Wednesday, April 25

SESSION VI

8:30 a.m.- 12 Noon	COD BUSINESS MEETING	*Navajo Room*
12 Noon	ADJOURNMENT	

Association of American Medical Colleges

COUNCIL OF DEANS SPRING MEETING

PROGRAM

MEDICAL EDUCATION AND THE UNIVERSITY

April 22-25, 1979
Radisson Resort & Racquet Club
Scottsdale, Arizona

1979 SPRING MEETING OF THE COUNCIL OF DEANS

April 22-25, 1979
Scottsdale, Arizona

MEDICAL EDUCATION AND THE UNIVERSITY

PROGRAM

Sunday, April 22

SESSION I

1:00 p.m.- 5:00 p.m. ARRIVAL & REGISTRATION — *Lobby*

5:30 p.m.- 7:00 p.m. WELCOME & PRELUDE TO COD BUSINESS MEETING — *Navajo Room*

7:00 p.m.- 8:30 p.m. RECEPTION — *Poolside*

Monday, April 23

SESSION II

8:30 a.m.- 10:15 a.m. — *Navajo Room*

THE PLACE AND FUNCTION OF THE MEDICAL COLLEGE IN ACADEME

—John W. Ryan, Ph.D.
President
Indiana University

—Thomas A. Bartlett, Ph.D.
President
Association of American Universities

10:15 a.m.- 10:45 a.m. BREAK

SESSION III

10:45 a.m.- 12:30 p.m. — *Navajo Room*

PRE-PROFESSIONAL—PRE-CLINICAL EDUCATION: COPING WITH THE TRANSITION

"Problems of an Arts & Sciences College"
—Patricia Geisler, Ph.D.
Associate Dean
Columbia College

"Constructing a Bridge"
—M. Lea Rudee, Ph.D.
Provost
Warren College, University of California at San Diego

"The Rochester Plan"
—Frank E. Young, M.D., Ph.D.
Chairman of Microbiology
University of Rochester School of Medicine

12:30 p.m.- UNSCHEDULED TIME

Tuesday, April 24

SESSION IV

8:30 a.m.- 10:15 a.m. — *Navajo Room*

CRITICAL VALUES IN MEDICAL EDUCATION: TWO PERSPECTIVES

—Daniel C. Tosteson, M.D.
Dean
Harvard Medical School

—Richard H. Moy, M.D.
Dean
Southern Illinois University School of Medicine

10:15 a.m.- 10:45 a.m. BREAK

SESSION V

10:45 a.m.- 12:30 p.m. — *Navajo Room*

MINORITY STUDENT OPPORTUNITIES IN THE POST-BAKKE ERA

—Peter J. Liacouras
Dean of the School of Law
Temple University

—Marion Mann, M.D.
Dean
Howard University College of Medicine

12:30 p.m.- UNSCHEDULED TIME

aamc association of american medical colleges

AGENDA

FOR

COUNCIL OF DEANS

SPRING BUSINESS MEETING

SESSION I
SUNDAY, APRIL 22, 1979
5:30 P.M. - 7:00 P.M.

SESSION II
WEDNESDAY, APRIL 25, 1979
8:30 A.M. - 12 NOON

NAVAJO ROOM
RADISSON RESORT & RACQUET CLUB
SCOTTSDALE, ARIZONA

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

COUNCIL OF DEANS
SPRING BUSINESS MEETING
Navajo Room
Radisson Resort & Racquet Club
Scottsdale, Arizona

AGENDA

Session I
5:30 - 7:00 p.m.
Sunday, April 22, 1979

Session II
8:30 - 12 Noon
Wednesday, April 25, 1979

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS
ANNUAL BUSINESS MEETING

Monday, October 23, 1978
2:00 pm - 5:00 pm
Ballroom C
New Orleans Hilton Hotel
New Orleans, Louisiana

M I N U T E S

I. Call to Order

The meeting was called to order at 2:00 p.m. by Julius R. Krevans, M.D., Chairman.

II. Quorum Call

Dr. Krevans announced the presence of a quorum.

III. Consideration of Minutes

The minutes of the April 27, 1978, Spring Business Meeting held at the Cottonwood Conference Center in Snowbird, Utah, were approved as submitted.

IV. President's Report

AAMC President, John A. D. Cooper, M.D., addressed the Council of Deans. He thanked the deans for their continued and impressive support during the past year for the projects and activities undertaken by the Association. Noting that a substantial focus in many of his reports had been on legislative developments, he stated his intention to leave that subject to other forums and to concentrate this report on a descriptive review of other AAMC programs and activities.

Dr. Cooper emphasized that much of the high priority work of the Association was accomplished through the mechanisms of Association wide Task Forces. He noted that the efforts of several such groups were nearing completion and that their work and recommendations would be reported on and in some cases acted upon during the course of this Annual Meeting: the Task Force on Student Financing and Task Force on Minority Student Opportunities in Medicine. The Task Force on the Support of Medical Education had progressed in its work and had prepared preliminary and interim recommendations. The Task Force on Graduate Medical Education was still in the initial stages of its efforts and planned to develop a final report in time for next year's Annual Meeting.

Dr. Cooper next highlighted a number of the Association's ongoing activities and programs. He cited the Management Advancement Program as the major, and by all accounts very successful, effort to assist the schools in improving their internal management capabilities. Dr. Cooper than catalogued the Association's publications and reporting mechanisms in place to achieve optimum communication between the AAMC staff and governing bodies and the AAMC members. He described the scope of the AAMC information systems and highlighted their utility in AAMC policy development and program management, as well as their availability as a source of useful information to the schools. Finally, Dr. Cooper pointed to some of the projects currently underway.

V. Action Items

A. Election of Provisional Institutional Members

The Council of Deans approved the election of the following schools to Provisional Institutional Membership:

Marshall University
School of Medicine

Catholic University of Puerto Rico
School of Medicine

School of Medicine
at Morehouse College

East Tennessee State University
College of Medicine

B. The Withholding of Medical Care by Physicians

At its June 1977 meeting, the Executive Council responded to a suggestion that the Association formulate a position of the withholding of professional services by physicians by appointing a working group to recommend a policy statement. The suggestion arose from a concern that the adoption of this technique by physicians as a means of bringing pressure to bear on the solution of perceived problems raised serious ethical issues. Strikes by practicing physicians over malpractice premiums and job actions by resident physicians for various reasons are examples of this practice which raised the concern.

This working group was chaired by Dr. Clayton Rich and its membership included: Dr. Steven C. Beering, Dean & Medical Center Director, Indiana University; Dr. Edward W. Hook, Chairman, Department of Medicine, University of Virginia; Dr. David Kindig, Director, Montifiore Hospital; Dr. Louis C. Lasagna, Chairman, Department of Pharmacology and Toxicology, University of Rochester; Dr. Albert Jonsen, Associate Professor of Bioethics, University of California, San Francisco; Dr. William Merritt, Department of Pediatrics, University of Maryland Hospital; and Paul Scoles, Class of '79, CMDNJ-Rutgers Medical School.

Several drafts of the resultant statement were considered by each of the Administrative Boards and the Executive Council. A review committee consisting of Mr. John Colloton, Dr. John Gronvall, Dr. Tim Oliver, Dr. Clayton Rich, and Mr. Paul Scoles further refined the paper and presented a draft to the Executive Council at the September 1978 meeting. The Council approved that draft.

Dr. Clayton Rich presented his committee's recommendation to the Full Council of Deans.

ACTION

The Council of Deans endorsed the recommended AAMC Position Statement on the Withholding of Medical Care by Physicians. (Copy appended to these minutes.)

C. Report of the Nominating Committee and Election of Officers

The Nominating Committee of the Council of Deans consisted of:

Stanley M. Aronson, Chairman
Ephraim Friedman
James T. Hamlin III
Charles C. Lobeck
Harry P. Ward

The committee solicited the membership for recommendations of persons to fill the available positions by memorandum dated April 7, 1978. The returned Advisory Ballots were tabulated and the results distributed to each committee member. The committee met by telephone conference call on June 16, 1978, and proposed the following slate:

For offices to be filled by vote of the Council of Deans:

Chairman-Elect of the Council of Deans:
Stuart Bondurant, M.D., Dean and President
Albany Medical College

Member-at-Large of the Council of Deans Administrative Board:
Allen W. Mathies, Jr., M.D., Dean
University of Southern California

For offices to be filled by election of the Assembly:

Chairman-Elect of the Assembly:
David L. Everhart, President
Northwestern Memorial Hospital

or

Charles B. Womer, President
University Hospitals of Cleveland

Council of Deans Representatives to the Executive Council:
Clayton Rich, M.D., Dean
Stanford University

William H. Luginbuhl, M.D., Dean
University of Vermont

John E. Chapman, M.D., Dean
Vanderbilt University

ACTION

The Council of Deans elected the slate of officers proposed above and endorsed the nominations of the other offices to be filled by subsequent vote of the Assembly.

VI. Discussion Items

A. Task Force Report on Minority Student Opportunities in Medicine

Paul Elliott, chairman of the Task Force, appeared before the Council of Deans to present this report. The Task Force noted a general societal mood suggesting a decreased commitment to affirmative action and a backing off in terms of funding and programmatic effort. Nevertheless, the Task Force felt that medical schools deserved commendation as the only institutions which had consistently furnished leadership in the area of affirmative action.

He summarized the goals of the Task Force. The major goal is to increase the number of minority students in the medical schools with the ultimate object of increasing the representation of minorities in the practice of medicine. This can only be accomplished by increasing the pool of qualified applicants from the undergraduate and high school levels. The Task Force suggested many approaches which the medical schools could take to achieve these results. Each of the recommendations was drawn from an approach currently successfully utilized by one of the schools whose programs were reviewed by the Task Force.

There was some discussion by the deans regarding the Pepper Bill, which addressed the problem of aiding and encouraging economically disadvantaged students to pursue training in the biomedical sciences, and the Association's support of the bill.

The Task Force acknowledged the need for additional funds to support medical school efforts to achieve the goals set out and noted that federal funds are limited and few legislative proposals addressed to the needs.

B. Task Force Report on Student Financing

Dr. Bernard Nelson presented the final report of the Task Force. He explained that the Task Force had rescinded a previous recommendation that the Federal government develop a special loan program for students in the health professions and instead recommended that the borrowing limits under the guaranteed student loan program be increased for medical students and that the repayment terms be modified to suit the growing debt. He also emphasized two points: the importance of available financial aid in recruiting minority students to medical schools, and the fact that specific reports regarding student financing are extremely helpful when it comes to meeting with members of the executive and legislative branches in formulating satisfactory student financing programs.

C. Task Force Report on the Support of Medical Education

Dr. Stuart Bondurant, chairperson of the Task Force, presented this report to the Council, including a summary of the recommendations of the Task Force and a tentative timetable, which included a final report to be completed early in 1979. The purpose of the Task Force was to develop a broad strategy for the support of medical education and the group considered this major issue from a legislative perspective. After dividing itself into five working groups, each writing a position statement for the final paper, the Task Force drafted its report and presented it to the various Administrative Boards and Executive Council. Following the implementation of suggested modifications by the Boards, a copy was sent to the full Council of Deans and Dr. Bondurant asked for comments and suggestions which could be incorporated into the final document.

D. Task Force Report on Graduate Medical Education

Dr. Kay Clawson briefly described the history of this Task Force and gave a progress report. In June of 1976, eighteen people were appointed to form the Task Force to Study Graduate Medical Education. This committee established four working groups which would study and make recommendations in four areas: transition, quality, accreditation, and specialty and geographic distribution. While the various working groups had been meeting, the only one which had issued a report was the Working Group on Transition.

Dr. Clawson outlined the four areas of concern which were addressed in the Transition Group's Report. First, there was the problem of career counseling which appeared to be uneven among the medical schools. It was suggested by the working group that an academic counselor be assigned to each student for the first two years of his tenure in medical school and that a second counselor be assigned at the end of two years with career counseling as his specific responsibility. He would provide the student with more specific advice, knowledge, and experiential information regarding career options.

Second, the group examined the electives system and concluded that the current procedure of allowing the student to choose electives in the fourth year should be retained. The belief was that if students had been properly counseled in their first three years, a wise selection of electives would occur in their final year. Third, the information available on graduate medical education was found to be sparse, inadequate, and out-of-date. It was the suggestion of the transition working group that the AMA and the AAMC join with the NRMP to put together a compilation of resources regarding graduate medical education. Finally, the application cycle and selection process was a concern of the working group. Their conclusion was that all programs accepting GMIs should use the NRMP. Although several members of the Task Force were uncomfortable with this idea, it was the recommendation that the use of NRMP should be a prerequisite for the program's accreditation by the LCGME. The group finally recommended that the deans preclude the sending of premature letters of recommendation by joining together in refusing to send out any letters before an agreed upon uniform date.

