by many years the advent of dependence. And this would be research on arthritis, research on incontinence, and research on dementia.

And it was suggested to us that for a couple of hundred million dollars in each of these three areas, significant progress could be made in understanding what produces dementia, what produces incontinence, what produces arthritis, treating them either to prevent their onset or delaying by many years their onset, at the savings of literally hundreds of billions of dollars over a period of time in the health care system.

Why do you feel a society that is so concerned about the rapidly rising cost of long-term health care for the elderly hasn't engaged in at least these three very, very promising areas of health care research?

Dr. AXELROD. I can only——

Representative SCHEUER. Excuse me. And why haven't we engaged in the research on these practices and procedures that would tell us which would help our health outcomes and which wouldn't, and under what circumstances they would and wouldn't?

Why haven't we done these two areas of research?

Dr. AXELROD. Certainly, with respect to high technology, there are economic interests that would seek to have the dissemination of instrumentation that has not necessarily met the tests that we would like to impose upon them.

So that there are conflicting elements within our society that seek to profit from development without necessarily having the kinds of evaluation that should take place.

We are constantly fighting that battle and it is constantly being fought within the Food and Drug Adminstration as well, of the imposition of the kind of restraint we have never been willing to take with respect to high technology.

But I think that there are clearly economic interests that are manifest in seeking to provide for the immediate diffusion of every new technology without evaluation.

The difficulty with the recommendations for research on specific areas is that there are many other areas in which effective research can be carried out, and arthritis, incontinence, and dementia are constantly competing in the face of a diminishing commitment for basic research or even behavioral research.

It certainly is possible that the investment of $100 million or $200 million in arthritis or incontinence or dementia research would provide major results in terms of long-term reductions of additional costs.

But I feel that we may be doing ourselves, and I say ourselves in terms of professionals, a major disservice in promising what we cannot deliver. I think one of the problems that we have is that

some elements of the scientific community have been discredited by making promises that they cannot fulfill, and I think Congress has become a little leery of acceptance of promises that $200 million in research will provide a return that is worth $2 or $3 billion.

I think it inevitably will have a positive impact with respect to preventing the advent of dependence in many in our society. But I don't think there is any sure conclusion that a simple investment will provide for a multiple in terms of the return on that investment in each and every one of these areas.

And it may well be that we will postpone some of the expenses, but not necessarily eliminate them. We have to be very careful in suggesting that each one of the efforts which we undertake will result in major reductions in cost.

BEHAVIORAL RESEARCH CRITICAL

There is another area which you have touched upon and which I think is perhaps even more important and transcends the issue of research on arthritis, incontinence, and dementia. And that is fundamental research concerning behavior on social context of health and illness because of its increasing importance and prevention and treatment.

As I'm sure you're aware, we confronted and are continuing to confront the AIDS epidemic with little new information on sexual behavior. There has been little that has been done in recent years that provides us with a clear analysis of the transitions that have occurred since the Kinsey report.

So that as we look at the need for research, I would urge that we recognize that behavioral, motivational research, the social context of health care not be neglected because I am honestly of the opinion that they will be more important and may be the critical elements of the future in the delivery of health care services, that the education of the physician and the ability to intervene will increasingly depend upon our knowledge of ways in which we can formulate behavior and certainly motivate changes in behavior.

And it's indeed possible that that same kind of investment in arthritis, incontinence, and dementia will also have larger payoffs.

But I think if I were to say today what I thought would be the most effective area of research in terms of a dollar contribution, my feeling is increasingly that the behavioral and social context of health and illness may be one of the most productive areas, or may be some of the most productive areas.

That's hard for me to say, as someone who is a molecular biologist, someone who's a cell biologist who has always been somewhat disdainful of motivational studies and social behavior. But as I have become increasingly involved in dealing with public health problems, I become increasingly aware of the difficulties that we have and our lack of knowledge in behavioral areas.

Representative SCHEUER. That was a marvelous answer and it would suggest questions that would keep us here until dusk.

LACK OF PEER REVIEW AND CONSUMER INFORMATION

Let me ask you another question about research. We have an extraordinarily expensive and very harmful phenomenon in our soci-

ety known as malpractice. It's driving many doctors out of business. Neurosurgeons and gynecologists are ceasing to perform that function, making access to neurosurgery and access to top qualify childbirth care difficult in many areas of the country and impossible in others.

Yet, the medical profession has done painfully little to screen out the 20,000 doctors, or roughly 20,000 among 515,000, who the New England Journal of Medicine says are drug addicted, alcoholic, or clearly mentally incompetent to carry out satisfactory medical practice.

Why hasn't the medical community done a better job of screening the 4 or 5 percent of its members who are delivering painfully substandard health care? And why, as a last resort, as a fail-safe device, has the medical community not delivered to health consumers the information about health providers that would help consumers—and that's all of us—avoid the health care providers who would, according to their own records, doctor-specific and hospital-specific records, threaten to negatively impact their health outcomes?

Why don't we give health consumers the ability to select from one of the overwhelming majority of the health providers those that would promise to deliver excellent health outcomes?

Why does the medical community invoke a kind of medieval guild system of privacy on information that you would think is vital in order to make intelligent consumer health choices, information about hospitals that have two or three times the rate of nosocomial infections as other hospitals, perhaps double the rate of iatrogenic or physician error as comparable hospitals?

Why can't we, as health consumers, identify physicians, doctors that have had a record as long as your arm of malpractice judgments against them? Why can't health consumers know whether a doctor has been delicensed in one State and in another State and in a third State and been subject to censure after formal due process by a State health board?

It seems to me that in a country that vaunts free enterprise forces and the free workings of private market forces, in a country that overwhelms consumers with an almost unbelievable outpouring of information about products and services, whether it's a hair dryer, a washing machine, a car, a television set, a resort hotel, or whatever, we deny them this essential information to make intelligent choices among alternative health providers.

That's a long question, but I think it's an important one. Why haven't we done that kind of research as to how to prepare information about health providers that is professional, that is understandable by health consumers, that is fair to the health providers, and disseminated in a way that makes it practical and available to health consumers?

If we could liberate consumers to make intelligent choices among health care providers, wouldn't that in itself augment the inadequate performance of the health care community itself in screening out the 20,000 or so health care practitioners in this country who are delivering painfully substandard health care?

Dr. AXELROD. You've asked a series of very difficult questions, Mr. Chairman, and I will try to address some of the elements of the very complex issue you have raised.

I think the problems as you have identified it is correctly a medieval problem in some respects. If one looks carefully at the Hippocratic oath or the oath of Maimonides or Hammurabi, which are generally the three oaths that are taken by physicians when they embark upon their medical careers, one finds an interesting contradiction with respect to those very oaths. And that is that there is a distinction that is made between the fealty that a physician has to his peers as well as the responsibilities to his patients. There's a distinction.

And that distinction, it seems to me, characterizes a great deal of what the problem has been over the years with respect to the fealty of individual physicians to other members of the profession, as opposed to his responsibilities for the patients for whom he assumes a direct role in terms of their health care services.

I believe that is beginning to break down and that there is an increasing recognition that a physician cannot place fealty to his profession or to his peers above the responsibility that he has to his patients.

But it is interesting if one looks at the Hippocratic oath. It does make that distinction.

I have thought about that frequently because I think it has been the basis for a great deal of misunderstanding even among physicians as to what the Hippocratic oath did and said with respect to their activities.

The peer responsibilities have, I think, been diminished to some extent by immunity that's been provided for taking information to medical review boards. The liabilities have been effectively eliminated, at least in terms of financial liabilities. But there remain the potential for individual lawsuits, nuisance lawsuits in which an individual physician ends up spending a considerable part of his time in court as a result of defamatory suits, all kinds of legal machinations that result in a great deal of lost time and effort that have in fact made physicians reluctant to become a part of the peer review process that I think you appropriately are seeking.

It is changing. There is in New York an impaired physician program that is sponsored by the State medical society that has been effective in identifying impaired physicians and has worked reasonably effectively.

I don't mean to suggest that it has 100 percent of impaired physicians enrolled in the program, or that they have been identified. But there certainly has been progress with respect to impaired physicians.

The issue with respect to information for consumers is a difficult one and it is one that I think also is changing. We have initiated in New York a series of reports that provide information on procedures conducted within institutions, morbidity and mortality rates at each of the institutions. We are about to publish volume/procedure relationship, for institutions, that identifies increased mortality in those institutions that do less than a minimum number of procedures of a certain kind.

That kind of consumer information, I think, must be provided to the public. But it cannot be provided in a vacuum. It has to be provided with supporting information that will allow the public to interpret it. I think many consumers have difficulty in interpreting the information that is being provided to them, as well meaning as it may be.

The other concern I have is the assumption that that information will be effective also is dependent upon the fact that free market activities are expected, or free market principles are expected to function within health care.

It doesn't function within health care. The free market does not exist within health care. People seek health care services primarily when they're desperate. They don't seek them on a regular basis, except in unusual circumstances. But they do not seek medical assistance except when they are required by some form of medical problem or catastrophe.

And the ability to exercise the kind of choice that otherwise would be exercised by consumers in the selection of a refrigerator or a television set is not exercised with respect to the selection of a provider.

So having information alone will not be sufficient.

Additionally, there has been an effort on the part of the Health Care Financing Administration to provide for additional information on individual physicians, as well as individual institutions. But that has also been fraught with difficulties in interpretation.

And finally, there is the registry that was to be established this past year through the contract with the American Medical Association that would provide for a clearinghouse of all physicians who had been sanctioned in the various States. My understanding is that for funding reasons, that has not yet been initiated.

MALPRACTICE AND LEGAL REFORM

So the issue with respect to malpractice is, one, that, indeed, is costly. But I think more important is that it has destroyed the relationship between patient and doctor. They are becoming increasingly adversarial and the only way of resolving that may be for a change with respect to the entire tort fault system, one that provides an administrative process and at the same time, provides increased deterrence.

Representative SCHEUER. I think you're absolutely on target. As a matter of fact, we had a hearing Tuesday of this week on alternatives to the present tort system. I am convinced that we should be moving in that direction and perhaps we'll make some advances on a State-by-State basis.

Do you think moving to an alternative to the tort system should come incrementally by individual States sticking their toe into the water, so to speak, and gaining some experience that we can all look at? Or should it come through the Congress and the next administration, and should we try some uniform approaches across the country, perhaps some alternative approaches?

Dr. AXELROD. My feeling would be that experimentation at the State level with various approaches to alternatives to the tort fault system may be the most effective way of determining the best kind

of approach because there are different problems in different States. Malpractice costs in different States are quite different. The nature of the problem is quite different.

I think that the Federal Government should evaluate the experiences that can be had by virtue of some 50 States embarking upon a series of experiments before mandating a series of changes that could result in disaster or catastrophe for everyone.

So I would certainly encourage a State-by-State approach. Perhaps the Federal Government could provide some assistance in terms of special financing through medicare or whatever to States that embark upon major changes in tort fault without fully understanding what the direct impact would be upon the costs associated with the delivery of those services.

The existing malpractice system among all other things is one of the most inequitable systems that we possibly could have put in place. And I think that if we are indeed to attempt to achieve some equity and equality, then there has to be a major modification of the system. And that may be costly initially with respect to making everyone who has an adverse event eligible to receive certain benefits. But I believe those benefits may have to be covered by, initially, at least, by insurance carriers or third-party payers in one form or another.

DISSEMINATING CONSUMER INFORMATION

Representative SCHEUER. Dr. Axelrod, you've been testifying before us for almost an hour and I fear we've abused your patience.

Let me just ask you one last question. You say that you're making advances in New York in empowering consumers with a great deal more knowledge than they've had before, and you so testified in a hearing we had a week or two ago in New York City.

Dr. AXELROD. Yes.

Representative SCHEUER. And we welcome that, and we applaud that; what you're doing in New York State is a quantum jump forward.

Would you think that New York State and other States might experiment somewhat in how that information is prepared for the benefit of health consumers? And I would particularly cite the HCFA release of hospital data that came in seven volumes each approximately the size of a telephone book. That is not very helpful to consumers.

Would you consider that maybe we can do some research and experimentation on how that information can be prepared and how it can be disseminated? And that possibly in the dissemination process, there might be some counseling involved there. As you suggested, these are very tricky, very sophisticated, very complicated, sometimes very scientific questions that many, if not most, health consumers are not able to judge very well.

Could you envisage a system whereby information is made available in a looseleaf book, computer terminal, or whatever, with the presence of a health counselor there, perhaps in a public library, perhaps in a high school, perhaps in a hospital?

Who knows where? Perhaps in a community center, a church, a synagogue. Who knows? A place where you would combine the

advice of a sophisticated, well-trained counselor who could consult with a person on general health behavior, preventive health behavior, and their particular health emergency that requires them to pick a health provider, a counselor who would help give a little bit more meaning and understanding to the kind of data that you're about to prepare.

Dr. AXELROD. I think that the formulation that you have provided is one that should be pursued. I think the idea of embarking upon a number of experiments in the various States is a worthwhile suggestion.

I am convinced that in order to make that information available, it needs to be provided in supermarkets, in bodegas, in drug stores, rather than necessarily in libraries, because I think libraries do not necessarily bring to them a significant portion of the population that is most in need of consumer health information.

So I would certainly opt for dealing more with marketplace type operations than I would with educational institutions, except that I would encourage, certainly, the schools and libraries to become part of a network to provide information.

But I think in order to be effective for some of the populations for whom we are most concerned, it will have to be in consumer-related areas, such as stores, bodegas, wherever.

And the question, I think, also becomes, is it affordable? At what level? And, again, I think the reason for the experimentation is to determine the cost effectiveness of each of the programs that could be structured to provide that information. It even could be—a series of comparisons could be carried even within a given State on ways to provide that information, the location of that information, the multiple languages in which it would have to be provided in States like New York to ensure that it was effective.

I think all of those things need to be evaluated. But, certainly, the time has come for us to stop talking about it and do it.

Representative SCHEUER. On that wonderful note, stop talking about it, but doing it, we'll end your testimony and thank you very much for coming.

Dr. AXELROD. Thank you very much.

Representative SCHEUER. Thank you for the marvelous quality of your testimony. We know how busy you are and we're very grateful that you came.

Dr. AXELROD. Thank you very much.

Representative SCHEUER. Thank you very much, Dr. Axelrod.

I want to ask unanimous consent that we keep the record open for inserting selected material from a hearing on the quality of care, information for health consumers, which was conducted by the Committee on Science, Space, and Technology on June 6, 1988, in New York City.

This material will be made part of the record of this hearing under the rules of the Science, Space, and Technology Committee regarding the editing of transcripts.

[The selected material follows:]

INSERTS FOR THE RECORD
SELECTED MATERIAL FROM JUNE 6, 1988 HEARINGS OF

COMMITTEE OF SCIENCE, SPACE, AND TECHNOLOGY
U. S. HOUSE OF REPRESENTATIVES
WASHINGTON, D. C. 20515

SUBCOMMITTEE ON NATURAL RESOURCES, AGRICULTURE RESEARCH AND ENVIRONMENT

HEARING ON

QUALITY OF MEDICAL CARE: INFORMATION FOR CONSUMERS

OPENING STATEMENT BY CONGRESSMAN JAMES H. SCHEUER, CHAIRMAN

WITNESS LIST

PANEL I: Is There A Problem?

Dr. Lowell S. Levin, Professor
Yale University School of Medicine
and Author, Medicine on Trial

Ms. Sondra Bauernfeind, Founder
Victims Against Medical Abuse
accompanied by
Ms. Marian Stackhouse
Sullivan County Coroner

Mrs. Elaine O'Rourke, Secretary
Stop Hospital and Medical Errors (SHAME)

Mr. Louis Krieger, Chairman
New York City Legislative Committee
American Association of Retired Persons

Mr. Robert Krughoff, President
Consumers' Checkbook

Ms. Esther Lustig, Director
External Affairs and Development
Lexington Center for the Deaf and Hearing Impaired

PANEL II -- Defining the Problem

Dr. Jane Sisk
The Quality of Medical Care: Information for Consumers
Office of Technology Assessment

PANEL III -- Government's Efforts to Solve the Problem

Mr. William Toby, Regional Administrator
Health Care Financing Administration

Dr. David Axelrod, Commissioner
New York State Department of Health

PANEL IV -- Solutions from Health Care Providers

Dr. Charles J. Sherman, President
Medical Society of the State of New York

Dr. Juanita K. Hunter, President
New York State Nurses Association

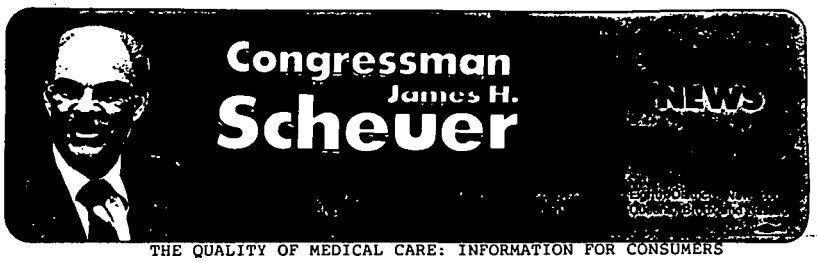
Ms. Suzanne G. Martin, Assistant Vice President
Medical Case Mix and Utilization Management
New York City Health and Hospital Corporation

Mr. Kenneth Raske, President
The Greater New York Hospital Association

Ms. Carolyn F. Scanlan, Executive Vice President
Hospital Association of New York State

Ms. Carol Dye, Executive Director
Hospital Trustee of New York State

Additional Witness: Ms. Rose Ann Liveo
President of SHAME



THE QUALITY OF MEDICAL CARE: INFORMATION FOR CONSUMERS
JUNE 6, 1988

Today we will hear testimony on an issue which is critically important to every citizen of this country -- namely the quality of medical care they receive. Despite the tremendous emphasis we as a society place on medical technology, very little attention has been paid to making information available to consumers about the quality of health care services.

Although consumers can obtain information to guide them in making the purchase of everyting ranging from cars to stereo equipment and washing machines, there is really no place that consumers can reference information about the quality of care offered by hospitals and physicians.

Almost two years ago, the Health Care Financing Administration (HCFA) released the first Medicare Hospital Mortality Index. This was a watershed in health care, throwing the weight of the government behind the notion that health care is, like anything else Americans purchase, subject to consumer judgements about cost and quality. I strongly commend HCFA for this undertaking. The survey was confined to an analysis of Medicare billing information and as such had certain limitations. While it provided information on hospital mortality rates, it did not address the performance of individual physicians and nurses.

The time has come, I believe, to make information regarding the quality of health care available to consumers in a form that is intelligible, accessible and easy to read. Two years ago, several Members of Congress joined me in requesting the Office of Technology Assessment to consider how this Herculean task could be accomplished. The report which we are releasing today, The Quality of Medical Care: Information for Consumers, informs us that there are indeed certain indicators of quality -- which go beyond whether or not a patient dies -- which when taken in the aggregate give an accurate impression of the care that an individual is likely to receive.

Health care professionals have been quick to point out that various indicators of quality can be misleading. I agree. To consider a single item such as a hospital's unadjusted mortality rate without considering whether that hospital treats a high percentage of terminally ill patients, like Sloan-Kettering Cancer Center is unfair to the institution and misleading to consumers.

This report suggests that consumers be given information on several indicators such as: Whether a physician is board certified and practicing in his or her area of training; Whether a physician has been sanctioned or disciplined by a state medical board; Whether the hospital has been accredited and whether there are areas in which the hospital has deficiencies; Whether the rate of nosocomial infections at a particular hospital exceeds the norm; Whether a certain surgical procedure is performed ten times a week or ten times a year.

Taken together, information such as this will aid consumers in choosing medical services with as much thoughtfulness as they make any other major purchase. Maybe even more -- the stakes are higher.

New York State has been a leader in developing techniques to assess the quality of health care and in disseminating this information to the public. I am delighted to welcome the distinguished representatives from the New York Health care industry who will testify today.

I also welcome the representatives of Victims Against Medical Abuse and SHAME -- Stop Hospital and Medical Abuse. This group gives a voice to those who unfortunately cannot represent themselves. I have been told that if a consumers' guide to hospital and health care services had been available, Mrs. Elaine O'Rourke of Brooklyn, would have made a different decision in seeking medical treatment for her little boy.

I will be working with my colleagues in the House to develop pilot programs to make this information available to consumers. I am looking forward to hearing the suggestions that will be presented today.

Testimony of

LOWELL S. LEVIN

Yale University

I am Lowell S. Levin, Professor of Public Health, Yale University School of Medicine, New Haven, Connecticut and Chairperson of the Board of Directors of the People's Medical Society, a national non-profit health advocacy organization with its headquarters in Emmaus, Pennsylvania.

My teaching and research over nearly two decades have focused on health consumerism, with a particular emphasis on how to help people gain more control over their health destinies. The first pre-requisite for this process is access to information about the range and seriousness of health hazards and access to information that can help individuals and communities reduce their health risks. Such risk reductions stem from knowledge that improves health decision-making among informed choices for action.

For years now the federal government has collected and disseminated to the public a vast amount of health risk data on a timely basis. We have been warned about salt, cholesterol, sugar, smoking, drug use, alcohol consumption, obesity, lack of exercise and all manner of environmental pollutants as well as some, if not all, occupational hazards. And now AIDS! Indeed there has been a veritable blizzard of health advisories and alerts, perhaps even to a point where some persons have been rendered desensitized and

bewildered to a point that they simply give up and go back to their original not-so-healthy behavior. Overall, however, the level of health consciousness has never been higher with the public eagerly seeking and pursuing ways and means to preserve and promote their health. Most of this interest has been related to lifestyle behavior where the message is directed at individual responsibility for change. The goal is to raise the level of personal protection from those diseases known to have a major behavioral component in their etiology.

In sharp contrast to the commendable government and voluntary health sector efforts to inform the public about lifestyle-related risk, there is virtually a total void in information on the vast source disease, disability, and death emanating from those institutions and professionals providing medical care. So-called iatrogenic or doctor/hospital caused disease or injury is pandemic in the United States, affecting approximately 20 percent of hospitalized patients and an unknown proportion of patients being cared for in doctors' offices.

I have recently co-authored a book on this subject entitled, Medicine on Trial (Prentice Hall, 1988), which catalogues the shockingly high levels of disease and injury through the entire hospital experience. The data reported in this book were drawn from the medical, peer reviewed, literature itself, mainly primary resources. Critiques and interpretations of these studies also

were drawn from medical experts knowledgeable about each subject of study.

The material is organized in terms of major problem areas, including physician and nurse impairment, overdependence on and breakdown of medical technology, anesthesiology-related complications, diagnostic error, failures in professional training, laboratory testing abuse and error, unnecessary surgery and surgical error, nosocomial (hospital caused) infections, medication error, breakdown in the caregiver-patient relationship, and failures in the profession of medicine as well as the institutions in which they work to effectively monitor quality and competence and to take disciplinary action. I shall submit a copy of Medicine on Trial as an exhibit for your detailed review.

Hospital caused illnesses and injuries are, of course, known to the public on the basis of individual experiences but the massive overall incidence of these assaults are not well appreciated by the public. Collecting and categorizing literally thousands of studies done over the last decade revealed the overall pattern of the problem as systems wide with the hospital in the center. One national expert has called the situation an "iatrogenic epidemic." All hospitals appear to some degree to offer poor quality in one or another aspect of the care they provide. Just how bad the situation is cannot be precisely determined. We are at the mercy of inadequate audit systems, episodic studies in depth, research

studies that vary in populations studied and observational techniques, and above all, we (the public) are rarely, if ever, informed about the results of audit or special studies. The public is simply left in the dark on matters relating to the safety and quality of health care provided by hospitals. The public is unaware of the level of risk they run for hospital neglect, malfeasance, or sheer incompetence. There is precious little hospital accountability to the public. There is even less public involvement in the quality control process. How many of you can recite the nosocomial infection rate at your community hospital? How many of you are aware of the medications error rate there? Do you know the relative frequency with which certain surgical or medical management procedures are done? We know, for example, that hospitals that do more of procedure X predictably have a better success rate with that procedure. But such data are not routinely known to the public. In effect, the public is buying an item sight unseen, deciding on the basis of blind faith rather than an informed judgment. I have heard it said, in unbelievable arrogance, that such information would simply confuse the public or reduce its confidence in medical care to the point that people would avoid seeking care. Health professionals often find it convenient to infantalize lay people, suggesting that a compliant, unquestioning patient is a good patient. A little knowledge may be a dangerous thing, but no knowledge at all can be fatal!

It is my own position, and the position of the People's Medical Society, that we should mandate full public disclosure of data pertinent to the quality of hospital care. These data must be provided annually in a language and style which is easily understood by ordinary citizens. Given the inequities in the implementation of medical care standards among states, it is argued here that federal disclosure legislation be enacted to affect all hospitals in receipt of federal funds, either capital or operating. The People's Medical Society asked Lori B. Andrews, an attorney with the American Bar Foundation and Vice-Chairperson of the Board of Directors of the People's Medical Society, to prepare a Model Hospital Disclosure Act. This Model Act can be found on pages 214-220 of Medicine on Trial.

It is our contention that public access to such information as called for in this Model Act can have a powerful affect on the quality and cost of health care in two ways. First, it provides data vital to an informed choice of hospital for the patient seeking care. Secondly, the simultaneous and standardized publication of hospital quality data invites public comparisons among hospitals and this could stimulate hospital efforts to institute tighter quality control, including more forthright disciplinary action, improved selection of personnel, enhanced continuing education, and the revision of what care they undertake to provide. It may even encourage hospitals to undertake demonstrations in quality control.

I want to give special emphasis to this last point on the importance of quality control demonstrations. While I do believe full disclosure of hospital quality data is a sine qua non for reform, I am under no illusion that it in itself is sufficient. It is necessary, but not sufficient. There needs to be, as well, substantial resources put into designing and testing innovative approaches to enhancing the quality and safety of hospital care. We should approach such studies as carefully and diligently as we would approach other areas of medical research and public health research related to disease prevention. After all, we are dealing here with a general category of disease, which in its combined categories, is by far and away the most prevalent disease in the industrial world. Yet we have no National Institute of Iatrogenic Disease and we give but paltry support to the field of clinical epidemiology for purposes of quality control research. And I must sadly add that my own field of public health has received little encouragement through grants and contracts to support hospital-based demonstrations in quality control.*

The issue we face in reducing hospital iatrogenic disease is, of course, far too serious to leave exclusively in the hands of hospitals and physicians -- even public health experts. There must be a serious commitment as well to involve the public in the process of research and demonstration. It is the public that may provide the innovative hypotheses, the innovative strategies for reform. Without public involvement, my fear is that we shall simply

* Demonstrations are also needed re methods of disseminating hospital quality-of-care data to the public.

encourage the fox to continue as warden of the chicken coop. The self-policing track record of hospitals and physicians does not offer much encouragement.

The present system of hospital quality control has failed us. And the public, by default of adequate information about the negative aspects of medical care, has in effect been lied to. All the efforts and resources purportedly at work to protect the public (and those that in recent days have been promised) are woefully inadequate, conceptually, technically, and politically. Only very small and uneven incremental change can be expected without a national program of quality control that starts with full disclosure and is accompanied by diverse demonstrations with full public involvement. The burden of human suffering and excessive costs of hospital iatrogenesis is simply too high to allow business as usual. These hearings represent an opportunity to inform the public of the problem and our government's deep concern to enact first time federal legislation on the road to a solution. The People's Medical Society as well as, I am sure, other voluntary health advocacy groups, are ready to help in concert with a federal initiative. The health care system is a public trust. And it is time that the public exercises a crucial aspect of its control over that system. It is too late for hospitals to plea bargain their way out of greater public oversight. We need full hospital disclosure and we need it now.

Thank you for your attention.

Respectfully submitted,

Lowell S. Levin, Ed.D., M.P.H.
Professor of Public Health
Yale University School of Medicine

TESTIMONY: CONGRESSIONAL HEARING JUNE 6, 1988
HON. JAMES H. SCHEUER, CHAIRMAN
SUBCOMMITTEE ON NATURAL RESOURCES, AGRICULTURE RESEARCH AND ENVIRONMENT

" The regimen I adopt shall be for the benefit of my patients accordi to my ability and judgment, and not for their hurt or for any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortion. Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any act of seduction, of male or female, of bond or free. Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets." So stated Hippocrates almost 2500 years ago.

It seems that the only part of the Hippocratic oath which the medical world fights to keep is the part about secrecy. And it is this very secrecy which poises a threat to the medical consumer.

My name is Sondra Bauernfeind. I reside in Mongaup Valley, New York . I am the founder of Victims of Medical Abuse and chairman of the Sullivan County Conservative Party. I am a science teacher by profession and a victim of medical abuse by accident.

Today I will present to you documentation which will prove to you without a shadow of doubt that the medical profession has slipped behind a " Brotherhood of Silence" to hide the true facts which take place when medical abuse exists. This secrecy extends from the doctors to the nurses to the hospital personnel to the very New York State Department of Health in a network of cover-up to protect the medical profession to the detriment of the victim.

The unsuspecting victim offers up his body as the sacrificial lamb to the medical profession when in complete ignorance he seeks medical treatment from a person who has been anointed with the title of " doctor ".

The topic of today's hearing focuses on the concern that information regarding the quality of medical care providers and facilities is not available to consumers. I wholeheartedly agree with you in this concern. If we had only known before the fact instead of after the mistakes had been made, I truly believe that my husband would be alive today.

My late father was a country doctor and there were many times when I would drive him to a patient's home in the wee hours of the morning when he would be called upon to administer to the sick. It always seemed as though people got really sick at 2 A.M. in the morning. I remember one evening house call during a blizzard when the car could not go down the country lane which was blocked with drifting snow and my father, black medical bag in hand, walked through knee deep drifted snow over half a mile to get to his patient. I also remember the dinner lectures about gallstones complete with the specimens filling a small glass bottle set on the table while we ate supper. My father still was making house calls at 79 to a few of his patients who just would not let him retire.

My father loved his chosen profession and along with his own practice, he served as the emergency room doctor and the anesthesiologist in Community General Hospital. It was sometime in the 1970's that I started to hear my father express disgust with some of the doctors with whom he was acquainted. I remember one instance which made him very upset. A young mother of two was to be delivered with her third child. She was extremely distraught and my father was to give her the anesthesia. He said that he tried to talk the obstetrician into waiting until the woman had calmed down. Instead, the obstetricia insisted on doing the Cesarean section and got another doctor to give the anesthesia. The woman went into shock and died. The baby was not breathing and was discarded into the plastic bucket on the floor. My father grabbed the baby and proceeded to give it CPR and brought the baby back to life. When he told my husband and me of this incident he said " At least she did not die in vain. Her baby lived." I do not know if this incident was ever reported to the Department of Health, but this is an example of what can be covered up by the

"Brotherhood of Silence". It is so bizarre and horrible the question is who would ever believe one doctor if the others involved would not verify what was said.

My first exposure to medical abuse, although at that time I did not realize it by its name, was back in 1960 when my late husband caught diabetes while in the Army. He had been exposed to Coxsackievirus B 4 while on mess duty. His temperature soared to 106 and he was packed in ice. He survived that incident and returned to duty as a telephone installer with the Signal Corps. About three months later he started to realize the classic symptoms of diabetes - extreme thirst and excessive urination especially at night; blurred vision; fatigue ; unsteadiness; numbness of the extremities - When he went for medical help he was given two asprin and " G.I. gin" and told to report for duty. When he persisted in asking for help, he was sent to see a psychiatrist who told him it was all in his head. Finally, after almost a year of uncontrolled diabetes, he was now numb up to his knees and could no longer climb telephone poles to hook up the range phones. He went back to the company doctor. This time there was a new doctor on base who ordered a blood glucose test. Upon getting the results of a blood glucose of over 500, my husband was immediately ordered into the base hospital where he remained until his honorable discharge. The May 24, 1979 issue of The New England Journal of Medicine (pp. 1173 - 1179) discloses a study conducted by Dr. Yoon of the National Naval Medical Center at Bethesda, Maryland which is entitled " Virus-induced Diabetes Mellitus" In this study a healthy 10-year-old boy was admitted to the hospital in diabetic ketoacidosis within three days on onset of symptoms of a flu-like illness. He died seven days later and virus pathogens taken from his pancreas were isolated and inoculated into mouse, monkey and human cell cultures. All organisms inoculated developed diabetes. Both the clinical picture and animal studies suggested that the boy's diabetes was virus induced.

It wasn't until January 5, 1979 that my husband again met with medical abuse. Up until that time, my father was always there to intercede on our behalf and medical disasters were diverted.

Sometime in late November, 1978, my husband was adding another 12 inches of glass wool insulation to the attic. He bumped his elbow and got a small piece of glass wool in his eye. This caused him to be absent from his New York Telephone Company job for three days. Because of an "Absence Control " policy, he had to be seen by a Telephone Company doctor. Upon such an examination, the telephone company doctor told my husband that if he stopped and saw a doctor on his way home it would not be too soon as his blood pressure was so very high. My father was retired at this time and suffering from cataracts, so he advised my husband to see a particular doctor in a near-by town some 12 miles away. My husband wanted to see a doctor in the town where he worked so that he could walk to the doctor's office on his lunch hour and not miss any time from work.

We looked in the Yellow Pages of the telephone directory and found a Medical Group. My father knew some of the doctors associated with the group and suggested that we make an appointment to see one that he recommended. An appointment was made with this doctor, but when my husband arrived for his appointment, he discovered that he had been switched to the " new boy in town". My father did not know anything about him except that he had privileges at the local hospital. Big mistake Number One - accepting another doctor than the one planned on being seen by.

Big Mistake Number Two - when the doctor brags that he is the "best internist in the county - if you do not run out of the office you may be in for Big Mistake Number Three:

Big Mistake Number Three - I cannot regulate you out of the hospital. You must go in for tests. The mistake is when you do not seek a second opinion especially in regard to high blood pressure , particula when the nurse gets a much lower blood pressure reading than the doctor within minutes of being tested. We now know about " white coat hypertension": The high reading may be caused by the doctor.

On March 15,1979, without proper informed consent, my husband was given an IVP using a radiopaque contrast agent called Renografin. He was left unattended on the metal slab in the radiology room for approximately two hours, where my father found him unconscious when he went looking for him after learning that he had been given the test.

According to the Physicians Desk Reference, Renografin should be given "under the direction of personnel with the prerequisite training and with a through knowledge of the particular procedure to be performed." It also states " Consideration must be given to the fundctional ability of the kidneys before injecting this preparation." Although my father had several conversations with this doctor and had advised him that there may be kidney problems, the test was ordered anyway.

Unfortunately, two days later, on March 17, 1979, my husband had to be transferred to the Intensive Care Unit suffering from acute kidney failure and vomiting blood. At this time I was told that it could be due to a "brain tumor or an intestinal obstruction." But by now I had in my possession a copy of the Physicians Desk Reference and had looked up Renografin and knew the adverse reactions to the agent. When I realized that I was being lied to about the cause of my husband's condition, which included a general rash, vomiting blood and extreme tachycardia with two missed heart beats in a row and a pulse rate of over 140 beats per minute, I fired the doctor right there on the floor of the ICU. My father advised us to bring a malpractice suit against the doctor and the hospital. This suit was settled out of court and we were put under a "gag order". The hospital go off scott free, however. My husband left the hospital after eight days in the intensive care unit, under the care of the doctor orginally suggested by my father.

Ironically, after my husband passed away on February 7, 1983, I was contacted by the daughter of a woman who had been taken to this same hospital D.O.A. on August 19, 1982. In the emergency room, this same doctor worked on her for seven(7) minutes until she was pronounced dead. Although the medical records of this incident show that there was no implantation of a pacemaker or of an arterial blood gas test, this same doctor fraudulantly billed Medicare $672.50 for both services. After over a year of trying to correct this incorrect billing, we finally turned the case over to the Inspector General's Hot Line and the money was returned to Medicare.

Although my husband returned to work following the I.V.P. episode, he did not feel right and gradually his kidneys stopped working. On May 13, 1983, he was placed on peritoneal dialysis for chronic kidney failure. My father had passed away in February of 1980.

By this time my husband was blind in the left eye from improper laser surgery done in 1979, but still with an undaunted spirit and determination to go on with life. He was driving, shopping, going to dog shows and meetings and handling the affairs of the household as far as bill paying and outside yard work.

On December 14, 1983 I was called out of my classroom to the office for a telephone call from Dr. Guy McCoy from Albany Medical Center Hospital. He had been trying to get my husband that morning to advise him that there was a kidney available for him . John was out getting his car greased and the oil changed and was getting an IRA certificate at our local bank. And so I was called to see if I knew where John could be reached. I wish I had broken both legs on the way to the office so that I could not have answered that telephone call. But fate did not let that happen and I spoke to Dr. McCoy and eventually John came home and his sister reached him and told him to call Albany Medical Center Hospital. And that was the beginning of the end.

I have never seen such gross disregard for scientific method or proper medical care as I witnessed at Albany Medical Center Hospital. Even before my husband was taken to surgery, a resident put in a central line catheter "atypically" and his right lung collapsed. The same resident put in an I.V. catheter in his left arm - and he got four different pathogens and blood poisoning at this location. All this is confirmed in the medical records. And yet the New York State Department of Health could find nothing wrong with this treatment. The medical records comprise 1260 pages in length and include, in some cases, downright lies ie. " Quiet night without complaints " when in fact my husband was vomiting 800 cc of blood and I was catching it in emesis containers.

His diabetes was allowed to run uncontrolled because residents were prescribing improper amounts of insulin. A urninary tract infection was disregarded for three months because "they" assumed the specimens were being taken improperly. If anyone was voiding cloudy, foul smelling urine, the person would immediately go to a doctor. Here he was in a hospital with doctors all around and no one seemed to care even though he was running a constant fever of " undertermined origin ".

Here are some questions I must get answers to:
1) why didn't the surgeon, Dr. Neil Lempert, give my husband the information needed for him to make an informed consent to the renal transplant surgery? Why was this left up to two residents, who never signed the back of the informed consent form?
2) Why was a foley catheter left in place for 17 days when it is dangerous to leave one in for more than five days due to infection?
3) Why were the staples left in for almost a month and were so overgrown with flesh that some had to be cut out?
4) Why was there a hair entwined in the narcrotic tissue which I had to remove after the transplanted kidney was removed and after an undetected abcess was finally opened leaving my husband with a wound large enough for me to get both hands into as I had to wash it out with a water pick and then stuff with Betadine soaked gauzes?
5) Why is it impossible for the victim to take part in any investigations being conducted on their complaint by the Department of Health?
6) Why is the victim left at the mercy of the medical provider with no one to really intercede on the victims side?
7) Why is it impossible to find out information about the people to whom the patient entrusts his or her very life when one can read about a toaster or an automobile or a resort hotel?
8) Why is there no provision for negligent homocide in cases where gross negligence results in the death of the patient?
9) Why are interns and residents allowed to work on patients without an experienced attending physician present and directly supervising their work? A teacher cannot teach properly when the pupil is not observed in technique and procedure.
10) Why does it take so long for incompetent doctors and other medical personnel to be removed from the profession?

Since Victims of Medical Abuse has been operating as a self-help volunteer group, hundreds of people have asked for help. Most of their stories have a familiar ring - all have been seeking help from the Department of Health or other sources and finally in desperation, turn to this organization. Just the fact that someone is willing to believe their story is a great comfort. The usual

answer from the Department of Health is the standard " We have investigated your complaint and can find nothing to substantiate your claim." One must have the temperment and perseverance of a pit bull terrior to continue seeking the answers which one knows to be the truth.

There is a Second Holocaust which is sweeping our nation today. It is in the medical profession, and just as the First Holocaust almost brought civilization to its knees, this Second Holocaust is much more dangerous and insidious for it is disguised as health care.

There must be a nationwide network which will give consumers of medical care the information they need to make wise and informed decisions about the health care provider they choose to care for them.

There must be a means for the medical consumer to check on the quality of medical care provided by health care facilities which include the attitude concerning "Do Not Resuscitate " orders and whether a hospital has a " quiet room" where patients are put to die. It would help if the patient knew that being placed in a particular room meant that the doctor had given up on him. The patient may want to protest such treatment.

Medical records must be changed so that all the information for one day is easily determinable at a glance instead of having to search through five or six different areas to check on one patient. It is no wonder that many drug reactions are missed or that doctor's orders are mis-read. I would suggest that these medical records be made standard so that every health care provider will know exactly where to look for certain information. Just as traffic lights are standard, so should medical records be standardized.

There must be a way that the victim can offically challenge the information or mis-information contained in the medical records so that the medical records represent a true picture of all of the medical care provided.

In closing, I wish to compliment you on holding a hearing such as this because it is imperative that consumers be able to get the

information they need to make intelligent choices for their health needs. Health care is the largest part of our national and local government budgets. We all know that without health there is no wealth, for one cannot buy health. Please continue in your efforts to help those in need of medical care get the proper care they are searching for. Thank you.

Mrs. Sondra Bauernfeind, Founder
Victims of Medical Abuse

TESTIMONY OF ELAINE O'ROURKE
BEFORE THE COMMITTEE ON
SCIENCE, SPACE AND TECHNOLOGY

JUNE 6, 1988

GOOD MORNING. THANK YOU CONGRESSMAN SCHEUER, AND DISTINGUISHED GUESTS. MY NAME IS ELAINE O'ROURKE. I'M HERE TODAY TO TELL YOU ABOUT MY SON PATRICK.

PATRICK WAS A NORMAL, HEALTHY LITTLE BOY. LIKE ALL LITTLE BOYS, HE PLAYED BASEBALL WITH HIS FRIENDS, RAN AROUND THE HOUSE CHASING HIS SISTER, AND LOVED TO PLAY OUTDOORS. ABOUT NINE YEARS AGO, THIS ALL CHANGED.

OUR SON PATRICK WHO WAS EIGHT YEARS OLD, ENTERED LUTHERAN MEDICAL CENTER IN BROOKLYN, NEW YORK. PATRICK WAS GOING INTO THE HOSPITAL FOR A VERY MINOR PROCEDURE. PATRICK WAS EMBARRASSED THAT HE WAS STILL BED WETTING.

UNDER THE ADVICE OF OUR FAMILY PHYSICIAN AND A UROLOGIST, PATRICK NEEDED A SMALL OPENING IN THE PENIS, WHICH IS CALLED MEATAL STENOSIS. THIS IS A PROCEDURE THAT CAN BE DONE IN A DOCTOR'S OFFICE. THE SURGEON ADVISED MY HUSBAND AND I THAT IT WOULD BE BEST TO HAVE THE SURGERY DONE IN THE HOSPITAL BECAUSE IT WOULD BE MORE COMFORTABLE FOR PATRICK AND AFTERWARDS, TESTS COULD BE PERFORMED.

PATRICK WAS TO BE IN THE OPERATING ROOM 15 MINUTES. WE WAITED FRANTICALLY, FOR OVER THREE HOURS AND HEARD NOTHING OF THE RESULTS OF THE SURGERY. AFTER INSISTING ON SEEING OUR SON, THE SURGEON AND ANESTHESIOLOGIST FINALLY CAME TO TELL US THAT THERE HAD BEEN A PROBLEM AND WITH THE "HELP OF GOD", PATRICK WOULD BE ALRIGHT.

WE WERE TOLD NOTHING, NOTHING OF HIS CONDITION. WE WERE TAKEN TO THE RECOVERY ROOM TO SEE PATRICK. PATRICK WAS LAYING ON A TABLE HOOKED UP TO MACHINERY AND A RESPIRATOR TO ASSIST HIM IN BREATHING.

WE FOUND OUR THAT PATRICK HAD GONE INTO CARDIAC ARREST ON THE OPERATING TABLE. HE HAD DIED. MY HUSBAND AND I DO NOT KNOW HOW LONG HE WAS DEAD. PATRICK WAS RESUSCITATED BUT HE WAS LEFT IN A COMA WITH SEVERE BRAIN DAMAGE. WE WERE TOLD THAT HE WOULDN'T LIVE MUCH LONGER.

EVEN AS I SPEAK TO YOU TODAY, I DO NOT KNOW WHAT REALLY HAPPENED TO PATRICK. THE SURGEON TOLD MY HUSBAND AND I THAT THE STAFF IN THE OPERATING ROOM WERE BUSY WHEN THEY NOTICED A MONITOR WENT OFF. AS THE NURSE WENT TO GET NEW LEADS, THE SURGEON REALIZED THAT PATRICK HAD SUFFERED A CARDIAC ARREST.

DURING A NOVEMBER 1978 INTERVIEW ON TELEVISION, THE SURGEON TALKED ABOUT THIS MEDICAL TRAGEDY AND SAID THAT PATRICK WAS NOT BEING MONITORED CAREFULLY.

IN JANUARY 1979, THE NEW YORK STATE DEPARTMENT OF HEALTH STARTED AN INVESTIGATION OF OUR SON'S CASE.

WE WERE NOT AWARE THAT THESE KINDS OF MEDICAL ACCIDENTS HAPPEN IN HOSPITALS. WE WERE NOT AWARE THAT PATIENTS WERE NOT MONITORED PROPERLY.

WE ALSO FOUND OUT THAT WE WERE NOT ALONE. EIGHT WEEKS EARLIER AN 18 MONTH OLD CHILD ALSO SUFFERED A CARDIAC ARREST DURING A TONSILLECTOMY. I CALLED THE MOTHER OF THIS CHILD. I CRIED TO HER THAT IF SHE HAD COME FORWARD AND TOLD HER STORY TO THE MEDICA, PATRICK WOULD NOT BE IN THE SERIOUS CONDITION HE IS IN NOW.

THE MOTHER TOLD ME THAT SHE TRIED TO COME FORWARD BUT SHE IS A PUERTO RICAN WOMAN ON WELFARE. SHE DIDN'T THINK ANYONE WOULD LISTEN TO HER STORY.

IF WE ONLY HAD SOME WAY OF SHARING MEDICAL INFORMATION, WE COULD PREVENT TRAGEDIES LIKE THIS FROM HAPPENING.

THE NEW YORK STATE HEALTH DEPARTMENT FOUND DEFICIENCY IN LUTHERAN MEDICAL HOSPITAL IN BROOKLYN, HOWEVER, IT IS VERY MINOR DEFICIENCY IN INTAKE AND OUTTAKE PROCEDURES, DIETS NOT BEING RECORDED, NURSES NOT SIGNING NOTES, ETC. THERE WAS NEVER A DEFICIENCY IN THE OPERATING ROOM.

THIS TERRIBLE INCIDENT HAPPENED TO PATRICK NINE YEARS AGO. MY HUSBAND AND I WORKED HARD TO TRY TO MAKE THE PUBLIC AWARE OF BEING BETTER CONSUMERS OF MEDICAL CARE. WE URGE PEOPLE TO ASK QUESTIONS AND "SHOP AROUND" FOR QUALITY MEDICAL CARE.

OUR STORY HAS BEEN TOLD BY LOCAL NEWS, IN NEWSPAPER ARTICLES AND ON NATIONAL TELEVISION IN A 20/20 SEGMENT. BUT WHAT HAS REALLY CHANGED? NO LAWS WERE CHANGED. MOST PEOPLE FEEL THAT THESE THINGS DON'T HAPPEN TO THEM - ONLY TO OTHERS.

PATRICK IS NOT THE ONLY VICTIM OF MEDICAL NEGLIGENCE. THROUGH THE ORGANIZATION SHAME, STOP HOSPITAL AND MEDICAL ERRORS, I HAVE MET MANY OTHER VICTIMS OF MEDICAL NEGLIGENCE.

ROSE ANN LIVEO LOST HER MOTHER-IN-LAW, ANNA, IN ANOTHER BROOKLYN HOSPITAL. ANNA WENT INTO THE HOSPITAL FOR A BUNION REMOVAL. THE WOMAN NEVER CAME OUT OF THE HOSPITAL AND LAID IN A COMA FOR 28 DAYS AND THEN DIED.

JOE AGUNZO LOST HIS NINETEEN YEAR OLD SISTER LISA ANN, WHO ENTERED THE HOSPITAL FOR SINUSITIS. THE FAMILY WAS ADVISED THAT LISA ANN HAD TO HAVE HER SINUS DRAINED. LISA DIED IN THE HOSPITAL.

BILLY ALBANESE, AGE 12 WAS RUSHED TO AN EMERGENCY ROOM AT NASSAU HOSPITAL NOW CALLED WINTHROP UNIVERSITY HOSPITAL IN MINEOLA. HE WAS IN A LIFE AND DEATH SITUATION. BILLY WAS SEEN BY TWO UNLICENSED DOCTORS, AT A VERY CRUCIAL TIME IN HIS LIFE. HE DID NOT RECEIVE THE PROPER CARE. HIS FATHER WAS TOLD THAT BILLY WAS IN A CHRONIC VEGETATIVE STATE AND WOULD NEVER COME OUT OF HIS COMA. NOW, 3 1/2 YEARS LATER, BILLY IS OUT OF HIS COMA. HE CAN WALK WITH ASSISTANCE.

DAVID AND KATHY ASTOR WERE TESTED NEGATIVE FOR TAY-SACHS DISEASE. THEY HAD A BABY WHO WAS DIAGNOSED WITH THE DISEASE. DUE TO IMPROPER LAB TESTING, THESE PARENTS ARE NOW WATCHING THEIR THREE YEAR OLD DAUGHTER DIE A PAINFUL DEATH.

UNFORTUNATELY, THOUSANDS OF CASES OF MEDICAL NEGLIGENCE CONTINUES TO HAPPEN.

SO WHAT HAVE WE LEARNED FROM ALL OF THESE STORIES?

I'VE LEARNED THAT WE NEED INFORMATION. WE NEED TO KNOW AS MUCH ABOUT OUR MEDICAL PROFESSIONALS AS WE DO ABOUT THE ELECTRONIC EQUIPMENT WE BUY.

AS CONSUMERS OF MEDICAL CARE, WE, THE PUBLIC NEED TO BE ABLE TO CHECK ON A DOCTOR'S CREDENTIALS, AND ON THEIR TRACK RECORD.

I HOPE THAT NO ONE IN THIS ROOM HAS TO LOSE A LOVED ONE, OR SEE SOMEONE LEFT PERMANENTLY INJURED DUE TO MEDICAL NEGLECT.

TODAY, PATRICK REMAINS SEVERELY INCAPACITATED WITH SPASTIC PARALYSIS, TOTALLY DEPENDENT FOR DAILY CARE AND UNABLE TO DO ANYTHING FOR HIMSELF. HE REQUIRES 24 HOUR NURSING CARE. THE PROGNOSIS IS VERY POOR FOR ANY SUBSTANTIAL IMPROVEMENT.

I KNOW THAT FOR THE REST OF MY LIFE AND FOR THE REST OF PATRICK'S LIFE, I WILL CONTINUE TO DEDICATE MY ENERGIES TO CHANGING THE WAY OUR MEDICAL SYSTEM WORKS.

I AM A MEMBER OF SHAME. THIS ORGANIZATION SEEKS TO:

- ENCOURAGE QUALITY HEALTH CARE FOR ALL PATIENTS,

- GATHER AND PUBLISH INFORMATION, AND

- PROVIDE SUPPORT FOR INJURED PATIENTS AND THEIR FAMILIES.

WE DON'T NEED ANYMORE DEATHS AND INJURIES TO TELL US IT IS TIME FOR CONSUMERS OF MEDICAL CARE TO TAKE MORE CONTROL OVER THE QUALITY OF THESE SERVICES. WE KNOW THE TIME IS NOW.

THANK YOU CONGRESSMAN SCHEUER FOR THE OPPORTUNITY TO SPEAK TODAY. I HOPE WE CAN BOTH WORK FOR CHANGE.

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

INFORMATION FOR CONSUMERS
ABOUT QUALITY OF MEDICAL CARE

before the

HOUSE COMMITTEE ON SCIENCE, SPACE AND TECHNOLOGY

SUBCOMMITTEE ON NATURAL RESOURCES,

RESEARCH AND ENVIRONMENT

Field Hearing
New York, NY
June 6, 1988

Presented by:

Louis Krieger,

Chairman, New York City Legislative Committee

American Association of Retired Persons, 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

Louise D. Crooks *President* Horace B. Deets *Executive Director*

Thank you, Chairman Scheuer.

My name is Louis Krieger, Chairman of the AARP New York City Legislative Committee. The American Association of Retired Persons is pleased to participate in this hearing marking the release of an important Office of Technology Assessment report concerning consumer access to information on the quality of health care services.

The authors of the OTA report have produced an impressive descriptive and analytical piece. The thoughtful discussions of quality indicators and policy options will not only enable the research and policy communities to better understand important interrelationships, but will also facilitate wiser judgments on the most efective use of the increasing flow of health care quality data.

In this testimony, I will discuss the Association's goals for implementation of the national malpractice data bank, the proper scope of a quality assessment and information disclosure system, and conclude with specific comments on HCFA and PRO data disclosures

I. Proper Implementation of a Malpractice Data Bank

On one specific indicator, malpractice actions, the report points out current difficulties involved in using malpractice data as a quality indicator; it also properly points out that the

to-be-implemented Health Care Quality Improvement Act of 1986 will provide a very useful new source of data for researchers. In this connection, however, the recently published proposed regulations on the HCQIA national data bank lack any required mechanism for informing the public as to whether the overall goals of the Act are being achieved, i.e., 1) whether the required information on malpractice payments, and licensure and privileges actions is being reported; and 2) whether hospitals and other health care entities are using the information in making prospective privileges decisions.

To rectify this we urge the following requirements be added to the regulations:

1. A requirement that the data bank contractor produce reports at least annually, but preferably semi-annually, containing aggregate statistical information on various categories of data being collected.

2. A requirement that the data bank publish a list of any hospitals or licensure boards that are known to be out of compliance with the obligation to consult the data bank. Inasmuch as all hospitals must consult the bank at least once every two years, it would be a simple matter to track hospital compliance and report accordingly.

II. Parameters of a Quality Assessment and Information Disclosure System

The Association wishes to share its observations on several major areas of concern regarding the public's access to quality of care information.

Public disclosure of comprehensive, analyzed and uniform data can yield two positive results: 1) a more informed patient community that is also more confident about its health care choices and 2) a new health system dynamic that will lead health care providers to compete on the basis of quality. The debate about data disclosure has shifted from a focus on whether information should be published at all, to how to release data so consumers can use it effectively. We must rise to the challenge of turning raw statistics into a picture patients can understand.

Determinations of quality must be based on the entire episode of illness, not just on a particular setting of care. Thus, HCFA's efforts to link Parts A and B data must proceed as a high priority project. Moreover, physicians must be required to include uniformly-coded diagnosis data on Part B claims. Such information is important to the measuring and monitoring of quality in various settings of care. Finally, high priority must be given to the development of patient-oriented quality

assessment in post-hospital care, such as skilled nursing facilities (SNFs) and home health care.

Constructing such a data-based quality assessment and assurance system will require much greater coordination among the HCFA contractors administering Medicare. Intermediaries, carriers, and PROs must begin to collect and process basic data elements in a uniform way to assure comparability among providers. Standardization of quality of care measures and methodologies will give greater assurance to beneficiaries about the quality of their medical care and lead to nationally representative information.

The information collected by this quality assessment and assurance system should serve as the basis for a national epidemiological data base of relevant patient-level data on the overall quality of care to Medicare patients, regardless of the setting of care. Such a data base will be an invaluable tool for assessing beneficiaries access to the various levels of care and lead to a greater understanding of the ways in which quality affects beneficiaries' health status and quality of life.

III. The HCFA Mortality Data Releases

In 1986, HCFA opened the door to publicly available statistically-based quality analysis when it published hospital mortality data for hospitals with significantly aberrant records.

Last December, in its second major release of hospital mortality data, this time for every hospital participating in the Medicare program, HCFA published categorized numbers of Medicare patients treated, the percentages of Medicare patients who died within 30 days of admission, and predicted ranges of mortality based on the patient population of that hospital.

AARP views the HCFA mortality data disclosures as important steps in an evolving public process. The disclosures do not constitute a report card on any particular hospital; they do, however, mark a significant milestone in the drive towards a comprehensive health care data disclosure strategy.

