



# association of american medical colleges

## MEETING SCHEDULE COUNCIL OF TEACHING HOSPITALS ADMINISTRATIVE BOARD

June 25-26, 1980  
Washington Hilton Hotel  
Washington, D.C.

### WEDNESDAY, June 25

6:00pm	Joint Administrative Board Meeting	Military Room
7:00pm	Reception and Dinner	Hemisphere Room

### THURSDAY, June 26

8:30am	COTH Administrative Board Business Meeting  (Coffee and Danish)	Edison Room
12:30pm	Joint COTH/COD/CAS/OSR Administrative Board Luncheon	Map Room
1:30pm	Executive Council Business Meeting	Caucus Room

Council of Teaching Hospitals  
Administrative Board  
Meeting

June 25-26, 1980  
Washington Hilton Hotel

9:00 a.m. - 12:30 p.m.

A G E N D A

- I. Call to Order
- II. Consideration of Minutes Page 1
- III. Membership Application
- Community Hospital of Indianapolis, Inc. Page 13  
Santa Clara Valley Medical Center Page 24  
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- IV. Discussion of COTH Annual Meeting Program and COTH Spring Meeting Page 57
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- VI. A Position Paper: The Expansion and Improvement of Health Insurance in the United States Executive Council Agenda Page 19
- Also see "National Health Insurance and Its Implications for Academic Health Centers" Separate Attachment  
By Mr. Colton
- VII. Distribution by Assembly Memoranda Executive Council Agenda Page 37
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XV.	Adjournment	

Association of American Medical Colleges  
COTH Administrative Board Meeting

Washington Hilton Hotel  
Washington, D.C.  
March 20, 1980

M I N U T E S

PRESENT:

John W. Colloton, Chairman  
Stuart J. Marylander, Chairman-Elect  
Robert M. Heyssel, MD, Immediate Past Chairman  
Dennis R. Barry  
Fred J. Cowell  
Robert E. Frank  
Earl J. Frederick  
Mark S. Levitan  
Robert K. Match, MD  
Malcom Randall  
John A. Reinertsen  
William T. Robinson, AHA Representative

ABSENT:

Mitchell T. Rabkin, MD, Secretary

GUESTS:

Anna C. Epps, PhD  
David L. Everhart  
Edward J. Stemmler, MD  
Charles B. Womer

STAFF:

James D. Bentley, PhD  
Judith Braslow  
Peter W. Butler  
James I. Hudson  
Charles N. Kahn  
Thomas J. Kennedy  
Richard M. Knapp, PhD  
Mary McGrane  
Dario Prieto

## Call to Order

Mr. Colloton called the meeting to order at 9:00am in the Kalorama Room of the Washington Hilton Hotel. He introduced Melissa Wubbold who joined the Department of Teaching Hospitals staff as Dr. Knapp's secretary on February 1.

Mr. Colloton reported that the Executive Committee, following the last Board Meeting, considered the proposal for a study of state university-owned hospitals presented by John Westerman and Jeptha Dalston. The letter which appears as Appendix A to these minutes indicates AAMC interest in the problems of state university hospitals. He further reported that an invitation had been sent to Mr. Westerman and Dr. Dalston asking them and the other members of the Consortium to meet with the Executive Committee at the April 9th Council of Deans Meeting to discuss details for organizing such a study.

Dr. Bartlett commented that he had assembled a list of private university-owned teaching hospitals, and had informally discussed with executives from many of these institutions the utility of forming a group of these institutions to study their unique problems. He went on to say that at present he has no plans to assemble such a group but that interest was expressed among hospital directors, deans and university presidents from these institutions to examine the problems confronting teaching hospitals owned by private universities. Dr. Heyssel expressed concern about the usefulness of forming interest groups of major teaching hospitals along the lines of common types of ownership.

Next, Mr. Colloton noted the programs for the COTH Spring Meeting had been mailed to the membership. He complimented both the Planning Committee, chaired by Mr. Frederick, and the staff on developing an excellent program. Further, he asked, due to the difficulty in making hotel arrangements, that planning for the 1981 Spring Meeting begin soon. The Board agreed future meetings should continue with a business oriented agenda and be held in centrally located cities. Mr. Marylander agreed to proceed with planning for the 1981 meeting and said he would appoint a planning committee for that gathering by the June Board Meeting.

Mr. Colloton also reported that the Department of Teaching Hospitals staff had responded to the Health Care Financing Administration's (HCFA) request for comments on its draft survey regarding executive compensation for hospitals, skilled nursing facilities and home health care providers. Dr. Knapp added that the staff in preparing these comments incorporated suggestions forwarded to the staff by members of the Board.

Dr. Match pointed out that similar compensation data had been used

to set limitations on reimbursable compensation for management personnel in the nursing home industry. He asked Dr. Knapp whether HCFA now had similar plans to set limitations on compensation for hospital management. Dr. Knapp replied that he was presently unable to ascertain precisely how HCFA would use the data, but that it appeared from the cover letter of the draft survey HCFA would set salary limitations for reimbursement purposes with the data. He asserted that a likely outcome of such limits for the industry would be similar to the fee-for-service profile which led to physicians raising charges to the top of the scales.

#### Consideration of Minutes

ACTION: It was moved, seconded and carried to approve the minutes of the January 24, 1980 COTH Administrative Board Meeting.

#### Membership Applications

Dr. Bentley reviewed two applications for COTH membership and upon staff recommendation the following actions resulted:

ACTION: It was moved, seconded and carried to approve the Carle Foundation Hospital, Urbana, Illinois for corresponding membership.

ACTION: It was moved, seconded and carried to approve the Ohio Valley Medical Center, Wheeling, West Virginia for corresponding membership.

#### I. Report on Professional and Technical Advisory Committee of the JCAH

Mr. Colloton introduced Mr. Everhart who reported to the Board on his observations as the COTH representative to the Joint Commission on Accreditation of Hospitals' (JACH) Professional and Technical Committee (PTACH) on hospital accreditation.

Mr. Everhart described the recent reorganization of JCAH and the role in this process assumed by the JCAH's new president, Dr. John Affeldt. He also explained the functions of the PTACs within the JCAH organizational structure and the types of groups represented on these PTACs. Additionally, he reported that the PTAC members were invited to sit on committees of the JCAH and he had been chosen to represent his PTAC on the Committee on Accreditation, the body which considers the survey results and staff recommendations for institutions seeking JCAH accreditation.

Mr. Everhart observed from his recent experience with the JCAH that Dr. Affeldt and his Chicago staff were oriented towards helping hospitals improve rather than simply punishing institutions by limiting and/or withholding accreditation. He also identified some of the serious problems JCAH faces, including the difficulty in recruiting and retaining good surveyors and the high cost to institutions of the accreditation process. In concluding this overview, Mr. Everhart asserted that despite its many imperfections, accreditation by the JCAH was preferable to direct involvement of the federal government in the accreditation process.

Next, Mr. Everhart outlined his primary purposes for appearing before the board: (1) to get the Board's feedback on accreditation issues or problems COTH members would like to have brought to the attention of the JCAH, and (2) to get advice on specific issues confronting the JCAH task force on psychiatric care standards to which he has been appointed.

Dr. Heyssel commented on recent problems Johns Hopkins Hospital experienced with JCAH surveyors, but also reported satisfaction with the treatment of his institution's problems by the JCAH staff in Chicago. He also covered two further items: (1) that the present maximum accreditation of two years was insufficient and should be extended, and (2) that the JCAH should concentrate its efforts in surveys to issues as quality since, as is the case in Maryland, state and local government currently do a good job of regulating such areas as fire, safety and food preparation.

In reply to the first point, Mr. Everhart agreed that the length of accreditation should be extended, but, despite debate on issue within JCAH, it was unlikely that any change in JCAH policy on the issue would be made in the near future. Addressing the second point, Mr. Everhart described the effort in some states to combine visits of JCAH surveyors with surveyors representing state and local certification agencies. Dr. Heyssel replied that his concern was not so much with duplication as with the JCAH surveyors who do not seem to understand how a university teaching hospital functions. Mr. Reinertsen cited better experiences with JCAH surveyors who appeared to understand the unique characteristics of his institution.

Mr. Marylander then observed the great danger of the federal government usurping the present functions of the JCAH and described his institution's recent experience with a federal government validation survey following a survey by the JCAH.

Dr. Match added to the comments on the time between JCAH surveys. He pointed out that the frequency of JCAH reviews caused problems in many areas such as New York where particular JCAH

mandates to repair or renovate facilities could not be met within the time frames set by the JCAH because of the further requirement for these institutions to receive approval for sizable capital projects from health planning agencies.

Mr. Robinson described a movement among the American Hospital Association (AHA) members to bring complaints about the JCAH before the AHA's Regional Advisory Boards (RABs). He explained that AHA members in many states were especially concerned about the quality of JCAH surveyors, the cost of surveys, length of accreditation and an alleged inflexibility of the JCAH staff in Chicago. He concluded these issues would likely be taken to the AHA Board following consideration by the RABs.

The last topic covered by Mr. Everhart was the accreditation standards for psychiatric facilities in short term acute care hospitals. He explained that the current standards for assessing such facilities in hospitals had been found to be insufficient. This problem he pointed out was a growing concern to many as more hospitals open or expand psychiatric facilities in order to bolster declining acute care bed occupancies.

Mr. Everhart who is serving on the present JCAH task force to study this situation described the attempt of an early committee representing both the short term acute care hospital and the free standing psychiatric hospitals to set standards for these psychiatric facilities. This effort failed, Mr. Everhart explained, because the two sides could not come to an agreement on standards. However, the present body had come to agreement, and set "tough" standards which are directed at standardizing the care psychiatric patients receive in short term acute care hospitals. He further informed the Board that these standards are now going through the approval process within the JCAH but should take effect by the first of next year.

Dr. Bartlett complained that in the past his institution had to go through multiple psychiatric accreditation surveys. Mr. Everhart replied these surveys would be merged under the new plan. Dr. Bartlett further stated that some states were having trouble receiving accreditation for their psychiatric hospitals and that new standards might place the JCAH on a "collision track with government". Dr. Heysel concurred and explained that the unplanned, arbitrary closing of state psychiatric institutions contributed directly to the proliferation of psychiatric wards in community hospitals.

Mr. Everhart agreed about the problems these trends presented and expressed the hope that the use of the standards would have a positive effect. He also explained that the task force had recommended joint surveys conducted by psychiatric and hospital surveyors when the volume of services, quality level of a program, or the nature of the problems warranted.



Mr. Everhart agreed to distribute these new standards to the Board as soon as he received clearance from the JCAH. Mr. Colloton thanked Mr. Everhart for representing the AAMC with the JCAH and asked him to continue to keep the Board abreast of future JCAH activities.

## II. Report of the Ad Hoc Committee on Distinctive Characteristics and Related Costs of Teaching Hospitals

Mr. Levitan, as Chairman of the Ad Hoc Committee, reviewed for the Board the agenda of the second meeting of his committee held on March 19.

Among the items discussed at the committee meeting which Mr. Levitan reviewed was the joint sponsorship by the AAMC and the AHA of a day long conference on case mix. Mr. Levitan reported that his committee expressed concern about the appropriateness of the AAMC participating in such a conference at this time. Committee members felt that the agenda presently planned for the conference would not be sufficiently sophisticated to meet the needs of the COTH members. The Board concurred with the conclusion of the committee, and recommended that the staff seek alternatives to co-sponsorship by the AAMC and AHA of the planned conference. It was further suggested by the Board that a comprehensive meeting on case mix be held for interested COTH members at some point in the near future.

Mr. Levitan continued his report, outlining the proposed staff activities considered by the committee. These proposed activities included an assessment of the assumptions Medicare plans to use in estimating hospital case mix and resource allocation; a case mix profile of teaching hospitals; a programmed services profile of teaching hospitals; a financial profile of teaching hospitals; and a compilation of these profiles into a comprehensive description of the teaching hospital.

The Board discussed these items and affirmed the committee's approval of the current direction of staff work.

## III. Housestaff Meeting

The Board briefly discussed the plan for an invitational meeting for residents to be held by the AAMC in January, 1981 (as discussed on page 108 of the Executive Council Agenda). The proposed format for this meeting would focus on the theme of evaluating residents and residency programs.

Mr. Womer explained that the 1979 meeting of housestaff representatives and the one proposed for next January were being held with the purpose of developing stronger links between the AAMC and housestaff. He also pointed out that it is felt by the AAMC leadership, however, that it would not be appropriate at the present time to form a housestaff organization within the AAMC like the Organization of Student Representatives.

The Board concurred with Mr. Womer's support of the invitational meeting as well as his opposition to forming a housestaff organization within the AAMC.

#### IV. Responding to State Legislative Initiatives Affecting Important AAMC Interests

The Board discussed procedures for the AAMC to follow (as discussed on pages 70-74, Executive Council Agenda) when the AAMC finds it necessary to take a position and/or action on an issue before a state legislature or court. There was a consensus among the Board members that the procedures proposed were inappropriate and too restrictive and that it was essential that a national association retain maximum flexibility. Board members also agreed that the officers of the AAMC were in the best position in specific cases to decide who it is essential to inform before the AAMC takes action.

ACTION: It was moved, seconded and carried not to place specific requirements on the officers of the AAMC before they take positions and/or actions on issues before a state legislature or court and to recommend that officers of the AAMC retain the maximum flexibility in setting AAMC policy concerning state issues.

#### V. A Strategy for a Study of the General Education of the Physician

The Board briefly discussed the strategy (as discussed on pages 124-126, Executive Council Agenda) for a proposed study of medical education which Mr. Colloton announced had been submitted for funding to the Commonwealth Fund. Dr. Bartlett expressed concern that the panel to be appointed by the Executive Council to oversee the study did not reflect in its membership sufficient attention to practicing physicians. Mr. Marylander warned that the AMA has a strong position paper addressing the issue of the practicing physician's role in general action, and that the AAMC should be sensitive to this issue in any study of the general education of the physician.

## VI. Hospital Costs: Increased Competition Versus Mandatory Controls

Mr. Colloton reported that both he and Dr. Knapp had testified for the AAMC on the previous day before the Senate Finance Committee on the topic of competition in the health care field. He pointed out that the AAMC testimony touched on all the appropriate issues with respect to multiple missions which affect what teaching hospitals produce and the type of tertiary care these hospitals provide. In summary, felt the Committee was sympathetic to the unique conditions under which the academic medical centers operate. However, he also indicated that there are some on the Committee, including Senator Durenburger, who called for these hearings, who are convinced the costs of medical education should not be funded from the patient care dollars. He concluded in saying that the AAMC has much work ahead in educating Senator Durenburger and others to the complexities involved in financing academic medical centers.

Opening the discussion on the AAMC's testimony and the competition issue in general, Mr. Marylander remarked that the AAMC should sponsor an analysis of the defects in the competitive health care delivery model. From his viewpoint, the competitive model was currently attractive to many in the hospital field as the only potentially viable alternative to regulation. He contended, however, that this model, as propounded by its advocates, remains highly theoretical and does not provide sufficient answers to many fundamental issues including: how quality care will be sustained; who will pay for those who opt for the cheaper health plan and later run into trouble; who will finance the care of the indigent; and how capacity will be maintained to provide appropriate care to a mobile population. He further expressed concern that the recent HMO legislation which encouraged the expansion of the capacity of prepaid facilities contradicts the intent of the planning legislation which is designed to restrict expansion of the nation's health care delivery plant. This contradiction, he asserted, will cause many institutions who assume that they will be better off in a competitive system to have tremendous occupancy problems.

Dr. Bartlett noted his appreciation of the problems with competitive theory which Mr. Marylander outlined, but stressed that the AAMC should not take a "defensive" position on the issue of competition. He stated that the "regulatory bed" had been harmful to the hospital industry, and that teaching hospitals should be able to compete effectively in a competitive environment. He also pointed out in the present market place, most teaching hospitals had been able to do quite well. Dr. Heyssel concurred with Dr. Bartlett and noted despite the obvious problems, such as the quality care question and the provision of services for the indigent and the seriously ill, teaching hospitals

and the AAMC cannot afford to be negative on the issue of competition in health care. He asserted that Congress would view AAMC opposition to both the regulatory alternative and competition as support for the status quo, and there is no question that the status quo is currently unacceptable to the lawmakers. He continued on to say that funding for health care was going to be reduced whether by means of increased regulation or the application of marketplace forces to the health care system. The advantage of the marketplace, according to Dr. Heyssel, is that it would provide the providers themselves the opportunity to influence how the limited funds will eventually be distributed.

Mr. Reinertsen supported Dr. Heyssel's position. He further pointed out that some form of the competitive model will likely be adopted to the health care system, and it would be to the advantage of the teaching hospitals to assume a role in the actual transformation of marketplace principles to practice in health care.

In further discussion, Mr. Marylander argued that the competitive model when applied to health care would require a great deal of regulation, and, therefore, create a situation where government would limit resources which physicians and hospitals would have responsibility for rationing. He concluded that it would be inappropriate for physicians and hospitals to assume the role of rationers. Replying to this, Dr. Heyssel asserted that the competitive model would allow for rationing on the demand rather than the supply side of the economic curve, so that the informed consumer rather than the provider would be making the choice as to what health care they actually need.

Mr. Colloton concluded the discussion with the suggestions that a "think group" be appointed to further examine the issue and develop the AAMC's position on competition.

ACTION: It was moved, seconded and carried that it be recommended to the Executive Council to form an ad hoc committee on competition to consider the potential impact of competition on teaching hospitals and medical schools; discuss appropriate responses to these potential impacts; and formulate an AAMC position on the competitive model to be used for testimony before Congress and/or a point of departure for AAMC negotiations with federal agencies.

## VII. Carter Administration and Waxman Health Manpower Bills

Dr. Stemmler and Dr. Kennedy, preparing testimony for the

afternoon of the meeting on the Administration and Waxman Manpower Bills before the Health Subcommittee of the House Commerce Committee reviewed the legislation for the Board and sought guidance on the AAMC positions on these issues.

Specifically, Dr. Stemmler and Dr. Kennedy asked for comments on two aspects of the legislation: (1) modifications of Title V which would permit Medicare Part B reimbursement for resident services provided in a primary care setting, and (2) reduction of funding to a medical school if a specific percentage of the institution's residents either did not complete the first and second year or the third year in a primary care field.

As for change in Title V, Dr. Stemmler suggested the AAMC was to recognize the problems with reimbursing medical education in the primary care setting, but not to support the method of funding which would allow resident services to be billed for. The Board concurred with this position. Dr. Heyssel pointed out that reimbursing in the fashion suggested by the legislation would not solve the problem of funding medical education in the primary care setting because the patients treated in this setting at most teaching hospitals are primarily Medicaid, so that the prescribed fees that would be paid are well below the actual cost for the professional services. He said no such solution would be viable as long as there was an insufficient amount of funding available in the system.

Dr. Kennedy reviewed the provision of the legislation which would discount funding to medical schools if specific percentages of an institution's residents at affiliated hospitals chose to leave primary care residency programs to subspecialize. Dr. Stemmler outlined the AAMC objections to this provision. These objections followed two lines of argument: (1) that the medical schools cannot directly affect the directions residency training takes at affiliated teaching hospitals, and (2) that the current trends indicate the number of primary care residents who remain in their programs is increasing at a substantial rate. Dr. Stemmler argued these two factors should make it unnecessary for the Congress to set arbitrary requirements on medical schools for controlling the careers of residents. The Board concurred with these points. Mr. Roberts remarked that such restrictions as those outlined in the legislation would compel him to severely curtail many essential services which are in demand by the patient population his institution serves.

VIII. Proposed Plan for the Implementation of the Goals and Recommendations of the Report of the AAMC Task Force on Minority Student Opportunities in Medicine

Dr. Epps read the proposed plan (as presented on pages 24-36, Executive Council Agenda).