Dr. Clawson concluded with the observation that all recommendations of the Working Group on Transition appear to be feasible and that progress reports of the other working groups would be presented as submitted.

E. Ad Hoc Committee on Continuing Medical Education

Dr. John Jones presented the status of this committee to the full Council. He explained that there has been an increase in continuing medical education and that CME has actually become a part of the recertification process in some states. At the last COD meeting and at subsequent meetings of the Southern and Midwest-Great Plains Deans, several suggestions were elicited as to ways of achieving the objectives of CME: that CME should be accepted as a major mission of medical schools; that there should be an assessment of all CME programs regarding compliance with appropriate CME objectives; that schools should accept the broad definition of CME; that the system for awarding credit for CME should be revised; and that the AAMC, the medical schools and other organizations promote research and development in CME.

F. Biomedical Research Policy Developments

Dr. Ted Cooper presented a brief status report on this topic. He emphasized two items: the AAMC statement on biomedical research, recently formulated, would provide the basis for AAMC testimony and positions on issues as they arise; and the procedures to be followed by HEW in arriving at a set of principles which would serve as a basis for a new five year plan.

VII. Information Item

Harrison Owen, Executive Director of the Administrative Scholars Program at the Veterans Administration, spoke briefly to the Council regarding a new program at the VA open to all health and health-related professionals. The primary focus of the program concerns problems of policy and administration as these relate to the management of large health care systems and Mr. Owen asked for the support of the deans in encouraging prospective applicants.

VIII. Old Business

No old business was brought before the Council.

IX. New Business

A resolution, "Research Opportunities for Undergraduate Medical Students," as submitted by the Western Region and approved by the full OSR full membership and the COD Administrative Board, was presented to the full Council for their approval. The text of the resolution follows:

Research Opportunities for Undergraduate Medical Students

WHEREAS, firsthand research experience contributes greatly to the development of scientific thought processes which are of value in all areas of medicine and continuing education;

WHEREAS, medical undergraduates have the opportunity to devote smaller blocks of time to research endeavors than is required for post-graduate research commitments;

WHEREAS, many medical students have been unaware of opportunities or have been unable to fully utilize such opportunities because of problems with scheduling, funding, etc.;

BE IT THEREFORE RESOLVED THAT, COD-OSR-CAS form a joint committee to investigate possibilities for improving and encouraging research opportunities, basic as well as clinical, for medical students with an interest towards funding, scheduling, and student research presentations.

ACTION

The Council of Deans endorsed the resolution as presented.

X. Installation of Chairman

Dr. Christopher Fordham III, Dean at the University of North Carolina, was installed as the new Chairman of the Council of Deans and reminded the Council that the 1979 Spring Meeting will be held from April 22-25 at the Radisson Resort & Racquet Club in Scottsdale, Arizona.

Dr. Fordham thanked Dr. Krevans for his eighteen months of leadership of the Council of Deans. He expressed his appreciation in poetry:

Here's to Julie Krevans.
He's got wisdom, wit and charm.
He's worked hard for the Council.
And, alas, he's done us no harm!

XI. Adjournment

The meeting was adjourned at 4:15 p.m.

THE WITHHOLDING OF MEDICAL CARE BY PHYSICIANS

BACKGROUND

The medical schools, teaching hospitals and academic societies of the AAMC have a unique responsibility for the education of physicians. As organizations, as representatives of the professionals who constitute a significant portion of the medical community and as providers of medical care, they should maintain by both precept and example the high standards of the medical profession.

Mindful of this responsibility, the AAMC advances the following statement on the withholding of care by physicians. The statement emphasizes the ethical issues that students and physicians must resolve for themselves when they are called upon to consider concerted action to withhold medical care.

STATEMENT

Fundamental ethical tenets of the medical profession mandate that physicians provide care for the sick and neither abandon nor exploit their patients. These ethical tenets apply to physicians whether they are acting individually or in concert as members of groups or associations.

An important ethical issue, one not ordinarily present in the traditional relationship between an individual physician and his patients, emerges when physicians act together to restrict or withhold medical services. An individual physician need not accept as his patient every person who seeks medical attention because, in most situations, alternative sources of care are available. However, the option of alternative care may be foreclosed when physicians act together to limit or withhold medical care. It is clear that physicians acting in concert have an ethical responsibility to all of those in the general public who could be patients of individual physicians had a group decision denying them some form of medical care not been made. When such a decision is implemented by all available physicians, these physicians abandon members of the public seeking medical care. Therefore, physicians who act in concert to restrict or withhold medical care contravene some of the profession's primary ethical precepts.

(Physicians are, of course, justified in refusing to perform procedures or acts designed to further inherently corrupt or evil purposes. Indeed there is an ethical mandate that they do so, but such acts are not properly defined as medical care.)

In the recent past groups of physicians have acted to restrict or withhold medical care in order to call attention to social issues, such as the need to improve the quality of care afforded one segment of the public. An analysis of the ethical considerations raised by this practice begins with the recognition that physicians are members of the public with special knowledge and experience which provide a unique perspective on the conditions of medical practice, the relations between the profession and the public, and the major social issues involving health and welfare. Physicians acting

individually or together have a special social responsibility to provide advice and leadership in such matters. However, in advancing positions about social issues, physicians act as specially informed citizens, not from their unique and primary positions as healers. Any attempt to justify on ethical grounds the decision to restrict medical care in order to advance an assumed social good confounds the specific role of physicians in society as providers of healing services, with a more general role shared with all other citizens. These considerations make it doubtful that a justification reasonably can be advanced. To the extent that an element of self-interest motivates a decision to limit or withhold professional services, ethical justification of that stance is even more suspect.

Because the ethics and public duty of the profession restrain physicians from acting in concert to withhold services, they should avoid this powerful method of advancing their interests. It is a responsibility of society to forgo exploitation of this ethical standard by providing a fair process for resolving valid economic and organizational issues which influence the welfare of the profession and the quality of medical care.

The Association of American Medical Colleges reaffirms its support of fair processes for resolving concerns of medical professionals and opposes the withholding of medical care by groups of physicians as a means of resolving such issues.

COALITION FOR HEALTH FUNDING - TABLE OF FUNDING RECOMMENDATIONS

($ in thousands)

Section 1. Recommendations to L-HEW Subcommittee	FY1978 APPROPRIATION	FY1979 AUTHORIZATION	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980 PRESIDENT'S BUDGET	FY1980 CHF RECOMMENDATION
I. HEALTH SERVICES ADMINISTRATION						
A. Community Health Services						
1. Community health centers-p.12	268,000	348,000	269,500 A/	405,000 B/	381,000 B/	403,000 B/
2. Home health services-p.21	6,000	14,000	6,000*	16,100	804	6,000
3. Comp health grants to states-p.13	90,000	103,000	90,000*	150,000	52,000	115,000
4. Hypertension-p.14	11,000	20,000	11,000*	24,500	13,261	24,500
5. Maternal and child health-p.15						
a. Grants to states-p.15	332,500)		345,500)		357,400)	(372,016)
b. Research and training-p.16	)--- 29,354)	399,864	)--- 32,177)	399,864	)--- 14,843)	399,864 (27,848)
c. Sudden infant death syndrome-p.17	2,802	3,500	2,802*	4,000	2,802	4,000
6. Genetic Services-p.20	7,578 14/	17,500	7,567*14/	21,500	7,567	15,000
7. Family planning-p.18	135,000	203,800	135,000	234,405	145,000	175,000
8. Migrant health-p.19	34,500	43,000	34,500*	48,500	41,400	42,000
9. National health service corps-p.22	42,565	64,000	58,000	70,000	81,825	81,825
10. Black lung clinics (new program)		10,000	7,500	10,000	7,500	7,500
11. Program support	25,763	OPEN	29,863	OPEN	34,704	34,704
12. Hemophilia centers (Treatment & Blood Separation Centers)	3,000	6,500	3,000*	8,000	3,000	3,000
B. Health Care Services and Systems						
1. Patient care and spec. health services:						
a. Hospitals and clinics	175,678	OPEN	172,504	OPEN	166,434	166,434
b. Federal employee health	624	OPEN	686	OPEN	728	728
c. Payments to Hawaii	1,400	OPEN	1,600	OPEN	1,600	1,600
2. Emergency medical services-p.23	42,625	125,000	33,700	EXPIRED	39,625	45,900 **
3. Program support	6,246	OPEN	7,059	OPEN	8,988	7,500
C. Buildings & Facilities	15,000	OPEN	---	OPEN	3,000	3,000
D. Program Management	6,393	OPEN	7,026	OPEN	7,416	7,000
II. CENTER FOR DISEASE CONTROL -- See pages 25 & 26						
A. Disease Control						
1. Project grants						
a. Venereal disease	32,000	45,000	32,000*	51,500	32,000	37,190
b. Immunization	31,200	52,000	31,200*	39,500	33,532	35,000
c. Rat control	13,000	14,500	13,000*	15,500	13,000	15,100
d. Lead-based paint poisoning prev.	10,250	14,000	10,250*	14,000	10,250	11,172
2. Disease investigation and control	56,042	OPEN	64,000	OPEN	83,351	83,351
(Fluoridation grants)	(0)		(1,500)		(6,224)	(10,000)
(Diabetes control)	(1,500)		(1,500)		(1,500)	(7,000)

($ in thousands)

C.D.C. Continued	FY1978 APPROPRIATION	FY1979 AUTHORIZATION	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980 PRESIDENT'S BUDGET	FY1980 CHF RECOMMENDATION
3. Laboratory improvement	20,197	OPEN	18,956	OPEN	18,311	18,311
4. Health education	4,580	OPEN	12,560	21,000	12,700	12,700
5. Grants for preventive health service programs		N/A	N/A	20,000	18,000	18,000
B. Occupational Safety and Health	56,265	OPEN	61,994	OPEN	76,552	76,552
C. Buildings & Facilities	---	OPEN	1,912	OPEN	11,436	11,436
D. Program Management	3,366	OPEN	3,427	OPEN	3,703	3,703
III. NATIONAL INSTITUTES OF HEALTH						
A. Cancer-p.29	872,388	1,015,000	937,129	1,030,000 17/	936,958	1,008,492
(Research training)	(20,163)	1/	(20,129)	1/	(20,410)	(21,968)
B. Heart, Lung, and Blood-p.30	447,909	510,000	506,776	560,000 17/	507,344	583,500
(Research training)	(24,762)	1/	(21,192)	1/	(25,000)	(28,752)
C. Dental Research-p.31	61,728	OPEN	65,213	OPEN	66,118	75,000
(Research training)	(4,198)	1/	(3,293)	1/	(4,198)	(4,762)
D. Arthritis, Metabolism, Digestive Diseases-p.32	260,253	OPEN	302,767	OPEN 2/	305,746	362,500
(Research training)	(16,777)	1/	(14,898)	1/	(17,877)	(21,195)
E. Neurological, Communicative Disorders and Stroke-p.34	178,438	OPEN	212,365	OPEN	212,322	250,000
(Research training)	(7,322)	1/	(7,365)	1/	(7,322)	(8,621)
F. Allergy and Infectious Diseases-p.35	162,341	OPEN	191,328	OPEN	190,202	224,000
(Research training)	(8,323)	1/	(8,130)	1/	(7,847)	(9,241)
G. General Medical Sciences-p.36	230,796	OPEN	277,628	OPEN	280,378	320,000
(Research training)	(46,630)	1/	(46,570)	1/	(45,422)	(51,841)
H. Child Health and Human Development-p.38	166,390	OPEN	190,130	OPEN	204,381	243,100
(Research training)	(9,820)	1/	(10,238)	1/	(9,820)	(11,680)
I. Aging-p.39	37,305	OPEN	56,911	OPEN	56,510	68,000
(Research training)	(2,390)	1/	(2,385)	1/	(1,984)	(2,387)
J. Eye-p.40	85,400	OPEN	105,192	OPEN	104,528	125,000
(Research training)	(4,643)	1/	(4,643)	1/	(4,643)	(5,552)
K. Environmental Health Sciences-p.42	64,241	OPEN	78,080	OPEN	79,012	92,000
(Research training)	(5,485)	1/	(4,568)	1/	(6,568)	(7.648)
L. Research Resources-p.43	145,095	OPEN	154,164	OPEN	154,199	180,000
(Research training)	(515)	1/	(515)	1/	(550)	(642)
M. Fogarty Center-p.44	8,483	OPEN	8,989	OPEN	8,989	10,000
N. National Library of Medicine-p.45	37,619	3/	41,431	3/	41,431	48,000
O. Office of the Director-p.46	18,900	OPEN	19,673	OPEN	21,062	22,500
P. Buildings & Facilities-p.47	65,650	OPEN	67,950	OPEN	3,250	23,000
IV. ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION						
A. National Institute of Mental Health						
1. Research-p.48	111,857	OPEN PLUS 8,000	130,807	OPEN PLUS 9,000	160,168	166,168
2. Training-p.48	84,400	OPEN 4/	90,400	OPEN 4/	89,354	110,700
a. Clinical training	(68,263)	OPEN	(74,263)	OPEN	(70,663)	85,263
b. Research training	(16,137)	OPEN	(16,137)	OPEN	(18,691)	25,437
3. Community support programs-p.53	7,600	indefinite	7,600	indefinite	7,600	9,000
4. Community mental health centers-p.51						
a. Planning	0	1,500	0	1,000	0	1,000
b. Initial operations	30,489	34,500	30,489*	35,000	0	35,000
c. Continuation grants	205,447	SSAN	250,059	SSAN	214,512	230,500