Mortality is an outcome measure, a gross measure of the quality of care provided to Medicare patients. But mortality is just one measure of outcome. AARP expects to see a variety of process of care and outcomes of care measures developed and reported to the public on a routine basis.

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Mortality data alone cannot establish a particular hospital's quality of care. Such data is most useful to consumers as a basis for questioning medical professionals about the significance it may have in a particular patient's case. Thus, if one is anticipating treatment at a particular hospital, that individual can examine the mortality rate for that hospital and compare it to the hospital's expected mortality rate. If it is outside the range, or at the high or low end of the range, the individual can ask his or her physician about it and about the significance of any explanatory comments the hospital has made.

The disclosure of hospital specific mortality data on Medicare patients should also help generate a constructive dialogue between providers and consumers of health care on what constitutes quality of care, and how best to measure it; in the process, society's expectations of health care encounters will likely become more realistic. This could well help to ease what has come to be called the "malpractice crisis." The best way to align society's expectations of medicine more closely with clinical performance, is to provide more information, presented in an understandable way to the public.

The Association continues to analyze this data and plans to offer suggestions for improving the third data release set for next December. AARP believes that any risks of disclosing imperfect data are outweighed by the value of the information-

dynamic fostered by this release, and its contribution to improving hospitals' performance over the long term. In this connection, the Association foresees that data disclosure will, in and of itself, propel the generation of ever more reliable data.

IV. Data Disclosures By Peer Review Organizations

We want to take this occasion to note the ongoing importance of another aspect of the disclosure issue, namely, Peer Review Organizations's sharing of information with the public.

The new PRO scope of work places increased emphasis on quality of care review and a corresponding intervention strategy. From beneficiaries' point of view, quality review should be the raison d'etre of the PRO program. Thus, the Association is gratified that since the first scope of work, and with AARP's urging and prodding, there has been a continued evolution in PRO priorities towards greater emphasis on quality. In this connection, the scope's requirements for greater profiling of PROs' review findings is a further step towards translating the mass of raw review findings into information about patterns of care that, in turn, can lead to improvements in care.

At the same time, Mr. Chairman, there is an overriding need for analyzed, comparative data and information about the outcomes and implications of PRO review activities. PROs' role as disseminator of data will become ever more critical to an informed public.

Under the PRO confidentiality regulations, a PRO may currently 1)release to the public "interpretations and generalizations on the quality of health care that identify a particular institution"; and 2) disclose practitioner information with the practitioner's consent. In addition, an institution or group of practitioners may redisclose PRO quality review study information (limited to health care services they provide.

Two years ago California Medical Review, Inc (CMRI), the California PRO, became the first peer review organization to initiate, under its discretionary authority, a disclosure of data regarding hospital care in its state. CMRI's action was a commendable step in the direction of providing access to detailed performance data on a provider and procedure specific basis. As part of the PRO regulatory framework, CMRI solicited and published the comments of the hospitals covered by the report. The result, a combination of statistics and explanations, was a harbinger of the development of an important tool in identifying and analyzing performance problems.

Further efforts in this direction should include individual PRO releases of information based upon their much increased profiling and beneficiary complaint tracking responsibilities. In addition, in view of the fact that HCFA will soon be receiving data from PROs in a non-report format, i.e., as data elements on tape, the agency itself should develop a set of useful reports that could regularly be disseminated to the public.

When all is said and done, AARP remains concerned about the lack of public information available to assess the actual thrust and focus of PRO review activities along the entire continuum of review, from generic screening to forthcoming quality denials to the rare but highly charged resort to sanctions authority.

From the public's point of view, what contributes to impatience and skepticism about the emphasis on the peer education process is the fog that envelops the peer review process. PRO decisions should be based on the best clinical interests of the patient community; the only way to determine whether that is in fact occurring is through disclosure of data and information that communicate what performance standards are being used to affect physician and provider behavior.

The public needs to know, for example, under what circumstances and according to what criteria physicians are being questioned on their hospital admitting practices; the public

needs to know what quality of care concerns lead to the imposition of a corrective action plan or a sanction recommendation. We are not talking in this particular connection about the identification of individuals, but the identification of patterns, criteria, standards and case-specific examples that can assure the public that the grant of review authority to the professional community, with all the attendant self regulation privileges and immunities, is being exercised properly.

In summary, Mr. Chairman, PRO-held data, if carefully analyzed and compared, could yield important insights into the quality of health care services for patients and the impact of PRO review, both in a given PRO area and between PRO areas. I t may in fact be time for a major reexamination of the rules on PROs' public disclosures, with a view towards the development of a revised regulation that will produce greater data sharing without undermining PROs' ability to perform their review mission.

AARP appreciates this opportunity to offer our views in connection with OTA's release of its report. We want to conclude by saluting your own deep interest in and commitment to the goal of greater public access to health care data.

STATEMENT OF ROBERT M. KRUGHOFF,
REPRESENTING CONSUMERS' CHECKBOOK MAGAZINE
before
SUBCOMMITTEE ON NATURAL RESOURCES, AGRICULTURE RESEARCH AND ENVIRONMENT
U. S. HOUSE OF REPRESENTATIVES

June 6, 1988

Thank you for for inviting me and Consumers' CHECKBOOK magazine, of which I am president, to participate in your exploration of ways to make information on the quality of medical care available to consumers.

Since you have a number of experts to testify before you, and since you have an excellent report by the Office of Technology Assessment to provide broad background for your deliberations, I will focus my remarks on a description of the practical experience my organization has had in making information on quality of providers available to consumers - and on some opportunities we have spotted in the process for the federal government to make additional useful information available.

Mine is a nonprofit organizaion. Among other activities, we publish a magazine in two versions, entitled Washington [D.C.] Consumers' CHECKBOOK and Bay Area [San Francisco] Consumers' CHECKBOOK. This magazine, with a paid circulation of about 40,000 in the Washington metropolitan area and about 25,000 in the San Francisco Bay Area, evaluates local service establishments, such as, auto repair shops, plumbers, banks, and hospitals. We attempt to do for local services what Consumer Reports magazine does for products.

We also publish occasional books for distribution nationally. Two such books in the health care field are our Guide to Health Insurance Plans for Federal Employees (which we have published every year since 1979 and which

typically sells about 35,000 copies per year) and a brandnew book entitled Consumers' Guide to Hospitals. This latter book contains general advice on choosing a hospital, getting the best care wherever you go, and cutting hospital costs. The bulk of the 200-page book, however, is composed of data - information from Medicare records on hospital size, ownership and control, teaching programs, and medical school affiliation - and mortality data on nearly 6,000 hospitals, reprinted (without the thousands of pages of hospital comments) from HCFA's 7-volume, December 1987 release.

Publicly Available Data We've Published

Our articles in CHECKBOOK magazine reveal a wide range of publicly available data. The following are examples of some of the kinds of information we have published on various types of health care providers:

Hospital inpatient care

- o Mortality data. We published unadjusted mortality rates for specific diagnostic/procedure categories from data earlier released by California Medical Review, Inc. We published mortality rates, which we adjusted for patient age and sex, using data from discharge records maintained by the Maryland Health Services Cost Review Commission. And we published data on perinatal mortality rates, adjusted for sex, race, birth weight, and plurality (twins vs. single birth) from a database maintained by the Community and Organization Research Institute, University of California, Santa Barbara.
- o Volume data. We published data on overall bed count. In addition, we published data on number of cases in certain diagnosis/procedure categories, based on discharge records maintained by the California Office of Statewide Health Planning and Development and the Maryland Health Services Cost Review Commission. We selected diagnosis/procedure categories in which mortality appeared to be

related to volume in an analysis done for us by Harold Luft and Deborah Garnick of the University of California, San Francisco.

- Malpractice settlements. We published data from the California Department of Health Services showing the number of malpractice settlements of over $3,000 per 100 beds. (We gave our readers especially strong cautions about the great difficulty of deriving any meaningful conclusions from these data.)
- Board certification of physicians. We reported the percentage of physicians on each hospital's medical staff who were board certified according to hospital-filed reports maintained by the California Office of Statewide Health Planning.
- 24-hour coverage of key services. Using data from reports hospitals must file with the California Office of Statewide Health Planning and Development, we reported whether hospitals had 24-hour coverage of such key services as anesthesiology, laboratory, and operating room.
- Ownership and control, medical school affiliation, and teaching programs. Using data we collected from the hospitals themselves and checked in the American Hospital Association's Guide to the Health Care Field, we reported on ownership/control, residency programs, and university affiliation.
- Physicians' ratings. We mailed questionnaires to all the physicians in the two metropolitan areas and published for each area more than 420 respondents' ratings of the hospitals with which they were familiar with regard to quality of laboratory services, sufficiency of the number of nurses on duty, overall average quality of nurses, average skill of attending physicians, quality of communication within the hospital's staff, pleasantness of rooms, and other factors.
- Nurses' ratings. We mailed questionnaires to more than 25,000 nurses

in each metropolitan area and published for each area about 2,000 respondents' ratings of hospitals in which they had worked. The ratings were on the same types of factors as those listed above for physicians.

- o Patients' ratings. We published for each area the average rating given each hospital by about 3,000 CHECKBOOK and Consumer Reports magazine subscribers whom we surveyed by mail.
- o Prices. Based on our surveys of hospitals, we published prices for semi-private rooms, intensive care rooms, and an hour in the operating room for major surgery.

Health Maintenance Organizations

- o Percent of physicians who are board certified, percent who are American medical graduates, and percent who have faculty appointments. We published these ratios based on our surveys of the HMOs. We corroborated the HMOs'claims about individual physicians by checking the American Medical Association Directory and the Directory of Medical Specialists. Where HMOs did not respond, we secured names of physicians from HMO marketing materials and from reports filed with the federal Office of Personnel Management and the California Public Employees Retirement System.
- o Percent of doctors listed in book, "Best Doctors in the U.S." This book is based on the opinions of surveyed doctors (mostly university faculty) when asked which doctors in the U.S. they thought were best.
- o Hospitals used. This information, gathered from the HMOs, was related to our earlier evaluation of hospitals.
- o Midlevel professionals per physician in primary care. Based on survey of HMOs.
- o Physician turnover. Based on our examination of physician lists for a

series of years.

- Percent of federal employees who transferred out of plan during a recent "open season." From data maintained by the federal Office of Personnel Management, we reported both the actual transfer out percentage and an adjusted percentage we calculated based on a regression analysis we did to take into account such non-quality-related factors as plan premium, presence of HMO competitors in the area, and age of plan members.
- Average wait for an appointment. Based on tests in which our researchers tried to schedule appointments for general physicals and for treatment of a minor stomach upset.
- Free or discounted classes offered by plan in a recent period. Based on our researchers' attempts to schedule classes of various types by calling plans.
- Patients' ratings. In both areas, we surveyed more than 1500 CHECKBOOK and Consumer Reports magazine subscribers for their ratings of physicians affiliated with the various HMOs. We asked them to rate the physicians with regard to making them feel at ease when they described their concerns, explaining the nature of their case, arranging to see them promptly, being easy to reach by phone, giving helpful advice by phone, and other factors.
- Patients' choices at time of treatment. We surveyed the plans for their policies on patients' choice of doctors within plan, rights to see specialists outside plan, and rights to second opinions.
- Physician compensation formulas. We surveyed plans for their contractual arrangements for compensating physicians - capitation, fee-for-service, salary, holdbacks, risk pools, etc.
- Premiums and benefits. We surveyed plans for their premiums and

benefits. To allow easier comparison of benefits across plans, we calculated an actuarial estimate of the value of each plan's benefits.

Physicians

- o Patients' ratings. Based on a survey in which we collected more than 10,000 ratings from CHECKBOOK and Consumer Reports subscribers, we published ratings of individual physicians on making their patients feel at ease when the patients' describe their concerns, arranging to see patients quickly, and the other factors described above in connection with HMO physicians.
- o Board certification, medical school attended and date of graduation, and hospital staff memberships. We gathered these data from the physicians and confirmed with directories and hospitals.

Other types of providers

- o For nursing homes, incidence of bedsores, Medicare inspection deficiencies, and ratings given by surveyed members of the clergy who regularly visit the homes.
- o For dentists, ratings by more 8,700 surveyed patients who evaluated their dentists on such factors as doing the work properly, discussing symptoms, instructing on prevention, being gentle, arranging appointment promptly, and keeping a clean office.
- o For hospital emergency services, ratings by nurses, ratings by ambulance operators who visit regularly, number and qualifications of physicians on duty at various times of day, and patient ratings of staff pleasantness, staff attentiveness, and average waiting time.

Our reports reveal large provider-to-provider differences on the various measures we have used. For example, we've found hospitals where fewer than 40 percent of physicians are board certified while at other hospitals 100 percent are board certified; we've found hospitals where fewer than 60 percent

of the nurses gave favorable ratings to the quality of the other nurses while at other hospitals more than 90 percent gave such favorable ratings; we've found HMOs where, after adjustment, the rate of out-transfers was as high as 16 percent while at other HMOs the out-transfer rate was as low as 6 percent; and we've found doctors whose effort to explain patients' diagnosis, treatment, and outlook for recovery was rated "superior" by fewer than 30 percent of surveyed patients while other doctors got "superior" ratings from 100 percent of their surveyed patients.

Making more and better data available

Although I've pointed out many types of data that are available to the public, what's available falls dramatically short of what is needed if consumers are to have enough information to reduce even modestly the risk of sub-optimal choice of medical care provider.

(Note that even a number of the data items I've described are not available in all parts of the country. For example, information on the certification of hospital physicians and on malpractice settlements is available in public records in California but not in the Washington, D.C., area jurisdictions we study; discharge records are available in state agencies in California and Maryland but not in Virginia or the District of Columbia; and information on "open season" transfers-out of HMOs is available for plans that have a substantial number of federal employee members but not for plans that do not.)

Several levels of effort are needed over the long run. First, research is need to develop better ways to control for patient condition in relating provider performance to outcome. Second, an on-going research effort must be maintained at a high level to build a far broader body of knowledge of the relationships between various treatment techniques/processes and outcomes. Third, efficient means of gathering data on patient condition, treatment

processes, and outcomes (including negative outcomes other than death) must be developed - along with means to assure that they are accurately implemented. And, of course, research is needed to determine the best means to communicate provider-quality information to the public so that it is used to make decisions.

But there are steps that can be taken easily in the short run. One area of opportunity is for the federal government to cease being so paternalistic about its data. In a concern that data would be misused, HCFA, for example, published only the "range of predicted mortality rate" and the actual mortality rate for each hospital and case category in its December 1987 release. Possibilities for further analysis of the data would have been greatly enhanced if HCFA had also published the best estimate of the expected mortality rate for each hospital for each case category. But HCFA was concerned that the media would misuse this information. Worse still, HCFA refused to release in electronic form even the information it published in printed form. This for all practical purposes prevented any further analysis of the data - for example, to assess the relationship between case volume and outcome.

Also, there are many data elements that it appears could be collected and/or made available at relatively modest cost. For example, it seems that the federal government could make a condition of participation in the Medicare program a hospital's public disclosure of all deficiencies found by JCAH. Similarly, hospitals could be required to report to HCFA the percentage of physicians who are board certified. (Not only is this information currently reported to the state of California; it is also reported voluntarily to the American Hospital Association, which markets it at a high price to commercial users under a license that prohibits its being released to the public.)

The hospital discharge records maintained by HCFA don't contain

information on the HMO or PPO, if any, under whose auspices a patient was being cared for; adding such information would seem to be easy and might allow meaningful comparison of outcomes for HMOs and PPOs.

The records derived from nursing home inspections might be enhanced to include information on staff turnover and more information on the use of physical and chemical restraints

The details of the performance of medical laboratories on individual samples might be required to be made available, not just the overall pass-fail decision of the certifying agency.

Hospitals, physicians, HMOs, home health care agencies, nursing homes, and others could be required as a condition of Medicare participation to dispense at the end of each complete service transaction a patient satisfaction questionnaire for return to an independent data analysis agency.

This is just a sampling of the possibilities. The point is that at relatively little cost a much improved body of information on provider quality could be assembled.

The CHAIRMAN. Thank you very much.

Now, we'll hear from Esther Lustig, Director of External Affairs and Development for the Lexington Center for the Deaf and Hearing Impaired, and to my knowledge, a person who is very well plugged in to the entire New York City health care delivery system, both public and private.

Ms. Lustig, why don't you tell us what you feel can be done and ought to be done to empower consumers with the knowledge that they need to make intelligent decisions on health care providers?

Ms. LUSTIG. I believe that the greatest obstacle to the free flow of information to the consumer is the lack of knowledge by the consumer. They ought to be demanding this information.

Most consumers are not aware that they can, nor have we made them aware that they have an obligation to ask before they walk into a doctor's office or before they enter a hospital situation.

In a system as entrepreneurial as ours, I really believe that if the demand were there, the supply would come. Some very savvy, private sector group, not for profit group, government sector groups would spend a great deal of time developing information and informing the public if the public made it very clear that they wanted this information to be known.

Most of us spend an enormous amount of time shopping for a wide range of consumer goods and services. We would not consider purchasing a car or a washing machine or any one of a number of consumer goods without reading a number of publications, without becoming informed. Although we've never worked on an assembly line in Detroit, we feel perfectly competent to ask a whole series of questions about how a car is put together, what it will do, how it will perform.

We even have this pattern that we use for picking professional services. No one in this room would enter a university and spend that kind of money without making site visits, without checking it out, without knowing what that particular university offers us——

The CHAIRMAN. And comparing it with other universities.

Ms. LUSTIG. Exactly. No one would consider doing that. When it comes to the most important service one can personally utilize, we somehow don't feel we have a right to ask.

I have seen the most active consumers become shrinking violets when it comes to asking their doctors certain questions, informing them, finding out about hospitals.

One of the hospitals that was mentioned here today is now closed. It's closed because of bad medical practice. It happens to be the hospital that is closest to my home. I wouldn't consider using that facility. I didn't consider using it 5 years ago, I wouldn't consider using it 10 years ago, yet people in my community did.

The CHAIRMAN. How did you get information to make the judgment that that facility was unacceptable to your point of view?

Ms. LUSTIG. The first thing I do when I walk into a doctor's office is I do look up at the wall. And I do see where that doctor was graduated from and I do make some value judgments, and I might not always be right. But when it comes to my personal health care, I'd rather err on the side of caution than on the side of having made a very great mistake.

The CHAIRMAN. You're evading my question. What I asked you was how were you able to come to the decision 5 years ago that led you to the conclusion that that hospital was offering inadequate quality of health care, and that you wouldn't under any circumstances go there? What made you different from all those people in your community who did go there? What knowledge did you have that they didn't have and how did you acquire it?

Ms. LUSTIG. I have had the benefit of certain knowledge and my value judgments were not based on a precise science. My value judgments were based on my feeling that a majority of the doctors that were part of this particular facility had not been graduated from what we know to be the best medical schools that this country has to offer, they were not doctors that had other affiliations with university hospitals and so on.

I felt more comfortable just using another facility. It was not a perfect science, but it was something that I was comfortable with.

The CHAIRMAN. Did you have any reason to believe 5 years ago from the way you absorbed information, more or less by osmosis, through gossip, through however you're plugged in to the health care community, that this hospital was systematically delivering an inferior and unacceptable quality of health care?

Ms. LUSTIG. No. I didn't have the benefit of that knowledge. But I do think that the public would have been informed much sooner if enough people had asked that question.

There is also another reason why I think consumers don't always work at becoming informed and that is because whether or not they perceive it we know it's not a reality, they frequently don't pay for the service directly. It is paid for by a third party provider.

Therefore, one does not feel the same need to go out and find out why a person is being billed or what the service that they're getting involved.

I received a statement this weekend from my health care provider informing me that they had made certain payments to my doctor, and I don't question the validity of that billing.

What I do question is the fact that it tells me the date of my visit, which department processed it, the charges that were submitted, that I don't have to pay for this, it's covered in full—terrific. I can put it in my drawer.

What it doesn't tell me anywhere on this bill is what's been billed. If anyone of my credit card companies had sent me a bill without telling me what I purchased, I would be calling that credit card company to raise all heck. But there isn't a need to here, because I am not paying for it directly.

In conclusion, the way that we can best inform the consumer is by making the consumer first aware through a wide variety of sources—public service messages, part of teaching at the very earliest age in the school system that this is an area where you have not only a right but an obligation to become informed.

You need to have a healthy respect for the profession, you need not be in awe of it.

The CHAIRMAN. Thank you for that very sensitive and thoughtful presentation.

Dr. Levin, we're up to you. We've saved you——

THE QUALITY OF MEDICAL CARE: INFORMATION FOR CONSUMERS

Testimony of Jane E. Sisk, Ph.D.
Office of Technology Assessment
U.S. Congress

Before the Subcommittee on Natural Resources,
Agriculture Research and Environment
House Committee on Science, Space, and Technology

New York, New York
June 6, 1988

I am Jane Sisk, Senior Associate at the Office of Technology Assessment. My testimony today is drawn from a report that OTA recently completed on The Quality of Medical Care: Information for Consumers, which this subcommittee requested.

The report addressed whether valid information on the quality of medical care can be developed and made available to the public to guide their choices of physicians and hospitals. There is growing interest in Congress and elsewhere for better information for consumers on the quality of care. In part, this interest reflects a societal trend to promote the role of consumers. Specific to medical care, recent changes in how physicians and hospitals are paid have raised concerns that providers facing restricted budgets and low payment rates might skimp on services to the detriment of patients' health and that third-party payers will seek low-cost providers without sufficient attention to the quality of care.

Advocates of better quality-of-care information expect that individuals and organizations would use it to select hospitals and physicians, thereby exerting leverage on these providers to improve their performance. Besides individual consumers, employers, unions, third-party payers are engaged in selecting physicians and hospitals and in monitoring their performance, and all to some degree have lacked information on the quality of care. Medical providers themselves have lacked such information and could use it to make decisions: physicians to select hospitals for staff appointment, to select hospitals and other physicians for patient referral, and to interpret data for patients; hospitals to monitor their performance and to grant physicians admitting privileges.

The OTA report concluded that several indicators of quality offer useful information to individuals and organizations selecting hospitals and physicians. Although none of the indicators give conclusive evaluations of a

physician's or hospital's quality across the full range of medical care, purchasers of care and medical providers could use several of these indicators to flag areas of concern for further exploration. To improve the validity of the information, the report advises consumers to combine data from more than one indicator and to draw information from more than one year.

The report evaluated the following possible indicators of quality: hospital mortality rates; adverse events in hospitals, as illustrated by infections acquired in hospitals; formal disciplinary actions by State medical boards; sanctions imposed by the Department of Health and Human Services (HHS) based on recommendations from utilization and quality control peer review organizations (PROs); malpractice compensation; evaluation of physicians' performance for a particular condition, such as hypertension; volume of services in hospitals or performed by physicians; scope of hospital services, with emphasis on emergency services, cancer care, and neonatal intensive care units; physician specialization; and patients' assessments of their care. Although OTA attempted to select the most promising indicators, the ones evaluated may not include the best measures for consumer use.

Quality assessment techniques have not progressed to the point that one may rely solely on information about patients' outcomes (patients' health and satisfaction). For hospital mortality rates and adverse events such as hospital-acquired infections, it is important to follow a two-step process: first, to collect data about the adverse event, and second, to examine medical records to determine whether a quality problem exists. For hospital-acquired infections, infections in surgical wounds can be measured more reliably than hospital infections overall.

For consumers who consider physicians' character as well as skills in judging the quality of care, formal disciplinary actions by State medical boards provide the most valid information about poor-quality physicians. The

PRO/HHS sanctioning process is also rigorous, but it is newer and still undergoing refinement. Single incidents of malpractice compensation have little significance for a provider's technical quality, but repeated awards, especially for similar errors, justify attention. Evaluations of a physician's performance for a particular condition, such as hypertension, can produce valid assessments of quality if assessment criteria relate to medical services that have been shown to be efficacious. How well a physician manages one condition, however, is not necessarily generalizable to other conditions.

For certain services, such as coronary artery bypass surgery and total hip replacement, lower volumes in hospitals have been associated with higher rates of patient complications. This relationship has not been documented for all services studied or for services performed by physicians. Consumers would be well advised to consider hospital volumes for more than one year and to consider volume along with other possible indicators of quality, such as hospital mortality rates. External guidelines based on expert opinion appear to offer a reasonable basis for assessing the adequacy of a hospital's scope of services. This indicator, however, has not been validated by linking the results to patients' outcomes or to the appropriate use of services. Physicians practicing in the area of their training are likely to deliver higher quality care; certification by a medical speciality board, however, has not been associated with the quality of a physician's care.

Patients' ratings of their care provide valid information about the interpersonal aspects of ambulatory and inpatient care. Patients' ratings of the technical aspects of care also appear to be promising, especially for physicians' ambulatory care. Patients' ratings, like other measures of patients' outcomes, may reflect factors other than quality, such as the preferences of the particular patients in a physician's practice.

The OTA report places high priority on improving information on indicators that are already being disseminated and used, namely hospital mortality rates, adverse events, HHS sanctions recommended by peer review organizations, and physician specialization. The report also gives higher priority to efforts to identify and improve physicians and hospitals whose quality falls below acceptable levels than to efforts to distinguish among good-quality providers.

Individuals could use quality-of-care information to question their providers about possible problems. But patients may be reluctant to question their physicians, and physicians may not be a reliable or knowledgable source to interpret the data. Organized purchasers, such as employers and third-party payers, and consumer advocates may have experts to interpret the information. Such organizations also have more leverage to exert through the market. As mentioned earlier, physicians and hospitals might use quality-of-care information in establishing relationships with other providers and in examining their own practices.

Difficulties may arise from the providers' response to quality-of-care information. Using some of the indicators may encourage undesirable behavior; for example, providers might relax their criteria for using a procedure to increase their volume of certain services or they might fail to document certain adverse events. A conflict may thus arise between a climate to encourage providers to examine and improve their care and efforts to make quality assessments more publicly available. This unresolved conflict is troubling, because most quality assessments depend on the participation of medical professionals.

The report developed policy options that Congress could consider to address several problems in five areas of quality assessment. The first would fund research and demonstrations to improve quality assessment techniques.

Current techniques do not adjust adequately for patient and environmental factors that influence patients' health and satisfaction independently of the quality of care. This problem affects the validity of using hospital mortality rates to evaluate the quality of care.

The second set of options addresses the problem of ensuring the quality of assessments that are made. Under these options, Congress would require that the Medicare and Medicaid programs select and apply indicators to assess the quality of physicians and hospitals participating in these programs. Congress could also require HHS to brief State and local groups on selected indicators and methods of constructing them.

The third set of options would seek to improve the availability of data required to assess the quality of care. The options relate to demonstrations to collect clinical data and a task force to develop uniform requirements for reporting data.

In the fourth category are options relating to making available to the public information that is now regularly compiled. One option would require Medicare and Medicaid hospitals to make public certain indicators, including any contingencies from the accreditation process that the Joint Commission on the Accreditation of Healthcare Organizations conducts. Another option relates to disclosure of PRO data on specific physicians.

To improve the dissemination of quality-of-care information, the fifth set of options considers establishing an HHS office or conducting research and demonstrations on how to disseminate information. How individuals and organizations use quality-of-care information and how information can most effectively be communicated remain largely unexplored.

I would be glad to answer questions on the policy options or any other facets of the report.

BIOGRAPHICAL SKETCH

JANE E. SISK

Jane E. Sisk is a senior associate in the Health Program of the Office of Technology Assessment, U.S. Congress, Washington, D.C. She has been a project director at OTA since 1981, when she returned after three years as a Veterans Administration Scholar based at the National Center for Health Services Research. She recently directed a project on evaluating the quality of medical care for consumers and a study on the effectiveness of AIDS education. Her previous projects have dealt with the costs of AIDS, Medicare payment for physician services, cost-effectiveness analysis of vaccines, policies related to the medical devices industry, and assessments of specific medical technologies. Her interests center on financing and prevention. She received a Ph.D. in economics from McGill University and a B.A. in international relations from Brown University.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

WILLIAM TOBY

REGIONAL ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON NATURAL RESOURCES, AGRICULTURE

RESEARCH AND ENVIRONMENT

COMMITTEE ON SCIENCE, SPACE, AND TECHNOLOGY

JUNE 6, 1988

Mr. Chairman, I am William Toby, Regional Administrator of the Health Care Financing Administration. I am pleased to discuss with you HCFA's agenda for promoting quality medical care and the important role of sharing information about the quality of medical providers with the public.

Allow me to begin by assuring you that the Health Care Financing Administration has no higher priority than ensuring that Medicare beneficiaries receive the high quality health care they deserve. Quality is, and will continue to be, at the top of our agenda.

The Medicare program has entered its third decade. As Medicare matures, its focus continues to evolve. The emphasis during the 1960s, the program's early years, was access to medical care. Increased access, the high cost of health care and other variables, however, led to rapidly escalating expenditures and a subsequent call for cost containment in the 1970s. Concern that efforts to curb costs could also hinder quality has encouraged closer scrutiny of services paid for by Medicare and the mechanisms in place to ensure quality care. I would like to share with you today HCFAs perspective on quality, and the system we have in place to safeguard it.

Structure, Process and Outcome

Quality is a complex notion which has often been explored in

three ways: the structure of health services delivery, the process by which providers render care, and the outcome of that care. Because structure and process are relatively easy to define and measure, they have been the focus of past quality efforts. More recently, however, we have sought to complete the structure-process-outcome trilogy by adding measures of outcome to our evaluation of quality in the Medicare program. And, an integral component of our outcome-oriented approach is the dissemination of the data we collect to providers, researchers and consumers.

An Overview of the Current System

Medicare currently uses a two-tiered quality assurance system. The first tier is composed of the Medicare Conditions of Participation: these are requirements all institutional providers such as hospitals and skilled nursing facilities must meet in order to receive Medicare payments. One Condition of Participation, for example, is the requirement that all hospitals conduct utilization review to assure that only medically necessary and appropriate care is being provided. State survey agencies monitor the correction of any deficiencies identified through this mechanism. In addition, Federal teams also perform institutional inspections to validate state surveys.

The second tier focuses on the quality of care rendered to Medicare beneficiaries. The backbone of this quality assurance

system is the Peer Review Organizations (PROs). PROs are state-wide physician organizations with which HCFA contracts to review the quality, medical necessity and appropriateness of care provided to beneficiaries. PROs currently review about 25 percent of all inpatient records. In order to enforce quality standards, PROs have the authority to undertake such corrective actions as provider education, intensified review and payment denials.

While the PROs initially focused more on utilization review, HCFA emphasized and strengthened quality assurance in the second contract scope of work in 1986. In addition, review of health maintenance organizations which serve Medicare beneficiaries has recently begun. During the third scope of work which begins this October, PROs will be required to enhance communication between providers and the PROs, increase emphasis on beneficiary outreach programs and meet other expanded requirements. PROs which fail to meet their contractual obligations will not have their contracts renewed.

A Third Tier

While the Medicare Conditions of Participation and PROs have contributed much to assuring high quality of care in the Medicare program, we can -- and must -- do better. We have requested increased budget authority for quality assurance and research activities while we continue to make significant strides within

the context of our present budget. HCFAs current efforts are directed at building a third tier to assure quality care while we continue to preserve and strengthen the first and second levels. The foundation for the third tier will be the generation and dissemination of quality-related data to providers, researchers and the general public. We at HCFA believe that sharing such information rewards providers of quality care and facilitates the public's interest in health care information.

Quality Information Release

In December, 1987, HCFA released Medicare Hospital Mortality Information which focused on deaths within thirty days of admission for sixteen illness categories at approximately 6,000 hospitals. The release was the culmination of over a year of work at HCFA in consultation with industry experts and consumer representatives. The mortality information for each hospital was adjusted to account for many of the factors known to affect the probability of death including age, sex, prior hospital admission, diagnosis on admission and the presence of co-existing health conditions. This information permits hospitals and PROs to identify potential problems for further review.

The release of hospital mortality information is a significant step toward providing consumers with information about the quality of the health care they receive. We hope that such information will help beneficiaries ask questions of their

physicians and make informed choices about their health care.

In addition to the hospital mortality data release, HCFA is preparing to make available information about the quality of care received in nursing homes. In order to measure quality in nursing homes, we have developed indicators related to such resident outcomes as proper nutrition and adequate health care. These indicators will be observed during state survey agency inspections and used as the basis for facility-specific profiles. We expect the information to be released this summer.

As with the hospital data release, we have worked closely with providers, consumers, academicians and state and federal officials to ensure that the release is clear and informative. We believe than an information release structured with the help of experts and supplemented by appropriate explanatory material will be a landmark in our attempt both to measure quality in nursing homes and to share available information with the public.

The Effectiveness of Medical Services

An important component of promoting a high quality Medicare program is ensuring that the services provided to beneficiaries are clearly effective as shown by good medical evidence. This task is challenging because of the growing body of knowledge suggesting there is much uncertainty about the effectiveness of

many medical procedures. For example, John Wennberg of Dartmouth Medical School has found that residents of New Haven were about twice as likely as residents of Boston to undergo coronary artery bypass surgery, but the probability of undergoing carotid endarterectomy is reversed for residents of these two urban, academic communities. In addition, Mark Chassin and his colleagues at the RAND Corporation found that as many as 17 percent of coronary angiograms and upper gastrointestinal endoscopies and 32 percent of carotid endarterectomies were inappropriate.

HCFA strongly believes that additional information is needed on what works in the practice of medicine and has initiated a number of activities in this regard. We are currently analyzing the effectiveness of several medical procedures, and are continuing to study variations in medical practice, re-hospitalizations, mortality patterns and outcomes across both large and small geographic areas.

In addition, we have several ongoing research activities examining broader quality issues. For example, we have entered into a cooperative agreement with the Institute of Medicine to design a strategy for reviewing and assuring quality of care under Medicare.

We have also compiled a hospital admission data base, known as

the Medicare Provider Analysis Review (MEDPAR) file, which permits analysis of patient outcomes. The file contains data from hospital bills of Medicare beneficiaries discharged from Medicare certified hospitals including demographic information, diagnoses, surgical procedures, and utilization of hospital resources.. We used the MEDPAR file to construct information for the hospital mortality release. In order to facilitate effectiveness research, HCFA published a notice in the Federal Register on May 3, 1988 notifying the public that a version of the MEDPAR file will be available for approved effectiveness research.

We believe that better information on the effectiveness of medical services will allow the medical community to build consensus on appropriate medical practice. Such consensus will likely lead to a more clearly defined standard of practice, an end which we believe can only promote quality of care for Medicare beneficiaries.

Conclusion

HCFA will face unprecedented challenges and opportunities during Medicare's third decade. As the population continues to age and the federal deficit exerts its pressure, we must have in place a solid quality assurance mechanism for the Medicare program. We believe that the three-tiered system we envision can withstand those pressures and ensure that Medicare beneficiaries are

receiving the quality of care they demand.

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BIOGRAPHY OF WILLIAM TOBY
REGIONAL ADMINISTRATOR
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

William Toby has served as Regional Administrator of the Health Care Financing Administration in Region II since the formation of this new agency on June 19, 1977.

Mr. Toby is responsible for the Medicare and Medicaid programs. On a total basis, these provide funds in the amount of $14.2 billion to more than 8.2 million people in New York, New Jersey, Puerto Rico and the U.S. Virgin Islands.

Prior to this appointment, Mr. Toby was Regional Commissioner of HEW's Social and Rehabilitation Service (SRS) in Region II, with responsibility for Medicaid, public assistance, and social service programs.

Before being named SRS Regional Commissioner, Mr. Toby had served New York City's Office of the Mayor as inter-governmental relations officer and held top positions with HEW and the National Urban League.

Mr. Toby has been the recipient of numerous awards, including the U.S. Department of Health and Human Services' Award for Exceptional Achievement in controlling Medicaid costs in New York State, the first Health Care Financing Administration Leadership Award for outstanding service in managing the Medicare and Medicaid programs in Region II, a Gubernatorial Citation from Governor Hugh Carey, and an Appreciation Award from the International Health Economics and Managment Institute.

Mr. Toby was born in Augusta, Georgia, on August 12, 1934. His family later moved to New York City, where he dropped out of high school at the age of 16. He completed his high school education during the Korean War while serving with the Air Force in England.

After being discharged from the service, he earned a bachelor's degree at West Virginia State College in Spanish studies in 1961, a master's in social work at Adelphi University in 1963 and a master's in public administration from Harvard University in 1986.

Mr. Toby is married to the former Diane Anderson, of Aberdeen, South Dakota. They live at 129 Willoughby Avenue, Brooklyn, with twin twenty-two-year-old sons, Kenneth and Michael.

STATEMENT OF DR. DAVID AXELROD, COMMISSIONER OF NEW YORK STATE DEPARTMENT OF HEALTH

Dr. AXELROD. I think that I would first like to deal with a series of statements perhaps that would place the conditions of health care in New York State in better perspective.

One of the statements that we have heard is that New York State is no better or worse than other states, those major industrial states, the larger states in the Union and I would suggest to you that I think New York State is better.

New York State is better because the comparisons are being made by the use of actual data that are available in New York State, that are probably not available in any other state in the union. The state of New York has never felt that it could delegate responsibility for assurance to any voluntary organizations. It views the responsibilities for the assurance of the quality of health care as a basic, non delegatable responsibility.

While we can worry about the precise definition of quality of care, the problem is really not to formulate a precise definition but to evaluate the components and decide on how we can inform the consumer, how we can deal with the problems that the consumer faces in the selection of a physician and the selection of an institution for the kind of care that he or she may require.

What has not happened is an evaluation of the quality of services rendered and the focus on the quality of health care at the same time as these very major changes occurred in medical technology. The level of expenditure that's been associated with quality activities has been relatively low in comparison with the extraordinary cost associated with many of the procedures.

I'm sure that had we had a more careful evaluation of coronary bypass surgery, it is likely that we would have been much more cautious with respect to numbers of individuals who have been subjected to coronary bypass surgery.

It is because of this lack of data on the quality of health care that New York State embarked in the last several years on one of the most comprehensive analyses of quality in the entire country. We have focused on both the physician, as well as the institution. With respect to the physician, we have attempted to develop a mechanism for assuring that we monitor the development of competence, that we provide for a mechanism that assures the maintenance of competence and that we provide an effective mechanism for the monitoring of that competence, all of which become part of the public domain.

With respect to the development of competence, I'm sure you have heard of the proposed regulations that would limit the number of hours of continuous on-call duty for house staff. That is not a humanitarian instinct. That is a concern with the quality of care that can be rendered by an individual resident who is exhausted, sleep-deprived and the impact that he or she will have on the patients for whom they have responsibility.

Our concern relates to the entire training process. It also involves medical students. It provides for a credentialing of medical students in terms of the procedures which they can carry out.

The public should have a clear indication of what procedures can be carried out by medical students or residents who are in training and at what point they may be allowed to carry out those specific procedures.

With respect to the maintenance of competence, we have suggested that there be a recredentialing process, that every third licensure application for a position should be accompanied by a certification of the physician's continuing competence in the area in which he has demonstrated his specialization.

We do not believe that a simple examination is going to provide all of the information required. We are in the process of developing a multi-tiered review, which will include a chart review of the activities of that physician to assure that he is providing quality. That information should be available to the public and will be available to the public, that every third licensure application will contain within it a certification of an examination or a review by a properly credentialing body of that individual's capabilities.

The difficulty is we have two groups of physicians with whom we have to concern ourselves. One is those who have hospital privileges and whose capabilities are continuously being peer-monitored, peer-reviewed, and we also have some 20 percent or so of physicians who have no hospital privileges and who are not monitored by peers.

In addition, we also have those same physicians who in a hospital environment, may have one quality of practice as opposed to another quality of practice that may characterize their office as opposed to their hospital practice.

In the development of a mechanism for credentialing and recredentialing, we must assure ourselves that all elements of the physician community are properly evaluated.

We also have a mechanism for the continuous monitoring of the competence of physicians through the impaired physician program, through misconduct proceedings, through malpractice information and through the PRO.

One of the difficulties we have had in accessing the PRO information is while there has been a certain recognition of the responsibility of the Department of Health and the state of New York in providing for a monitoring physician competence, we have not been able to access the PRO information on a timely basis so that we can provide to the public an assurance of the quality of care rendered by each of the physicians.

With respect to hospitals, we have a public incident reporting system where every adverse event occurring in an institution is reported to the Department and becomes a part of the public record.

We also have the joint JCAH review which has been modified to a significant extent over the past several years as a result of the Department's concern that the JCAH review was process oriented and not sufficiently outcome oriented.

As a result of some cooperative agreements that have been engendered by the new president, Dr. O'Leery, we have been able to

reach an accord with respect to the future of the acceptance of the JCAH review, JCAHO review now in the state of New York.

Because of the lack of focus on outcome, we had at one point considered dropping the JCAHO review as being equivalent to the state review for the purposes of accreditation for Medicaid. We now believe that we have moved to the point where there is a greater focus on outcome and that we can accord the JCAHO review the kind of responsibility, the kind of consistency that we believe it should have with the desires of the Department.

We have a complaint investigations division, which is responsible for investigating every compliant that comes into the department within 48 hours to determine whether or not it represents an imminent hazard to the individuals within the institution. If it does not, then it follows a more routine investigation.

Beyond all of that, we have recently instituted a new mechanism for providing gathering of data, comparison of data within institutions, that is designed to assist institutions, rather than the Department in evaluating the quality assurance within its own institution.

It's called the Platform Project. It provides for an opportunity for hospitals to become part of the integrated data system which the New York State Department of Health has managed for a number of years. It does not provide the department with the opportunity to access data except for that which is statutorily required, but it does provide the institutions with an opportunity to compare each his own data, or its own data with that of other institutions or enter into agreements with the exchange of information that will help the institution with respect to its own quality program.

This past year, the Governor directed that we create a Consumer Health Information Council, which we are designed to assist the individual in the interpretation of information, to provide for a full recognition of the responsibilities that we have to make the information accessible as well as intelligible to the general public.

It consists of a number of representatives of major groups within the state who have had continuous concerns about their ability to access and to access intelligible information.

We have put out a report that deals with cardiac surgery. The mortality rates associated with various institutions, whether it relates to coronary bypass surgery, the catheterization procedures, or whether it relates to a variety of procedures. Each of the institutions as categorized by the numbers of procedures, the age distribution, the payor source as well as the morbidity and mortality as we have defined it.

We are also about to release a report on volume mortality studies, which identifies certain procedures in which we have been able to identify a relationship between mortality and the number of procedures that have been performed at certain institutions.

For example, several of the procedures in which we have been able to identify a clear volume mortality relationship are graft procedures for abdominal aneurysms, gastrectomies—these are the kinds of procedures where there appear to be clear relationships between the number of procedures performed and the ultimate mortality associated with it.

But there is a very major problem, and that problem relates to informed consent. I don't know how a patient can provide proper informed consent. What kind of information can be given to a patient at the time at which he or she makes a determination that this is an appropriate procedure for him or for her?

We have a major problem in defining in language that is clearly understood by the individual that that is a true judgment based upon his best information that can be provided to him. Dr. Robin and his definition of an iatrogenic epidemic of major proportion, has suggested that there be a video tape prepared for each of the major procedures which are being thrust at the public, that prior to a hysterectomy or prior to a Caesarean section or prior to a gastrectomy, that the patient be fully apprised of the nature of the procedure, the mortality, the morbidity, the likelihood of success, all of the kinds of factors that one would hope would be part of a development of the protocol for the individual institutions providing that information.

I do believe that there is an urgent need for a greater recognition of the kind of information that is provided to an individual for informed consent.

We are in the midst of a major revolution. We are in the midst of catching up with the enormous advances that have been made in technology without which there could have been no development of the technological capability for analysis, for assessment, for the gathering of data, for the development of the kind of policy that would assure that the public is fully informed of all of the elements that are part of the health care system.

We have to make certain as a governmental entity that necessary services are being provided, that they're being provided at the highest level possible and that there is a continuous public accountability by not just government but by the voluntary providers as well.

We also have to make certain the licensure and certification procedures achieve what they are intended to achieve, and that is, the continued competence of individuals who are responsible for providing the care of those individuals on whom they are practicing.

Recognizing the development of the extensive data that has occurred within the department as well as throughout the country, the Consumer Health Information Council which the Governor created has embarked on a number of other activities which, I think, bear careful scrutiny. I think they are indicative of a role that can be played by a Consumer Council.

The Consumer Council is concerned with the different populations, the different languages being spoken, the level of literacy throughout the population—all of the things that are going to have to be dealt with if we are going to have a truly informed public.

The publication of a doctors' directory that offers information on costs for procedures, that identifies the specialties, the affiliations with respect to individual hospitals and the certification status of than individual or recertification where it relates to board certification by an independent board.

The council has suggested, and we are in the process of implementing the creation of a state-wide and regional hot line referral service capable of linking citizens with the services they need or to

TESTIMONY OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK AT A PUBLIC HEARING CONDUCTED BY THE U.S HOUSE OF REPRESENTATIVES SCIENCE, SPACE AND TECHNOLOGY SUBCOMMITTEE ON NATURAL RESOURCES, AGRICULTURE RESEARCH AND ENVIRONMENT AT THE GSA BUILDING, NEW YORK CITY, JUNE 6, 1988, 10:00 AM

I am Doctor Charles D. Sherman, president of the Medical Society of the State of New York. I am a clinical professor of surgery at the University of Rochester School of Medicine and Dentistry and maintain a private surgical practice in Rochester.

The State Medical Society represents nearly 28,000 physicians in New York State. On their behalf, I would like to thank the subcommittee for this opportunity to present our views on the issues mentioned in Congressman Scheuer's letter to me of May 26, 1988.

As I understand it from that letter, you wish to know how information about the quality of medical care can be compiled and made available to the general public. You also wish to hear testimony regarding initiatives taken by the Medical Society toward assuring the highest standards of medical care.

It is self-evident, I believe, that the quality of medical care provided to patients depends initially and fundamentally on the quality of medical education that physicians receive during their medical school years, in post graduate education programs and in continuing medical education throughout their careers. I am particularly pleased to respond to your inquiry because medical education has been a special interest of mine throughout my medical career. In addition to my teaching duties at the

University of Rochester, I am a member of the American Medical Association's Council on Medical Education and its Commission to Review Standards for Evaluating Medical Education and Training. I also serve as vice chairman of the AMA's Accreditation Council for Continuing Medical Education and as a member of the AMA Committee on Foreign Medical Graduates. Finally, I am actively involved in the worldwide educational efforts of the International Union Against Cancer and the World Health Organization.

With all that, I must concede to you that the term "quality of medical care" is not easily defined. The American Medical Association Council on Medical Service report, "Quality of Care" (adopted by the AMA House of Delegates in June 1986), included the comment that care of high quality "is consistently related to favorable patient outcomes... Patient outcome reflects the degree of effectiveness with which health care professionals combine their skills and compassion with the use of technology for the patient's benefit."

Quality health care is directly related to quality medical education. For centuries, the medical profession has held this concept as one of medicine's most important credos.

In the frontier days of America very few trained physicians "braved the new world." Anyone could claim to be a doctor -- and all sorts of people did. Slowly a small cadre of physicians

trained in Europe arrived and took apprentices. Then "medical schools" developed. In the 1840s New York physicians were instrumental in forming the AMA primarily because of a felt need for setting higher standards for education at the national level. In the 1890s the founding of Johns Hopkins set the highest standards of all. The great watershed in U.S. medical education came with the Flexner report, in 1910, which recommended high standards for all schools including a four year curriculum. Within a short time over half the schools closed.

In addition to setting standards for medical schools, an increasingly sophisticated system of accreditation was established to make certain that those standards were, in fact, met. Today each school is surveyed periodically by a high powered team representing the A.M.A. and the Association of American Medical Colleges (AAMC).

From the twenties through the fifties the development of the specialty societies and specialty boards were very important factors in setting the standards for internship and residency training and for developing site visits by "residency review committees" to ensure that the standards that had been promulgated were followed.

From the very beginning the concept of learning through working with patients and of increasing responsibility under

supervision has been a unique feature of American medical education.

During the last half of the twentieth century there has been such an explosion in information that knowledge doubled every few years. Much of what one learned in medical school was out-of-date within a decade or so after leaving formal educational programs. While medicine had always been considered a profession where "lifetime learning was vital to the care of the patient," it has become even more important to try to ensure that physicians keep up-to-date as much as possible after leaving their residency training programs.

Formalized continuing medical education (conferences, courses, and seminars) has been developed, and attention paid to attempts to improve the standards in continuing medical education. Although we now have a national Accreditation Council for Continuing Medical Education, (ACCME) many of us feel that these more formalized programs at the national level are only a relatively small and less important part of all the things that the profession does to keep up-to-date. There are now several national organizations committed to a variety of activities in continuing medical education, and one of the most important of these is the Alliance for Continuing Medical Education (ACME).

The ACME was organized by a New York physician, Dr. William Felch, who was its first executive director. It is now headed by another New York physician, Dr. Richard Pierson. So, you can see that New York continues to take a leading role in medical education. Many consider CME the most important part of medical education, since it lasts the several decades of a physician's practicing career.

In today's world, the educational programs at the hospital level are among the most important ways that we guarantee quality care of the public. These include, but are not limited to:

1) Death and complications conferences to analyze problems that occur and devise means of preventing them in the future.
2) Case reviews and chart reviews so that each hospital case is reviewed after discharge for inadequacies and for additional data needed to complete the chart. Any problems identified are referred back for action.
3) Tissue committees to make sure that the indications for surgery correspond to the pathological specimens resected.
4) Each specialty and almost every subspecialty in the hospital has frequent conferences covering special cases and subjects of interest in their field.

5) Special lectures, symposiums, courses, and other educational programs are organized.

6) Hospital directors of continuing medical education have been appointed in many hospitals to help the educational programs of the entire institution.

7) Quality assurance departments are now standard in most hospitals and use a variety of methods to ensure quality care.

8) Just as with medical schools and with residency training programs, the process of setting standards and ensuring those standards are adhered to has been developed voluntarily by the medical profession which formed the Joint Commission on Accreditation of Healthcare Organizations for this purpose (JCAHO). While this process remains important, the JCAHO today is trying to go one step further and evaluation outcomes, to make even more certain that all patients receive quality care.

Other quality control measures include the following:

1) Physicians are required by law in New York State to report misconduct of their peers to the OPMC.

2) All reimbursement systems have quality control mechanisms so that payments are not made for inappropriate care.

3) The AMA and the Federation of State Medical Boards have organized a nationwide reporting system for serious infractions.

4) Medical Society of the State of New York has a Committee for Physicians' Health to identify and treat physicians with substance abuse or mental health problems.

The quality and necessity of medical care under the Medicare program are reviewed in each state by a Peer Review Organization under contract to the federal government. In New York, that work is done by the State's Medical Society's Empire State Medical, Scientific and Educational Foundation. The Foundation's responsibility includes dissemination to the public of information on the rights of patients under Medicare.

The Medical Society of the State of New York has been in the forefront of utilization review and quality assurance since 1972 when it encouraged, stimulated, and directly assisted development of local peer review groups known as Professional Standards Review Organizations (PSROs) by serving as the State's PSRO Support Center.

As the PRO for New York State, The Foundation reviews the quality of care of approximately 28% of all Medicare discharges. In addition The Foundation conducts preadmission and preprocedure reviews in specific diagnoses related groups, review of inpatient and intervening care for Medicare risk-sharing Health Maintenance Organization (HMOs), and also conducts an aggressive outreach program for patients (consumers), physicians, and providers. This educational component -- with special emphasis on identification of actual or potential problems, and subsequent education for physicians is, in our opinion, the most vital part of the Foundations' activities.

Elected to the Foundation's policy making Board are two consumer representatives -- one from the American Assoication of Retried Persons and one for the New York State Senior Action council. The Foundation's commitment to patient advocacy equals that of its commitment to physician education. Its publications for consumers on patient rights under medicare have beeen proclaimed as being among the best such publications in the country. Since September 1986, thirty-nine physicnas have been called in for potential sanction by the Foundation, and 21 have satisfactorily met our conditions. Two have not, and these two

have been referred by the PRO for sanction to the Secretary of Health and Human Services. The remaining 16 are pending a final outcome. The Health Care Finance Administration and the PRO agree that sanctions are a failure of the peer review system, and the number of sanctions referred is far less a measure of a PRO's effectiveness than are the PRO's actions to intervene to correct deficiencies, thus improving the quality of care while not removing otherwise competent physicians from the community, especially in rural areas.

The American medical profession can be proud of the fact that it has over a period of many decades continuously developed and refined the many mechanisms that have brought medical care in the United States to a level of quality that is unsurpassed in the world.

Our record is less clear with respect to educating the public to the indicators of quality that they can look for. The public wants health care information, wants to know how to select a physician or hospital, and so on, and often finds such information hard to find, incomplete, confusing and hard to understand.

That is not to say that we haven't tried to meet this need. We do provide public referral services to qualified physicians

through the county medical societies. We do publish information handouts on health issues that reach the public through physicians' offices and at such events as state and county fairs. We do provide public service announcements on health care issues for broadcast by radio and television stations. Through the Peer Review Organization we publish information designed to assist Medicare patients with questions they might have regarding their care.

The AMA, the State Medical Society, county medical societies, medical specialty societies, hospitals and other institutions, the pharmaceutical industry and others all contibute to this information stream.

Most reliable, perhaps, or at least most common, is the kind of word-of-mouth that has always helped newcomers in a community identify professionals in all fields who are reliable and of high quality.

But the public needs to know the right questions to ask on subjects ranging from their physicial condition to the latest health care news to the meaning of the diplomas and certificates hanging on the physician's office wall.

Obviously, much more needs to be done in the area of informing the public.

Council Report

Quality of Care

Council on Medical Service

AS GOVERNMENT, business, and other payers search for methods to reduce their health care costs, and as competition intensifies in the health sector, efforts to preserve the quality of health care will become increasingly important. Pressure will grow for changes in delivery and financing systems that may tend to reduce the quality of care provided. Public debate will increasingly focus on how to define and measure quality, as health professionals, payers, and consumers address such issues as ensuring quality of care in contracting with provider groups; deceptiveness of advertisements stating that certain providers give "the highest quality health care available"; the feasibility of incorporating a measure of quality in reimbursing hospitals or any other health care providers; and evaluating the effectiveness of various treatment modalities and delivery systems.

The Council believes that the challenge posed by this evolving health care environment is threefold: to foster a broader public understanding of what is meant by the term "high-quality medical care" and of the current mechanisms used to assess and ensure quality; to develop guidelines regarding appropriate methods for assessing or measuring the quality of care; and to encourage wide and systematic use of quality assessment findings to improve the care delivered, and thus increase overall access to care of high quality.

From the Council on Medical Service, American Medical Association, Chicago.

Report A of the Council on Medical Service, adopted by the House of Delegates of the American Medical Association at the Annual Meeting, June 18, 1986.

Reprint requests to Council on Medical Service, American Medical Association, 535 N Dearborn St, Chicago, IL 60610 (Nicholas Grifin).

The present report is intended to inform the House of Delegates of the activity undertaken by the Council on Medical Service in response to this challenge and to enlist the House's support in that effort.

Definition of Care of High Quality

At the 1984 Annual Meeting, the House of Delegates adopted Council on Medical Service Report I, which conceptually defined care of high quality as care "which consistently contributes to improvement or maintenance of the quality and/or duration of life." This definition essentially characterizes such care as that which is consistently related to favorable patient outcomes. It recognizes that, *when other variables that could affect outcome (eg, patient age, sex, living environment, attitude toward illness, health history, severity of illness, natural history of the disease, etc) are adequately measured and accounted for,* patient outcome reflects the degree of effectiveness with which health professionals combine their own skill and compassion with the use of technology for the patient's benefit. Implicit in the definition is the need to develop more precise and meaningful criteria of "favorable" outcomes.