ACTION: It was moved, seconded and carried to endorse the report of the AAMC Task Force on Minority Student Opportunities in Medicine and recommend that the Executive Council approve the proposed plan presented by the Task Force.

The meeting was adjourned at 12:00.

February 4, 1980

John H. Westerman  
 General Director and  
 Associate Professor  
 University of Minnesota Hospitals  
 and Clinics  
 420 Delaware Street, S.E.  
 Minneapolis, Minnesota 55455

Jeptha W. Dalston, Ph.D.  
 Director  
 University Hospital  
 1405 East Ann Street  
 Ann Arbor, Michigan 48104

Dear John and Jep:

Thank you very much for joining the COTH Administrative Board last Thursday morning to discuss the unique problems faced by the chief executives of state university-owned hospitals. I believe we are all better informed as a result of your presentations, and we look forward to working with you and your colleagues to resolve these problems. To this end, the AAMC Executive Committee discussed this entire matter thoroughly on the evening of January 24th. Following discussion, it was unanimously concluded that the AAMC should become firmly committed to sponsoring a study of these problems and their optimal resolution.

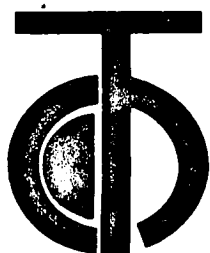
We could envision several options for structuring the study framework with appropriate review and guidance from a steering committee composed of hospital directors, a clinical department chairman, a medical school dean, a university vice president, a university president, and possibly others. We believe the involvement of such individuals would give considerable strength to the study's credibility and funding, and be more likely to lead to actual resolution of these problems.

The purpose of this letter is to invite you and the other six hospital chief executives who have "signed on" to participate in the study to a meeting with the AAMC Executive Committee representatives. I believe such a meeting would be useful, and an excellent first step. Dick Knapp will be calling you in the next few days to discuss an appropriate date and time. This is an important subject and I would like to see the activity move forward as quickly as possible.

Sincerely,

John A. D. Cooper, M.D.

cc: AAMC Executive Committee  
 COTH Administrative Board



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

Association of American Medical Colleges  
Council of Teaching Hospitals  
Suite 200  
One Dupont Circle, N.W.  
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Community Hospital of Indianapolis, Inc.  
Hospital Address: (Street) 1500 N. Ritter  
(City) Indianapolis (State) Indiana (Zip) 46219  
(Area Code)/Telephone Number: ( 317 ) 353-1411  
Name of Hospital's Chief Executive Officer: Allen M. Hicks  
Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>850</u>	Admissions:	<u>27,320</u>
	<u>685 w/newborn</u>	Visits: Emergency Room:	<u>57,601</u>
Average Daily Census:	<u>654 without</u>	Visits: Outpatient <del>xxx</del>	
		<del>xxxxx</del>	<u>215,095</u>
Total Live Births:	<u>1,424</u>		



B. Financial Data

Total Operating Expenses: \$ 44,042,114

Total Payroll Expenses: \$ 22,545,680

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 246,600

Supervising Faculty: \$ 156,000

C. Staffing Data

Number of Personnel: Full-Time: 1,876  
Part-Time: 710

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 166

With Medical School Faculty Appointments: 61

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Family Practice (Director) \_\_\_\_\_  
\_\_\_\_\_

Does the hospital have a full-time salaried Director of Medical Education?: Yes

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>9/mo - 58/yr</u>	<u>38/yr</u>	<u>elective</u>
Surgery	<u>8/mo - 82/yr</u>	<u>9/yr</u>	<u>elective</u>
Ob-Gyn	<u>1/mo - 12/yr</u>	<u>8/yr</u>	<u>elective</u>
Pediatrics	<u>1/mo - 10/yr</u>	<u>9/yr</u>	<u>elective</u>
Family Practice	<u>3/mo - 36/yr</u>	<u>10/yr</u>	<u>elective</u>
Psychiatry	<u>---</u>	<u>---</u>	<u>elective</u>
Other: <u>Clin. Anes.</u>	<u>1/mo - 12/yr</u>	<u>7/yr</u>	<u>elective</u>
<u>Behav. Science</u>	<u>1/mo - 11/yr</u>	<u>6/yr</u>	<u>elective</u>
<u>ENT</u>	<u>2/mo - 22/yr</u>	<u>5/yr</u>	<u>elective</u>
<u>Gen Emer Treatment</u>	<u>6/mo - 72/yr</u>	<u>23/yr</u>	<u>elective</u>
<u>Neurology</u>	<u>3/mo - 30/yr</u>	<u>5/yr</u>	<u>elective</u>

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> <sup>1</sup>	<u>Positions Offered</u>	<u>Positions Filled by U.S. &amp; Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> <sup>2</sup>
First Year Flexible	_____	_____	_____	_____
Medicine	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Ob-Gyn	_____	_____	_____	_____
Pediatrics	_____	_____	_____	_____
Family Practice	5 1st yr. 15 total	15	0	9/1/75
Psychiatry	_____	_____	_____	_____
Other: Cardiology Fellowship	2	2	0	7/1/77
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

<sup>1</sup>As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical\* and Categorical programs should be reported under the clinical service of the supervising program director.

<sup>2</sup>As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

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IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: Indiana University

Dean of Affiliated Medical School: Steven Beering, M.D.

Information Submitted by: (Name) Glenn J. Bingle, M.D., Ph.D.

(Title) Director of Medical Education

Signature of Hospital's Chief Executive Officer:

Robert T. Clark (Date) 4/14/80

### Undergraduate medical education

Community Hospital has the fourth largest senior elective program in the state which involves approximately 60 physicians and an average of 12 to 15 senior medical students per month rotating through the hospital.

We have an apprentice externship program in the emergency room and also in obstetrics and gynecology, which totals approximately 40 externs. We sponsor a yearly Physical Diagnosis Class, participated in the university's Clinical Medicine I program, Clinical Pathology Course, and Sophomore History Taking. Currently, we are participating in the freshman medical student Medical Education Community Orientation program.

### Graduate medical education

The major objective of the graduate medical educational program at Community Hospital is to educate primary care physicians in the specialty of family practice. The residency program, which began in 1974, was reviewed by the Liaison Committee in Graduate Medical Education in 1975 and received provisional approval to offer 3 years of graduate medical education in family practice.

The residency program began with three residents and currently we accept five residents per year.

### Continuing medical education

Community Hospital was accredited in the fall of 1975 for continuing medical education and, at the present time, we are approved for all programs for the American Medical Association Physician's Recognition Awards and similarly Family Practice Credit Hours. Our continuing medical education program has been revamped so that a physician may easily acquire 50 credit hours of Category I credit toward the AMA Physician's Recognition Award without traveling outside the institution. Conferences are held four mornings weekly on Tuesday, Wednesday, Thursday, and Friday. The Friday conference is routinely an oncology conference. A clinical case conference is held on the second Friday monthly and a heart conference on the first and fourth Fridays monthly. The Radiology Department, in addition to teaching conferences, has a diagnostic test, "Pearl of the Week",

as a challenge for all interested physicians and students. Awards are given to those for making a correct diagnosis.

Daily bedside rounds are held on all services with the resident on the specific service. In addition, general patient discussion and didactic work is also carried out. All students in attendance at Community Hospital are urged to attend any and all conferences, rounds, etc.

#### Overview of Community Hospital

Community Hospital is a unique combination of general medical-surgical practice in specialized services. Over 18% of our admissions are by family physicians who practice comprehensive family medicine. Community Hospital also has unusual services not found in the typical community hospital.

Examples of these include:

Rehabilitation Center for Pain - an inpatient unit whose goal is to help people learn to lead productive lives while dealing with chronic pain. One of the few examples of the use of a holistic medicine approach found in the United States.

August F. Hook Rehabilitation Center - a 24 bed inpatient unit and outpatient facility. The largest rehabilitation center in the state of Indiana. Students selecting this area for study become familiar with rehabilitation nursing, physical therapy, occupational therapy, speech therapy, social service, and clinical psychology.

Cancer Center - which incorporates a 12 bed inpatient active treatment unit, surgical oncologist, radiation therapists, and chemotherapy for the comprehensive treatment of the cancer patient.

Gallahue Mental Health Center -

All of the special programs mentioned are available for senior elective students and residents from our programs.

At Community Hospital, we have a large Education and Training Department in which we have full facilities, not only as for space; but as to audio visual equipment and television equipment for use by the Education Department and the staff. We also participate in the teleconference at Indiana University and have four outlets in various areas for viewing the programs. Our new library, under the direction of a full time librarian and expanded staff, is operational next to the departmental offices for the Department of Medical Education. The collection now contains 750 books and 180 subscriptions and the utilization is increasing monthly.



INDIANA UNIVERSITY

*School of Medicine*

1100 WEST MICHIGAN STREET  
INDIANAPOLIS, INDIANA 46202

OFFICE OF THE DEAN

TELEPHONE: 317/264-8157

July 3, 1978

Dr. Richard M. Knapp  
Director  
Department of Teaching Hospitals  
Association of American Medical Colleges  
One Dupont Circle  
Washington, D.C. 20036

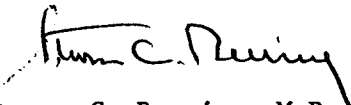
Dear Dr. Knapp:

I am pleased to endorse the application of Community Hospital of Indianapolis, Inc. for corresponding membership in the Council of Teaching Hospitals. The Community Hospital has for many years been one of our key affiliates in the City of Indianapolis. The strengths of this institution are well delineated in the application. We are, of course, particularly pleased with the strong Family Practice Residency program, the full-time emergency room arrangement and the strong senior electives in all major medical and surgical specialties.

The administrator and the director of medical education are fully supportive of our Medical School programs as well as general education endeavors for Allied Health professionals, members of the hospital staff and the lay public.

It is a pleasure to recommend the Community Hospital to you.

Sincerely yours,

  
Steven C. Beering, M.D.  
Dean

SCB/cm

cc: Dr. Glenn Bingle

## UNIVERSITY AFFILIATION AGREEMENT

### I. INTRODUCTION

This document is an agreement between Community Hospital of Indianapolis, Inc. and Indiana University School of Medicine regarding an association for cooperative pursuit of their respective goals.

### II. GOALS

Both institutions recognize that they share mutual goals of optimum patient care, undergraduate medical education, graduate medical education, continuing education of the physician, research; development of better systems for health care delivery and community service.

### III. OBJECTIVES

Both parties recognize that their responsibilities and abilities vary in each of the above areas. They agree to cooperate in those areas where such mutual cooperations will aid the accomplishment of these goals. This agreement is designed to improve and extend existing cooperative programs and to foster additional cooperative programs.

The agreement provides a means for improved communications between the respective institutions and for better coordination of the efforts of the institutions in accomplishing mutual objectives.

### IV. PATIENT CARE

1. Community Hospital agrees to accept undergraduate and graduate students in various specialties, feeling that the presence of such students in the hospital contributes to excellence in patient care.
2. Community Hospital will extend attending consulting medical staff privileges to selected medical school faculty members, upon recommendation by the Executive Council of the Medical Staff and approval by the Board of Directors of the hospital.

### V. UNDERGRADUATE MEDICAL EDUCATION

1. Community Hospital will continue to assist in undergraduate medical education by sharing its teaching facilities and patients, and provide staff supervision for undergraduate medical education.
2. Specific courses and numbers of students will be agreed upon mutually by the respective medical staff departments and by both institutions and will be reviewed annually.
3. If funds become available, Indiana University School of Medicine agrees to reimburse Community Hospital for those portions of the undergraduate program conducted at Community Hospital that are a formal part of the Medical School curriculum.



## VI. GRADUATE MEDICAL EDUCATION

1. Efforts will be made by both parties toward integration of training programs in various specialties as appropriate.
2. Existing cooperative graduate programs will be continued and the development of new cooperative programs encouraged.
3. Both institutions recognize that residents have moral and legal responsibility to the hospital in which they work and that they will participate in teaching undergraduate medical students. Education and supervision of interns and residents in cooperative programs will be assumed by the hospital teaching faculty and the Indiana University faculty.

## VII. CONTINUING EDUCATION

1. Community Hospital will publicize postgraduate educational courses sponsored by the Indiana University School of Medicine and Indiana University agrees to do likewise.
2. Community Hospital and Indiana University School of Medicine agree to work toward the development of a system to jointly:
  - a. evaluate continuing education needs
  - b. cooperate in program development
  - c. coordinate program planning
  - d. share program evaluation methodologies
3. Community Hospital and Indiana University School of Medicine agree to provide facilities and speakers for selected courses to be sponsored jointly.

## VIII. RESEARCH

1. Community Hospital will cooperate in selected research activities of Indiana University to which the hospital can make a meaningful contribution and which will be of benefit to the hospital, without compromising the primary roles of patient care and education.
2. Indiana University School of Medicine agrees to provide professional advice and administrative consultation for members of the Community Hospital staff regarding research projects.

## IX. FACULTY

1. Indiana University School of Medicine will extend faculty appointments to those members of the Community Hospital medical staff who contribute significantly to the educational program.
2. The individual candidate for faculty appointment will be reviewed and approved by each institution at its respective departmental level. Final approval of faculty appointment and rank is reserved to the Indiana University School of Medicine administration and the Indiana University Board of Trustees.

- 3. Community Hospital will encourage its staff to participate in the educational activities of the Indiana University Medical Center and affiliated hospitals.
- 4. Indiana University School of Medicine will encourage participation of its faculty members in educational activities at Community Hospital.

X. PUBLICATIONS

Indiana University agrees to recognize Community Hospital as an associated hospital in its literature and Community Hospital will make similar identification in its publications.

XI. TERM OF AGREEMENT

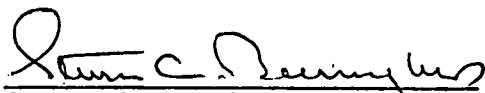
This agreement is for a continuous period, but subject to annual renewal or modification by consent of both parties. The agreement may be terminated provided notice in writing is given to the other party at least one year prior to the proposed date of termination.

XII. REVIEW COMMITTEE

- 1. A review Committee will be constituted to review, evaluate, and modify the programs carried out under this agreement.
- 2. The Committee will consist of a member of Community Hospital administration, The Director of Medical Education, and three (3) members of the hospital medical staff, chosen from the Program and Education Committee, as well as a member of the Office of the Dean of Indiana University School of Medicine and three (3) members of the school's faculty.

INDIANA UNIVERSITY SCHOOL  
OF MEDICINE

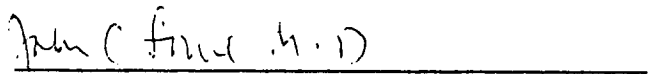
COMMUNITY HOSPITAL OF INDIANAPOLIS, INC.

  
 Steven C. Beering, M.D.  
 Dean of the School of Medicine

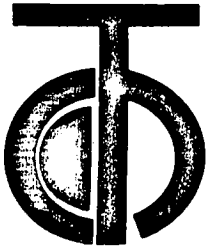
  
 Glenn J. Bingle, M.D., Ph.D.  
 Director of Medical Education

  
 Allen M. Hicks, President

  
 Otto N. Frenzel III  
 Chairman of the Board of Directors

  
 John C. Lowe, M.D.  
 Chairman, Program & Education Committee

Date July 19, 1979



APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

Association of American Medical Colleges  
Council of Teaching Hospitals  
Suite 200  
One Dupont Circle, N.W.  
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Santa Clara Valley Medical Center  
Hospital Address: (Street) 751 S. Bascom Avenue  
(City) San Jose (State) Ca (Zip) 95128  
(Area Code)/Telephone Number: ( 408 ) 279-5101  
Name of Hospital's Chief Executive Officer: Robert Sillen  
Title of Hospital's Chief Executive Officer: Executive Director

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>487</u>	Admissions:	<u>8,274</u>
Average Daily Census:	<u>289</u>	Visits: Emergency Room:	<u>43,847</u>
Total Live Births:	<u>762</u>	Visits: Outpatient or Clinic:	<u>87,602</u>

B. Financial Data

Total Operating Expenses: \$ 53,348,847

Total Payroll Expenses: \$ 35,083,241

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 2,143,872

Supervising Faculty: \$ 3,473,195

C. Staffing Data

Number of Personnel: Full-Time: 1,435

Part-Time: 346

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 382

With Medical School Faculty Appointments: \_\_\_\_\_

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

\_\_\_\_\_  
 \_\_\_\_\_

Does the hospital have a full-time salaried Director of Medical Education?: Yes

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>6</u>	<u>6</u>	<u>Required</u>
Surgery	<u>3</u>	<u>3</u>	<u>Required</u>
Ob-Gyn	<u>4</u>	<u>4</u>	<u>Elective</u>
Pediatrics	<u>8</u>	<u>8</u>	<u>Required</u>
Family Practice	<u>0</u>	<u>0</u>	_____
Psychiatry	<u>0</u>	<u>0</u>	_____
Other: <u>Cardiology</u>	<u>1</u>	<u>1</u>	<u>Elective</u>
<u>Neurology</u>	<u>1</u>	<u>1</u>	<u>Elective</u>
<u>Emerg. Dept.</u>	<u>3</u>	<u>3</u>	<u>Elective</u>
Ortho	<u>1</u>	<u>1</u>	<u>Elective</u>
G. I.	<u>1</u>	<u>1</u>	<u>Elective</u>

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> <sup>1</sup>	<u>Positions Offered</u>	<u>Positions Filled by U.S. &amp; Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> <sup>2</sup>
First Year Flexible	6	6	0	1973
Medicine	7	7	0	1973
Surgery	0			
Ob-Gyn	0			
Pediatrics	0			
Family Practice	0			
Psychiatry	0			
Other:				
<u>Pathology</u>	8	6	2	Prior to 1952
<u>Radiology</u>	9	8	1	"

<sup>1</sup>As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical\* and Categorical programs should be reported under the clinical service of the supervising program director.

<sup>2</sup>As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

**IV. SUPPLEMENTARY INFORMATION**

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

**V. SUPPORTING DOCUMENTS**

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: Stanford University School of Medicine

Dean of Affiliated Medical School: Lawrence G. Crowley, M.D.

Information Submitted by: (Name) Robert Sillen

(Title) Hospital Administrator

Signature of Hospital's Chief Executive Officer:

 (Date) 4-21-80



STANFORD UNIVERSITY MEDICAL CENTER

STANFORD, CALIFORNIA 94305 • (415) 497-5247

LAWRENCE G. CROWLEY, M.D.

STANFORD UNIVERSITY SCHOOL OF MEDICINE  
Acting Vice-President for Medical Affairs  
and Dean of the School of Medicine

April 1, 1980

Association of American Medical Colleges  
Council of Teaching Hospitals  
Suite 200  
One Dupont Circle, N.W.  
Washington, D.C. 20036

To Whom It May Concern:

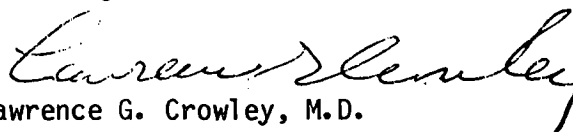
I am writing in support of the Santa Clara Valley Medical Center's application for membership in the Council of Teaching Hospitals.

The S.C.V.M.C. plays a vital role in the teaching program of Stanford University's School of Medicine. The training that takes place includes medical students and residents under the supervision of full-time Stanford faculty members located at the S.C.V.M.C. On a quarterly basis generally 30 medical students are taking clinical clerkships there and over 50 residents are doing rotations.

The S.C.V.M.C. contributes a patient population to the educational process that complements the population at Stanford Hospital which comprises primarily tertiary care patients.

The Valley Medical Center is one of our major affiliated hospitals. I strongly support their application.