ADAMHA Continued	FY1978 APPROPRIATION	FY1979 AUTHORIZATION	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980 PRESIDENT'S BUDGET	FY1980 CHF RECOMMENDATION
			($ in thousands)			
d. Conversion grants	19,372	30,000	19,372*	25,000	1,840	7,200
e. Consultation & education	8,245	20,000	8,245*	not authorized	11,938	18,600
f. Financial distress	5,488	25,000	5,488*	EXPIRED	12,765	20,200**
g. Facilities	0	EXPIRED	0	EXPIRED		
h. New mental health services act (new program)--	--	--	--	--	99,100 13/	0
5. Program support	29,513	OPEN	31,173	OPEN	35,937	35,848
B. National Institute on Drug Abuse-p.54						
1. Research	34,092	OPEN	42,930	EXPIRED	50,304	55,000**
2. Training						
a. Clinical training	9,379	OPEN	9,379	EXPIRED	7,978	10,200**
b. Research training	621	5/	621	5/	702	800
3. Community programs						
a. Project grants & contracts	161,000	177,000	161,000*	EXPIRED	161,000	161,000**
b. Grants to states	40,000	45,000	40,000*	EXPIRED	0	0**
4. Program support	16,817	OPEN	18,178	EXPIRED	18,570	18,570**
C. National Institute on Alcohol Abuse and Alcoholism-p.55						
1. Research						
a. Grants	13,182	28,000	16,197	EXPIRED	17,878	19,000**
b. Research centers	3,000	6,000	6,000	EXPIRED	7,200	8,000**
2. Training						
a. Clinical training	5,052	OPEN	5,052	EXPIRED	4,075	10,000**
b. Research training	2,148	OPEN 6/	2,148*	OPEN 6/	1,300	5,000
3. Community programs						
a. Project grants & contracts	78,706	102,500	78,706	EXPIRES 9/30/79	93,323	120,000**
b. Grants to states	56,800	85,000	56,800	EXPIRES 9/30/79		58,500**
4. Program support	9,660	OPEN	10,202	OPEN	10,240	10,240
D. Block Grants					99,000	0 16/
E. Buildings & Facilities	350	OPEN	0	OPEN	0	0
F. Program Management	7,632	OPEN	8,112	OPEN	9,826	9,826
G. St. Elizabeth's Hospital	74,171	OPEN	75,824	OPEN	85,119	90,000
H. Construction and Renovation (SEH)	54,210	OPEN	0	OPEN	0	0

($ in thousands)

	FY1978 APPROPRIATION	FY1979 AUTHORIZATION	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980 PRESIDENT'S BUDGET	FY1980 CHF RECOMMENDATION
V. HEALTH RESOURCES ADMINISTRATION						
A. Health Planning and Resource Development						
1. Health planning-p.58						
a. HSA grants	107,000	EXPIRED	107,000*	EXPIRED	115,400	115,400**
b. States' grants	29,500	EXPIRED	29,500*	EXPIRED	30,000	30,000**
c. Rate regulation (Hospital cost) Moved to HCFA	2,000	6,000	7/	EXPIRED		0**
d. Planning methods/centers	6,500	OPEN	6,500*	OPEN	0	0
e. Modernization and life safety codes (Sec. 1613 and 1625(a))	8/	8/	8/	8/		
f. Resource development	0	0	0	0	0	
g. Special medical facilities	2,750	EXPIRED	----------			
2. Program support	11,383	OPEN	11,882	OPEN	9,132	9,132
B. Health Manpower						
1. Health professions, capitation grants-p.59						
a. Medicine, osteopathy, & dentistry (MOD)	120,100	186,777	120,100 15/	196,470	0	120,100
b. MOD, bonus phase-out	---	---	---	---		
c. Veterinary, optometry, pharmacy & podiatry (includes bonus phase-out)	18,000	33,202	18,000 15/	33,724	0	18,000
d. Public health	5,900	10,462	5,900 15/	11,060	0	9,800
e. Startup assistance	2,000	5,000 12/	5,000	5,000 12/	0	5,000
f. Financial distress	3,000	5,000 12/	5,000	5,000 12/	5,000	5,000
2. Health teaching facilities						
a. Construction grants-p.64	6,500	40,000	0	40,000	0	20,000
b. Interest subsidies	2,000	3,000	3,000	4,300	4,300	4,300
3. Health Fac. Financing						
a. Conversion/closure	---	---	---	---	30,000	30,000
4. Health professions, student assistance-p.61						
a. Health professions student loans	20,000	27,000	10,000	28,000	0	28,000
b. Loan repayments	1,500	SSAN	1,500	SSAN	0	1,500
c. National Health Service Corps scholarship	60,000	140,000	75,000	200,000	79,500	100,000
d. Health Professions Scholarships		Program Discontinued----------				
e. Exceptional need scholarships	5,000	17,000	7,000	18,000	0	18,000
f. Shortage area scholarships	0	---	---	---	0	
5. Health professions, special educational assistance-p.62						
a. Family medicine/general dentistry residencies	45,000	45,000	45,000	50,000	40,500	47,500
b. Family medicine departments	0	15,000	0	20,000	15,000	15,000
c. Primary care residencies and training (Gen. pediatrics/Internal Med.)	15,000	20,000	17,500	25,000	25,000	25,000
d. Interdisciplinary training (Primary care--special projects)	4,000 --	15,000 12/ 12/	7,141 --	15,000 12/ 12/	6,000 (6,000)	10,000 (6,000)
e. Physicians assistants	9,100	30,000 10/	9,100	35,000 10/	9,100	9,100
f. Area health education centers	17,000	30,000	20,000	40,000	5,825	30,000

($ in thousands)

HRA continued	FY1978 APPROPRIATION	FY1979 AUTHORIZATION	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980 PRESIDENT'S BUDGET	FY1980 CHF RECOMMENDATION
g. Disadvantaged assistance	(15,000)	(21,000)	(19,000)	(21,000)	(19,068)	(20,000)
1) Health professions	14,500	20,000	18,000	20,000	18,068	20,000
2) Allied health	500	1,000	1,000	1,000	1,000	0
h. Foreign medical transfers	2,000	3,000	1,000	4,000	0	0
i. Emergency medical training	6,000	10,000	6,000	EXPIRED	0	0**
j. National Advisory Committee on Graduate Medical Education	1,000	SSAN	1,000	SSAN	1,000	1,000
k. Supply & distribution reports	1,000	SSAN	2,700	SSAN	5,400	7,500
l. Project grants--MOD		Program discontinued----------				
m. Project grants--VOPP		Program discontinued----------				
n. Manpower initiatives		Program discontinued----------				
6. Dental health education						
a. TEAM grants-p.63	3,500	30,000 10/	2,000	35,000 10/	2,000	2,000
(Dental extenders)	2,000	10/	2,000	10/	2,000	2,000
b. Educational development	500	SSAN	0	SSAN	0	0
7. Nursing, institutional assistance-p.68						
a. Capitation	30,000	EXPIRED	30,000*	EXPIRED	0	35,000**
b. Advanced nursing training	12,000	EXPIRED	12,000*	EXPIRED	0	15,000**
c. Nurse practitioner training	13,000	EXPIRED	13,000*	EXPIRED	13,000	15,000**
d. Special projects	15,000	EXPIRED	15,000*	EXPIRED	1,743	18,000**
e. Financial distress	0	EXPIRED	0	EXPIRED	0	0**
8. Nursing facilities-p.68						
a. Construction grants	3,500	EXPIRED	3,500*	EXPIRED	0	7,500**
b. Interest subsidies	0	EXPIRED	0	EXPIRED	0	0**
9. Nursing, student assistance-p.68						
a. Loans	22,500	EXPIRED	22,500*	EXPIRED	0	25,000**
b. Scholarships	9,000	EXPIRED	9,000*	EXPIRED	0	11,000**
c. Traineeships	13,000	EXPIRED	13,000*	EXPIRED	0	17,000**
10. Nursing Research-p.70						
a. Fellowships (Research training)	1,000	EXPIRED	1,000	EXPIRED	0	3,000**
b. Projects	5,000	SSAN	5,000	SSAN	0	9,000
11. Allied Health-p.67						
a. Special projects	16,500	24,000	10,500	26,000		12,500
b. Special improvement grants		Program discontinued----------				
c. Traineeships	3,000	5,000	2,500	5,500	0	3,500

HRA continued	FY1978 APPROPRIATION	FY1979 AUTHORIZATION	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980 PRESIDENT'S BUDGET	FY1980 CHF RECOMMENDATION
			($ in thousands)			
12. Public Health & Health Administration-p.65						
a. Special projects--public health & health administration	5,000	5,500	5,000	6,000	5,000	6,000
b. Public health traineeships	7,000	9,000	7,000	10,000	7,000	10,000
c. Health administration program support (grants & training)	3,000	3,500	3,000	3,750	3,000	3,300
d. Health administration traineeships	1,500	2,500	2,000	2,500	2,000	2,500
13. D.C. Medical & Dental		Program Discontinued ----------				
14. Program Support (BHM)						
a. HRA Overhead, Regional Offices		OPEN		OPEN		
b. Div. of Associated health professions		OPEN		OPEN		
c. Div. of Dentistry		OPEN		OPEN		
d. Div. of Medicine		OPEN		OPEN		
e. Div. of Nursing		OPEN		OPEN		
f. Other Programmatic Activities		OPEN		OPEN		
g. Support Activities		OPEN		OPEN		
Subtotal, Program support (BHM)	(19,478) 11/		(19,756)		(13,916)	(13,916)
Subtotal, Health Manpower						
C. Program Management (HRA)	12,847	OPEN	13,241	13,241	12,364	12,364
D. Sales Insufficiencies	2,592	SSAN	2,412	SSAN	2,000	2,000
E. Medical Facilities Guarantee and Loan Fund	41,000	SSAN	42,000	SSAN	45,000	45,000
VI. OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH						
A. Health Statistics-p.71	37,956	OPEN	38,634	OPEN	48,585	48,585
B. Health Services Research-p.72	33,234	OPEN	33,348	OPEN	29,295	29,295
C. Health Maintenance Organizations-p.73						
1. Grants and Contracts	21,100	OPEN PLUS 31,000		65,000		
2. Program Support	5,034	OPEN		OPEN		
Subtotal, HMO's	(26,134)		(22,807)		(73,607)	(73,607)
D. Special Health Programs-p.75	4,207	OPEN	2,833	OPEN	22,329	22,329
E. Public Health Service Management-p.75	20,937	OPEN	21,548	OPEN	21,777	21,777
F. Retirement & Medical Benefits for Commissioned Officers-p.75	56,948	SSAN	65,083	65,083	76,925	76,925
G. Scientific Activities Overseas-p.75	11,387	SSAN	11,387	SSAN	6,520	6,520
H. Adolescent Health-p.74	---	---	7,000	65,000	60,000	60,000
I. Health Care Technology-p.76	---		---	25,000	5,000	5,000
VII. OFFICE OF HUMAN DEVELOPMENT SERVICES (selections)(Not included in Budget Function 550 - health)						
A. Rehabilitation Services Administration-p.77						
1. Basic State Grants	760,472	808,000	817,500	880,000	817,500 9/	880,000
2. Innovation & Expansion	18,000	45,000	18,000*	50,000	11,700	21,000
3. Service Projects & Construction	(38,228)		(26,728)		(26,800)	(31,500)
a. Training services & facilities improvement grants	7,400	SSAN		SSAN		9,000
b. Construction	8,000	SSAN		SSAN		0
c. Service projects	22,828	SSAN		SSAN		22,500
4. Training	30,500	34,000	30,500*	40,000	25,500	35,000
5. Independent living	---	80,000	2,000	150,000	10,000	100,000

Rehab services continued	FY1978 APPROPRIATION	FY1979 AUTHORIZATION	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980 PRESIDENT'S BUDGET	FY1980 CHF RECOMMENDATION
			($ in thousands)			
B. National Institute for Handicapped Research -p.80	31,500	50,000	31,500*	75,000	27,500	50,000
Subtotal, Rehabilitation						
C. Developmental Disabilities -p.79						
1. State Grants	33,058	55,000	33.058*	65,000	49,880	38,016
2. Service Grants	19,567	20,000	19,567*	22.000	5,557	22,502
3. University Affiliated Facilities	6,500	12,000	6,500*	14,000	3,000	14.000
Section 2. Recommendations to Agriculture Subcommittee						
VIII. FOOD & DRUG ADMINISTRATION--see p.11						
A. Salaries & Expenses						
1. Food	87,718	OPEN	85,788	OPEN	91,301	
2. Drugs & Devices	128,226	OPEN	135,559	OPEN	146,239	
3. Radiological Products	20,262	OPEN	20,489	OPEN	21,837	
4. Natl. Ctr. Tox Research	13,866	OPEN	13,974	OPEN	15,049	
5. Program Management	37,139	OPEN	39,344	OPEN	41,870	
Subtotal, Salaries & expenses	(287,251)	OPEN	(295,154)		(316,296)	
B. Buildings & Facilities	6,665	OPEN	10,459	OPEN	4,372	
TOTAL, FDA	293,916		305,613	350,000	320,668	343,206
Section 3. Recommendations to Interior Subcommittee						
IX. INDIAN HEALTH SERVICE--see p.24						
A. Indian Health Services	441,936	OPEN	477,041	OPEN	535,116	535,116
B. Indian Health Facilities	71,257	OPEN	76,960	OPEN	50,240	50,240

FOOTNOTES

A/ Includes $16,500,000 for health underserved rural areas with an open authorization. $16,500,000 appropriation and $253,000,000 covered under continuing resolution.