The Council believes there are a number of important elements in addition to favorable outcome that can be used to identify care of high quality. All have an important relationship to successful patient outcomes, but can be evaluated independently of such outcomes. Including favorable outcome as one characteristic, therefore, the Council believes that care of high quality should (*a*) produce the optimal improvement in the patient's physiological status, physical function, emotional and intellectual performance, and comfort at the earliest time possible consistent with the best interests of the patient; (*b*) emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions; (*c*) be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care; (*d*) seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process; (*e*) be based on accepted principles of medical science and the proficient use of appropriate technological and professional resources; (*f*) be provided with sensitivity to the stress and anxiety that illness can generate and with concern for the patient's overall welfare; (*g*) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and (*h*) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation.

The Council believes that these eight "essential elements of quality" provide a logical framework around which to organize professionally conducted quality assessment programs and on which

to construct specific criteria for such assessment. In addition, a number of these elements can provide patients with a better frame of reference to make judgments about the quality of care that they receive.

Recommendation

The Council on Medical Service recommends that the Association endorse these elements as essential characteristics defining medical care of high quality and that this definition be communicated by the Association to the profession, the payers, and the public through all appropriate channels.

To further enhance public understanding of the complex factors influencing quality of care and facilitate informed choice, the Council has prepared a brochure for distribution through physicians' offices and other channels. It describes the major approaches utilized by medicine to assure care of high quality, ranging from licensure, certification, and accreditation through continuing education and peer review. The Council is now exploring preparation of a second brochure providing specific suggestions as to how patients can evaluate the quality of care they receive.

Guidelines for Quality Assessment

The heart of any program to assess the quality of medical care is peer review, or the evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. At the 1981 Interim Meeting, the Council proposed and the House adopted nine Principles for Voluntary Medical Peer Review (Council on Medical Service Report A, December 1981). These principles were intended to be generic, and should be found in any organization or system concerned with assessing the quality of medical care.

To supplement these 1981 Principles and further assist in the development of effective peer review programs, the Council has prepared the following guidelines as to the scope and process of quality assessment activity. These guidelines are based on the Council's continuing study of this subject and its discussions with other groups and individuals concerned with improving the quality assessment process. The Council believes that they should be incorporated into any peer review system, whether voluntary or government-mandated, whether sponsored or conducted by medical societies, medical groups, hospital medical staffs, payers, foundations, corporate review programs, or federal agencies. These guidelines help to delineate the "how" of any quality measurement process; the essential elements identified earlier in this report constitute the "what," or the characteristics to be measured. The guidelines are as follows:

1. *The criteria utilized to assess the degree to which medical care exhibits the essential elements of quality should be developed and concurred in by the professionals whose performance will be reviewed.* Such participation is imperative not only to the acceptability of the assessment process, but to assure the relevance of the criteria developed.

2. *Such criteria can be derived from any one of the three basic variables of care: structure, process, or outcome. However, emphasis in the review process should be on statistically verifying linkages between specific elements of structure and process, and favorable outcomes, rather than on isolated examination of each variable.* "Structure" is generally defined as the facilities, equipment, services, and manpower available for care and the credentials and qualifications of the health professionals involved. "Process" refers to the content of care, ie, how the patient was moved into, through, and out of the health care system and the services that were provided during the care episode. "Outcome" refers to the results of care, and can encompass biologic changes in disease, comfort, ability for self-care, physical function and mobility, emotional and intellectual performance, patient satisfaction and self-perception of health, health knowledge and compliance with medical care, and viability of family, job, and social role functioning. While all three care elements have individual merit as indicators of quality, the review system should also attempt to statistically identify and "validate" on an ongoing basis those elements of structure and process that are consistently associated with favorable patient outcomes. This enables more informed attempts to change physician practice behavior when indicated, as well as assuring the relevance of the structure- and process-based criteria used in assessment.

3. *To better isolate the effects of structure and process on outcome, outcome studies should be conducted on a prospective as well as retrospective basis to the degree possible.* It can be difficult to distinguish between the effects of care provided and other factors that can also influence outcome, such as patient age, history and life-style, stage of disease, and attitude toward illness. As opposed to after-the-fact outcome evaluation, the identification of "expected" outcomes on a preservice basis, and subsequent comparison with actual results, can allow better identification of individual risk factors and the allocation of patients to similar risk categories better suited to analysis.

4. *The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in quality assessment.* As a practical matter, it is often more feasible to use intermediate outcomes or immediate treatment results as indicators of quality rather than long-term morbidity and mortality data. In addition, the direct effects of care received are progressively obscured over time.

5. *Blanket review of all medical care provided is neither practical nor needed to assure high quality of care. Review can be conducted on a targeted basis (eg, specific diagnoses, services, or providers), a sampling basis, or a combination of both, depending on the goals of the review process.* The review system may isolate specific aspects of medical care for analysis, such as services exhibiting high variation in regional utilization rates or a high utilization rate generally, diagnoses associated with high mortality or morbidity or for which multiple treatment options exist, or even specific practitioners or institutions. However, judgments as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on examination of single or isolated cases, because of the inherent variability of biologic systems. By contrast, when general assessment of the quality of care provided by a given health care system or across systems is desired, random sampling of all care episodes may be the more appropriate approach.

6. *Both explicit and implicit criteria are useful in assessing the quality of care.* Explicit criteria are highly structured, specific, and written—eg, "specific laboratory/diagnostic tests indicated in treatment of chronic urinary tract infection"—and require little or no individual judgment by the evaluator. Implicit criteria tend to have little or no formal or written structure and tend to be based more on the internalized expectations and judgment of an expert practitioner acting as an evaluator. Explicit criteria are needed to maintain consistency and objectivity in the assessment process; implicit criteria are needed to accommodate legiti-

mate professional differences regarding optimal treatment and allow the unique features of each individual case to be considered.

7. *Prior consultation as appropriate, concurrent peer review, and retrospective peer review are all valid aspects of quality assessment.* Professional consultations when appropriate before a course of treatment is initiated can help assure a medical consensus as to the appropriate course of care and contribute to improved quality. However, the Council shares the strong conviction of this House that the increasing number of payer-instituted, cost-driven programs calling for prior review of the necessity for surgical, medical, or hospital care should not be implemented in a way that would impair the quality of care provided. Two other Council reports before the House at this meeting—Report B and Report D—contain recommendations designed to ensure payer accountability for any prior authorization decisions that may adversely affect the patient and to improve the administration of prior authorization programs contributing to improved quality of care. Similarly, concurrent and retrospective review, when conducted on the same basis, can also make special contributions to the quality assessment process, through "on-line" identification and correction of care deficiencies in the former instance, and increased emphasis on patient outcomes in the latter.

8. *Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance.* The purpose of quality assessment is to improve the care of patients. Accordingly, the results of such assessment should be systematically conveyed to the practitioners reviewed, and such professionals should be assisted in improving their knowledge and in modifying their practice behaviors where indicated.

9. *The quality assessment process itself should be subject to continued evaluation and modification as needed.* The criteria by which quality of care is assessed, and the quality assessment methodology itself, must be continuously reviewed and revised by the physicians using them to reflect increased scientific knowledge, improved technologies, availability of resources, and other developments relating to the demand for and provision of medical care.

Recommendation

The Council on Medical Service recommends that the Association endorse these guidelines for quality assessment and encourage their incorporation into and use in any system designed to review the quality of medical care.

The Council will continue its study of quality assessment programs and will bring additional recommendations concerning the operation of such programs to the House of Delegates as appropriate. The Council also plans to evaluate the effectiveness of various approaches to quality *assurance*, or the use of assessment findings to improve the care delivered, with the goal of increasing overall access to care of high quality. To assure their equity and validity, all such quality assurance systems must be sensitive to the multiple differences between patients with ostensibly the "same" condition, and should be based on evaluation of overall practice patterns rather than on adherence to specified criteria in single cases. The Council will report its findings to the House in this area as well.

Editorials

The 'New' AMA

A Rededication to Excellence

to promote the science and art of medicine and the betterment of public health

This is a *JAMA* theme issue on quality. It stems from our overriding current professional concern with preserving the quality of care for the sick. The issue was inspired by the tenor and achievements of the June 1986 Annual Meeting of the AMA, which reflect clearly the extraordinary active directions now being taken by organized medicine in the United States.

The tone of the meeting was struck early by outgoing President Harrison Rogers, MD, who, in a characteristically straight-to-the-point speech, summarized the intense activity of his year as official spokesman and listener for the Association. Urging the highest standards of quality of care, President Rogers has frequently emphasized that the golden age of medicine is ahead, not behind. He maintained that there is no longer any one best way to practice medicine but that competent, conscientious, and effective physicians practice equally well in many settings and in many practice arrangements. He challenged physicians to be visibly good citizens and encouraged them to run for public office. And he reminded us once again that our professionalism, our freedom, our welfare, and our success will always be determined by the final arbiter of every issue in this country: "the court of public opinion." Incoming President John Coury, MD, whose inauguration address appears in this issue, calls for rededication to the best possible patient care.[1] In between these two speeches, politics ran hot but dignified. The House, recognizing the unusual strengths of existing leadership, returned all eligible members of the Board of Trustees, promoted its chairman, William S. Hotchkiss, MD, to President-Elect, and added two more scientists, Ray W. Gifford, MD, and Stefano Bertozzi, to the Board.

The 1847 Preamble to the Constitution of the American Medical Association declared the purpose to be:

> for cultivating and advancing medical knowledge; for elevating the standard of medical education; for promoting the usefulness, honor and interest of the medical profession; for enlightening and directing public opinion in regard to the duties, responsibilities and requirements of medical men; . . . and for facilitating and fostering friendly intercourse between those engaged in it.

By 1901, the statement of purpose had evolved into the following:

> to federate into one compact organization the medical profession of the United States, for the purpose of fostering the growth and the diffusion of medical knowledge, . . . of securing the enactment and enforcement of medical laws, . . . and of representing to the world the practical accomplishments of scientific medicine, with power to acquire and hold property, publish journals, etc."

By 1920, Article 2 of the constitution stated that "the objects of the association are to promote the science and art of medicine and the betterment of public health."[2]

Against that historical backdrop, let us look in some detail at a selection of the remarkable activities that characterize the AMA in 1986.

Initiatives in Science and Education

For much of the past, the AMA has been central to the process of medical education and deeply involved in supporting science. Through *JAMA* and the family of specialty journals, this tie has remained solid for many decades. The editors of the AMA's journals are chosen from academic medicine by a rigorous search process, and they and their editorial boards have absolute editorial freedom. But critics have suggested that in some other parts of the AMA the commitment to science and education has been less consistent. Today's AMA is characterized by a rededication to the centrality of science and education in the current mission and function (as much as by any other one element). The recently established (1976) Council on Scientific Affairs and its solid record of accomplishments in assessing and disseminating medical scientific knowledge from its members, from distinguished panels, and from excellent staff illustrate this emphasis. Recently, AMA leaders have successfully recruited top medical administrators, educators, and scientists in their most productive years from academia. Among them are M. Roy Schwarz, MD, Carlos J. M. Martini, MD, William R. Hendee, PhD, and DeWitt C. Baldwin, Jr, MD. The excitement and enthusiasm generated by their presence and plans demonstrate the AMA's commitment to the intellectual advance of medical science, along with its long-standing involvement in clinical practice, politics, and economics as these affect physicians individually and collectively.

Ethical Initiatives

On its founding in 1847, the AMA established a code of medical ethics that informed physicians of the conduct expected of them by their peers. In 1858, the first committee on ethics was appointed for the purpose of implementation. In 1873, the Committee on Ethics had its name and structure changed to the Judicial Council, established to decide all questions of an ethical or judicial nature relevant to the AMA. Reflecting the profound changes being produced by our current technological revolution and the resulting wrenching moral and ethical human dilemmas physicians face every day, the AMA changed the name of this body in

June 1985 to the Council on Ethical and Judicial Affairs. Not long thereafter, in March 1986, this council issued an enormously important statement regarding the withholding of life support in terminally ill patients.[3] This statement has drawn worldwide attention and has already been used as a guide in courtroom proceedings.

Initiatives in Public Health and Preventive Medicine

Consistent with some of its earliest objectives, the AMA is vigorously pursuing many public health initiatives on a wide variety of subjects through educational efforts, support for research, pursuit of law change, and litigation. Among these initiatives are increased use of automobile seat belts, prevention of transmission of the AIDS virus, and prevention of driving after drinking alcohol. But the prototype is the all-out attack on tobacco. The overall goal, of course, is a tobacco-free society by the year 2000. But along the way to this goal are many steps. The 1986 Annual Meeting considered eight separate resolutions from four states and the resident physician and medical student sections and adopted a consolidated 12-part substitute resolution that calls for

enactment of anti-smoking policies, including a ban on smoking at all AMA-sponsored meetings and the development of non-smoking policies for members and staff; support of federal legislation to control smoking in public places, to permit local government to adopt anti-smoking regulations, to ban vending machine sales of all tobacco products, and to set the minimum legal age for purchasing tobacco products at 21; continued support of legislation to raise the federal excise tax on cigarettes, with revenues going to Medicare; support for legislation banning the sale of tobacco products in health care institutions; support of legislation banning smoking on commercial airline flights; and continued support of educational efforts to warn young people about the hazards of tobacco.

Quality Assurance Initiatives

The American Society for Quality Control (ASQC) defines quality as "the totality of features and characteristics of a product or service that bears on its ability to satisfy given needs." The ASQC defines quality control as "the operational techniques and activities which sustain a quality of product or service that will satisfy given needs." Clearly, noting a problem is not sufficient in quality control. A proper system finds it necessary to take corrective action to eliminate the causes of the problem and to prevent its recurrence. Thus, quality assurance becomes "all those planned or systematic actions necessary to provide adequate confidence that a product or service will satisfy given needs."[4]

The AMA has been extremely active in quality control and assurance for a long time. Among the many areas in which it attempts to assure quality are the following:

- The AMA participates in the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the Accreditation Council for Continuing Medical Education, and the Committee on Allied Health Education and Accreditation and Residency Training Program Supervision.
- The AMA has been a corporate member of the Joint Commission on Accreditation of Hospitals since its formation in 1951.
- The AMA is the world's largest medical publisher, constantly contributing to medical knowledge.
- The AMA is involved in assessment of geographic variations in utilization.
- The AMA's Diagnostic and Therapeutic Technology Assessment (DATTA) project evaluates new medical technologies.
- The AMA physician master file contains confidential current and historical information on all Doctors of Medicine in the United States, both members and nonmembers of the AMA, from their earliest days in medical school until death, providing a physician profile service to hospitals and other health care and licensing organizations to ensure that individuals applying for staff privileges possess the training and credentials claimed.
- The AMA has developed model legislation that many states have used to encourage physician participation in the peer review process.
- To identify physicians who misprescribe therapeutic drugs, the AMA has introduced the Prescription Abuse Data Synthesis (PADS) model into 25 states, hosted in each state by the medical association.
- At least 26 states have enacted one or more legislative provisions that have been patterned after AMA model legislation on medical discipline. The AMA drafted the Hatch-Inouye-Lent bill on professional liability for federal legislative consideration. If passed, this bill would provide major reforms in the areas of peer review, discipline, and risk management.

Major new initiatives in the area of quality of care were adopted by the House of Delegates in June 1986. These include the report of the Council on Medical Service entitled "Quality of Care"[5] that defines quality at many levels and the report of the Board of Trustees entitled "AMA Initiative on Quality of Medical Care and Professional Self-regulation,"[6] both of which are published in this issue.

Legal Initiatives

The AMA long has been active and successful on the federal level and in cooperation with members of the federation on the state level in promoting proposed new laws and regulations it supports and preventing the enactment of proposed new laws and regulations it opposes. Recently, it has expanded its efforts in the courts as well as in a series of creative and sweeping actions to protect physician and patient interests, particularly in the Supreme Court. Its bold and energetic general counsel, Kirk B. Johnson, JD, working with an excellent staff as well as superb private attorneys, should be given principal credit for these and other initiatives:

- The AMA has intervened, as amicus curiae, together with the NAACP, the AFL-CIO, and the Sierra Club in a Supreme Court case in which the Department of Justice is challenging the right of associations to represent their members in the courts.
- The AMA has filed an amicus brief on behalf of itself and the Joint Commission on Accreditation of Hospitals asking the US Court of Appeals for the ninth circuit to overturn the ruling in the Astoria Clinic case in which two hospital members were found guilty of antitrust violations for participating in peer review.
- And, of course, the Supreme Court recently, at the AMA's urging, strongly reaffirmed the importance of parental, physician, and community involvement—as op-

posed to federal intervention—in the difficult decisions about treatment of severely impaired infants. In this famous "Baby Doe" case, the court found no evidence of discrimination and struck down government regulations.

Representation Initiatives

The number of physicians in the United States is at an all-time high and is increasing rapidly. The total number of AMA members is also at an all-time high (1985 peak 239 000, excluding students). There was a time, as recently as 1958, when an overwhelming majority of physicians (73%) belonged to the AMA. But that was when dues were $25 per year and unified membership in state and county medical societies along with the AMA was commonplace. This percentage began to decline in 1963 and fell steadily until about 1980, when it became fairly stable at about 45%. Our detractors try to make political hay from that decline. What they fail to realize is that official policy of the AMA is formulated by the House of Delegates. Voting members in the House in 1986 include representatives of 50 state associations, 66 national medical specialty societies, the resident physician and medical student sections, the section on medical schools, and the hospital medical staff section and one delegate each from the Army, Navy, Air Force, Public Health Service, and Veterans Administration. Through this form of representative government, the AMA speaks not only for the 45% of physicians that are members but in fact speaks for the approximately 90% of US physicians who belong to one or more of these groups represented in the House.

Management Initiatives

In an imaginative approach to improved management, the AMA adopted the Lewis Allen system in July 1985. Implementation has been proceeding step by step from the top down with extensive participatory management as well. A reorganization at the top has resulted from this extensive self-study, and Whalen M. Strobhar, a longtime successful AMA administrator, was appointed earlier this year as the chief operating officer with the title Deputy Executive Vice President. This move was made to provide more effective and efficient daily management and to free up medicine's great communicators, James H. Sammons, MD, and James S. Todd, MD, the Executive Vice President and Senior Deputy Executive Vice President, respectively, to carry the message on the major medical political issues of the time—professional liability, quality of care, professional self-discipline, and similar challenges—to the public, the profession, and Congress. Each major management position has created a comprehensive position charter, with critical objectives and measurable standards of performance. This interlocking system engenders flexibility, utilizes ongoing strategic planning to the fullest extent, and streamlines the organization for top performance.

All this and fiscal responsibility too. It is enough to make a person proud to be a member and even prouder to work for the AMA. The future is bright and filled with fresh challenge as physicians everywhere strive for the highest possible quality of care. We enter this future eagerly.

George D. Lundberg, MD

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2. Fishbein M: *A History of the American Medical Association 1847 to 1947*. Philadelphia, WB Saunders Co, 1947.
3. Dickey NW: Withholding or withdrawing treatment. *JAMA* 1986;256:471.
4. Lundberg GD: Peer review: Definition and needs. *The Internist* 1986; 27:19.
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6. Board of Trustees: AMA initiative on quality of medical care and professional self-regulation. *JAMA* 1986;256:1036-1037.

The Setting of Standards of Care

The opportunity for self-determination, for being one's own boss, has been for many of us one of the pluses of being a physician. With surprising and somewhat painful alacrity, elements of this independence are being constrained as external societal forces try to control costs and guarantee the outcome of care. The article that appears in this issue by Eichhorn et al entitled "Standards for Patient Monitoring During Anesthesia at Harvard Medical School" exemplifies an interesting, creative response to these forces. As such, it is presented not so much to enlighten *JAMA*'s readership concerning monitoring as one aspect of anesthetic care, but as an example of a process for extracting a collective minimum standard from individuals long accustomed to defining their own destiny and unaccustomed to others telling them what they should do. The essence of our role as problem-solving givers of care is independent thought and action. Anything that appears to constrain that freedom will be viewed as threatening one's ability to provide care in the way each of us believes to be the best.

See also p 1017.

We are being provoked to be accountable for both the costs and benefits of our care. Regrettably, this provocation is coming more from without than from within our

Board of Trustees Report

AMA Initiative on Quality of Medical Care and Professional Self-Regulation

Background: Physicians and Quality Assurance

Providing quality care is the physician's foremost ethical obligation, and it is the basis of public trust in physicians. Improving the quality of medical care has been a central purpose of the American Medical Association (AMA) since it was established in 1847.

Quality is difficult to measure, and even where measurements exist, they are often challenged as to their precision and application. But there is little doubt that Americans receive high-quality medical care. The evidence is that the quality both of care and of the health care professional have never been higher in this country. Taking just one crude measure, mortality rates for virtually every major surgical operation have fallen substantially over the last decade.

Physicians and their professional organizations have established a variety of mechanisms to protect the quality of the care of patients. The quality standards of US medical education, residency training, and hospital care derive from physicians and from organizations that physicians helped establish and that physicians maintain today. The leading clinical and educational journals in medicine are published by physician organizations. The only complete source for physician data and credentialing is maintained by a physician organization. The most comprehensive data base on drugs and diseases is compiled and disseminated by that same physician organization. The vast majority of physicians belong to at least one professional association that has as its principal focus quality assurance, risk management, impaired physician programs, or continuing medical education programs. Medical ethics are vigorously debated, formulated, and enforced in the first instance by physicians themselves.

Physicians also regularly engage in self-policing in a most basic and important way—they don't refer patients to questionable colleagues—and, in accordance with criteria mandated by the Joint Commission on the Accreditation of Hospitals (JCAH), physicians on hospital medical staffs restrict or deny hospital privileges to physicians believed to provide less than the best medical care. Physicians and their organizations also work closely and effectively with medical disciplinary boards in many states, and procedures for quality assurance, peer review, and discipline are largely in place today in every state. Medical societies have drafted or supported much of the recent legislation that has strengthened those procedures.

True incompetence or serious impairment that goes completely unchecked by all of the formal and informal control mechanisms occurs, but not commonly. Even where state disciplinary boards are underfunded and understaffed, their performance is better than generally perceived. For every officially reported sanction by a state board, ten times as many cases are handled by the boards in unreported yet binding agreements that both protect the public and permit good physicians with problems to be rehabilitated.

But the profession can and must do more. The challenge is to continue to exercise leadership in improving quality assurance systems in an environment in which concerns of cost and economics have become predominant. The profession must also respond to criticism that it has not taken strong enough action in quality assurance, particularly in disciplining within its own ranks.

The public tends to measure the effectiveness of quality control by the number of official license revocations by state medical disciplinary boards. And on that measure, the record is not good overall. In part, because of the fear of personal liability, physicians are reluctant to report colleagues to state medical boards, and adverse hospital review determinations too often stay within the hospital. Peer review can be more careful, vigorous, and uniform, and too little scientific evaluation of the efficacy of quality assurance and risk management programs has been undertaken.

From the Board of Trustees, American Medical Association, Chicago.

This is Report QQ, adopted by the House of Delegates at the American Medical Association's Annual Meeting, June 15 to 19, 1986.

Reprint requests to Office of Policy and Issue Management, American Medical Association, 535 N Dearborn St, Chicago, IL 60610 (Severine J. Brocki).

A New Initiative

The profession must deal directly with these problems while at the same time addressing the broader issues of quality assurance. The Board of Trustees therefore announces a new AMA initiative—to go forward immediately and in conjunction with a strengthening of its traditional quality assurance activities. The elements of the initiative are as follows:

1. The AMA will call on all physicians to renew their commitment to report professional misconduct and incompetence and to participate actively in peer review. In addition:

- To symbolize its own commitment, the AMA will review the rolls of its 280 000 members and expel any member who has engaged in serious misconduct or has been found to be incompetent.
- The AMA will publish and make available to its members and nonmembers comprehensive, updated guidelines for peer review and reporting, which, if followed, should provide protection from liability.
- The AMA will assist in the defense of any county, state, or national medical society that incurs litigation as a result of the society's good faith efforts at peer review and reporting incompetence.
- The AMA announces the initiation of a cooperative effort with the Department of Justice to clarify and to expand areas of peer review that can be performed free of antitrust exposure. The Department has expressed its commitment to assist physicians in appropriate self-regulation.

2. The AMA will expand and improve its physician data bank so that any hospital medical staff or other appropriate body seeking to verify the credentials and practice history of any physician, including past disciplinary actions by state medical boards, the Department of Health and Human Services, or other hospitals, may receive complete record verification within one week.

The AMA's physician data bank—known as the Masterfile—is the only source of basic credentialing data on every physician practicing in the United States. Today, the data on each physician include the physician's birthplace, age, address, medical school, residency training, specialty, board certification, hospital affiliation, states of licensure, and any state medical board disciplinary action. Most hospitals, and several US government agencies, routinely use the Masterfile to check physicians' credentials. Over 250 000 requests were filled in 1985.

The AMA's new initiative is (1) to reduce the time necessary to obtain a Masterfile credential check to five days—through expanded computer use and staffing; (2) to make use of the Masterfile mandatory by hospitals—by proposing an amendment to Joint Commission on the JCAH standards to that effect; and (3) to improve the Masterfile's data base by seeking to add hospital disciplinary actions and significant Health and Human Services sanctions.

(The AMA will ask for the cooperation of the JCAH, the American Hospital Association, the Federation of American Hospitals, and the Inspector General of Health and Human Services in obtaining the additional data. The AMA will also continue to work closely with the Federation of State Medical Boards in sharing and facilitating the dissemination of discipline data. In states where good faith reporting to the Masterfile would not be sufficiently protected by statute, the AMA will, if necessary, seek expansion of those states' hospital licensing laws.)

Through this initiative, two gaps in the system will be closed: imposters or dishonest physicians will be uncovered more efficiently and medical staffs will be aware of all significant past disciplinary problems of an applicant who has moved from another state or hospital.

3. The AMA will expand its activities in broader quality of care issues. Physicians face new challenges in quality assurance as medical knowledge and technology increase, as the number of delivery mechanisms grows, and as cost considerations receive overriding emphasis. Included in this expanded program are the following activities:

- The development, through the Council on Medical Service, of a definition of quality and guidelines for measuring quality.

To foster peer review mechanisms that focus on true quality considerations and take into account the state of the art in medicine, quality measurement tools must exist. Report A of the Council on Medical Service (A-86) defines eight essential elements of high-quality care and provides specific guidelines for quality assessment methodologies. The AMA will further develop and implement these quality assurance and assessment methodologies.

- The design of improved peer review and quality assurance systems.

The AMA will research and seek to improve peer review and quality assurance programs in all health care facilities and will intensify its study of variations in medical practice. In doing so it will work with the Federation, national medical specialty societies, and the JCAH and its members, the American College of Surgeons, the American College of Physicians, the American Hospital Association, and the American Dental Association.

- The review of standards for medical education.

The AMA will appoint a commission to study methodologies for evaluating the clinical performance and behavioral characteristics of medical students. The commission will also study methods to evaluate the competence of graduates of foreign medical schools.

Quality in medical care is strongly dependent on the standards of admission and progression through programs of medical education. Council on Medical Education Report B (A-82), "Future Directions for Medical Education," recommended that the AMA, in cooperation with others, continue to review and define standards for medical education at all levels. The AMA will vigorously continue to do so.

Conclusion

The effectiveness of the AMA's role as the primary representative of the profession to the public derives in large part from the strength of its efforts to help physicians provide medical care of the highest quality for patients. Quality assurance and self-regulation must therefore remain at the heart of the AMA's programs. The AMA should represent the best in medicine and the best in the profession. Vigorous pursuit of the foregoing initiatives, in conjunction with the AMA's traditional quality assurance activities, will help the AMA achieve these goals. The Board of Trustees will keep the House of Delegates informed of the progress of this program.

INAUGURAL ADDRESS OF THE PRESIDENT

MR. PRESIDENT, FRIENDS, DISTINGUISHED COLLEAGUES, GUESTS.

QUALITY HEALTH CARE IS DIRECTLY RELATED TO QUALITY MEDICAL EDUCATION. FOR CENTURIES, THE MEDICAL PROFESSION HAS HELD THIS CONCEPT AS ONE OF MEDICINE'S MOST IMPORTANT CREDOS. IN THIS PRESIDENTIAL ADDRESS I WANT TO OUTLINE FOR YOU WHAT OUR PROFESSION IN AMERICA HAS DONE TO AMPLIFY THAT CONCEPT, TO NOTE OUR CURRENT POSITION, AND TO SUGGEST FUTURE ACTIONS. I INTEND TO CONCLUDE WITH A SHORT STATEMENT OUTLINING WHY THIS WHOLE MECHANISM OF EDUCATION FOR QUALITY CONTROL SHOULD REMAIN A VOLUNTARY ONE OF THE PROFESSION, AND HOW IMPOSITION OF AN OUTSIDE "RECREDENTIALING BUREAUCRACY" IMPOSED BY OUR STATE HEALTH DEPARTMENT WOULD BE DISASTROUS FOR THE PROFESSION AND THE PUBLIC.

I. EARLY EFFORTS IN MEDICAL EDUCATION IN THE U.S.

IN THE FRONTIER DAYS OF AMERICA VERY FEW TRAINED PHYSICIANS "BRAVED THE NEW WORLD." ANYONE COULD CLAIM TO BE A DOCTOR -- AND ALL SORTS OF PEOPLE DID. SLOWLY A SMALL CADRE OF PHYSICIANS TRAINED IN EUROPE ARRIVED AND TOOK APPRENTICES. THEN "MEDICAL SCHOOLS" DEVELOPED -- MOSTLY PROPRIETARY, MOSTLY DIDACTIC, SUPPLEMENTING THE PRACTICAL APPRENTICESHIPS. IN THE 184ØS NEW YORK PHYSICIANS WERE INSTRUMENTAL IN

FORMING THE AMA PRIMARILY BECAUSE OF A FELT NEED FOR SETTING HIGHER STANDARDS FOR EDUCATION AT THE NATIONAL LEVEL. IN THE 189ØS THE FOUNDING OF JOHNS HOPKINS SET THE HIGHEST STANDARDS OF ALL -- YOU EVEN HAD TO HAVE A COLLEGE DEGREE TO BE ADMITTED. THE GREAT WATERSHED IN U.S. MEDICAL EDUCATION CAME WITH THE FLEXNER REPORT, WHICH RECOMMENDED HIGH STANDARDS FOR ALL SCHOOLS INCLUDING A FOUR YEAR CURRICULUM. WITHIN A SHORT TIME OVER HALF THE SCHOOLS CLOSED.

ONE OF THE SIDE EFFECTS OF THIS UPHEAVAL IN MEDICAL EDUCATION WAS AN UNFORTUNATE ONE FOR ORGANIZED MEDICINE. UP UNTIL THAT TIME ALL OF THE LEADERS OF THE MEDICAL PROFESSION AT LARGE WERE ALSO LEADERS IN THE AMA. AFTER THE FLEXNER REPORT, WITH THE MARKED EMPHASIS ON UPGRADING THE QUALITY OF MEDICAL SCHOOL EDUCATION, MANY OF THE LEADERS OF AMERICAN MEDICINE CONCENTRATED UPON IMPROVING THEIR MEDICAL SCHOOLS AND DID NOT PARTICIPATE NEARLY SO ACTIVELY IN ORGANIZED MEDICINE. INDEED, IT IS NOT UNFAIR TO SAY THAT DURING THE TWENTIES AND THIRTIES ACADEMIA TENDED TO LOOK DOWN ON THOSE PHYSICIANS WHO REMAINED ACTIVE IN ORGANIZED MEDICINE.

IN ADDITION TO SETTING STANDARDS FOR MEDICAL SCHOOLS, AN INCREASINGLY SOPHISTICATED SYSTEM OF ACCREDITATION WAS ESTABLISHED TO MAKE CERTAIN THAT THOSE STANDARDS WERE, IN FACT, MET. TODAY EACH SCHOOL IS SURVEYED PERIODICALLY BY A HIGH POWERED TEAM REPRESENTING THE AMA AND THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC).

II. Residency Training and Board Certification

From the twenties through the fifties the development of the specialty societies and specialty boards were very important factors in setting the standards for internship and residency training and for developing site visits by "residency review committees" to ensure that the standards that had been promulgated were followed. Both the AMA's Council on Medical Education and the American College of Surgeons were instrumental in this development.

Although the medical schools and the specialty societies and boards initially concentrated almost exclusively on educational and scientific matters, in the sixties they belatedly began to recognize that the socioeconomics and "the environment" in which medicine is practiced is just as important for patient care as is the strict attention to education itself, and both groups began to develop policies and actions in the socioeconomic field (although sometimes at odds with the concerns of organized medicine.)

(Parenthetically, it is interesting to note that today 25-35% of the budgets of medical schools come from the professional fees earned by their faculties)

Before moving on, one should note that from the very beginning the concept of learning through working with patients and of increasing responsibility under supervision has been a unique feature of American medical education.

III. CONTINUING MEDICAL EDUCATION

DURING THE LAST HALF OF THE TWENTIETH CENTURY THERE HAS BEEN SUCH AN EXPLOSION IN INFORMATION THAT KNOWLEDGE DOUBLED EVERY FEW YEARS. MUCH OF WHAT ONE LEARNED IN MEDICAL SCHOOL WAS OUT-OF-DATE WITHIN A DECADE OR SO AFTER LEAVING FORMAL EDUCATIONAL PROGRAMS. WHILE MEDICINE HAD ALWAYS BEEN CONSIDERED A PROFESSION WHERE "LIFETIME LEARNING WAS VITAL TO THE CARE OF THE PATIENT", IT HAS BECOME EVEN MORE IMPORTANT TO TRY TO ENSURE THAT PHYSICIANS KEEP UP-TO-DATE AS MUCH AS POSSIBLE AFTER LEAVING THEIR RESIDENCY TRAINING PROGRAMS. CONTINUING MEDICAL EDUCATION IS PERSONAL AND SELF-DIRECTED. BILL RUHE, THEN AN AMA VICE PRESIDENT, SHOWED A FEW YEARS AGO THAT PHYSICIANS FEEL THEIR MOST IMPORTANT CONTINUING MEDICAL EDUCATION IS DERIVED FROM READING BOOKS AND JOURNALS. NEVERTHELESS, MORE FORMALIZED CONTINUING MEDICAL EDUCATION -- CONFERENCES, COURSES, AND SEMINARS, HAVE BEEN DEVELOPED, AND ATTENTION BEGAN TO BE PAID TO ATTEMPTS TO IMPROVE THE STANDARDS IN CONTINUING MEDICAL EDUCATION JUST AS HAS BEEN ACCOMPLISHED IN MEDICAL SCHOOL EDUCATION AND RESIDENCY TRAINING. ALTHOUGH WE NOW HAVE A NATIONAL ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION, (ACCME) MANY OF US FEEL THAT THESE MORE FORMALIZED PROGRAMS AT THE NATIONAL LEVEL ARE ONLY A RELATIVELY SMALL AND LESS IMPORTANT PART OF ALL THE THINGS THAT THE MEDICAL PROFESSION DOES TO KEEP

UP-TO-DATE. THERE ARE NOW SEVERAL NATIONAL ORGANIZATIONS COMMITTED TO A VARIETY OF ACTIVITIES IN CONTINUING MEDICAL EDUCATION, AND ONE OF THE MOST IMPORTANT OF THESE IS THE ALLIANCE FOR CONTINUING MEDICAL EDUCATION (ACME). THE ACME WAS ORGANIZED BY A NEW YORK PHYSICIAN, DR. WILLIAM FELCH, WHO HAS BEEN ITS EXECUTIVE DIRECTOR SINCE ITS INCEPTION, AND IT IS NOW HEADED BY ANOTHER NEW YORK PHYSICIAN, DR. RICHARD PIERSON. SO, YOU CAN SEE THAT NEW YORK CONTINUES TO TAKE A LEADING ROLE IN MEDICAL EDUCATION. MANY CONSIDER CME THE MOST IMPORTANT PART OF MEDICAL EDUCATION, SINCE IT LASTS THE SEVERAL DECADES OF A PHYSICIAN'S PRACTICING CAREER.

IV. HOSPITAL QUALITY CONTROL AND EDUCATIONAL METHODS

IN TODAY'S WORLD, THE EDUCATIONAL PROGRAMS AT THE HOSPITAL LEVEL ARE ONE OF THE MOST IMPORTANT WAYS THAT WE GUARANTEE QUALITY CARE OF THE PUBLIC. THESE INCLUDE, BUT ARE NOT LIMITED TO:

1) DEATH AND COMPLICATIONS CONFERENCES TO ANALYZE PROBLEMS THAT OCCUR AND DEVISE MEANS OF PREVENTING THEM IN THE FUTURE.
2) CASE REVIEWS AND CHART REVIEWS SO THAT EACH HOSPITAL CASE IS REVIEWED AFTER DISCHARGE FOR INADEQUACIES AND FOR ADDITIONAL DATA NEEDED TO COMPLETE THE CHART. ANY PROBLEMS IDENTIFIED ARE REFERRED BACK FOR ACTION.

3) TISSUE COMMITTEES TO MAKE SURE THAT THE INDICATIONS FOR SURGERY CORRESPOND TO THE PATHOLOGICAL SPECIMENS RESECTED.

4) EACH SPECIALTY AND ALMOST EVERY SUBSPECIALTY IN THE HOSPITAL HAS FREQUENT CONFERENCES COVERING SPECIAL CASES AND SUBJECTS OF INTEREST IN THEIR FIELD.

5) SPECIAL LECTURES, SYMPOSIUMS, COURSES, AND OTHER EDUCATIONAL PROGRAMS ARE ORGANIZED.

6) HOSPITAL DIRECTORS OF CONTINUING MEDICAL EDUCATION HAVE BEEN APPOINTED IN MANY HOSPITALS TO HELP THE EDUCATIONAL PROGRAMS OF THE ENTIRE INSTITUTION.

7) QUALITY ASSURANCE DEPARTMENTS ARE NOW STANDARD IN MOST HOSPITALS AND USE A VARIETY OF METHODS TO ENSURE THE QUALITY OF CARE.

8) JUST AS WITH MEDICAL SCHOOLS AND WITH RESIDENCY TRAINING PROGRAMS, THE <u>PROCESS</u> OF SETTING STANDARDS AND ENSURING THOSE STANDARDS ARE ADHERED TO HAS BEEN DEVELOPED <u>VOLUNTARILY</u> BY THE MEDICAL PROFESSION WHICH FORMED THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS FOR THIS PURPOSE (JCAHO). WHILE THIS PROCESS REMAINS IMPORTANT, THE JCAHO TODAY IS TRYING TO GO ONE STEP FURTHER AND EVALUATE <u>OUTCOMES</u>, TO MAKE EVEN MORE CERTAIN THAT ALL PATIENTS RECEIVE QUALITY CARE.

V. OTHER QUALITY CONTROL MEASURES

1. IN RECENT YEARS, PROFESSIONAL PEER REVIEW (PRO) ORGANIZATIONS HAVE BEEN ORGANIZED ALL OVER THE COUNTRY AND HAVE DEVELOPED CLINICAL CARE STANDARDS FOR PATIENTS WITH EACH KIND OF ILLNESS. SPECIALIZED PHYSICIAN REVIEWERS AUDIT CASES WHICH HAVE BEEN IDENTIFIED FOR REVIEW BY LESS SOPHISTICATED PERSONNEL. THE CONCEPT IS TO IDENTIFY IN MORE DETAIL EXACTLY WHAT QUALITY CARE MEANS AND TO TAKE A VARIETY OF ACTIONS TO ENSURE THAT EACH PATIENT GETS SUCH CARE. SANCTIONS OF PHYSICIANS ARE MADE IN A FEW INSTANCES, ALTHOUGH THE GENERAL APPROACH IS AN EDUCATIONAL RATHER THAN A PUNITIVE ONE. REMEDIAL ACTION MAY BE REQUIRED. SOME PHYSICIANS MAY BE REFERRED TO THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT (OPMC) FOR REVIEW. IN NEW YORK STATE THIS PRO IS ORGANIZED UNDER THE AEGIS OF MSSNY AND IS, ONE OF OUR LARGEST ACTIVITIES. IT IS IMPORTANT TO NOTE THAT THIS PROCESS INCLUDES REVIEW OF OFFICE BASED PHYSICIANS.
2. PHYSICIANS ARE REQUIRED BY LAW TO REPORT MISCONDUCT OF THEIR PEERS TO THE OPMC.
3. ALL REIMBURSEMENT SYSTEMS HAVE QUALITY CONTROL MECHANISMS SO THAT PAYMENTS ARE NOT MADE FOR INAPPROPRIATE CARE.
4. THE AMA AND THE FEDERATION OF STATE MEDICAL

BOARDS HAVE ORGANIZED A NATIONWIDE REPORTING SYSTEM FOR SERIOUS INFRACTIONS.

5. MSSNY HAS A COMMITTEE FOR PHYSICIANS' HEALTH TO IDENTIFY AND TREAT PHYSICIANS WITH SUBSTANCE ABUSE OR MENTAL HEALTH PROBLEMS.

VI. FACTORS BEYOND PHYSICIAN CONTROL THAT AFFECT PATIENT CARE

I THINK I HAVE SHOWN QUITE CLEARLY THAT OUR PROFESSION HAS SET STANDARDS FOR EDUCATION AND TRAINING THAT TRANSLATE INTO THE BEST MEDICAL CARE IN THE WORLD. AND WE CONTINUE TO FINE TUNE ALL OF THESE THINGS THAT ARE NECESSARY FOR SUCH CARE. BUT THERE ARE OTHER FACTORS THAT AFFECT THE QUALITY OF PATIENT CARE AND MANY OF THESE RELATE TO THE ROLE OF GOVERNMENT. LET ME ILLUSTRATE JUST THREE OF THEM:

1. FIRST AND FOREMOST, APPROPRIATE CHANGES IN OUR LIFESTYLE, INDIVIDUALLY AND COLLECTIVELY, WOULD MAKE A GREATER IMPACT ON IMPROVING OUR HEALTH THAN ALL OTHER HEALTH ACTIVITIES COMBINED. YET WE SPEND A FRACTION OF 1% OF THE HEALTH BUDGET ON HEALTH EDUCATION IN OUR SCHOOLS AND HEALTH PROMOTION IN ADULTS. WE MUST DEMAND THAT OUR STATE GOVERNMENT DO A BETTER JOB. PROBLEMS RELATED TO DRUG, ALCOHOL, AND TOBACCO USE TAKE A HUGE TOLL ON OUR PEOPLE (ESPECIALLY THE YOUNG) AND USE UP A LARGE PORTION OF OUR HEALTH RESOURCES.

2. SECONDLY, THE BUREAUCRACY SURROUNDING MEDICAID AND MEDICARE HAS BECOME STIFLING. WITH EACH SUCCESSIVE SET OF RULES AND REGULATIONS TO CLOSE SMALLER AND SMALLER LOOPHOLES PHYSICIANS ARE MORE AND MORE RESTRICTED IN TRYING TO DELIVER QUALITY CARE. ALL OF US -- GOVERNMENT, PHYSICIANS, AND PATIENTS ARE SPENDING SO MUCH TIME AND EFFORT ON PAPERWORK AND PROCESS THAT PATIENT CARE OFTEN TAKES SECOND PLACE. MAJOR OVERHAULS ARE DESPERATELY NEEDED. MSSNY IS JOINING THE AMA TO FIGHT FOR SUCH CHANGES.

3. THIRDLY, WE NEED A HUGE NUMBER OF NEW NURSING HOME BEDS AT A COST WE CAN AFFORD. LARGE NUMBERS OF OLDER PEOPLE REMAIN IN ACUTE CARE HOSPITALS, SOMETIMES FOR OVER A YEAR, BECAUSE THERE AREN'T NURSING HOME BEDS FOR THEM. CHRONIC CARE BEDS ARE SIMPLY NOT AVAILABLE. RULES AND REGULATIONS ARE SUCH THAT IT COSTS ALMOST AS MUCH TO BUILD AND MAINTAIN A NURSING HOME BED AS IT DOES FOR A HOSPITAL BED. THE HUGE SPECTER OF AIDS LOOMING OVER US COMPOUNDS THE PROBLEM OF ENSURING AN ADEQUATE NUMBER OF BEDS. WE WILL CONTINUE TO URGE STATE GOVERNMENT TO CORRECT THIS HUGE DEFICIT.

BUT THERE ARE OTHER IMPORTANT FAILURES OF GOVERNMENT IN RELATION TO HEALTH, PARTICULARLY TO THE HEALTH NEEDS OF MINORITIES.

-- MANY OF OUR PATIENTS DON'T HAVE ENOUGH EDUCATION TO UNDERSTAND HOW TO EVEN UTILIZE THE MEDICAL CARE SYSTEM AVAILABLE TO THEM
-- MANY PATIENTS ARE SICK BECAUSE OF INADEQUATE NUTRITION
-- WE TREAT RAT BITES, LEAD POISONING, CRIME VICTIMS -- AND THEN SEND THEM BACK TO THE GHETTO FOR REPEAT PERFORMANCES
-- WE DEVELOP HIGH TECHNOLOGY MEDICAL CARE AND DON'T ENSURE THAT IT IS AVAILABLE TO ALL -- MILLIONS OF AMERICANS HAVE NO INSURANCE AT ALL.

TO SUMMARIZE:

ADEQUATE EDUCATION, ADEQUATE NUTRITION, ADEQUATE HOUSING IN A LOW CRIME ENVIRONMENT, ADEQUATE INCOME FOR THE NECESSITIES OF LIFE INCLUDING HEALTH INSURANCE -- ALL THESE ARE ESSENTIAL FOR GOOD HEALTH. THE MEDICAL PROFESSION CAN'T ENSURE ALL THESE THINGS. GOVERNMENT MUST TAKE THE LEADING ROLE TO SET THE STAGE SO THESE PROBLEMS ARE OVERCOME.

IN THIS CONTEXT I WOULD LIKE TO COMMENT ON THE DEPARTMENT OF HEALTH'S PLAN FOR THE "RECREDENTIALING" OF PHYSICIANS. AS I HAVE SO CLEARLY DEMONSTRATED,

THE PROFESSION ITSELF HAS CONTINUOUSLY DEVELOPED AND REFINED MANY MECHANISMS FOR QUALITY CONTROL. THE HUGE -- AND VITAL -- DIFFERENCE IS THAT NOW THE DEPARTMENT OF HEALTH WANTS TO HAVE CONTROL OF THIS PROCESS AND THEREFORE CONTROL OF THE PROFESSION. THE DEPARTMENT OF HEALTH WANTS TO DEVELOP A STATE BUREAUCRACY TO BE ABLE TO SEARCH OUT AND IDENTIFY THE SMALLEST CRITICISM (WHETHER VALID OR NOT) FOR EACH INDIVIDUAL PHYSICIAN AND TO USE THIS INFORMATION FOR THEIR OWN PURPOSE. TO TRY TO ACHIEVE 100% PERFECTION BY REQUIRING INCREASINGLY STRINGENT RULES AND REGULATIONS WOULD STRANGULATE THE PROFESSION. I CAN TELL YOU NOW -- THE MEDICAL SOCIETY OF THE STATE OF NEW YORK -- AND, INDEED ALL THE PHYSICIANS IN NEW YORK WILL SIMPLY NOT TOLERATE SUCH CONTROL. WE ALREADY HAVE MANY MECHANISMS TO IDENTIFY ERRANT PHYSICIANS AND THEY SHALL BE PENALIZED APPROPRIATELY. BUT TO STIFLE THE PROFESSION WITH AN EXTREMELY EXPENSIVE AND TIME CONSUMING BUREAUCRATIC MORASS MAKES NO SENSE AT ALL.

SHALL WE REFUSE TO DEAL WITH THE COMMISSIONER? OF COURSE NOT! OUR STATE GOVERNMENT HAS A HUGE STAKE IN THE HEALTH OF THE PUBLIC - WE MUST CONTINUE TO INTERACT BUT WE WILL NOT TOLERATE AN AUTHORITARIAN BUREAUCRATIC CONTROL. LET US DEMAND THAT THE COMMISSIONER AND STATE GOVERNMENT TURN FROM TRYING TO DICTATE HOW DOCTORS SHOULD PRACTICE AND SPEND MORE EFFORTS IN THE OTHER AREAS THAT HAVE A HUGE IMPACT ON THE HEALTH OF OUR CITIZENS.

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VII. So What of the Future?

A. We must continue to fine tune our system of medical education in directions that further guarantee quality care. "Future Directions in Medical Education" lists some 42 such recommendations.

B. MSSNY needs to work more closely with the specialty medical societies to give them support for their scientific meetings, other educational programs, and to develop pilot projects for quality care.

C. MSSNY needs to collaborate with the departments of medical education in our 14 medical schools in strengthening continuing medical education projects in their regions, to collect information on educational needs, to identify system and individual failures and to devise solutions to problems found - including remedial programs.

D. MSSNY needs to combine forces with the Hospital Association of New York State (HANYS) to further strengthen educational and quality control mechanisms in our hospitals, which is probably the single most important focus we have -- that's where the real action is.

E. Since costs considerations are forcing us more and more to practice outside the hospital,

WE NEED TO DEVISE BETTER SELF-INSTRUCTIONAL AND OTHER EDUCATIONAL METHODS FOR PHYSICIANS IN THEIR OWN OFFICES.

F. AND FINALLY, TO DO ALL OF THESE THINGS MSSNY MUST STRENGTHEN ITS EDUCATION DIVISION.

I BELIEVE WE CAN DO ALL THESE THINGS. WE MUST DO ALL THESE THINGS IF WE ARE TO RETAIN CONTROL OF OUR PROFESSION.

TESTIMONY

OF

THE NEW YORK STATE NURSES ASSOCIATION

BY

JUANITA K. HUNTER, EdD, RN

TO

THE SUBCOMMITTEE ON

NATURAL RESOURCES, AGRICULTURAL RESEARCH AND ENVIRONMENT

OF THE

U. S. HOUSE OF REPRESENTATIVES

COMMITTEE ON SCIENCE, SPACE, AND TECHNOLOGY

June 6, 1988

New York, New York

Good morning. I am Dr. Juanita Hunter, President of the New York State Nurses Association and also Clinical Assistant Professor of Nursing at the State University of New York in Buffalo. The New York State Nurses Association is the professional association of more than 30,000 Registered Nurses. We are the oldest and largest nurses association in the country.

I am very pleased to have this opportunity to speak to you this morning on behalf of the Board of Directors and our membership about the quality of nursing care. As a former public health nurse, and in my current role as project director for a grant funded program which provides nursing care to the homeless, I am acutely aware of the multiple factors which enter in to assuring quality care to all of our citizens.

The current crisis in health care related to the severe nursing shortage nationwide gives us a new opportunity to address the multiple factors related to retention and recruitment of nurses. The quality of nursing care consumers can expect, now and in the future, is directly related to retention and recruitment of nurses.

The several causes of the nursing shortage most frequently cited are:

1. The lack of standardization of nursing education;
2. Salaries and benefits which are not commensurate with nursing role responsibilities and limited access to higher lifetime earnings;
3. A lack of control over nursing practice leading to job dissatisfaction, job fatigue and burnout; and
4. Perception of nursing as less attractive or less prestigious than other career opportunities for women.

It is clear that the current health care environment severely limits the ability of registered nurses to provide the high quality of care needed by consumers. The increased demand for nursing care is without question due to the advances in technology, shorter hospital stays, increased patient acuity and the increased older, fragile patient population. The more complex the health care needs, the more skilled nursing care that is needed.

The nursing profession has long been aware that the explosive advances in science and technology, the dramatic changes in health care delivery systems and the changing population demographics call for concomitant changes in nursing education. Since 1965, the American Nurses' Association has held the position that the minimum preparation for technical nurses should be the associate degree in nursing and the minimum preparation for professional nurses should be the baccalaureate degree in nursing. Two distinct careers in nursing based on standardized nursing education systems would diminish confusion on the part of consumers of nursing care. Further standardized nursing education would facilitate career mobility for nurses. Additionally, this would also decrease current misunderstanding on the part of prospective students who seek nursing careers. The enactment of such legislation proposed by the New York State Nurses Association every year since 1976 would address several of the areas of concern related to the nursing shortage.

Roles for baccalaureate prepared nurses can be differentiated from nurses prepared in other educational programs. Baccalaureate prepared nurses provide greater flexibility in meeting the multiple client needs in current and future health care systems. They have more knowledge of complex environments

and they perform more autonomously in isolated environments. Substantial, sophisticated clinical judgment and planning are increasingly required in extended care facilities and in home health care. Increasingly, advanced technological skills and knowledge of computers are required in health care delivery. Baccalaureate nursing programs generally include content in their curricula which focus on these areas. Tebbitt has outlined 10 qualities which make baccalaureate prepared nurses more effective in acute care settings. I have attached these to my written testimony.

Cost containment measures enacted in recent years also have implications for quality nursing care. Both federal and state regulatory agencies must look at their procedures for reimbursement to health facilities as they relate to nursing costs and the effect on the compensation of nurses, including salaries and benefits. Historically, shortages of nurses have always been alleviated by improved wages and benefits. It is important to note that the relative economic position of nurses when compared to other professions has actually eroded since 1982. Despite significant publicity about the shortage of nurses, nurses' wages increased only 4%, on average, in 1986.

In the "National DRG Nurse Costing Study", data were compiled related to the cost per case of delivering direct, hands-on nursing care. The data reveal which DRG's require the most nursing resources. (See attachment). For example, 82.6% of the cost of DRG #106, coronary bypass with cardiac catheterization, is for nursing care. If patient acuity and nursing intensity were factored into the reimbursement methodology, health facilities would have more incentive to improve nurses' salaries and benefits. The reimbursement frameworks must be reviewed. Improved compensation packages for nurses would

make nursing more attractive and competitive for prospective students and would decrease the numbers of nurses seeking employment outside the nursing profession.

Nothing is more critical to quality patient care than the work environment for nurses. One of the most confusing things for consumers and the most frustrating misunderstanding for nurses is the rubric which equates health care with medical care. This widely held view denies the interdisciplinary coordination and collaboration necessary for successful patient outcomes. A recent study by Draper found that hospital staff (physicians and nurses) interaction and coordination was the only component that explained variation in death rates in the intensive care units of hospitals. In this study, the hospital with the significantly lower-than-predicted death rate utilized primary nursing and a support system of master's prepared clinical specialists. In this hospital, surgery was cancelled if adequate numbers of nursing staff were not available. It is estimated that registered nurses deliver 90% of all hospital care. Most consumers not needing nursing care do not require hospital care. Quality care, then, can only be assured when there are adequate numbers of well-educated and prepared nurses performing in a care environment where they are provided the support resources, both human and technological, to carry out competent nursing measures.

We must be very cautious in this time of nursing shortage and cost containment that we do not utilize unprepared personnel to perform nursing functions beyond their scope of practice and preparation. This "downsubstitution" will not solve the nursing shortage, but will have the effect of decreasing the safety of clients in institutions and lowering the quality of health care of our citizens.

Registered nurses need facilities to expand the employment and utilization of ancillary personnel to assist in the clinical and non-clinical tasks not requiring sophisticated nursing knowledge. Provision of these support personnel will permit registered nurses to carry out those patient care activities which are most therapeutic, including; assessment, diagnosis, treatment planning, and evaluation. The nursing care provided is based on the intensity and complexity of the patient care needed.

Health facilities should also employ unit secretaries on a twenty-four hour basis. Evening and night shift nurses are particularly burdened by time-consuming tasks which secretarial staff could do. There must also be sufficient numbers of personnel in ancillary departments, such as dietary, housekeeping, transportation and pharmacy. Nurses should not be asked to pick up trays from the dietary department or medications from the pharmacy. Nurses should not be expected to take care of housekeeping chores on any shift. Nurses should not be required to accompany patients to other laboratory or treatment areas unless a patient needs professional nursing assistance off the unit.

Health facilities should increase the utilization of more efficient informational and systems technology to support patient care. This suggestion relates to the chronic problem of excessive paperwork required to accommodate the vast and often duplicative regulatory processes. All policies related to routine documentation should be reviewed. Most of the paperwork undoubtedly has been generated in the current climate of legal protectionism. However, the result is often meaningless, time-consuming routine and repetitious documentation.

Computerized charting and bedside records should be encouraged. Access to patient data on a computer could reduce inefficient and time-consuming telephone calls.