Sincerely,

  
Lawrence G. Crowley, M.D.

LGC :mp

A G R E E M E N T

THE FOLLOWING is an Agreement between the COUNTY OF SANTA CLARA (hereinafter referred to as "County") and THE BOARD OF TRUSTEES OF THE LELAND STANFORD JUNIOR UNIVERSITY, a body having corporate powers under the laws of the State of California (hereinafter referred to as "Stanford").

WHEREAS, County is required by law to furnish medical care for the indigent; and

WHEREAS, it has recently been demonstrated that the only adequate means for the furnishing of such care is the utilization of the services of qualified residents and interns in conjunction with the visiting staff; and

WHEREAS, the services of qualified residents and interns are becoming increasingly difficult to obtain; and

WHEREAS, positions with "teaching hospitals" are most attractive to qualified residents and interns; and

WHEREAS, it is difficult to become a "teaching hospital" without an affiliation with a school of medicine; and

WHEREAS, such affiliations are a common practice throughout California and the United States; and

WHEREAS, a school of medicine benefits from an affiliation in that the school may discharge its obligation in medical education and research to combat the rapidly expanding gap between that which is known to medical science and that which is applied to practice; and

WHEREAS, the modern facilities of County Hospital would furnish Stanford with the needed crucible in which knowledge and practice may be mixed; and

*Consented by additional action  
Feb 21, 1965 by Sec. 26, 1967 - see  
Exhibit A attached.*

*[Handwritten signatures]*

Date FEB 9 1965  
APPROVED \_\_\_\_\_

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WHEREAS, the above recitals demonstrate that it would be to the mutual benefit of County and Stanford that there be an affiliation between Stanford and the County Hospital,

NOW, THEREFORE, pursuant to California Health and Safety Code Section 1451, the parties agree as follows:

1. Furnishing of Teaching and Medical Services by Stanford:

Members of the faculty of the Stanford School of Medicine, experienced in the various specialties of the medical profession and acceptable to the Director of Medical Institutions of County, shall from time to time be assigned to render teaching and medical services of an exceptional character at County Hospital under the direction of the Director of Medical Institutions of County.

2. Designation of Number of Physicians and Specialties:

The number of physicians to perform services under this Agreement and the designation of their specialities shall be as shown on Exhibit A, attached hereto. Changes hereafter made in the number of physicians or designation of specialities shall be accomplished by modification of Exhibit A. Any such proposed modified exhibits shall be approved in writing by Stanford and the Director of Medical Institutions of County, and shall become effective when approved by minute order of the Board of Supervisors of County and affixed to this Agreement. Such modifications shall follow the form of Exhibit A attached hereto.

3. Payment:

County shall reimburse Stanford on an hourly cost basis for each hour of service by any such physician at County Hospital, such cost to include reasonable overhead as determined by generally accepted accounting methods and to be in accordance with the prevailing salary scales of the Stanford School of Medicine;

provided, however, that such reimbursement shall not exceed 1900 hours per year per physician.

4. Statements:

Stanford shall furnish the Director of Medical Institutions of County at such intervals as are mutually agreeable a statement of hours of service performed under this Agreement. Upon approval thereof by Director, County shall reimburse Stanford at the rate herein specified.

5. Status of the Parties:

This Agreement is not to be construed as a surrender or delegation of any of County's powers, express or implied, with respect to the medical institutions of County. Neither Stanford nor the physicians it assigns pursuant to this Agreement shall be deemed to be employees or agents of County. Stanford shall provide professional malpractice and workmen's compensation insurance coverage on the physicians assigned by it pursuant to this Agreement.

6. Status of this Agreement:

This Agreement shall be deemed to supercede that certain agreement between County and Stanford dated October 27, 1964.

7. Term:

This Agreement is to commence March 1, 1965, for a period of one year and shall be deemed automatically renewed from year to year unless sooner cancelled by either party upon thirty (30) days' written notice.

IN WITNESS WHEREOF, County and Stanford have caused the  
execution of this Agreement on FEB 2 1965.

COUNTY OF SANTA CLARA

By *[Signature]*  
Chairman, Board of Supervisors  
"County"

ATTEST: JEAN PULLAN, Clerk  
Board of Supervisors

*Jean Pullan*

THE BOARD OF TRUSTEES OF THE  
LELAND STANFORD JUNIOR UNIVERSITY

By *[Signature]*  
D. B. Adams  
Business Manager

"Stanford"

NFB:gmw  
2/3/65

BEFORE THE COUNTY OF SANTA CLARA AND THE BOARD OF TRUSTEES OF THE LELAND STANFORD JUNIOR UNIVERSITY

IT IS HEREBY AGREED by and between the parties hereto that Exhibit A of that certain agreement dated February 2, 1965 is modified to read as follows:

EXHIBIT A

<u>Number</u>	<u>Designation</u>	<u>Date to Take Effect</u>
One *	Physician Specialist	November 1, 1964
One *	Physician Specialist	March 1, 1965
One *	Physician Specialist	July 1, 1966
One-half (1) *	Physician Specialist	June 24, 1968
Two *	Physician Specialist	March 1, 1969
Three *	Physician Specialist	July 1, 1969
One-half (1) *	Physician Specialist	July 1, 1969
Two & One-half *	Physician Specialist	February 1, 1970

(\* ) Or the equivalent thereof

(1) Not to exceed 950 hours per year

IN WITNESS WHEREOF, the parties hereto have executed this agreement as of the dates indicated below.

Approved "County"

By *N. B. Nelson*  
 Norman B. Nelson, M.D.  
 Director, Dept. of Medical Institutions

Dated *Dec 19, 1969*

Approved "Stanford"

The Board of Trustees of the Leland-Stanford Junior University.

By *A. E. Brandin*  
 A. E. Brandin  
 Vice President for Business Affairs

Dated *Dec 19, 1969*

Approved "County"

By *Jean Pullan*  
 Chairman, Board of Supervisors

Dated **DEC 2 1969**

ATTEST:

*Jean Pullan*  
 Jean Pullan, Clerk

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the dates hereinafter set forth.

Dated: MAY 9 1972

ATTEST: DONALD M. RAINS, Clerk  
Board of Supervisors

Donald M Rains

COUNTY OF SANTA CLARA

Charles A. Quinn

Chairman, Board of Supervisors  
COUNTY

Dated: 5/26/72

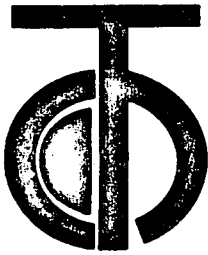
Approved as to form:

(125) Manjiv

STANFORD UNIVERSITY HOSPITAL

By Dr. Thomas A. Stone  
Director

STANFORD



APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

Association of American Medical Colleges  
Council of Teaching Hospitals  
Suite 200  
One Dupont Circle, N.W.  
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: The University of Texas System Cancer Center  
M. D. Anderson Hospital and Tumor Institute

Hospital Address: (Street) 6723 Bertner Avenue

(City) Houston (State) Texas (Zip) 77030

(Area Code)/Telephone Number: ( 713 ) 792-6000

Name of Hospital's Chief Executive Officer: Charles A. LeMaistre, M.D.

Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>408</u>	Admissions:	<u>10,947</u>
Average Daily Census:	<u>365.5</u>	Visits: Emergency Room:	<u>n/a</u>
Total Live Births:	<u>n/a</u>	Visits: Outpatient or Clinic:	<u>330,522</u>

B. Financial Data

Total Operating Expenses: \$ 105,948,251 State Funds

Total Payroll Expenses: \$ 70,082,759 State Funds

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 2,500,000  
 Supervising Faculty: \$ not available

C. Staffing Data

Number of Personnel: Full-Time: 4,904  
 Part-Time: 371

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 200  
 With Medical School Faculty Appointments: 8

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

<u>Anesthesiology</u>	<u>Gynecology</u>	<u>Pathology</u>	<u>Surgery (Gen.)</u>
<u>Dev. Therapeutics</u>	<u>Internal Medicine</u>	<u>Pediatrics</u>	<u>Surgery (H &amp; N)</u>
<u>Diag. Radiology</u>	<u>Laboratory Med.</u>	<u>Radiotherapy</u>	<u>Urology</u>

Does the hospital have a full-time salaried Director of Medical Education?: Yes

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>4</u>	<u>24</u>	<u>required</u>
Surgery	<u>3</u>	<u>18</u>	<u>"</u>
Ob-Gyn	<u>9</u>	<u>37</u>	<u>"</u>
Pediatrics	<u>7</u>	<u>150</u>	<u>"</u>
Family Practice			
Psychiatry			
Other: _____			
<u>Diagnostic Radiology</u>	<u>6</u>	<u>55</u>	<u>elective</u>
_____			

B. Graduate Medical Education (please see attached pages on integrated and) (affiliated training programs)

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

Type of Residency <sup>1</sup>	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program <sup>2</sup>
THE UNIVERSITY OF TEXAS SYSTEM CANCER CENTER M. D. ANDERSON HOSPITAL AND TUMOR INSTITUTE RESIDENT AND FELLOWSHIP PROGRAMS				
First Year Flexible				
Medicine	48	24	24	
Surgery	10	9	1	1947
Ob/Gyn	6	6	0	
Pediatrics	8	5	3	
Family Practice				
Psychiatry				
Other:				
Diagnostic Radiology	6	5	1	
Pathology	15	10	5	1950
Radiotherapy	16	9	7	1970
Urology	3	2	1	
Maxillofacial Prosthetics	8	6	2	1961

<sup>1</sup>As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical\* and Categorical programs should be reported under the clinical service of the supervising program director.

<sup>2</sup>As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.



IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: The University of Texas  
Medical School at Houston

Dean of Affiliated Medical School: Robert L. Tuttle, M.D.

---

Information Submitted by: (Name) George R. Blumenschein, M.D.  
(Title) Associate Director, Education

Signature of Hospital's Chief Executive Officer:  
Charles A. LeMaistre, MD. (Date) April 22, 1980

#### IV. SUPPLEMENTARY INFORMATION

The University of Texas System Cancer Center is a large subspecialty oncology institution. It has 13 clinical subspecialty departments and 5 basic science departments. It employs a fulltime faculty of over 200 physicians who are faculty members in The University of Texas. This institution is considered a health educational unit in The University of Texas System. Many members of the faculty hold joint professorial appointments in other health units of The University of Texas.

Our major teaching commitment is at the fellowship level. We offer 130 oncology subspecialty fellowships. In addition we have 47 residents rotating through the institution on integrated training programs with The University of Texas Medical School at Houston or with affiliated programs associated with Baylor College of Medicine and other medical institutions. Medical students rotate through our institution as required clerkships and electives from The University of Texas Medical School at Houston and from other U.S.A. medical schools. We have family practice residents in training who rotate on electives from family practice programs in the State of Texas.

Most of the clinical care programs are conducted as clinical research protocol treatment programs. The major effort of the institution is clinical research and applied clinical research. There is also a significant basic science program ongoing in basic science departments and in several of the clinical departments. A research paper is required from each of the fellows to receive certification for fellowship training in this institution.



March 3, 1980

6431 Fannin, Rm. C.010  
P. O. Box 20708  
Houston, Texas 77030  
(713) 792-5000

Associations of American Medical Colleges  
Council of Teaching Hospitals  
Suite 200  
One Dupont Circle, N.W.  
Washington, D.C. 20036

Gentlemen:

The University of Texas Medical School at Houston was authorized in September, 1969. Since that time the school has completed and occupied its major facility, recruited 350 full-time and 40 part-time faculty, enrolled nine entering classes, and graduated seven classes of medical students.

Our primary teaching hospital is the Hermann Hospital which is physically joined to the medical school building. The M.D. Anderson Hospital is formally affiliated with the medical school and has been since the inception of the school. The affiliation is close and is crucial to the continued development of the school. As you are aware, the M.D. Anderson is part of The University of Texas System, which, in itself, denotes a close relationship. The faculty, both basic science and clinical, of that institution were instrumental in assisting in the rapid start-up of the medical school, being heavily involved in basic science and clinical teaching programs. The basic science faculty, for example, were responsible for the first courses in Histology, Cell Biology, and Pathology taught in the medical school prior to the arrival of full-time medical school faculty. Similarly, courses in Physical Diagnosis clerkship experience in Medicine, Surgery, and Pediatrics, and fourth year electives have been presented by M.D. Anderson clinical faculty. The same relationships, although less dependent upon extensive involvement of M.D. Anderson faculty because of the expansion of medical school faculty, exists today and is planned for the future. Many of the faculty share cross-appointments and some are jointly funded by the two institutions. The relationship is becoming increasingly interdependent.

It is most appropriate that M.D. Anderson become a member of the Council of Teaching Hospitals and I strongly recommend approval.

Sincerely,

A handwritten signature in cursive script that reads "Robert L. Tuttle".

Robert L. Tuttle, M.D.  
Dean

/jl



# THE UNIVERSITY OF TEXAS SYSTEM CANCER CENTER



Texas Medical Center Houston, Texas 77025

R. Lee Clark, M.D.  
President

September 22, 1975

President Charles A. Berry, M.D.  
The University of Texas Health  
Science Center at Houston  
Houston, Texas 77025

Dear Chuck:

The enclosed affiliation agreement between M. D. Anderson and the UT Medical School at Houston was drawn up when Dr. Cheves Smythe assumed duties as Dean of the Medical School, after a lengthy study by both Doctor Smythe and Dr. Robert C. Hickey. I would appreciate Doctor Tuttle, and future deans, reviewing the document with us upon assuming their duties. Doctor Hickey is in charge of our academic relations assisted by Dr. George Blumenschein, Assistant Director for Education.

The agreement is subject to change as matters develop in our relationship and provides for a joint committee to "make recommendations relative to the continuing effective implementation of this agreement" (II.I.1) and also provides for a joint Program Planning Committee to "consider potential and projected matters of joint concern" (II.I.4). I am suggesting to Doctor Hickey that he contact Doctor Tuttle to set up these committees (possibly one committee could serve both functions), and I am also proposing that Doctor Blumenschein be a member of the committee, representing our institution.

Sincerely yours,

R. Lee Clark, M.D.  
President

RLC:bjr

cc: Dr. Robert C. Hickey  
Mr. Joe E. Boyd, Jr.  
Dr. George Blumenschein ✓  
Dr. Robert L. Tuttle



LAW OFFICE

THE UNIVERSITY OF TEXAS SYSTEM

P. O. BOX 7727

AUSTIN, TEXAS 78712

February 10, 1971

MEMORANDUM

To: Mr. Arthur Dilly

From: Burnell Waldrep

Subject: AFFILIATION BETWEEN HOUSTON MEDICAL AND MDA

There is enclosed for your consideration the agreement between The University of Texas Medical School at Houston and The University of Texas M. D. Anderson Hospital and Tumor Institute at Houston. We have taken the liberty of changing the arrangement, but there are no changes of substance.

As we view it, this agreement is primarily inter-institutional and cooperative in nature. I suppose it is intended to document a working program between the two institutions. In view of this, we agree with you that this type of arrangement would not require regental action. However, if in the future there is an appropriation of funds for programs in this area, it would appear that regental approval would be required.

Please let us know if anything additional is needed.

*Burnell Waldrep*

BW:tr  
Enc.

*I concur in above and ask that  
Mr Waldrep's memo be made a permanent attachment  
to the document*

*Charles Martie*

HOUSTON MEDICAL SCHOOL AND M. D. ANDERSON: AFFILIATION AGREEMENT. --Chancellor LeMaistre reported for the information of the Board of Regents that the following affiliation agreement (Pages 130-142) between The University of Texas Medical School at Houston and The University of Texas M. D. Anderson Hospital and Tumor Institute at Houston had been negotiated and executed by the respective chief administrative officers of those components. He stated that the agreement had been reviewed and approved by appropriate System Administration officials. This is an interinstitutional agreement and did not need regental approval but was submitted for information to the Board of Regents together with a memorandum from University Attorney Waldrep who advised that if, in the future, funds are specifically appropriated for these joint programs, regental approval would be required.

Chancellor LeMaistre further stated that as any amendments to this agreement are negotiated and executed, these too will be submitted for information.

Below is the memorandum from University Attorney Waldrep with respect to this affiliation agreement.

MEMORANDUM

To: Mr. Arthur Dilly

February 10, 1971

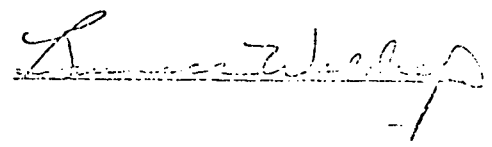
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As we view it, this agreement is primarily inter-institutional and cooperative in nature. I suppose it is intended to document a working program between the two institutions. In view of this, we agree with you that this type of arrangement would not require regental action. However, if in the future there is an appropriation of funds for programs in this area, it would appear that regental approval would be required.

Please let us know if anything additional is needed.



BW:tr  
Enc.

This AGREEMENT by and between two institutions of The University of Texas System, THE UNIVERSITY OF TEXAS MEDICAL SCHOOL AT HOUSTON, hereinafter referred to as "School," and THE UNIVERSITY OF TEXAS M. D. ANDERSON HOSPITAL AND TUMOR INSTITUTE AT HOUSTON, hereinafter called "Anderson,"

WITNESSETH:

WHEREAS, each institution is an integral part of The University of Texas System and is governed by the rules and regulations of the Board of Regents; and

WHEREAS, School and Anderson seek and agree upon a closer working relationship best possible to the realization of their commitments to the people of Texas and the Southwest, and wish to present in common a program of excellence in medical health, science, and education; and

WHEREAS, it is the desire of the parties to coordinate the resources entrusted to improve health care and, with others, to continue to develop Houston as a superior medical center and health resource; and

WHEREAS, the Dean of School and the President of Anderson accept the responsibility for carrying out cooperative inter-institutional endeavors where related and mutually beneficial in their common goal of better health care for the citizens of Texas:

NOW, THEREFORE, in consideration of the mutual benefits and with the intent to develop both institutions to their maximum potential, School and Anderson hereby agree as follows:

I. GENERAL PROVISIONS

A. This agreement is made pursuant to the provisions of Article 2606c-1.1 and Article 2603c, Vernon's Civil Statutes, and the rules and regulations of the Board of Regents. Any

alteration or amendment shall be negotiated through the respective executive heads of School and Anderson and subsequently approved by System Administration.

B. Anderson and School shall retain all jurisdictional powers incident to their status as separate components of The University of Texas System.

C. The provisions of this agreement and the bylaws of the staffs of Anderson and School shall be in agreement.

D. Anderson agrees to provide for the operation and maintenance of an accredited hospital for teaching, research, and patient care as an integral unit of the undergraduate and clinical graduate education programs of School.

E. Anderson shall retain final jurisdiction over the admission of its patients, including bed assignments, but shall consult with School in the formulation of policies affecting undergraduate and clinical graduate medical teaching.

F. This agreement is for a term of thirty (30) years, and shall commence on the date of its execution and may be terminated upon the mutual consent of the parties. A period of at least three (3) years shall be allowed to effect such termination. This agreement may be amended in writing upon the concurrence of System Administration.

## II. MAJOR SPECIFIC CONSIDERATIONS

Anderson and School may engage in programs either separately or jointly to accomplish these goals. Since each has the capacity to enhance or limit directly and indirectly the success of the other, the following major areas for specific consideration are enumerated to aid interactions between Anderson and School.

### A. Faculty and Staff Appointments

During the initial organizational phases of the establishment of School in Houston, School will



utilize only selected services for its teaching programs. After the effective date of this agreement, Anderson, in consultation with School, will give due consideration to the academic interests and qualifications of new staff applicants prior to professional staff appointment.