B/ This refers only to Sec. 330 Community Health Centers. President's Budget includes in addition to Sec. 330 amounts for new programs (i.e. Sec. 328, Sec. 340).

1/ Each NIH Institute and ADAMHA receive a pro-rate share of total authorizations for the National Research Service Awards of $197,500,000 for FY79 and $210,000,000 in FY80. This has not yet been allocated. 1979 Supplemental will be limited to original 1979 President's budget and $210,000,000 will be held to the President's FY80 budget request.

2/ NIAMDD has a number of internal special program authorities which limit those programs, but do not directly control the level of total appropriation.

3/ Extramural program is limited to $15,000,000 and $16,500,000 in 1979 and 1980, respectively. Otherwise, the authorization is open.

4/ Research training covered by National Research Service Awards authorization shared with NIH. 1979 financing under continuing resolution for mental health is $16,137,000.

5/ Research training covered by National Research Service Awards authorization. 1979 financing under continuing resolution is $621,000.

6/ Research training covered by National Research Service Awards authorization. 1979 financing under continuing resolution is $2,148,000.

7/ Amount currently under review by O.M.B.

8/ 1976 appropriation of $40,000,000 available through 9/30/79. No funds have been utilized.

9/ Dependent upon amendments to act which eliminate cost of living increase; otherwise it is 880,000,000.

10/ This authorization of $30,000,000 in 1979 and $35,000,000 in 1980 is also the authority cited for the activities dental TEAM practice and dental and physician extenders.

11/ Financed through HRA assessment procedures $19,478,000.

12/ This authorization of $25,000,000 is authority cited for the activities of financial distress, start-up, primary care-special projects, and interdisciplinary training and curriculum development.

13/ Proposed by President's budget for later transmittal.

14/ Includes funding of sickle cell testing and education centers.

15/ President's budget message recommends a rescission in the FY1979 appropriation to a level of $67,300,000 for capitation broken up as follows: MOD $61,400,000, VOPP 0, and PH $5,900,000.

16/ CHF does not support the concept of these Block Grants and therefore recommends no funding.

17/ Does not include research training.

( ) Subtotal numbers enclosed in parentheses are non-add entries.

* Funding under continuing resolution pending enactment of supplemental appropriation.

** For those programs whose authorization levels expire in FY1979, the Coalition has made its recommendation based on our best estimate of need.

SSAN Such sums as necessary.

COMPARISON OF MAJOR
NATIONAL HEALTH INSURANCE PROPOSALS
AND AAMC POSITIONS ON NHI

	AAMC TASK FORCE POSITION ON NATIONAL HEALTH INSURANCE (As Testified 11/6/75-House Ways & Means Health Subcommittee)	THE NATIONAL HEALTH INSURANCE ACT OF 1979 (Kennedy/Labor-Outlined in Senate October 2, 1978)	CATASTROPHIC HEALTH INSURANCE PROGRAM (Title I of S.350 and of S.351 introduced by Sen. Long on 2/6/79)	TENTATIVE NATIONAL HEALTH PLAN (NHP) - PHASE I (Staff Draft of Administration Plan, February 1979)	TENTATIVE NATIONAL HEALTH PLAN (NHP) - FINAL (Staff Draft of Administration Plan, February 1979)
COVERAGE	Universal coverage requiring as a matter of law not only that the opportunity to obtain adequate health insurance coverage must be made available to each individual but also that he must take advantage of this opportunity.	Universal coverage through mandated employer-employee contributions, with employers to cover most costs; mandated benefits for employed and self-employed; costs of poor and unemployed paid by federal subsidies; elderly covered through upgraded Medicare comprehensive benefits.	Universal coverage, but not mandatory. Family medical expenses paid after $2,000 in a year. Family hospital costs paid after 60 days of hospitalization in a year. Employer can choose to cover his employees through a public plan or a private insurance plan. Effective date will be January 1, 1980.	Aged and Disabled: No change, covered by Medicare. Low-income families: current Medicaid recipients remain on Medicaid. Medicaid categorically eligible people with high medical expenses can spend their way into Medicaid income eligibility by off-setting medical expenses against their income. All newly-eligible low-income children and pregnant women added to HealthCare. Employees: employers required to cover all full-time workers for all costs over $2500 attributable to services covered in the standard HealthCare benefit package at a minimum. All others: no change.	Universal, mandatory coverage through either HealthCare or private insurance plans.
BENEFITS	Comprehensive benefits within the resources available. Any exclusion should fit into one of the following categories: (1) services for which insufficient personnel and facilities exist for provision on a universal basis; (2) initially, services not traditionally included in an individual's personal health care expenditures and financed instead through general revenues as public health expenditures (e.g., long-term care for chronic mental illness); and (3) benefits which would pose unreasonable administrative burdens. Except for services excluded for these reasons, covered services should include, at a minimum and without limit, hospital services (including active treatment in psychiatric hospitals), physician services and other appropriate professional and paramedical services wherever provided, and diagnostic laboratory and therapeutic radiologic services wherever provided such services as home health services, rehabilitation services, cost-beneficial preventive services, emergency medical services, and crisis-intervention mental health services.	Uniform and comprehensive benefits for inpatient and outpatient services, physicians' services, home health services, x-rays, lab tests, specified mental health benefits; preventive care and health promotion; prescription drugs to be phased in (immediate coverage for elderly); as well as protection against catastrophic illness.	Same as those covered under the Medicare program without any upper limits on hospital days: inpatient hospital services, post-hospital extended care services, medical and other health services, outpatient physical therapy services, rural health clinic services. Private insurance plans must provide at least this benefit package.	Aged and Disabled: current Medicare benefits except that all limits would be removed on hospital services. Low-income: current Medicaid benefits. HealthCare members would receive all final NHP benefits except drugs. Employees: final NHP benefits except drugs at a minimum. All Others: no change.	Comprehensive, standard minimum benefit package available through HealthCare or private insurance plans. The basic benefit would cover inpatient hospital and extended care services when necessary to diagnose or treat an accident, illness, or pregnancy. Medical, surgical, and other health services necessary to treat such conditions (including diagnosis, therapy, surgery, consultation, and counseling) would be covered. A specified set of home health (100 visits) mental health, (30 inpatient days, $1000 outpatient services) drug, and alcohol abuse, outpatient drugs ($250 deductible) and preventive services would be covered.

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COST CONTROLS	Not specifically addressed.	Cost controls (caps) would go into effect upon enactment. Overall revenue and expenditure limits would be imposed on hospitals, as well as a revenue cap on physicians' services. Non-supervisory employee wages would be exempted. Two years after enactment, prospective budgeting of hospital and physician expenditures would be the cost control mechanism, with hospital budgets and physicians' fees negotiated yearly on a statewide basis. A national ceiling on health expenditures would also be established. Increases would be tied to the rise of other goods and services and regulated nationally, by area and state.	Not specifically addressed.	Hospital Cost Containment Plan would be implemented. All physicians would be required to accept assignment for Medicare, Medicaid, and HealthCare beneficiaries using a single fee schedule. The goal of federal reimbursement policy would be to stabilize health spending as a percent of GNP. A variety of other System Reforms would precede Phase I and continue throughout the Plan: Increased competition would be encouraged by: employers of 25 or more employees would be required to offer all area HMO plans; employers would pay the same percentage of the HMO premium as the insurance premium. Stronger planning would be encouraged by: incentive grants to close beds and decertify services coupled with withholding of reimbursement for decertified services; areas with more than 4 beds per 1,000 would be required to close 2 beds for every new bed built; future payments to institutions which exceed amounts needed to service debt for approved projects could be channeled into State controlled fund; national limit on capital spending set annually. Increased efficiency would be encouraged through grant programs focused on organizing delivery systems to substitute ambulatory for inpatient services, preventive for curative care, mid-level professionals for doctors, and primary care practitioners for specialists. PSRO's would cover all beneficiaries, private as well as public starting in Phase III.	
ADMINISTRATION	Regardless of the extent to which private health insurance is to be included in a national health insurance program, the federal government has a responsibility for safeguarding the public by effectively regulating the private insurers. Such regulation will be most effective if done by a single federal agency, independent of the agency charged with administering the national health insurance program, which will license, monitor, and otherwise regulate all health insurance underwriters. This agency should also be charged with the duty to promulgate standards governing carrier solvency, risk-selection, loss ratios, and premium rates.	A federal Public Authority (members appointed by the President, confirmed by the Senate, with at least 50 percent consumers) will certify consortia of either insurance companies, non-profit health service plans or HMOs for participation; will consolidate Medicare/Medicaid into a single federal program; will regulate all providers/insurers; and will contract with states and territories to establish State Authorities which will implement national policy, negotiate the hospital budgets and physician fee schedules, and administer all local insurance coverage. Consumer and provider advisory councils would be provided through a federally certified and regulated private insurance industry.	Employer and self-employed insurance plans must be approved by the Secretary, DHEW. The plans must meet specified benefit and coverage requirements. Plans will be approved on the basis of regulations issued by the Secretary, including (potentially) recommendations from state insurance department. Self-insured employer plans must demonstrate financial and administrative capabilities. The Secretary will appoint an Actuarial Committee, which will recommend a Table of Values of Catastrophic Health insurance coverage to enable employers et al to determine the actuarial value of the coverage provided under any plan. The public plan will be administered by HCFA using carriers and intermediaries as in the Medicare program.	The Federal government would: • manage the national health insurance enrollment system, assuring that all individuals are covered through either HealthCare or an approved private plan; • exercise administrative and policy control over the entire NHP and HealthCare program; • set standards for health insurance plans and HMOs governing those aspects of the insurance policy or HMO operations which are relevant to successful NHP operations. For example, benefits covered, cost-sharing, reimbursement of providers; • negotiate health care provider reimbursement rates (to be paid under either HealthCare or participating private plans); • manage the Federal Reinsurance Fund; • pay subsidies to low-income households whose premium costs exceed specified levels; • administer the resource development and services fund. State governments would continue their traditional responsibilities in the areas of: • certification and licensure of personnel; • regulation of insurance for solvency, reserves and other financial standards; • hospital rate regulation (under Federal guidelines) if desired by the State; • administration of long term care benefits and optional services.	