Health facilities should implement patient acuity classification systems and utilize these systems to determine staffing ratios and assignments of nursing personnel. Further, hospitals should close beds to elective admissions when there are insufficient nursing personnel to provide the intensity of care required.

Implementation of nursing service delivery models that utilize and respect the judgment of nurse unit managers with regard to staffing and patient care needs should be encouraged. Decentralized nursing service departments and models of shared governance have been successful in promoting satisfying professional nursing practice environments.

The New York State Nurses Association has, thus, identified several strategies or solutions which, if implemented, would assure a steady supply of professional nurses to meet the current and future needs of consumers.

These include:

1. Standardization of nursing education for two careers in nursing, the basis of the most rational and logical career ladder for nurses.
2. Improving economic rewards for nurses through increased salaries and benefits commensurate with education and experience.
3. Improving the practice environment for nurses through increased professional autonomy in decision making and increasing authority of nurses over nursing practice.
4. Enhancing the image of nursing as a lifetime career for prospective nursing students and consumers.

Consumers should further be aware that nursing is a highly self-regulating profession. Our nursing education programs withstand accreditation procedures and individual nurses are licensed. The professional association for nurses (ANA) has developed standards of nursing practice and a code of ethics. Continued competency in nursing is assured through certification, continuing education and peer review mechanisms. Through all of these processes, the nursing profession assures the public that we have mechanisms in place for quality control and accountability for nursing practice.

I will conclude my testimony with a series of indicators for consumers seeking a nursing service model for quality nursing care:

1. The profession's standards for nursing care are utilized.
2. The nursing services provided are clearly identified to the consumer in the hospital literature and in the billing process.
3. Quality assurance mechanisms are in place. The nursing department evaluates patient outcomes.
4. Ancillary personnel are employed in sufficient numbers to carry out non-nursing functions.
5. The institution fosters a professional nursing environment which encourages:
   (a) clinical career ladders
   (b) creative staffing and scheduling
   (c) continuing education and staff development programs
   (d) comprehensive patient teaching programs

(e) shared governance

(f) professional identity

(g) nursing scholarship and research

(h) community involvement

6. A patient acuity classification system is in place to determine staffing needs. Policies are in place to close beds when there are insufficient nurses to provide quality care.

7. The compensation and benefit package is sufficient to support a professional identity and retain nurses in the system.

8. The Chief Nurse Executive has advanced preparation for a role in finance, management, organizational leadership and policy development?

Though certainly this is not an exhaustive list of all possible quality indicators for nursing, we believe if these concepts were implemented, consumers could be assured of quality nursing care.

Thank you for the opportunity to share with you the views of the New York State Nurses Association. I would be pleased to answer any questions.

10 Qualities Prepare BSN Nurses For Acute Care, Director Says

Graduates of baccalaureate nursing programs exhibit 10 qualities that make them especially effective in acute care hospitals, according to Barbara Volk Tebbitt, RN, senior associate director and director of nursing services at the University of Minnesota Hospitals and Clinics.

Tebbitt described the knowledge and skills of BSN nurses in testimony before the North Dakota Board of Nursing at a hearing in Bismarck Oct. 12. The hearing was the first of nine conducted in cities across the state to gather information in preparation for decisions about proposed rules and regulations affecting the education and licensing of registered nurses and licensed practical nurses. (See story on page 1.)

Tebbitt, who heads a staff of 1,800 nurses and administers an annual budget of $68 million, said that the list identifies skills and knowledge she needs from new graduates in the "rapidly changing, technology driven" acute care setting. She described the following list as "a synopsis of the thoughts, opinions and beliefs of the 44 head nurses at the University of Minnesota Hospitals and Clinics."

The head nurses perceive that baccalaureate prepared nurses:

- Exhibit more comprehensive understanding of the nursing process, particularly assessment and documentation. This relates directly to patient care activities which are most therapeutic to the presenting condition.
- Demonstrate better patient teaching skills in assessing needs and setting priorities for teaching because they have a basic understanding of the teaching/learning process. Setting priorities to respond to patient learning readiness is a key factor for effective and efficient patient care since the length of stay in hospitals has decreased.
- Appear to have broader exposure to concepts of primary nursing, standardized care plans, nursing diagnosis or nursing problems. These are essential elements for continuity of care in light of the increased intensity and complexity of patient care needs.
- Demonstrate better understanding of basic sciences (particularly chemistry) and pharmaceutics. After penetrating each orifice, organ and vessel, science is now combining pharmaceuticals for treatment. The professional nurse needs to know what is happening, what is causing that response and why, and then take appropriate action.
- Are aware of underlying concepts of care that can be transferred or modified, although their technical and patient comfort skills are initially underdeveloped. The baccalaureate nurse does not rely on "rote" skills but on knowledge bases and learns quickly. However, it is imperative that technical and clinical skills continue to be addressed by baccalaureate programs.
- Have experience in community health which brings insight and resources to the discharge planning process. Again, this is an important element in light of decreased inpatient days and increased referrals to outpatient facilities and community agencies.
- Are more comfortable involving families in care and defining appropriate parameters for that involvement since many have been introduced to the self-care framework, which places responsibility for certain care behaviors on patients and families. These activities often relate to behaviors required after discharge.
- Relate in a more collaborative manner with other health care professionals. They are oriented to an interdisciplinary philosophy noting the importance of their contributions to the team and ultimately to the plan of care for the patient.
- Have increased ability to conceptualize, solve problems and make decisions by being able to see beyond clinical/physical manifestations and to incorporate a more comprehensive, holistic view. This includes the integration of the concepts mentioned earlier.
- Have more exposure to leadership theory and preparation for the charge nurse role or strong primary nurse role and are able to give direction to others.

Tebbitt cited two additional qualities of BSN prepared nurses which, she said, contribute to their effectiveness in the work setting: they have better verbal and written communication skills and are able to deal with change and conflict in flexible, objective and less biased ways.

"Five years ago this differentiation was not so apparent," Tebbitt said. "Graduates of baccalaureate programs in nursing have progressively improved in the areas identified." Tebbitt said she believes the baccalaureate is essential to the achievement of the goals of professional nurses.

Tebbitt, who holds a master's degree, said that as a nurse executive she has employed registered nurses and licensed practical nurses for the past 17 years in urban and rural settings. She was appointed by the governor of Minnesota to chair a 17-member task force on nursing recruitment, utilization and retention. She currently chairs a 15-member work group for the National Commission on Nursing Implementation Project. She is a member of the Council on Patient Services of the American Hospital Association, a member of the board of directors of the American Journal of Nursing Company and a member of the board of the American Organization of Nurse Executives.

Reprinted from: The American Nurse. vol. 17, no. 10 (December 1985), p. 3 +.

THE TOP 20

The most expensive DRGs in terms of variable nursing labor costs per case

DRG #	Description	Nursing labor cost per case	RN cost component	Average LOS (days)
106	Coronary bypass with cardiac catheterization	$1,547.80	82.6%	15.7
110	Major reconstructive vascular procedures without pump (patient over 70)	$1,497.68	78.6	15.8
1	Craniotomy (patient over 17), except for trauma	$1,492.18	75.0	15.1
148	Major small and large bowel procedures (patient over 69)	$1,263.49	70.4	14.8
462	Rehabilitation	$1,262.19	55.2	21.7
121	Circulatory disorders with acute myocardial infarction and complications	$1,204.51	82.2	11.6
210	Hip and femur procedures, except major joints (patient over 90)	$1,195.70	65.0	14.2
14	Specific cerebrovascular disorders, except transient ischemic attacks	$1,018.76	67.8	11.0
416	Septicemia (patient over 17)	$981.61	67.1	10.1
430	Psychoses	$917.97	58.4	16.6
209	Major joint and limb reattachment procedures	$865.85	63.7	13.2
89	Simple pneumonia or pleurisy (patient over 69)	$780.05	66.9	9.2
122	Circulatory disorders with acute myocardial infarction and without complications	$748.93	83.1	8.2
320	Kidney/urinary tract infections (patient over 69)	$728.60	64.9	8.1
82	Respiratory neoplasms	$720.86	68.5	9.4
108	Other cardiovascular or thoracic procedures	$710.31	79.6	7.4
296	Nutritional/miscellaneous metabolic disorders (patient over 69)	$670.13	66.9	7.7
127	Heart failure/shock	$665.33	70.5	8.2
88	Chronic obstructive pulmonary disease	$569.97	66.0	8.0
174	Gastrointestinal hemorrhage (patient over 69)	$565.75	68.6	6.9

Source: Medicus Systems Corp., 1986

Graphics by Hospitals

TESTIMONY OF THE
NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

BEFORE THE

SUBCOMMITTEE ON NATURAL RESOURCES, AGRICULTURE RESEARCH AND ENVIRONMENT
COMMITTEE ON SCIENCE, SPACE AND TECHNOLOGY
U.S. HOUSE OF REPRESENTATIVES

JUNE 6, 1988

SUZANNE G. MARTIN
ASSISTANT VICE PRESIDENT
MEDICAL CASEMIX AND UTILIZATION MANAGEMENT

I am Suzanne G. Martin, an Assistant Vice President of the New York City Health and Hospitals Corporation and I thank the Committee for this opportunity to address the issue of public dissemination of information on medical care provided by specific health providers.

By way of background let me briefly describe HHC's institutions, scope of services and patient population. HHC is a public benefit corporation, consisting of 11 acute care hospitals, 5 long term care facilities and over 40 community-based outpatient clinics. Our mission is to provide quality medical care to all, regardless of ability to pay. Over 16% of our inpatients and 40% of our outpatients are medically indigent; 51% of our inpatients have Medicaid and 12% have Medicare coverage. We deliver over 2.6 million days of hospital inpatient care and 5 million clinic and emergency room visits a year. We provide a full range of services but our service mix is unlike most hospitals: 11% of our discharges are from psychiatric or substance abuse units, about 27% of our inpatients are maternity related and newborn cases, 11% are pediatrics. We have a relatively small surgical caseload. Approximately 13% of our Medicine beds are currently occupied by AIDS patients, 65% of whom are IV drug abusers. Over 73% of all of our patients are admitted through the emergency room. 39% of our Medicare

patients have more than five secondary diagnoses and 10% have their discharge delayed because of the unavailability of necessary post-hospital services in the community.

As a public benefit corporation, with most of our $2.2 billion dollar budget coming from public funds, operating in a State with a very regulated health care industry, HHC is subject to intense public scrutiny. There are a multitude of public and private interests, from the New York Times, to the Citizens Budget Commission, to the State Health Department, to the PRO, to the Health Care Financing Administration, to the City and State Comptrollers, who are routinely requesting and receiving information on everything from our budget, to the number of AIDS patients receiving AZT, to the number of low birthweight newborns, to the number of RNs. Last year over 26,500 of HHC's medical records were reviewed by peer review organizations under contract with Medicare or Medicaid. Regular reports of on-site monitorings by the NYS Health Department and JCAHO are available to the public, sometimes even before the hospitals themselves have received and responded to the citations and comments. Beginning in July, the State will initiate even more rigorous surveys that will involve state personnel spending prolonged periods of time in hospitals observing the process of medical care and talking with patients, in addition to their routine

tours of the facilities and reviews of medical records. While the magnitude and level of surveillance and the time required to respond to information requests and citations of possible negative findings is sometimes overwhelming, a public hospital, like any hospital, must be fully accountable for demonstrating the appropriate care of patients and the appropriate expenditure of public funds.

Although there is a wealth of information about specific New York State hospitals in the public domain, it is unclear how much of this information is useful to or used by consumers. Much of the information is not readily accessible; much may be too detailed to be very helpful. Consumers may be looking for one reliable source of data that describes for each hospital what particular services are offered and whether the quality of those services is average/above average/below average. It would be relatively easy for a hospital to describe what services it offers and a measure of the volume of services (e.g., number of procedures). To be able to provide valid and reliable indicators of quality would be much more difficult.

The underlying assumption in these hearings is that consumers will be able to utilize published information to make

better choices about where and from whom to receive their health care. We must recognize, however, that not all patients have equal access to all facilities or to all physicians. Patients without a private physician cannot easily obtain admission to a hospital, particularly if they are not regular clinic patients in that facility. Patients with no insurance are generally very limited in their choice of providers. While some patients are willing to seek care in hospitals outside of their neighborhoods, other patients will not, or cannot, particularly when they do not have time or resources to "shop" around. It is the job of federal and state oversight agencies to ensure that all services provided by hospitals meet recognized standards of care so that no consumers are faced with dangerous situations if they are unable to gain admission to their "first choice" facility. Government agencies should also ensure adequate medical coverage to increase patient access and a true right to choose.

To develop a hospital grading system to sort out the A + hospitals from the C - hospitals would be very difficult. Sincemost hospitals have particular areas of excellence (microsurgery at Bellevue for example), consumers might prefer that hospital ratings be service or even procedure based. The patient's interest is in both the technical skills of the staff

and the facilities and amenities of an institution. Some hospitals are better equiped with diagnostic or laboratory testing equipment than others, some have more "prestigious" medical staffs, some have more nurses (although in NYC there are never enough), some have all semi-private or private rooms with TVs. Some of these items are easier to measure and describe than others, with the most difficult to measure items being the ones consumers are most interested in: the skills of the medical and nursing staff and the availability and appropriate management of resources key for optimizing outcome of care.

I don't have any simple answers to the question of what are the best indicators. I do have a lot of experience criticizing one of the most used indicators -- mortality rates. The basic problem here is outlined quite clearly in the Office of Technology's recent report on the Quality of Medical Care: "mortality can result from many factors other than poor quality care and methods to adjust for such factors are generally inadequate." HCFA is working on statistical models to predict hospital death rates with information provided on Medicare bills. These models are limited, however, by the types of information on the bill which exclude diagnoses that don't fit in the 5 spaces allowed; the severity of the patient's illness; and whether the

patient was homeless, undernourished and without any health care for a period of time. HCFA also chose not to include all information that is on the bill including the patient's race, whether the patient was a substance abuser, whether the patient was an emergency room admission, whether the patient was in a coma at the time of admission and other acute conditions that HCFA could not verify were present at the point of admission or developed during the hospital stay. Given HHC's somewhat unique patient population we believe that exclusion of these characteristics from HCFA's model results in an underprediction of HHC's expected mortality rate.

Another HCFA decision that hurt HHC was the inclusion of only the patient's last 1986 admission in their mortality rate calculation. 20% of all of HHC's Medicare cases are treated and discharged and have subsequent admissions to other hospitals, so that total number of patients treated is not reflected in the final calculation. This percentage is higher than most hospitals because as trauma centers we have a disproportionate share of high risk patients who may appear at our hospitals although their regular source of care is a voluntary facility. If these patients survive they may have a subsequent admission out of the public system and thus be lost to our patient count, but those

who die, primarily heart attack and accident cases brought in by ambulance, will be included in our count of deaths. The other systematic bias in the HCFA approach has been the lack of any adjustment to account for hospitals located in areas with particularly high rates of morbidity. If for example, the community treated at a particular hospital has a mortality rate 400 times the national average and if, as is true in NYS, more than 69% of the deaths occur in hospitals, the hospitals that service the highest-risk communities will have higher than average death rates, irrespective of the quality of care provided.

This is not to suggest that we don't think mortality data are important and that we don't internally scrutinize our mortality rates. We trend mortality rates over time, compare them across our facilities and conduct 100% chart review of all deaths. We do not think, however, that mortality rates are good proxies for the quality of medical care. When NYS auditors conducted chart reviews of over 8000 deaths in NYC, hospitals with higher than "expected" death rates based on HCFA's analysis did not have a higher proportion of quality problems than other hospitals. Nevertheless the publication of death rates, if you are one of the unlikely "high outlier" mortality hospitals, can

be very damaging to your hospital reputation. More serious is that the often unwarranted anxiety created in patients who have no where else to go for their care undermines the ability of public hospitals to address their mission.

The Health and Hospitals Corporation is committed to monitoring the delivery of medical services and to continuing our efforts to improve patient care. We fully accept the need for public oversight and wish to express our interest in participating in efforts to develop performance indicators that will be useful to consumers. Such indicators will become more meaningful when we are able to better measure risks associated with individual patients and when all patients have improved access to services and providers.

GNYHA
GREATER NEW YORK HOSPITAL ASSOCIATION
61 West 62nd Street / New York, N.Y. 10023 / (212) 246-7100
Kenneth E. Raske, President

TESTIMONY
OF
KENNETH E. RASKE, PRESIDENT
GREATER NEW YORK HOSPITAL ASSOCIATION
BEFORE
THE COMMITTEE ON SCIENCE, SPACE, AND TECHNOLOGY
OF THE
UNITED STATES HOUSE OF REPRESENTATIVES
HELD AT
THE GENERAL SERVICES ADMINISTRATION BUILDING
26 FEDERAL PLAZA
NEW YORK, NEW YORK

Monday, June 6, 1988

TESTIMONY
OF
KENNETH E. RASKE, PRESIDENT
GREATER NEW YORK HOSPITAL ASSOCIATION
BEFORE
THE COMMITTEE ON SCIENCE, SPACE, AND TECHNOLOGY
OF THE
UNITED STATES HOUSE OF REPRESENTATIVES

Good afternoon Chairman Scheuer, ladies and gentlemen. I am Kenneth E. Raske, President of the Greater New York Hospital Association (GNYHA) which represents 99 not-for-profit hospitals and long term care facilities in New York City and surrounding communities. I come before you today to discuss certain quality of care-related initiatives undertaken by the Association, on behalf of its members, to address some of the issues raised by your report. Specifically, I plan to review the environment and climate in New York State as it relates to the issue of quality of medical care and the dissemination of information on quality of care, and the various activities underway in hospitals in New York State to meet national, State and industry standards to monitor quality of care delivered in the hospital. Additionally, as you requested, I will present an overview of the Association's unique quality assurance initiative and the products one can expect from such an initiative. In the final section of the testimony, I will address the issue with which the bulk of your report deals: Should information about the quality of medical care be made available to the public and, if so, how should that information be made public?

I. QUALITY ASSURANCE (QA) — THE REGULATORY REQUIREMENTS IN NEW YORK STATE

Over the past 20 to 30 years, the art of quality assurance has been evolving within the health care profession as new methods of evaluating and assessing the care provided have been raised, refined and become part of the health care delivery system.

During the past several years, there has been interest on the part of providers in more accurately measuring, assessing, and improving the quality of care rendered to patients. Additionally, the legislative and regulatory apparatus in the State of New York have taken definite steps to ensure that hospitals undertake certain activities

specifically related to the identification and resolution of problems in order to avoid their recurrence. In addition to the Statewide statutory focus on quality assurance, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has been in the process of refining its own requirements related to quality assurance mandates for institutions. Specifically, JCAHO has been refocusing its energies toward a more continuous, outcome-oriented review of patient care. The JCAHO's outcome-oriented quality assurance initiative, currently under development, is one more step in the process of improving the methods by which providers, hospitals and physicians alike evaluate the care they render to the public.

Specific New York State Quality Assurance (QA) Requirements

Triggered by increasing concerns on the part of lawmakers, the public and providers about issues related to malpractice insurance and claims, the Legislature of the State of New York required, by law (i.e., The Medical Malpractice Comprehensive Reform Act of 1985, found in Attachment 1) a series of quality assurance activities and a quality assurance structure for hospitals. The law and accompanying regulations require:

- that the hospital have a quality assurance program and plan that are approved by the governing body of the institution;

- that at least one member of the governing body of the hospital be a member of the Quality Assurance Committee;

- that the Quality Assurance Committee be responsible for overseeing the development and implementation of the quality assurance plan and the activities of the quality assurance program;

- that the hospital institute a structured medical malpractice and dental malpractice prevention program that meets the spirit and intent of the law;

- that the institution develop a systematic program to evaluate the performance of health care providers that includes the use of criteria-based monitoring efforts that reflect accepted standards of practice; and

- that the institution utilize a variety of data sources in its evaluation of the quality of care rendered by individual practitioners who are appointed, reappointed, and granted privileges to practice in its institution.

Credentialing and Privileging

Vigorous implementation of the last requirement cited above, the creation and use of data profiles on all practitioners to determine their individual competence, is one of the keys to ensuring that high quality care is fostered.

Integrated and effective procedures for credentialing and delineation of privileges, as these are known, are the cornerstones of a hospital's quality assurance efforts. By this we mean that the various quality assurance activities ongoing in an institution and the information gleaned from those reviews and those processes are integrated into the process that evaluates practitioners for the purpose of biennial reappointment to a hospital's medical staff. It is through the creation of individual practitioner profiles and the use of the information in the profiles by others who are qualified to do so, that a hospital ensures that the quality of care its practitioners render is high. Use of these profiles in the credentialing and privileging processes should permit consumers to feel confident that practitioners who practice within institutions are reevaluated at frequent and regular intervals based on their current performance not just on their past academic credentials and training experiences.

Additionally, in New York State, each hospital is required to share information about practitioners in its institutions with other institutions from which they receive a request for practitioner-specific information. Therefore, if one institution has curtailed, suspended or denied privileges to a specific practitioner based on peer review and the use of the profile, the facts are transmitted to another hospital for its use in its own reappointment process.

Incident Reporting

Additionally, hospitals in New York State are required to report, to the New York State Department of Health, within 24 hours, incidents related to untoward patient care events. This program has been in effect since 1985. (See Attachment 2.)

The incident reporting program requires hospitals to identify, in a timely manner, certain events or incidents that, while not necessarily indicative of malpractice, have occurred outside of the naturally expected course of a disease, treatment, or, because of its occurrence, prolong a patient's stay. Other reportable incidents include environmental occurrences in which patient care might be jeopardized. After immediate, oral reporting to the New York State Department of Health, hospitals are required to submit a written follow-up report which reflects the results of a hospital's own investigation of the event. Hospitals also integrate information from this program into their own QA efforts and, if a case so warrants, implements measures designed to prevent a recurrence of the incident.

Specific types of incidents required to be reported include, but are not limited to:

- o patient deaths or impairments of bodily function in circumstances not related to the natural course of illness, disease or proper treatment;
- o equipment malfunction during treatment or diagnosis which did or could have adversely affected a patient or health care facility personnel;
- o poisoning;
- o elopements; and
- o strikes by facility staff.

External Review Agents

In addition to specific State statutory initiatives related to mandating certain QA processes within hospitals, the contracts of the Medicaid utilization review agents for the State of New York have been deliberately streamlined to reflect a more focused approach in the evaluation of quality of care. For example, all mortalities

are reviewed by the Medicaid utilization review agent in an effort to identify certain quality of care concerns. This review is, of course, in addition to the activities of the Federally-mandated peer review organization (PRO) in New York State which, according to Congressional mandates, has refocused its efforts more in the direction of quality of care review and less in the direction of evaluating the utilization of days and services by Medicare beneficiaries. Both of these agents utilize certain quality of care monitoring tools for each chart they review in order to screen for certain basic quality of care problems.

As can be determined from the above, the environment in New York State is heavily focused on the issues of quality of care. This environment has led to a series of initiatives within hospitals that are wide-ranging, ongoing and vigorous. In the next section of this testimony, GNYHA outlines some of those efforts.

II. QUALITY ASSURANCE (QA) — HOSPITAL EFFORTS IN NEW YORK STATE

Quality assurance (QA) has been carefully woven into the fabric of hospitals' overall efforts to deliver high quality patient care. The various components of a hospital's QA program, quality assessment and monitoring, are the processes by which patient care and factors related to patient care are evaluated by a cohesive and systematic means. QA involves the setting of standards (criteria) and the review of care to determine whether a given standard has been met. Historically, QA programs have focused on process. However, this has changed and, increasingly, hospitals are evaluating and focusing on outcomes of care.

As noted above, QA has been an integral part of hospital activities for many years and the cornerstone of those activities is the identification of those physicians who do not provide generally accepted standards of patient care. This is accomplished through use of a mechanism entitled peer review which has traditionally been a part of a medical staff's responsibilities. Peer review means that once a possible quality problem has been identified, it is validated [or invalidated] as a problem by a process which involves utilizing the other practitioners with expertise in the area under review.

Hospital-based QA programs are designed to assure that the performance of all physicians and other professional staff are objectively and uniformly assessed. QA efforts are focused on the collection of readily available, reliable data that are becoming more available more quickly as methods for evaluation become more timely. As described above, unique QA findings are used as key data elements in the reappointment and delineation of the privileges processes in hospitals.

Hospital QA Activities

The medical QA process within hospitals relies heavily on the validation of deviations from generally accepted standards of practice. Identification of an individual practice variation may come through any of a number of medical staff quality assurance functions. Monthly clinical departmental quality reviews, morbidity and mortality review, drug usage evaluation, infection control program review, surgical case review, medical record review, and blood usage review, are only a few of the required medical staff activities in hospitals' quality assurance programs. A brief description of some of these activities follows:

1. Drug Usage Evaluation is the planned, criteria-based, ongoing, systematic monitoring and evaluation of the prophylactic, therapeutic and empiric use of drugs to assure appropriateness, safety and effectiveness of usage.

2. Infection Control monitoring provides for the establishment and review of effective measures to prevent, identify and control infections acquired in the hospital or brought into the hospital from the community.

3. Surgical Case Review involves the review of all surgical cases of all practitioners or, when appropriate, reasonable samples thereof, for justification of the quality and appropriateness of the procedures performed including all cases in which a major discrepancy exists between the preoperative and postoperative diagnosis.

4. Medical Record Review requires the ongoing, concurrent review of the quality of departmental medical records including the clinical pertinence, timeliness and completeness of the records.

5. Blood Usage Review involves the review of the appropriateness of a reasonable sample of transfusions of blood components including evaluation of all confirmed transfusion reactions, reviews of the ordering practices for blood and blood products and the adequacy of blood banking services.

6. Nursing Departments and Clinical and Support Services are required to develop planned and systematic processes both for the monitoring and evaluation of the quality and appropriateness of patient care as well as for resolving identified problems. These required activities mirror those of the medical staff in that they must be assessed in relation to their effects on patient care.

7. The Competency and Performance of Allied Professional Staff must also be monitored and reassessed at frequent intervals.

8. Other Ongoing QA Activities Within A Hospital include, but are not limited to, utilization review, which generally involves the prior approval of patients with certain categories of procedures for hospitalization; concurrent review of patients during their stay to screen for certain potential adverse events; risk management, which is comprised of risk reduction efforts, claims management and insurance management and loss control; and the development of a program to evaluate and follow up on patient complaints.

Criteria Development and Use

The essential element of all hospital QA programs is the development of objective criteria to assess patient care practices. In order to assess conformance with generally accepted standards of care, all clinical and clinically-related departments must develop criteria that are clinically valid and based upon current practice standards. As mentioned previously, hospitals are presently devoting a significant amount of energy to focusing on and evaluating outcomes of care.

A hospital's quality assurance program currently involves the identification of indicators and establishment of criteria to assess the practice of patient care delivery to ensure that it meets the generally accepted standards of care. The process of monitoring established indicators and criteria can be done concurrently,

retrospectively or even prospectively. Although, these are all accepted quality assurance monitoring techniques, to date, no scientific study has validated the use of these techniques.

Additionally, many hospitals utilize certain "generic" screens on all cases to identify cases that may require further review and analysis. This technique, known variously as occurrence screening and generic screening, is a useful tool for concurrent problem identification and resolution and is also useful in focusing the retrospective review efforts of hospitals and external review agencies alike.

Internal Use of Hospital-Generated QA Data

Quality assurance programs collect a large amount of data and information to be utilized internally for the review of the process and outcome of patient care. This body of information assists hospital professionals in evaluating medical staff for the purposes of credentialing, reappointment and delineation of clinical privileges. In the evaluation of patient care, the collection of certain information related to particular indicators of quality of care can highlight procedural or treatment plan problems which can then be modified. The internal use of quality assurance information enhances health care professionals' ability to assess and modify patient care outcomes and establish mechanisms to possibly mitigate similar problems in the future.

III. QUALITY ASSURANCE — GNYHA'S INITIATIVES

The Greater New York Hospital Association has undertaken a multifaceted approach to assist its members in the area of quality assurance. In this effort, GNYHA is continuing to 1) develop guidelines for hospitals to use in their QA programs, specifically for the credentialing and reappointment function, 2) compile and disseminate educational material, 3) develop research projects to assist in evaluating the methods by which QA is being accomplished, and 4) hold regional QA discussion groups for hospital staff involved in QA. These groups which meet at least quarterly, serve as forums for the exchange of substantive information related to the utility of certain QA indicators and assurance activities and the sharing of innovative QA strategies among providers.

The Goal of GNYHA's Initiative

The overall goal of the initiative is to assist hospitals in effectively meeting their statutory requirements related to quality assurance and in developing new programs and evaluation methods by which QA can be accomplished. One of the other goals of GNYHA's initiative is to assist member hospitals in the development and implementation of integrated quality assurance, utilization review, and risk management programs. This approach will assist hospitals in creating a quality assurance program that builds upon the hospital's existing resources.

Educational Material

As part of its initial efforts, GNYHA's QA Committee prepared a primer on QA entitled "QA BASICS: Quality Assurance Issues for Hospital Trustees, Physicians and Administrators," a copy of which is attached to this testimony. This QA booklet provides a definition and description of quality assurance, identifies the hospital staff who participate in the process and outlines basic organizational requirements of QA at the hospital level. The booklet provides definitions of quality assurance, describes the relative roles of those on the hospital staff who must participate in the QA process to make it effective and the mechanisms by which this participation can be translated into action. Information contained in this document may already be known to hospital industry leadership, however, it was felt that all of this information should be compiled into a single source that would serve as a reference guide for hospitals in New York City. This booklet is being disseminated by hospitals in New York City to their medical staffs and trustees as part of a hospitals' ongoing efforts to educate and update their staff on QA responsibilities.

Additionally, under the auspices of the Association, a booklet entitled "A Patient's Guide to the DRG System and Discharge Review" [Discharge Review is a New York State-mandated program to provide protection for consumers against the possibility of premature discharge. A copy of the booklet is attached.] By assisting in the development and publication of this booklet in English and Spanish, and an accompanying rider tape for member hospitals' use, GNYHA evidenced its ongoing commitment to participating in the education of consumers about their health care.

GNYHA's Research Agenda

Needs Assessment

GNYHA has also prepared a research agenda related to quality assurance. As part of this effort, a Quality Assurance Needs Assessment Survey was conducted to evaluate ongoing quality assurance activities in order to develop a compendium of approaches to hospital quality review activities. The survey was an initial step in gathering information from member hospitals to identify both how quality assurance programs are organized in different types of hospitals, as well as effective systems for quality assurance. The results have been useful in the identification of systems that are effective and those which can be easily translated into another hospital environment. The results have also aided GNYHA's QA Committee in its efforts to refine and update its ongoing agenda.

Grant Proposal

GNYHA's research effort also includes development of a grant proposal, the basis of which is to evaluate the relative effectiveness of quality assessment techniques. The focus on quality has drawn considerable attention to the fact that traditional, so–called "process–oriented" quality assurance and assessment mechanisms fall short of providing the information needed to be effective; that new mechanisms (e.g., concurrent review, incident reporting, mortality review, etc.) are being adopted without the benefit of empirical validation; and the some mechanisms (e.g., clinical prediction models/rules), which have been at least partially validated, are being generally overlooked.

In light of the universal interest in developing and implementing effective quality assurance programs, there is a critical need to assess the efficacy of ongoing quality assurance activities and other activities that may also be beneficial. GNYHA's research agenda is aimed at just this. If funding is obtained, GNYHA will assemble a working group of national experts on quality assurance and evaluation research to develop the research protocol for an appropriate study. Ultimately, a subsection of GNYHA's membership may participate in a demonstration project to analyze the relative merit and efficacy of different QA strategies.

§ 2. Section four of chapter four hundred two of the laws of nineteen hundred eighty-three, amending the general business law relating to conversion of rental residential property to cooperative or condominium ownership in certain municipalities in the counties of Nassau, Westchester and Rockland, is amended to read as follows:

§ 4. This act shall take effect immediately; provided, that the provisions of sections one and three of this act shall remain in full force and effect only until [July first] and including June fifth, nineteen hundred [eighty-five] eighty-seven; and provided further that any plan accepted for filing by the department of law on or before the effective date of this act shall continue to be governed by the provisions of section three hundred fifty-two-eee of the general business law as they had existed immediately prior to the effective date of this act.

§ 3. Regardless of the date on which it shall have become a law, any provision of a chapter of the laws of nineteen hundred eighty-five which amends section three hundred fifty-two-eee or three hundred fifty-two-eeee of the general business law shall be subject to the provisions of sections two and three of this act and shall remain in effect in accordance therewith, unless such chapter specifically excludes itself from the provisions of this act.

§ 4. This act shall take effect immediately.

MEDICAL MALPRACTICE INSURANCE—COMPREHENSIVE REFORM

Memoranda relating to this chapter, see Legislative and Executive Memoranda, post

CHAPTER 294

Approved July 2, 1985, effective as provided in section 25

Message of necessity, pursuant to Art. III, sec. 14, of Const.

AN ACT to amend the public health law, the civil practice law and rules, the education law, the insurance law, and the judiciary law, in relation to medical and dental malpractice, making an appropriation therefor and providing for the repeal of certain provisions added by this act upon their expiration

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Legislative findings and declaration. The legislature hereby finds and declares that a comprehensive reform of the medical and dental malpractice adjudication system is necessary in order to ensure the continued availability and affordability of quality health services in New York state. Escalating malpractice insurance premiums discourage physicians and dentists from initiating or continuing their practice in New York and contribute to the rising cost of health care as premium costs are passed along to the health care consumer. The legislature finds, therefore, that steps must be taken to reduce the cost of malpractice insurance and to restrain associated health care costs, while

assuring the availability of compensation for persons injured as a result of malpractice. By expediting case resolution, discouraging frivolous claims and defenses, moderating attorney contingency fees, limiting the opportunity for double recoveries, and requiring the periodic payment of large future awards, the legislature intends to reduce the escalating cost of malpractice insurance and to improve the adjudication of malpractice claims. The legislature further finds that hospitals must enhance their efforts to reduce medical and dental malpractice through the establishment of medical and dental malpractice prevention programs and through greater scrutiny of physicians and dentists prior to granting hospital privileges and that increased resources should be devoted to the investigation and prosecution of professional misconduct. The legislature finds that the public interest further requires that premium levels for physicians and dentists must be restrained to the extent feasible in order to maintain high quality medical services for New York and to explore alternative long-term approaches to the malpractice issue.

§ 2. Paragraph (a) of subdivision one of section twenty-eight hundred three-e of the public health law, as amended by chapter one thousand five of the laws of nineteen hundred eighty-four, is amended to read as follows:

(a) Hospitals and other facilities approved pursuant to this article shall make a report or cause a report to be made within thirty days of the occurrence of any of the following: the suspension, restriction, termination or curtailment of the training, employment, association or professional privileges or the denial of the certification of completion of training of an individual licensed pursuant to the provisions of title eight of the education law or of a medical resident with such facility for reasons related in any way to alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare; the voluntary or involuntary resignation or withdrawal of association or of privileges with such facility to avoid the imposition of disciplinary measures; or the receipt of information which indicates that any professional licensee or medical resident has been convicted of a crime; the denial of staff privileges to a physician if the reasons stated for such denial are related to alleged mental or physical impairment, incompetence, malpractice, misconduct or impairment of patient safety or welfare.

§ 3. Such law is amended by adding two new sections twenty-eight hundred five-j and twenty-eight hundred five-k to read as follows:

§ 2805-j. Medical and dental malpractice prevention program. 1. Every hospital shall maintain a coordinated program for the identification and prevention of medical and dental malpractice. Such program shall include at least the following:

(a) The establishment of a quality assurance committee with the responsibility to review the services rendered in the hospital in order to improve the quality of medical and dental care of patients and to prevent medical and dental malpractice. Such committee shall oversee and coordinate the medical and dental malpractice prevention program and shall insure that information gathered pursuant to the program is utilized to review and to revise hospital policies and procedures. At least one member of the committee shall be a member of the governing board of the hospital who is not otherwise affiliated with the hospital in an employment or contractual capacity;

(b) A medical and dental staff privileges sanction procedure through which credentials, physical and mental capacity and competence in delivering health care services are periodically reviewed as part of an evaluation of staff privileges;

(c) The periodic review of the credentials, physical and mental capacity and competence in delivering health care services of all persons who are employed or associated with the hospital;

(d) A procedure for the prompt resolution of grievances by patients or their representatives related to accidents, injuries, treatment and other events that may result in claims of medical or dental malpractice;

(e) The maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes and incidents injurious to patients, patient grievances, professional liability premiums, settlements, awards, costs incurred by the hospital for patient injury prevention and safety improvement activities;

(f) The maintenance of relevant and appropriate information gathered pursuant to paragraphs (a) through (e) of this subdivision concerning individual physicians and dentists within the physician's or dentist's personnel or credential file maintained by the hospital;

(g) Education programs dealing with patient safety, injury prevention, staff responsibility to report professional misconduct, the legal aspects of patient care, improved communication with patients and causes of malpractice claims for staff personnel engaged in patient care activities;

(h) Continuing education programs for medical and dental staff in their areas of specialty; and

(i) Policies to ensure compliance with the reporting requirements of section twenty-eight hundred three-e of this article and subdivision eleven of section two hundred thirty of this chapter.

2. Any person who, in good faith and without malice, provides information to further the purposes of the medical and dental malpractice prevention program or who, in good faith and without malice, participates on the quality assurance committee shall not be subject to an action for civil damages or other relief as a result of such activity.

3. The commissioner shall make, adopt, promulgate and enforce such rules and regulations as he may deem appropriate to effectuate the purposes of this section.

§ 2805-k. Investigations prior to granting or renewing privileges. 1. Prior to granting or renewing professional privileges or association of any physician or dentist or hiring a physician or dentist, a hospital or facility approved pursuant to this article shall request from the physician or dentist and the physician or dentist shall be required to provide the following information:

(a) The name of any hospital or facility with or at which the physician or dentist had or has any association, employment, privileges or practice;

(b) Where such association, employment, privilege or practice was discontinued, the reasons for its discontinuation;

(c) Any pending professional medical or dental misconduct proceedings or any pending medical malpractice actions in this state or another state, the substance of the allegations in such proceedings or actions, and any additional information concerning such proceedings or actions as the physician or dentist may deem appropriate;

(d) The substance of the findings in such actions or proceedings and any additional information concerning such actions or proceedings as the physician or dentist may deem appropriate;

(e) A waiver by the physician or dentist of any confidentiality provisions concerning the information required to be provided to hospitals pursuant to this subdivision; and

(f) A verification by the physician or dentist that the information provided by the physician or dentist is true and accurate.

2. Prior to granting privileges or association to any physician or dentist, or hiring a physician or dentist, any hospital or facility approved pursuant to this article shall request from any hospital with or at which such physician or dentist had or has privileges, was associated, or was employed, the following information concerning such physician or dentist:

(a) Any pending professional medical conduct proceedings or any pending medical malpractice actions, in this state or another state;

(b) Any judgment or settlement of a medical malpractice action and any finding of professional misconduct in this state or another; and

(c) Any information required to be reported by hospitals pursuant to section twenty-eight hundred three of this article.

3. If requested by the department, a hospital shall provide documentation that, prior to granting privileges, association or employing a physician or dentist, it has complied with the requirements of subdivisions one and two of this section and that, prior to renewing privileges, association or employment, it has complied with the requirements of subdivision one of this section. Copies of the information and documentation required pursuant to subdivisions one and two of this section shall be placed in the physician's or dentist's personnel or credentials file maintained by the hospital.

4. Any hospital which receives a request for information from another hospital pursuant to subdivision one or two of this section shall provide such information concerning the physician or dentist in question to the extent such information is known to the hospital receiving such a request, including the reasons for suspension, termination, curtailment of employment or privileges at the hospital. Any hospital or hospital employee providing such information in good faith shall not be liable in any civil action for the release of such information.

§ 4. Subdivision (d) of section thirty-one hundred one of the civil practice law and rules is amended to read as follows:

(d) [Material prepared for litigation. The following shall not be obtainable unless the court finds that the material can no longer be duplicated because of a change in conditions and that withholding it will result in injustice or undue hardship:

1. any opinion of an expert prepared for litigation; and

2. any writing or anything created by or for a party or his agent in preparation for litigation]

Trial preparation.

1. Experts. (i) Upon request, each party shall identify each person whom the party expects to call as an expert witness at trial and shall disclose in reasonable detail the subject matter on which each expert is expected to testify, the substance of the facts and opinions on which each expert is expected to testify, the qualifications of each expert witness and a summary of the grounds for each expert's opinion. However, where a party for good cause shown retains an expert an insufficient

period of time before the commencement of trial to give appropriate notice thereof, the party shall not thereupon be precluded from introducing the expert's testimony at the trial solely on grounds of noncompliance with this paragraph. In that instance, upon motion of any party, made before or at trial, or on its own initiative, the court may make whatever order may be just. In an action for medical or dental malpractice, a party, in responding to a request, may omit the names of medical or dental experts but shall be required to disclose all other information concerning such experts otherwise required by this paragraph.

(ii) Further disclosure concerning the expected testimony of any expert may be obtained only by court order upon a showing of special circumstances and subject to restrictions as to scope and provisions concerning fees and expenses as the court may deem appropriate. However, a party, without court order, may take the testimony of a person authorized to practice medicine or dentistry who is the party's treating or retained expert, as described in paragraph three of subdivision (a) of this section, in which event any other party shall be entitled to the full disclosure authorized by this article with respect to that expert without court order.

2. Materials. Subject to the provisions of paragraph one of this subdivision, materials otherwise discoverable under subdivision (a) of this section and prepared in anticipation of litigation or for trial by or for another party, or by or for that other party's representative (including an attorney, consultant, surety, indemnitor, insurer or agent), may be obtained only upon a showing that the party seeking discovery has substantial need of the materials in the preparation of the case and is unable without undue hardship to obtain the substantial equivalent of the materials by other means. In ordering discovery of the materials when the required showing has been made, the court shall protect against disclosure of the mental impressions, conclusions, opinions or legal theories of an attorney or other representative of a party concerning the litigation.

§ 5. Such law and rules is amended by adding a new rule thirty-four hundred six to read as follows:

Rule 3406. Mandatory filing and pre-calendar conference in dental and medical malpractice actions. (a) Mandatory filing. Not more than sixty days after issue is joined, the plaintiff in an action to recover damages for dental or medical malpractice shall file with the clerk of the court in which the action is commenced a notice of dental or medical malpractice action, on a form to be specified by the chief administrator of the courts. Together with such notice, the plaintiff shall file: (i) proof of service of such notice upon all other parties to the action; (ii) proof that, if demanded, authorizations to obtain medical, dental and hospital records have been served upon the defendants in the action; and (iii) such other papers as may be required to be filed by rule of the chief administrator of the courts. The time for filing a notice of dental or medical malpractice action may be extended by the court only upon a motion made pursuant to section two thousand four of this chapter.

(b) Pre-calendar conference. The chief administrator of the courts, in accordance with such standards and administrative policies as may be promulgated pursuant to section twenty-eight of article six of the constitution, shall adopt special calendar control rules for actions to recover damages for dental or medical malpractice. Such rules shall

require a pre-calendar conference in such an action, the purpose of which shall include, but not be limited to, encouraging settlement, simplifying or limiting issues and establishing a timetable for disclosure, future conferences, and trial. The timetable for disclosure shall provide for the completion of disclosure not later than twelve months after the notice of dental or medical malpractice is filed and shall require that all parties be ready for the trial of the case not later than eighteen months after such notice is filed. The initial pre-calendar conference shall be held after issue is joined in a case but before a note of issue is filed and before a medical malpractice panel hearing, if any, is scheduled. To the extent feasible, the justice convening the pre-calendar conference shall hear and decide all subsequent pre-trial motions in the case and shall be assigned the trial of the case. The chief administrator of the courts also shall provide for the imposition of costs or other sanctions, including imposition of reasonable attorney's fees, dismissal of an action, claim, cross-claim, counterclaim or defense, or rendering a judgment by default for failure of a party or a party's attorney to comply with these special calendar control rules or any order of a court made thereunder. The chief administrator of the courts, in the exercise of discretion, may provide for exemption from the requirement of a pre-calendar conference in any judicial district or a county where there exists no demonstrated need for such conferences.

§ 6. Subdivision (d) of rule forty-one hundred eleven of such law and rules, as added by chapter nine hundred fifty-five of the laws of nineteen hundred seventy-six, is amended to read as follows:

(d) Itemized verdict in medical or dental malpractice actions. In a medical or dental malpractice action the court shall instruct the jury that if the jury finds a verdict awarding damages it shall in its verdict specify the applicable elements of special and general damages upon which the award is based and the amount assigned to each element, including but not limited to medical expenses, dental expenses, loss of earnings, impairment of earning ability, and pain and suffering. In a medical or dental malpractice action, each element shall be further itemized into amounts intended to compensate for damages which have been incurred prior to the verdict and amounts intended to compensate for damages to be incurred in the future. In itemizing amounts intended to compensate for future damages, the jury shall set forth the period of years over which such amounts are intended to provide compensation. In computing said damages, the jury shall be instructed to award the full amount of future damages, as calculated, without reduction to present value.

§ 7. Subdivision (b) of section forty-two hundred thirteen of such law and rules, as amended by chapter seven hundred one of the laws of nineteen hundred eighty-four, is amended to read as follows:

(b) Form of decision. The decision of the court may be oral or in writing and shall state the facts it deems essential. In a medical or dental malpractice action or in an action against a public employer or a public employee who is subject to indemnification by a public employer with respect to such action or both, as such terms are defined in subdivision (b) of section forty-five hundred forty-five, for personal injury or wrongful death arising out of an injury sustained by a public employee while acting within the scope of his public employment or duties, a decision awarding damages shall specify the applicable ele-

ments of special and general damages upon which the award is based and the amount assigned to each element, including but not limited to medical expenses, dental expenses, loss of earnings, impairment of earning ability, and pain and suffering. In a medical or dental malpractice action, each element shall be further itemized into amounts intended to compensate for damages which have been incurred prior to the decision and amounts intended to compensate for damages to be incurred in the future. In itemizing amounts intended to compensate for future damages, the court shall set forth the period of years over which such amounts are intended to provide compensation. In computing said damages, the court shall award the full amount of future damages, as calculated, without reduction to present value.

§ 8. Subdivision (a) of section forty-five hundred forty-five of such law and rules, as added by chapter seven hundred one of the laws of nineteen hundred eighty-four, is amended to read as follows:

(a) Action for medical or dental malpractice. In any action for medical or dental malpractice where the plaintiff seeks to recover for the cost of medical care, dental care, custodial care or rehabilitation services, loss of earnings or other economic loss, evidence shall be admissible for consideration by the court to establish that any such past or future cost or expense was or will, with reasonable certainty, be replaced or indemnified, in whole or in part, from any collateral source such as insurance (except for life insurance), social security (except those benefits provided under title XVIII of the social security act)[1], workers' compensation or employee benefit programs (except such collateral sources entitled by law to liens against any recovery of the plaintiff). If the court finds that any such cost or expense was or will, with reasonable certainty, be replaced or indemnified from any collateral source, it shall reduce the amount of the award by such finding, minus an amount equal to the premiums paid by the plaintiff for such benefits for the two-year period immediately preceding the accrual of such action and minus an amount equal to the projected future cost to the plaintiff of maintaining such benefits. In order to find that any future cost or expense will, with reasonable certainty, be replaced or indemnified by the collateral source, the court must find that the plaintiff is legally entitled to the continued receipt of such collateral source, pursuant to a contract or otherwise enforceable agreement, subject only to the continued payment of a premium and such other financial obligations as may be required by such agreement.

[1] 42 U.S.C.A. § 1395 et seq.

§ 9. Such law and rules is amended by adding a new article fifty-A to read as follows:

ARTICLE 50-A
PERIODIC PAYMENT OF
JUDGMENTS IN MEDICAL AND DENTAL MALPRACTICE ACTIONS

5031. Basis for determining judgment to be entered.
5032. Form of security.
5033. Posting and maintaining security.
5034. Failure to make payment.
5035. Effect of death of judgment creditor.
5036. Adjustment of payments.
5037. Settlements.
5038. Assignment of periodic installments.
5039. Duties of superintendent of insurance.

§ 5031. Basis for determining judgment to be entered. In order to determine what judgment is to be entered on a verdict in an action to recover damages for dental or medical malpractice under this article, the court shall proceed as follows:

(a) The court shall apply to the findings of past and future damages any applicable rules of law, including set-offs, credits, comparative negligence pursuant to section fourteen hundred eleven of this chapter, additurs, and remittiturs, in calculating the respective amounts of past and future damages claimants are entitled to recover and defendants are obligated to pay.

(b) The court shall enter judgment in lump sum for past damages, for future damages not in excess of two hundred fifty thousand dollars, and for any damages, fees or costs payable in lump sum or otherwise under subdivisions (c) and (d) of this section. For the purposes of this section, any lump sum payment of a portion of future damages shall be deemed to include the elements of future damages in the same proportion as such elements comprise of the total award for future damages as determined by the trier of fact.

(c) Payment of litigation expenses and that portion of the attorney's fees related to past damages shall be payable in a lump sum. Payment of that portion of the attorney's fees related to future damages for which, pursuant to this article, the claimant is entitled to a lump sum payment shall also be payable in a lump sum. Payment of that portion of the attorney's fees related to the future periodically paid damages shall also be payable in a lump sum, based on the present value of the annuity contract purchased to provide payment of such future periodically paid damages pursuant to subdivision (e) of this section.

(d) Upon election of a subrogee or a lien holder, including an employer or insurer who provides workers' compensation, filed within the time permitted by rule of court, any part of future damages allocable to reimbursement of payments previously made by the subrogee or the lien holder shall be paid in lump sum to the subrogee or the lien holder in such amount as is calculable and determinable under the law in effect at the time of such payment.

(e) With respect to awards of future damages in excess of two hundred fifty thousand dollars in an action to recover damages for dental or medical malpractice, the court shall enter judgment as follows:

After making any adjustments prescribed by subdivisions (b), (c) and (d) of this section, the court shall enter a judgment for the amount of the present value of an annuity contract that will provide for the payment of the remaining amounts of future damages in periodic installments. The present value of such contract shall be determined in accordance with generally accepted actuarial practices by applying the discount rate in effect at the time of the award to the full amount of the remaining future damages, as calculated pursuant to this subdivision. The period of time over which such periodic payments shall be made and the period of time used to calculate the present value of the annuity contract shall be the period of years determined by the trier of fact in arriving at the itemized verdict; provided, however, that the period of time over which such periodic payments shall be made and the period of time used to calculate the present value for damages attributable to pain and suffering shall be ten years or the period of time determined by the trier of fact, whichever is less. The court, as part of its judgment, shall direct that the defendants and their in-

surance carriers shall be required to offer and to guarantee the purchase and payment of such an annuity contract. Such annuity contract shall provide for the payment of the annual payments of such remaining future damages over the period of time determined pursuant to this subdivision. The annual payment for the first year shall be calculated by dividing the remaining amount of future damages by the number of years over which such payments shall be made and the payment due in each succeeding year shall be computed by adding four percent to the previous year's payment. Where payment of a portion of the future damages terminates in accordance with the provisions of this article, the four percent added payment shall be based only upon that portion of the damages that remains subject to continued payment. Unless otherwise agreed, the annual sum so arrived at shall be paid in equal monthly installments and in advance.

(f) With the consent of the claimant and any party liable, in whole or in part, for the judgment, the court shall enter judgment for the amount found for future damages attributable to said party as such are determinable without regard to the provisions of this article.

§ 5032. Form of security. Security authorized or required for payment of a judgment for periodic installments entered in accordance with this article must be in the form of an annuity contract, executed by a qualified insurer and approved by the superintendent of insurance pursuant to section five thousand thirty-nine of this article, and approved by the court.

§ 5033. Posting and maintaining security. (a) If the court enters a judgment for periodic installments, each party liable for all or a portion of such judgment shall separately or jointly with one or more others post security in an amount necessary to secure payment for the amount of the judgment for future periodic installments within thirty days after the date the judgment is entered. A liability insurer having a contractual obligation and any other person adjudged to have an obligation to pay all or part of a judgment for periodic installments on behalf of a judgment debtor is obligated to post security to the extent of its contractual or adjudged obligation if the judgment debtor has not done so.

(b) A judgment creditor or successor in interest and any party having rights may move that the court find that security has not been posted and maintained with regard to a judgment obligation owing to the moving party. Upon so finding, the court shall order that security complying with this article be posted within thirty days. If security is not posted within that time and subdivision (c) of this section does not apply, the court shall enter a judgment for the lump sum as such sum is determinable under the law without regard to this article.

(c) If a judgment debtor who is the only person liable for a portion of a judgment for periodic installments fails to post and maintain security, the right to lump sum payment described in subdivision (b) of this section applies only against that judgment debtor and the portion of the judgment so owed.

(d) If more than one party is liable for all or a portion of a judgment requiring security under this article and the required security is posted by one or more but fewer than all of the parties liable, the security requirements are satisfied and those posting security may proceed under subdivision (b) of this section to enforce rights for

security or lump sum payment to satisfy or protect rights of reimbursement from a party not posting security.

§ 5034. Failure to make payment. If at any time following entry of judgment, a judgment debtor fails for any reason to make a payment in a timely fashion according to the terms of this article, the judgment creditor may petition the court which rendered the original judgment for an order requiring payment by the judgment debtor of the outstanding payments in a lump sum. In calculating the amount of the lump sum judgment, the court shall total the remaining periodic payments due and owing to the judgment creditor, as calculated pursuant to subdivision (b) of section five thousand thirty-one of this article, and shall not convert these amounts to their present value. The court may also require the payment of interest on the outstanding judgment.

§ 5035. Effect of death of judgment creditor. (a) Unless otherwise agreed between the parties at the time security is posted pursuant to section five thousand thirty-three of this article, in all cases covered by this article in which future damages are payable in periodic installments, the liability for payment of any installments for medical, dental or other costs of health care or noneconomic loss not yet due at the death of the judgment creditor terminates upon the death of the judgment creditor.

(b) The portion of any periodic payment allocable to loss of future earnings shall not be reduced or terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support immediately prior to his death to the extent that such duty of support exists under applicable law at the time of the death of the judgment creditor. Such payments to such persons shall continue for the remainder of the period as originally found by the jury or until such duty of support ceases to exist, whichever occurs first. In such cases, the court which rendered the original judgment may, upon petition of any party in interest, modify the judgment to award and apportion the future payments of such unpaid future damages in accordance with this subdivision which apportioned amounts shall be payable in the future as provided for in this article. In the event that the judgment creditor does not owe a duty of support to any person at the time of the death of the judgment creditor or such duty ceases to exist, the remaining payments shall be considered part of the estate of the judgment creditor. In such cases, the court which rendered the original judgment may, upon petition of any party in interest, convert those portions of such periodic payments allocable to the loss of future earnings to a lump sum by calculating the present value of such payments in order to assist in the settlement of the estate of the judgment creditor.

§ 5036. Adjustment of payments. (a) If, at any time after entry of judgment, a judgment creditor or successor in interest can establish that the continued payment of the judgment in periodic installments will impose a hardship, the court may, in its discretion, order that the remaining payments or a portion thereof shall be made to the judgment creditor in a lump sum. The court shall, before entering such an order, find that: (i) unanticipated and substantial medical, dental or other needs have arisen that warrant the payment of the remaining payments, or a portion thereof, in a lump sum; (ii) ordering such a lump sum payment would not impose an unreasonable financial burden on the judgment debtor or debtors; (iii) ordering such a lump sum payment will accommodate the

future medical and other needs of the judgment creditor; and (iv) ordering such a lump sum payment would further the interests of justice.

(b) If a lump sum payment is ordered by the court, such lump sum shall be calculated on the basis of the present value of remaining periodic payments, or portions thereof, that are converted into a lump sum payment. The remaining future periodic payments, if any, shall be reduced accordingly.

§ 5037. Settlements. Nothing in this article shall be construed to limit the right of a plaintiff, defendant or defendants and any insurer to settle dental or medical malpractice claims as they consider appropriate and in their complete discretion.