Within Anderson the staff involved in teaching programs will continue as members of the general faculty of The University of Texas System. All members of the staff of those specific services selected for undergraduate medical teaching will be encouraged to seek additional academic appointments in School, for it is understood and agreed that ultimately, with the full activation of School in Houston, the entire undergraduate and the clinical graduate medical teaching staff of Anderson shall hold appointments on the faculty of School. The same provisions apply to the basic science or research staffs. It is further agreed:

1. Academic appointments in both institutions will conform to the titles and ranks used by The University of Texas System.
2. For each individual the assignment to research, education, or service programs will be determined by each individual's talents, commitments, interests, abilities, and availability.
3. Academic ranks and titles for faculty members holding appointments in both institutions will characteristically be equivalent. Hospital staff appointments need not be equivalent. Responsibility for tenure will reside with the institution of primary appointment.

4. Anderson will assess the interests and wishes of all members of its active staff concerning Medical School appointments. On the date a particular discipline or service is selected by School for development of an undergraduate teaching program, Anderson will designate to School from that particular service or discipline all of those persons for whom Medical School faculty appointments are recommended.

School will then determine, in consultation with Anderson, the nature of the faculty appointment of such individuals in School. The teaching obligations, if any, will be negotiated individually by School and Anderson to include appropriate inter-institutional fiscal transfers. It is understood that the foregoing applies only to those members of Anderson roster when the specific discipline is selected by School for development of its teaching program. It does not apply to those staff services not involved in teaching.

5. Within the services selected by School for its teaching programs, School will assume the guiding responsibility for its undergraduate and those jointly administered clinical graduate educational programs of Anderson, through delegation of such responsibility to mutually agreed-upon members of Anderson staff.
6. Anderson shall appoint, after consultation with School, full-time academic leaders in departments, services, or divisions involved in undergraduate and selected graduate medical teaching programs.

7. In the selection of senior department, division, and service chiefs for both School and Anderson, search committees will be appointed. Each institution shall consult the other in the selection and charge to such search committees whose final recommendations will be reported to both institutions for review.
8. While veto is not a prerogative of either institution in the selection of the other's staff, consultation is mandatory.
9. It is also agreed that:
  - (a) All professional appointments to the medical staff shall be reviewed annually by Anderson and School.
  - (b) Anderson and School agree that a professor designated as chief of a given division, service or department for The University of Texas Medical School at Houston will be responsible for its educational programs in undergraduate education. Actual operational responsibility for such programs may be delegated to individuals who must be acceptable to both School and Anderson.
  - (c) The professor responsible for academic leadership in departments, divisions, or services may be housed in either institution as agreed upon.

B. House Staff Appointments and Responsibilities

House staff members have both legal and moral responsibilities to the hospital in which they work and a responsibility to School for the teaching of undergraduate medical students. The responsibility for the

appointment and recruitment of house staff members shall be shared by Anderson and School where shared-residency programs exist. In consideration of the foregoing, the following specific conditions are agreed to:

1. In all joint programs, Anderson and School faculty shall cooperate in filling positions with highly qualified candidates.
2. On those services not selected by School for teaching purposes, Anderson will have primary responsibility for recruitment of house staff members.
3. On-going commitments at Anderson will be honored until an acceptable negotiated change in current, on-going shared residency programs can be agreed upon.
4. After establishment of the medical school, appointments of interns and residents shall be made by Anderson in conjunction with School, except that Anderson may retain fellowships, and other on-going programs not agreed upon as in the "shared" category.

C. Availability of Patients for Teaching

After the effective date of this agreement and in recognition that types of patients in hospitals are changing, of the need to educate students in the care of all types of patients and in the care of patients with diverse types of illnesses; and that almost all patients today quite readily accept the implied premise that upon entry to a teaching hospital for care, they will participate in teaching programs, the following specific conditions are agreed to:

1. All patients in Anderson shall be available for teaching purposes.
2. Exception may be granted upon concurrence by the chief of a major service upon recommendation of a physician when the physician feels that participation in a teaching program might adversely affect a patient's condition, a research program, or for other good and sufficient reason.
3. No members of the faculty will be granted any special exemptions from teaching on their patients.
4. Additional costs for teaching purposes must not be conspicuous or unreasonably additive for either patients or third party carriers.

D. Medical Student Responsibilities and Facilities

1. Medical students will be responsibly involved, under supervision, in the management and care of patients as a learning process. This will be accomplished through the students' participation with the medical care team consisting of interns, residents, and faculty and staff physicians.
2. In recognition of the fact that a university teaching hospital and clinic requires considerably more space for the educational programs of the medical students and house staff, Anderson agrees to provide such space. In all new construction and modernization programs, Anderson will give consideration to the following requirements:
  - (a) Charting areas of sufficient size to accommodate reasonably, students, house staff, staff physicians and nurses;
  - (b) provisions for well-equipped conference-demonstration rooms for teaching programs on each large patient floor area of the hospital and clinic;

- (c) patient room facilities of sufficient size to permit students and staff to observe and to make bedside rounds;
- (d) sleeping-in facilities for students while on night call on such services as intensive and special care and as otherwise agreed upon;
- (e) special treatment rooms on each floor to demonstrate special procedures to students;
- (f) satellite library;
- (g) locker space for students;
- (h) if possible, development of off-campus additional specialized teaching resources.

E. Joint Responsibilities for Research

School and Anderson agree to develop cooperatively clinical and basic research. Research projects may be jointly sponsored by School and Anderson. In such instances, the following specific conditions are agreed to:

1. Research reviews and surveillance of human experimentation will be carried out separately for the two institutions. In-house approval by one institution will not imply approval by the other.
2. Procedures for scientific review and administrative approval will be the prerogative of the respective institutions, and budgets will be separate and specifically identifiable.
3. When a joint program of research is instituted, the investigators, resources, plans, funding and compliance with rules for human experimentation and biohazards must be identified, recorded, and approved by each institution for that portion of the research to be done in each institution and the faculty time committed.

4. Unexpended funds and equipment purchased in pursuit of the research project must be assigned specifically to one or the other institution by the conclusion of the joint project.
5. In joint projects credit to researchers and institutions shall be assured.

F. Service (Patient Care) Activities

1. School and Anderson will cooperate in recruiting a sufficient number of qualified physicians to direct and supervise adequately professional medical services to all in-patients and out-patients for which they are responsible.
2. All professional care shall be provided for by the faculties of Anderson and School, the latter as development permits. The staff(s) shall be closed.
3. Plans for management of revenues generated by service activities will conform to The University of Texas System practices and policies. Such revenues generated by Anderson shall continue to be managed under its long-established plan and principles. Any fee or revenue management plan developed by School will be a separate entity. However, all fees generated for an identifiable service will revert to the plan of the institution less business costs in which the faculty member holds his primary appointment; such fees will be managed according to that institution's procedures.

G. Sharing of Common Facilities and Services

Plans may be drawn to provide for common services required by both Anderson and School; this will avoid expensive and unnecessary duplication of equipment and

facilities. Such common services, when available, may be operated by either School or Anderson. These may include heating, telephones, post office, laundry, food, computer, parking, specialized diagnostic procedures, animal resources, library, physical plant, etc. In consideration of the foregoing, the following specific conditions are agreed to:

1. That joint facilities agreements will be established and reviewed annually by the Dean of School and President of Anderson, together or with a higher administrative authority;
2. such agreements shall cover all jointly shared services;
3. highly specialized, expensive, and infrequently used research, therapeutic, and laboratory procedures may be established or obtained at either School or Anderson, rather than establishing such services separately.

#### H. Financial Considerations

Anderson, in its traditional role of public service, recognizes that the educational programs contribute materially to the quality of patient care. Nonetheless, certain specific financial considerations must be agreed upon:

1. Anderson shall bear its costs for supporting and maintaining its staff of interns, residents, fellows and other such personnel;
2. School shall pay all identifiable costs incurred in the operations of its undergraduate educational program;
3. in jointly sponsored research projects (see Sec. II-E), there shall be definite agreement in the administration of research funds and overhead,



provision of staff, facilities, ownership of equipment purchased with research funds, and credits;

4. costs not described herein may be negotiated;
5. this joint agreement established by Anderson and School shall be reviewed annually by the President of Anderson and the Dean of School. Such reviews shall involve fair and equitable pro rata division of all costs involved not expressed as the responsibility of either Anderson or School and at the end of the accounting period a cost settlement will be agreed upon.

I. Organization for Effective Communication

1. From the staffs of Anderson and School a committee shall be selected to make recommendations relative to the continuing effective implementation of this agreement. This committee shall meet at least several times annually, and the President of Anderson and the Dean of School shall be ex officio members.
2. In those areas which are relevant to the programs of other biomedical units in Houston, items will be referred to the Administrative Council of these units for discussion and counsel (or such administrative organizations as replaces the Administrative Council).
3. To the Health Affairs Advisory Council and to the Vice-Chancellor of Health Affairs will be referred such matters as need attention and advice or which would be benefited by consideration at these levels.

4. The President of Anderson and the Dean of School shall also establish a Program Planning Committee to consider potential and projected matters of joint concern to Anderson and School and to consider optimal allocation and application of the mutual resources. This committee will render an annual report to the Dean of School and the President of Anderson. Both the Dean (School) and the President (Anderson) are ex officio committee members.

III. ON-GOING EDUCATIONAL AND/OR OTHER AFFILIATION AGREEMENTS OF ANDERSON

Anderson through the years has established liaisons, particularly in education, with other institutions. Those effective at the date of this agreement will be honored.

A. The on-going arrangements as exemplified by those at the Hermann Hospital, Center Pavilion, St. Joseph Hospital, and Dental Branch will be recognized.

B. House officer, residency, and fellowship training programs now in force will remain in force until modified upon mutual agreement as provided for under Section II-B.

C. Programs in health science education to include training of allied health science students, baccalaureate and nonbaccalaureate students are to be continued under current arrangements until alternate mutually agreed upon reorganizations are effected.

D. Although Anderson is a resource of The University of Texas System, medical students from other than Texas medical schools, from both the United States and abroad, will continue to be encouraged to serve in elective training and educational experiences at Anderson. Such arrangements will be negotiated with the deans of the respective schools and Anderson Office.

of Education. It is the intent that filling said places will not be competitive with the needs of The University of Texas Medical School at Houston.

E. Arrangements between Anderson and The University of Texas Graduate School of Biomedical Sciences at Houston for cooperative participation in predoctoral, postdoctoral, and continuing educational programs will be continued. Such arrangements regarding students, faculty, staff, and joint sharing of facilities may be modified as the goal of a common basic science faculty of The University of Texas at Houston is pursued.

EXECUTED this 26th day of April, 1971.

THE UNIVERSITY OF TEXAS  
MEDICAL SCHOOL AT HOUSTON

By *Charles Noel Snyke*  
Charles Noel Snyke, M.D.  
Dean

THE UNIVERSITY OF TEXAS  
M. D. ANDERSON HOSPITAL AND  
TUMOR INSTITUTE AT HOUSTON

By *R. Lee Clark*  
R. Lee Clark, M.D.  
President

Approved:

*William H. Knisely*  
William H. Knisely, M.D.  
Vice-Chancellor for  
Health Affairs

*Charles A. Maestre*  
Charles A. Maestre, M.D.  
Chancellor

COTH ANNUAL MEETING PROGRAM AND  
COTH SPRING MEETING

The speakers and program outline for the 1980 AAMC Annual Meeting plenary sessions are set forth on the following two pages. At this point we do not have a theme or speakers for the COTH general session to be held on Monday, October 27. We would like a discussion of what theme would be appropriate, as well as some specific suggestions for speakers.

Mr. Marylander will identify the composition of the 1981 COTH Spring Meeting Planning Committee, and the staff would appreciate reactions to this year's program as well as program suggestions for the 1981 meeting.

The staff recommends that the 1981 meeting be held in Boston or Philadelphia with Boston being preferred if hotel accommodations are available.

Dr. Clemente, Chairman of the Council of Academic Societies, has suggested the possibility of a joint half day session if CAS and COTH could arrange to meet on the same dates in the same city. We would like the Board's reaction to such a proposal.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES--1980 ANNUAL MEETING

"The New Biology and the Future of Medical Education"

Plenary Sessions -- Preliminary Schedule

Monday, October 27

- 9:00 a.m. DeWitt Stetten, M.D.  
Senior Science Advisor  
National Institutes of  
Health  
The Evolution of New Ideas:  
general introduction to the  
meeting's theme, tracing  
interaction of funding,  
research, and new knowledge
- 9:30 a.m. Eric Kandel, M.D.  
Director, Division of  
Neurobiology and  
Behavior  
Columbia University College  
of Physicians & Surgeons  
The New Biology: Neurobiology:  
scientific advances in  
neurobiology (Sponsored by  
Burroughs Wellcome Fund)
- 10:00 a.m. Coffee Break
- 10:30 a.m. Philip Leder, M.D.  
Chief, Laboratory of  
Molecular Genetics  
National Institute of Child  
Health & Human Development  
The New Biology: DNA Research  
scientific advances in DNA  
research (Sponsored by  
Burroughs Wellcome Fund)
- 11:00 a.m. Daniel Tosteson, M.D.  
Dean  
Harvard Medical School  
Alan Gregg Memorial Lecture:  
relation of new biology and  
scientific advances to medical  
education and medical practice
- 11:30 a.m. Adjournment

Tuesday, October 28

- 9:15 a.m. Presentation of Abraham Flexner Award by John Gronvall,  
Chairman of Flexner Award Committee
- 9:30 a.m. Presentation of Borden Award by Harriet Dustan, Chairman  
of Borden Award Committee
- 9:45 a.m. Keynote Address: Gerald Piel, Publisher, Scientific  
American
- 10:15 a.m. Chairman's Address: Charles Womer, President, University  
Hospitals of Cleveland
- 10:45 a.m. Adjournment

BIOMEDICAL TECHNOLOGY: ITS IMPACT  
ON MEDICAL EDUCATION AND MEDICAL PRACTICE

Tuesday, October 28, 1980  
2:00 pm - 4:00 pm  
Washington Hilton Hotel

Moderator: Charles A. Sanders, M.D.  
General Director  
Massachusetts General Hospital

Panelists: Robert H. Ebert, M.D.  
President  
Milbank Memorial Fund

Dr. Ebert will discuss the discovery/invention of new technology and its incorporation into medical education and medical practice; the evaluation of new technology, including the timing of the review, the criteria, and who reviews; and the point at which new technology replaces the old in the education and practice settings.

Steve Schroeder, M.D.  
Associate Professor of Medicine  
University of California, San Francisco

Dr. Schroeder will discuss the utilization of laboratory and x-ray technology, to shift the focus of the session away from just the "big technologies" such as CAT scanners.

Walter J. McNerney  
President  
Blue Cross/Blue Shield Associations

Mr. McNerney will discuss how technology gets paid for; when new technology replaces the old for reimbursement purposes; the role of cost in decisions about reimbursement for new technology; and the medical necessity project.

Association of American Medical Colleges

POSSIBLE MEETING WITH  
NATIONAL COMMISSION ON RESEARCH

Background

Over the past several years, the relationship between the Federal government and the research universities has become increasingly adversarial. Persons both within the government agencies that fund research and within the universities that receive some of those monies have become concerned about the effects of the deterioration of the relationship. Government involvement in the support of research at these academic institutions has increased, as have the paperwork, regulations, and accountability.

In an attempt to solve problems inherent in the government funding mechanisms and to improve the understanding between government agencies and universities involved in research, the National Commission on Research was founded in the latter half of 1978 by the Association of American Universities, the National Academy of Sciences, the American Council on Education, the National Association of State Universities and Land-Grant Colleges, and several other organizations. The Commission is funded through grants from several foundations. It works independently of its founders to examine the process by which the Federal government supports academic research and to propose changes designed to improve that process.

Thirteen leaders with backgrounds in education, business, and government have accepted appointments as unpaid Commissioners and faced the challenge of accomplishing the above goals in a relatively short period of time, with a target date of June, 1980. William H. Sewell, professor of sociology at the University of Wisconsin, serves as Chairman; and Cornelius J. Pings, Vice Provost and Dean of Graduate Studies at the California Institute of Technology, serves as Director.

Subcommittees were appointed to investigate each of the basic issues and to draft position papers for discussion by the entire Commission.

The Commission is now publishing and disseminating a series of position papers reporting on the conclusions from the investigations.

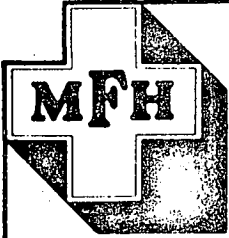
The Titles of Reports now published or in process include:

- Accountability: Restoring the Quality of the Partnership  
(Published March, 1980)
- Review Processes: Assessing the Quality of Research Proposals  
(In Press)
- Funding Mechanisms: Balancing Objectives and Resources in  
University Research  
(In Press)
- Industry-University-Government Relationships (In preparation)
- Scientific Personnel (Contemplated)

Question:

The Commission has asked for an opportunity to meet with leaders of the AAMC. Does the COTH Administrative Board wish to meet with Dr. Pings, other staff of the Commission and the CAS Administrative Board on Wednesday, September 24 (evening) or Thursday, September 25 (morning)?





**OFFICERS**

GEORGE L. BURNS, *Chairman of the Board*  
EDWARD N. MARLETTE, *Chairman, Executive Committee*  
JOHN N. WALSH, JR., *Vice Chairman of the Board*  
L. NELSON HOPKINS, JR., *Secretary*  
JAMES M. DILLON, *Treasurer*  
LEON C. CARSON, *President*

**MEDICAL STAFF OFFICERS**

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GERALD SWARTZ, M.D., *President-Elect*  
FRANK J. BOLGAN, M.D., *Secretary*  
NORMAN E. HORNUNG, M.D., *Treasurer*

27 May 1980

Richard M. Knapp, Ph.D., Director  
Department of Teaching Hospitals  
Association of American Medical Colleges  
One Dupont Circle, N.W., Suite 200  
Washington, D.C. 20036

Dear Doctor Knapp:

The AAMC has devoted a considerable amount of time to the issue of whether or not house staff are students or employees of teaching hospitals. While this issue seems for the moment to be at the "Mexican standoff" stage there is yet another issue that should be of concern which I have heard nothing about.

This issue is how many weeks of time "on station" constitutes a year of educational activity for a house officer. This is related to one of the most frequently debated issues in the area of fringe benefits for house officers - vacations. As one goes through the Essentials of a Residency and the Special Requirements of various residencies this issue is hardly mentioned directly. The general impression is that this is something that may be worked out locally to the mutual satisfaction of the program director and the members of his departmental house staff. This is far from the real situation, and leaves the program director as a target for house staff barbs and the issue for general argumentative debate between house staff and hospital administration.

I have tried to find some precise solution to this issue by writing to the various Specialty Boards for which we have residencies at this hospital - eight in number. I have answers back from three - all noncommittal and an answer from the ABMS which also is non-committal. Our hospital Education Committee, the one responsible for house staff matters, has examined what they have available to them. The Program Director for anaesthesiology indicates that his area/specialty has faced this squarely and has set specific limits for the amount of vacation which is what we are now giving: two weeks during PGY-I and three weeks during PGY-II, with the possibility of negotiated further time for attending truly major medical meetings in the field. Beyond this the Department of Medicine Program Director indicates he can only fall back on the requirement of 24 months of specific internal medicine training with the resident in a position of responsibility for patient care during years 2 and 3 of that program.

The point to all this is simply that as a result of having the establishment more or less running scared, the house staffs have negotiated themselves into the position of having four weeks off per year as paid vacation at many hospitals. The Internal Medicine Program Director asks how he can certify 24 months of educational training during years two and three of that residency if the resident is in fact away from the hospital on vacation for one full four week period in each of these years.