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FINANCING	No specific financing mechanism proposed, however, the method used should mandate universal coverage and make certain that individuals are not caught in gaps of coverage with changes in employment or financial status. The ideal program should have no cost-sharing provisions. If a particular health insurance proposal includes such cost-sharing mechanisms as deductibles, coinsurance, or co-payments, they should be held to minimum levels, and their effect on utilization should be evaluated.	Financing would be derived from a combination of employer-employee payroll taxes which would distribute overall costs by ability to pay and federal subsidies from general revenue to cover premiums for the unemployed, poor and elderly.	Payments for services under the public plan will be based on Medicare principles. The public plan will be financed through a 1% payroll tax on employers. Employers who choose the private insurance option would subtract from their tax liability approved premiums paid for private policies, and would receive a 50% tax credit against their overall 1% tax liability. These funds will be placed in a Federal Catastrophic Health Insurance Trust Fund. There will be no tax on nor any contribution by the employee. The financing mechanism assures that individuals are not caught in gaps in coverage.	Medicare and Medicaid financing would remain the same except that the additional cost of Medicaid spend-down would be financed entirely by federal revenues. HealthCare would be financed by federal general revenues. Employers would be required to pay at least 50% of premium costs associated with minimum benefit package.	Employers and individuals would pay premiums to either HealthCare or an approved private plan. The federal government would either pay or help subsidize premiums on behalf of the aged, low income persons and low wage employers. Employers would pay a minimum of 75% of premium charges, and could purchase HealthCare at the going premium or 8% of payroll. The aged and disabled would pay a premium equal to 25% of the single adult premium. Persons with incomes below a Low Income Standard would pay no premium. The majority of funds for HealthCare subsidies would come from general revenues. Federal excise taxes on alcohol and tobacco would be increased with the proceeds earmarked for the NHP. A state/federal matching program may be established for Medicaid Long Term Care services. All covered services except preventive service would be subject to a 25% cost-sharing requirement. However, no individual would pay more than $750, no family more than $1500 in cost-sharing. Low-income families would be excused from all cost-sharing.
COSTS	AAMC supports no specific national health insurance proposal and has projected no cost estimates for a program.	1981 - $18.8 billion; 1983 - $21.7 billion for basic health services for the poor, unemployed, and Medicare upgrading; prescription drugs for the elderly, 1981-$3.5 billion, 1983 - $4.1 billion.	$5-7 billion, "rough cost projections, based on somewhat out-dated data."	At no point would expanded services from the plan lead to a net increase in total health expenditures. Total health system expenditures could be reduced by $25 billion in FY 1983.	At no point would expanded services from the plan lead to a net increase in total health expenditures. Total health system expenditures could be reduced by $25 billion in FY 1983.
HEALTH MANPOWER DEVELOPMENT	The Association strongly believes that national health insurance is an appropriate mechanism for financing graduate medical education. Such financing has historically come from public and private insurance programs and other patient care revenues and should not be jeopardized. However, this financing has been much more adequate in support of inpatient services than for outpatient services. During the past several years, there has been substantial pressure, and subsequent institutional commitment to provide more educational experience in ambulatory care settings and to produce more primary care physicians. The long-range financing of these commitments, as well as health manpower development generally, must be addressed by the NHI program.	Not specifically addressed.	Not specifically addressed. However, it has the same advantages and disadvantages as the Medicare program.	A variety of System Reforms will be initiated prior to Phase I and will continue: • Expansion of grants for primary care residencies. Institutions receiving grants to support more primary care residencies would not be allowed to increase their total number of residencies. Thus they would be forced to reduce specialty training at the same time. • National Health Services Corps (NHSC) scholarships would play an important role, and NHSC physicians would be placed in rural and urban shortage areas and in institutions now understaffed (such as prisons and State mental hospitals). • Special project grants would expand training of primary care nurses, nurse practitioners and physician assistants to help meet the needs of underserved areas by increasing the availability of lower cost health practitioners and increasing the productivity of physicians. • The number of minority men and women in health professions would be increased through incentive grants to institutions for recruiting and preparing applicants for professional schools.	

	AAMC TASK FORCE POSITION ON NATIONAL HEALTH INSURANCE (As Testified 11/6/75-House Ways & Means Health Subcommittee)	THE NATIONAL HEALTH INSURANCE ACT OF 1979 (Kennedy/Labor-Outlined in Senate October 2, 1978)	CATASTROPHIC HEALTH INSURANCE PROGRAM (Title I of S.350 and of S.351 introduced by Sen. Long on 2/6/79)	TENTATIVE NATIONAL HEALTH PLAN (NHP) - PHASE I (Staff Draft of Administration Plan, February 1979)	TENTATIVE NATIONAL HEALTH PLAN (NHP) - FINAL (Staff Draft of Administration Plan, February 1979)
TEACHING PHYSICIAN REIMBURSEMENT	A fair and reasonable reimbursement policy for physician services should be incorporated into any NHI program. This policy should provide payment for high quality medical services on an equal basis irrespective of the setting, should not impede the training of medical students and residents, and should recognize the team approach to medical care in the teaching setting. In addition, the AAMC has consistently supported a policy which would finance graduate medical education from the institutionally generated health care dollar. This policy includes the financing of teachers --supervising physicians--as well as house officers. Where an individual institution develops a management control procedure which validly identifies, differentiates and records educational supervision provided jointly and inseparably with professional medical services, the Association recommends that the teaching time of the supervising physician be allowed as a reimbursable cost.	Not specifically addressed.	Not specifically addressed. However, it has the same advantages and disadvantages as the Medicare program.	Not specifically addressed.	Not specifically addressed.
TEACHING HOSPITAL REIMBURSEMENT	Reimbursement to institutional providers under any NHI program must reflect the fact that there are valid differences among the various types of hospitals in the cost of delivering care. Teaching hospitals differ from the nation's other hospitals because of their medical education and supervised research responsibilities, as well as their provision of more complicated patient care. The NHI program must establish payment mechanisms which recognize these distinctive characteristics of teaching hospitals and their accompanying costs.	Not specifically addressed.	Not specifically addressed. However, it has the same advantages and disadvantages as the Medicare program.	Not specifically addressed.	Not specifically addressed.
PHILANTHROPY	The Association recommends specific language be included in any national health insurance program to protect and encourage private philanthropy for health care institutions and programs.	Not specifically addressed.	The bill will amend Title XI of the Social Security Act: "It is the policy of the Congress that philanthropic support for health care be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system and access to health care services." Unrestricted grants, gifts, and endowments and income therefrom will not be deducted from operating costs. Contributions restricted to specific operating costs will be deducted from the operating costs. Interest expense may be reduced by such interest income.	Not specifically addressed.	Not specifically addressed.

AAMC HOUSESTAFF INVITATIONAL MEETING

At the June 1978 meeting of the AAMC Executive Committee, Dr. Robert G. Petersdorf asked the Committee to consider housestaff involvement in AAMC activities. Dr. Petersdorf's request was prompted by his awareness of the activities of the American Medical Association's Resident Physician Section and his belief that the AAMC should examine its own potential for obtaining similar contributions from housestaff.

An ad hoc Committee on Housestaff met in December, and recommended that at this time the Association not establish a formal housestaff representation to the AAMC. The Committee did recommend that the Association organize a meeting of residents to discuss issues in graduate medical education of mutual concern and interest to residents and constituent organizations of the Association. The Committee specifically recommended that discussions not extend to economic and working condition matters of local jurisdiction.

In January the Executive Committee reviewed the Committee report and recommended that a meeting of residents be held to review and discuss the report of the Association's Task Force on Graduate Medical Education prior to the preparation of the final report for the Assembly. This was agreed to by the Executive Council in March. The plan for the meeting follows:

Dates:

Friday, October 5 - Saturday, October 6

Place:

Washington, D. C.

Participants:

Approximately 30 residents, members of the Task Force on Graduate Medical Education, AAMC officers and staff

Selection Procedures:

The Association will ask each medical school dean, after consultation with administrators of affiliated hospitals, to submit the names of three nominees (each from a different specialty) with a brief biography. The OSR Administrative Board will be asked to submit one nominee for each specialty. AAMC staff will review the nominees, and select 30 with due regard to specialty, institutional, regional, and demographic balance.

Agenda:

Report of the five Working Groups of the Task Force on Graduate Medical Education

Format:

A plenary session to provide an overview and background; small group discussions on Working Group Reports; a plenary session to discuss the Task Force Report

(PROPOSED REVISION)

THE ESSENTIALS OF ACCREDITED RESIDENCIES IN GRADUATE MEDICAL EDUCATION

Graduate medical education in the United States is the second phase in the continuum of medical education. Physicians enter programs in graduate medical education after completing their undergraduate phase in order to prepare themselves to be practitioners. The graduate phase is essential as indicated in this statement in the Liaison Committee on Medical Education's (LCME) "Structure and Functions of a Medical School":

> *"The undergraduate period of medical education leading to the M.D. degree is no longer sufficient to prepare a student for independent medical practice without supplementation by a graduate training period which will vary in length depending upon the type of practice the student selects."*

During the undergraduate phase, students gain knowledge of the sciences basic to medicine and learn to apply that knowledge to clinical problems. Skills in collecting data are developed by interviewing and examining patients and selecting and applying laboratory procedures under the guidance and supervision of the faculty and residents. Students learn to utilize these data to arrive at diagnostic hypotheses and make therapeutic decisions. These basic skills are learned by rotations through a variety of clinical disciplines in both inpatient and outpatient settings. Undergraduate medical students have limited opportunities to assume personal responsibility for patient care, and generally do not participate in the care of individual patients for an extended period of time.

Physicians in graduate medical education are, by convention, called resident physicians or residents. During the graduate phase, the knowledge and skills acquired in medical school are expanded through the progressive assumption of personal responsibility for patient care in supervised, clinical, educational environments which provide opportunities to learn about the variability of human beings in health and disease and about their biological, psychological and social problems. As residents progressively gain more knowledge and skill they are provided greater latitude to make decisions and treat patients, but always under supervision.

Graduate medical education is organized programmatically. For each specialty of medicine there are programs which concentrate on providing education and training in that specialty. Institutions vary in the number and variety of the specialty programs they provide. Some may offer programs in nearly all of the specialties, while others sponsor only a limited number, consistent with their clinical resources and mission. Each program is organized and directed by a program director and has an identified staff which is responsible for the education, training and supervision of its residents. Each institution is responsible for the provision of sufficient resources and internal supervision to assure the proper conduct of all of its programs.

During the graduate phase of their education most residents, in addition to attaining the knowledge and skills needed to be practitioners, seek to complete training requirements for certification by a specialty board. Each board generally requires that graduate medical education be

obtained in a program reviewed and approved by the Residency Review Committee (RRC) for that specialty and accredited by the Liaison Committee on Graduate Medical Education (LCGME).

APPROVAL AND ACCREDITATION

Approval and accreditation of training programs are voluntary efforts of all parties involved in graduate medical education. By this process the quality of training programs is upgraded and assurance is provided medical students, residents, specialty boards, and the public that programs are of high quality.

To be approved and accredited, graduate medical education programs must meet the Special Requirements for a specialty and be sponsored by an institution which meets the General Requirements for graduate medical education. The Special and General Requirements are the standards against which programs and institutions are judged by Residency Review Committees (RRCs) and the Liaison Committee on Graduate Medical Education (LCGME) in the process of review, approval and accreditation.

There is an established Residency Review Committee for each of the specialties in medicine for which certification is provided by a specialty board.

Residency Review Committees

~~RRC~~	Represented Organizations
Allergy & Immunology	American Board of Allergy & Immunology (A Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics) AMA Council on Medical Education

RRC		Represented Organizations
1	Anesthesiology	American Board of Anesthesiology AMA Council on Medical Education
2	Colon & Rectal Surgery	American Board of Colon & Rectal Surgery AMA Council on Medical Education American College of Surgeons
3	Dermatology	American Board of Dermatology AMA Council on Medical Education
4	Family Practice	American Board of Family Practice AMA Council on Medical Education American Academy of Family Physicians
5	Internal Medicine	American Board of Internal Medicine AMA Council on Medical Education American College of Physicians
6	Neurological Surgery	American Board of Neurological Surgery AMA Council on Medical Education American College of Surgeons
7	Nuclear Medicine	American Board of Nuclear Medicine *(A Conjoint Board of the American Board of Internal Medicine, the American Board of Pathology and the American Board of Radiology)* AMA Council on Medical Education
8	Obstetrics-Gynecology	American Board of Obstetrics & Gynecology AMA Council on Medical Education American College of Obstetricians and Gynecologists
9	Ophthalmology	American Board of Ophthalmology AMA Council on Medical Education
10	Orthopaedic Surgery	American Board of Orthopaedic Surgery AMA Council on Medical Education American Academy of Orthopaedic Surgeons
11	Otolaryngology	American Board of Otolaryngology AMA Council on Medical Education American College of Surgeons
12	Pathology	American Board of Pathology AMA Council on Medical Education

	RRC	Represented Organizations
1	Pediatrics	American Board of Pediatrics AMA Council on Medical Education American Academy of Pediatrics
2	Physical Medicine & Rehabilitation	American Board of Physical Medicine & Rehabilitation AMA Council on Medical Education
3	Plastic Surgery	American Board of Plastic Surgery AMA Council on Medical Education American College of Surgeons
4	Preventive Medicine	American Board of Preventive Medicine AMA Council on Medical Education
5	Psychiatry & Neurology	American Board of Psychiatry & Neurology AMA Council on Medical Education
6	Radiology	American Board of Radiology AMA Council on Medical Education
7	Surgery	American Board of Surgery AMA Council on Medical Education American College of Surgeons
8	Thoracic Surgery	American Board of Thoracic Surgery AMA Council on Medical Education American College of Surgeons
9	Urology	American Board of Urology AMA Council on Medical Education American College of Surgeons

The Liaison Committee on Graduate Medical Education is composed of representatives of the following national professional organizations which are concerned with and involved in graduate medical education:

American Board of Medical Specialties
American Hospital Association
American Medical Association
Association of American Medical Colleges
Council of Medical Specialty Societies

In addition there is a resident representative, there is a federal representative, and there is a public representative.