§ 5038. Assignment of periodic installments. An assignment of or an agreement to assign any right to periodic installments for future damages contained in a judgment entered under this article is enforceable only as to amounts: (a) to secure payment of alimony, maintenance, or child support; (b) for the cost of products, services, or accommodations provided or to be provided by the assignee for medical, dental or other health care; or (c) for attorney's fees and other expenses of litigation incurred in securing the judgment.

§ 5039. Duties of superintendent of insurance. The superintendent of insurance shall establish rules and procedures for determining which insurers, self-insurers, plans or arrangements are financially qualified to provide the security required under this article and to be designated as qualified insurers.

§ 10. Such law and rules is amended by adding a new section eighty-three hundred three-a to read as follows:

§ 8303-a. Costs upon frivolous claims and counterclaims in dental and medical malpractice actions. (a) If in a dental or medical malpractice action, an action or claim is commenced or continued by a plaintiff or a counterclaim, defense or cross claim is commenced or continued by a defendant that is found, at any time during the proceedings or upon judgment, to be frivolous by the court, the court shall award to the successful party costs and reasonable attorney's fees not exceeding ten thousand dollars.

(b) The costs and fees awarded under subdivision (a) of this section shall be assessed either against the party bringing the action, claim, cross claim, defense or counterclaim or against the attorney for such party, or against both, as may be determined by the court, based upon the circumstances of the case. Such costs and fees shall be in addition to any other judgment awarded to the successful party.

(c) In order to find the action, claim, counterclaim, defense or cross claim to be frivolous under subdivision (a) of this section, the court must find one or more of the following:

(i) the action, claim, counterclaim, defense or cross claim was commenced, used or continued in bad faith, solely to delay or prolong the resolution of the litigation or to harass or maliciously injure another;

(ii) the action, claim, counterclaim, defense or cross claim was commenced or continued in bad faith without any reasonable basis in law or fact and could not be supported by a good faith argument for an extension, modification or reversal of existing law. If the action, claim, counterclaim, defense or cross claim was promptly discontinued when the party or the attorney learned or should have learned that the action, claim, counterclaim, defense or cross claim lacked such a reasonable

basis, the court may find that the party or the attorney did not act in bad faith.

§ 11. Subdivision five of section sixty-five hundred nine of the education law is amended by adding a new paragraph (d) to read as follows:

(d) Having his license to practice medicine revoked, suspended or having other disciplinary action taken, or having his application for a license refused, revoked or suspended or having voluntarily or otherwise surrendered his license after a disciplinary action was instituted by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the revocation, suspension or other disciplinary action involving the license or refusal, revocation or suspension of an application for a license or the surrender of the license would, if committed in New York state, constitute professional misconduct under the laws of New York state.

§ 12. Subdivision eleven of section sixty-five hundred nine of such law, as added by chapter three hundred forty of the laws of nineteen hundred eighty, is amended to read as follows:

(11) A violation of section twenty-eight hundred three-d or twenty-eight hundred five-k of the public health law.

§ 13. Section six thousand five hundred twenty-four of such law is amended by adding a new subdivision ten to read as follows:

(10) For every license or registration issued after the effective date of this subdivision, an additional fee of ninety dollars shall be paid and deposited in the general fund for the purpose of increasing expenditures made pursuant to section two hundred thirty of the public health law in relation to the operation of the office of professional medical conduct within the department of health. The amount of the funds expended as a result of such increase shall not be greater than such additional fees collected over the licensure period.

§ 14. Subdivision one of section one hundred forty-eight-a of the judiciary law, as amended by chapter ninety-five of the laws of nineteen hundred seventy-eight, is amended to read as follows:

1. Each appellate division of the supreme court shall establish within its judicial department a medical malpractice panel or panels to facilitate the disposition of medical malpractice actions, including malpractice actions where a hospital is a named defendant, in the supreme court; provided, however, the provisions of this section shall not apply to the disposition of such actions in the fifth judicial district or in the county of Suffolk. The number and locations of such panels and the rules governing the operation thereof shall be determined by the respective appellate divisions.

§ 15. Subdivisions two, three and four of section four hundred seventy-four-a of such law, as added by chapter nine hundred fifty-five of the laws of nineteen hundred seventy-six, are amended to read as follows:

2. Notwithstanding any inconsistent judicial rule, a contingent fee in a medical or dental malpractice action shall not exceed the amount of compensation provided for in [either of] the following [schedules] schedule:

[SCHEDULE A]

[50] 30 percent of the first [$1,000] $250,000 of the sum recovered;
[40] 25 percent of the next [$2,000] $250,000 of the sum recovered;
[35] 20 percent of the next [$22,000] $500,000 of the sum recovered;
[25] 15 percent of the next $250,000 of the sum recovered;

10 percent of any amount over [$25,000] $1,250,000 of the sum recovered[; or

SCHEDULE B

A percentage not exceeding thirty-three and one-third percent of the sum recovered, if the initial contractual arrangement between the client and the attorney so provides, in which event the procedure hereinafter provided for making application for additional compensation because of extraordinary circumstances shall not apply].

3. Such [percentage] percentages shall be computed on the net sum recovered after deducting from the amount recovered expenses and disbursements for expert testimony and investigative or other services properly chargeable to the enforcement of the claim or prosecution of the action. In computing the fee, the costs as taxed, including interest upon a judgment, shall be deemed part of the amount recovered. For the following or similar items there shall be no deduction in computing such percentages: liens, assignments or claims in favor of hospitals, for medical care, dental care and treatment by doctors and nurses, or of self-insurers or insurance carriers.

4. In the event that claimant's or plaintiff's attorney believes in good faith that the fee [schedules] schedule set forth in subdivision two of this section, because of extraordinary circumstances, will not give him adequate compensation, application for greater compensation may be made upon affidavit with written notice and an opportunity to be heard to the claimant or plaintiff and other persons holding liens or assignments on the recovery. Such application shall be made to the justice of the trial part to which the action had been sent for trial; or, if it had not been sent to a part for trial, then to the justice presiding at the trial term calendar part of the court in which the action had been instituted; or, if no action had been instituted, then to the justice presiding at the trial term calendar part of the Supreme Court for the county in the judicial department in which the attorney has an office. Upon such application, the justice, in his discretion, if extraordinary circumstances are found to be present, and without regard to the claimant's or plaintiff's consent, may fix as reasonable compensation for legal services rendered an amount greater than that specified in the [schedules] schedule set forth in subdivision two of this section, provided, however, that such greater amount shall not exceed the fee fixed pursuant to the contractual arrangement, if any, between the claimant or plaintiff and the attorney. If the application is granted, the justice shall make a written order accordingly, briefly stating the reasons for granting the greater compensation; and a copy of such order shall be served on all persons entitled to receive notice of the application.

§ 16. The insurance law is amended by adding a new section two thousand three hundred forty-three to read as follows:

§ 2343. Medical malpractice insurance rates; special additional provisions regarding such rates. (a) Whereas the provisions of a chapter of the laws of nineteen hundred eighty-five regarding medical and dental malpractice will have both a prospective and retrospective effect upon the loss experience of physicians, dentists and hospitals professional liability insurers, including the medical malpractice insurance association, the superintendent is directed forthwith to review rates previously in effect for the period commencing July first, nineteen hundred eighty-four and ending June thirtieth, nineteen hundred eighty-

five, and, where appropriate, require modification of such rates for such period.

(b) Any such modified rate shall remain in effect as a provisional rate for the period commencing July first, nineteen hundred eighty-five and ending on November thirtieth, nineteen hundred eighty-five. The superintendent, subsequent to December first, nineteen hundred eighty-five, shall approve final rates for the period commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred eighty-six. No insurer shall have the duty to file for final rates for the period commencing July first, nineteen hundred eighty-five prior to December first, nineteen hundred eighty-five.

(c) Notwithstanding any other provision of this chapter, no application for an order of rehabilitation or liquidation of a domestic insurer whose primary liability arises from the business of medical malpractice insurance, as that term is defined in subsection (b) of section five thousand five hundred one of this chapter, shall be made on the grounds specified in subsection (a) or (c) of section seven thousand four hundred two of this chapter at any time prior to December first, nineteen hundred eighty-five.

(d) The superintendent shall promulgate a regulation, which may be amended from time to time, establishing a physicians professional liability insurance merit rating plan which reflects an individual physician's or surgeon's experience with respect to incidents or occurrences of alleged medical malpractice. The regulation shall establish standards and limitations intended to insure that merit rating plans are reasonable and are not unfairly discriminatory, inequitable, violative of public policy or otherwise contrary to the best interests of the people of this state. Such regulation shall include:

(1) reasonable standards to be applied in arriving at premium rates, surcharges and discounts based on an evaluation of the hazards of the insured, geographical area, specialties of practice, past and prospective loss and expense experience for medical malpractice insurance written and to be written in this state, trends in the frequency and severity of losses, and the limited nature, if any, of the practice of the insured;

(2) rules for recognizing experience of individual risks;

(3) any other factors deemed relevant in a system of merit rating for the purpose of establishing equitable merit rates.

The superintendent shall also consider, in establishing such regulation, whether premium rates unfairly burden physicians who are initiating their practice, those who are transitioning to retirement or those who practice part-time or hold academic positions.

Insurers shall review merit rating plans which were approved by the superintendent prior to the promulgation of the regulation required by this subsection and shall, before January first, nineteen hundred eighty-six, file with the superintendent statements that their merit rating plans conform with the regulation, or file an appropriate plan or amendments to their existing plans which will bring them into compliance with the standards of the regulation. Any such amendments shall become effective upon approval by the superintendent.

§ 17. Such law is amended by adding a new section three thousand four hundred thirty-seven to read as follows:

§ 3437. Insurance contracts for medical malpractice; availability of additional coverages. (a) Every authorized insurer which issues a policy

of medical or dental malpractice insurance with primary levels of insurance in an amount equal to or greater than one million dollars for each claimant under that policy and three million dollars for all claimants under that policy in any one year must make available, and, if requested by the policyholder, provide coverage of at least one million dollars per claimant and three million dollars for all claimants in excess of such primary levels of insurance. Such insurers shall, subject to the approval of the superintendent, make available and, if requested by the policyholder, provide additional excess coverage in an amount requested by such policyholder.

(b) With respect to the excess coverage and additional excess coverage required to be made available on and after July first, nineteen hundred eighty-five by subsection (a) of this section, the superintendent shall establish and promulgate provisional rates to be charged for such excess coverage and additional excess coverage. The superintendent, subsequent to December first, nineteen hundred eighty-five, shall approve final rates for such excess coverage and additional excess coverage for the period commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred eighty-six. No insurer shall have the duty to file for final rates for such excess coverage or additional excess coverage for the period commencing July first, nineteen hundred eighty-five prior to December first, nineteen hundred eighty-five.

§ 18. Paragraph one of subsection (e) of section five thousand five hundred two of such law is amended to read as follows:

(1) To issue, or to cause to be issued, policies of insurance to physician applicants subject to primary limits specified in the plan of operation not in excess of one million dollars for each claimant under one policy and three million dollars for all claimants under one policy in any one year, and excess coverage as provided in this paragraph. Each applicant shall be entitled to purchase a policy providing primary limits not to exceed one million dollars for each claimant and three million dollars for all claimants in any one year. In addition, any applicant insured by the association in an amount equal to or greater than one million dollars for each claimant and three million dollars for all claimants in any one year, or any other applicant covered under a policy or policies providing such primary levels of insurance against liability for medical or dental malpractice that is issued by an authorized insurer, shall be entitled to purchase a policy from the association providing excess coverage of at least one million dollars per claimant and three million dollars for all claimants in any one year. The association shall, subject to the approval of the superintendent, make available, and if requested by the applicant, provide additional excess coverage in an amount requested by such applicant. With respect to the coverage required to be made available on and after July first, nineteen hundred eighty-five by this paragraph, the superintendent shall establish and promulgate provisional rates to be charged for such excess coverage and additional excess coverage. The superintendent, subsequent to December first, nineteen hundred eighty-five, shall approve final rates for such excess coverage for the period commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred eighty-six. The association shall not have the duty to file for final rates for such excess coverage and additional excess coverage for the period commencing July first, nineteen hundred eighty-five and prior to December first, nineteen hundred eighty-five.

§ 19. Every general hospital which maintains facilities for providing emergency medical care shall purchase a policy for excess insurance coverage, as authorized by paragraph one of subsection e of section five thousand five hundred two and section three thousand four hundred thirty-seven of the insurance law, or shall provide equivalent excess coverage in a form approved by the superintendent of insurance, for medical or dental malpractice occurrences between July first, nineteen hundred eighty-five and June thirtieth, nineteen hundred eighty-six for physicians or dentists requesting such coverage and having professional privileges in such hospital who, from time to time, provide emergency medical or dental care in such hospital to persons who require such care, provided, however, that such physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million dollars for each claimant and three million dollars for all claimants under that policy during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage must, when combined with the physician's or dentist's primary malpractice insurance coverage, total an aggregate level of two million dollars for each claimant and six million dollars for all claimants from all such policies with respect to occurrences in such year. In the event that a physician or dentist has professional privileges in more than one hospital, such excess coverage shall be purchased or provided by the hospital designated by such physician or dentist as the hospital with which the physician or dentist is primarily affiliated.

§ 20. Notwithstanding the provisions of subdivision five of section twenty-eight hundred seven-a of the public health law, the commissioner of health or his designees shall adjust the inpatient revenue cap for those general hospitals which are required to purchase a policy for excess insurance coverage for medical malpractice occurrences or who provide equivalent excess insurance coverage pursuant to section nineteen of this act. An adjustment shall be made to the inpatient revenue cap of such hospitals to reflect the cost of such excess coverage for the period of July first, nineteen hundred eighty-five to December thirty-first, nineteen hundred eighty-five. Such adjustment shall be made by the commissioner of health within sixty days of submission of adequate evidence of costs incurred for such excess coverage.

§ 21. Notwithstanding the provisions of article twenty-eight of the public health law[1] relating to rate adjustment, the commissioner of health or his designee shall adjust the established rate for those general hospitals which are required to purchase a policy for excess insurance coverage for medical malpractice occurrences or who provide equivalent excess coverage pursuant to section nineteen of this act. An adjustment effective January first, nineteen hundred eighty-six, shall be made to the established rate to reflect the cost of such excess coverage for the period January first, nineteen hundred eighty-six to June thirtieth, nineteen hundred eighty-six and shall not be carried forward.

[1] Public Health Law § 2800 et seq.

§ 22. The chief administrator of the courts shall conduct a study of the impact of section fourteen of this act upon the disposition of medical malpractice actions in the fifth judicial district and in the county of Suffolk, as compared to medical malpractice actions in the seventh judicial district and in the county of Nassau. On or before January first, nineteen hundred eighty-eight, the chief administrator shall pre-

Additions in text indicated by underline;

pare and transmit to the legislature, the governor and the chief judge of the court of appeals a report of his findings, including but not limited to numbers of actions brought, the speed with which cases reached final disposition, and the impact of the panels on the adjudication of the action, together with any appropriate recommendations.

§ 23. Severability. If any provision of any section of this act shall be held void or unconstitutional, all other provisions and all other sections of this act which are not expressly held to be void or unconstitutional shall continue in full force and effect.

§ 24. Appropriation. The sum of two million dollars ($2,000,000), or so much thereof as may be necessary, is hereby appropriated to the department of health from any moneys in the state treasury in the general fund to the credit of the state purposes account not otherwise appropriated, to improve and expand the operations of the office of professional medical conduct. Such sum shall be payable on the audit and warrant of the state comptroller on vouchers certified or approved by the commissioner of health, or his duly designated representative in the manner prescribed by law.

§ 25. This act shall take effect July first, nineteen hundred eighty-five; provided, however, that: section four of this act shall be applicable to any actions commenced on or after such date; sections five, six, seven, eight, nine and ten of this act shall be applicable to any action for dental or medical malpractice commenced on or after such date; section fourteen of this act shall apply to medical malpractice actions for which a medical malpractice panel hearing has not been conducted by such date; section fifteen of this act shall be applicable to any retainer agreement executed on or after such date; section three thousand four hundred thirty-seven of the insurance law, as added by section seventeen of this act, shall be of no further force or effect on and after July first, nineteen hundred eighty-six when upon such date such section of the insurance law shall be deemed repealed; the amendment made by section eighteen of this act to paragraph one of subsection (e) of section five thousand five hundred two of the insurance law shall be of no further force or effect on and after July first, nineteen hundred eighty-six when upon such date the provisions of paragraph one of subsection (e) of section five thousand five hundred two of the insurance law as they existed immediately before the effective date of section eighteen of this act shall be deemed revived and in full force or effect on and after such date; section nineteen of this act shall be of no further force or effect on and after July first, nineteen hundred eighty-six; section twenty of this act shall be of no further force or effect on and after December thirty-first, nineteen hundred eighty-five; and except that section twenty-one of this act shall take effect on January first, nineteen hundred eighty-six and shall be of no further force or effect on and after July first, nineteen hundred eighty-six.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEMORANDUM

Series - 85 - 100
Date - 9/30/85

HEALTH FACILITIES SERIES: H - 61

SUBJECT: Incident Reporting for Hospitals

At the June 27, 1985 State Hospital Review and Planning Council meeting, Section 405.37 Incident Reporting of 10NYCRR was adopted. Section 405.37 requires the timely telephone reporting to the appropriate Area Office of the Office of Health Systems Management (OHSM) by hospitals of emergencies and other incidents which threaten the safety of the patients or the staff in the hospital. The objective of the new regulations is to assure quality care to all patients in hospitals. The primary function of the reporting of certain events or situations is to enable the Office of Health Systems Management to ensure that hospital administrators and their staff become aware of problems, take corrective measures, and minimize the potential for recurrence of the same or similar events or situations. The prompt reporting of incidents which have threatened the safety of patients can ensure that immediate steps are taken to protect other patients from exposure to the same or similar risk. Furthermore, the reporting of such events or situations in an orderly and uniform manner facilitates the identification of trends, both within a specific hospital and on a statewide basis, which ultimately will foster the development and implementation of preventive strategies.

The regulations will be filed with the Secretary of State during September in order to be effective October 1, 1985.

Provisions of the Regulations

The new regulations have added the following requirements:

- Incidents to be reported include:

  1. patients deaths or impairments of bodily functions in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards;

  2. fires in the facility which disrupt the provision of patient care services or cause harm to patients or staff;

  3. equipment malfunction during treatment or diagnosis of a patient which did or could have adversely affected a patient or health facility personnel;

4. poisoning occurring within the facility;

5. strikes by facility staff;

6. disasters or other emergency situations external to the hospital environment which affect health facility operations; and

7. termination of any services vital to the continued safe operation of the health facility or to the health and safety of its patients and personnel, including but not limited to, the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food, or contract services.

- Such incidents must be reported to the appropriate OHSH Area Office within 24 hours of the occurrence or of the hospital's knowledge of such an occurrence.
- Within five days of the initial notification, the hospital must submit written notification of the incident to the OHSH Area Office.
- Hospitals must perform internal investigations of incidents described by the first four categories.
- The written notification of the incident submitted to the OHSH Area Office must include a completion date for the hospital's internal investigation of the incident.
- Within 24 hours of that completion date, the hospital must provide the Area Administrator of the OHSH Area Office with a copy of the report of the hospital's internal investigation.
- The Department of Health maintains the authority to investigate incidents at any time.

Persons Required to Report

The hospital administrator or his/her designee, as the representative of the governing body of the hospital, should submit the report. While the hospital administrator shall be responsible for assuring that the Department is notified of all incidents required by the regulations, this would not preclude the Department from accepting and investigating reports from any (professional or other) employee of the facility.

Guidelines

The regulations require the prompt reporting of a range of seven different types or categories of incidents. In order to facilitate the reporting requirements for hospitals, the following guidelines for each type of the reportable incidents have been developed.

The regulations require the reporting of

1. "patients deaths or impairments of bodily functions in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards." This category of incidents to be reported should be limited to those events or occurrences which have caused or contributed to actual harm to patients including those incidents which might prolong hospitalization, which might cause greater complications in the patient's (response to the) treatment regime, which might be of a long-term or lasting nature, which might be life-threatening or cause major changes in the patient's status, or which might require transfer to a facility or unit providing a more intense level of care. The following examples represent a few of the incidents which would fit this category if they occur in the hospital.

   - Anesthesia incidents resulting in coma, permanent disabilities, or death.
   - Patient arrests during surgery due to improper intubation.
   - Medication error resulting in coma, permanent disabilities, allergic reactions, death.
   - Adverse medication reaction resulting in anaphylactic shock.
   - Patient falls resulting in fractures.
   - Rapes, molestations or assaults to patients (including child abuse) in the hospital.
   - Suicides and attempted suicides.

2. "fires in the facility which disrupt the provision of patient care services or cause harm to patients or staff." The following examples represent a few of the possible events which would be included in this category of incidents.

   - A fire which requires the evacuation or relocation of patients from a room, a floor, a wing or a building.

   - A kitchen fire which closes the hospital kitchen, and requires the hospital to use the services of an outside dietary supplier.

   - A fire which causes any patient services to be delayed for an hour or more.

3. "equipment malfunction during treatment or diagnosis of a patient which did or could have adversely affected a patient or health facility personnel." The incidents which require reporting under this category of incidents involve harm to patients or failure to provide needed services on a timely basis to patients because of equipment malfunction. Types of equipment which might malfunction and adversely affect patients and would be reported under this category of incidents are:

   - Automatic medication administration machines

   - Respirators

   - Patient monitoring equipment

   - Dialysis equipment

   - Anesthesia equipment

4. "poisoning occurring within the facility." This category of reportable incidents involves contaminated (bacteriological or chemical) water supply, food and drugs, as well as lethal medication errors which would also be reportable under the first category of incidents.

5. "strikes by facility staff." This category of reportable incidents includes all facility employees and all staff associated with the hospital. These incidents should be reported at the time of the hospital's receipt of the ten day strike notice or at the start of an unannounced strike.

6. "disasters or other emergency situations external to the hospital environment which affect health facility operations." This category of incidents which must be reported includes any external event which affects the hospital's ability to meet patient care needs. The following examples represent a few of the events which fit this category when they adversely affect facility operations:

   - Snow emergency
   - Chemical spill/exposure
   - Contamination of water supply
   - A major fire/explosion
   - Flood

7. "termination of any services vital to the continued safe operation of the health facility or to the health and safety of its patients and personnel, including but not limited to, the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food, or contract services." Incidents included in this category require reporting when other arrangements to maintain services or to re-initiate services promptly cannot be established.

It must be noted that the examples provided following the seven categories of incidents which must be reported to the New York State Department of Health, are offered as guidelines to assist hospital staff in determining if an event is a "reportable" incident. These examples are not intended to serve as exhaustive or all inclusive listings. It is suggested that hospitals contact their Area Office of the Department of Health to request assistance in determining if a questionable event is indeed "reportable".

Reporting Procedure

- How to Make Reports

Reports of incidents as defined in the regulations should be made within 24 hours of occurrence or of the hospital's knowledge that a reportable incident has occurred to the Office of Health Systems Management of the NYS Department of Health. During regular working hours (8:00 a.m.-5:00 p.m.), calls should

be made directly to the appropriate Area Office of the Health Department. Telephone numbers for each Area Office are listed at the end of this memorandum. If telephone reports must be made after-hours, the contact number is the OHSH Hotline (518) 445-9989.

The person making the telephone report must provide the following pertinent information:

a. The name and address of the hospital.

b. A brief description of the incident, including a description of the patient(s)' condition(s) following the incident and some indication of the severity of the incident.

c. Date and time of incident.

d. The name, title and work telephone number of the person making the report.

e. Medical record numbers of any patients involved in the incident.

f. Names and titles of any hospital staff involved in the incident.

g. Location of incident.

h. Medical record numbers of any patient witnesses to incident.

i. Names and titles of any hospital staff who were witnesses to incident (include relationship to patient if any).

j. Any corrective actions taken immediately.

k. Any other pertinent information which is not requested specifically but which may be significant.

- Written Reports

The initial telephone notification regarding an incident must be followed up within five days, with a completed Written Notification Form (copy attached) submitted to the appropriate Area Office. A supply of the Written Notification Forms will be made available to each hospital for this purpose. The hospital is required to include a completion date for the hospital's investigation of certain incidents in accordance with the requirements of the regulations.

- Hospital Investigation

Hospitals are required to conduct internal investigations of all incidents which fall into the following categories:

1. patients deaths or impairments of bodily functions in circumstances other than those related to the natural course of illness, disease, or proper treatment in accordance with generally accepted medical standards;

2. fires in the facility which disrupt the provision of patient care services or cause harm to patients or staff;

3. equipment malfunction during treatment or diagnosis of a patient which did or could have adversely affected a patient or health facility personnel; and

4. poisoning occurring within the facility.

As stated earlier in this memorandum, hospitals are required to include a completion date for their investigation of the four categories of incidents which require internal investigations, on the Written Notification Form. Thereafter, a copy of the completed hospital investigation report will be expected by the Area Office within 24 hours of that completion date.

The Investigation Report completed by the hospital must include the following items:

a. Facility name, address and telephone number.

b. The date and time the Area Office was initially notified of the incident (telephone notification).

c. A detailed description of the incident, including a description of the patient(s)' condition(s) following the incident.

d. A description of any/all follow-up care provided (including x-rays and other diagnostic procedures and results) with dates and times in relation to the occurrence.

e. Post-incident diagnosis.

f. Present condition of individual(s) involved in the incident.

g. Investigation summary.

1. Chronology of steps taken to investigate incident (include any interviews and record/document reviews).

2. Review of findings/conclusions as to cause.

3. Review of any/all actions taken to prevent recurrence of incident or similar incidents.

4. Listing of any hospital committees which have reviewed or will review the incidents and the dates scheduled for the review(s).

h. Name, title, and signature of individual completing this report.

The addresses and telephone numbers of the Office of Health Systems Management Area Offices are:

Albany Area Office
Building #7A, State Campus
Albany, New York 12226
Attention: Area Hospital
Program Director
(518) 457-2910

Buffalo Area Office
584 Delaware Avenue
Buffalo, New York 14202
Attention: Area Hospital
Program Director
(716) 847-4357

Rochester Area Office
Bevier Building
42 South Washington Street
Rochester, New York 14608
Attention: Area Hospital
Program Director
(716) 262-2010

Syracuse Area Office
677 South Salina Street
Syracuse, New York 13202
Attention: Area Hospital
Program Director
(315) 428-4757

New Rochelle Area Office
145 Huguenot Street-6th Floor
New Rochelle, New York 10801
Attention: Area Hospital
Program Director
(914) 632-3701

New York City Area Office
116 West 32nd Street
New York, New York 10001
Attention: Area Hospital
Program Director
(212) 502-0829 or
(212) 502-0820

Attached to this memorandum are the following:

- A copy of the incident reporting regulations, 10NYCRR 405.37.
- An initial supply of the Written Notification Report Forms.

All inquiries or questions concerning this memorandum, should be addressed to the Bureau of Hospital Services, Room 2038, Corning Tower, Empire State Plaza, Albany, New York 12237, telephone number (518) 474-5013.

David G. Starks
Deputy Director for Health Care
Standards and Surveillance

ENDORSED BY:

Raymond Sweeney
Director
Office of Health Systems Management

DISTRIBUTION: All General Hospitals
and Other Interested Parties

JOINT COMMISSION ON
ACCREDITATION OF HOSPITALS

1984 ANNUAL REPORT SERIES STATISTICAL TABLES

The statistical tables in this section are available by health service area, county and hospital. For your convenience, an order form is included at the end of this report series

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21C Home Health Services, Other Institution, Left Against Medical Advice and Died

TESTIMONY

OF

HOSPITAL ASSOCIATION OF NEW YORK STATE

June 6, 1988 Hearing

as Conducted by the Subcommittee on Natural Resources, Agriculture Research, and Environment of the House Committee on Science, Space and Technology

QUALITY OF MEDICAL CARE AND INFORMATION TO CONSUMERS

74 N. Pearl Street, Albany, New York 12207 518/434-7600

PRESENTOR BIOGRAPHY

CAROLYN F. SCANLAN is the Executive Vice President of the Hospital Association of New York State and was appointed to her position with the Association in January 1987. In addition to serving as HANYS' Executive Vice President, Ms. Scanlan serves as the Chief Executive Officer of the Hospital Educational and Research Fund (HERF), which is affiliated with HANYS. Prior to her appointment with HANYS, Ms. Scanlan served as Vice President of Clinical and Ambulatory Services at St. Peter's Hospital, a 437-bed facility in Albany. For 15 years, Ms. Scanlan was employed by the New York State Department of Health, where she held a variety of positions. Her last position with the Department was as Assistant Director of the Division of Health Care Standards and Surveillance for the Office of Health Systems Management, where she was responsible for oversight of the quality and scope of patient care services provided by all licensed health care facilities in New York State. Ms. Scanlan holds a B.A. in Psychology from Skidmore College and an M.S. in Health Services Administration from Russell Sage College.

I am Carolyn F. Scanlan, Executive Vice President of the Hospital Association of New York State (HANYS). On behalf of our 300 non-profit, voluntary and public hospitals and related health care facilities, I would like to thank Congressman Scheuer and the other members of this Subcommittee for the opportunity to testify before you in regard to our Association's initiatives to assure the highest standards of care within New York State hospitals.

Hospital associations have an obligation to encourage and support hospitals in their roles of providing high quality health care. Today, that mission takes on new importance as rising public expectations and increasing governmental scrutiny combine to put quality issues in the spotlight. In New York State, a continuous, public focus on the delivery of quality care makes it imperative that the Hospital Association of New York State provide leadership in defining, measuring, and ensuring high standards of quality care.

The capabilities of New York's hospital system, enhanced by the latest medical technologies, have never been greater, and the quality of care has never been better. However, the same technological advances that have expanded our abilities, have also begun to focus in on problem areas. As such, problems that formerly went unnoticed now can be highlighted, dissected, analyzed, and publicly displayed.

As a result, HANYS has undertaken a major quality assurance initiative. The primary goal of this initiative is to help hospitals effectively implement approaches to patient care monitoring and quality assurance. The basic objectives of quality assurance is to identify and resolve problems in patient care and to identify and take advantage of opportunities for improvement in care. Increased scrutiny of hospitals by regulatory agencies, rising public

expectations, and continued modifications to state regulations and surveillance protocols make it imperative that the hospital community develop a coordinated approach to the monitoring of patient care.

HANYS' goals include:

- direction and guidance in the collection and analysis of data to identify patterns and trends that indicate both problem and "best practice" areas;
- provision of advice and direction in the initiation and coordination of education of hospital staff and trustees, promotion of public awareness, and advocacy efforts with the New York State Department of Health and other agencies;
- serving as the catalyst for the formation of an independent, private-sector research institute on quality, which will develop objective quality of care measurements.

RESEARCH AND EVALUATION

HANYS has worked with various oversight agencies to identify, collate, and evaluate information collected to identify patterns and trends that might indicate both problem and "best practice" areas. In New York State, uniform data are collected on all patient discharges (SPARCS data system).[1] HANYS is using these data to generate reports to perform quality assurance reviews. The reports permit hospitals to compare their individual experiences against regional and statewide norms in categories of DRGs, major clinical classifications, admission type, specific disease categories, surgical procedures, payer status, etc.

Through examination of hospital specific and regional data, hospitals can begin to compare their individual experiences with a

regional "norm." As with all statistical information, it is important to remember that data cannot be judged at face value but, rather, must be interpreted in light of the particular characteristics of each institution. It is difficult to compare individual hospitals because patient mix may vary. These reports are a useful tool for identifying institutional variances from an aggregate norm. Once identified, variances can be referred to the appropriate individuals and committees within the hospital for explanation. Reasons for some discrepancies will be readily apparent to individual facilities. Other variances may require a more critical look at health care practices. Based upon the findings, appropriate action can then be taken to ensure the provision of high quality care. Hospitals can use the information contained in the reports as an internal quality assurance tool to assess their own performance, in the risk management process to monitor areas where there appears to be an increased exposure to liability such as surgical related complications, and to develop practitioner profiles as required by the regulatory agencies.

As one of its first quality assurance activities, HANYS surveyed hospitals statewide to ascertain current quality assurance practices and procedures. Member facilities completed a detailed survey on essential lines of communication, required data sources, documentation requirements, and the role and responsibilities of the medical staff, hospital administration, and governing body. The results of this survey are being used to:

- assess the scope and effectiveness of hospitals' existing quality assurance programs,

- evaluate the uniformity of existing efforts,
- identify any program or gaps needs, and
- identify approaches that are effective and upon which hospitals can build.

INFORMATION SYSTEMS AND PRODUCTS

HANYS is extending its network of resources to include the manufacturing sector by developing relationships with leading businesses that have promoted quality in the manufacturing industry. HANYS hopes to learn from these groups' experiences and to adapt them to gain valuable insights and available techniques that might relate to quality of care.

To meet the demands of member hospitals for high quality consulting services in the quality assurance arena, HANYS directed its fee-for-service divisions to focus new product development and new services on quality assurance, risk management, and utilization review. HANYS Utilization Information Service staff evaluated several commercial products and have now introduced a PC-based system for customized hospital utilization management. The service has also become associated with a software vendor that offers an automated system for quality assurance and related functions. In addition, the service has expanded its quality assurance consulting capacity, and adjunct physician consultants have been used more extensively in the consulting service.

EDUCATIONAL PROGRAMMING

HANYS will continue to identify the nature and needs of the various audiences to be educated (physicians, nursing staff, quality assurance professionals, utilization review coordinators, and board

members). During 1987, HANYS's Hospital Educational and Research Fund presented programs that updated and educated 3,000 people on the subject of hospital quality assurance techniques and DOH initiatives, and anticipates an ambitious plan for continued programming for 6,000 participants during 1988.

PUBLIC AWARENESS

Because quality has become an increasingly important concern, hospitals must be prepared to collect, analyze, understand, and explain available data on the delivery of care. HANYS assists hospitals as issues continue to effect the public's perception of the quality of care.

HANYS continues to work with the public affairs staff of the New York State Department of Health and the federally-designated Peer Review Organization to develop equitable information procedures. HANYS is emphasizing the need for regulatory policies and procedures on the release of information to the media and public, and for cultivating a positive working relationship so that the information can be released in an appropriate manner.

Finally, HANYS will develop relationships with consumer groups across the state. Meetings with these groups should enable the mutual dissemination of information and promote the discussion of issues related to patients' rights and responsibilities.

RESEARCH INSTITUTE

HANYS is exploring the feasibility of establishing a New York State Research Institute on Quality. First, in order to put this feasibility study in perspective, HANYS is conducting an environmental assessment delineating the variety of activities

currently in process nationally. As one reviews these other activities, the following themes appear:

- the emphasis on measurement of quality;
- the move toward outcomes of care;
- the impact of PPS on the organization, delivery, and quality of services;
- the interface of hospital and alternative delivery systems and its impact upon quality; and
- the consumer perspective and thirst for data relative to hospital performance (including quality).

The HANYS Institute would undertake research that includes scientific analysis to identify key indicators of morbidity and mortality so that outcomes can be measured and the quality of hospital care improved. The institute will call upon known medical and educational experts to derive long-range implications and applications for measuring, assessing, and assuring quality of care within hospitals. Major philanthropic foundations and corporations, and HANYS's membership will provide required financial support. Even though the establishment and productivity of such an institute will take a long time, HANYS is stressing the importance of its success because of the challenges it presents.

Now to the questions raised by this Subcommittee in regard to how information about the quality of medical care can be compiled and made available to the public. As has been discussed, HANYS has begun work to analyze data for use by hospitals in their quality assurance processes. Additionally, HANYS feels that additional development

work needs to be performed in regard to how to assess, measure and reflect further data elements. These would include -

- Concurrent Quality Assessment Review Model. A concurrent review system by definition must be able to identify and take corrective action by intervening while a patient is still under treatment. Ideally, review should occur while a patient is in the hospital; realistically, in this era of decreasing lengths of stay and increasing ambulatory care options, concurrent review may be one of the few ways of realistically identifying problems or opportunities to improve care; the other way is the use of retrospective review. In addition, such a system must not only monitor quality of care but must also "manage" quality. Thus, the term "quality management" is used to reflect the administrative and clinical management of the integration and assessment of clinical case review, utilization review, risk management, infection control, and other review activities such as hospital-wide quality assurance, as well as the administrative and clinical management of these functions. HANYS is preparing such a review model to be released in the fall of this year.
- Organizational Indicators. Based on the premise that hospitals are complex organizations in which a variety of inputs, processes, and structures produce outcomes, it is necessary to explore what is the type and nature of information that trustees, chief executive officers, and medical staffs require in order to make informed decisions as well as to exercise their relative responsibility for

quality care. Three basic questions must be addressed:

1. How does the hospital's hierarchy determine that appropriate systems are in place to identify opportunities to improve care?
2. Given that appropriate systems are in place, are individual incidents aberrations or do they represent a consistent pattern?
3. What type of assistance through education, technical assistance, and advocacy can JCAHO and HANYS provide hospital trustees, CEOs, and medical staffs?

- Clinical Indicators. The JCAHO's "Agenda for Change" through its clinical indicator task force is identifying indicators in an on-going basis in a variety of clinical areas. These are being tested in a sample of hospitals, one in New York State. These clinical indicators will further hospitals' abilities in describing care.
- Access and Continuity of Care. As hospital length of stay declines and as a variety of ambulatory and non-acute care services are provided outside the hospital, it increasingly becomes difficult to determine quality outcomes. Standards and methodologies are needed to assist in the tracking and identification of problems and opportunities to improve outcomes when care is provided across settings.

These research activities will include a variety of factors including the importance of data integrity. Central to this are two concepts -- reliability and validity. In fact. they are basic to the understanding of any data. Reliability answers the question -- if we

measure the same set of objects again and again with the same or comparable measuring instrument, will we get the same or similar results? This question should be answered as development of indicators and criteria continue. Validity may be defined simply as the extent to which the instrument actually does what it purports to do. It should be noted that while validity is dependent upon reliability, it is independent of reliability.

This additional data will enable hospitals to better understand themselves. The development of these valid and reliable indicators will also enable hospitals to technically describe themselves to others.

However, it is not clear that these types of data help the public make reasonable and informed choices in regard to medical care. Indeed, who is the public and what is its expectations? The use of the phrase consumer is the new way to describe the patient; i.e., the individual who has or will need to seek medical treatment from a hospital and physician on either an emergency or scheduled basis. "Consumers select providers based on imperfect information, and the extent of their rational (and semirational) search behavior suggests an ongoing process in which they seek to balance their priorities among technical quality (for example, outcome statistics), personal care-giving quality, and out-of-pocket-price."[2] The challenge, therefore, is how to provide the technical quality data to consumers.

HANYS believes that more empirical data should be provided to the public; but how and in what format? Chapter 2 of the United States Congress, Office of Technology Assessment report, "The Quality of Medical Care: Information for Consumers," accurately describes the

dilemma - "Although quality-of-care information is increasingly being generated for public use by government agencies, consumer organizations, the popular press, and health care organizations, much of the information is unevaluated, not systematically produced and disseminated, expensive to acquire, or difficult for lay people to interpret."[3]

For example, when HCFA released the December 1987 mortality data, HANYS stated concern with the methodology and its explanation to the public. These concerns included:

- One of the stated purposes of the data release was to provide consumers with comparative information which would enable them to make quality judgments about providers. HCFA itself admitted the limitations of a model of this type and the potential for misinterpretation by consumers and the media, but did not indicate what steps would be taken to preclude inappropriately simplistic evaluations and superficial attributions to elements not captured by the model.

  A statement of the uses and limits of the analysis for determining quality of care needed to be clearly documented in understandable language. Consumers had to be able to understand how the findings could be interpreted, and perhaps more importantly, what interpretations would exceed the predictive capabilities of the model.

- Over the long term, the purpose of the data release should be to assist providers in developing and monitoring the effect of policies of practice which lead to high quality

care. In order to themselves interpret the meaning of the data, hospitals must be able to link their aggregate mortality performance to their own medical records in order to separate potential quality problems from cases where post-hospital mortality is clearly unrelated to care in the hospital.

- There were substantial problems with the model in terms of the variables which had or had not been included to capture patient characteristics. HCFA indicated that many of the factors affecting the probability of death were not included because information was not readily available. If important elements which effect the probability of mortality could not be incorporated, then that seriously compromised the meaningfulness of the data and called into question whether actual mortality data should be compared to "predicted" mortality at all, since the non-technical user will take those "predictions" at face value.
- Finally, regardless of what methodology was utilized to develop a prediction of expected mortality for comparison to actual mortality, the strength of the connection between mortality and quality of care was not established. HCFA itself addressed this point in the Federal Register, admitting that "a difference between a hospital's actual and expected mortality rates cannot be definitely construed as reflecting especially high or low quality of care. This difference may, in fact, result from factors not included in the predictive model."

This was something of a disingenuous admission on HCFA's part, since HCFA was fully aware, having undergone the experience of the first data release, that that was precisely the interpretation that would be placed upon the data by the non-technical user, i.e., that a large difference between expected and actual mortality means that the quality of the institution was suspect. Release of this mortality data needed the adjustments of the above items in order to make it understandable and usable by consumers.

Similarly, in June of this year, the New York State Department of Health plans to publish a detailed statistical review of hysterectomy operations performed at acute care hospitals in New York State. The Department has issued similar reports on Cesarean childbirth and those published on cardiac surgery by the Department's Cardiac Advisory Committee. This current report is based upon the SPARCS data (see Footnote 1). HANYS believes that SPARCS' data can be put to a range of public health uses by institutions, practitioners, consumers, academics and many others. As regulators and analysts, the Department can be expected by the public to identify and build upon insights provided by these data. The public at large can utilize these data as well, to better understand public health issues and questions vital to their own individual health status.

As the Office of Technology Assessment report suggests, current methods of data aggregation are incomplete and untested as to validity and reliability. In this instance, receipt of such information in regard to specific hospital rates does not take into consideration individual provider characteristics, such as patient

severity of illness factors, which effect the need and, therefore, number of these surgical procedures. Additionally, without a universal norm of an acceptable rate, the numbers released have no benchmark for comparison.

Despite these problems, HANYS believes that the public's rights to knowledge obligates government and providers to release these types of data. Perhaps a steady release of selected data will "de-mystify" what has been considered "secrets of hospitals."

The New York State Department of Health Consumer Health Information Council has begun to tackle these issues in attempts to define who the consumer really is and what information consumers want or should know to ask for. HANYS, while not a member of this Council, regularly attends its meetings and welcomes the development of a statewide policy on the dissemination of reliable and valid data which will foster informed consumers. The recent pamphlet, "Understanding AIDS: A Message from the Surgeon General," is an example of informative, concise information sharing. More of this kind of public data sharing can only help to enhance the knowledge of the health care system.

We must be cautious of the release of data for the sake of its release. The use of specific criteria, while important, may overwhelm other critical operational concerns. For example, continued bombardment of the public with negative information in regard to hospitals and physicians only serves to heighten distrust and cynicism in regard to the health care system. It also continues to discourage students from entering nursing schools and other health care professional training centers and creates negative-image work places for current health care professionals. This type of data

sharing is unacceptable, is not informative to the public, and does not enhance overall knowledge about hospitals.

The use of single statistic releases; e.g., airplane company on-time rates; may create perverse incentives for compliance or "good records," at the sake of other less publicized activities; e.g., hours of maintenance. In seeking useful, but simple, measures for consumers to understand, caution must be used in their creation.

SUMMARY

Much work is currently underway to improve quality assessment techniques. Continued support of this research, and the development of rigorous scrutiny of their reliability and validity will lead to enhanced data for the public domain.

Hospitals must continually evaluate their performance in order to achieve their mission of providing quality patient care. These evaluations should include analysis of data gathered both from within and outside the organization. Hospitals have available a wealth of data with which to evaluate relative performance and quality of care. However, these data only become usable as information after they have been interpreted within the context of the organization and relevant contributing factors. By properly integrating and interpreting performance data, hospitals will have the ability to strategically position themselves as advocates of information. This informtion will not only enable the hospital to better monitor and improve the care it provides, it will also help consumers make informed health care decisions.

Footnotes

1 Since 1979, the State has operated the Statewide Planning and Research System (SPARCS). SPARCS receives, processes, stores, and analyzes inpatient data from all general hospitals and links the functions of healthcare resource planning, financing, and surveillance of hospital services in New York State. SPARCS was designed to make use of existing data sources to the greatest extent possible to minimize duplicative reporting requirements. SPARCS collects data from two sources: the Discharge Data Abstract and the Uniform Billing Form. The largest segment of SPARCS users consists of hospitals requesting their own data and management consultants acting on behalf of their client hospitals. This is also a role played by HANYS. The second most frequent user of SPARCS data is the New York State Department of Health.

2 Eastaugh, Steven R., Sc.D., "Hospital Quality Scorecards, Patient Severity, and the Emerging Value Shopper," Hospital & Health Services Administration, November/December 1986, pg. 92

3 United States Congress, Office of Technology Assessment, "The Quality of Medical Care: Information for Consumers," United States Government Printing Office, June 1988, pg. 33.

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SUBCOMMITTEE ON NATURAL RESOURCES, AGRICULTURE
RESEARCH AND ENVIRONMENT

Hearing on The Quality of Medical Care;

Information for Consumers

June 6, 1988

Testimony of

Hospital Trustees of New York State

The Quality of Medical Care; Information for Consumers

Testimony of Hospital Trustees of New York State

June 6, 1988

House Subcommittee on Natural Resources, Agriculture Research and Environment

Hospital Trustees of New York State is a statewide organization representing 175 voluntary and municipal hospitals and their 4,000 trustees in the state of New York. Hospital Trustees was begun in 1980 to strengthen the governance capabilities of hospital trustees. We address this goal through the improvement of educational opportunities for trustees, by assuming an active role in shaping health policy, and by promoting the development of cooperative and complementary roles for trustees, administrators, and medical staffs. Our priority for 1987 and beyond has been to assist hospital trustees in the development of sound quality assurance monitoring systems. Our initiatives in this area have provided us with information which relates directly to the topic of this hearing, and we thank the Subcommittee for the opportunity to address the issue of consumer information on the quality of medical care.

The Role of a Hospital Trustee

First, however, I think it is important to understand what a hospital trustee is and the role that this individual plays since their role is a critical element in both the assessment and assurance of quality medical care. A hospital trustee in our state is a volunteer who gives his or her time to a hospital through service on a board in order to make the hospital and the health care delivery system of the community better. The concept of public trust from which the word "trustee" is taken evolves from our historical creation of public charities, or institutions which benefit the public generally. In the exercise of the public trust, the trustee has two primary and complementary duties:

1. To maintain, utilize and protect the resources of the hospital corporation; and,

2. To exercise corporate responsibility for all medical staff actions and for maintaining a documented monitoring system for assuring the quality of patient care.

A governing board of a hospital meets the quality assessment and assurance goal through performance of specific tasks:

1. Ensuring that credentials are reviewed and privileges are granted and renewed based on the demonstrated professional competence of the health care practitioners involved;

2. Making certain that the hospital's quality assurance program effectively identifies, assesses, and resolves patient care problems;

3. Monitoring institutional liability experience and taking required actions to reduce exposure and loss; and,

4. Ensuring that employees are retained and promoted on the basis of demonstrated competence and acceptable performance.

These activities are central to hospital boards throughout the country. In New York State, however, we have specific requirements which were instituted to prevent medical malpractice. These requirements mandate the creation of a Qualtiy Assurance Plan and a multidisciplinary Quality Assurance Committee, one member of which must be an uncompensated trustee.

In addressing the topic of consumer information on the quality of medical care, we would like to point out that the trustee of a hospital serves as the link to the community. The trustee is a consumer of health care services who plays a unique role in that they are more involved in the affairs of the hospital than the average consumer. This is an important distinction because it allows us to view this topic from the vantage point of the trustee to see how this particular consumer utilizes information on medical care quality to make the hospital a better place for other consumers. It is from this perspective that we offer our comments regarding consumer information on the quality of medical care.

The Quality Assurance Activities of Hospital Trustees of New York State

Hospital Trustees of New York State recently completed a study of five hospitals to review the structures utilized by hospitals to assess and assure quality, the ways in which board members get information on quality, and how specific problems are solved once they are identified. We specifically chose five different types of hospitals: a 700 bed academic teaching center in upstate New York,

a 500 bed community hospital on Long Island, a 160 bed rural hospital in upstate New York, a 600 bed teaching hospital in New York City, and a 200 bed community hospital in Rochester. One of the hospitals had implemented a computerized severity of illness outcome measure assessment program. One had purchased another product which utilizes occurrence screens and clinical indicators. All of the hospitals had made substantial changes in their quality assurance programs as a result of their increased understanding of the process needed for quality assessment. We also found that each of the hospitals were substantially different in the ways in which they had structured their quality assurance programs and that the structures were selected for reasons specific to the institution.

From our study, we found that the following were important to the success of the quality assurance process:

- The technology is available to assist hospitals with the establishment of computerized systems for monitoring;

however, there has been some delay in selecting systems due to the fact that quality assessment is evolutionary and that many hospitals have awaited the development of the indicators being proposed by the Joint Commission on Healthcare Organizations.

- The most important element in successful quality assessment and assurance is communication. Trustees bear the ultimate authority for decisions which are clinical in nature. In order to exercise this responsibility in a reasonable manner, they need information in a form which assists in identifying trends and patterns in care. Trustees are policy-makers and monitors in this activity. Physicians are clinicians who are trained to look at the specific. Putting information in a form which physicians and trustees can use is essential for appropriate review and decision-making.

- Effective quality assurance systems integrate quality assurance activities with medical records, utilization review, risk management and infection control. In addition, the overall effectiveness is dependent upon the necessary level of staffing.

- Hospitals which have devoted both time and resources to sophisticated quality assurance programs have learned that resolving problems at the lowest level in the organization assists with the processing of information. This allows the action taken to be reported and pushes the policy decisions to those individuals who have the authority in the institution.

- Much of quality assurance is focused on the physician in the hospital setting. Fully integrated and effective systems have also included nursing in the process in a form that allows them to be active partners in quality management.

- In all of the hospitals studied, the chief executive officer took an active role in the development of the Quality Assurance Plan and its implementation. The administrative staffs worked together as a team dedicated to improving the system where possible.

- The quality assurance professional in a hospital is an indispensible part of the system. The hospitals studied rely upon their quality assurance departments and professionals for not only support to the system but daily implementation.

- Successful implementation of a quality assurance system also depends upon education. The education must be ongoing and must give all the participants in hospital services an idea of what is expected of them. Successful committee work depends in part upon a review of the requirements plus examples of the format to be used for reporting actions taken.

The medical staff plays a major role in managing quality assurance. It is, however, sometimes the medical staff which must be convinced of the value of the new approaches to quality assurance. Tradition is a powerful determinant and medical staff members are mindful of their organizational culture. They are also, unfortunately, well aware of the potential for

litigation -- whether it is a medical malpractice action taken by a patient or a restraint of trade action taken by a fellow physician whose privileges have been restricted or denied. Hospitals that have been successful in their efforts have been aware of the sensitivities of their medical staffs and have attempted to inform them of the new requirements, the means for implementing a Quality Assurance Plan, and finally, have actively sought medical staff participation in the development and implementation of the Quality Assurance Plan.

In order to achieve medical staff participation, there must be particular attention paid to confidentiality, due process, and support for the department chairmen and chiefs of service. When a case does not meet the standard of care, it is important for the individual physician to have an opportunity to discuss the case with the department chairman or division chief. If appropriate, physicians welcome the opportunity to present a rebuttal and have that included in their physician profile.

The Model Hospital Board Quality Assurance Project demonstrated that quality assessment and assurance are evolutionary. Just as hospital boards over the years have developed and implemented methods of accounting to assist them in their fiduciary role, we believe that as standards and measurements for quality are developed that boards, administrators, medical staffs, and nurses will all become better able to both monitor and improve patient care. In the interim, we must be mindful of the fact that people are working towards the goal of improving care through better systems. The speed of development may not have met with the approval of all; however, organizational systems that are imposed upon people without their understanding and commitment to those systems will ultimately fail.

In addition to the Model Hospital Board Quality Assurance Project, Hospital Trustees of New York State has begun a publication, "Trustee QA Bulletin," which is mailed to the 4,000 volunteer trustees in New York. Copies of that publication are included here along with the earlier bulletins which describe the changes in New York statute and regulation. Perhaps the "Trustee QA Bulletin" most relevant to this topic is the one entitled, "Using Data To Measure Quality." In

that particular document, we identified for trustees several internal sources of data which could be utilized to assist with quality management. We have also held educational forums on Quality Assurance, and we intend to continue these efforts throughout 1988 and 1989.

Quality of Care Information for Consumers

The question before the Subcommittee is whether or not Hospital Trustees supports the proposition that information concerning some indicators of the quality of care can be made available to consumers. We do support this proposition; however, we believe that that question is integrally linked to the question of what kind of information and in what form.

In addressing the specific concern which is before the Subcommittee, we would like to commend you for the excellent study,"The Quality of Medical Care; Information for Consumers," which was undertaken by the Office of Technology Assessment. The work demonstrates a broad understanding of the possibilities and the limitations of providing information on quality medical care at this time. As is pointed out in this document:

> "The quality of medical care has many dimensions, a fact that reflects the diversity of acceptable outcomes for patients and the complexity of the medical care process."

With regard to data which can serve us in the identification of "quality," we believe that until such time as data can meet the criteria you have set forth in the study, i.e., reliability, validity and feasability for utilization, we should be extremely wary of the benefits of putting such information in the public domain.

Hospital Trustees of New York State believes that the goal of sharing information with the public is appropriate. However, we must first ask ourselves why we are interested in making such information public. The primary reason provided is that, "people seeking medical care deserve information so that they can avoid poor providers and seek good providers." Additional rationales are that, "over a longer period of time, information on specific providers could form

part of a larger effort to educate the public about the quality of medical care," and that public information on the quality of care will, "stimulate the medical community, as a collective and as individuals, to improve their quality." We would submit that the goal which precedes those is to simply improve the quality of medical care.

If we are to provide the public with information, we must be sure that it is valid and that it will assist them in making a decision. As you point out, the manner in which the information is conveyed is important, and we agree that we need to convey more than one type of information. We have found that one of the best ways for the public to make determinations is to learn to ask questions of providers and physicians. In short, we may need to "empower" the public through a variety of means which will ultimately assist them in making a quality choice when faced with the need for medical care. We must also ensure that they have a sense of responsibility for these choices.

With regard to information about providers, we need to keep in mind that some information relates to physicians and some relates to health care institutions. Raw data is meaningless unless we have weighted it with respect to certain patient factors. Raw data can in fact be harmful at certain times. For example, unless the public understands the limitations of the data (e.g., mortality data), they may make false conclusions about providers. To the extent that we have data available about trends in institutions or in the practice of certain providers, the first place that that data should be utilized is in the institutions. Information regarding mortality rates, adverse events, and physician performance can help the individuals, specifically, the hospital trustees who are responsible for the assessment and management of quality. Improving the quality of our data and making sure that it is applied in our evaluation processes -- whether that evaluation is of institutions or physicians -- will stimulate the medical community as a collective and as individuals to improve their quality.

Hospital Trustees has found that as "consumers" who have the responsibility for oversight of medical staff activities, the task of applying data in a balanced fashion is not an easy one. However, as our activities have shown, the process of improving

quality assessment and assurance is underway and is improving. To the extent we can, we must first see that the mechanisms which serve to assess and assure quality have the data and utilize it.

We would be remiss, however, if we did not bring to this Subcommittee our experience. As a state, we have led the way with our statutes and regulations which have put in place quality assessment requirements. Hospitals are surveyed on their compliance with these requirements. However, we are currently experiencing a situation in which the public has begun to lose confidence in the hospital system. The erosion of public confidence can occur when incidents are habitually publicized. We do not mean to suggest that all hospitals in our state are blameless. Nor do we mean to suggest that consumers should not be made aware of quality problems when they are identified. However, physicians and hospitals are fallible. When they fail -- and they do on occasion -- they can be judged on the basis of an incident that may not have been avoided. When those types of incidents occur, it is our experience that hospitals cannot adequately modify the public's perception because there is a presumption that any response is defensive and intended to cover-up the facts.