As long as the individual teaching hospitals are left to negotiate their individual ways through this underbrush there will be no uniformity, descriptions of the teaching programs expected by various residencies will be a brambles of uncertainty, and the establishment will be in the position of a leaderless mob rather than an organization.

After ten years of trying to come up with sensible answers to questions such as this I am on the verge of retiring to pursue my hobbies. It "macht es mir nichts aus" what the answer may be, but it is high time someone began to think about what the answer is to this situation. If graduate medical education is to be an organized program of education then it is long since overdue in getting organized on this and several other points. Since there is no other central organization which could address this issue on an across the board basis, seeking concurrence among the various residency programs and doing so as a representative of the majority of teaching hospitals, better positioned than the COTH, why not do something about this matter.

I am not so foolish as to think it will ever be possible to obtain uniformity amongst this very disparate group of teaching hospitals on all items in the fringe benefits roster - and I am not so sure there should be. However, this is an issue in the area of program content and this is an area concerning which there should be uniformity if the residencies are to be regarded as meeting a common minimum standard of performance. Meeting such a common minimum is related to public credibility and acceptance. In my book the approach should be not to how much vacation is given but to how much time "on-site" and actively engaged in educational activities is required. If a house staff demands a full month vacation each year and the Board says 24 months of training then it should take that house staff 26 months to complete that portion of the residency program. Such an arrangement would of course get all sorts of things out of kilter but it would at least be honest and make common sense regarding minimum requirements.

Best wishes,



Harry J. Alvis, M.D.  
Director, Medical Education

HJA/ja



**association of american  
medical colleges**

JOHN A. D. COOPER, M.D., PH.D.  
PRESIDENT

202: 828-0460

May 23, 1980

Colin C. Rorrie, Jr., Ph.D.  
Director, Bureau of Health Planning  
3700 East-West Highway  
Room 6-22  
Hyattsville, Maryland 20782

Re: NPRM Amending Regulations Governing Certificate of Need Reviews By  
State Health Planning and Development Agencies and Health Systems Agencies--  
42 CFR Parts 122 and 123

Dear Dr. Rorrie:

The Association of American Medical Colleges (AAMC) appreciates this opportunity to respond to the Public Health Service's invitation, published in the March 26, 1980 Federal Register (Volume 45, No. 60), for written comments and recommendations on the proposed regulations governing certificate of need (CON) reviews by State health planning and development agencies (State Agencies) and health systems agencies (HSAs). The AAMC's membership includes all of the nation's schools of medicine, 67 academic medical societies, and more than 425 of the major teaching hospitals in the United States. Because of their joint involvement in health resources development and health services delivery, the proposed regulations are of direct interest to the Association's constituency.

The AAMC has supported the present planning program from its inception and endorses the development of regulations which implement the law in a fair, effective and realistic manner. Such regulations must not make demands on planning agencies and providers which fail to recognize the limits of their capabilities and resources, and must respect as well the special needs of those entities responsible for the education and training of the nation's health care professionals, and for the provision of services and resources which extend beyond health service area boundaries. In this latter regard, the Association is pleased that in Section 123.412(a) (10), (11) and (12) of the proposed CON regulations, the Secretary has followed strictly the substance of the statutory provisions requiring that the criteria for HSA and State Agency CON reviews include consideration of the clinical and access needs of health professions training programs, and the special needs and circumstances of those entities providing a substantial proportion of their services and resources to individuals residing outside of their immediate health service areas.

While the Association believes the above CON considerations further equitability within the review process, we do have some serious concerns regarding other provisions of the proposed regulations. Comments on these specific provisions are attached to this correspondence. However, prior to presenting them, the AAMC would like to discuss a more general, but equally serious concern which is in need of resolution. Clearly, the Association's membership is responsible for not only the education and training of the vast majority of physicians and other health professionals in this country, but also for the conduct of a substantial portion of the nation's biomedical research efforts. The proposed regulations have raised questions among our constituents relative to both of these commitments.

Regarding their impact on training programs, many of our member teaching hospitals and schools are concerned that the annual \$75,000 operating expenditure threshold for CON review of new institutional health services could be grossly misapplied to the development or expansion of residency training programs in areas of existing institutional health services, particularly primary care. While such programs have a primary educational component, they also inherently have a service component for training purposes and may well entail operating expenditures in excess of the threshold (i.e., for such items as faculty salaries and student stipends alone). However, they do not necessarily bring about the introduction of a new health service or a significant change in the health services available in an area. Where there is clearly no substantial effect on area health services, the AAMC believes that submission of a formal training program proposal to a potentially costly and time consuming review process would be wasteful of the resources of both the applicant and reviewing body. Therefore, the Association urges the Bureau of Health Planning (BHP) to address this issue prior to promulgating final CON regulations and to specifically exempt from review coverage those proposed training program operating expenditures (in excess of \$75,000 annually) that do not involve a significant change in the health services available in an area or the addition of a new health service.

As proposed, it is feared that the amended CON regulations would also include within the scope of review coverage non-patient care related basic research proposals simply because they may represent capital expenditures "made by or on behalf of health care facilities." The AAMC contends that the Bureau's interpretation of the statute does not accurately portray Congressional intent with respect to either manpower projects without significant impact on patient services or proposed non-patient service related expenditures on research programs, facilities, and equipment. In amending Section 1513(e) (1) (B) of the health planning act, Congress specifically provided that both research and training projects under the Public Health Service Act should not be reviewed by HSAs under their "review and approval of proposed uses of federal funds" responsibility when the training project would not alter health service availability, or when the research project would not change the delivery or availability of services to those in an area who are not direct participants in the research. The reasoning appears clear. Congress simply deemed such reviews to be unnecessary by virtue of their lack of significant patient service impact, regardless of the applicant's identity as

May 23, 1980

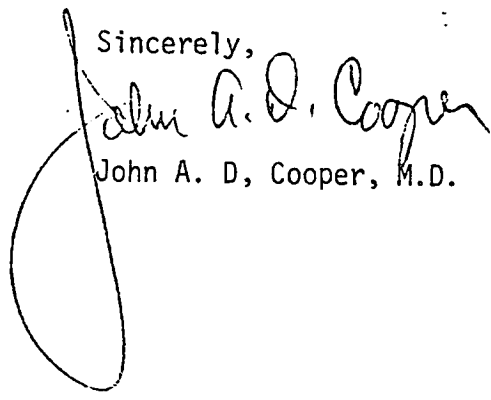
- 3 -

Colin C. Rorrie, Jr.

a "health care facility." Since the above citation is the only acknowledgement in the statute which clearly states Congressional opinion on the issue of research and training projects within only minor health service impacts, the Association calls for the exemption of such projects (and accompanying facilities and equipment) from the CON review process as a more accurate interpretation of legislative intent.

It is our hope that serious consideration will be given to the above recommendations, and that they and the specific comments attached will prove useful in refining the regulations prior to their final publication. I and members of the AAMC staff would be pleased to discuss these matters with you at any time.

Sincerely,



John A. D. Cooper, M.D.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COMMENTS ON THE PROPOSED CERTIFICATE OF

NEED REGULATIONS ISSUED MARCH 26, 1980

1. Procedures for Review

- Section 123.403 (d) of the NPRM requires that each decision of the State Agency to issue a Certificate of Need (CON) must be consistent with the State Health Plan (SHP), except in emergency circumstances. Since review of SHPs occurs triennially and much can change during a three-year period, the AAMC believes that the final regulations should require consideration of the SHP in State Agency decisions and permit written justification for inconsistencies with the plan.
- Relative to Section 123.406 (c) which addresses procedures for proposing construction projects, the AAMC recommends that no more than a 30-day notice of intent should be required to inform the State Agency of the scope and nature of a proposed construction project.
- The Association is supportive of the concept of batch processing as provided in Section 123.410(a) (1) of the proposed regulations. However, we urge that the final regulations include the criteria and procedures for the objective and non-discriminatory consideration of similar applications, and that they be issued only after the Secretary has identified the meaning of "competitive factors" in regulations. In addition, the final regulations should specify that reviewing agencies must give adequate notice to providers of the timetable for the batching and review of applications, and provide for special consideration of applications submitted to address needs of recognized urgency.
- Section 123.410(a) (4) and (5)--the Association firmly supports the provision that the State Agency may not require from a CON applicant whose project is under review any information which is not prescribed and published as being required. However, the AAMC believes that the provision requiring submission of periodic reports by providers on the development of proposals subject to review should be accompanied by a requirement that the State Agency must protect the confidentiality of that information in light of the competitive forces in the service area.

- The provisions under Section 123.410(a) (14) would permit virtually anyone to seek judicial review of a CON decision and further delay the process. The AAMC believes that those able to obtain judicial review in an appropriate state court should be limited only to parties who participated in the public hearing during the course of review and sought administrative review of the decision.
- Section 123.410(a) (17) now prohibits automatic approvals of CON applications when the State Agency fails to reach a decision within the 90-day period allotted it. The AAMC believes that the 90-day review period is a reasonable time within which an administratively effective State Agency should be held accountable to render a decision, and cautions that any protracted procedural delays will only escalate project costs and the potential cost to the public. Therefore, the Association recommends that the final regulations restore the provision which provides for a "pocket approval" to projects which are not processed within the required time. Where a delay is justifiable, the State Agency must first receive the formal agreement of the applicant to postpone the determination of need.

## 2. Scope of CON Review Programs

- In the preamble to the proposed regulations, the "Definition of Health Care Facilities" is discussed and it is stated that "health services are reviewable if they are provided in (emphasis added) or through health care facilities." Section 1531(5) of the planning act is then cited. In reading this Section, the AAMC believes that the definition of institutional health services is clearly explained as meaning those "services provided through (emphasis added) health care facilities". There is no mention of the term "in health care facilities" and was strictly a reference to the provision of inpatient health services, or the acquisition of major medical equipment or a capital expenditure solely for such purposes. Inclusion of the term "in health care facilities" could be interpreted, for example, as subjecting to review those members of a hospital's medical staff or of a medical school's faculty who may lease space from a health care facility for the provision of services or use of medical equipment on an outpatient basis. The AAMC contends that such interpretations were not intended by the statute. Therefore, we call for clarification of this preamble language and elimination of the nebulous term "in" health care facilities.
- Paragraph G on Page 20028 of the proposed regulations states that a CON may be required when a health care facility refinances an existing debt which exceeds the capital expenditure minimum. Such a review would create significant additional hospital expenditures (and cost increases) and deter from a health care facility's ability to lower its internal operational costs. This provision, though not separately described in the regulations, is another case where excessive government regulations would compromise the ability of hospitals to effectively manage their existing debt with the freedom needed in today's unstable money market. For these reasons, the AAMC recommends that this provision be stricken from the regulations.

- Under Section 123.401 -- "Definitions", it is believed that the inclusion of a specific reference to CT Scanners as a separate health service subject to CON review is excessive. The CT Scanner is a type of radiology equipment that has been recognized by Medicare and other payors as medically effective. Therefore, the AAMC contends that CT Scanners should be treated as any other major medical equipment, with costs being the only criteria examined to determine CON review necessity.
- Under Section 123.404(a) (2) and (3), the statutory terms "change in bed capacity" and "change in services" are redefined to include decreases in bed capacity and terminations of services. The AAMC believes this expanded definition will serve to increase the cost and delay of CON reviews by adding to the review burden of the planning agencies and by impeding the voluntary cost containment and capacity reduction efforts of health care facility management. It is recommended that the statutory terms return to their original definitions, or that review at least be limited to proposed reductions or service terminations that exceed the applicable capital expenditure threshold. In addition, the final regulations should be written in a manner that would preclude review of projects in relation to the \$75,000 annual operating expense threshold, when they represent only technological or scientific improvements of existing services, or do not constitute new services or have major cost impact on health services availability or delivery in the service area. In this same regard, the Association reiterates its position that operating and capital expenditures for training and research projects without a significant impact on health services availability or delivery should be explicitly exempted from CON review.
- Section 123.405(b) prescribes exemptions from review for Health Maintenance Organizations (HMOs). In light of the new emphasis on the role of competition in the planning of our health care system, the Association strongly believes that HMOs, which are seeking to capture the patient populations of other health care facilities, should be subject to the same review criteria and procedures as these other "competing" facilities, lest they be given an unfair competitive advantage.
- Section 123.407 addresses special reviews to eliminate imminent fire, building, or life safety code hazards. In the belief that such reviews should be conducted expeditiously, the AAMC recommends that determinations made by the appropriate State and local fire, building, or life safety code review bodies as to the existence of imminent hazards should suffice for the planning agencies' approval of the proposal to eliminate them. In addition, the regulations should require the reviewing agencies to establish a definite reduced time schedule for review and determinations of such applications, as well as other kinds of projects which would essentially have minimal impact on the health care system, such as repair, replacement or maintenance projects requiring capital expenditures.



### 3. Access To Services

- The data required in Section 123.412(a) (5) and (6) to demonstrate access to proposed services would be difficult, if not impossible to compile. Utilization data are not commonly maintained by hospitals on the basis of race, ethnic origin, income level and handicap status. In many instances, hospitals may not even be legally permitted to obtain such information from the patient (Medicare and Medicaid beneficiaries included) upon admission. Instead, a more realistic approach would be to require applicants to provide data which disproves non-equal access when such is suggested by data known to the reviewing agency.
- Section (a) (6) (II) recommends that HSA and State Agency CON reviews include consideration of the applicant's past performance in meeting uncompensated care and community service obligations under federal assistance programs. To require the reviewing body to perform Hill-Burton compliance evaluations for purposes of Certificate Of Need review would not only be duplicative of the efforts of the Hill-Burton agency and a clear case of excessive government regulation, but also would require the performance of an assessment which the planning agencies are not authorized to conduct. The reviewing agency is also encouraged in the NPRM to consider the existence of any unresolvent (sic) civil rights access complaints against the applicant. Since an unresolved case is, by definition, one which has yet to receive a final ruling by an appropriate court, consideration of this information as criteria in the CON process may well be a violation of the applicant's due process rights. The AAMC recommends the removal of this provision from the regulations.
- The access criteria should, according to Section 123.412(a) (6) (III), include consideration by the planning agencies of the extent to which physicians with admitting privileges at the applicant's facility admit Medicare and Medicaid patients. Consideration of such data, if available, could serve to unfairly penalize a hospital for a situation over which it has no control, since neither Medicare nor Medicaid require physicians to accept their beneficiaries. The AAMC recommends the elimination of this provision from the regulations.
- Section 123.412(a) (6) (IV) recommends that the access criteria include consideration by the planning agencies of the extent to which the applicant offers alternative means of access to its services, other than through admission by a physician. This criterion fails to recognize the fact that admission to hospitals, whether through the admissions department, emergency room or clinic, requires (by law in most instances) the order of a physician. The AAMC recommends that this criterion be deleted from the regulations.
- The access criteria in Section 123.412(a) (6) suggested for consideration by HSAs and State Agencies in their Certificate Of Need reviews would not necessarily be directly related to the service being proposed. The final regulations should limit any and all conditions for CON approval only to those criteria reasonably related to the proposed project under review.

#### 4. Other Criteria for CON Review

- Section 123.412(a) (8) would encourage the reviewing agencies to assess the applicant's resources (including personnel and funds) and evaluate alternative uses of them for the provision of other health services. The AAMC strongly objects to this provision for it would essentially empower the planning agency with defacto authority to tell the applicant how best to use its resources. This would be excessive use of regulatory authority to infringe on management prerogative and should be deleted from the regulations. At the same time, Section 123.412(a) (17) would require consideration of the effect of competition on the supply of health services being reviewed. The two provisions appear to be contradictions in terms. The former criterion would serve to limit and discourage applicant initiative to make improvements in the health care system, while the latter seeks to enhance competition, an area in need of greater definition in the regulations. The latter provision should be eliminated from these regulations as well. The factors relative to competitive effects should be clearly identified in separate regulations addressing the new emphasis on the role of competition, as introduced in the planning amendments.
- Section 123.412(a) (19) would require consideration of the "appropriateness" of existing services and facilities similar to those proposed. Aside from the obvious question of whether the timing of Certificate Of Need and appropriateness review can be coordinated appropriately, the conditioning of a CON finding on a appropriateness finding could clearly constitute the imposition of sanctions on the applicant which, according to the final appropriateness review regulations, are a matter requiring state legislative enactment. The Association, therefore, urges that this provision be deleted from the regulations.
- In the case of existing services or facilities under review, Section 123.412(a) (20) calls upon the HSAs and State Agencies to consider the quality of care provided by those facilities in the past. Even among investigators who have for many years sought to find the most appropriate means for measuring the quality of care, there is great disparity of thought. The state of the art is still in an early stage. The AAMC would not include HSAs and State Agencies among those with expertise in quality of care measurement and does not believe they are qualified to make such determinations. Therefore, the Association also recommends removal of this criteria at this juncture in the state of the art of quality care assessment.

#### 5. Effective Dates

- According to the proposed regulations, the effective date for those portions of the amendments that require legislative changes is determined as follows: (1) If the legislature of the state was in regular session on October 4, 1979, and the legislature will be in session for at least twelve months from that date, the effective

date is October 4, 1980; (2) For all other states, the effective date is twelve months from the date of the beginning of the first regular session of the legislature beginning after October 4, 1979. While most states will have to enact revised CON legislation by January 1, 1981, some must do so as early as October 1980. In either case, the AAMC believes that the regulations provide insufficient time for legislatures to adopt the necessary amendments to their CON laws or risk losing their state's planning program funding. The Association does not believe that Congress intended that states have so little time to comply and that the effective date, as amended, would more accurately be interpreted as requiring that states enact necessary legislation during the first regular legislative session that begins on or after October 4, 1980. Assuming that final regulations will be issued in a timely manner, amending them to this interpretation should allow states at least one year to make the necessary modifications to their laws. The AAMC recommends such an amendment to the regulations and would endorse, if deemed necessary, any legislative proposal at the national level that would extend the compliance deadline at least one year from the date of publication of final regulations.



# association of american medical colleges

JOHN A. D. COOPER, M.D., PH.D.  
PRESIDENT

202: 828-0460

June 2, 1980

Mr. Earl Collier  
Acting Administrator  
Health Care Financing Administration  
Department of Health and Human  
Services  
P.O. Box 17073  
Baltimore, Maryland 21235

RE: Proposed Schedule of Limits  
on Routine Operating Costs,  
File Code BPP-26-PN

Dear Mr. Collier:

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to comment on the proposed schedule of limits on hospital inpatient routine operating costs that was published on April 1, 1980 in the Federal Register. The Association represents all of the nation's medical schools; 70 academic societies, and 330 non-profit, major teaching hospitals which participate in the Medicare program. These hospitals account for approximately five percent of all non-federal, short-term hospitals; 18 percent of all admissions; and approximately 30 percent of all hospital outpatient services. In addition, they typically provide a wide range of tertiary care, referral services to intensely ill patients and sponsor or participate in most of the nation's medical education programs. Thus, limits on Medicare hospital payments which may affect the educational programs, research, and patient care responsibilities of teaching hospitals are of direct interest to the Association and its members.

## POLICY ISSUES

As stated in P.L. 92-603, Section 223 defines reasonable costs for reimbursement under the Medicare program as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The report of the Senate Finance Committee on P.L. 92-603 noted that these costs are those "that flow from marked inefficiency in operation or conditions of excessive service" and that institutions "should not be shielded from the economic consequences of its inefficiency." Furthermore, the report said that "health care institutions like other entities in our economy should be encouraged to perform efficiently and when they fail to do so should expect to suffer the financial consequences." Thus, Section 223 was designed by Congress to address inefficiency and unnecessary or excessive services.