Each RRC develops Special Requirements for training programs in its specialty. These Special Requirements, which have been approved by the RRC's sponsoring organizations and the LCGME, set forth the requirements for the essential educational content, instructional activities, patient care responsibilities, supervision, and facilities that should be provided by programs in a particular specialty. Guides to assist program directors in interpreting the Special Requirements are also prepared by RRCs.

The General Requirements delineate the responsibilities of institutions that sponsor graduate medical education programs. The General Requirements also delineate training program requirements and responsibilities which are common to all RRCs, institutions, and programs regardless of specialty. The General Requirements have been established by the LCGME in collaboration with the RRCs and approved by the Coordinating Council on Medical Education and each of its five sponsoring organizations.* An assessment of whether institutions fulfill these General Requirements is made in the process of review of their graduate programs prior to action by the RRCs and the LCGME.

*The Coordinating Council on Medical Education (CCME) is composed of representatives of the same five professional organizations which sponsor the LCGME. It is responsible for the development and consideration of major policies for all three phases of medical education. The CCME also oversees the Liaison Committee on Medical Education (LCME accredits undergraduate medical education) and the Liaison Committee on Continuing Medical Education (LCCME accredits continuing medical education).

Actions by the RRCs are based upon information gained through written submissions by program directors and assessments made on site by assigned visitors. Actions of the RRCs, after review and approval by the LCGME, determine the accreditation status of programs. The LCGME is also responsible for adjudication of appeals of adverse decisions and has established policies and procedures for appeal. Current operating policies and procedures for review, approval, accreditation and appeal are contained in the *Manual of Structure and Functions for Residency Review Committees*, which is revised and updated annually.** Information concerning the accreditation status of any program may be obtained by communication with the Secretary of the LCGME.

PART I. GENERAL REQUIREMENTS

Programs in graduate medical education are sponsored by organizational units involved in providing medical care and health services. These units are referred to as institutions. The principal institutions for graduate medical education are hospitals. In order to provide the complete education and training experience established by the Special Requirements of a specialty, programs may involve more than one institution and various types of settings, which can include clinics, medical schools and various health agencies. Whatever the institutional form, providing ~~health services~~ *education and training* of the highest quality as well as ~~education and training~~ *health services* must be a major mission. Graduate medical education requires

**General Requirements, Special Requirements, Guides, and the *Manual of Structure and Functions for Residency Review Committees* can be obtained from: The Secretary, Liaison Committee on Graduate Medical Education, 535 North Dearborn, Chicago, Illinois 60610

that residents be directly involved in the provision of excellent patient care under supervision in an environment which stresses scholarly pursuits and inquiry. The educational mission must not be compromised by an excessive reliance on residents to fulfill institutional service obligations. The need for an institutional commitment to education is expressed in this policy statement which was promulgated by the Coordinating Council on Medical Education and approved by its sponsoring organizations in 1974:

> *"Institutions, organizations and agencies offering programs in graduate medical education must assume responsibility for the educational validity of all such programs. This responsibility includes assuring an administrative system which provides for management of resources dedicated to education and providing for involvement of teaching staff in selection of candidates, program planning, program review and evaluation of participants.*
>
> *While educational programs in the several fields of medicine properly differ from one another, as they do from one institution to another, institutions and their teaching staffs must ensure that all programs offered are consistent with their goals and meet the standards set forth by them and by voluntary accrediting agencies.*
>
> *The governing boards, the administration, and the teaching staff must recognize that engagement with graduate medical education creates obligations beyond the provision of safe and timely medical care. Resources and time must be provided for the proper discharge of these obligations. The teaching staff and administration, with review by the governing board, must (a) establish the general objectives of graduate medical education; (b) apportion residency and fellowship positions among the several programs offered; (c) review instructional plans for each specific program; (d) develop criteria for selection of candidates; (e) develop methods for evaluating, on a regular basis, the effectiveness of the programs and the competency of persons who are in the programs. Evaluation should include input from those in training.*

Facilities and teaching staff shall be appropriate and sufficient for effective accomplishment of the educational mission of each program. If outside facilities or staff are needed to fulfill program needs, the primary sponsor must maintain full responsibility for the quality of education provided"

Implementation of these General Requirements requires that the program directors and teaching staffs of sponsored programs work with each other and the institutional administration and governing authorities to provide an operating system for educational resource allocation and quality control which ensures that sponsored programs can fully meet the Special Requirements set forth in Part II of these Essentials. In order to prevent duplication of effort and needless reiteration, many of the resources provided by institutions for their training programs are not specifically mentioned in this document. They do appear in the current *Accreditation Manual for Hospitals* issued by the Joint Commission on Accreditation of Hospitals.*

1. *Responsibilities of Institutions*

Ensuring that each specialty program fully meets the Special Requirements for approval by its RRC is an overall institutional responsibility. The specifications set forth in this section make necessary an institutional system for the allocation of educational resources and the maintenance of the quality of all sponsored programs.

*The *Accreditation Manual for Hospitals* can be obtained from: The Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, Illinois 60611

1.1. The LCGME expects institutions sponsoring programs in graduate medical education to provide documentary evidence of a commitment to medical education by:

a) The governing board,

b) The administration

c) ~~The clinical departments.~~ *Teaching Staff*

This evidence should consist of:

1.1.1 A written statement setting forth the reasons why the institution sponsors graduate medical education:
There should be evidence of agreement to this statement by the clinical departments, the administration, and the governing board.

1.1.2 A detailed plan which sets forth ~~how~~ *the process by which* institutional resources are organized and distributed for educational purposes:
~~Such resources include teaching staff, patients, physical facilities, and financial support. There should be clear evidence that the plan is agreed to by the administration, program directors, and the governing board.~~ Those responsible for administration of the plan should be identified by name and title in the institution's table of organization.

Provide evidence of an
1.1.3 ~~An~~ operational system, based on institutional policies, establishing how the sponsored programs provide for:

a) The appointment of teaching staff,

b) The selection of residents,

c) The apportionment of residents among programs

d) The supervision of residents

e d) The evaluation and advancement of residents

f e) The dismissal of residents whose performance is unsatisfactory, and

g f) The assurance of due process for residents and teaching staff.

These policies *and procedures* should be ~~agreed to by the administration and clinical departments, incorporated in a manual of policies and procedures, and reviewed and approved by the governing board.~~ *have institutional approval.* There should be clear evidence of adherence to these policies and procedures by program directors.

1.1.4 An operational system for periodic internal analysis of each sponsored program by representatives of *the teaching staff* ~~clinical departments~~, residents, and administration. Such analysis should include the appraisal of:

a) The goals and objectives of each program,

b) The instructional plans formulated to achieve these goals,

c) The effectiveness of each program in meeting its goals, and

d) The effectiveness of utilization of the resources provided.

There should be evidence that these analyses are effective, and that mechanisms exist to correct identified deficiencies.

Accomplishing the requirements set forth in Sections 1.1.1 through 1.1.4 may be delegated to a committee composed of program directors or their representatives and others concerned with or involved in an

institution's educational mission. However, once a system is established and agreed to, it is essential that all programs comply with the accepted policies and procedures. Failure by a program to comply may jeopardize the approval of that program by its RRC. Failure of an institution to establish or implement the necessary policies and procedures set forth in these General Requirements may jeopardize the accreditation status of all of its programs.

1.2 Interinstitutional Agreements: When the resources of two or more institutions are utilized for the conduct of one or more programs, each participating institution or organizational unit is expected to demonstrate a commitment to graduate medical education as set forth in 1.1.1 through 1.1.4. Documentary evidence of agreements, approved by *the* institution*s* ~~governing boards~~, should be available for inspection by assigned site visitors. The following items should be covered in such interinstitutional agreements.

1.2.1 Items of Agreement:

a) Designation of program director: A director for each specialty program should be agreed to and designated. The scope of the director's authority to direct and coordinate the program's activities in all participating institutions should be clearly set forth in a written statement.

b) Teaching staff: The teaching staff responsible for providing the educational program and supervising the residents in each institution should be designated.

c) Educational contribution: The expected contribution to the educational objectives to be provided by each institution to each program should be delineated.

d) Assignment of residents: The period of assignment of residents to the segment of a program provided by each institution, and any priority of assignment, should be set forth.

e) Financial commitment: Each institution's financial commitment to the direct support of each program should be specifically identified. Compensation and other benefits for residents should be as consistent as possible from institution to institution.

1.2.2 When several institutions or organizational units participate in sponsoring multiple programs, mechanisms should be developed to coordinate the overall educational mission and facilitate the accomplishment of the policies and procedures set forth in sub-sections 1.1. and 1.2.

1.3 Facilities and Resources: Institutional facilities and resources should be adequate to provide the educational experiences and opportunities set forth in the Special Requirements for each sponsored program. These include, but are not limited to, an adequate library providing access to standard reference texts and current journals, sufficient space for instructional exercises, adequate facilities for residents to carry out their patient care and personal educational responsibilities, and a medical record system which facilitates both quality patient care and education.

1.4 Hospital Accreditation: Hospitals sponsoring or participating in programs of graduate medical education are expected to be accredited by the Joint Commission on Accreditation of Hospitals. If a hospital is not so accredited, the reasons why accreditation was not sought or was denied should be explained and justified.

2. *Program Organization and Responsibilities*

Programs in graduate medical education usually are developed by individual specialty groups or departments. Program content and organization should be delineated by a statement of goals and objectives, supplemented by a statement outlining the scope of clinical experience and rotations provided, its duration, and any special features, such as opportunities for investigation, ambulatory care experience in different settings, etc.

All programs are encouraged to ~~place an emphasis~~ *emphasize* on the development of their residents' teaching and interpersonal skills. Teaching about the socio-economics of health care and demonstrating cost consciousness in the provision of medical services should be incorporated into all programs.

The educational effectiveness of a residency training program depends largely on the quality of its supervision and organization. The responsibility for these important functions lies with the department heads who in most instances are also the program directors. The program directors should have qualifications and breadth of experience which will enable them to carry out an effective training program. Each program director accepts the responsibility of resident selection, evaluation and promotion within the framework of the policies of the sponsoring institution. The development of program ~~curriculum and goals~~ *goals and curriculum*, the integration of resident physicians

into departmental activities including patient care, research and teaching of other members of the health care team, as well as the extent to which various evaluation techniques employed are additional responsibilities of the program director.

The fundamental conceptual framework for curriculum, programmatic goals and evaluation standards should be to enable resident physicians to practice their specialties in a compassionate, scientific, and cost-effective manner upon completion of their training programs.

The sponsoring institution is expected to assist program directors in carrying out their responsibilities through the development of appropriate institutional ~~policy~~ *policies* to assure excellence in resident physician education. When a Residency Review Committee reviews a program prior to making recommendations to the Liaison Committee on Graduate Medical Education regarding its accreditation status, the extent to which the sponsoring institution is supporting the efforts of the program director through its institutional policies will be taken into consideration.

2.1 Qualifications of Program Staff: The individuals who have responsibility for the conduct of graduate medical education programs should be specifically identified.

2.1.1 The Program Director: The director of each program should have the qualifications set forth in the Special Requirements for that program. Each director should have the authority and time needed to fulfill administrative and teaching responsibilities in order to achieve the educational goals of the program and to participate with other program directors in maintaining the quality of all institutional programs.

2.1.2 Teaching Staff: The teaching staff should have the qualifications set forth in the Special Requirements for the program in which they are primarily involved. The staff should be selected for their willingness and ability to contribute to the educational objectives of their own program and to the overall educational mission of the institution.

Teaching physicians should be mindful of the important role that other members of the health care team play in patient care and should involve them,as appropriate, in accomplishing the educational objectives of their programs.

2.2 Relationships Between Medical Staff and Graduate Programs: In some institutions the program staff and the non-teaching staff are differentiated. Where this is the case, the institutional educational plan (1.1.2) should clearly delineate the agreements reached regarding the utilization of institutional resources for education. This should include agreement as to whether residents and teaching staff may have contact with the patients of members of the medical staff not involved in the teaching programs and what responsibilities residents have for such patients.

3. *Eligibility and Selection of Residents*

Physicians with the following qualifications are eligible to enter graduate medical education programs accredited by the LCGME:

3.1 Unrestricted Eligibility: Unrestricted eligibility is accorded to those with the following qualifications:

3.1.1 Graduates from tne institutions in the U.S. and Canada accredited by the Liaison Committee on Medical Education,

3.1.2 Graduates from institutions in the U.S. accredited by the American Osteopathic Association, ~~unless prohibited by Special Requirements,~~

3.1.3 Graduates of medical schools which are not accredited by the LCME who meet the following additional qualifications:

a) Have fulfilled the educational requirements to practice in the country in which they have had their medical education, or, if a national of the country concerned, have obtained an unrestricted license or certificate of full registration to practice in that country, have passed examinations designated as acceptable by the LCGME for determination of professional preparedness and capability to comprehend and utilize the English language, and have had their credentials validated by an organization or agency acceptable to the LCGME, or

b) Have a full and unrestricted license to practice medicine in a U.S. jurisdiction providing such license.