The public airing of information on medical care must be tempered by concerns for validity, reliability, and the degree to which the information represents a true indicator of disquality, keeping in mind that one incident is not an adequate basis for such a determination. With respect to all kinds of data proposed for public dissemination, we must be mindful of the need for a denominator if we are to utilize the data for purposes of comparison and judgment.

Ensuring that the information has the appropriate context is part of the need to provide consumers with the skills to utilize the information. We repeat that first we must assist consumers in asking appropriate questions, and second, we must assist them in understanding the information received and then utilizing it to make a choice. This task will not be easy because medical choices are often emotionally laden choices. Therefore, to the extent that we can, we must utilize some of the lessons learned by hospital trustees: we must provide the information in the lay person's language, and we must help them understand the options which they have available to them.

Policy Options and Recommendations

The report, "The Quality of Medical Care; Information for Consumers," offers a number of policy options and recommendations. Hospital Trustees supports the broad goals of:

- improving quality assessment techniques;
- ensuring the quality of quality assessments; and,
- improving the availability of required data.

As the report notes, two relevant issues arise when considering public policy: "whether public information about hospital and physician quality has sufficient importance to justify governmental action and which approaches or options are likely to prove most effective in bringing about the desired results.

We believe that there is a role for government in this area. Government has and should continue to strengthen research and demonstrations which will improve techniques for assessing the quality of

medical care; however, where those efforts are already underway in the private sector, government may not need to duplicate those efforts.

Mandating the Department of Health and Human Services to work with national experts may have some utility if it is determined that a combined and coordinated effort is not underway or if it is found that such an effort will lead to greater coordination and dissemination of information on indicators. Once a determination is made that the indicators are reliable and valid, then they should be considered for application to federally funded health care programs.

Stimulating these efforts by the creation of new mandates and new departments may not be necessary at this time. As is pointed out in the Office of Technology Assessment's Report, many states have a variety of efforts underway to accomplish the goals you have set forth. Monitoring and evaluating these efforts may be more beneficial at this time, especially since these efforts incorporate the types of information and indicators discussed in the report.

Finally, the options for making information public cannot be entertained until we are certain that we have valid, reliable and useful data for the public.

To the extent that we can, we should make available the information that we believe will help consumers. We should also remember to not only share the information that illustrates poor quality, but should highlight the providers and physicians who have demonstrated an ability to meet the standards which have been set.

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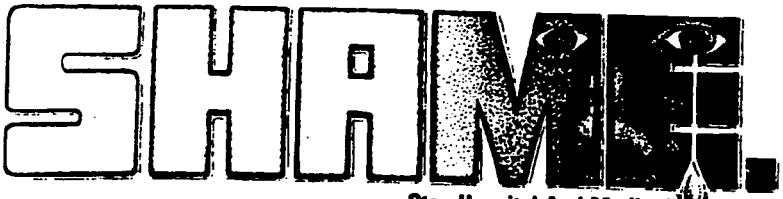
Carol Dye is currently the Executive Director of the Hospital Trustees of New York State which is a statewide voluntary organization representing 175 voluntary and public hospitals in the State of New York and their 4,000 trustees. Hospital Trustees of New York State provides education, communications on health-related issues, and public policy development to its membership.

Hospital Trustees completed a study of proprietary health care in 1985, and is currently studying the issue of the medically indigent. The organization achieved passage of immunity for trustees from third-party liability suits and with the Hospital Association of New York State has recently formed a captive insurance vehicle to write D & O, General Liability, and Excess Medical Malpractice coverage.

Prior to joining Hospital Trustees in 1985, Ms. Dye was the Director of the Center for Governmental Affairs for the Child Welfare League of America in Washington, D.C. The League is a national not-for-profit organization consisting of 320 public and private voluntary agencies in North America which serve children, youth, and families. Ms. Dye was also the Director of the Office of Regional, Provincial and State Child Care Associations, a national organization representing over 1,400 child and family serving agencies in North America. While in Washington, Ms. Dye worked specifically, on issues of strategic planning, federal reimbursement and the voluntary sector's role in delivery of services.

Ms. Dye has a Masters Degree in English from the University of Oklahoma and has published various articles on government child welfare policy.

Ms. Dye sits on the Board of Directors at the Parsons Child and Family Agency in Albany, New York and has been recently appointed to the Joint Commission on Accreditation of Hospitals Advisory Committee on Education and Publications.



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June 6, 1988

Testimony by Rose Ann Liveo

President and Founder

S.H.A.M.E. (Stop Hospitals and Medical Errors)

Congressman Schoer, Dr. Lee, and members of the committee. Thank you for the opportunity to present testimony on medical malpractice.

I am here today out of the concern for the many innocent victims of medical malpractice. In an age of sophisticated medical technology, there is still a great deal of incompetent and negligent medicine being practiced today. It seems to me that everyone is aware that there are problems, but no one is doing anything to correct them.

My concern for the problems of medical malpractice arose from two personal tragedies that occured three and a half years ago. My mother-in-law Anna Liveo entered a Brooklyn hospital on November 7, 1984 for a simple surgery to remove a bunion, and she came out of that surgery brain dead! And only a month later, my nephew entered a hospital in Manhatten to undergo surgery, with the doctors informing my sister that her son's stay would only be seven to ten days. Nine months and seven surgeries later, my nephew left the hospital still suffering the effects of the incompetent medical care he received. Needless to say, the profound

effect these two experiences had on both families was overwhelming. It should not happen twice to one family.

I felt something had to be done to prevent medical errors from happening. I began to research information that might have helped us to prevent this nightmare from occuring. Through my research, I found many books on the mishaps in the medical profession, and also about what can go wrong when you are not an educated health care consumer. There were many other aspects about the medical profession that were not being addressed.

Findings indicate that American surgeons perform nearly 2 1/2 million unnecessary operations each year, resulting in 12,000 deaths. What justifiction can there be when a patient dies from an unnecessary operation, or when the operation falls into the class of such medical wisecracks as "when in doubt, take it out"?

(from Managing Your Doctor)

Their are many concerned doctors who have carried their messages directly to the public in an attempt to correct this abuse. I think it's time the medical profession weed out the bad from the good.

In New York State, it is not required by law that the anesthesiologists be board certified. I feel that dispensing anesthesia is a life threatening procedure, and that there can be complications if the doctor who is administering the anestesia is not highly qualified.

(Taken from Examining Your Doctor, to avoid medical mishaps (Dr. Kra writes))

Ten thousands people die each year because of anesthesia, and an estiamted two thousand of these victims did not need surgery to begin with. There is a risk associated with anesthesia even under the best

conditions. Death is mainly the result of cardiac arrest and insufficent oxygen reaching the brain and heart. Other complications include eye damage, spinal cord paralysis with complete paralysis of the body, kidney failure, liver failure, and aspirations into the lungs (resulting in pneumonia and death). Several studies have found human error to be the cause of 85% of the deaths attributed to anesthesia. And did you know that many anesthesiologists have such large practices that if they can't be at every operation they are responsible for, they hire anesthetists (nurses wuth some advanced training) to do the job.

In Febuary of 1983, Health Commissioner Dr. David Axelrod said at a conference on professional medical misconduct "patients are harmed and/or abused by impaired, dishonest and incompetent doctors and other health care professionals". If statistics held true, at least one in every ten doctors are either incompetent or mentally or physically impared. Drug addiction and alcoholism are the prime "impairs".

In August of 1985, Governer Cuomo signed a bill to crack down on risky drivers who are caught driving drunk. Under the new law, drivers involved in accidents resulting in a death or injury could be sentenced to 15 years in jail if they were under the influence of drugs or alcohol.

There must be thousands of doctors who are practicing medicine and performing operations while under the influence of drugs and alcohol. How long can this unprofessional behavior continue before something is done to protect the public?

In June of last year, the Illinois Medical Association said "Cocaine abuse had increased dramatically in 5 years. There are 300,000 doctors in the U.S, and researchers say that one in five doctors abuse

drugs or alcohol, with more than a third injecting narcotics, and others turning to cocaine".

The Harvard School of Public Health reported in the New England Journal of Medicine that "the average patient has one chance in twelve of encountering a drug using doctor. One out of every twelve doctors uses recreational drugs such as cocaine and marijuana".

Dr. Sidney Wolfe, head of the Public Citizens Health Research Group, estimates that 5% to 15% of the nations half-million practicing doctors are incompetent because of inadequate skills, poor education, or addiction to drugs or alcohol.

A 1984 study by the G.A.O. showed that it takes more than 2 1/2 years, on average, to revoke a doctor's license.

A draft report from the U.S Department of Health and Human Services found that doctors not reporting their incompetent colleagues add "billions of dollars" to the country's yearly health bill.

City Council President Andrew Stein said "American doctors are killing and maiming thousands of patients every year and for the most part, they are getting away with it." And he estimates that as many as 200,000 Americans are injured or killed in hospitals each year as a result of negligent care.

Our organization supports City Council President Andrew Stein's call for a Presidential commision, making medical negligence a nation priority.

In Oct. of 1985, hospitals were required to report information concerning incidents resulting in patients deaths or impairments that resulted from circumstances other than those related to the natural course

of illness. By Jan. of 1986, there were 775 "unusual" incidents reported. State Health Department Commissioner David Axelrod said he was "increasingly" concerned about the number of events occuring within hospitals. Under the Freedom of Information Act, we were not able to obtain this information. This information has been deemed "confidential" and becomes part of the personal files.

We know more about the track record and repair records of our automobiles and appliances than that of our doctors and hospitals. We, the patients, demand to know what the mistakes have been, by whom, and how the mistakes were made. The patient is a consumer and the consumer has a right to know this. Many errors can be prevented by the reforms we advocate, including changes in (1) state and federal legislation, (2) Health Department regulations and (3) hospital procedures.

The real fact is that there are many acts of malpractice that are never sued for. The National Institute of Health concluded that only one of every 15 victims of malpractice has sued. We need laws that not only protect the victim who has a lawsuit pending, but all patients in general.

SHAME, the voice of the patient, can and will not be ignored.

SHAME is going to fight for better quality health care, and provide a network of support for victims of medical malpractice and negligence.

NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE

Representative SCHEUER. We'll hear from former Governor Robert Ray and former Congressman Paul Rogers.

These two distinguished leaders serve as cochairmen of the National Leadership Commission on Health Care. Governor Ray is currently the president of Life Investors Insurance Co. of America, and served as Governor of Iowa from 1969 to 1983.

Is that true?

Mr. RAY. Yes, sir.

Representative SCHEUER. My goodness. [Laughter.]

Congressman Paul Rogers, who is currently practicing law in Washington in the firm of Hogan and Hartson, served in the House representing the State of Florida from 1955 to 1979. And from 1971 to 1979, he served as a very distinguished chairman of the Health and Environment Subcommittee of the energy and Commerce Committee, on which I serve, and I had the privilege and pleasure of serving under Chairman Rogers when he chaired this subcommittee.

So we are very pleased and honored to have the two of you testifying here this morning. Please take such time as you may need, both of you, to chat with us, in the neighborhood of 10 minutes or so. And be informed that your prepared statement will be printed in full in the record. And hopefully, you'll sit and chat with us as if we were in a living room with a glass of nonalcoholic beer in our hands.

So, Governor Ray, why don't you take such time as you may need and chat with us informally.

STATEMENT OF ROBERT D. RAY, PRESIDENT, LIFE INVESTORS INSURANCE CO. OF AMERICA, AND COCHAIRMAN, NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE

Mr. RAY. Thank you very much. I will chat with you as informally as I can, being scripted. And I'm very pleased that I have the opportunity to be with Paul Rogers, who is the expert of this team. And I want to sincerely thank you, Mr. Chairman, for giving us the opportunity, the National Leadership Commission on Health Care, to appear here. Your important series of hearings on the future of the American health care system comes at what the commission believes to be a very critical time of reassessment of the issues facing the country in health care.

Your work is vital in paving the way for further improvements in health care. We would hope very much that our commission and the work of the commission can be helpful to you as your hearings will be helpful to us.

COST CONTAINMENT IN IOWA

I joined the National Leadership Commission on Health Care out of a conviction borne when I was Governor of Iowa that no single entity in our society can ever solve its health care problems alone.

Soon after I took office in 1969, I was confronted with Blue Cross & Blue Shield informing us they were imposing a 30-percent increase in the premiums on our State employees.

There was absolutely no money in the budget to cover that huge increase in medical costs, and when we sat with the leaders of the "Blues" and tried to negotiate some kind of a reasonable increase, we were confronted with another shock. And that was they told us that there would be a like increase the following year.

As you know, in the legislative process, the budget is set and you don't go back and ask for more money, at least until the next year. And we had to scamper and try to find enough money just to cover those costs. And there is never enough money to meet all of the needs, and so the money came from other sources where there were critical needs.

We responded also to the increased costs which were being felt, I might add, throughout the State, by forming a government-private business task force to explore ways to hold down health care costs in the State. This blue ribbon commission was determined to find a way to control costs, and worked very diligently over a period of about 2 years. But it proved essentially impossible at the State level to make a great difference.

Some of the recommendations made by this group were picked up by the Iowa Health Policy Corp., which was a business and, I might add, labor organization to deal with these same problems.

They had some success and had an effect on cost containment, although the costs were continuing to escalate in Iowa, as they were across the Nation when I left office in 1983.

Because this is a continuing problem, we have set in place in our State, my State, an ongoing series of efforts. One, the business coalition, or the Iowa Health Policy Corp., continues to search for ways to cut back, if not on total costs, at least on cost increases.

Another outgrowth of the earlier effort is the Iowa Health Data Commission, a pioneer effort in gathering and analyzing information.

We now know, for example, that if you live in certain communities, your chances of having a hysterectomy are four times greater than if you live in other communities within the State. The same is true with hernias.

We also know that costs vary and can even double from one part of the State to another. Documenting these regional variations gives everyone in the system a fresh insight into the cost and quality of care, which, in itself, has had a very positive effect.

So we have made some progress, but it is not very significant in the face of the rising costs and the increasing numbers of people without good access to health care and the troublesome signs of problems with the quality of care.

LEADERSHIP COMMISSION IS A BIPARTISAN PARTNERSHIP

We are a country which is a country of reaction. We so often wait until there's a serious crisis to act and then, of course, we always respond. And we respond in ways that perhaps we wouldn't if we had just anticipated and had taken some action previously.

Representative SCHEUER. We sometimes overreact.

Mr. RAY. And then we overreact, so very true. The crisis I encountered at the State level in not being able to afford health care

premium increases is clearly becoming a national crisis in this era of limited resources.

That is why I and a group of concerned private citizens thought it was time to convene the first broadly based group in 35 years to take a hard look at solving the problems of cost, quality, and access to health care.

The commission is notable for several reasons. First, it includes people from all the groups necessary to effect change—corporations, providers, insurers, labor, consumers, and public policy leaders. The commission is unusual in including top-level officers from major corporations and the labor movement. Corporations and unions are looking for ways to control their soaring health care costs. And the members of this commission are frustrated by the difficulty of controlling these costs. They are convinced that much of what has been done in the past has been cost shifting rather than cost cutting.

Second, the commission is bipartisan.

Representative SCHEUER. Excuse me. Cost shifting? From whom to whom?

Mr. RAY. Well, as an example, when you put limitations with medicare, the hospitals pick it up from the private carriers and the private providers.

So there is constant shifting in the hospitals, and I think with the doctors as well.

The commission is bipartisan, including policymakers from both parties who have served at the National and State levels. Former Presidents Carter, Ford, and Nixon are honorary cochairpersons.

NEED COMPREHENSIVE HEALTH CARE SOLUTION

Third, the commission has examined the efforts taken in the past to control costs and has found that the piecemeal approach to change that typified the actions of the past simply is not working.

Certainly, it can be said some expenditures have been curbed. Hospital stays, for example, are shorter and that would seem to save money. But, in response to your question, we now do more for many of the patients who enter the hospital and many patients are now treated in ambulatory settings instead of hospitals. And as a result, there has been an upsurge of expenditures for ambulatory care with no change in the bottom line. The upward curve of expenditures continues to soar.

The commission has become convinced that only a systemic solution incorporating all aspects of health care can ever hope to control costs of providing access to a high-quality system.

The earlier expenditures alone have gone beyond the half-trillion dollar mark, with medical prices rising at twice the rate of the consumer price index last year. And the cruel paradox is that while we spend over 11 percent of our gross national product on health care, more than any other country in the world, we are one of the few industrial countries that leaves numbers of our people outside the system.

In fact, almost a million people a year have recently joined the ranks of the uninsured at the same time our expenditures have risen by hundreds of millions of dollars a year.

Yet, the general indicators of health are no better in this country for all our expenditures more than other industrialized societies in the world.

And I've heard that this morning and I'm sure that you've heard it repeatedly, by those 70 experts that have made an appearance here; in some cases, they are disturbingly worse. And as the numbers show, infant mortality being an example.

The confluence of unpleasant news led our commission to ask why and to encounter further disturbing findings in the area of the quality of care.

PERSISTENT INTERVENTION IS PERSISTENT IGNORANCE

In fact, it is becoming painfully clear that money does not necessarily buy quality. There has been a crescendo of troublesome reports, articles and stories relating the results of research into the appropriateness, effectiveness, and quality of care.

The stories make clear that the very success of biomedical research and the technology explosion have the potential to outpace our present capability to effectively assess them. And we have excess capacity in our system, low-hospital occupancy rates, excess beds, increasingly high numbers of physicians, which probably all fuel cost increases, and which certainly do not promote efficiency.

What we have today, in fact, is persistent intervention in the face of persistent ignorance. A doctor wrote recently in the Journal of the American Medical Association about what he called the "cascades of cardiology." He wrote of processes that, once started, are hard to stop. One test leads to another and then another, with too little pause to think in between.

A patient with unusual chest pain receives an exercise test that shows suspicious changes leading to an isotope study resulting in suggestive defects in a shadowy image, thus leading to an arteriogram, showing some coronary artery disease, and so on down the cascade.

The physician ordering each procedure may also perform and be paid for each one, interpret the results and order still more tests.

Now, that's not to say that these procedures are all done for the financial gain of the physician or institution, but the temptation is always there.

It is in the financial interest of all of us, as patients and as taxpayers, looking at a significant budget deficit, to remove the perverse incentives that are building to our health care system.

LACK OF UNIFORM CARE

Perhaps even more basic to the quality of care is what Dr. John Wennberg of Dartmouth Medical School refers to as, and I quote this, "intellectual confusion in the heartland of scientific medicine."

A recent study undertaken by him and his team of researchers illustrates this point. Wennberg's team examined hospital admissions in two similar cities, and I think you've had testimony on this—Boston and New Haven—and found that we invest in ratio and proportion 16 percent of the gross national product in the

health of Bostonians, as opposed to 9 percent in the health of New Havenities.

Representative SCHEUER. Any differences in the health outcomes?

Mr. RAY. I think not. I think the study indicates that.

The lay person, and the area, the demographics are quite similar, and that's the reason I think the study was made in those two cities.

The lay person, the potential person in either of these cities, has to be dismayed by these numbers, knowing that each city's residents receive most of their care in hospitals and from physicians affiliated with some of the Nation's finest medical schools.

Why is the number of operations for the same conditions so different in these cities?

In a recent article, Wennberg goes on to say that, and I quote, "The practice styles in these communities have very different implications for costs. But the alternative theories about appropriate practice they represent have gone unchallenged or examined by academic medicine."

Many of our most common treatments lack adequate evaluation and are seldom studied under average conditions of use. A statewide study of prostatectomies, the most common operation for men over 65, conducted by Wennberg and his team in Maine showed the death rate associated with this procedure was four times what doctors had thought. Moreover, the study found a far greater risk of impotence, incontinence, and need to repeat the procedure than anyone had known.

Once urologists in Maine were told the results of the study, the number of prostatectomies dropped by 15 percent.

The corporate members of our commission and other third-party payers now believe——

Representative SCHEUER. Excuse me, Governor.

Did they find that a disproportionate percentage of the maloutcomes of those prostatectomies came from a small percentage of the doctors or surgeons who performed them?

Mr. RAY. I don't know the answer to that. Does anyone know? I do not recall noticing that.

Representative SCHEUER. Was this Dr. Lindberg's study?

Mr. RAY. Wennberg.

Representative SCHEUER. OK. Please proceed. I regret the interruption.

NEED CARE ASSESSMENT TO REDUCE WASTE

Mr. RAY. All right. I started to say the corporate members of our commission and other third-party payers now believe they should know whether or not what they are paying for is actually appropriate and effective care.

They've heard from some researchers who have suggested that one-fifth to two-fifths of procedures performed may not be warranted because either they do not improve health status or they improve it so little, that they may not be worth the risks or costs.

They don't understand why our health care system has never invested in sufficient research to determine what guidelines should

be used to decide when the most common procedures are appropriate, equivocal or inappropriate.

The up-front investment in this kind of research would cost several millions of dollars. But the potential savings are in the hundreds of millions, if not billions of dollars.

The indication is that this work could be done by well-trained people and that the results would save huge amounts of money, improve the quality of care, and perhaps even improve the quality of life of the people who would not undergo needless procedures, with all the attendant risks.

Such illustrious researchers as Dr. Robert Brook of the Rand Corp., using panels of physicians, have studied some of the more common procedures, including carotid endarterectomy, coronary angiography, and gastrointestinal endoscopy, and found that as many as a third were inappropriate and another third equivocal.

To break the cycle that would otherwise lead to this country spending 15 percent of GNP, or $1½ trillion, on health care by the year 2000, with ever more people falling outside the system and persistent questions remaining about the value of much of the most expensive interventions we make, the only logical response is one that ties all of these problems together and recognizes their interrelated nature—the problems are systemic. The solutions must be also.

NEED PARTNERSHIP FOR COST CONTAINMENT

Just as I found that no state alone could dampen the rising prices of health care it encounters, so, too, the Federal Government, which pays 40 percent of the bill, cannot alone affect systemwide costs.

In fact, we have watched cost-cutting efforts in hospital area result in cost shifting and resulting increases in the outpatient area.

Nor by their individual efforts can systemwide savings be realized by large corporations or labor unions, and certainly not individuals who share the major cost of care.

But we could do it together, with the best advice from the most perceptive physicians and nurses and medical administrators we can find. Indeed, that is what the National Leadership Commission on Health Care is in the process of trying to do.

We are in fact developing three major elements of a plan for the future of health care in America. One, a vision of the future system we could enjoy. Two, a systemic strategy to guide us there. And three, a practical plan of action steps to take immediately that would demonstrate the feasibility of the larger strategy.

So I speak for the commission and Paul Rogers will speak for himself and the commission, when I say I appreciate very much what you're doing and your willingness to very thoroughly look at this whole picture, not just a piece of it. And I was impressed this morning as I listened to your questions and your comments. It's obvious to me that you have more than just a superficial interest in this major problem in this country.

Thank you.

[The prepared statement of Mr. Ray follows:]

PREPARED STATEMENT OF ROBERT D. RAY*

Mr. Chairman, Members of the Committee: I want to thank you, on behalf of myself and the National Leadership Commission on Health Care, for the opportunity to appear before you today. Your important series of hearings on the future of the American health care system comes at what the Commission believes to be a critical time of reassessment of the issues facing the country in health care. Your work is vital in paving the way for further improvements in health care.

I joined the National Leadership Commission on Health Care out of a conviction, born when I was Governor of Iowa, that no single entity in our society can solve its health care problems alone. When I became Governor in 1969, Blue Cross informed us that they were putting in place a 30 percent increase in premiums for state employees. There was no money in the budget to cover this huge increase in medical costs, and when we convened a meeting with Blue Cross, we were told that there would be another 30 percent increase the following year.

We responded to the increased costs, which were being felt throughout the state, by forming a government-private business task force to explore ways to hold down health care costs. This blue-ribbon commission was determined to find a way to control costs and worked hard at its task over several years. But it proved essentially impossible at the state level to make much difference. Some of the recommendations made by this group were picked up by the Iowa Health Policy Corporation. They had some effect on cost containment, although costs were continuing to escalate in Iowa, as they were across the nation, when I left office in 1983.

Because this is a continuing problem, we have set in place in Iowa an ongoing series of efforts. One, the business coalition, or the Iowa Health Policy Corporation, continues to

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* Robert D. Ray is President of the Life Investors Insurance Company of America. From 1969 to 1983, he was Governor of Iowa. He is currently co-chairman with Paul Rogers of the bipartisan National Leadership Commission on Health Care.

search for ways to cut back, if not on costs, at least on cost increases. Another outgrowth of the earlier effort is the Health Data Commission, which gathers and analyzes information. We now know, for example, that if you live in certain communities, your chances of having a hysterectomy are four times greater than if you live in other communities. The same is true with hernias. We also know that costs vary and can even double from one part of the state to another. Documenting these regional variations gives everyone in the system a fresh insight into the cost and quality of care, which in itself has had a positive effect.

So we may have made some progress, but it is insignificant in the face of the rising costs, increasing numbers of people without good access to health care, and troublesome signs of problems with the quality of care. It is unfortunate, but I think it is true, that we are a country that responds to crises. The crisis I encountered at the state level of not being able to afford health care premium increases is clearly becoming a national crisis in this era of scarce resources. That is why I and a group of concerned private citizens thought it was time to convene the first broadly based group in 35 years to take a hard look at solving the problems of the cost, quality, and access to care.

The Commission is notable for several reasons. First, it includes people from all the groups necessary to effect change -- corporations, providers, insurers, labor, consumers, and public policy leaders. The Commission is unusual in including top-level officers from major corporations and the labor movement. Corporations and unions are looking for ways to control their soaring health care costs, and the members of this Commission are frustrated by the difficulty of controlling these costs. They are convinced that much of what has been done in the past has been cost shifting rather than cost cutting.

Second, the Commission is bipartisan, including policymakers from both parties who have served at the national and state levels. Former Presidents Carter, Ford, and Nixon are honorary co-chairmen.

Third, the Commission has examined the efforts taken in the past to control costs and has found that the piecemeal approach to change that typified the actions of the past simply has not worked. Certainly some expenditures have been curbed. Hospital stays, for example, are shorter, and that would seem to save money. But we now do more for many of the patients who enter the hospital, and many patients are now treated in ambulatory settings instead of hospitals. As a result, there has been an upsurge of expenditures for ambulatory care, with no change in the bottom line. The upward curve of expenditures continues to soar. The Commission has become convinced that only a systemic solution, incorporating all aspects of health care, can ever hope to control costs while providing access to a high quality system.

Yearly expenditures alone have gone beyond the half-trillion dollar mark, with medical prices rising at twice the rate of the consumer price index last year. And the cruel paradox is that while we spend over 11 percent of our Gross National Product on health care, more than any other country in the world, we are one of the few industrial countries that leaves large numbers of our people outside the system. In fact, almost a million people a year have recently joined the ranks of the uninsured at the same time our expenditures have risen by hundreds of millions of dollars a year. Yet the general indicators of health are no better in this country, for all our expenditures, than any other industrialized society in the world. And in some cases they are disturbingly worse, as the numbers show for infant mortality.

This confluence of unpleasant news led our Commission to ask why and to encounter further disturbing findings in the area of the quality of care.

In fact, it is becoming painfully clear that money does not necessarily buy quality. There has been a crescendo of troublesome reports, articles, and stories relating the results of research into the appropriateness, effectiveness, and quality of care. The stories make clear that the very successes of biomedical research and the technology explosion have the potential to outpace our present capability to effectively assess them. And we have excess capacity in our system -- low hospital occupancy rates, excess beds, and very high numbers of physicians -- which probably fuel cost increases and which certainly do not promote efficiency.

What we have today in fact is persistent intervention in the face of persistent ignorance. A doctor wrote recently in the Journal of the American Medical Association of what he called the "cascades of cardiology." He wrote of processes that, once started, are hard to stop. " One test leads to another and then another, with too little pause to think in between." A patient with unusual chest pain receives an exercise test that shows suspicious changes, leading to an isotope study resulting in suggestive defects in a shadowy image, thus leading to an arteriogram showing some coronary artery disease, and so on down the cascade. The physician ordering each procedure may also perform and be paid for each one, interpret the results and order still more tests. That is not to say these procedures are all done for the financial gain of the physician or institution, but the temptation is there. It is in the financial interest of all of us, as patients and as taxpayers, looking at a significant budget deficit, to remove the perverse incentives that are built into our health care system.

Perhaps even more basic to the quality of care is what Dr. John Wennberg of Dartmouth Medical School refers to as the "intellectual confusion in the heartland of scientific medicine." A recent study undertaken by Wennberg and his team of researchers illustrates his point. Wennberg's team examined hospital admissions in two similar cities, Boston and

New Haven, and found that we invest 16 percent of the gross national product (GNP) in the health of Bostonians as opposed to 9 percent in the health of New Havenites.

The layperson, a potential patient in either of these cities, has to be dismayed by these numbers, knowing that each city's residents "receive most of their care in hospitals and from physicians affiliated with some of the nation's finest medical schools." Why is the number of operations for the same condition so different in these cities? In a recent article, Wennberg goes on to say that "The practice styles in these communities have very different implications for costs, but the alternative theories about appropriate practice they represent have gone unchallenged or examined by academic medicine."

Many of our most common treatments lack adequate evaluation and are seldom studied under average conditions of use. A statewide study of prostatectomies, the most common operation for men over 65, conducted by Wennberg and his team in Maine, showed the death rate associated with this procedure was four times what doctors had thought. Moreover, the study found a far greater risk of impotence, incontinence, and need to repeat the procedure than anyone had known. Once urologists in Maine were told the results of the study, the number of prostatectomies dropped by 15 percent.

The corporate members of our Commission and other third-party payers now believe they should know whether or not what they are paying for is actually appropriate and effective care. They have heard from some researchers who have suggested that one-fifth to two-fifths of procedures performed may not be warranted because either they do not improve health status or they improve it so little that they may not be worth the risks or costs. They don't understand why our health care system has never invested in sufficient research to determine what guidelines should be used to decide when the most common procedures are appropriate, equivocal, or inappropriate. The up-front investment in this

kind of research would cost tens of millions of dollars, and the potential savings are in the hundreds of millions, if not billions.

The indication is that this work could be done by well-trained people and that the results would save huge amounts of money, improve the quality of care, and perhaps even improve the quality of life of the people who would not undergo needless procedures, with all the attendant risks. Such illustrious researchers as Dr. Robert Brook of the RAND Corporation, using panels of physicians, have studied some of the more common procedures (including carotid endarterectomy, coronary angiography, and upper gastrointestinal endoscopy) and found that as many as a third were inappropriate and another third equivocal.

To break the cycle that would otherwise lead to this country spending 15 percent of GNP, or $1.5 trillion on health care in the year 2000, with ever more people falling outside the system, and persistent questions remaining about the value of much of the most expensive interventions we make, the only response is one that ties all these problems together and recognizes their interrelated nature. The problems are systemic; the solutions must be also.

Just as I found that no one state alone could dampen the rising prices of health care it encounters, so too the federal government, which pays 40 percent of the bill, cannot alone affect system-wide costs. In fact, we have watched cost-cutting efforts in the hospital area result in cost shifting and resulting increases in the outpatient area. Not by their individual efforts can system-wide saving be realized by large corporations or labor unions, and certainly not by individuals, who share the major cost of care. But we could do it together, with the best advice from the most perceptive physicians and nurses and medical administrators we can find. Indeed, that is what the National Leadership Commission is all about.

We are in fact developing three major elements of a plan for the future of health care in America: a vision of the future system we could enjoy, a systemic strategy to guide us there, and a practical plan of action steps to take immediately that would demonstrate the feasibility of the larger strategy. I speak for the Commission and my co-chairman, Paul Rogers, when I ask the indulgence of the Joint Economic Committee to allow us to present our findings to you early in 1989.

Representative SCHEUER. Thank you very much, Governor Ray. We're very grateful for your highly informed and sophisticated testimony.

I don't think I could have served under Paul Rogers from 1971 to 1979 without learning something about this field under his outstanding leadership. And if that is reflected in this hearing, it's a tribute to the next witness, whom I'm very happy to welcome here, a man from whom I have learned much and who has held out the hand of friendship to me, which I greatly appreciate and value.

Our next witness will be the Honorable Paul Rogers, former Member of Congress and chairman of the House Subcommittee on Health and Environment from 1971 to 1979.

We're delighted to have you here, Paul. Please proceed at will and take as much time as you may need. We're eagerly awaiting your testimony.

STATEMENT OF PAUL G. ROGERS, ATTORNEY, HOGAN & HARTSON, AND COCHAIRMAN, NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE

PIVOTAL TIME IN MEDICINE

Mr. ROGERS. Thank you very much, Mr. Chairman. You're very gracious, as always. It's good to be back. I enjoyed your hearings this morning. It brought back memories of the times we spent before. And I'm very proud of what you are doing in setting a record here to educate the public and the Congress on what needs to be done for the future. I think it is very important and I'm delighted that you're undertaken this task and are giving it sufficient exposure with the array of witnesses that you've had in your series of hearings.

It is most important because this is a pivotal time for medicine.

Representative SCHEUER. Why is it a pivotal time?

Mr. ROGERS. Because we're making such changes now, so many things are happening. The cost factor has just overwhelmed us. The quality factor. Access.

And so I think its very important that you have started these hearings and are laying the foundation to bring about some solutions for the future.

Governor Ray has ably presented the makeup of our commission, some of the things we've looked at as to the initial problems—access, quality, and cost that all of us recognize as significant problems.

But I want to do three things quickly, and I'll cut this down because I also remember that your time is limited and you have to be going to other duties.

First, I just want to emphasize some areas of emerging importance. Second, I would like to present the commission's plan to develop a vision of the future. And third, to explain our strategy to achieve the vision in a practical manner.

Let me say at the beginning, and I'm sure you would share this, I believe that America's health care system at its best is unsurpassed. Our doctors, I think, without question, are the ablest in the world, the best trained. They have at their fingertips an unparalleled array of technologies that we could hardly imagine a few

years ago. Any people from all over the world, of course, come to our shores in search of care and cures that are not available in their own countries.

So our potential here in this nation to be a model for delivery of health care in the 21th century, is remarkable. We have the capacity, if we'll do it.

NEED ASSESSMENT OF TECHNOLOGY AND CLINICAL CARE

Now, the first of the three points to make. The troublesome issue, and you've discussed it already, so I'm not going to pursue it in detail, that has emerged from research of some our finest doctors and our scientists indicates that there really is a serious gap in our understanding of when it is appropriate and when it is effective to perform some of the most common procedures we use.

The president of the Association of Academic Health Centers, most of the medical centers in the country, Dr. Roger Bulger, put it well when he wrote, "We have developed through our research an incredible array of interventions, many of which have found their way into the routine practice of everyday health care delivery. A depressingly small minority of these techniques has been exposed to tough, critical analysis of their effectiveness and cost effectiveness."

Representative SCHEUER. Just to footnote that.

Mr. ROGERS. Yes.

Representative SCHEUER. Governor Ray mentioned that between 20 and 40 percent of medical procedures are unnecessary, not indicated, or perhaps even unhealthful. So you're talking about 20 to 40 percent, between one-fifth and two-fifths.

We have received testimony that between a quarter and one-third are unnecessary, unhealthful, or contraindicated. So that would be 25 percent to 33⅓ percent.

So you have, in effect, almost the identical bracketing. There seems to be quite a consensus that between 20 and 40 percent, or 25 percent, 33⅓ percent. But somewhere in that area.

Mr. RAY. Whatever figures you use, it's significant.

Representative SCHEUER. And not only are they significant, but there's a clear consensus among the medical profession that it's of the order of magnitude that you have suggested. That's really beyond question.

Please proceed.

Mr. ROGERS. It is true.

Representative SCHEUER. And there are an enormous number of operations, treatments, procedures, and enormous costs.

Mr. ROGERS. And costs.

Representative SCHEUER. And enormous impact on patients, both positive and negative.

Mr. ROGERS. Very definitely. Let me just give another example. And this comes from one of the most recent issues of the Journal of the American Medical Association, where an article raises doubts about the appropriateness of the widespread use of one of the latest technologies, the magnetic resonance imaging, MRI.

You may have already heard testimony, but the article by researchers from Harvard, from Mt. Sinai in your own city, and the

Veterans' Administration describes serious gaps in the proper evaluation of this technology, MRI, including the fact that not one evaluation of the 54 studied in this eminent group contained an appropriate statistical analysis.

Now, the authors concluded, that "health care professionals paying for expensive, innovative diagnostic technology themselves should demand better research on diagnostic efficacy."

And the editorial goes on to say, with all of the costs of this expensive technology, we really ought to know how it's carried out because technology development and its widespread use that you've discussed this morning has really far outstripped our capacity because of the lack of research of when and how to best utilize it.

And it really is inconsistent with the scientific basis of modern medicine not to build an adequate analysis of how to use it.

The basic elements of sound science is part of the best tradition of medical education, training, and the delivery of care in a collegial setting. It's already, as you had mentioned earlier, I think, Mr. Chairman, part of the drug approval process. I expect most Americans, if you were to ask——

Representative SCHEUER. Where they scrutinize a new application for a period of anywhere from 5 to 10 years, at a cost to the applicant of anywhere from $50 to $100 million.

Mr. ROGERS. That now has gone up to $125 million.

Representative SCHEUER. Exactly. And where they scrutinize it with a super microscope, every gnat's eyelash of that application, for safety and effectiveness in the most painfully agonized review that some of us have criticized for being too costly and too time consuming.

But if you compare that review of drugs with the absence of any comparable review whatsoever of all kinds of medical procedures and processes and products and operations and whatnot, it's mind blowing.

Mr. ROGERS. Yes, it is. As a matter of fact, I expect the American people, Mr. Chairman, if you were to ask them, would think, or just assume that sound scientific assessment had been done on all of these other procedures, not just on drugs.

Unfortunately, that's just not the case.

Now, to do this kind of assessment, which I think is so important and which we've been looking at and talking about, would really cost a fraction, a tiny fraction of the amount we spend on total health care costs.

Representative SCHEUER. And the amount that we'd save if we had those guidelines to help us make decisions to do it or not to do it would make the cost worthwhile.

Mr. ROGERS. That's right. So that's really what we need to begin to move into, a proper assessment not only of technology, but of clinical practice.

I think the two need to be addressed really at the same time.

So much of it—it's the old American way. You know, we've done it this way, so we just kind of accept it without really studying and seeing how effective it is.

KEY ELEMENTS OF A BASIC HEALTH CARE SYSTEM

All right, that brings me, then, to the second point and I'll try to conclude quickly.

We need a vision, I think, for America's health care for the next century. It's time for us to really put this into place. We need to have a goal in mind as we reexamine where we have been and where we are going. This systemwide vision, I think, should incorporate access for all, access for all to an adequate level of care with cost-effective delivery of services, appropriate, effective quality care.

Now, those are really the three anchors of any system that should be a part of this vision for America.

We also should try to encourage a better relationship between doctor and patient. That's enormously important. That has been split apart because of this malpractice problem. And, of course, if we can begin to improve the patient-doctor relationship, I think you'll find that malpractice would be reduced. I think your suggestion of learning from State action is obviously the route that must be taken. Let the various States do some demonstration projects and then the Federal Government can pick these projects which succeed.

We also need to define what we mean by cost-effective, high-quality care. And we need a continuum of followup to see a proper evaluation, peer review, to follow that right up as the system develops.

Already, I think we can be encouraged by work begun in the quality and appropriateness area by such organizations as the Institute of Medicine, the Joint Commission on the Accreditation of Health Care Organizations, and the AMA. And, of course, the Health Care Financing Administration, Council of Medical Specialties Societies, and many individual specialty societies.

STRATEGY TO ACHIEVE HEALTH CARE GOALS

The third and final point I'll make is that we need a strategy to actually try to bring about the vision. No one can do it alone. We're finding as this commission came together with various groups represented, that we really need a new and effective public-private partnership to invest in this whole future.

It must include the providers. You have to include the insurers, the business, the labor, and the patients. The doctors definitely must be a part of it to help make it work.

It's been interesting in our commission that we brought representatives of all these groups together and it's been encouraging to see that they put aside their parochial interests to come in and looking and trying to build what they think are the important features of this national vision.

Now, we over the next several months are going to try to hammer out a strategy to enable us to present a plan for the future. And we're also going to develop an outline or so of a few demonstration projects that can get us started on the way. We think we'd better have a road test or two, as you think, and I think very wise, before we move the whole nation into something.

The commission is in the process of briefing the two Presidential candidates to let them be aware that we have a private citizen, bi-

partisan approach to present some information to pull it together. But the problems are so large and systemic, they can only be resolved, I think, if we put aside hard, partisan approaches.

Representative SCHEUER. Fiorella La Guardia once said, there's no Republican or Democratic way to clean the streets.

I think there's no Republican or Democratic way to rationalize the health care system and make it effective and safe and right for the American people.

Mr. ROGERS. I agree. And I think what you're doing in these hearings, as I said, is laying the foundation for what needs to be done.

We would like, Mr. Chairman, to bring back to you and your committee the commission's vision of what the health care system could be like, should be like, we think, and we will try to bring back a chart to illustrate the new strategy, and how to accomplish it.

It is the commission's hope that the new vision for the future, a new systemic strategic of the health care system and the demonstration projects we develop will together provide a basis for the Congress, a new administration, and the private sector, to join together in a new strategy for the health of this country.

I commend you for what you're doing. I think it's excellent. And this will help educate the American public of the vast problem we face and what can be done.

[The prepared statement of Mr. Rogers follows:]

PREPARED STATEMENT OF PAUL G. ROGERS*

Mr. Chairman, Members of the Committee: I very much appreciate your invitation to the National Leadership Commission on Health Care, to my co-chairman Governor Ray and myself, to testify before the Joint Economic Committee. We believe as you do that this is a pivotal period in the nation's health care system. In fact, your hearings are important to both an understanding of the problems in the system and the potential for their resolution.

Governor Ray has ably presented what the Commission is about and who its members are. He has also presented a cogent analysis of the systemic problems which exist in the cost, quality, and access to care which the Commission has closely examined. I would like to do three things: to emphasize some areas of emerging importance, to present the Commission's plan to develop a vision for the future, and to explain our strategy to achieve that vision in a practical manner.

There is surely no need to delve further with this knowledgeable committee into the cruel paradox of soaring health care expenditures at a time of decreasing access for millions to our health care system. But I would like to emphasize at the outset that I believe America's health care system at its best is unsurpassed. Our doctors are the ablest and best trained in the world. They have at their fingertips an unparalleled array of technologies that none of us could even imagine a few decades ago. People from all over the world come to our shores in search of the care and cures available in few countries. Our potential to become a model for the world in the delivery of health care into the twenty-first century is remarkable.

That leads me to the first of the three points I would like to make today. The troublesome issues that have emerged from the research of some of our finest doctors and

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* Paul G. Rogers is an attorney with Hogan and Hartson. He was a Member of Congress from Florida from 1955 to 1979 and was Chairman of the Subcommittee on Health and the Environment of the Committee on Energy and Commerce from 1971 through 1979. He is co-chairman with Robert D. Ray of the National Leadership Commission on Health Care.

scientists in recent years indicates there is a serious gap in our understanding of when it is appropriate and effective to perform some of the most common procedures we do today. The President of the Association of Academic Health Centers, Dr. Roger Bulger, put it well when he wrote: "We have developed through our research an incredible array of interventions, many of which have found their way into the routine practice of everyday health care delivery. A depressingly small minority of these techniques has been exposed to tough, critical analyses of their cost effectiveness. We have swallowed more new technologies than we can digest."

For example, one of the most recent issues of the Journal of the American Medical Association raises serious doubts about the appropriateness of the widespread use of one of our latest technologies, magnetic resonance imaging, or MRI. The article, by prominent researchers at Harvard, Mt. Sinai in New York and the Veterans Administration, describes serious gaps in the proper evaluation of this technology, including the fact that not one evaluation of the fifty-four studied by this eminent group contained an appropriate statistical analysis. The authors "conclude that health care professionals paying for expensive innovative diagnostic technology should demand better research on diagnostic efficacy."

An editorial by a doctor in the same issue of the journal commented that the authors' conclusion "suggests that the proliferation of MRI technology is based on inadequate evidence that MRI does more good than harm. Considering the cost of installing and operating MRI hardware (at least 1 to 2 million dollars, depending on the type of machinery), these conclusions raise serious doubts about whether limited resources are being wisely used, at least from the perspective of the likelihood of improved clarity of diagnosis or patient outcome."

I would argue that this and many other pieces of evidence presented in the American Medical Association's Journal, the New England Journal of Medicine, and other leading medical journals lead us to the following inescapable conclusion. Technology development and its widespread use has, in many instances, far outstripped our capacity to understand when and how to utilize it. It is inconsistent with the scientific basis of modern medicine not to build adequate analysis of our technologies and procedures into what we do.

In fact, this basic element of sound science is part of the best tradition of medical education, training, and the delivery of care in collegial settings. It is already a part of the process whereby we evaluate drugs in this country, and I expect most Americans, if you were to ask them, would say they just assumed that sound, scientific assessment is applied to the rest of medical care. Unfortunately, too often that is not the case.

To do this kind of assessment in a systematic fashion would cost a tiny fraction of the total amount we spend today on health care, and that up-front investment in clinical research to evaluate technology would, I believe, lead to both higher quality care and significant saving of money in future years. Some researchers have spoken of spending just one twenty-fifth of one percent of our health care expenditures on appropriateness research: first, to conduct all the needed assessment of new technology; second, to examine, where necessary, technology already in use; and third, to feed that information to the providers and users of care.

Much of what we do in medicine, as in everything else in life, we do because we have always done it that way. It is time to step back and examine what we are doing and where we should be going in health care, which is what you are doing in these hearings and what the Commission is trying to do.

That brings me to my second point, the need for a vision for the American health care system for the year 2000 and beyond. We need to have a goal in mind as we reexamine where we have been and where we are going. This system-wide vision should incorporate access for all to an adequate level of care with cost-effective delivery of services, and appropriate, effective, and high quality care. Those are the three anchors of our policy. We believe America can achieve this vision.

We start from the belief that an adequate level of health care is a social good and that it is a moral obligation of a society to provide everyone with access to the health care system. We would like to see patient and provider alike educated to understand the enormous importance of a strong doctor-patient relationship. The kind of trusting relationship I am talking about could even go a good part of the way toward ending the unpleasant malpractice atmosphere that beleaguers so many physicians today. We must incorporate a solution for the malpractice problem into our vision. We have started by taking the views of the experts who have developed a variety of options to improve the current system. The Commission's deliberations on improving quality and appropriateness would not be complete without addressing the role of medical malpractice in physician behavior.

We must also define what we mean by cost-effective, high quality care. We should define who is responsible for it at every level. We must define the continuum of services to be provided. And we need to build into such a new system the quality assurance measures that would ensure that continuous feedback about the care rendered is built into the system. Such a system would provide a culture of continual improvement for the entire system of health care. There is a new concept with growing appeal throughout the country: do it right the first time, rather than do it quickly and go about fixing it later. We could build such a quest for continuing quality and, not coincidentally, more efficiency, into

our vision for the future. We are encouraged by the work already begun in the quality and appropriateness area by such organizations as the Institute of Medicine, the Joint Commission on the Accreditation of Healthcare Organizations, the American Medical Association, the Health Care Financing Administration, the Council of Medical Specialty Societies, and many of the individual specialty societies.

The third and final point I would like to make is that we need a new strategy to achieve our vision, and no one can do this alone: individuals, business, unions, states, or the federal government. What we need is a new and effective public-private partnership to invest in the future of America's health care system. A system that works involves all sectors. Not just government but providers, insurers, business, labor, patients (consumers), doctors, and nurses. The National Leadership Commission on Health Care has brought these people together so that the players who are ultimately part of the strategy are the very ones who developed it. These individuals can then carry the strategy back to the broader groups they represent.

We are in the process over the next several months of hammering out this strategy. The strategy will enable us to reach the Commission's vision of the future. We will also develop the outline of one or more demonstration projects to take us part of the way there. Perhaps a road test is the best way for everyone to get a look at the new model health care system we will propose.

The Commission will brief the two presidential candidates and their staffs. We believe it is helpful to everyone that there is a private, bipartisan effort to resolve these problems. Just as health professionals are involved in finding new solutions to the problems that beset us, so too are nontraditional groups involved: the corporations and labor unions who are deeply involved in the effort to improve America's competitive position. The prob-

lems are so large and systemic that they can only be resolved if we all put aside our partisan differences and resolve to find answers.

What you are doing in these hearings will lay the foundation for what needs to be done. We would like to bring back to this body the Commission's vision of what the health care system could look like, the course we have charted to take us there, and the demonstration projects that will illustrate what the new strategy will be able to accomplish. It is the Commission's hope that this new vision of the future, a new systemic strategy for the health care system, and the demonstration projects we develop will together provide a basis for Congress, a new administration, and the private sector to join together in a new investment strategy for the health of the country.

Representative SCHEUER. Well, I am very grateful to both of you for coming to testify here today. You've given us remarkably useful and cogent and practical and hands-on testimony.

Congressman Rogers, may I ask when your report will be available because, frankly, if you have anything that would be appropriate now or in the very near future, I would be glad to hold the record of this hearing open so that we could print in the record your committee's very valuable analyses and reports and recommendations.

Mr. ROGERS. Well, that's very kind of you. I think the current schedule is try to get it publicly released about January. But we'd like to discuss that with you.

Representative SCHEUER. Let's discuss it. Maybe there's some kind of synopsis, maybe there's some kind of statement you can give us that would encapsulate and summarize the body of your recommendations at this point in time which would be very, very helpful to us.

Mr. ROGERS. And may I impose on you, Mr. Chairman, to introduce you to the people who really are the workers. We get to speak for them sometimes, but Dr. Henry Simmons, who is president of the National Leadership Commission on Health Care, and Dr. Peggy Rhoades, who is our director, do the hard work.

Would you stand?

Mr. RAY. They're shy, as you can tell. [Laughter.]

NEED BIPARTISAN SOLUTION

The other thing I wanted to mention to you is you commented that this is a problem and the solution will be both a Republican and Democratic one, not either/or.

Representative SCHEUER. It has to be.

Mr. RAY. I sit here and I look up in front and I realize that you're carrying an awful lot of the weight for both Republicans and Democrats. I applaud you for not only being here and conducting these hearings, but the active participation of you as the chairman. I think that's very commendable.

Representative SCHEUER. Well, we've had quite a degree of participation from our members.

As Paul Rogers knows very well, all 535 of us in this institution are pulled from pillar to post. We're overstretched and the time demands on us are incredible and really not very rational.

We didn't have any participation today. We had the Prime Minister of Australia appearing before the House in the last hour or two. I regret that more Members of Congress didn't have the privilege of hearing you. But they'll certainly read your testimony and we will certainly include it in our report and concentrate on what you've had to say because, frankly, we've had a very distinguished group of medical and health professionals appear before us in what have been 40 or 50 hours' worth of hearings and dozens and dozens of witnesses.

But you are the two preeminent lay people with towering political experience and background, and you have evidenced marvelous political leadership, and have brought your talents to bear on our national health system. It's absolutely essential that we have that

kind of nonhealth professional, but political and social and societal expertise and leadership that you two have brought to this matter.

FINANCE TRAINING IN CARE ASSESSMENT

Let me ask the two of you, as men who have had this towering political experience and just as towering political credibility, how have we gotten to this point where we're spending all these billions on high technology, on processes, on procedures, on operations, on surgery, on products, and virtually nothing as a society in letting either the health professionals know or letting health consumer know what works and what doesn't work?

You've taken us to the mountaintop and shown us a condition that's almost unbelievable in a sophisticated, high-technology society that we haven't learned to review and appraise and examine in a scholarly way what our health professionals and the free enterprise community hath wrought. How can this be?

Mr. ROGERS. Well, I think a lot of it maybe started because medicine is an art. It started that way, as you know, and it's taken a few hundred years now to get us where we're moving toward science all the time.

When we go to the doctor, the doctor is supposed to know what he's doing. And they get these practices going and no one stops to really analyze.

Representative SCHEUER. Well, what I'm really asking is how could we be at this position, especially with the explosion in the last decade or two of these products, of new technology?

I mean, when you think of it, CAT scanners, MRI that you discussed, Congressman Rogers, open-heart surgery, organ transplants. All of these date back little more than a decade. We've had an explosion of high-technology outputs from our society, from the science and technology that our brilliant academic and industrial community, health industry, have produced.

How come there's been so little effort at evaluating it?

Mr. ROGERS. Because we haven't paid for it, that's why. If we insisted that these studies be done and provided financing for those studies, they would have been done. And that's what we have to face up to.

It's just like I noticed your question to the Surgeon General about why haven't we moved more toward prevention? Counseling? And he said, well, the glamour. That's part of it. The glamour of doing the acute, dramatic saving of a life. That is where the doctor gets the satisfaction. Unfortunately, one doesn't see the results of prevention for years.

But the main reason is because we're not paying doctors to do counseling and preventive medicine. And they're not going to do it until they're paid. We have to arrange some mechanism to bring about change.

Representative SCHEUER. It isn't to be found in the reimbursement schedule. That's what you're saying.

Mr. ROGERS. Well, of course.

Mr. RAY. Isn't all of this so exciting? Two things. One is health is, to most people, the most important thing of life. And so, cost doesn't make a lot of difference.

Second, they haven't had to worry about costs when providers covered total costs in the past. And then, third, all technology is exciting and we live in that age when everything is new and different and more exciting.

We used to marvel at the television set. Then we marvelled at going to the Moon. And now, when you have an MRI, and if you've ever been in one and you look at what it does and it looks at that skeletal arrangement from all different angles, it's very exciting. And everyone believes that they'll spend anything on health to feel better, to have a longer life.

Now we're beginning to look at it a little differently, as I heard it discussed earlier by the Surgeon General. States are looking at it differently. People have to look at it differently. And certainly, providers look at it differently.

So I think you live in this special country that has led us to believe that there's going to be something better tomorrow and let's reach for it and we'll somehow afford it.

Well, we're finding we can't afford everything. And not all of it is producing good results. I remember companies got so enchanted with new computers. They bought computers very rapidly and went broke because they couldn't afford the computers and they couldn't afford training people and having people use them when they could use a card system that was much better.

I think the medical profession is somewhat in that same state.

Representative SCHEUER. Well, you talk about training. Are we failing to train doctors? Are we failing to train peer review committees in hospitals how to effectively evaluate all these new procedures and processes and products?

How should that training program be organized? And who should pay for it? And how should it be institutionalized? Should we require a small percentage, perhaps a percentage point or two, of what is spent in developing new technology, whether it's in the public sector or the private sector be set aside for evaluation?

How should we do that, Congressman Rogers. You've had so much experience as the leader of health legislation here for almost a decade.

Mr. ROGERS. I think what you suggest is probably a good idea. Certainly, we have to find some technique to bring about those studies and we're going to have to have some technique to pay for it.

It may be as the developers themselves come forward, maybe research should be part of an approval process that will at least give us an effectiveness study.

Representative SCHEUER. We do that, don't we, with the Food and Drug Administration?

Mr. ROGERS. Certainly.

Representative SCHEUER. We require the drug companies to pay very substantial fees that, in effect, cover a good deal of the cost of the scrutiny and the evaluation that FDA gives.

Mr. ROGERS. And there is some, of course, done with the medical device law, as you recall. But we're not doing the tying together of the delivery techniques and, an outcomes study, which probably should be done. The commission will be looking at this, and we'll come back to you.

Representative SCHEUER. Very good. I can't think of anything that would be more helpful.

Are you under time pressure?

Mr. ROGERS. No. I just don't want to hold you up.

Representative SCHEUER. Should doctors be trained in medical school to be a little more selective or should doctors be instructed in hospitals through peer review groups and quality control groups to be a little bit more selective in these high-tech procedures and techniques and surgery and so forth?