Since 1974, when the Section 223 regulations were initially enforced, the Association has repeatedly argued that the methodology used to construct the limits is not consistent with Congressional intent. Limits have been promulgated annually, but no criteria have been developed to measure "efficiency"; HCFA has not attempted to define what services are "unnecessary"; and the methodology has never incorporated any indicator of "excessive service." Instead, Section 223 limits have been arbitrary and superficial and have been used to meet budgetary goals rather than to screen inefficient hospitals. The limitations have not been used to penalize inefficiency or encourage efficiency, but as a cost containment measure to limit Medicare spending. Significantly, last fall the House of Representatives endorsed the health industry's Voluntary Effort which continues to be successful. It is inconsistent both in light of original P.L. 92-603 legislative language as well as the recent Congressional vote on cost containment to use Section 223 as a method to impose mandatory cost controls on approximately one fifth of the nation's hospitals.

#### TECHNICAL ISSUES

The Association recognizes that the methodology employed to determine the limits is somewhat more equitable than the highly deficient methods used in the past. The addition of the educational adjustment, in particular, and the expanded definition of labor costs result in better comparisons of hospital costs. However, methodological weaknesses exist that could be corrected:

- the methodology used to classify hospitals does not result in homogeneous groups of hospitals,
- energy and malpractice costs which are highly variable should be excluded,
- the adjustment factor for education needs modification and clarification,
- the process of adjusting for errors in cost projections needs additional explanation,
- the exception process is inadequate, and
- the limits do not recognize the costs associated with the provision of complex, tertiary care services to intensely ill patients.

In commenting on these deficiencies, specific recommendations are given which are reasonable and could be incorporated in the methodology.

### Classification of Hospitals

The Senate Finance Committee report on Section 223 of P.L. 92-603 stated that "costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of services provided, the type of patient treated, the location of the institution and various other factors affecting the efficient delivery of needed health services." The report went on to say that "to the extent that differences in provider costs can be expected to result from such factors . . . recognition should be given to the variations in costs accepted as reasonable." The present classification scheme takes only two variables into account: bedsize and urban/rural location. The seven groups resulting from this classification system have a range of only \$10 for the group's base limits. In other words, bedsize and urban/rural location as used in the methodology apparently explain very little of the differences in routine inpatient operating costs among hospitals, yet are used as the principle grouping variables. The deficiencies introduced by this simplistic approach are not corrected or ameliorated by the subsequent adjustments for local wages, education, and covered days of care. The adjustments are nothing more than alterations to an inadequate cross classification approach.

The deficiencies of this simplistic classification scheme is most apparent when regional comparisons are made. According to HCFA data, nine percent of all COTH members in the south are projected to be over the limit, compared to 17 percent in the northeast, 30 percent in the west, and 40 percent in the midwest. Certainly, these wide regional variations in penalties cannot be attributed merely to inefficiency.

Within the midwest region, those most seriously penalized are county and municipal hospitals. For example, five such hospitals are estimated to have per diem routine costs that will exceed the limits by the following amounts: \$82, \$68, \$62, \$61, and \$54. If the HCFA projections are correct, penalties for these five institutions will total over \$11 million. The Department of Health and Human Services has appointed a task force to assess the financial plight of municipal hospitals and Congress has held special hearings. As these discussions proceed, the Association strongly believes that the impact of Section 223 limits on some of these institutions should be closely examined.

### Patient Case Mix

Patient case mix has a substantial effect on hospital costs. For example, as early as 1977, Martin Feldstein reported in Economic Analysis for Health Service Efficiency that case mix could account for 25 percent of the variation in per case costs across hospitals. As mentioned above, the legislative history of Section 223 recognizes that hospital costs vary with the nature and scope of services provided and the type of patient treated. Despite the evidence in the literature and stated legislative intent, case mix complexity has yet to be included in the methodology.

Although case mix measures and applications are in their infancy and the current popular measures may have serious weaknesses, the Association:

- supports further research funding by HCFA to examine the strengths, weaknesses, and limitations of applying existing case mix measures to reimbursement methodologies; and
- supports further research funding by HCFA to develop new case mix measures which might best reflect a hospital's case mix and the resources required to treat that case mix.

It is premature to incorporate a case mix measure in this year's proposed limits. However, more explicit guidelines for exceptions based on case mix should be made publicly available so that children's hospitals, other specialty hospitals, and tertiary care centers, which have intensely ill patients requiring a wide range of services, may be granted an exception in a timely fashion.

#### Excluded Costs

If a cross classification approach to comparing hospital costs is adopted, the Association supports the exclusion of or adjustments for atypical or uncontrollable costs. Exclusions should be incorporated in the methodology if the resulting cross classification scheme provides more homogeneous groups of hospitals. The exclusion of medical education and capital related costs, which was initiated last year, was an appropriate step. In addition to excluding these costs, the Association strongly recommends that adjustments or exclusions from the definition of routine costs be made for the following two costs:

- Energy Costs -- energy sources and costs are largely explainable by regional location. One would expect hospitals in cold climates where oil is the predominantly used fuel to incur substantially higher heating bills than those incurred by hospitals in moderate climates. Adjustments to limits for atypical energy costs could be constructed in a manner that is consistent with energy conservation goals but recognizes legitimate variations in local energy prices and consumption.
- Malpractice Insurance Costs -- malpractice claims and settlement experiences vary significantly in different areas of the nation. Excluding these costs would help to ensure that the costs remaining in routine operating services more closely reflect the costs of operation within the control of the hospital.

#### Establishing the Limits

The Association is opposed to a simplistic approach which equates statistical variations in costs with unnecessary, inefficient, or excessive costs. The explanatory language in the proposed schedule of limits states the "refinements to our

methodology for deriving and adjusting the limits significantly improve the provision with which individual hospitals' limits can be determined and thereby justify use of an implicit factor that is smaller than the 15 percent allowance we used published on June 1, 1979." This justification is totally inappropriate because last year's proposal to use 115 percent of the mean limits was found to be arbitrary, geographically inequitable, and was never implemented. Even with the changes in the methodology under the proposed regulations, the 12 percent allowance, which is even lower than the indefensible 15 percent limit, still arbitrarily impacts some groups of hospitals more than others. Because the methodology does not exclude many costs that are uncontrollable by the hospital, the Association strongly opposes limits set at 112 percent of the means for labor and non-labor costs.

### Adjustments to Limits

#### Education Cost Adjustment

In previous letters of comment on Section 223, the Association has repeatedly argued that teaching hospitals experience atypical costs associated with their commitment to educating physicians and other health professionals. These costs include the direct costs of resident stipends and benefits, faculty compensation, educational supplies, and space. In addition, there are many indirect costs resulting from the presence of physicians-in-training. The Association is extremely pleased that the proposed limits explicitly recognize that both direct and indirect costs exist, and accordingly, have made adjustments for teaching hospitals.

The proposed measure used to make the educational cost adjustment is the number of full-time-equivalent interns and residents in approved educational programs. The Association supports the concept of using the number of physicians in graduate programs in adjusting a hospital's limit. However, limiting the number to only interns and residents in approved programs is inappropriate. Teaching hospitals are the settings for the subspecialty training of clinical fellows. Although many clinical fellows are funded by non-patient care revenues, they do have the same if not a greater impact on hospital routine costs than interns and residents do. The proposed notice cites the maintenance of more detailed and complete medical records as one example of the indirect costs of graduate medical education. The Association believes this is true for clinical fellows as well as for interns and residents. The importance of documenting a patient's condition and treatment is stressed at all levels of medical education, including subspecialty training. The number of clinical fellows in the nation represents only a small fraction of the total number of residents, but for some hospitals, the number is quite high and their impact on hospital costs is significant. Thus, the Association strongly recommends that:

- the education cost adjustment to a hospital's limit include not only the number of FTE interns and residents, but the number of FTE clinical fellows as well.



In constructing the proposed limits the Association was informed that the Medicare certification survey completed by each hospital was the primary source used to obtain the number of FTE interns and residents. Some of the figures reported for individual hospitals appear to be inaccurate. The Association believes that HCFA should make comparisons between this data and the figures actually reported by hospitals to their intermediaries under the proposed guidelines so that the accuracy of the proposed limits may be assessed. In addition, assuming the educational cost adjustment will be continued in setting future limits, the Association recommends that:

- the number of FTE interns, residents, and clinical fellows as defined by the final notice that are actually reported to the intermediary for the purposes of Section 223 should be used to set the group limits rather than data obtained from surveys used for other purposes.

According to the proposed payment limitations, the education cost adjustment is applied to "the hospital's limit as computed under steps 1-6." However, the education cost adjustment appears as the eighth step in setting the limits. Thus, the final notice of limits should state:

- for those hospitals which received an adjustment for covered days of care (step 7), the educational adjustment applies to the limit calculated under steps 1-7, not steps 1-6.

#### Wage Index

In order for a hospital to provide quality medical care, it must provide benefits and set its wage scale at a level which will attract and retain a sufficient number and mix of health professionals needed to treat its patients. There are also other services a hospital must purchase for which the price is directly related to local wage rates. For these reasons, the Association is pleased that the proposed regulations have expanded the definition of labor related costs to reflect more accurately the effect of local wages on routine operating costs.

In supporting the expanded definition of labor related costs, the Association would like to reiterate that regional biases in the limits persist. The midwestern and western hospitals still bear a disproportionate share of the penalties despite no empirical evidence that hospitals in these areas are less efficient or wasteful. This bias is one example of the undesirable consequences of setting limits based on statistical variations rather than empirical, documented evidence of excessive, unnecessary costs.

#### Projecting and Trending Data

No matter how sophisticated or equitable the hospital classification is, the proposed limits will have serious deficiencies if the market basket projections are not accurate. The Association recognizes and appreciates that

the market basket index has been carefully developed and has attempted to include examination of a wide variety of data sources. However, the market basket index is deficient in that it measures only the increased costs of a constant set of commodities. It does not account for changes in the mix of goods and services purchased by hospitals. The distinction in what is measured by the index is critical for tertiary care hospitals. As health planning and peer review activities concentrate the more complex cases in tertiary care hospitals, these hospitals are finding that a significant portion of their increase in costs results from a need to purchase more of the relatively expensive goods and services. In order to recognize this factor, the Association recommends:

- that the market basket index used in the proposed regulations be supplemented by an additional index to account for changes in the composition of the market basket.

The proposed regulations state that "the projected rate of increase in the market basket index will be adjusted if the actual rate of the increase is more than .3 of 1 percentage point above the estimated rate." Furthermore, the proposed notice states that "the actual rate of increase will be published in the Federal Register and will be used to adjust a hospital's cost limit at time of final settlement." The methodology for creating the market basket index is sufficiently outlined in the proposed limits. However, the Association is concerned that when adjustments are made and published, the calculations and statistics used for the individual components of the index are not explicitly outlined. Because of the importance of accurately estimating this index, the Association strongly recommends:

- that the detailed projections and sources of data used to arrive at the estimate of actual cost increases be published in the Federal Register, and
- that the actual rate of increase as estimated by the market basket index be published in the Federal Register, even if the rate is below the .3 of 1 percentage adjustment threshold.

#### Exception Process

Experience gained since the development and initial implementation of Section 223 has demonstrated the urgent need for a viable, timely exception and appeal process. An effective and equitable process has not functioned under the present Section 223 cost limitations. On July 10, 1979, approximately 100 members of the Council of Teaching Hospitals met with Leonard Schaeffer and other HCFA officials to discuss Section 223. At that meeting, these concerns were expressed about the exception process, and assurances were made that HCFA was in the process of developing more explicit guidelines for the exception process which would be available to all hospitals in the near future. Similar

June 2, 1980

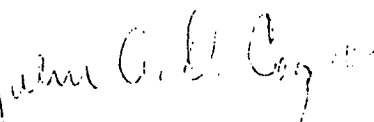
promises were made last fall, but no such document has been published yet. To facilitate the process for those hospitals which legitimately have atypical costs, the Association urges that:

- explicit guidelines describing the exception process and the criteria used to rule on these requests be published promptly.

#### CONCLUSION

Since the 1974 regulations establishing routine service payment limitations, the Association has objected to the methodology to determine limitations. The methodology proposed in the April 1, 1980 Federal Register reduces two of the deficiencies of prior methods by recognizing the indirect costs of medical education and by more accurately accounting for the impact of local wages on routine operating costs. Nevertheless, the methodology still falls short of measuring in any meaningful, defensible way the purported sources of concern -- inefficiency and the provision of unnecessary services. The Association in this letter of comment has provided realistic recommendations which could be easily implemented within the final notice of the schedule of limits. For example, further corrections should be made for regional biases; energy and malpractice insurance costs should be excluded from the definition of routine operating costs; the method of counting the number of interns and residents should be modified; adjustments to the market basket index projections should be explicitly outlined; and guidelines for the exception process should be formalized and published. The Association would be pleased to work directly with HCFA officials to further comment upon and implement these recommendations.

Sincerely,



John A.D. Cooper, M.D.



# association of american medical colleges

JOHN A. D. COOPER, M.D., PH.D.  
PRESIDENT

May 27, 1980

202: 828-0460

Mr. Leonard D. Schaeffer  
Administrator  
Health Care Financing Administration  
Department of Health and Human  
Services  
Room 5220, Switzer Building  
330 C Street, S.W.  
Washington, D.C. 20013

Dear Mr. Schaeffer:

The Association of American Medical Colleges is pleased to have this opportunity to comment on proposed HCFA regulations, RDS-1-P, "Medicare and Medicaid Programs, Annual Hospital Report." This proposed regulation is of direct interest to the Association's members, especially to the 325 major not-for-profit, municipal, and state hospitals belonging to the Association's Council of Teaching Hospitals.

The Association is strongly opposed to the proposed HCFA regulation of March 19th which would impose the Annual Hospital Report (AHR). AHR, like its predecessor SHUR, is seriously deficient as a uniform reporting system for both policy and technical reasons. Therefore, the AAMC urges the Health Care Financing Administration to withdraw the Notice of Proposed Rulemaking and to develop a reasonable and concise reporting system which minimizes compliance costs at hospital, intermediary, and Federal agency levels.

## POLICY CONCERNS

### Excessive Use of Authority

Section 19 of P.L. 95-142, clearly provides the Secretary of HHS with the authority to develop and implement a uniform reporting system for hospitals. In addition, the language of the Act and of the Ways and Means Committee Report clearly indicate that Congress did not grant the Secretary authority to implement a uniform hospital accounting system:

In reporting under such a (uniform) system, hospitals shall employ such chart of accounts, definitions, principles, and statistics as the Secretary may prescribe in order to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary. (Emphasis added. 42 U.S.C. Section 1320(a)).

Although proposals have been made to require uniform accounting as well as uniform reporting, the bill does not mandate a uniform accounting system. Your Committee was not prepared to conclude that a uniform accounting system is necessary in order to generate the required comparable data. (Emphasis added. H.R. Report No. 393, Part 1, 95th Congress).

The Annual Report for Hospitals is essentially a uniform hospital accounting system because the proposed functional reporting of costs and revenues requires that in-depth accounting and statistical records be developed and maintained on an AHR-compatible basis throughout the year. This is contrary to the Congressional intent.

The AAMC is opposed to mandating a uniform accounting system for hospitals, believes the law does not require such an accounting system, and recognizes the Congressional intent that uniform reporting would not require uniform accounting. Therefore, the AAMC urges HHS to immediately withdraw the Annual Hospital Report.

#### Requirement of Excessive Information

The creation and maintenance of financial and statistical information is expensive. If such information is collected but unused, the hospital's expenditure of time and effort is wasteful. In an era of increased cost consciousness of hospital operations, HHS should strive to minimize Federally imposed costs and waste. Unfortunately, the Annual Hospital Report is not oriented in this direction. In many instances, the AHR attempts to justify the collection of data by citing undefined health planning, rate setting, and national health insurance uses for the data. Because these uses are undefined, however, it is unclear what use will be made of the required recordkeeping. AHR does not attempt to minimize reporting requirements, to use estimated and sample data, or to use aggregate level reporting. Therefore, the AAMC is opposed to AHR and its implicit requirement for costly recordkeeping in the absence of clearly defined uses for the collected data.

#### Reporting and Reimbursement

A uniform reporting system should attempt to obtain comparable data from all reporting parties. In accomplishing this objective, distinctive organizational characteristics and features will be masked in the interest of uniformity. This principle is contrary to the principles of hospital reimbursement which have been established to pay hospitals for the true cost of providing their distinctive program of patient and community services. This contraction of principles can not be reconciled. If the reporting system accepts the distinctiveness principle, uniformity will be undermined; if the reimbursement system accepts the uniformity principles, equity will be undermined. The current version of the AHR fails to accept this dilemma. It proposes to use AHR as a basis for reimbursement.

The AAMC is opposed to using Annual Hospital Reports for hospital reimbursement. If the Medicare program is to fulfill its legal mandate to pay all of the costs of caring for Medicare beneficiaries, the Medicare reimbursement reports must be retained as separate and distinct from those promulgated for uniform reporting.

#### Paying for Uniform Reporting

The introduction and maintenance of a uniform reporting system for hospitals will increase the costs of a hospital's operation without increasing the number or volume of services it provides to its patients. At the institutional level, the costs of uniform reporting are contrary to the present emphasis on cost containment, improved productivity, and hospital efficiency. Because of these contradictions and in recognition of the fact that the hospitals would be adopting a uniform system solely because of a Federal government requirement, the AAMC believes HCFA should pay for the costs of implementing any uniform reporting system on a dollar-for-dollar basis using the Medicare reimbursement system. Such costs should be excluded from the determination of any payment limitation, including present and proposed routine service limitations.

#### TECHNICAL CONCERNS

##### Simplicity of Reporting

The proposed Annual Hospital Report incorporates accounting and data collection principles imposing unique, special, and costly recordkeeping requirements. The AAMC does not believe these unique recordkeeping requirements can be justified if their costs and benefits are compared. To obtain a cost effective system, the AAMC strongly recommends development of a uniform reporting program which includes the following principles:

- audited financial statements prepared in accordance with generally accepted accounting principles (GAAP) should be used for balance sheet, income statement, fund balance, and financial position data. Where HCFA seeks to impose a restraint or limitation on GAAP, a brief reconciliation schedule should be used to convert audited financial statements to HCFA reporting requirements.
- functional cost centers should be consolidated to obtain the minimum number of centers necessary to characterize major hospital similarities and differences.
- statistical reclassification entries and sampling procedures should be used whenever practical and reasonable. And,
- the materiality concept should be applied at the institutional rather than cost center level.

The adoption of these principles and their incorporation in a uniform reporting system would substantially contribute to the system's efficiency and cost effectiveness.

#### INFORMATION DISCLOSURE

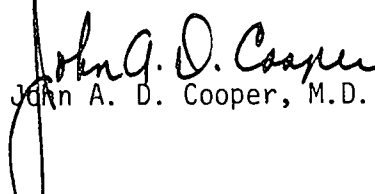
The Notice of Proposed Rulemaking advocates making all information submitted on Annual Hospital Reports publicly available. This proposed position is highly undesirable.

Hospitals are economic enterprises with social and public purposes. They are in competition with one another and with other sources of medical care. Financial, statistical, and operational data are business property which should not be publicly released unless there is a clear and over-riding public purpose served by such disclosure. To assist physicians and patients in making cost conscious decisions, the AAMC supports publishing data on the charges made for standard hospital services and for routine ancillary services. The Association would oppose, however, publicly releasing data on individual salaries, manning levels of specific services, or contract arrangements for purchased services. Such disclosure would tend to penalize efficient hospitals by failing to protect both proprietary knowledge and business acumen. Thus, the AAMC recommends that data from any uniform reporting system be considered confidential unless it is clearly necessary for the efficient operation of another government agency and permission for the release of the information has been formally obtained from the identified hospitals.