3.1.4 U.S. citizen graduates from institutions not accredited by the LCME who cannot qualify under Section 3.1.3, but who meet the following qualifications:

a) Have successfully completed the licensure examination in a U.S. jurisdiction in which the law or regulations provide that a full and unrestricted license to practice will be granted after successful completion of a specified period of graduate medical education; or

b) Have completed in an accredited U.S. college or university undergraduate premedical education of acceptable

quality; have successfully completed all of the formal educational requirements of a foreign medical school, but have not been granted the privilege to practice medicine by the country in which the medical school is located by reason of not having completed a period of required service; and have passed an examination designated as acceptable by the LCGME for determination of professional preparedness.

3.2 Restricted Eligibility: Restricted eligibility for foreign nationals to enroll in LCGME programs is accorded under the following circumstances:

a) When a U.S. medical school and one or more of its affiliated hospitals have a documented bilateral agreement, approved by an agency recognized for that purpose by the LCGME, with an official agency or recognized institution in the physician's country of origin to provide an educational program designed to prepare the physician to make specific contributions in a health field upon return to the country in which the sponsoring agency or institution is located; and

b) The physician has been granted an unrestricted license or certificate of full recognition to practice medicine in the country wherein the agency or institution making the agreement referred to in (a) is located; and

c) The physician has passed examinations designated as acceptable by the LCGME for determination of professional preparedness and capability to comprehend and utilize the English language; and

d) The physician has made a formal commitment to return to the country in which the sponsoring agency or institution is located; and

e) The credentials of the physician and the existence of a suitable agreement have been validated by an organization or agency acceptable to the LCGME.

Restricted eligibility shall be limited to the time necessary to complete the program agreed to by the parties as referenced in (a), without regard to whether such agreement fulfills the requirements for certification by a specialty board.

3.3 The Enrollment of Non-Eligibles: The enrollment of non-eligible residents may be cause for withdrawal of approval and accreditation.

3.4 Special Educational Provisions for Residents Who Are Not Graduates of LCME Accredited Medical Schools: Institutions and programs providing education and training to residents eligible under Sections 3.1.3, 3.1.4, and 3.2 should make special educational provisions to correct deficiencies these residents may have in their professional preparation and their knowledge of the United States health care system, medical practices and ethics, and United States culture and cultural values.*

*The Role of the Foreign Medical Graduate, a Report of the Coordinating Council on Medical Education, 1978 (for copies, address: Secretary, CCME, P. O. Box 7586, Chicago, Illinois 60680)

3.5 Selection, Recruitment and the Transition between Undergraduate and Graduate Medical Education: Eligible physicians may enter graduate medical education at any time after they have attained the M.D. degree. Institutions and their sponsored graduate programs are expected to select residents with due consideration of their preparedness to enter into the program they have selected. Criteria for their selection should include personal characteristics and aptitude as well as academic credentials.

In selecting residents from medical schools accredited by the LCME for first graduate year positions, institutions and all of their sponsored programs are expected to participate in the National Residency Matching Program (NRMP*) and abide by its policies and procedures (certain programs sponsored by the federal uniformed services may be exempt). Programs which select residents to begin their first residency year at the second graduate year level should not offer appointments to students ~~prematurely, and certainly not~~ before the beginning of their final year of medical school.

4. *Types of Programs*

Graduate programs of two types may be provided to residents by institutions:

4.1 Categorical Programs: Categorical (C) are programs in a specialty which meets the Special Requirements of the RRC for that specialty. Some specialties require that residents have complementary educational

*The NRMP is an agency sponsored by: American Hospital Association, American Medical Association, American Protestant Hospital Association, Association of American Medical Colleges, Catholic Hospital Association, American Medical Student Association, American Board of Medical Specialties, and Council on Medical Specialty Societies.

experiences in other disciplines. Whether it is required that such experiences precede or be interwoven into the education and training for the specialty, institutions sponsoring such programs should make the necessary arrangements for residents to gain these complementary experiences in *educational settings which fulfill the Special Requirements for* ~~programs approved by the RRC of the~~ specialty providing the experience.

~~Categorical programs which require educational experience in a variety of clinical disciplines may be conducted in any educational setting which meets the General Requirements and the Special Requirements of the RRC for such specialties.~~*

4.2 Transitional Programs: Transitional (T) are programs for residents ordinarily in their first graduate year who desire a broad experience in several specialties before entering further training.**

Institutions or consortia of institutions which sponsor an accredited program in internal medicine and at least two other accredited programs from amongst the following: family practice, obstetrics and gynecology, pathology, pediatrics, psychiatry, radiology or surgery; may offer a transitional year if the following conditions are met:

a) There is a qualified director (or associate director) on site responsible for planning the program, counseling the residents, and coordinating their evaluation;

b) There is an institutional committee, composed at least of the representatives of the accredited programs providing the components of the transitional year, charged to assist the director in program development and evaluation;

* This merges what have been termed Categorical and Categorical* designations.

** These programs are intended to replace those previously designated as Flexible programs.

c) At least three quarters of the education and training of the transitional year is provided by staff assigned to the accredited programs sponsored by the institution. The balance of the year is spent in educational settings selected by the director and approved by the institutional transitional program committee;

d) The residents in each of their assignments are associated with senior residents in the participating specialties.

5. *Relationships between Institutions, Programs, and Residents*

5.1 Responsibilities of Institutions and Programs

5.1.1 Teaching and Learning: An environment wherein both the teaching staff and the residents are seeking to improve their knowledge and skills is essential. Residents may be assigned by program directors to assume responsibility for teaching more junior residents and students. Special attention should be given to assisting residents to acquire skills in teaching and evaluating those for whom they are responsible. The clinical departments are expected to organize ~~formal~~ teaching sessions tailored to meet the Special Requirements of their programs. Participation in these sessions by teaching staff from other clinical departments and by teaching staff from the basic science disciplines is encouraged.

5.1.2 Participation in Policy Development and Review: Residents should be involved by institutions and programs in the development of policies. Their day-to-day involvement with institutional and departmental activities may provide unique perspectives which can be of significant value in improving education and patient care.

5.1.3 Supervision: There must be institutional and program policies and procedures that ensure that all residents are supervised in carrying out their patient care responsibilities. The level and method of supervision must be consistent with the Special Requirements for each program. Supervision should promote the professional growth of each resident while maintaining the quality of the care of patients.

5.1.4 Counseling and Support Services: Program directors and teaching staff should be sensitive to the need for the timely provision of counseling and psychological support services to residents. Graduate medical education places increasing responsibilities on residents and requires sustained intellectual and physical effort. For some, these demands will, at times, cause physical or emotional stress. Institutional awareness, empathy, and responsiveness towards these problems are vital to the educational process.

5.1.5 Evaluation and Advancement: As set forth in Section 1.1.3 (d), there should be an institutional policy for the evaluation and advancement of residents. Evaluation criteria for each specialty should meet the standards set by the RRC of that specialty. The institutional system should assure that each program:

a) Periodically, and at least annually, evaluates the knowledge, skills, and professional growth of its residents, using appropriate criteria and procedures.

b) Provides to residents an assessment of their performance, at least annually.

c) Advances residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement.

d) Recommends acceptance of residents for certification by a specialty board only after an evaluation to establish that their *knowledge,* clinical skills and professional attitudes are consistent with the standards for that specialty, and

e) Maintains a personal record of evaluation for each resident which is accessible to the resident.

5.1.6 Due Process: As set forth in Section 1.1.3 (f), there should be institutional policies and procedures which provide for due process when actions are contemplated which will result in dismissal or will significantly threaten a resident's intended career development or when there are grievances against a program or institution. *The development of* These policies and procedures should *involve* ~~be agreed to by the~~ residents, program directors, teaching staff, and administration. ~~and approved by the governing board.~~ *They should be approved by the institution.* The details of their implementation should be made known to the residents, program directors, and adhered to by all programs sponsored by the institution.

5.1.7 Reporting Requirements: Institutions sponsoring accredited programs in graduate medical education must report annually the names of individuals enrolled in their programs, the institutions from which they received the M.D. degree (or equivalent), the program in which they are currently enrolled,

and the program in which they were enrolled for the previous year; in addition, institutions must report those individuals successfully completing their sponsored programs. These reports shall be supplied to the LCGME and the agencies designated by it as having responsibility for the recording of credit and the collection and analysis of data on physician manpower development.

5.2 Resident Physician Responsibilities: Resident physicians are expected to:

5.2.1 2 Participate in safe, effective, and compassionate patient care under supervision, commensurate with their level of advancement and responsibility.

5.2.2 3 Participate fully in the educational activities of their program and, as required, assume responsibility for teaching and supervising other residents and students.

5.2.3 4 Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.

5.2.4 5 Participate in institutional committees and councils, and

5.2.5 1 Develop a personal program of self study and professional growth with guidance from the teaching staff.

5.3 Agreement with Residents: There should be a written agreement with each resident. Parties to this agreement should be the program director, the individual designated as having institutional authority, and the resident. The agreement should encompass the following:

5.3.1 The educational experience to be provided to the resident, including the nature of assignments to other programs or institutions.

5.3.2 Resident's responsibilities as set forth in Section 5.2.

5.3.3 ~~Compensation~~ *Stipend*

5.3.4 Vacation, professional leave, and sick leave

5.3.5 Practice privileges and other activities outside the educational program.

5.3.6 Malpractice coverage and other insurance benefits.

5.3.7 Individual educational plans, ~~such as a reduced schedule or educational opportunities~~ tailored to meet a resident's personal needs or career plans.

5.3.8 Guarantee of Due Process as set forth in Section 5.1.6 in case of disciplinary action or contemplated dismissal or grievance against a program or the institution.

oOo

All institutions and programs are expected to comply with the foregoing General Requirements. Recognizing that implementation of these requirements by most institutions will necessitate considerable modification of present policies and procedures, the LCGME intends to develop a phased program which will provide sufficient time to permit institutions to adapt to these requirements.

The Special Requirements, which follow, apply to programs in each specialty and set forth the standards which must be met in order to gain approval by the Residency Review Committees and accreditation by the LCGME.

PART II. SPECIAL REQUIREMENTS

PROPOSAL FOR FLEX I AND FLEX II EXAMINATIONS

Background

The AAMC Executive Committee met January 18 with Ray Casterline, Chairman, and Bryant Galusha and Henry Cramblett of the Committee for the Continued Study of Uniform Licensure of the Federation of State Medical Boards. The Federation is comprised of those state bodies with physician licensing authority, and is the successor organization to the Confederation of State Boards and the Confederation of Reciprocity.

Paths to Graduate Medical Education: Graduate medical education training positions in U.S. teaching institutions are open to individuals holding an M.D. degree from an LCME accredited U.S. medical school or to graduates of foreign medical schools (including U.S. citizens) who pass a qualifying examination. Until recently this exam was the Educational Commission for Foreign Medical Graduates' exam, but in 1977 this was replaced for alien FMG's by the two-day Visa Qualifying Examination (VQE) and a prerequisite English examination. American citizens who are graduates of foreign medical schools, however, continue to sit for the ECFMG examination as a prerequisite for entry to graduate medical education, as do alien FMG's already in permanent residence in the United States. Items for the VQE and ECFMG are chosen from the National Board of Medical Examiners' pool of questions, and scoring is standardized directly on the performance on the same questions by the reference group of United States medical students. The basic science and clinical science sections must each be passed by the examinee. In 1978 3,217 candidates sat for the VQE of whom 734 or 23% passed both parts I and II. An additional 211 (6.6%) individuals who had passed Part I in 1977 passed Part II.

The AMA's Fifth Pathway program, which has never been endorsed by the AAMC, allows USFMG's who have completed all the formal requirements of the foreign medical school except internship and/or social service, to enter first year GME positions after passing Part I of the NBME, the ECFMG, or the FLEX exam, and the successful completion of a year of supervised clinical experience under the auspices of an accredited medical school.

Paths to Licensure: Candidates can be licensed in most states by endorsement through passing the National Board of Medical Examiners examination (Parts I, II and III) or by passing the Federation Licensing Examination (FLEX).

National Board of Medical Examiners: The NBME was established in 1915 and its initial purpose was to prepare and administer examinations to physicians so state medical boards would have the option of accepting candidates for licensure without further local examination.

The current NBME exam consists of:

Part I: two-day multiple-choice examination in each of the traditional basic medical sciences (anatomy, behavioral sciences, biochemistry, micro-

biology, pathology, pharmacology, and physiology).

Part II: two-day multiple-choice examination in each of the traditional clinical sciences (internal medicine, obstetrics and gynecology, pediatrics, preventive medicine and public health, psychiatry, and surgery).

Part III: one-day comprehensive examination of additional aspects of clinical competence involving multiple-choice and programmed testing techniques.