Should they have to justify it? Should they have to explain why they're doing it, so that there's a record that they did go through a judgmental process, a serious judgment process in selecting a procedure and considering alternates and so forth and validating this procedure for its effectiveness in terms of improving health outcomes, for its cost effectiveness, for its reasonableness, its appropriateness?

Should that be part of the process that has to take place before a doctor engages in surgery or uses a new product, a new high-tech product or system?

Mr. ROGERS. Well, I think, basically, this is the process that goes through that doctor's mind, and it should.

Now, I don't think you want to make too many hard regulations where you, in effect, are binding the physician so he's afraid to do anything. I think you have to be very careful about that because there still is a lot of art in medicine, of course, along with the science background.

But I think that is a process a doctor goes through. You take second opinion. It's simply an extension of what you're saying there, that it's a confirmed judgment that this surgery is appropriate or that certain procedures should be used.

Now, as we do studies, we'll be able to know better how to make those judgments. For instance, right now, Blue Cross & Blue Shield will not pay for certain testing on certain diseases, you see. They won't pay for it because they say it's a useless one. It's been shown that these really are not helpful.

Well, that payment mechanism is a very strong lever to get people to react quickly. And as we gain this knowledge, that will be used.

So I think it will go through a doctor's mind and, of course, there will be constant training. There should be, yes, in medical schools. It's a constant problem, I think, to keep doctors up to date with all the new technology, what's really effective, what isn't.

But what they have to have is testing to really make intelligent judgments.

Mr. RAY. I think the commission has been very much interested in that very subject. There's more and more pressure for physicians to do precisely what you're talking about, anyway. Malpractice is a case in point.

I think however it comes about, it's almost inevitable, but that that's going to be an outcome.

I wanted to also make the comment—I was surprised about the training of physicians in med schools. I was surprised to learn how many doctors perform certain procedures that seem quite appropriate to that doctor because that's what the doctor learned in med

school, only to find out that those procedures were never tested. There's been no followup, no research, no evaluation whether it's good or bad or whether it's the right procedure or not.

They're doing what they were taught to do and they think and believe and that's the reason I think sometimes they get resentful when people question them, because they know they're doing what they were taught to do.

Representative SCHEUER. Twenty or 30 years ago.

Mr. RAY. Twenty or 30 years ago.

Mr. ROGERS. That's right.

NEED JOINT PUBLIC-PRIVATE TECHNOLOGY ASSESSMENT

Representative SCHEUER. Now, Mr. Rogers, you're aware that shortly after this administration took office, it abolished the National Center for Health Care Technology, which is the agency responsible for providing assessments of new major medical technologies. And this was transferred to another agency.

It's apparently still within HHS, but is has a minor role in the National Center for Health Services Research.

Based on your experience, how do we take this whole question of appraisal of new health technology and evaluation of new health technology off the back burner. How do we get it out of the shadows and onto the front burner where we fund it properly and require testing and evaluation of all new procedures, products of all kinds, just, as a routine matter, as we do with the Food and Drug Administration?

And how do we mandate that doctors have to make reasonable judgments based on a consideration of alternatives that are part of a record before they go ahead and invoke this new procedure or new product or new surgical technique?

Mr. ROGERS. Well, a lot will be testing. I think it has to be done in the private sector as well as governmental. But I think the Government will have a definite role, no question about it.

Representative SCHEUER. And what should that role be?

Mr. ROGERS. I think we need to have a center where research can be done or coordinated, where we have the expertise.

Now whether it would be done at the Institute of Medicare or at the National Institutes of Health, where extramural research is combined with some intramural research, that could be possible. But I think it should be a joint private and governmental approach.

Also, I think the whole process of the doctor making the judgment has to be an educational process, bringing the knowledge to them. It has to be ingrained in them in their medical school and their whole training. And I don't think we've done a proper job. And a lot of it is because, as Governor Ray said, they simply haven't had the real facts there to use or to train with because they haven't had that knowledge.

So that is an area that the commission, I hope, will address. I'm sure it will because it's so important. And we hope to come back with some suggestions that we would be glad to share with you.

Representative SCHEUER. Well, very good. We will convene a hearing on your thinking, your conclusions, your recommendations,

just as soon as that report is ready. And, of course, I would yield to my colleague, Congressman Waxman of California, who now chairs that Health and Environment Subcommittee

Mr. ROGERS. Maybe we could do it jointly.

Representative SCHEUER. Maybe we could.

Mr. ROGERS. We'll talk about it, anyhow, and see what we can do.

Representative SCHEUER. Right.

Mr. ROGERS. Thank you.

Representative SCHEUER. This has been extremely helpful testimony this morning, from two hands-on practitioners of not the medical arts, so much as the governmental arts in the field of health care, and it been an extremely valuable additional overlay to the 8 or 9 days that we've had already of testimony from health professionals.

You have augmented their testimony in a way that is incomparably valuable to us and we thank you very, very much for your testimony.

Mr. ROGERS. Thank you, Mr. Chairman. Thank you for your graciousness to us. We will be in touch. We commend you.

Representative SCHEUER. Wonderful.

Mr. RAY. Meanwhile, stay healthy. [Laughter.]

Representative SCHEUER. Thank you. I have to participate in what's going on on the floor now. So we're going to have to suspend this hearing for about 15 or 20 minutes.

Let's say until about 12:35, maybe 12:40. I regret this, but it's one of those things.

Thank you very much.

[A 20-minute recess was taken.]

ROLE OF RESEARCH AND PREVENTION

Representative SCHEUER. Well, the subcommittee will recommence its hearing.

I want to express my deep apologies to you gentlemen for having killed—what, almost 2 hours? I am mortified. But that's the way the congressional schedule went.

We'll conclude this hearing and, indeed, the entire set of hearings, with a panel on the role of research and prevention.

We have two very distinguished witnesses. It's proper that we should end this set of hearings on the need for research, which is manifest, and the need for prevention which is even more manifest.

We'll hear from Mr. William Raub, Deputy Director of the National Institutes of Health, and Mr. Edmund J. McTernan, professor and dean of the School of Allied Health Professions at the State University of New York at Stonybrook in my own State.

I don't know if either of you gentlemen were here when we were hearing the other witnesses. But you heard some of the matters we were discussing and the need for research, the urgent need for more focus on prevention and health care and wellness, rather than sickness care, curative care.

So we'd be happy to hear you address, if you wish, any of the questions that you heard discussed either by members of prior panels or from myself.

Now, your statements as prepared will be printed in the record. So what I hope you will do is take such time as you wish. We're now down to the last panel. There's nobody waiting for us. You can take as much time as you'd like and chat with us informally, with the sure knowledge that your prepared statements will be printed in the record.

All right. So, Mr. Raub, why don't you start out and take such time as you may need.

STATEMENT OF WILLIAM F. RAUB, DEPUTY DIRECTOR, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. RAUB. Thank you very much, Mr. Chairman.

Representative SCHEUER. Again, my profound apologies for this long delay.

Mr. RAUB. No apology necessary, sir. It goes with the territory.

Representative SCHEUER. Thank you.

Mr. RAUB. I'm pleased to have this opportunity to represent the National Institutes of Health in this important and informative series of hearings.

My oral testimony today will highlight a few points from the prepared statement that we already have submitted, as you indicated.

Biomedical research has led to remarkable improvements in the health of our citizens and holds promise for even more impressive advances. Both the pace and the character of this research have markedly increased in the recent past, largely due to the strong, sustained support that the Congress and the President have provided through the National Institutes of Health.

The most prominent qualitative change has been the maturation of molecular biology, with the attendant emergence of biotechnology-based agents and procedures for the diagnosis, treatment, and prevention of disease.

At the same time, the pace is becoming ever more brisk, as medical scientists progressively shorten the time between discovery and application. Thus, no one can project with certainty the nature and effects of these discoveries over the next 5 years, much less into the next century.

GOOD SYSTEM OF RESEARCH IN PLACE

Nevertheless, some general areas of future progress seem clear.

Beginning in the broadest terms, Mr. Chairman, my NIH colleagues and I suggest that our current approach to fostering biomedical research will serve the Nation well for the foreseeable future. The NIH invests in scientific inquiry all across the spectrum, from basic science to targeted projects directly in health care settings.

We place particular emphasis on the elucidation of fundamental life processes at the cellular and molecular levels in health and disease, for such insights generally are the key to opening new avenues for targeted efforts.

At the same time, we are quick to pursue promising leads for clinical trials of new, preventive, diagnostic, or treatment measures, for such efforts are vital to ensuring that the results of publi-

cally funded research in basic science are put to appropriate use in the national health care system without undue delay.

Moreover, we pursue our objectives through a heterogenous array of performers, including our intramural laboratories and clinics, those of academic health centers and other institutions of higher education, and a host of other not-for-profit and commercial organizations.

All told, over 1,600 institutions are engaged in NIH-funded research. Although the relative emphasis among objectives and strategies surely will change from time to time, the current model should serve effectively far into the 21st century.

IMMENSE HEALTH BENEFITS FROM RESEARCH

Biomedical and behavioral research results have already yielded immense health benefits. For example, the development of vaccines led to the worldwide elimination of smallpox and to the effective prevention of polio, diptheria, measles, yellow fever, and other infectious diseases.

Similarly, great advances have been made in the treatment of many cancers, with one-half of all cancer cases now regarded as curable if diagnosed early and if treated in accord with the latest knowledge. And the decline in deaths from stroke has been greater than 50 percent over the last 30 years.

To be sure, high-tech medicine, as discussed this morning, has played its part. The revolution in microelectronics and computers has fostered an unprecedented series of important medical technologic innovations, such as noninvasive diagnostic imaging procedures. CAT scanning, ultrasound and magnetic resonance imaging have led to the improved ability to detect and accurately diagnose disease or its lethal consequences at the earliest and most treatable, and perhaps even preventable, stage.

At the same time, rapid advances in biophysics have led to improved surgical techniques and tools. Lasers are now being used routinely in the control and treatment of diseases of the retina of the eye, diseases that in the past would have led to blindness, and in the control of bleeding in a variety of surgical situations and procedures.

Carefully focused ultrasound is being used successfully in the treatment of kidney and gall bladder stones, mitigating the need for more expensive and traumatic invasive surgical procedures.

Perhaps the headiest area of research advance in recent years has been the area of molecular biology. Recombinant DNA and gene-cloning techniques have enabled production of biologically active substances, such as growth hormone and insulin, as well as tissue plasminogen activator, known as TPA, a substance that can dissolve clots in the coronary arteries in a matter of minutes, thus preventing the loss of heart muscle that would have normally occurred with the acute closure of a coronary artery in a heart attack.

Recombinant DNA techniques have also led to rapid elucidation of complex disease processes. For example, the work of Nobel Prize recipients Drs. Brown and Goldstein, which led to the discovery of

a special cell receptor that is critical in controlling the level of blood cholesterol.

Other advances in molecular biology have produced a knowledge explosion regarding the immune system, leading to marked improvement in the ability of patients to receive and tolerate organ transplants, opening promising new approaches in the treatment of many different cancers, and providing the conceptual basis for much of the research to combat acquired immunodeficiency syndrome.

Present knowledge of the human genome has led to the identification of gene markers for Huntington's disease, muscular dystrophy, and one type of Alzheimer's disease, with the potential for the first time of an effective treatment and possibly complete prevention of these conditions, perhaps early in the next century.

COST EFFECTIVENESS OF RESEARCH

Turning from looking at gains from research in terms of improved health to the cost effectiveness of such research, I will cite but one example in the interest of brevity. My prepared statement presents several others and many more still could be provided for the record if the committee would find that useful.

Consider the prevention and treatment of neonatal respiratory distress syndrome, a life-threatening set of breathing problems that often afflict babies right after birth, especially when that birth is premature.

Extensive studies in animal models demonstrated that administration of synthetic and natural corticosteroids before birth accelerated lung maturation and significantly diminished the occurrence of respiratory distress syndrome.

A clinical trial conducted by our National Heart, Lung, and Blood Institute between 1976 and 1983 demonstrated the safety and efficacy of corticosteroid administration for pregnant women with expected premature delivery and gestational age between 26 and 37 weeks.

The Institute estimates that the annual health care cost of this condition before corticosteroid treatment was used was almost $1.5 billion. After treatment, the annual cost was just over $1 billion, or an annual savings in the range of $500 million.

FUTURE CHALLENGES IN RESEARCH AND APPLICATIONS

The 21st century will bring its excitement, but also its challenges. And among those that we will face, two warrant special attention.

First, if we are to maintain the pace of scientific advances, we must ensure that there is a continuing supply of bright and well-trained scientists. However, the number of Americans available for these careers may be declining. For example, the number of 22-year-olds is projected to drop more than 25 percent from its current level before the end of this century. If even the current number remains stable, a significant increase in the proportion of 22-year-olds attaining scientific and engineering degrees would be required to meet the projected research needs.

Unfortunately, the baccalaureate degrees awarded in the life sciences have declined steadily since 1977 to the present. Our educational programs at all levels will face an enormous task in attracting and preparing the talent that will be needed as we go into the next century.

Another challenge is that of transferring gained knowledge into practical application. To accomplish this, NIH recognized in the early 1970's that the Nation needed a new process to assess new and controversial technologies, while presenting them in a fashion that would facilitate their application into the practice of medicine.

This led to the creation of our Office of Medical Applications and Research as a means of transferring these discoveries to practicing physicians in a timely manner.

Over the past 11 years, this Office has administered 69 consensus development conferences, as we call them, covering a wide range of medical procedures, drug treatment and medical device usage. This consensus process has become a principal scientific forum where medical innovations are assessed and results publicly disseminated.

We intend to continue and to strengthen this process in the future.

FUTURE EXPECTATIONS AND NEEDS

In conclusion, Mr. Chairman, advances in biomedical research and its derivative technologies hold great promise for improving the health of Americans in the next century. This research almost surely will make it possible to prevent many diseases outright and to intervene so early in the course of others that most adverse effects are averted.

The result in savings and lives, suffering and health care costs should repay the investment many times over.

This morning, we heard eloquent testimony with respect to the need for effective and sustained public health information and related activities. NIH strongly endorses those concepts.

We stress, however, that the public health arena needs a scientifically sound message if it is to have its full and true effectiveness. We see NIH's principal role as ensuring the generation of the scientifically sound message and participating as best we can in the array of professional and public education endeavors that would help achieve those public health goals.

Thank you, Mr. Chairman, for the opportunity to testify; and I'll be glad to respond as best I can to questions you may have.

[The prepared statement of Mr. Raub, together with supporting information, follows:]

PREPARED STATEMENT OF WILLIAM F. RAUB

Good morning Mr. Chairman. My name is Dr. William Raub, Deputy Director of the National Institutes of Health. I am pleased to appear before you today to discuss some of the recent and exciting developments that have occurred in biomedical research and to cautiously suggest some directions this research may take us.

Biomedical research is an important national enterprise that has led to remarkable improvements in the health of our citizens, and that continues to hold promise for even more impressive advances. The pace and character of this research have markedly increased in the past several years, largely due to the support and conduct of such research by NIH. The most prominent qualitative change has been the maturation of molecular biology with the attendant emergence of biotechnology-based agents and procedures for diagnosis and treatment of disease. At the same time, the pace continues to increase as medical scientists progressively shorten the time between discovery and application. Thus, accurate projections of the nature and effects of these discoveries are difficult over the next five years, much less into the next century. Nevertheless, some general areas of future progress seem clear and prognostication reasonable.

Beginning in the broadest terms, my colleagues and I suggest that our current approach to fostering biomedical research will serve the Nation well

for the foreseeable future. The NIH invests in scientific inquiry all across the spectrum from basic science to targeted projects directly in health care settings. We place particular emphasis on the elucidation of fundamental life processes at the cellular and molecular levels in health and disease, for such insights generally are the key to opening new avenues for targeted efforts. At the same time, we are quick to pursue promising leads for clinical trials of new preventive, diagnostic, or treatment measures, for such efforts are vital to ensuring that the results of Federally funded basic science are put to appropriate use in the national health care system without undue delay. Moreover, we pursue our objectives through a heterogenous array of performers, including our intramural laboratories and clinics, those of academia health centers and other institutions of higher education, and a host of other not-for-profit and commercial organizations. Although the relative emphasis among objectives and strategies surely will change from time to time, the current model should serve effectively far into the twenty-first century.

Biomedical and behavioral research results have already yielded immense health benefits. For instance, the development of vaccines led to the worldwide elimination of smallpox, and to the effective prevention of polio, diphtheria, measles, yellow fever, and other infectious diseases. The diagnosis of many neurologic disorders that previously required invasive and potentially risky tests such as cerebral angiography or pneumoencephalography can now be accomplished on an outpatient basis more safely with CAT and MRI

scanning. Many surgical procedures can be performed more quickly and safely with new technologies. The death rate from coronary heart disease has declined at an unprecedented rate. Great advances have been made in the treatment of many cancers with one half of all cancer cases now regarded as curable if diagnosed early and if treated in accord with the latest knowledge; and the decline in deaths from stroke has been greater than 50 percent over the last 30 years.

The revolution in microelectronics and computers has fostered an unprecedented series of important medical technologic innovations, notably in the use of non-invasive diagnostic procedures such as CAT-scanning, ultrasound and magnetic resonance imaging, in the use of monitoring equipment for the fetus and newborns, and in the now-routine use of intensive care units for critically ill patients. These techniques have led to the improved ability to detect and accurately diagnose disease or its lethal consequences at the earliest and more treatable and perhaps even preventable stages.

For example, diagnosing early disease changes in the arteries to the heart is now possible and will continue to improve over the next several years. Soon, with minimal inconvenience and risk to the patient we will be able to identify accurately and follow the development of atherosclerotic plaques in these arteries and intervene before the artery becomes so narrowed that blood flow is significantly compromised. With these techniques the prevention of

heart attacks will be improved even more than possible today. Further, the years of epidemiological and prevention research have allowed us to identify the important, modifiable life style risk factors, namely high blood cholesterol, high blood pressure and cigarette smoking, that increase the risk for these dreaded diseases. Ongoing research results should help us to intervene to prevent diseases and disabilities even more effectively than we have been able to do in the past.

Rapid advances in biophysics have led to improved surgical techniques and tools. Lasers are now being used routinely in the control and treatment of disease of the retina of the eye that in the past would have led to blindness and in the control of bleeding in a variety of surgical procedures. Carefully focused ultrasound is being used successfully in the treatment of kidney and gallbladder stones, mitigating the need for more expensive and traumatic surgical techniques.

A variety of improvements in biologically suitable materials has allowed the development of improved pacemakers and defibrillators for the heart, of implantable insulin pumps for the diabetic patient, of artificial joints to replace destroyed and painful arthritic joints, of dental implants to permanently replace lost teeth, and of cochlear implants that allow totally deaf people to hear sound.

A virtual explosion in molecular biology has led to recombinant DNA and gene cloning techniques that have enabled production of biologically active substances such as growth hormone and insulin, as well as tissue plasminogen activator (TPA), a substance that can dissolve clots in the coronary arteries in a matter of minutes, thus preventing the loss of heart muscle that would have normally occurred with the acute closure of a coronary artery in a heart attack. Recombinant DNA techniques have also led to rapid elucidation of complex disease processes, for example, the work of Nobel Prize recipients Drs. Brown and Goldstein, which led to the discovery of a special cell receptor that is critical in controlling the level of blood cholesterol. Other advances in molecular biology have produced a knowledge explosion regarding the immune system, leading to marked improvement in the ability of patients to receive and tolerate organ transplants, opening promising new approaches in the treatment of many different cancers, and providing the conceptual basis for much of the resarch to combat acquired immunodeficiency syndrome.

Present knowledge of the human genome has led to the identification of gene markers for Huntington's disease, muscular dystrophy, and one type of Alzheimer's disease, with the potential for the first time of an effective treatment and possibly complete prevention of these conditions, perhaps early in the next century. The NIH and its grantees historically have had the leadership role in mapping and sequencing the human genome. There is tremendous excitement and promise about what these efforts hold for the future of humankind.

For example, last week in the Washington Post, on the front page, a story highlighted how scientists at the National Institutes of Health have designed a novel medical experiment that would put genetically altered cells in human beings. Drs. Steven Rosenberg, NCI, and W. French Anderson, NHLBI, proposed inserting a "marker" gene into a newly identified type of cancer-fighting cell and then placing the altered cells into patients. The proposed procedure, while not a therapy, would initially be used to help follow the progress of a new cancer therapy being used to attack melanoma, a skin cancer, and kidney cancer. More significantly, it would institute a class of treatment that doctors have been pursuing for more than a decade. Ultimately, doctors hope, human gene therapy could be used to cure such illnesses as cystic fibrosis, muscular dystrophy, or sickle cell anemia.

Turning from looking at gains from research in terms of improved health, to the cost effectiveness of such research, I would cite just three examples of health care cost savings resulting from biomedical research efforts.

Research efforts from the mid-1960's onward, much of which was NIH-funded, resulted in an effective vaccine for hepatitis B in 1982. Hepatitis B virus (HBV) is responsible for a significant disease burden in populations around the world. In the United States an estimated 200,000 cases are estimated to occur

each year. Transmission is most commonly by contaminated needles or blood, through sexual contact, or perinatal transmission from infected mother to her newborn infant. Both presentation of disease symptoms and outcome are variable. Infections in adults and children can be either asymptomatic or symptomatic. Disease in symptomatic cases ranges from mild pain and impairment to fulminant hepatitis and death during the acute phase of infection. Both symptomatic or asymptomatic infections have outcomes of either full recovery or development of chronic disease. It is estimated that yearly health costs of this disease before the vaccine were about 225 million dollars, and afterwards about 130 million dollars, an annual savings of nearly 100 million dollars.

Another area is the prevention and treatment of the neonatal respiratory distress syndrome. Extensive studies in animal models for respiratory distress syndrome (RDS) had demonstrated that antenatal administration of synthetic (dexamethasone) and natural (cortisol) corticosteroids accelerated lung maturation and significantly diminished the occurrence of RDS. An NHLBI-sponsored clinical trial was conducted between 1976 and 1983 and demonstrated the safety and efficacy of corticosteroid administration for pregnant women with anticipated premature delivery and gestational age between 26 and 37 weeks. It is estimated that the annual health care cost of this condition before the treatment was $1,455,000,000. After treatment the annual cost was $1,155,000,000, or a savings of $300,000,000.

A third area of the cost saving effects of biomedical research application has been in the treatment of diabetic retinal disease by laser surgery called photocoagulation. In 1971 a nationwide clinical trial, the Diabetic Retinopathy Study (DRS), was begun under the sponsorship of the National Eye Institute to determine conclusively whether photocoagulation was safe and effective for treating advanced stages of diabetic retinopathy. The DRS showed that photocoagulation treatment can substantially reduce the chance that people with advanced diabetic retinopathy will suffer severe visual loss. It was estimated that the annual cost of this disorder was 71 million dollars before laser treatment and 39 million dollars after, for an annual savings of 32 million dollars. The positive findings of the DRS suggested that photocoagulation might also be effective in treating less advanced stages of diabetic retinopathy. A controlled clinical trial to test this hypothesis, known as the Early Treatment Diabetic Retinopathy Study (ETDRS), was begun in 1977 and is continuing today.

Challenges

To maintain the pace of scientific advances we must ensure that there is a continuing supply of bright and well-trained scientists. The Government-University-Industry Research Roundtable (GUIRR) of the National Academy of Sciences has been exploring issues relating to the development, identification, recruitment and retention of such science and engineering talent. In evaluating the talent pool, the GUIRR predicts that the demand for scientists and

engineers will remain strong in both industry and academia, but that at the same time the number of Americans available for these careers may be declining. For example, the number of 22-year-olds is projected to drop more than 25 percent from its current level before the end of this century. If even the current number remained stable, a significant increase in the proportion of 22-year-olds attaining scientific and engineering degrees would be required to meet the projected research needs. In fact, the roundtable group estimated that to maintain the 1985 level of potential research trainees into the 1990s, the degree award rate would have to increase by 30 percent. Unfortunately, the baccalaureate degrees awarded in the life sciences has decreased steadily since 1977 to the present; in 1977, 78,472 degrees were awarded whereas only 57,812 were awarded in 1985, a 26% decrease.

Another challenge is transferring gained knowledge into practical application. To accomplish this, the NIH recognized in the early 70's that a creative process must be developed, that would assess new and controversial technologies, while presenting them in a fashion that would facilitate their application into the practice of medicine. This led to the creation of the Office of Medical Applications of Research (OMAR) as a means of transferring these discoveries to practicing physicians in a timely fashion. Over the past 11 years OMAR has administered 69 consensus development conferences covering a wide range of medical procedures, drug treatment and medical device usage. The NIH consensus process is the main scientific forum in the nation where medical

innovations are assessed and the results publicly disseminated. Many of these conferences have evaluated the safety and efficacy of such complex medical technologies as CAT and MRI scanning, coronary artery bypass surgery, total hip joint replacement, intraocular lens implantation, and plasmapharesis. The consensus statements that have resulted from these meetings have provided important guidance to other government agencies, third party payers, and the public.

Summary

In conclusion, advances in biomedical research and its derivative technologies hold great promise for improving the health of Americans in the next century. This research almost surely will make it possible to prevent many diseases outright and to intervening so early in the course of others that most adverse effects are averted. The resultant savings in lives, suffering, and health care costs should repay many times over the investment in gaining the knowledge that makes such savings possible.

This concludes my prepared statement. I would be pleased to answer any questions you might have.

APPENDIX

NIAMS MULTIPURPOSE ARTHRITIS CENTERS

The Multipurpose Arthritis Centers (MACs) Program was authorized by the National Arthritis Act of 1974 and funded after the National Commission on Arthritis and Musculoskeletal Diseases delivered the Arthritis Plan to Congress in 1976. In 1977 and 1978, 22 centers were funded from about 70 applications. There were three components in these early MACs: Research, Education and Training, primarily for health professionals. Community programs were geared primarily toward the development of teaching aids to reach primary care providers and identifying under served patient populations. Development and Feasibility Studies were introduced in 1978 and existing centers were encouraged to apply for them as supplements. In 1979, as the initial three year funding expired and a large number of Centers came up for renewal, the MACs began their rapid evolution to a primarily research orientation in all components. Core units were added in 1980. In 1982, The three components were renamed Research, Education and Community/Health Services Research, acknowledging the emergence of Health Services Research as a significant element in Center activities. In Research and Education/Community/ Health Services Research. The focus is now quite clearly directed to research in both these components. Thus, the Education/Community/Health Services Research component has had a rapidly evolving role in the MACs.

With this background, it is easier to understand why it is difficult to point to concrete measurements of the impact of the Education/Community/ Health Services Research component. During 1977-80, the goals were largely oriented at training health professionals and the patients about arthritis. Little emphasis was placed on measuring the effectiveness of the training , much less the impact. Questions about evaluation of programs and their impact are not prominent in summary statements until 1983-84.

On a community health level, most Multipurpose Arthritis and Musculoskeletal Disease Centers provide leadership in community and state arthritis awareness. The following are notes taken from recent reports of the various long standing Centers to the Program Director at NIH to illustrate programs that have had an impact for health care.

- The University of Alabama at Birmingham Multipurpose Arthritis and Musculoskeletal Diseases Center has developed programs to reach a rural, medically under served community. Working with the Center, the School of Public Health evaluated the cost and impact of rheumatic diseases in Alabama and the specific need for services and for health manpower training. This study lead to the development of Project H.E.L.P., a service network that provides an organized system to disseminate information programs and materials and the technical expertise to support community health resource development. The center also established the Arthritis Information Service (AIS), a toll-free public information telephone service for Alabama. This

service is staffed by trained volunteers. In addition to responding to public inquiries about arthritis, the AIS provides arthritis related program content for the community organization meetings and health fairs.

- The Indiana University Multipurpose Arthritis and Musculoskeletal Diseases Center has worked with the State Board of Health and the Subcommittee on Handicapping Conditions in Adults Task Force to identify state deficiencies in the care for patients with arthritis and to generate state level health policies. A slide tape program on Arthritis and the Elderly, developed by the Indiana Multipurpose Arthritis and Musculoskeletal Diseases Center, is highly popular and has been viewed by approximately 4,000 people. The program is designed for use by leaders of programs for senior citizens and does not require inperson participation of professional staff. At the university, a unique **Performing Arts Medicine Program** has been established, consisting of patient care activities, research and education/outreach programs. The clinic, which is multidisciplinary and staffed by physicians who are themselves musicians, deals with performance-related health problems of instrumentalists, vocalists and dancers.

- The Multipurpose Arthritis and Musculoskeletal Diseases Center at Boston University has presented a major continuing medical education course entitled **"Workshops in Musculoskeletal Disease: A Unique Learning Experience for the Practitioner"**, attended by fifty internists and family practitioners from the New England and New York areas. An ongoing program has been the development of instruments for a formal evaluation of the status of family practice and internal medicine house officer education in rheumatology. A major contribution to health services research at the national level has been the **Arthritis Impact Measurement Scale (AIMS)**. This health status measure is a self administered patient self-report on problems on nine specific areas: mobility,physical activity, dexterity, household activities, activities of daily living, social activity, anxiety, depression and pain. The AIMS instrument has proved highly successful and is being used by a wide variety of researchers in and outside of rheumatology areas.

- The Multipurpose Arthritis and Musculoskeletal Diseases Center at the University of California at San Francisco has focused on health services research. One project has been to establish a panel of patients with rheumatoid arthritis being seen by board certified rheumatologist. To this panel of about 1000 patients, questions can be posed to address problems for health research. Such panel studies have included how work characteristics alter the probability of work loss among patients with rheumatoid arthritis and a determination of the risk factors for institutionalization among elderly persons with rheumatoid arthritis. Another study is examining how various therapies for rheumatoid arthritis affect the patient's life.

- The Multipurpose Arthritis and Musculoskeletal Diseases Center at Stanford University developed the **Arthritis-Self-Management Program**. This important and impressive program has been shown to increase

patient self-management behavior, decrease pain, and shows trends toward less disability and depression. Originally tested and developed with over 4,000 arthritic patients in the San Francisco Bay area, over 15,000 patients nationwide have now participated in the program. The Arthritis Foundation has disseminated the program. The Center has the cooperation of major medical care systems, such as the Kaiser Health Plan and the Midpennisula Health whether certain services are cost effective and/or increase patient satisfaction. The Stanford Multipurpose Arthritis and Musculoskeletal Diseases Center has also played a major role in the American Rheumatism Association Medical Information System (ARAMIS).

- The Multipurpose Arthritis and Musculoskeletal Diseases Center at Brigham and Women's Hospital in Boston has addressed issues of health care services and clinical epidemiology. Productive,collaborative relationships with neighborhood health care centers and the local branches of the U.S. Postal Service and the Social Security Administration have been developed to improve the healthcare of a large number of individuals. One ongoing project is a study designed to reduce the incidence of lifting related back injuries and musculoskeletal injuries to the neck, shoulders,chest, chest, thighs and hips in the Boston postal workers. The outcome of this study is expected to have a significant impact on the health and health-care costs of these workers.

- The Multipurpose Arthritis and Musculoskeletal Diseases Center at Case Western Reserve University has worked on a number of community and state projects to develop and promote community outreach activities. These range from the development of patient registries to interaction with the Ohio Department of Health Arthritis Advisory Committee. The Center has worked to develop patient education programs and has developed a major audiovisual resource library used throughout the United States.

- The University of Connecticut Multipurpose Arthritis and Musculoskeletal Diseases Center has developed outreach programs for the elderly, for low-literacy patients, and for patients with juvenile arthritis and their families. Computer based educational programs have been developed for these groups and are being disseminated through the community and into neighboring states.

- The Multipurpose Arthritis and Musculoskeletal Diseases Center at Northwestern University in Chicago has been effective in developing means of studying the interaction of arthritis and musculoskeletal disease with the patient's family and social functions. These are allowing researchers to conduct more sophisticated studies, such as the prevalence of musculoskeletal disease in the elderly, and testing the cost effective intervention strategies aimed at maintaining independent functioning.

- Multipurpose Arthritis and Musculoskeletal Diseases Center at the University of Missouri at Colombia developed a computer based program to improve the clinical problem-solving skills in arthritis for advanced medical students and practitioners. This program, called

AI/RHEUM, (AI for artificial intelligence) utilizes a computer based expert system in rheumatology tied with a videodisc for displaying classic clinical findings. This system allows the user to put data about the patient and to be presented with likely diagnosis for the many common varieties of arthritis. With the tentative diagnosis, the user is presented with a list of further procedures that would aid in confirming the diagnosis, recommending these procedures with both the invasive quality and the cost of the procedure in mind. AI/RHEUM is now a project of the National Library of Medicine, and has been shown to be accurate in a number of studies on both the United States and Japan. The educators at the University of Missouri are now working on a new system, AI/LEARN, designed to teach clinical skills in arthritis to medical students and general practitioners.

- The University of Missouri at Columbia has also provided leadership to the State through the Missouri Task Force on Arthritis. This Task Force developed the State of Missouri Arthritis Program which established eight regional arthritis centers. Seven regions were designated to operate programs in education of patients, families, and the public about arthritis. They also provide education to health professionals, and facilitate improved patient care and other arthritis control activities. The State of Missouri has become a leader in comprehensive provision of services to a large population of chronically disabled persons through the impetus of the Multipurpose Arthritis and Musculoskeletal Diseases Center.

- The Multipurpose Arthritis and Musculoskeletal Diseases Center at the University of North Carolina at Chapel Hill established a model comprehensive care clinic for persons with arthritis in the town of Wilson, NC. The aim of the project was to demonstrate that early aggressive management leads to improved outcomes such as joint score, functional index, pain score, and employment. While this was not shown, the project was highly successful in establishing important interactions. The project provided unique collaboration between the Wilson-Greene District Health Department , North Carolina Department of Human Resources,University of North Carolina at Chapel Hill School of Medicine and Division of Vocational Rehabilitation Services and two physician group practices. Because of the project, the Home Health Agency of the Wilson/Greene District Health Department added occupational therapy services and assigned a registered nurse to become project coordinator. The local vocational rehabilitation counselor gained an increased knowledge and appreciation of the variability and potential employability of arthritis patients. The ties between the primary practice clinics and the University of North Carolina at Chapel Hill Division of Rheumatology were strengthened. The patient support group continued to meet regularly under the auspices of the Health Department and the North Carolina Chapter, Arthritis Foundation.

NATIONAL INSTITUTE ON AGING
EXTRAMURAL RESEARCH ON URINARY INCONTINENCE

NIA RESEARCH ON URINARY INCONTINENCE IN OLDER PERSONS

Urinary incontinence is a significant cause of disability and dependency among older persons. At least ten percent of the population over 65 years old have some degree of urinary incontinence, and at least two percent of community-dwelling person over 65 years old are afflicted with urinary incontinence severe enough to cause substantial limitation or alteration of daily activities.

In April 1983 a workshop on the prospects for clinical trials on behavioral therapies for urinary incontinence was held at the NIA. The consensus of the workshop was that controlled clinical trials of the behavioral therapies were necessary in order to advance knowledge in this area. Therefore, the NIA in collaboration with the then Division of Nursing, Health Resources and SErvices Administration (now the National Center for Nursing Research, NIH), published in early 1984, a request for applications (RFA) addressing this matter. The overall goal of the research solicited by the RFA was to determine the efficacy of specific behavioral interventions in reducing incontinence in the various diverse subpopulations of older persons with urinary incontinence.

In September 1985 the NIA made awards at five sites to conduct clinical trials of behavioral therapies for urinary incontinence in older persons. These trials have produced data on the efficacy of their interventions. Summaries of these follow:

- A study was conducted of 109 women, 55 years of age or older, who live in the community and suffer involuntary urine loss at least once a week. Subjects were randomized into those receiving treatment immediately and those without treatment (control group). Control subjects were treated after the observational (control) period. Treatment consisted of a six-week outpatient bladder training protocol of scheduled voidings without concomitant drug intervention. Outcome was assessed by determining number of incontinent episodes, diurnal and nocturnal micturition frequency as reported on standardized weekly urinary diary and objective quantitation of fluid loss. The mean age of the sample was 68+/- 9.

- The number of incontinent episodes per week was reduced form 22+/- 20 to 9+/-11 in the treatment group, while the number in the control changed from 21+/-19 to 17+/-17. The difference between treatment and control groups was highly significant ($p<.001$). The treatment group also had marked reductions in urinary frequency and nocturia compared to the controls. Treatment appeared to be equally effective in patients with urethral incompetence and those with detrusor instability. Comparison of effects of therapy at six weeks and six months also show no statistical differences ($p=0.1$ to $p=.04$). Outpatient bladder training is effective in managing urinary

incontinence in older community-dwelling women. Its effectiveness seems independent of whether the patients have either urethral incompetence, detrusor instability or both, and are maintained over time. The mechanism of action remains unclear, but seems to involve changes in behavior. (J.A. Fantl, U01 AG05170).

- A controlled clinical trial tested the effectiveness of a biofeedback therapy for 120 women with stress of mixed incontinence. All subjects were randomly assigned to either a Kegel exercise treatment to improve pelvic floor muscle performance (Group 1), biofeedback and Kegel exercises (Group 2), or a control (Group 3). The dependent variables were measured through self reports of urine loss, grams of urine lost during a sequence of provocative stress maneuvers, pelvic muscle activity and maximal urethral pressure obtained during a comprehensive urodynamic evaluation.

  Subjects were predominantly white, middle class, and married with a mean age of 62 years. The average subject had a 14 year urine loss history with 17 losses per week. All subjects were mentally competent, and nondepressed. The primary dependent variables showed no significant difference between treatment groups prior to the interventions. Pelvic muscle activity, recorded as both a quick and sustained contraction score, was found to be statistically improved in the biofeedback treatment group. Symptom,s of urine loss were significantly decreased in both treatment groups. Group 2 evidenced a 75 percent change, compared to the 50 percent reduction in symptoms in the Kegel exercise therapy alone. Grams of urine lost during a quantitation pad test also revealed statistical difference from pre- to post-treatment, which appears to be similar across treatment groups. Maximal urethral closure pressures were not significantly changed in either treatment group.

  The results of this single-blinded controlled trial appear to demonstrate that this type of behavioral therapy is effective for women with stress incontinence, and a viable alternative to surgery which can be accomplished within a primary health care setting. (P. Burns, U01 AG05260).

- A trial of "promoted voiding" treatment of urinary incontinence was conducted within 126 nursing home patients. These patients were severely disabled, with 75 percent demonstrating bladder abnormalities, 83 percent incapable of independent toileting, and a mean mini-mental status examination score of 7.5. In this study, patients were checked hourly, asked if they needed toileting assistance (prompted) and socially reinforced for appropriate toileting. The treatment was evaluated with a multiple baseline design in which subjects were randomly assigned to immediate or delayed treatment groups. The frequency of incontinence per twelve-hour period changed from 3.85 at baseline to 1.91 during treatment. Eighty-five percent of patients had a reduction in frequency of incontinence episode while on treatment. Effectiveness of the therapy was adversely affected by low bladder capacity and mobility deficits, e.g. inability to assist in transfer and to and from bed. The effects of the treatment do not appear to persist after prompting is discontinued. (J.F. Schnelle U01 AG05270)

- A Pennsylvania study employed a protocol similar to the prompted voiding approach described above, but observed somewhat different results. One hundred thirty-three incontinent women in seven nursing homes were randomly assigned to a 13-week bladder training program based on principles of behavior change, or to a control group that received usual treatment (no prompting). A 22-week follow-up period examined the durability of the treatment effects. The subjects' mean age was 85. They averaged two wet episodes per day during the three-week baseline period. They needed assistance with many activities of daily living, and were very cognitively impaired.

- The therapy became effective after six weeks of training. By the final month of training, the treatment women's wet episodes had been reduced by 0.57 episodes per day, or a 26 percent reduction over baseline. This reduction was statistically significant, both with respect to the baseline levels of incontinence and to the control women, whose improvement of 0.17 episode per day was not statistically significant. During the last month of training, 74 percent of the trainees showed some improvement over baseline, and 39 percent showed improved move than 50 percent. Analyses controlling for such independent variables as ADL score MMSE score, urological classification nd bladder capacity, age, and baseline wet episodes, revealed that treatment was responsible for a reduction in wet episodes by .45 episode per day after six weeks, a statistically significant reduction $p<.05$). Trainees with a high frequency of incontinence during baseline, those relatively more congitively intact residents, and residents with a normal bladder capacity responded better to this training program.

  An encouraging finding of this study is that improved incontinence was partially maintained during the follow-up period, even though the social reinforcement was terminated, in part because trainees had learned to make self-initiated request to toilet. One finding of the study is that in the short run, the labor costs of bladder training may be higher than the savings in laundry costs to he nursing homes. A program focused on more severely incontinent and more cognitively alert residents would reduce the time required to realized monetary payoff. A major requirement for the success of this kind of program is motivating nursing home staff (particularly nursing aids) to generate the higher work output necessary to produce more continence. (T. Hu, U10 AG05268)

- A study at the University of Arkansas evaluated the efficacy of biofeedback therapy for treatment of urinary incontinence in again chronic care inpatient men over 65 years of age. Baseline urinary incontinence measurements were made using telemetric monitoring of frequency and a pad weight exchange technique for volume determination. Patients were randomly assigned to a control group and an experimental group. The experimental group received immediate treatment consisting of five weeks of biofeedback therapy for bladder control. The control group received no incontinence therapy during the five week interval. The biofeedback therapy sessions were administered twice weekly for one hour. Biofeedback was provided to the patient as pitch variable audiofeedback and color line graphic video feedback using external anal sphincter electromyographic activity as the signal source. At the conclusion of the five week period, each group had urinary incontinence measurements. The mean incontinence frequency in the immediate treatment group was

26.5 episodes per five days at baseline and 10.0 episodes per five days after therapy. The mean incontinence frequency in the control group was 25.4 episodes per five days at baseline and 25.8 episodes per five days after the non-treated interval. After the five week interval, the number of incontinence episodes was significantly lower in the treatment group ($p=<.01$). The mean volume of involuntary urine loss in the immediate treatment group was 2623 cc per five days at baseline and 1043 cc per five days after treatment. The mean volume in the control group was 2817 cc per five days at baseline and 2988 cc per five days after the non-treated interval. After the five week interval, the volume of involuntary urine loss was significantly lower in the treatment group ($p=<.01$).

These results show that biofeedback therapy administered as described to aging chronic care inpatient men was associated with a significant reduction in the frequency of incontinent episodes and volume of involuntary urine loss. (P. O'Donnell, U01 AG05267)

NATIONAL CENTER FOR NURSING RESEARCH
URINARY INCONTINENCE RESEARCH

Urinary Incontinence

Urinary incontinence (UI) is a health problem suffered by a significant number of both community-dwelling and institutionalized people, especially the elderly. Its prevalence among community-dwelling females has been estimated to be as high as 40 percent. It interferes with physiological and social functioning, reduces quality of life, increases dependency among the elderly, is an important factor in elderly people entering nursing homes, and is responsible for significant health care delivery costs. Urinary incontinence is a nursing problem. Nursing personnel give 24 hour care to institutionalized patients and care for and counsel elderly people and their caregivers in the community. Effective nursing strategies are needed to help patients already afflicted as well as to assist vulnerable individuals prevent severe urinary tract dysfunction. Since it is estimated that of the $20 billion spent on nursing home care each year urinary incontinence accounts for about $0.5 to $1.5 billion, research in this area is important not only to improving quality of life but also to reducing health care costs.

The NCNR is participating with the National Institute on Aging in funding five cooperative agreements to carry out clinical trials testing the effectiveness of non-invasive behavioral strategies for the treatment of UI in the elderly individual. The studies involve outpatients who are tested and treated in nurse-run continence clinics, and inpatients in long-term care facilities. Interventions being studied include approaches such as bladder training, prompted voiding, biofeedback, social reinforcement, and pelvic muscle exercises. Findings will be used to promote self care and prevent permanent disability. The cost of UI and its treatment is also being examined in some of the studies.

Preliminary data suggests that some treatments are successful. In one study, nursing home patients were treated with prompted voiding and social reinforcement strategies. These interventions resulted in decreased incontinence episodes and increased episodes of appropriate toileting. Researchers are now analyzing the data to develop predictive factors for identifying individuals most likely to respond to the treatment and develop approaches for maintaining the effect of the treatment.

NATIONAL INSTITUTE ON AGING
DEMENTIA

Mission:

The neuroscience and Neuropsychology of Aging Program fosters and supports extramural and collaborative research and training to further the understanding of the aging process relevant to the neuroscience and associated areas of the psychological sciences. The activities of this program devoted to the aging nervous system can be distinguished by an interest in: aging as a process; age-related changes in the brain or nervous stem in the context of other age-related physiological or homeostatic regulatory changes (e.g. endocrine, dietary, immune, disease states); degenerative processes or pathological changes in the aging brain in the context of understanding normal age-related changes; and the sensory, perceptual, and cognitive processes and changes that occur with aging and their underlying biological mechanisms. An important component of this program is the support of basic, clinical, and epidemiological studies of Alzheimer;s disease and related dementias of aging. The NIA legislative mandate provides specific authority to the Institute to: support research on Alzheimer's disease (AD), establish Alzheimer's Disease Research Centers (Sec. 444 and 445, P.L. 99-158), establish Alzheimer's Disease Registry (Sec. 12, P.L. 99-158), conduct clinical trials for the treatment of Alzheimer's disease (P.L. 100-175, Sec. 301 (a)), promote research on diagnosis and epidemiology of AD (P.L. 990-660, Sec. 941 (b)(1)(A)).

Discussion of NNA Priorities

AD is one of the most prevalent, devastating and costly diseases of later life. The NNA has AD as one of its major emphases. Progress and achievements in the past year are numerous. The Alzhiemer's Disease Research Centers (ADRCs) have become an exceptional vehicle for the rapid exchange and transfer of scientific information and for facilitating collaboration between centers. An additional two centers to be awarded in FY 1988 will serve to expand the clinical and research base on AD; open opportunities for recruitment of new collaborative research initiatives tied to the larger ADRC program; increase the national effort to provide more sophisticated diagnostic procedures to wider segments of the U.S. population; and provide resources for more specialized training of health care providers.

Two awards will be made in FY 1988 for Leadership and Excellence in Alzheimer's Disease (LEAD). Title IX, Section 931 of P.L. 99-660 authorized the NIA Director to make awards to distinguished senior investigators who have made significant contributions to biomedical research related to AD and other dementias. This program is intended to strengthen the capabilities of established senior investigators who have distinguished records in biomedical research on AD; and allow recipients

time to devote to research and the research development of outstanding junior biomedical investigators who are interested in working on AD research. Eight applications were received from very prominent investigators.

The scientific opportunities in the neuroscience and the neuropsychology are particularly rich. Recent studies on the molecular genetics of AD have shown that there is a linkage between chromosome 21 and the familial or early onset (but not the late-onset) form of AD. This linkage involves a gene locus separate from that of Downs Syndrome (DS) and the beta-amyloid regions of this chromosome and is not associated with the duplication of this region as is found in DS. Further research is needed to pinpoint more precisely the gene locus, and if successful, to identify the protein for which it codes. An additional challenge would be to determine the roll—particularly the pathologic effects, if any—of the amyloid protein in this disease.

Evidence has emerged that nerve cell membranes derived from AD patients differ significantly from normal controls in the concentration of the various constituent phospholipid. Further studies are needed to define the membrane structure and to determine how changes in the phospholipid concentration may interact with membrane imbedded proteins.

Changes found in cytosol calcium concentration as a consequence of aging may be universal in all types of cells, including nerve cells. Additional research is needed to determine whether such changes occur in an abnormal manner or are accelerated as a consequence of a disease process and too discover the cause of such events. It is postulated that in AD such changes are due to hypoglycemia and/or hypoxic conditions created by changes in the brains microvasculature.

Nerve growth factor (NGF), which was previously thought to act only in the peripheral nervous system has now been round to be active within the central nervous system. NGF is able to prevent the degeneration of cholinergic neurons in adult rats after experimental lesions which mimic some of the cell losses found in AD in humans. This findings opens the potential of research using increased availability of NGF to human cholinergic cells to promote their survival in AD and thus perhaps retard or prevent memory loss.

ETIOLOGY OF ALZHEIMER'S DISEASE

Mission:

The purpose of the etiology unit of NNA is to support research to determine the cause or causes of AD and of the pathopysiologic chain, which results in the multiple abnormalities seen in AD. NIA supported investigators are approaching this problem from a variety of fronts: cholinergic, adrenergic, and neural peptide systems; excitatory amino acids; structural proteins; environmental toxins.

EPIDEMIOLOGY AND THE ALZHEIMER'S DISEASE PATIENT REGISTRIES

Mission:

The mission of the epidemiology and patient registry unit of NNA is to solicit and support investigations which address the incidence of prevalence and risk factors for AD and other demanding disorders of later life. The long range goals are to determine specific risk factors for AD which will lead to understanding the etiology of AD. An important thrust instruments for use in field studies.

TREATMENT AND MANAGEMENT

Mission:

The principle focus of the NNA is to develop the knowledge base to treat biological course of the disease and to manage the behavioral manifestation of the disease. The treatment and management focus is the patient and his/her behavior. The approach may use pharmacologic, behavioral or environmental, interventions, individually or in combinations. Although at present we may not be able to prevent, treat, or interrupt the course of the disease, we can develop the technologies to preserve function, reduce excess disability and ameliorate symptoms such as: wandering, insomnia, pacing, agitation, feeding difficulties, and incontinence. It is important to note that in order to fully develop research on treatment and management, we must more clearly understand the clinical course of AD and AD impinged upon other common diseases and conditions of older people. Efforts should be made to develop techniques (modify existing devices or methods or develop new ones) that will make it easier to care for AD patients and/or compensate for their functional disability.

There are many other important and related issues, including coping mechanisms used by families and caregivers; help seeking behaviors and responses of caregivers; economics of health care
for AD; and the nature of caregiving burdens and the means to reduce the burdens. However, the NNA's emphasis is limited to the treatment and management of the symptoms of the disease experienced by the patients.

TEACHING NURSING HOMES
NATIONAL INSTITUTE ON AGING

NIA Teaching Nursing Home Program

The NIA TNH Award Program which began in 1982, supports research by academic centers and nursing homes on health problems, therapies and health maintenance strategies for older-persons in nursing homes as well as other institutional and community settings.

The program title is intended to emphasize the analogy between the teaching hospital as a setting for research in acute care settings and the "Teaching Nursing Home" as one site to develop research in long term settings. Thus, despite the title, teaching training, or service activities per se are not supported by the TNH Program. It should be noted that the TNH Program supports geriatric research involving subjects other than nursing home residents, including community-dwelling and acute-care patients.

The NIA's rationale for its TNH Program came from the fact that though there were many strong clinical researchers and a fair number of strong geriatrician, there were not many strong geriatric researchers. Most clinical researchers did not have the background or experience to work with very old persons with multiple chronic illnesses, and few geriatrician had extensive research experience. The TNH Program was designed so that the strengths of these two groups would complement each other. The geriatrician would provide their expertise with older subjects, the clinical researchers would provide the research techniques of their specialty, and each group would learn from the other.

The NIA currently supports eight TNHs. The period of support is five years and can be renewed by competitive application. Four TNHs have had their renewal applications reviewed and it has been very gratifying to see that the renewals have done very well in peer review.

The research topics supported by the TNH Program cover a wide range. Though most of these projects are biomedical, the TNH Program supports some behavioral research as well (for example, one of the dementia projects focuses on caregivers of dementia patients). The following selected list of publications indicates that the TNH programs are doing well in presenting research data both in the specialty journals and also in main-line medical journals.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE
MATERIALS THAT PROVIDE DIETARY INFORMATION

THE NATIONAL CHOLESTEROL EDUCATION PROGRAM (NCEP)
NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

The goal of the NCEP is to contribute to reducing illness and death from coronary heart disease in the United States by lowering high blood cholesterol levels in Americans at risk. A number of NCEP publications are based on dietary guidelines to avoid too much fat, especially saturated fat, and cholesterol, and maintain desirable body weight.

Materials for Patients and the Public

- Facts About Blood Cholesterol--explains to the general public the importance of reducing a high blood cholesterol level, i.e. its relationship to coronary heart disease, and contains dietary advice for eating less fat, especially saturated fat, and cholesterol.

- Eating To Lower Your High Blood Cholesterol--contains dietary advice for people who have been diagnosed as having high or borderline-high blood cholesterol.

- So You Have High Blood Cholesterol--contains information on high blood cholesterol as one of the risk factors for coronary heart disease, the role of dietary factors on blood cholesterol levels, and general advice on dietary modifications to help reduce high blood cholesterol levels.

Materials for Health Professional--These materials include Dietary guidance information for patients.

- Report of the Expert Panel on the Detection, Evaluation and Treatment of High Blood Cholesterol in Adults--Offers physicians practical guidelines for detecting, evaluating, and treating patients with high blood cholesterol. The subject areas covered include classification of blood cholesterol, patient evaluation, dietary treatment, and drug treatment.

- Cholesterol: Current Concepts for Clinicians--This independent study module first published in 1987 offered continuing medical education credits from Hahnemann University, and presented current perspectives and information available from experts in the field of cholesterol research and management. Recently, the module has been updated in accordance with the NECP Adult Treatment Panel Report guidelines and will provide continuing medical education credits from Hahnemann University. The revised module will be available in late summer.

- NHLBI Minority Focus--An NCEP Strategy Development Workshop on cholesterol and minority health was held on May 7, 1987. The report, prepared from this workshop, emphasizes dietary changes appropriate for Blacks, Hispanics, Asian/Pacific Islanders, and Native Americans.

THE NATIONAL HIGH BLOOD PRESSURE PROGRAM (NHBPEP)
NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

The goal of the NHBPEP is to reduce death and disability related to high blood pressure through professional, patient, and public education. The relationship between diet and high blood pressure is addressed in program activities and publications.

Materials for Patients and the Public

Blacks and High Blood Pressure, and Questions About Weight, Salt, and High Blood Pressure—These two publications contain information on effects of diet, sodium, and weight control on blood pressure.

Materials for Health Professionals—The NHBPEP has a number of professional materials that provide dietary guidance information for patients.

- The 1988 Report of the Join National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (JNC IV) - This report contains a section on nonpharmacologic therapy that discusses weight reduction, restriction of alcohol and sodium, and modification of dietary fats.

- Nonpharmacologic Approaches to the Control of High Blood Pressure - Discusses how physicians can solve adherence problems related to maintaining desirable weight, reducing sodium, and moderating alcohol consumption.

- National High Blood Pressure 12-Month Kit - This 1988 kit contains program ideas and reproducible materials that promote the dietary modifications related to weight control and sodium.

- The Final Report of the Working Group on Hypertension and Diabetes - This report's section on treatment includes information on weight reduction, sodium restriction, and fat restriction for patients with hypertension and diabetes.

Other

- The Healthy Heart Handbook for Women - this brochure was published to answer the many requests from women for information about heart disease and stroke. It details the risk factors for women, ideas about prevention and control of these disorders and sources of more information. Heart disease is a very real threat to women and this booklet is dedicated to helping women take the steps necessary to help protect their health.

- Eating for Life - The forthcoming publication is a joint effort of the National Cancer Institute and the National Heart, Lung and Blood Institute on providing dietary guidance information to the public.

Illustration of the Nurse's Role in
Health Promotion and Disease Prevention:

A major concern in current health care delivery is the degree to which individuals comply with the recommendations of health professionals in treating illness or promoting healthful behaviors. The objective of several of NCNR's current studies is to enhance preventive nursing practice through the examination of behaviors in populations exhibiting actual or potential health compromising behavior. Variables that influence motivations for health promoting behaviors are being studied to provided the basis for future interventions. Researchers on one of the projects are studying the environmental and personal correlates of health compromising behaviors among young adolescents. Behaviors with long-term social and health consequences are being examined in a population of eighth graders in rural public school systems. The behaviors include cigarette smoking, drug and alcohol use, early sexual activity, excessive caffeine consumption, eating related and other health risk-taking behaviors.

Representative SCHEUER. Very good. Mr. McTernan, please proceed.