#### SUMMARY

While the AAMC supports the general concept of uniform hospital reporting, the Association opposes the proposed AHR system because it is an excessive use of the Secretary's authority, requires excessive information, combines reporting and reimbursement, and fails to provide necessary additional revenue for system introduction and maintenance. In lieu of AHR, the AAMC recommends a reporting system which uses audited financial statements, consolidated cost centers, statistically reclassified entries and sampling procedures, and a more liberalized concept of materiality. Finally, the AAMC recommends data from any uniform reporting system be considered confidential unless the particular item of data is necessary for the efficient operation of another government agency and formal, written consent has been obtained from the identified hospitals.

Sincerely,

  
John A. D. Cooper, M.D.

NATIONAL HEALTH INSURANCE AND ITS IMPLICATIONS  
FOR ACADEMIC HEALTH CENTERS

Presented to

The Association of American University Presidents

Washington, D.C.

April 21, 1980

by

John W. Colloton

Director, University of Iowa Hospitals and Clinics  
and Assistant to the University President for Health Services

and

Chairman, Council of Teaching Hospitals,  
Association of American Medical Colleges

(Submitted for publication. Not for quotation or distribution  
except to AAU member universities for internal use.)



## Introduction

I am pleased to have this opportunity to discuss with your Association some of the present challenges to our university academic health centers arising from the changing financial and political climate in this nation. Health care is being scrutinized to an unprecedented degree and a wide variety of concepts and proposals designed to change the financing and delivery of patient care are being espoused and implemented. One focus of these proposals has been the continuing debate relating to national health insurance. A full review of the potential impact of national health insurance on academic health centers requires an analysis not only of the financing of health services, but also proposals to reorganize health care delivery, the impact of present and proposed regulatory initiatives, quality of care issues, health planning implications, and a host of others. To narrow the issues somewhat, Chancellor Danforth has asked that I focus on specific areas of particular interest to University Presidents.

Therefore, in today's remarks I will briefly outline the history of federal involvement in health care issues; second, present an overview of current national health insurance proposals focusing particularly on evolving competitive models; third, examine the potential effect of these proposals on academic health centers; and finally, discuss some initiatives academic health centers should be taking to substantiate, communicate, and preserve their unique central role in any future health care system that evolves.

## Historical Perspective

The federal involvement in health care began in 1798 with passage of the Marine Hospital Service Act, the precursor of the Public Health Service. The initial effort toward a nationwide governmental health insurance program was the pre-World War I campaign of the American Association for Labor Legislation

which unsuccessfully advocated state government sponsored health insurance. Then in 1932 the Committee on the Costs of Medical Care, another voluntary body, published a report which proposed a national health insurance program. A similar program, proposed by President Franklin Roosevelt's cabinet-level Committee on Economic Security, was ignored by the Congress. Instead, the federal-state partnership in health was expanded in 1935 through the Social Security Act's formula grant programs for maternal and child health and crippled children's services.

President Truman, during the late 1940's, outlined a national health program in a succession of health messages, but few members of the Congress accepted the idea seriously. The growth in private insurance coverage, especially employer-financed coverage during World War II, had extended benefits to a large proportion of the population reducing the need for a national program providing coverage for all. However, concern for the elderly and the poor not covered by these plans led Congress in 1960 to enact the Kerr-Mills bill which provided matching grants-in-aid to states for the medically indigent aged and culminated in the passage of Medicare and Medicaid in 1965 under the stewardship of President Lyndon Johnson.

#### Present Environment in the United States

Although Medicare and Medicaid were considered forerunners of national health insurance at the time of their enactment, they have led some authorities to conclude that another massive infusion of federal funds into the health care system, in the absence of restructuring or reform, will only accelerate the rise in health care costs. The Congress, disappointed with the behavior of the health industry under intense regulation, is now turning to new approaches with a strong orientation to marketplace incentives and eventual curtailment of the severe

regulatory environment now prevailing. This approach, together with the acknowledged diversity and complexity of the health system, has resulted in recent legislative proposals that are more conservative in nature than any proposed during the past decade.

In contrast with traditional conclusions regarding the incompatibility of the health system and marketplace economics, some academic and congressional authorities are now of the opinion that the delivery of health services is not "unique" and that normal supply, demand, investment, choice, and efficiency characteristics of the marketplace can be made to apply. This may be partly true. However, underlying the competitive marketplace approaches is the assumption that hospitals provide a relatively standardized product which is identifiable in terms of cost and quality. This assumption raises several questions for the nation's teaching hospitals which have multiple products benefiting not only the individual patient, but society as a whole. Because these activities result in higher costs, presently financed through patient care revenues, price competition could jeopardize the future capacity of teaching hospitals to meet their multiple responsibilities, including medical education, new technology testing, clinical research, significant charity care, specialized services, and extensive ambulatory care programs operating on a subsidized basis. An underlying theme of this paper is that academic health centers must secure special attention and consideration in any program of marketplace competition or other form of national health insurance. The diverse and conflicting models of national health insurance engaging congressional attention make it essential that the unique characteristics and responsibilities of academic health centers be recognized and that a strategy be developed that will ensure the future viability of these national resources.

Various estimates indicate that twenty million Americans have no health insurance, either public or private, and that an additional ten percent of the

population has inadequate coverage.<sup>1,2</sup> Together, these two groups include about twenty percent of the United States' population. Any effort to fund expanded coverage for these citizens will impose an additional tax burden on the remaining eighty percent. During a period of inflation and economic stagnation, the prospect of placing further tax burdens on the population is obviously less likely than during a period of steady growth. However, it is clear that attention will continue to be focused on present gaps in coverage and that pressures will continue for control and reallocation of dollars to accommodate the underserved.

Most national health insurance proposals currently before the United States Congress address the issue of increased entitlement to provide benefits to those citizens not now adequately covered. This increased entitlement will undoubtedly increase health care costs. Each proposal thus represents a balancing of increased entitlements and benefits to those presently not covered with the attendant problems of financing and cost containment. Representative David A. Stockman (R-Mich.) recently made a forthright statement on the linkage of these issues when he said, "I think we are simply out of our minds as a Congress, as federal policymakers, if we plunge into National Health Insurance in the sense of further expansion of demand and entitlements before we make any real, appreciable progress on the cost containment side of the ledger."<sup>3</sup> Representative Stockman is convinced that fundamental reappraisals of our basic ideas about health care markets and the dynamics of growth in hospital costs are required, underscoring the need to expand discussion of national health insurance in order to prevent a hasty advance into what could become a national health quagmire.

There are in this nation proponents of national health insurance who support increased doses of federal regulation throughout the health care system, while there are others, such as Dr. Alain Enthoven of Stanford University and

Dr. Paul Ellwood of Interstudy who prefer the creation of "constructive competition" as an alternative. Considering the size and complexity of the health field and the number of talented academicians and analysts working in the field, the volume of analyses and alternative proposals which has emanated from within the system has been meager. A small group of individuals has done almost all of the work and is receiving a great deal of attention with respect to competitive proposals. There is a critical need for more ideas from within the health care field. As Moscato has recently indicated, "...even with the national congressional capacity for research and analysis, new ideas must come from the health community before these can be encouraged or required by law."<sup>4</sup>

#### General Implications for Academic Health Centers

"National Health Insurance," in all its proposed forms, presents a serious challenge to academic health centers. Expansion of the proportion of patients and financing sponsored by the federal government will intensify present constrictive forces arising from federal financing. Since a host of academic health center programs are heavily dependent on cash flow arising from patient service functions, they will be imperiled in the reformulation of patient care financing under national health insurance. Further restructuring of the health care delivery system will introduce new complexities which we cannot predict. However, one should consider what is at risk.

Academic health centers contribute substantially to the health care needs of the American people. In fact, the 323 non-federal short-term teaching hospitals comprising the Council of Teaching Hospitals of the Association of American Medical Colleges constitute only five percent<sup>5</sup> of all United States hospitals but they:

- a) admit approximately 20 percent of patients hospitalized in the United States,<sup>6</sup>
- b) accommodate 31 percent of hospital ambulatory patients,<sup>7</sup>

- c) operate more than half of the burn care units of our nation,<sup>8</sup>
- d) supply 44 percent of organ transplant services,<sup>9</sup>
- e) provide 40 percent of open heart surgical services, and<sup>10</sup>
- f) operate more than one-third of the nation's newborn intensive care units.<sup>11</sup>

Health science educational programs dependent upon these hospitals involve more than 600 health science colleges providing instruction to more than 215,000 students in medicine, dentistry, nursing, pharmacy and public health, in addition to 56,000 resident physicians in specialty training and an array of allied health trainees. The 30 teaching hospitals owned by member universities of the AAU currently provide the training environment for approximately 47 percent of all undergraduate medical students<sup>12</sup> and 21 percent of all resident physicians<sup>13</sup> in the United States.

Supporting these programs in AAU health centers is an annual cash flow from patient care services of \$2.5 billion dollars, composed of \$2.2 billion<sup>14</sup> of hospital revenues and \$314 million<sup>15</sup> of medical service revenues, based on 1978 data. This was approximately 23 percent of total revenues of all AAU members which own teaching hospitals. The comparable cash flow figures for all 113 medical schools and 323 non-federal affiliated teaching hospitals are \$14.5 billion for hospitals and \$514 million for medical services. A profile of present dollars flowing into AAU universities as reimbursement for health care services is set forth in Table I. Table II profiles health education colleges and student enrollment of AAU members. These two tables show the magnitude of dollars and societal resources in AAU academic health centers which will be at risk in the creation of mechanisms for financing national health insurance.

TABLE I

ANALYSIS OF ASSOCIATION OF AMERICAN UNIVERSITY BUDGETS  
TOTAL UNIVERSITY BUDGETS VS. HEALTH CARE EARNINGS ELEMENTS  
Fiscal Year 1978  
(000 Omitted)

A.A.U. MEMBER	Total University Budget	UNIVERSITY-OWNED TEACH- ING HOSPITAL BUDGET	
		Total	% of U Budget
<u>Members Owning University Hospital:</u>			
Duke University.....	\$ 196,074	\$ 101,517	51.3%
Indiana University.....	413,047	58,514	14.2
New York University.....	325,050	75,399	23.3
Ohio State University.....	383,227	82,420	21.5
Pennsylvania State University.....	337,013	33,982	10.1
Stanford University.....	369,871	95,179	25.7
University of California (Los Angeles).....	475,871	106,990	22.5
University of California System.....	1,108,270	273,421	24.7
University of Chicago.....	478,914	110,683	23.1
University of Colorado.....	241,395	44,483	18.4
University of Illinois.....	527,210	73,656	14.0
University of Iowa.....	241,950	83,369	34.5
University of Kansas.....	177,127	84,391	47.6
University of Maryland.....	367,336	82,880	22.6
University of Michigan.....	474,975	108,970	22.9
University of Minnesota.....	545,857	89,096	16.3
University of Missouri.....	308,955	45,021	14.6
University of Nebraska.....	224,777	29,806	13.3
University of North Carolina.....	632,951	75,219	11.9
University of Oregon.....	160,701	65,277	40.6
University of Pennsylvania.....	324,041	119,327	36.8
University of Rochester.....	209,765	85,159	40.6
University of Texas.....	743,667	65,670	8.8
University of Virginia.....	203,570	55,297	27.2
University of Washington.....	330,017	65,338	19.8
University of Wisconsin.....	751,644	47,661	6.3
Vanderbilt University.....	142,262	58,515	41.1
Subtotal.....	\$ (10,695,537)	\$ (2,217,840)	(20.7%)
Medical Service Plan Revenues.....			(2.1%)
			\$ (222,428)
<u>Members Not Owning University Hospital:</u>			
Brown University.....	\$ 66,893		
California Institute of Technology.....	330,760		
Case Western Reserve University.....	95,360		
Catholic University of America.....	34,101		
Clark University.....	15,895		
Columbia University.....	290,782		
Cornell University.....	297,028		
Harvard University.....	308,300		
Iowa State University.....	190,375		
Johns Hopkins University.....	291,105		
Massachusetts Institute of Technology.....	320,437		
McGill University.....	N.A.		
Michigan State University.....	289,217		
Northwestern University.....	159,468		
Princeton University.....	152,746		
Purdue University.....	222,696		
Syracuse University.....	123,173		
Tulane University.....	92,620		
University of California (Berkeley).....	279,986		
University of Pittsburgh.....	202,447		
University of Southern California.....	223,060		
University of Toronto.....	N.A.		
Washington University.....	155,425		
Yale University.....	216,493		
Subtotal.....	4,358,367		
Medical Service Plan Revenues.....			(2.1%)
			\$ (91,506)
GRAND TOTAL.....	\$ 15,053,904		
Total Medical Service Plan Revenues.....			(2.1%)
			\$ (313,934)

Sources: COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data (Fiscal Year Ending 1978). H.E.G.I.S. Survey-National Center for Education Statistics, Department of Health Education and Welfare.

TABLE II

ANALYSIS OF ACADEMIC HEALTH CENTER COLLEGES AND ENROLLMENT  
ASSOCIATION OF AMERICAN UNIVERSITIES VS. TOTAL UNITED STATES

1979

Health College	Colleges			Student Enrollment (Undergraduate ONLY)		
	No. of Colleges in U.S.	No. of Colleges in AAU		No. Enrolled in U.S.	No. Enrolled in AAU	
		Total	% of U.S. Total		Total	% of U.S. Total
Medicine.....	113	48	42.5%	61,886	28,819	46.6%
Dentistry.....	59	26	44.1%	21,930	11,455	52.2%
Nursing.....	348	50	14.4%	98,596	17,280	17.5%
Pharmacy.....	71	19	26.8%	23,078	6,145	26.6%
Public Health.....	20	14	70.0%	7,586	6,409	84.5%

\*\*\*\*\*

Teaching Hospital Medical Residencies	Residencies			Residents in Training		
	No. in U.S.	No. in AAU Hospitals		No. of Residents in U.S.	No. in AAU Hospitals	
	Total	% of U.S. Total		Total	% of U.S. Total	
	4,630	664	14.3%	56,184	11,601	20.6%

Sources: 1979-80 AAMC Directory of American Medical Education; 1979 American Dental Directory; State-Approved Schools of Nursing - R.N., 1979; Colleges of Pharmacy - Accredited Degree Programs, July 1, 1979; American Journal of Public Health, April, 1979, Vol. 69, No. 4.; 1979-80 Directory of Residency Training Programs.



In meeting their patient care responsibilities, academic health centers are confronted by a plethora of regulations from federal and state levels designed to monitor financing and delivery of patient care services. While the exact cost is not known, some studies have suggested that as much as 20 to 25 percent of hospital costs are incurred for activities mandated by governmental regulations.<sup>16</sup> This regulatory burden will presumably increase should a federal health care financing program be enacted. However, a competitive approach could reduce the amount of financial regulation at the expense of increased regulation in other areas.

#### National Health Insurance Options

Having reviewed the historical context of national health insurance proposals and the external forces affecting academic health centers, let us now move to some of the national health insurance and related proposals. While the proposals may be categorized in a variety of ways, I will focus on two: the scope of coverage and the various cost containment mechanisms being advocated.

The two basic approaches to scope of coverage are comprehensive coverage for all citizens and, secondly, incremental expansions of coverage over a period of years. Senator Kennedy (D-Mass.) and Representative Waxman (D-Cal.) have introduced the most widely discussed comprehensive bill (The Health Care for All Americans Act), which mandates broad health benefits for the entire population. The incremental proposals concentrate on (1) catastrophic illness coverage; (2) expansion of the number of persons eligible for categorical programs designed for the aged, poor, mothers and children; and (3) broadening of the services provided under existing categorical programs, such as Medicaid. An example of an incremental approach is the Administration's bill which consolidates Medicare and most of Medicaid into a federal program entitled "Healthcare," mandates employer coverage

of employees, and assures coverage of catastrophic expenses for all. Another example of an incremental approach is Senator Long's (D-La.) bill which provides catastrophic coverage for all citizens and expands Medicaid coverage. Incremental expansions are proposed for various reasons. Some proponents feel the present health system is successfully delivering quality care to most Americans and limited changes would fill perceived gaps. Others are actually proponents of comprehensive federal coverage, but feel an incremental approach is all that is politically possible and financially feasible at this time.

All incremental and comprehensive approaches include mechanisms designed to contain costs in order to minimize the additional cost of expanding the scope of coverage. There are three basic approaches to such cost containment goals: direct price and cost regulation; reliance on the National Voluntary Effort Program of hospitals, physicians, and other health professionals; and promotion of competition within the health care system.

The direct price and cost regulation approach includes such proposals as a national limit on health care expenditures to be allocated among the states, hospital revenue increase caps, limitations on all allowable costs, and nationalization of the ownership and operation of the health care system. In each, the federal government would assume responsibility for directly limiting health care expenditures, while in some cases, permitting state or local administration of the health care system.

The second approach is continued reliance on the national Voluntary Effort of hospitals, physicians, and other health professionals to contain costs. Most authorities agree that the Voluntary Effort has been effective during the past two and one half years.

The third approach to cost containment is to promote direct price competition among hospitals, doctors, and other health care providers. Because this model is now receiving dramatically increased congressional attention due to the growing

anti-regulation sentiment in this country, I will outline some of its features and implications. In general, competition is being approached on two distinct levels.

The first level being proposed would occur at the time the consumer obtains health insurance by mandating a choice of options among health insurance plans or Health Maintenance Organizations (HMO's) with various levels of benefits. It is theorized that individuals will opt for lower cost plans in making their selection. As a byproduct of this competition, it is further theorized that health insurance companies and HMO's will be motivated to shop for the least expensive providers and enter into exclusive contractual arrangements with hospitals and physicians, promoting direct price competition among hospitals and physicians.

The second level would occur at the time the consumer obtains health services through the use of out-of-pocket payments designed to make the consumer more cost conscious and, in turn, to lodge that sensitivity with physicians, hospitals, and other providers. Cost-sharing features are also designed to reduce consumer demand in general.

There are several competitive plans being espoused, but most embrace the following general principles based on the work of Enthoven, Ellwood, McClure, and others:

- 1) First, the employee is in effect given a fixed sum of dollars by the employer so that he may choose among health insurance plans or enroll in a Health Maintenance Organization. Enthoven has proposed that indigent citizens be provided with a direct voucher subsidy permitting them to directly purchase one of the approved health insurance or HMO packages, but none of the legislative proposals have adopted this feature.

- 2) Second, employees would have to select one of the insurance plans, but could choose between comprehensive coverage, a lesser coverage plan, or an HMO type plan. In most approaches, only health insurance plans or HMO's approved by the federal government would be allowed to compete.
- 3) If the employee chooses a plan that provides services for less money than the amount provided by the employer or the government, the consumer would receive the remainder as cash income - a reward for diligence in the medical marketplace.

Some hospitals are eagerly embracing the competitive option as a way to avoid direct price and cost regulation. All of the competitive proposals are based upon the principle that competition among health care insurance plans will force insurers to become more prudent buyers, thereby limiting the number of providers from which their enrollees may receive covered care. It is theorized that this will increase competition among health care providers seeking authorization to provide care and receive reimbursement from insurance plans. Some insurance plans will seek contractual relations with hospitals and doctors. Other plans, including most HMO's, will directly provide primary health care through their own staff and facilities, and, in some cases, even directly provide specialty care. On the other hand, some hospitals are already directly sponsoring health care plans, usually HMO's. In some areas, especially in rural states, there are a limited number of providers, so the expected competition among providers may not materialize. In urban areas with multiple providers, some competition is already occurring. Thus, there is a potential for a very complex intermingled environment. All hospitals, especially university teaching hospitals, should carefully examine the new competitive proposals to understand their full implications. While the competitive proposals have some highly positive features, they are certainly not a panacea.

and include several pitfalls which must be avoided through careful planning and communication with congressmen and others, if we are not to weaken the very underpinning of our academic health centers.

Some of the possible outcomes of the enactment of a competitive health insurance plan approach in this country include the following.