Medical students attending or graduates from LCME accredited schools may take Part I and Part II at any administration and in any order. An individual may take Part III if he has passed Parts I and II, holds an M.D. from an LCME accredited school, and has served six months of an approved residency. Individuals in two-year medical schools in the U.S. and Canada and COTRANS or school-sponsored U.S. foreign medical students may take Part I. In 1976 failure rates for Parts I, II, and III were 15%, 2%, and 3% respectively; the COTRANS group had a failure rate of 48% for Part I in 1977.

In addition to the Board of the NBME which is composed of 59 members drawn principally from the medical education community, the Board has fifteen test committees on which more than 100 faculty members serve.

All states except Louisiana and Texas will endorse the certificate of NBME for licensure.

In 1976 state boards of medical examiners issued initial licenses to 11,288 U.S. graduates, of which 8,020 (71%) were on the basis of NBME endorsement. 106 FMG's were also licensed by endorsement.

Federation Licensing Examination (FLEX): Until 1968 states had their own licensing examinations, but in that year the FSMB developed the FLEX exam based on test material from the NBME. The actual selection of questions for inclusion in any FLEX administration is done by FSMB committees composed of representatives of the state licensing boards.

The FSMB receives from the NBME, and passes on to the states, the weighted average scores and scores on individual subjects for each examinee. By June all 50 states will be using a uniform standard of scoring and weighting on FLEX as the final determinant of passing or failing candidates for licensure.

FLEX is the main method by which FMG's obtain state licensure. In 1976 98% of the FMG's receiving their initial licenses did so through FLEX, as did 3,268 USMG's (29%).

Proposal for FLEX I and FLEX II

The Federation is proposing the institution of a new system of two FLEX exams for all physicians. FLEX I would be administered prior to entry to graduate

medical education and would grant a license to practice under supervision in a residency training program. FLEX II would qualify a physician for an unrestricted license to practice and could be given after 1, 2, or 3 years of residency training. The FSMB Board of Directors has endorsed this policy and seeks the Association's cooperation as they continue preparations to implement it. FSMB representatives would compose both exams, presumably continuing to rely on the NBME pool of questions. The Federation views this process as a reaffirmation of the responsibility of state boards to license graduates for practice at all levels.

A similar proposal was put forth in 1973 by the NBME's Committee on Goals and Priorities. Qualifying A was conceived as validation by an external agency (NBME) of the graduate's competence to assume responsibility for patient care under supervision, and would be administered at the juncture between undergraduate and graduate medical education. Qualifying B would validate the candidate's competence for independent practice. The GAP Report envisioned USMG's and FMG's following the same path to graduate medical education and licensure.

The Association considered the GAP Report at its 1975 Assembly meeting. At that time the AAMC stated that the three part NBME examination "should not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school students and graduates in both the basic and clinical science aspects of medical education." The Association went on to support the formation of a qualifying exam for entrance into graduate medical education programs, the passage of which would be necessary but not sufficient for entry to a residency. Special emphasis was placed on the exam's assessing a student's basic science knowledge and concepts. The LCGME, through its accreditation process, was viewed as the appropriate agency to implement the requirement for such an exam.

Discussion Questions

The Executive Committee and staff have identified the following concerns, sufficient to warrant further discussion of this concept:

--What would be the effect if the responsibility for developing an exam at the midpoint of medical education passed from the faculty (such as in the case with NBME) to practitioners (the predominant participants in FSMB)?

--An advisory panel would be essential to assure sufficient emphasis on the biomedical sciences in the examination process, and the Federation's representatives have indicated that such a panel would be acceptable to them, but how and who would be selected must be considered. Would a practitioner-based exam admit as much weight to basic science question material as the NBME does?

--It is unclear what will occur to U.S. medical school graduates who fail FLEX I. What obligation will the medical schools have to such graduates? Develop remedial courses? Will the schools have any legal liability in relation to M.D. graduates who fail FLEX I?

--Since the Federation can only recommend adoption of the FLEX I and FLEX II system by its 56 member Boards, and cannot enforce compliance, what distortions in the pattern of residency training may occur in a transitional period?

--What role, other than student evaluation, would remain for NBME Parts I and II should FLEX I and II be implemented? Would this be sufficient to sustain the interest of the academicians who serve on test committees and the quality of their participation? Would medical students continue to pay the usual fees for Parts I and II if these no longer exist as an avenue to licensure? Would the schools now requiring students to pass Parts I and II for promotion continue to do so? If not, would a suitable substitute system of estimation of national standards of student achievement emerge? Who would pay for it?

--What guarantee exists that FSMB will continue to use the NBME to formulate test questions?

--LCMGE has not taken a position on a certifying qualifying exam.

--Several years ago the LCME rejected the concept of a certifying qualifying exam like FLEX I on the basis of some of the concerns raised above.

--Even if the implementation of a FLEX I or Qualifying A was judged appropriate, what are the politics of the timing of the decision and the authority for the examination?

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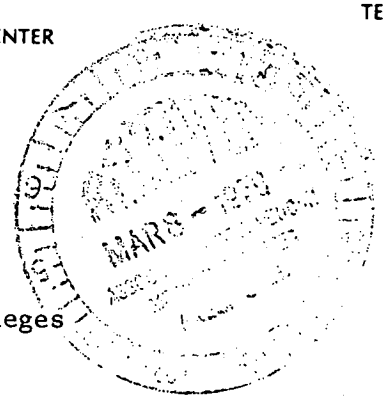

March 5, 1979

John A. D. Cooper, M.D.
Association of American Medical Colleges
One Dupont Circle, N.W. #200
Washington, DC 20036

Dear John:

The National Council on Health Planning and Development is charged by statute with the responsibility for making policy recommendations on major health issues facing the Federal government. The Council is composed of representatives from both the private and public sectors who have broad interest and expertise in health care affairs. The Council is structured into four Subcommittees, one of which is the Subcommittee on Productivity and Technology.

This Subcommittee is embarking on an effort to develop policy recommendations by collecting and synthesizing state-of-the-art knowledge on productivity and technology in health care. The ultimate product of this inquiry will be a set of monographs which cover three general areas:

a) Improvement of productivity at the institutional level, especially hospitals. The Subcommittee would like to describe the kinds of projects which institutional providers are employing to increase efficiency in management, in utilization and in general facility operations. The Subcommittee recognizes that many innovative institutions have introduced different productivity improvement programs, and it would like to examine the potential for the generalizability of such projects.

b) Improvement in the patterns of development, diffusion and utilization of new medical technologies and medical practices. There has been growing concern over the rapid manner in which new technologies (i.e., CT scanners and laboratory tests) and new medical practices (i.e., coronary artery by-pass surgery) are developed, validated and diffused. The Subcommittee recognizes the enormous cost and quality implications that the technology and medical practice issues have, and it would like to compile current knowledge and efforts directed toward an evaluation of the effectiveness, efficiency and policy impacts of this diffusion.

c) Changes in health manpower which affect productivity. The training and deployment of health manpower has undergone tremendous growth and change over the past ten years. New forms of provider practice, substitutions of types and levels of professionals and development of new forms of allied health personnel have altered the manner in which health care is delivered and the productivity of the delivery systems. The Subcommittee would like to be made aware of these changes and the impact that they have on the costs and productivity of health care delivery.

Productivity is most simply defined as "the number of outputs produced per unit of input." However, the obvious problem is that there is a lack of consensus as to what the appropriate measures of inputs and outputs should be. The extent to which useful measures of health care productivity have been developed will be a major area of concern to the Subcommittee.

The Subcommittee will address both the "efficiency" and the "effectiveness" of the production of health care. A health care production process is "efficient" (to economists, technically efficient) if the inputs required to produce a given level of output are minimized. A production process is "effective" (to economists, economically or allocatively efficient) if it minimizes the cost of the inputs which produce a certain level of output. This involves some valuation or measure of the appropriateness of a production process.

As part of its work, the Subcommittee is asking a variety of governmental and private organizations to report on projects or programs which are directed at measuring or improving the productivity of operations in the delivery of health care. By canvassing governmental agencies, academic researchers, provider groups, third party payors and other related groups, the Subcommittee hopes to include a wide spectrum of organizations in the development of these policy documents which will provide guidance to Federal decision makers. The Subcommittee would like to emphasize that this is a very informal request and response to this letter is absolutely voluntary. Beginning now and continuing through April, 1979, the Subcommittee will be receiving responses to this letter. The Subcommittee will assimilate all of the findings in its review of the literature and develop a set of policy recommendations on each of the three areas of concern.

At this time, the Subcommittee is asking your organization to respond briefly to the attached set of issues and problem areas relative to productivity and technology assessment. We are also asking your organization to assist us by soliciting responses from your constituent organizations or members, if appropriate. Please be as brief and specific as possible with your comments in response to the issue areas and append any additional information, footnotes or documents which amplify the basic response. The purpose of this informal request is to provide the Subcommittee with information about activities dealing with the measurement or improvement of productivity which is being conducted throughout the health care system.

If you have any questions, please do not hesitate to contact me or Mr. Martin Chin, staff to the Subcommittee's project, at (617) 856-3133. I look forward to your cooperation and interest in this project which will serve the best interests of all of us concerned with the provision of high quality health care for the Nation at the lowest cost.

Sincerely,

Philip Caper, M.D.
Chairman, Subcommittee on Productivity/Technology
National Council on Health Planning & Development

ATTACHMENT I

Issues Relating to Institutional Productivity

--- The Subcommittee has defined its scope of investigation to include both managerial and medical aspects of institutional care. We are interested in identifying projects which administrators may be implementing to improve facility operations (i.e. new programs in energy conservation, space usage, personnel management, facility planning, cost finding, fiscal management and other similar mechanisms). We are also interested in aspects of medical practice in the institutional setting (i.e. utilization review, decision making for capital growth, issues in scope of services, and other patient care related problems). In order to obtain a sense for the level of effort devoted to productivity improvement in institutional care, please respond to the following issues briefly and append any additional comments or documents.

1) Have you formulated an operational definition of productivity and if so, what is it?

2) Have you developed or pursued research on methodologies for measuring productivity in institutional care?

3) What are the major managerial and medical care delivery programs and projects aimed at improving institutional productivity which you sponsor or participate in? Briefly describe each major activity in a few lines. If there are particular settings where these projects are located, please provide the name, address and phone number of a contact person.

4) Have you assessed or do you plan to assess the potential for achieving cost savings and greater efficiency from productivity improvement projects?

5) What types of incentives exist currently which motivate productivity improvement in institutions? What types of changes in incentives do you favor in order to provide motivation to institutional providers and administrators to improve productivity?

ATTACHMENT II

Issues Relating to Technology and Medical Practice Assessment

--- The Subcommittee is interested in addressing the interface between the development and diffusion of technology and new medical practice and its impact on productivity in health care. The Council is aware that there are many such assessment activities which are on-going within the health care industry, both in government and in the private sector. The Subcommittee would like to collect the knowledge and findings of these studies and tie them into its recommendations for productivity policy. Please respond to the following questions briefly and append any additional comments or documents.

1) Have you formulated an operational definition of productivity of health care delivery as it relates to changes in medical technology and medical practice?

2) Have you developed or pursued research or methodologies for measuring productivity changes due to technological or medical practice innovation?

3) What are the major cost-benefit or cost-effectiveness efforts aimed at technology or medical practice which you have sponsored or participated in? Briefly describe each major activity in a few lines. If there are particular settings where these projects are located, please provide the name, address and phone number of a contact person.

4) Have you assessed or do you plan to assess the potential for improving health delivery productivity by developing policies and mechanisms relating to diffusion and deployment of technology and medical practice?

5) What types of incentives do you favor which may lead to more appropriate development and diffusion of technology and medical practice?

ATTACHMENT III

Issues Relating to Health Manpower Impact on Productivity

--- The Subcommittee is seeking to develop a description of major findings on the training and deployment of health manpower and the implications that new uses of manpower have for productivity in the health care system. The Subcommittee is interested in the educational policies which are generated for primary health providers (medicine, osteopathy, dentistry, veterinary medicine, optometry, psychology and podiatry) and for nursing and allied health professionals. The Subcommittee is concerned about changes within occupational categories which have impacted on productivity. The Subcommittee is also interested in the impact that the current mix of types and levels of providers has on productivity in the health care system. Please respond to the following questions briefly and append any additional comments or documents.

1) Have you formulated an operational definition of productivity as it relates to health manpower, and if so, what is it?

2) Have you developed or pursued research on methodologies for measuring productivity of health manpower?

3) What are the major manpower productivity assessment activities which you have sponsored or participated in? Briefly describe each major project in a few lines. If there are particular settings where these projects are located, please provide the name, address and phone number of a contact person.

4) Have you assessed or do you plan to assess the potential for increasing productivity of health care delivery via changes in health manpower training and deployment?

5) What changes in incentives for deployment of manpower do you favor in order to improve the productivity of health care delivery?

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