STATEMENT OF EDMUND J. McTERNAN, SR., PROFESSOR, HEALTH SCIENCES, AND DEAN, SCHOOL OF ALLIED HEALTH PROFESSIONS, STATE UNIVERSITY OF NEW YORK, STONY BROOK

ROLE OF PREVENTION

Mr. MCTERNAN. I, too, appreciate the privilege of being here and I want to echo what other people have said that we have tremendous respect for your conscientiousness in attending to the many duties that are loaded on you.

Representative SCHEUER. I apologize once again.

Mr. MCTERNAN. No problem at all. My responsibility, as I understand it, is primarily to address the role of prevention in American health care, and particularly the human resources that help make prevention efforts possible.

A good deal of my prepared statement unavoidably is duplicated and I don't want to waste your time by forcing you to listen to something you've already heard or read. So, basically, I think I can say what I think might be different in just a few, brief points.

You've already heard very eloquent testimony that the potentials of improved health promotion, disease prevention interventions for reduction of morbidity, improvement of the quality of life for the aged and others, reduced disability days and reduced cost of health care, are indeed enormous.

The potentials for the improvement of the health status of the American people are everywhere. Indeed, they're almost pervasive as you look around at our society at ways in which we could live healthier lives.

You've also heard from previous witnesses that, unfortunately, our society and the health care system which serves it is not really oriented toward health. It's really oriented toward the care of illness that's already occurred.

Societal structures and values unfortunately encourage health-negative behaviors. I think you, yourself, brought out this morning the fact that the system rewards care providers for treating disease. It does not reward or pay them for the time they spend in preventing disease. And in fact, there are lots of disincentives to providers for spending time on health prevention and patient education.

I think one thing I would like to be sure to say here is I'm a bit of an alarmist in a way because I think that the health care delivery shortage which is developing— I'm not addressing physicians, now, but particularly nurses and allied health practitioners—is truely very alarming.

You've mentioned the shortage of nurses. But qualitatively, the shortage of many other essential providers, physical therapists, occupational therapists, medical technologists—whom we thought we weren't going to need a few years ago and respiratory therapists, is far more severe. Salaries are spiraling, which is going to run costs up. Hospitals are desperate for personnel and they cannot fill their ranks with qualified personnel.

I just returned last week from the first World Congress on Allied Health and the Americans there were castigated rather severely by people from Third World countries for attempting to solve our health personnel shortage by draining their brainpower. They pointed out they have only a fraction of our gross national product, and yet we are hiring away the people they have paid to train. And that was rather embarrassing.

Representative SCHEUER. I've seen them leave a graduation ceremony for nurses in Sri Lanka and head for the airport.

Mr. MCTERNAN. Yes.

Representative SCHEUER. Right from the graduation ceremony, clutching their diplomas in their hand. Their bags are all packed and they're ready to go.

Now the fact is that many of these nursing personnel from Sri Lanka, from India, from the Philippines and other developing countries play indispensable roles in our health care delivery system.

But, at the same time, it is a tragedy that they're being lost to their own countries.

Mr. MCTERNAN. And, of course, many of them never return.

Representative SCHEUER. It's a terrible dilemma.

Mr. MCTERNAN. It really is. My main point is that with a few exceptions, our human resource for health care providers receive little or no preparation to function as health promoters or preventers of illness. We are merely prepared to extinguish fires after they've occurred.

Earlier witnesses have testified that it is possible to achieve significant payoff by engaging in health promotion and care. And I think we can witness the achievements which were outlined as a result of the "Objectives for the Nation" publication of the Public Health Service in 1980.

One important point, I think, is that the objectives focused on primary prevention. And while there are tremendous gains that have been made in primary prevention, there are tremendous additional gains we haven't really addressed, secondary prevention, early case finding and early treatment, and tertiary prevention, which is the minimization of the effects of illness after it has occurred.

There are tremendous potentials yet for us to get involved in those kinds of prevention activities.

BARRIERS AND LACK OF TRAINING IN PREVENTION

All health promotion interventions require the education and involvement of the individual. However, as the Surgeon General has pointed out, they also require professional expertise and leadership to guide people into effective health behaviors and, to some extent to protect them from charlatans and from cult kinds of activities.

At present, many of America's health care providers are neither prepared to engage in health promotion and in many of the professions, they are prevented from doing so by the way the system is structured. And I think that could be changed.

For an example, I have been primarily involved with the education of the allied health professions. And all of us have had the ex-

ample of having blood drawn and you walk in and the person behind the desk says, roll up your sleeve, make a fist, hold it, pulls out the blood and then says, OK roll down your sleeve, and that's it.

If that person could be both trained and permitted to reinforce health behaviors, like saying, instead of just sitting there drawing blood, say, oh, I see you're still smoking. Has your doctor talked about smoking?

There's a lot that could be done and there are millions of these interventions every day. But they are prevented by the way the system is structured.

Representative SCHEUER. Can you elaborate on that? Why are they prevented?

Mr. MCTERNAN. Well, they are told, you're not here—I think it's the medical hierarchy model, really. If you ask even a nurse, and I'm a registered nurse myself, but if you're asked a question, you're told, well, you have to ask your doctor about that.

Representative SCHEUER. They have to ask their doctor before they can discuss a patient's smoking habit?

Mr. MCTERNAN. Yes, pretty much, or they'll get chewed out quite royally. That's not your role. Your role is to draw the blood. And now these people are very well trained.

It's a hangover, I think, from the days when we used to just train them. Now we educate them in college programs.

Representative SCHEUER. That is absolutely absurd.

Mr. MCTERNAN. It really is.

Representative SCHEUER. If a person with an RN level of training can't talk to patients about smoking, alcoholism, diet, obesity, the elementary aspects of responsible personal behavior as far as health is concerned, that is absolutely mind blowing.

Mr. MCTERNAN. In many situations, they cannot without being criticized. And I think that's one of the reasons from what we're learning that is driving a lot of nurses out of nursing, because they feel that they are prevented from playing the professional role they're qualified and interested in playing.

Another example, if I may draw one from my own institution, in our School of Allied Health Professions, with funding, in fact, from Dr. Axelrod, who was here earlier, very modest funding, we have started an AIDS education program which is now outreaching into 119 colleges and universities in New York State. We know we reached 45,000 students in the last 6 months and 45,000 students 6 months before that, by far the largest AIDS education program directed at that high-risk group anywhere in the world.

Representative SCHEUER. High-risk group.

Mr. MCTERNAN. Oh, yes, late adolescents are now recognized as a high-risk group because they tend to be sexually active and experimenting. So it's important that they get the message.

Representative SCHEUER. The two high-risk groups, as I understood it, in AIDS were homosexuals and intravenous drug users.

Are college students likely to be involved in one of these two groups?

Mr. MCTERNAN. Well, another risk group are people who have multiple sex partners. College students, I suspect, are——

Representative SCHEUER. To the extent that they have sex with a person involved in these two groups.

Mr. MCTERNAN. Well, except that you don't know what your partner's previous sexual behavior has been.

Representative SCHEUER. Yes.

Mr. MCTERNAN. And there's this long window period between infectivity and when the test will show positivity.

Representative SCHEUER. Between what?

Mr. MCTERNAN. Between the time a person gets infected and the time that the antibodies will show up in the test.

Representative SCHEUER. Yes.

Mr. MCTERNAN. So even saying, I'm healthy, is no guarantee.

Representative SCHEUER. How long is that period?

Mr. MCTERNAN. It's believed to be from 7 to 10 years.

Representative SCHEUER. My goodness.

Mr. MCTERNAN. During which you can travel around the world countless times and infect countless people.

Representative SCHEUER. Yes.

Mr. MCTERNAN. But my point in this is that this is the situation in which allied health people working with medical support, but on their own initiative have developed a tremendous program in prevention. And there are many examples that could be used for that.

Another issue that came up this morning was the importance of reaching minority Americans. Many minority Americans coming from poorer economic circumstances are able to enter the health work force, pull through an allied health route, and have access to their communities, which sometimes nonminority people don't have.

So there's another important reason for us to find better ways to use the nonphysician health provider in prevention and allowing them to become more involved in prevention.

Representative SCHEUER. The paraprofessionals, so to speak.

Mr. MCTERNAN. Yes, although I try to avoid that word because I think they're professionals in their own right. But, yes, that's the term.

Representative SCHEUER. Well, they don't have medical degrees. They don't have RN degrees. They're something other than that. That doesn't mean they're less than that.

Mr. MCTERNAN. We use the term "allied health professionals" for some 85 different specialty fields, all of which have a baccalaureate degree or better.

I think part of the problem, part of the reason that people have not been allowed to talk to patients has been the very hierarchical way in which health care has been structured. I think the more recognition we're able to give these people, including using the term "professional," makes it better.

WAYS TO ENCOURAGE HEALTH PROMOTION/DISEASE PREVENTION

Anyway, to get this huge, untapped resource enlisted in the effort and to get more interest in health promotion and disease prevention among physicians and dentists and others, we think there's a need for both carrots and sticks.

A few years ago, the Public Health Service sponsored a series of workshops which came up with some 30-plus recommendations to get physicians, nurses, other health professionals, more interested and involved in health care. They involved what I call stick recommendations, such as modifying the accreditation requirements for approved schools to require that they teach prevention as well as just cure, encouraging licensing bodies in the States to ask questions on the licensing exams relating to preventive practices, those kinds of punitive, if you will, actions.

The carrots, of course, would be Federal programs to support demonstrations of health promotion, disease prevention. And sadly, I think we've had some backsliding here. There used to be a program by which very innovative projects could gain some Federal support. There were nine around the country. All of those were stopped about 2 years ago, I think because a very constrained Federal budget had to divert so much money to AIDS concerns, which, of course, is also a very important endeavor. But it was too bad to see these activities nipped in the bud, in a sense.

Out of those workshops, however, a group of health professionals that cut across all disciplines and who are committed to the concepts of health promotion and disease prevention got together, I think out of frustration, and formed an organization called the National Council on Education for Health Professionals and Health Promotion. It's a nongovernmental, nonofficial agency.

In fact, I'm here, I think, by virtue of the invitation from your subcommittee to that council. I know Dr. Wasserman from your district from Booth Memorial Hospital has become very active in that, and others have been as well.

The Government was unable to publish the recommendations of those Federal workshops. The National Council on Education for Health Professionals and Health Promotion has summarized and published these recommendations in this little document, which I will leave with the subcommittee.

That group, with only very limited resources, however, would certainly stand ready to assist the important work you're doing in any way possible.

On behalf of the council and on behalf of the American Society of Allied Health Professions, which I also represent, I do thank you, Mr. Chairman, for the opportunity to be here, and for a very fascinating day hearing very interesting testimony.

[The prepared statement of Mr. McTernan follows:]

PREPARED STATEMENT OF EDMUND J. McTERNAN, SR.

My name is Edmund McTernan, Sr. I am Professor of Health Sciences and Dean of the School of Allied Health Professions at the State University of New York at Stony Brook. However, I am participating in this hearing as the representative of the National Council on the Education of Health Professionals in Health Promotion, a non-governmental, not-for-profit organization of health care practitioners and educators interested in Health Promotion/Disease Prevention.

The Cost-effectiveness of Health Promotion/Disease Prevention (HP/DP) Programs

I understand that this part of today's hearing is intended to provide a focus upon the benefits of effective health promotion and disease prevention interventions in reducing morbidity and improving the quality of life for all Americans. While it is not our responsibility at this time to present the cost benefits of prevention, there is increasing evidence that those benefits are significant. It is clear that it pays to keep people healthy, rather than simply cure and rehabilitate disease or injury after the fact.

Benefits of HP/DP

Health promotion and disease prevention (HP/DP) efforts are wonderful things to be in favor of, for they can represent "win/win" choices for everyone. The studies conducted and published by recent Surgeons-General of the United States have already demonstrated that:

a) Morbidity and mortality can be effectively reduced by HP/DP efforts;

b) Consequent reductions in hospitalization and disability constitute significant cost savings through reduced need for health-care services;

and

c) The quality of life for large numbers of people can be significantly improved through practicable and relatively modest HP/DP programs (Healthy People, 1979; Objectives for the Nation, 1980).

There are many disease entities which are entirely preventable (including a number of infectious diseases); others which could be largely prevented or lessened through changes in our lifestyles (lung cancer, heart diseases, cerebrovascular accidents, dental caries, obesity, sexually transmitted diseases, and others); and still more in which the degree of disability and its consequences can be ameliorated (arthritis, sequelae of motor vehicle or industrial accidents, muscular dystrophy, certain birth defects, etc.). All of these maladies (and others like them) represent an immense burden upon society because of the need for care which they engender, the suffering which each patient and his/her family endures, and the lost value of the individual's services as a fully productive citizen.

The Traditional Status of Preventive Care in U.S. Health Values

Unfortunately, our health care system has never placed a suitable priority upon HP/DP care, and in fact that system is structured in ways which actually discourage both consumers and care-providers from placing an appropriate degree of emphasis upon avoiding or preventing disease and injury, instead of simply providing diagnosis, treatment, and rehabilitation after illness or injury has occurred.

Our advertising industry lures and cajoles people of all ages to engage in health destructive behaviors such as smoking, speeding, and substance abuse; while our health care reimbursement system largely excludes payment for preventive services. Individuals are told that it is far more attractive to live life on the edge, than safely. Physicians and other health professionals quickly learn that prevention may pay off for the consumer, but that their time spent in HP/DP activities will not be reimbursed.

During the first half of this current decade, an exhilarating new breeze stirred across the American health care system. Stimulated by the work of the Surgeon General of the United States, federal policy began to look seriously at HP/DP, and "carrot" programs designed to interest individuals and those who deliver their health care in prevention emerged tentatively upon the landscape. The two landmark publications, Healthy People (1979) and Promoting Health/ Preventing Disease: Objectives for the Nation (1980) caught the interest of at least a portion of the health care provider community.

An office of Disease Prevention/Health Promotion was established and placed directly within the Surgeon General's Office, to emphasize its importance. Federal health agencies were directed to assess their role in HP/DP, and those analyses were published in a third important publication (Public Health Reports, Supplement to the September-October 1983 issue, "Promoting Health/ Preventing Disease, Public Health Service Implementation Plans for Attaining the 'Objectives for the Nation'.")

Perhaps most importantly, the federal government "put its money where its mouth was," and the Congress allocated modest sums to encourage and support demonstration projects which would enhance HP/DP activities. The Public Health Services administered these funds in support of a series of innovative programs, some of which held great promise for cost and quality-effective prevention/promotion interventions.

As a result of these efforts, immense strides had been made towards the achievement of those Objectives for the Nation by the mid-1980's. By this time, too, many voices concerned with HP/DP were calling for the extension of this energy into secondary and tertiary prevention, as a means of achieving further, significant reductions in premature death and disability.

The Impact of AIDS Programming Upon HP/DP and other Federal Programs

Tragically, our society then entered the age of acquired immune deficiency Syndrome; being threatened by a deadly challenge for which there is still no cure, and which poses an immediate risk to life to millions of our people. This happened contemporaneously with an era in which: 1) near panic was developing about the national budget deficit, 2) administration policy was vigorously opposing almost all government involvement in social programs, in favor of the so-called "private sector," and 3) social programs were being given relatively low priority, in comparison to defense and similar interests.

The result was that the nascent and highly promising HP/DP initiative was essentially scrapped. The DP/HP office in the Public Health Service remained, as did some of the other lip-service to the concept of increased prevention, but little tangible support to encourage HP/DP developments was allowed to survive. Such funding as was available was diverted to AIDS programming.

The Three Levels of Prevention

We should remember that preventive care exists at three levels. The first level is concerned with primary prevention; that is, with attempts to prevent a disease from happening in the first place. Immunization against infectious diseases is a good example of primary prevention, as is health education designed to convince citizens to abandon self-destructive behaviors.

The next level is secondary prevention. This seeks to identify developing disease early, to institute therapy promptly, and to minimize the impact of that illness or the rate at which it develops in the individual. Finally, there is tertiary prevention, which seeks to institute protective and supportive measures, to prevent any further effects of illnesses or injuries which have already occurred.

Until the corpus of the infant HP/DP movement of the early 1980's was swept away by the need to divert available funding to AIDS-related programming, almost all of the emphasis of that new development was focused within the realm of primary prevention. This was understandable, since the planning for the programming which had been developed was carried out largely by public health personnel, who are traditionally most concerned with primary prevention endeavors.

The "Cast of Characters" Required for Effective HP/DP Programs

Primary care focuses to some extent upon specific groups of care providers, such as physicians (who can order and administer immunizations), dentists, dental hygienists, and a few other of the nation's many health care disciplines. A major emphasis must be placed upon the citizen/consumer, who ultimately controls his or her behavior and who makes the key decisions to engage in, or reject, positive health behaviors.

It is true that the key step in effective HP/DP effort is to engage each individual in altering his or her health-related behaviors. However, the public needs professional guidance and leadership in identifying valid HP/DP endeavors, as opposed to ineffective procedures promoted by cultists or those interested in profit at the cost of improved health.

Many health disciplines seem to have little potential for HP/DP involvement, when the effort is limited to primary prevention. However, when the prevention effort is extended to secondary and tertiary prevention, all the rest of the nation's huge human resource in health care can be brought into action. As an educator who has been primarily identified with the education of the nation's allied health professionals, I have been extremely frustrated that the HP/DP effort to date has largely excluded this tremendous potential resource for the reduction of disability and for the containment of health care costs.

The allied health professions include some 85 distinct disciplines. No one really knows how many practitioners exist in these fields, but 2.5 to 3 million would probably be a conservative estimate. Each of these practitioners serves many patients or clients each week. It would be relatively easy to alter the system so that these people would be empowered to act as patient/client educators and health advocates. It would be even easier to modify health professions curricula to provide them with the knowledge and skills they need to do so effectively.

The concept of high-priority approaches to preventive care is so new, and so foreign to the health care system which has developed in this nation, that federal leadership is absolutely essential to the achievement of the goal of a healthier populace and control of the costs which result from illness and injury. Important momentum which had developed for increased emphasis on HP/DP, especially in regard to the involvement of a broader spectrum of health professionals, was lost when federal funding for the modest demonstration programs which had been developed was ended.

The Need for Federal Leadership in the Future Development of HP/DP Priorities

Federal programming in support of really effective HP/DP programming must include stimulation of direct health education initiatives, designed to enlist the populace in the effort to improve its health status. However, it must also include programming which will stimulate the nation's health care professionals (medical, dental, nursing, allied health, and others) to re-examine their roles and to expand their involvement in promoting health and preventing disease.

Incidentally, I referred to the immense stress which the development of the AIDS crisis is putting on the health care system. This development, which may create a 16% increase in demand for health care services, plus the added services needed by an aging population with a variety of chronic health problems, will further exacerbate costs and demand. In AIDS, prevention is really the only effective weapon which our care system has at present. For the the elderly effective HP/DP interventions are the best hope for high quality of life during the latter years.

The National Council on Education of Health Professionals in Health Promotion

Recommendations to achieve the role and educational changes which are needed in support of the HP/DP effort came out of the series of HRSA-Bureau of Health Professions Workshops which were held in 1984. The National Council on Education of Health Professionals in Health Promotion has abbreviated these into a brochure, copies of which I have available with reprints of these comments. This Council stands ready to assist and support an effort to implement these recommendations, to the extent of its limited resources.

Mr. Scheuer, we support and applaud your interest in improving the health status of all Americans by increased emphasis on Health Promotion and Disease Prevention interventions. Thank you for your courtesy, and for the interest which you have shown in this crucial topic by scheduling this hearing.

Biographic note: Edmund J. McTernan, Sr. is Professor of Health Sciences, and Dean of the School of Allied Health Professions at the Health Sciences Center, State University of New York at Stony Brook.

He is a registered nurse with graduate preparation in Public Health Education, and a Fellow of the American College of Healthcare Executives.

Dr. McTernan is immediate Past-President of the American Society of Allied Health Professions, and a founding member of the National Council on the Education of Health Professionals in Health Promotion. He was recently appointed to the National Council on Health Professions Education.

IMBALANCES IN HEALTH CARE SYSTEM

Representative SCHEUER. Well, I thought it was a very fascinating hearing day. I regret, on the one hand, that you have been kept waiting so long. On the other hand, if you heard those panels that preceded you, you couldn't have helped but have been impressed and stimulated.

Let me ask both of you. Why do we have such imbalances in the health care system, with too many doctors and too few nurses, too many acute beds, too few nursing beds?

Are these imbalances caused by, perhaps, faulty reimbursement systems, the absence of reimbursement for counseling?

Mr. MCTERNAN. If I can take a shot at it first.

Representative SCHEUER. Yes.

Mr. MCTERNAN. I think one of the problems, we've been using the term "health care system." But, of course, we don't really have a system. We have a conglomeration that just grew like topsy.

Representative SCHEUER. You're so right.

Mr. MCTERNAN. And it is a capitalist system and people do what they get rewarded for doing, tangibly rewarded for doing. And all the excitement and all the money of the Blue Cross system, though it wasn't originally intended for that, really rewards acute care, it doesn't reward chronic care.

Representative SCHEUER. Yes.

Mr. MCTERNAN. It's very complex. But, certainly, in terms of long-term care and home care, something has to give. On Long Island now, our hospital is the AIDS center, just to use AIDS again as an example, for eastern Long Island. It cost about $950 a day.

Representative SCHEUER. Gee whiz.

Mr. MCTERNAN. We have no place to send the patients to.

Representative SCHEUER. Isn't it anomalous that we provide acute care, the most sophisticated kind of acute care at the cutting edge of high technology, and then after the operation or the treatment or the process, we don't have anything for the long recuperative period, the long-term care that is an inevitable result of that acute care.

Mr. MCTERNAN. I forget who the comedian at Harvard was who said, once the rockets go up, who cares where they come down?

Representative SCHEUER. Yes.

Mr. MCTERNAN. That's sort of the attitude that's been taken.

REASONS FOR LACK OF TECHNOLOGY ASSESSMENT

Representative SCHEUER. Yes. Let me ask you, Mr. Raub. You gave us a number of very exciting examples of new high-technology treatment modalities of one kind or another, and they are very exciting. I found in the field of nuclear medicine, for example, tremendous quantum jumps forward.

But let me take you back to the questions that were raised repeatedly by the witnesses this morning, that we're developing all these high-technology procedures, processes, products, surgical procedures, and all of that, but we really haven't done the proper kind of research to know which ones work, which ones don't work, under what circumstances, what kind of surrounding conditions that are indicated or counterindicated.

So that we come up with guesstimates—in prior days of hearings, we've heard a quarter to a third. Today, we heard from 20 percent to 40 percent. There's a certain consensus that of all medical procedures, processes, operations, surgery, 20 to 40 percent are not necessary, or are not helpful, and may be counterindicated and actually unhelpful.

Why do you think we've done so little on the end of learning when to apply all of these new developments when we're spending so much money in the development of these processes, these very expensive processes at the cutting edge of high technology?

Mr. RAUB. I think, as you, Mr. Chairman, and the witnesses this morning, and as Mr. McTernan indicated just now, a big part of it is the byproduct of a system that in the past we have all had reason to take pride in because it was pluralistic and because decisions were highly decentralized and asynchronous.

Indeed, there are many strengths resulting from that; and there are very few of us who would want to depart in a drastic way from the diversity in that system.

One of the things it has bred, though, is a cultural view of medicine that is a problem-solving one. There needs to be a sick person and then a reaction to that problem. Medical students and other health care professionals tend to be trained to react to the problem rather than to be involved as heavily as they might be in a preventive mode.

Until recent years, research in these areas, such as health services delivery and the evaluation of technology, was almost nonexistent and certainly not fashionable in the same sense as biomedical research. Whether research is in transplantation or in molecular biology these days it is seen to be very heady and very exciting.

Representative SCHEUER. It is heady and exciting. But it would also be heady and exciting to know how and under what circumstances, we ought to use all these things.

Mr. RAUB. You're absolutely right. One of the major needs, I believe, in the health care system is for a much stronger base of science underneath questions such as are these procedures ready for use, and even when they are, under what circumstances are they proper to use?

NIH IN CARE ASSESSMENT AND DISSEMINATION

There are some examples discussed in my prepared statement. If I may, I'll just elaborate on one that I think is an instance of an increasing kind of involvement by the National Institutes of Health.

A major theme in our Institutions' planning and budget deployment is in what we call clinical trials. These are highly rigorous, organized studies attempting to evaluate some new intervention, either a treatment or an attempt to prevent the development of further complications of disease. It's typically treatment A against treatment B or treatment A against no treatment at all, depending on the state of science in that particular field of health care at the time.

One of the examples given in the prepared statement is that of laser treatment of the eye problems in diabetics, what is called dia-

betic retinopathy. That disorder is one of the leading causes of new blindness in adults in the United States.

Before that clinical trial was launched, there was virtually nothing that opthalmologists or other physicians could do for their diabetic patients, other than give them some sympathy and chart the progressive loss of their vision.

What the clinical trial showed, through a randomized evaluation, is that laser treatment indeed is effective in preventing visual loss.

The ability to carry out the evaluation with a highly definitive scientific study on a new health care procedure was possible because it was planned and organized as the technology was emerging, well before ideas got locked in in the health community as to whether it was good or bad.

Once the positive result was achieved, it would have been very easy for our National Eye Institute to have stopped there, to have published the work in the appropriate scholarly journals and then, like the waiter to have said, "Well, that's someone else's table. Take it from here."

Instead, the Institute's director and staff realized that that was only part of the journey. The information had to be packaged and communicated in a way that not only ophthalmologists, but also internal medicine practitioners and others who see diabetic patients, would understand the circumstances under which the laser treatment could be carried out.

Therefore, one of the things the Institute did was prepare a set of easy-to-read, easy-to-handle informational materials that were shared not only with the general public, but with these physicians most likely to see diabetic patients.

In addition, the Institute's director personally, and some senior staff, arranged with the American Academy of Ophthalmologists, the major continuing education group of ophthalmologists, to have a series of continuing education sessions presented by the National Eye Institute staff, thus helping to orient physicians not only about the facts of this new technology, but also about the limitations and the circumstances under which it might be applied. That has been a continuing effort.

If you go beyond that program, I think there remains an unresolved problem, in that it is inevitable that there are some ophthalmologists still who are not applying or recommending the laser treatment when they should. There are still others who may well be using it in instances when they shouldn't, and still others who may be using it, say, at half the dosage or some other variation on the technique that has not been shown to be effective.

Representative SCHEUER. Or twice the dosage.

Mr. RAUB. Or twice the dosage, absolutely right. I don't present this as a problem solved, but I see it as an instance of the emerging kinds of involvement carried on by virtually every one of the Institutes that make up our organization. There is increasing realization that although the new knowledge is important, unless the new knowledge is packaged, communicated, and evaluated in the context of health care, including the establishment of its limits, the kinds of problems that we heard about this morning, and I'm sure you heard about in the earlier sessions, just will continue to be there.

FEDERAL TECHNOLOGY ASSESSMENT ACTIVITY

Representative SCHEUER. Yes. Mr. Raub, you're a leader in the National Institutes of Health. This administration, shortly after it took office in 1981, abolished the National Center for Health Care Technology and sort of passed out that function to the National Center for Health Services Research, where it has played a fairly modest and not very significant role.

Would you have any views as to how we ought to reestablish the integrity and the importance and the high priority of that function?

Mr. RAUB. I think one of the most important things is what you've been engaging in today and in the previous sessions, Mr. Chairman; namely, capturing and focusing the broad public interest, as well as the broad professional interest, in these issues of evaluating both emerging and existing health care technologies.

The functions that you described that previously had been with the National Center were not, strictly speaking, abolished, but were incorporated, as you say, in the other component. There is continuing discussion and debate both within the executive branch, and between it and the Congress, as to the proper focus and levels of funding of those activities. That is, I believe, an area in need of continued attention.

For NIH's part, while our statutory mission tends to stop short of explicit involvement in health services research, each of our Institutes, in very selective and deliberate ways, has entered into some of those areas. In the aggregate, we spend almost $50 million a year on what we classify as health services research, going beyond our traditional mission of laboratory and clinical research, and looking at some of the ways the new technologies and new information are used in the health care setting.

We expect our own mission to evolve and change in that area, in concert with the larger plans of the administration.

Representative SCHEUER. The way I figure it, $50 million a year is one-hundredth of 1 percent of our national health care budget of $500 billion.

And if you take the amount of wastage in the system that Uwe Reinhardt and Joe Califano estimated around $125 billion, $50 million would be four one-hundredths of 1 percent of the amount that is spent for unnecessary procedures and processes and what not.

Don't you think we might want to think about spending a great deal more than four one-hundredths of 1 percent of the wastage on evaluation of these new high technology processes, products, whatnot?

Mr. RAUB. I don't think there's any question about the opportunities that are out there.

Representative SCHEUER. And that the order of magnitude of the increase in evaluation spending should be very substantial. You wouldn't increase it 10 percent; you'd double it or treble it or increase it tenfold.

If you're talking about wasting $125 billion a year, it seems to me that you could usefully spend a billion a year so that you're spending three-quarters of 1 percent of the amount that you're wasting through the inability to define exactly the circumstances

and the conditions under which these high-technology processes should be used. To spend in the neighborhood of 1 or 2 percent of the amount wasted would be extremely minimal. And that would give you a budget of more than a billion dollars.

Would that sound reasonable to you?

Mr. RAUB. I can't follow your arithmetic, sir.

Representative SCHEUER. I would only not spend a billion dollars if the scientific community really couldn't input a billion dollars cost effectively into its research process. It might be more than you could jam into that funnel.

But if the research community could actually absorb that kind of funds and find the research talent to do it, I would think to spend 1 percent of the amount that we're alleged to be wasting would be a very modest and cost-effective expenditure.

Mr. RAUB. I think you've emphasized a very important point. Some of the difficulty in the health services research arena, as viewed from the NIH, has been the relatively small number of trained and interested individuals willing to commit themselves to research careers in those areas.

Representative SCHEUER. Well, would it help if your mission were changed statutorily so that there was a mandate for more continuous and systematic evaluations?

Might not the surety and the utter predictability of that funding, if it were made a statutory part of your mission, be helpful in attracting young people to come into this critically important field of evaluation?

Mr. RAUB. That's a set of issues that I'm sure that these hearings and related matters will put on the table for the Assistant Secretary for Health and for the Secretary, not only in determining the size and character of the overall effort, but——

Representative SCHEUER. Which Assistant Secretary?

Mr. RAUB. The Assistant Secretary of Health.

Representative SCHEUER. The current one or the future one?

Mr. RAUB. I expect both, sir.

Representative SCHEUER. Do you think that there's time in this last 6 months, in the waning days of this administration, for them to make these kinds of important decisions involving expenditure of significant funds?

Mr. RAUB. Only modest opportunity at best, given——

Representative SCHEUER. Pardon.

Mr. RAUB. I said, only modest opportunity at best, given the timing.

Representative SCHEUER. Yes.

Mr. RAUB. But in terms of the continuing functions, I was stressing the office, not the particular administration.

Representative SCHEUER. Right. If I had to guess, I would think the most constructive use of the next 6 months would be for folks like Mr. Raub and Mr. McTernan and our staff specialist and other members of the health community here on the Hill to get together to consolidate our intellectual forces and come up with a very well thought out, highly focused program of what we ought to do on the entire spectrum of these issues and have it available for the new administration.

Mr. McTERNAN. In the absence of that kind of activity, it's interesting to think about how the physicians get their education about the use of technology and primarily, I suspect it's from the manufacturers' detail men who call upon them, or the drug companies' detail men.

Representative SCHEUER. Sure.

Mr. McTERNAN. Whose mission, of course, is to encourage the use of this technology, not to evaluate it.

Representative SCHEUER. You're so right, Mr. McTernan. And if they do learn about it at medical school, what happens when they're out of medical school 10 years, 20 years, 30 years? Where are they being brought up to the mark? Where is their knowledge being——

Mr. McTERNAN. By the salesmen.

Representative SCHEUER. Pardon.

Mr. McTERNAN. By the salesmen.

Representative SCHEUER. By the salesmen. That's the wrong way to get that information. There ought to be a process somewhere in their medical practice where at periodic times they ought to be able to be brought along so that they can hit the deck running and know about the newest developments in analysis, appraisal, oversight, in the use of all of these new technologies.

We have to crank that into the system, it seems to me.

So we're talking about training health professionals to know more about appraisal of all of these matters and more about preventive medicine.

How do you communicate with patients? Who should do the communicating?

Again, I guess most of the doctors who are practicing today have been out of medical school more than 10 years when there was very little emphasis given to this kind of oversight and appraisal, and also very little focus or emphasis given, or priorities placed upon their counseling patients on the value of preventive health.

What do you think we ought to do with the vast percentage of doctors who are in this condition, who have been out of medical school more than 10 years, and who received very little or no training in these two very important areas?

What kind of process should we apply to bring them up to the mark in these two areas? What kind of retraining? What kind of courses? What kind of seminars?

How should they be exposed to the newest developments in what they should be doing with patients on preventive care and what they should be doing vis-a-vis new high-technology developments in health care to see whether they are appropriate and needed and cost effective?

Mr. RAUB. Many things will need to be done, but I can offer one suggestion. I alluded briefly in that earlier example to the American Academy of Ophthalmology as a continuing education group. Most of the specialty medical areas have an analogous kind of body devoted to the continuing education of members of the profession.

From our point of view as a research organization, we've increasingly been looking for ways to access those agendas in the way of

providing some of the kinds of materials that we think we can contribute that would broaden and strengthen those educational programs.

I believe, by the same token, from the vantage point of this subcommittee and the broad public and professional interest you've focused in these hearings, that there needs to be a broader public expectation that those continuing education processes would be exercised fully. There needs to be more focus in terms of keeping up with the latest advances, as well as keeping up with the latest knowledge about what's not indicated for use.

Representative SCHEUER. Sure.

Mr. RAUB. That would be one of the single most important things that could happen.

Representative SCHEUER. That's equally important.

Mr. RAUB. I believe the professions on the whole will respond positively to that; but a critical part of the dialog you've effected here will be, as I see it, getting those groups involved to pull their weight along with——

Representative SCHEUER. In some kind of continuing education process.

Mr. RAUB. Absolutely.

Representative SCHEUER. How might that be organized?

Mr. RAUB. The basic structure is there, in terms of most of these groups having such a function in place.

Assuming there will be a collection of reports from these hearings, and an attempt on the part of the subcommittee to assess these issues, as you have just done, I then suggest communicating those results to the major academies with some statement of the interest and the support from the subcommittee. The public expectation that these actions would convey, I think would be a major step in taking what is a fundamentally well-designed and well-organized system of continuing education and making sure that it has the full array of content and emphasis that's in keeping with the times.

Mr. MCTERNAN. I think most, if not all, medical schools have offices in continuing education, and nursing schools and allied health schools have similar endeavors.

The problem for me, for instance, has been that there is no funding for continuing education. It's viewed as a low-priority activity.

Representative SCHEUER. You say they have an office of continuing education.

Mr. MCTERNAN. That's right, most of them.

Representative SCHEUER. OK. What does that office do?

Mr. MCTERNAN. They organize short courses for practitioners, primarily.

Representative SCHEUER. Should there be a requirement on the part of a practitioner to engage in some kind of continuing education on a regular basis so that society is sure that he is up to the mark on new technology?

Mr. MCTERNAN. The physician assistants have a very interesting model that can be looked at. They have to be reexamined every 6 years.

Representative SCHEUER. Physician assistants.

Mr. McTERNAN. Assistants. But the older, more established health professions have been resistant to reexamination. Some of them, dieticians, nutritionists, for instance, have to complete a certain number of hours of continuing education. I know many of the specialty boards in medicine also have a requirement that there be ongoing, continuing education.

Representative SCHEUER. It seems to me that there's enough new knowledge, it's accumulating at a horrendous clip, at a geometric pace, that it would make sense to think about requiring all health professionals to engage in sharpening their knives periodically.

Mr. McTERNAN. The problem for the private practitioner is, first, they have to leave their practice to take the education, so they lose income while they're doing it. On top of which they have to pay for that education.

Representative SCHEUER. Well, maybe the education ought to be funded, at least, so they don't have to have out-of-pocket costs. That might be something that would be very worthwhile for society.

As far as their leaving their practice and losing some income for a week or two, it seems to me that they're licensed by the State to perform a public service. And part of that public service is that they're reasonably current on the state of the art.

Mr. McTERNAN. I think most practitioners recognize and are happy to do that within reasonable limits.

Representative SCHEUER. I would think that the State licensing boards could easily require that as a prerequisite to continue being licensed.

Mr. McTERNAN. For the nonphysician health care practitioner, the employed type, there's an added problem because as hospitals are feeling the added pinch, one of the first benefits they cut back on is educational benefits for their employees.

Representative SCHEUER. That's wrong. Society ought to do something about that.

Mr. McTERNAN. It certainly is.

Representative SCHEUER. Congress ought to. And we need your help in figuring out an answer to that. There are a lot of flaws in the health care system and we're trying to identify them in this set of hearings. And boy, you have certainly put your finger on one.

I'm all for hospitals and health care institutions of all kinds getting their act together and making sure that they're operating on an efficient, intelligent, cost-effective basis. But it seems to me to run flat into the face of reason to say the first place we're going to economize is on continuing health education.

Mr. McTERNAN. The experience of institutions like mine that sponsors continuing education has been reducing registration, reducing turnout, because the employees are no longer being reimbursed by their employer.

Representative SCHEUER. That is wrong.

Mr. McTERNAN. I agree.

Representative SCHEUER. And you've brought to our attention a very important point. If this hearing didn't have any other purpose than to identify that problem, it's well worth it.

RESEARCH ON DISABLING CONDITIONS OF THE ELDERLY

Let me ask you, Mr. Raub, about the field of research, and I'd be happy to have you, too, Mr. McTernan, answer this. We talked about research on whether processes and procedures and products are appropriate, needed, useful. Let's talk about the research that we discussed before that would seem to have an enormous payoff, especially in the care of the elderly, in deferring the onset of dependence.

And we talked about dementia. We talked about arthritis. We talked about incontinence, and several witnesses noted that a couple of hundred million dollars in each of those three areas would have the potential of producing major progress in deferring for a considerable period of time, if not preventing, the onset of these three major phenomena, which are responsible for the majority of nursing home placements, long-term care placements.

Why do you think the medical community, why do you think the National Institutes of Health have put so little effort, resources, funding, into research in these three areas? And what do you think the Congress ought to do about it?

Mr. RAUB. I like to think that in recent years, especially, Mr. Chairman, there's been a substantial increase and focus of investment in research in all of those areas.

As you probably know, some years back, there was created within the NIH the National Institute on Aging, which captured the growing interest in the public at large and in the medical profession to address these kinds of questions.

Representative SCHEUER. With chronic, disabling conditions.

Mr. RAUB. A major philosophical thrust of our National Institute on Aging speaks to just the point you were making, to try to prolong a high quality of life into the later years. Not only for the purpose of preventing the high cost of medical care, but also for making the life of those individuals in their later years as effective as possible.

Representative SCHEUER. Clearly, happier and more productive and more satisfying, if they're independent with all their faculties and can move about and they aren't crippled by incontinence, if they aren't disabled and imprisoned in their homes by incontinence, and they aren't imprisoned in their homes due to an arthritic condition that makes it painful for them to even move or walk, and not crippled in their communication with the outside world and their comprehension of the world around them by dementia.

My goodness, can you think of a greater contribution to wellness, to well-being, to the quality of life than deferring for a period of years the onset of any or all of these?

Mr. RAUB. One of the things the Aging Institute did early on was to introduce the concept of what it calls the teaching nursing home, the analog of the teaching hospital.

Representative SCHEUER. Yes.

Mr. RAUB. The idea was to have a firsthand, incontext research program not only with the view of making nursing home administration for patients as effective as possible, but, indeed, to also identify the kinds of things that might prevent these individuals from having to be in that sort of institutional setting. A further

goal is to enable individuals to even leave such institutions and resume a life with their families.

That research program continues.

In addition, within the last several years, the Congress also authorized and created a new Institute on Arthritis, Musculo-Skeletal and Skin Diseases. These programs existed previously, but the congressional action, with the concurrence of the President, has given a new focus on those problems. Much of the theme underlying these activities is, as you were saying, to deal with the chronic, disabling disorders with a view toward, in the long run, attacking their fundamental cause; but, in the short run, finding ways to ameliorate the difficulties.

Representative SCHEUER. Would you include, along with arthritis, incontinence?

Mr. RAUB. Yes. In fact, there is ongoing research on incontinence in two places—not only in the National Institute on Aging, but also in our newly created National Center for Nursing Research. Again, I believe that captures the changing spirit of the times. NIH has become involved formally, in this case, through the nursing research program, in those activities where nurses, in the full practice of their profession, are able to be included in research efforts.

So we have a number of ongoing research projects, including on urinary incontinence, the administration of certain respiratory therapies, and other types of——

Representative SCHEUER. Arthritis?

Mr. RAUB. On arthritis.

Representative SCHEUER. Dementia?

Mr. RAUB. Yes, all of those areas.

Representative SCHEUER. So you have the full package there.

Mr. RAUB. Yes, we have, sir.

Representative SCHEUER. Very interesting. Well, I must say what you're describing is a program that we should be carrying out, given our demographic projections which were clear to us 10 or 15 years ago. The tragedy of it is that we didn't start these things a decade or more ago. But here we are. It's important that we be knowledgeable about the urgent need to get on with it. And I welcome that.

PROVIDING CONSUMER INFORMATION

Let me just ask you one more question on the research. We've talked about these three, crippling and disabling chronic conditions, the need for research on them. We've talked about the need for research on appraising the appropriateness and the circumstances surrounding which various of these new high-technology procedures have taken place.

Let me ask you about the need for research on empowering consumers to be an effective force in screening out substandard providers, both doctors and hospitals, by making available to consumers hospital-specific and doctor-specific information, as to which of the hospitals and which of the doctors, based on the record, could be expected to enhance their health outputs, and which of them, a small percentage of them, admittedly, but still, a demonstrable percentage of 4 or 5 percent, could be expected to threaten their

ers, and properly from every point of view, how do you disseminate that?

And you may have heard me discuss this with Dr. Axelrod. I suggested schools, hospitals, libraries, universities. He said, yes, how about bodagas and supermarkets? Amazing, to hear from a very distinguished State health commissioner, the most distinguished in the country, if not one of the most. And he's talking about putting a computer terminal and maybe a person to counsel in a bodaga, in a supermarket.

I mean, that's a real quantum jump in our thinking. There's a guy who's really on the key vive. He's on the cutting edge of new thinking.

What do you think about that?

Mr. RAUB. Where I was going with my statement was not a defense of telephone books or large compilations, but, rather, to point out that, increasingly, each one of our Institutes is engaged in this kind of activity, of preparing easy-to-read booklets and other informational materials.

Representative SCHEUER. Easy to read for whom? For doctors?

Mr. RAUB. For patients.

Representative SCHEUER. For patients. That's good.

Mr. RAUB. Also, several of the Institutes have engaged in collaborative efforts, for example, with food companies, such as the National Heart, Lung, and Blood Institute and Giant Foods program, where, in the supermarket, right on the shelves where the products are placed are certain informational labels and other materials with respect to fat content of foods or fiber content of foods or salt content, and the like.

Representative SCHEUER. Sugar content.

Mr. RAUB. For example. Included in the program design is an evaluation process, that you might call research, which will attempt to assess what kinds of packaging of information material is effective, what kinds of outcomes are achieved by providing such information.

I expect that, as the various programs evolve we'll continue to do more of that as a way of attempting through our own initiatives, and in collaboration with various voluntary health organizations around the country, to deal with this question of how to inform the consumer and get patients to the point where they are very knowledgeable about the kinds of issues associated with their health the goal would be a consumer patient not only able to ask questions, but also able to understand information that's imparted to them and thus be much more of a participant in health care.

Mr. MCTERNAN. If I may comment on that, too.

Representative SCHEUER. Yes.

Mr. MCTERNAN. I certainly think that the empowerment of the consumer, of health care to be involved in decisions relating to their own care, has been an important development in the last few years and it's still going on.

Representative SCHEUER. Well, it hasn't happened yet. A few of us are talking about it.

Mr. MCTERNAN. That's true.

health outcomes and reduce their health and reduce the quality of their lives.

If the medical profession continues to do as inadequate a job as it is doing in screening out the doctors who as we've discussed, are drug addicted, alcoholic, mentally impaired, and otherwise incapable of carrying on a minimally effective health medical practice, why, as a last resort, as a fail-safe device, shouldn't we give health consumers the ability to make some of those judgments, if the professional health community can't make those judgments and bite the bullet and do something about it?

Wouldn't, as a last resort, it be a good thing to empower health consumers with that kind of knowledge that would be professionally prepared, that would be reliable, that would be relevant, that would be understandable by the average health consumer, of average education, average experience, average intelligence?

Would that be a significant addition not only to health outputs, because you have to assume that those 20,000 doctors that the New England Journal of Medicine identified, are going to be producing millions of health incidents every year, and a lot of them are going to be negative, if these 20,000 drug-addicted, alcoholic, mentally impaired doctors continue to be permitted to practice medicine?

Wouldn't, as a last resort, health consumers armed with histories of multiple malpractice judgements, of multiple delicensing, of multiple censure, of hospitals with rates of iatrogenic and nosocomial infections that are off the chart, wouldn't this have a very healthy, salutary, influence on the health care community from the point of view of weeding out the incompetents and weeding out those responsible for a high percentage of untoward health incidents?

Mr. RAUB. It seems to me there are two different, but related, issues that you have raised.

Clearly, the medical profession should take considerable responsibility with respect to the adequacy of performance of its members. I expect we'll see an increasing sense of responsibility on behalf of the profession and the State licensing boards and others as the public increasingly demands that medical professionals be competent to perform.

At the same time, I think there's another very encouraging trend going on in the country, and that is the increasing awareness on the part of patients themselves resulting in patients not only wanting to have a larger voice in the medical care decisions that are made about them, but also wanting a lot more knoweldge about what's going on.

Representative SCHEUER. That knowledge, in almost all circumstances, is not being made available, Mr. Raub. There are some experiments. HCFA has just produced seven telephone books. Really. I mean, give me a break. That is not appropriate for the average health consumer, to hand him seven telephone books.

It seems to me that maybe the National Institutes of Health could do some research on how do you massage the information that's contained in there to make it intelligible to health consumers. And then the next research project you might want to do is when you have information that you've massaged and that you've worked over so it's fair to the providers, intelligible to the consum-

Representative SCHEUER. And we're beginning to make progress at the margin. But I see a developing fire storm of criticism to all of us in the health care field if we don't answer that.

Do you remember the movie—what was the name of it?—where the guy was hanging out of the window? "Network," remember. He said, "I'm not going to take any more of that."

Mr. MCTERNAN. There's a caveat there.

Representative SCHEUER. I think people are going to say, "I'm not going to accept any more of this medieval sophistry. By golly, I want to know. If this guy's had a whole string of malpractice judgments against him, that is my right to know."

Mr. MCTERNAN. In our own State, though, I think you have to be a little bit careful, because in our own State recently, some information, partial information, was released about comparable data in hospitals.

Representative SCHEUER. That could be very dangerous, very confusing, very misleading, and very unfair. I'm totally with you

Mr. MCTERNAN. Because one of the hospitals was castigated and the reason was they took really sick patients.

Representative SCHEUER. But of course. You take Hanson Memorial, Sloane Kettering, where they take the most serious cases, many of them terminal cases in cancer from all over the country. It would be absurd to judge them the same as any community hospital on the percentage of their discharges who died after 6 months or 1 year.

I mean, that would be nonsensical.

But it's very interesting to note that in that hospital survey that HCFA distributed a year or more ago, when they said, what are the predicted mortalities and what were the actual mortalities, Sloane Kettering and Hanson Memorial came out beautifully. They had fewer than the predicted mortalities. And so did most of the tertiary hospitals around New York City, as I recall—NYU, Bellvue, Mt. Sinai, Columbia Presbyterian—and all of these first-class tertiary hospitals came out with less than expected mortality rates.

The problem children were these little community hospitals, 300-bed nonteaching hospitals out in the boondocks who were nontertiary hospital affiliated. They were the charnel houses. They were the places where it was dangerous to go if you got sick.

But how the heck does a person know that? I just think it's terribly important to develop information that is not misleading. Quite right, Mr. McTernan. And that is not partial and that is calibrated to reflect the kind of patient load that that hospital has.

I couldn't agree with you more. To do otherwise would be offensive to one's sense of fairness and decency.

We're not trying to prejudice competent, sincere, productive health service deliverers in our country. We're not trying to make things awkward for them at all. We're trying to help the health community identify the ones who have a demonstrated record of being incompetent and dangerous to one's health.

And since the medical community has done a less than adequate job, maybe we just ought to give that kind of knowledge to health consumers and show them how to use it, show them how to interpret it, and then turn them loose.

As I said before, and I don't want to bore you, our society overwhelms American consumers with information about clocks, television sets, hair dryers, automobiles, resort hotels, you name it.

The one thing, the one area of knowledge that we hide from them in this sort of medievel guilt mystique is information about health care providers that is hospital specific and doctor specific.

I know of nothing in the code of Hammurabi, in the Hippocratic oath, or in the teachings of Maimonides that tell us that doctors are entitled to be protected from their incompetence and their negligence from the health-consuming public.

Do either of you know of anything in——

Mr. RAUB. No, sir.

Representative SCHEUER. Well, I learned that today. I learned this from Dr. Axelrod, who instructed me that you can scrutinize the code of Hammurabi, you can scrutinize the Hippocratic oath, you can scrutinize the teachings of Maimonides and you will find nothing that protects doctors from the public knowing about their negligence and their incompetence.

Mr. MCTERNAN. If my memory serves me right, the Hippocratic oath also requires that you don't charge your teacher.

Representative SCHEUER. It what?

Mr. MCTERNAN. The Hippocratic oath requires that you not charge your teacher for care.

Representative SCHEUER. You don't charge your teacher?

Mr. MCTERNAN. Right, So the physician that taught you, you don't charge a fee to. I think that's in the Hippocratic oath, if my memory serves me correctly.

Representative SCHEUER. That's very touching. That's very interesting.

Well, we've kept you very long and I want to apologize once again for the lateness of the hour. I'm glad that you hung in there and made it possible for us to hear your excellent testimony, your truly outstanding testimony.

I'm very proud to have heard you. I'm proud to have chaired this series of nine hearings, of which this is the last day, the last panel.

I thank you. I'm grateful to you on behalf of the Congress. We'll be very much interested in hearing of your activities and the progress that we make along these various avenues that we've been discussing. We will keep the record open for material reporting on these activities that you may want to send to the subcommittee.

Mr. MCTERNAN. Thank you very much.

Mr. RAUB. Thank you.

Representative SCHEUER. Thank you very much. The hearing is adjourned subject to the call of the Chair.

[Whereupon, at 3:50 p.m., the subcommittee adjourned, subject to the call of the Chair.]

[The following information was subsequently supplied for the record:]

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StonyBrook

Mr. David Podoff
Joint Economic Committee
G-01 Dirksen Office Bldg.
Washington, D.C. 20510

September 19, 1988

Dear Mr. Podoff,

Once again, I apologize for the delay in following up on my promise to send along some added thoughts on ways in which utilization or under-utilization of health personnel, advance or obstruct the goal of quality health care for all Americans, within the capacity of the national economy. I will put down a few of my observations, which come from my experience as a Registered Nurse, former hospital administrator, and (for the past 25 years) an educator of allied health professionals.

It seems obvious that the basic problem is that our health care system, and the checks and balances placed upon it, was not planned, it just grew in a very haphazard fashion. Further, it has suffered from the anamoly that most decisions are made by the providers (especially physicians), not by the consumers or buyers. Therefore, the idea that it can be treated like any other free market is specious; it is anything but a "free" market!

Unfortunately, we do not have valid data about the allied health professionals (AHP's) within the system, primarily because Congress has never viewed them as of sufficient importance to count. A sort of "median" estimate of numbers would be that there are perhaps 3.5 million AHP's in practice today, distributed through almost 100 different specialized fields. If one considers the number of patient contacts/services these people deliver each year, the health care and economic implications are truly enormous.

Most of these disciplines were "spun off" by medicine during the expansions of health care knowledge and techniques which occurred around both World War I and II. Initially, most AHP's were given rote and very cursory training, usually in "OJT" or apprenticeship situations. Often the brightest people from unskilled worker groups were chosen for this training. The roles they were allowed to play were consequently very circumscribed, limited, and closely supervised. They were for the most part, extensions of the hand but not the mind of the supervising physician.

Like other bright humans, however, these new AHP's were intellectually involved in what they were doing, and they sought and obtained more and more information about their disciplines. Typically, the training programs first became formalized, then moved into hospital and eventually to collegiate settings. The curriculum and its contact expanded and became more sophisticated. Today, some 85 AH fields require a baccalaureate for entry, while

about a dozen others require graduate preprofessional preparation. The remainder demand a specialized associate degree, for the most part. Most of the fields also have stringent educational accreditation, and practice certification or licensure requirements.

A big plus about the contribution and role of the AHP in the health care system is that this entry level preparation is of course much shorter and less costly than that which has evolved for physician education. New practitioners can be prepared, and curriculum modifications can be introduced in a relatively rapid manner. Further, the salary scales paid to AHP's are less than those paid to physicians by a very considerable portion. Therefore, the cost per unit of service by an AHP is far less than for physician services. For that same reason, it is economic for society to utilize each AHP in the system as efficiently as possible.

The point I tried to make to Congressman Scheuer and to you at the hearing a few months ago was that inappropriate and outmoded constraints abound in the health care system. Many of these constraints were developed when the typical AHP was a product hand-tooled by her or his employer in an uncontrolled OJT situation, and were motivated by a real concern to protect the patient. Today a great number of those constraints are unnecessary. They serve to reduce the effectiveness of the AHP's, and they protect only the economic and political control of the medical and dental professions. In my opinion, many of these constraints detract from the potential for optimal care for older Americans.

One example is in the area of dental care. Large numbers of Americans, especially in poorer economic groups, do not receive adequate dental care. I would venture that few nursing home patients receive regular dental supervision. Dental hygienists, well prepared to administer prophylactic services and to recognize periodontal disease, are forbidden to practice except through the agency of a dentist in all states except Colorado. There, one young woman is delivering excellent and cost effective care to nursing home patients as a private practitioner. A majority of her patients have received no dental care for years, and she refers large numbers to local dentists who collaborate with her effectively. Costs to her patients are very reasonable, since the billing is not on the dentist's scale, nor does a dentist retain a share of her earnings. The American Dental Association has sued Colorado, to force it to require hygienists to practice under employment of a dentist.

A second example is the limitations which exist on the practice of physical therapists (PT's). It is hard to imagine how many older patients could benefit from physical therapy services, and who do not receive those services. Most states require that PT's treat patients only upon referral from M.D.'s; however, chiropractors and others are not subject to this restriction. The results are increased costs and reduced services to people, and (no doubt) the eruption of many secondary and tertiary problems which could be prevented by PT intervention.

These are just two examples of barriers to optimal and cost-effective care; to cite others would be no problem at all. I realize that most limitations arise from state medical legislation. However, demonstrations of optimal utilization of AHP's could be inexpensively encouraged within Federal health care agencies, and through modest federally-financed pilot programs. The savings in dollars and in improved health care could be immense.

There are many other ways in which AHP's could make far greater contributions to our health care system, and help to contain cost escalation. These will obviously be increasingly important as the population continues to age, and as those older people require require added health care services.

I regret that I will be out of the country for several weeks, and therefore unavailable to provide further documentation of my point. If you should want any added information about the allied health professions while I am away, I believe that Dr. Glenda Price (Ph.D.), Dean of the School of Allied Health Sciences at the University of Connecticut, Storrs, would be an excellent and knowledgeable source of information.

Thank you once again for the privilege of testifying before the committee, and for the invitation to prepare this letter.

Sincerely,

Edmund J. McTernan, MPH, Ed.D.
Professor and Dean

cc: Dean Glenda Price

Carolyn M. DelPolito, Ph.D
Executive Director
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