First, it will lead toward the evolution of our health system into a set of explicitly competing organized systems, forcing physicians and hospitals to compete on the basis of price or to convince patients that higher charges are justified by other factors.

Second, some proposals would limit the total governmental investment in health care to a federally determined per capita allotment, terminating the open-ended commitment of Medicare and Medicaid to meeting citizens' needs. However, it would avoid establishing an arbitrary limit on aggregate health expenditures by permitting citizens to spend after-tax dollars for additional health care insurance and/or services. Thus, government could control its expenditures without mandating reduced services for all.

Third, competition among insurance companies and HMO's will support attempts to impose controls on physician fees and hospital charges. Some of the proposals explicitly require participating physicians and hospitals to agree to government fee schedules and reimbursement rates; most, however, rely on market forces to mitigate fee and rate increases by not permitting participation of those who do not cooperate.

Fourth, in addition to individuals choosing less comprehensive systems, some health care insurance plans and providers may be motivated to reduce the scope, timeliness, and quality of their coverage and services in response to financial incentives and constraints. This is a risk of the growing concentration on economics. It is possible that competition may move us too far

from the focus on providing an adequate level and quality of service, especially for patients afflicted with complex diseases. If this occurs, we can anticipate increased regulation of the quality of care to offset economic disincentives included in various plans. Competition is largely a substitute for price and cost regulation, not for other forms of regulation.

Fifth, competitive proposals risk the reversal of the trend away from a two-class system of access to care. These risks are mitigated in some of the proposals by requiring all qualified plans to cover a minimum acceptable mix of services.

Sixth, significant disruption may be anticipated in the administration and the delivery of health care when 150 million Americans are injected into the medical marketplace personally searching for, seeking to understand, choosing, and binding themselves to a particular delivery and payment plan. Other longer term disruptions will be manifested as the health care system adjusts to competitive features.

Seventh, competitive models could weaken the ability of academic health centers to meet their broad responsibilities to the entire health system in a host of ways described in the next section of this paper.

#### Specific Implications for Academic Health Centers Arising from Competitive Models

The competitive proposals present threats to the mission of academic health centers in three areas: patient referral patterns, financing, and retention of quality patient care for our nation's citizens. Erosion in any of these areas will detract from the sophisticated teaching setting essential to prepare the doctors of tomorrow.

Fortunately, academic health centers still have time in which to address these issues. HMO's currently encompass only 4% of our nation's population.<sup>17</sup>

Despite these relatively small numbers, it must be recognized that competitive plans are expanding rapidly and their advocates intend to promote substantial growth in the period immediately ahead. Whether they will succeed is open to conjecture, but there is little question that these plans now have added momentum. Therefore, it is essential that the issues described below, of relevance both to academic health centers and the entire health delivery system, be addressed now while these plans are in an early stage of development and experimentation.

### Patient Referral Patterns

Most academic health centers depend on the constant flow of referred patients in order to render specialized services economically, provide the clinical base for broad teaching and research programs, and remain attractive to health science faculty. Thus, academic health centers and their teaching hospitals must be concerned with the implications of competitive models which, through financial disincentives, constrain community-level physicians from establishing referral relationships with tertiary care centers.

Will patients continue to be referred to university tertiary teaching hospitals or will they be shifted to advanced secondary-level hospitals and investor-owned institutions which are less expensive because they avoid many of the additional costs tertiary teaching hospitals cannot avoid? There is the risk that hospitals which concentrate on the high volume, less complicated specialty services will succeed in markets based on price competition at the expense of academic health center teaching hospitals. Another force working toward a shift in referral patterns is the development of multi-hospital systems which promote patient referral patterns within discrete networks.

There is a significant risk that insurers and HMO's, which contract with community physicians and hospitals, will not be willing to establish adequate

referral arrangements with high cost tertiary care centers to avail beneficiaries of their specialty services. As a result, patients may be retained in the home community or referred to non-academic health centers for specialty care. Such an eventuality would erode the critical mass of patients, comprehensive services, and faculty and staff necessary to preserve quality services, education and research in our nation's academic health centers. Competitive plans and HMO's could eliminate a portion of this conflict by avoiding contractual provisions which place community physicians at financial risk in making a clinical judgment regarding the need for consultative referral. Optimally, such decisions should be made in a pure clinical context.

#### Financial Implications

The financial problem becomes clear when we recognize that an underlying goal of many national health insurance proponents is to gain governmental control over the total flow of dollars to the health care system. In this manner, government hopes to constrict the present pattern of payment to hospitals and physicians to free funds in order to embrace those with inadequate health insurance coverage. Many national health insurance proposals are attempts to redistribute income and services in this nation by offering an additional health care entitlement to these citizens without increasing the present 9.5 percent of our gross national product devoted to health care.<sup>18</sup> The competitive approach is being espoused by some in an attempt to achieve this objective with a minimum of direct federal regulatory involvement.

The following comments and questions are raised to explore further some of the major financial issues concerning the multiple contributions of teaching hospitals.



The first and one of the most significant issues relates to how educational costs would be accommodated. The costs of residency training programs in teaching hospitals are now financed through general hospital operating revenues. The costs of these programs including instruction is at least \$1.5 billion<sup>19</sup> and is currently recognized as a legitimate hospital cost in third-party reimbursement formulae. In a competitive environment, these costs would obviously put teaching hospitals at a price disadvantage. Several theoretical alternatives for financing graduate medical education were recently explored by the "Task Force on Graduate Medical Education" of the Association of American Medical Colleges (AAMC), which concluded that none is likely to effectively replace funding through teaching hospital service reimbursement.<sup>20</sup> The alternatives explored include the following:

- 1) To finance graduate medical education from a separate governmental, tax-supported fund. The magnitude of such a fund, the complexities of its management and disbursements, and recent experience with medical school capitation support make this alternative an unrealistic option for long-term financing.
- 2) To transfer the obligation for financing graduate medical education to medical schools. Since medical schools would be able to finance such education only through appropriated tax dollars or philanthropy (without relying on professional fee income), this alternative would severely tax their already tight budgetary situation.
- 3) To utilize revenue generated by teaching physicians from professional fees. Reliance on professional fees could discourage patient admissions by some private practitioners who hold appointments on the staffs of teaching hospitals and could promote fee increases necessary to offset the costs of graduate medical education. Additionally, as a practical matter, the mix of

income sources for most teaching hospital staffs would make implementation of this apparently simple policy impossible.

4) To have residents pay for their own graduate medical education.

Such a policy would directly conflict with efforts to encourage students without financial means to enter medicine by increasing the burden of indebtedness, which must be repaid following completion of residency training. It could also reduce the quality of future practice as physicians who cannot afford to finish residency training opt to begin their practice earlier.

In summary, the AAMC study concluded there is no practical alternative to the present practice of supporting residency training through hospital patient care dollars. Nor, in the opinion of the Association, is there any good reason to look for other alternatives because the present approach, in fact, spreads the burden equitably across the population. The report stated this conclusion as follows: "Patients benefit from the services they receive as residents participate in their care in teaching hospitals, and 94% of all hospital revenues are now derived from third-party insurers. These insurers ... diffuse the educational costs throughout the population through their premium charges or taxation. These insurers have a social obligation to support graduate medical education, for the education and training of future practitioners is an essential investment by the public provided through private health insurance and government programs. This investment ensures that the medical care needs of future generations are met."<sup>21</sup>

The second financial implication involves the cost of developing and implementing innovative procedures and technology designed to enhance patient care. Some current hospital reimbursement formulae provide a component for "growth and development" to encourage this innovation. It is not clear how these working

capital requirements which are crucial to fulfilling the mission of tertiary teaching hospitals would be met under a competitive national health insurance program. Nor is it clear how services provided with innovative equipment would be compensated during the initial testing phases because health care insurers frequently exclude such procedures from coverage in their effort to minimize costs.

The third issue is the threat to biomedical research conducted within academic health centers. Some clinical research is indirectly supported by patient care earnings which would no longer be available due to competitive forces. However, the greater threat is that if other cost containment efforts fail, the government would be tempted to finance new service entitlements of any national health insurance program by reallocating monies now committed to research. In addition, pressure may grow for shifting some of the remaining money allocated to biomedical research from the clinical research areas in which academic health centers have excelled to the study of health education and prevention in the hope of developing ways to reduce the need for and utilization of health services. While patient care, health education and prevention are important goals, we must continue to foster the long-range importance of biomedical research, not only to patient care advances, but also to cost containment.

A fourth issue concerns charity costs. Most teaching hospitals have large-scale charity programs and will continue to care for those patients "falling between the cracks" of a national health insurance program. It is not clear how such charity care could be continued when institutions that avoid such care are at a competitive advantage. Some hospitals may have no choice but to continue charity care because they are providing it under federal and state mandates. However, this will not assure the needed charity care over the long run, for it will only lead to bankruptcy and closure, unless the costs are accommodated in some fashion.

A fifth issue is whether high cost, low volume specialized service could continue to be provided. Such services have historically been centralized in tertiary hospitals. It is unlikely that competitors would choose to provide these services. However, there is also a question whether teaching hospitals would be able to continue to provide them. Price competition could preclude cross-subsidization within teaching hospital pricing that have made these services possible. High prices resulting from elimination of the subsidy could lead insurance plans to exclude such services from coverage, forcing teaching hospitals to either end the services or develop a separate program to finance them.

A sixth issue is whether specialized ambulatory care could continue to be provided in teaching hospitals. Presently extensive ambulatory care deficits are being underwritten by a portion of inpatient charges. These deficits are over and above charity costs and arise from the reduced volume of patients who can be accommodated in clinics associated with teaching, the costs of which are not directly covered by either third parties or patients. Again, it is not clear how clinic-based care and the associated educational programs can continue if teaching hospitals are forced into direct price competition with hospitals that do not provide these heavily subsidized ambulatory programs.

It is important to recognize that many of the functions of teaching hospitals are performed simultaneously and that the resulting costs of individual responsibilities could be separated only through extensive studies that would ultimately have to be based on somewhat arbitrary criteria. Thus, it would be extremely difficult to identify and quantify the costs for these individual responsibilities even if other sources of funding could be found. It is not merely a matter of accounting transfers!

In addition to these problems arising from the multiple responsibilities of teaching hospitals, I would like to mention two other financial concerns emanating from the competitive approach: reduced professional fee payment

for teaching physicians and the risk of further costly regulation if the competitive approach fails to live up to expectations.

Professional fee payments for physician services may also be affected by the establishment of a national health insurance program. Either the competitive environment or direct economic regulation could reduce physician income earned through professional fees. This reduction would affect teaching physicians before private practitioners because of the relative ease with which the government can regulate fees emanating from institutions. Coupled with possible reductions in patient referrals, this loss could further jeopardize faculty practice plans which are now heavily relied upon to support medical education programs and to meet physician income levels essential to retention of excellent faculties. The differential impact on the teaching hospital environment would create incentives for physicians and dentists to leave academia in favor of private practice or to convert practice plans into more private practice oriented models, thereby curtailing their availability for academic program support. Unless the practice plans' losses could be replaced through general appropriation, endowment or other support, universities would be confronted with the difficult job of reallocating general university dollars to the extent they decide to sustain health education programs at present levels.

If a competitive approach is adopted and fails to live up to public or provider expectations, we may be confronted with the worst of both worlds: competition and regulation. As pressures inevitably mount to hold down the cost of any national health insurance program, the federal government may pursue adoption of revenue "caps" that would nullify any success we may have in modifying and accommodating the competitive approaches. Thus, we must remain diligent in our cost control efforts and creative in preserving multiple sources of funding. However, to the extent these efforts fail, it may become necessary for universities to redistribute university-wide funding allocations to support teaching hospital

educational functions, support a higher percentage of medical faculty salaries, and perpetuate clinical research programs so that the academic health center can successfully compete with non-teaching community hospitals for patient referrals necessary to fulfill the university's educational mission.

### Quality of Care

The patient referral and financial implications of a competitive approach to national health insurance could also adversely affect the quality of care delivered by the entire health care system. It is generally recognized that the quality of the nation's health care system has been anchored by its "core" university tertiary-level teaching hospitals delivering highly specialized patient care in support of the entire system. The teaching hospitals in academic health centers also serve as the clinical base for the discovery, delivery and dissemination of new knowledge and services; replenishment of community-based health professionals; and provision of the environment for extensive continuing education that enables practicing professionals to maintain "state of the art" knowledge. A reduction in the ability of teaching hospitals to finance these functions could, accordingly, erode the quality of the entire system. In addition, a reduction in the number and types of patients referred to teaching hospitals could not only reduce the access of patients with complex and expensive diseases to the appropriate level of care, but could also limit the opportunities of health science students to gain the broad clinical exposure necessary to quality health education.

In addition to threatening the ability of teaching hospitals to support quality care, a competitive system would challenge the traditional emphasis on providing the best care available by shifting the focus to cost. Health professionals and hospitals are already becoming increasingly sensitized to cost, so the shift has already begun. However, there is a danger that compe-

tition may move us too far in that direction, so that quality of care is sacrificed.

Quality differences are difficult to communicate to the average consumer, causing disproportionate consideration to be given to the cost of services. This facilitates the development of plans which are competitively priced, but do not assure access to tertiary level care. If the services in university teaching hospitals are either directly or indirectly excluded from the competitive plans, it will have a significant negative impact on academic health centers and, over time, on the aggregate health status of our citizens.

The concentration on economics in any competitive financing structure would eventually lead to a focus on quality control. The public will demand service and the government will expect a return on its investment in the form of increased health status for its citizens. Unfortunately, this return is difficult to quantify with existing measures of quality and health status. Therefore, it is imperative for academic health centers, with the full support of their parent universities, to pursue a position of leadership in the evaluation and preservation of high quality health services to patients, regardless of the health system changes mandated in any national health insurance program.

#### Representation of Educational Interests

Two major national associations are at the forefront of representing educational interests in the formulation of national health insurance - the Association of American Medical Colleges (AAMC) and the American Hospital Association. The primary responsibility has been carried by the AAMC through a number of initiatives.

First, the Association has adopted a policy statement on national health insurance supporting an expansion and improvement of both private and public health insurance embracing the following three features:

- a) an expansion and upgrading of the Medicaid program through broader eligibility of low-income citizens and a national standardization in scope of benefits,
- b) provision of incentives for employers to make catastrophic health insurance coverage more widely available, and
- c) formation of an independent certifying body or commission composed of insurers, providers, and consumers to set minimum standards for basic health insurance benefit packages.

In addition, the AAMC supports the appropriate use of cost-sharing mechanisms such as deductibles, coinsurance or copayments; fair and reasonable reimbursement for teaching physicians and institutional providers; and continuance of financing graduate medical education through patient service charges of teaching hospitals.<sup>22</sup>

The AAMC is currently examining the emerging competitive models through an Ad Hoc Committee charged with determining whether the missions of academic health centers can be properly accommodated under a competitive plan of national health insurance and, if so, how. Upon completion of its review, the committee will submit recommendations on Association policy relating to competition.

To monitor and plan for patient case mix reimbursement schemes which may be integrated into present or future governmental reimbursement policy, the AAMC has also established an Ad Hoc Committee on the "Distinctive Characteristics and Related Costs of Teaching Hospitals." Case mix reimbursement is a new mechanism which attempts to relate hospital payment to patient disease complexity. This committee, with support from the AAMC-Council of Teaching Hospital (COTH) staff members, is actively maintaining liaison with and monitoring the activities of case mix researchers throughout the nation. Educational workshops for COTH members are planned to discuss and evaluate case mix issues and their possible implications for academic health centers. Additionally, any proposals of the Health Care Financing Administration for a case mix reimbursement program



under Medicare will be tested through the research initiatives of the AAMC and its constituent hospitals. The Ad Hoc Committee will also undertake a comprehensive study to quantify the characteristics and costs of teaching hospitals, which will serve to document the unique contributions to society of teaching hospitals and evaluate their special resource requirements to meet present and future missions.

Finally the AAMC has provided testimony to the Congress on a host of legislative issues affecting academic health centers. In March, 1980, the Association presented testimony to the Subcommittee on Health of the Senate Committee on Finance which conveyed concerns about the potential negative impact of one of the competitive proposals, the "Health Incentives Reform Act" (S.1968).

The American Hospital Association (AHA) is unique among other health associations in recognizing the detrimental effect of price competition on academic health centers. AHA's president, John Alexander MacMahon, recently stated in testimony to the Subcommittee on Health of the House Committee on Ways and Means that:

Another issue which warrants further examination is the impact of price competition for certain types of providers. Specifically, we are concerned about the effect of price competition on institutions with major commitments to medical education and research which are usually financed in part with patient care revenues. Such institutions necessarily incur higher costs in the provision of services related to the expenses of these activities. Training of health personnel and research are essential activities. Therefore, unless and until other sources of support are available, provision must be made for these institutions so that they are not disadvantaged in a competitive environment because of their commitment to these programs.<sup>23</sup>

The AHA favors a phased national health insurance program which will assure access to health care coverage for all citizens within a service delivery and financing structure which is pluralistic in nature and supported by the best elements of the private health insurance system. The federal

role would be one of coordination and standard-setting rather than as a centralized, monolithic structure. Additionally, the AHA recommends that the program be phased to assure that benefits and services are provided in a realistic manner with available resources.<sup>24</sup>

At the opposite end of the continuum, the American Public Health Association (APHA) supports the implementation of a comprehensive national health insurance program leading to a National Health Service, administered by government and financed through a combination of special health service taxes on employers and employees and general tax revenues.<sup>25</sup> No assessment is made by the APHA, however, of the impact of a national health insurance proposal on the academic health center, although it recommends a "regional organization of hospitals."

Other professional and educational health associations have developed policy positions on national health insurance. However, none specifically addresses the impact of a national health insurance program on patient care, research and teaching programs in academic health centers.<sup>26,27,28,29,30</sup> It is incumbent upon all associations in the health field, as well as influential educational associations like the Association of American Universities, to formulate positions supportive of continued excellence in our academic health centers under any national health insurance program that might be enacted.

#### Planning at the Academic Health Center Level

The planning response of the academic health center to these issues has already commenced in some universities. Farsighted university administrators, teaching hospital directors and deans of medicine with clinical faculties are preparing for the challenges ahead by pursuing a number of planning initiatives.

##### A. Quality and Availability of Health Care

The first of these is the maintenance of quality of health services provided in our academic health centers and throughout the entire system in the face of

revenue constraints. Government has relied on regional Professional Standards Review Organizations (PSRO's) for review of utilization and quality of health services. Due to financial and other constraints, PSRO's have, since their inception in 1972, emphasized the more cost-oriented utilization issues as opposed to the difficult questions of clinical quality assurance. It is necessary for academic health centers to take the lead in developing workable measures and mechanisms to assure the latter. Academic health centers should also lead in evaluating the effect on quality of patient care arising from the various changes in the financing and style of clinical practice being espoused.

The academic health center has become the apex of a naturally stratified health care delivery system which, in many states, predates and is now the model sought in the health planning efforts of this nation. The National Health Planning and Resources Development Act recognized the desirability of this stratification. Two of the Act's goals are aimed at developing resources for various levels of care on a geographically integrated basis and assuring coordination of institutional health services. The Planning Act was recently modified to add the potentially conflicting goal of competition to the goal of planning coordination. A prime example of the type of conflict that could arise would be the tendency to proliferate tertiary-level specialty services at the local community level in order to provide them directly through HMO's or other competitive plans. It is necessary for academic health centers to assume leadership in assisting planners to arrive at an appropriate balance between coordination and competition which will accommodate the multiple missions of academic health centers and preserve the quality of patient care for all.

#### B. Patient Case Mix Studies

Another initiative of academic health centers is development of a methodology for determining teaching hospital patient case mix for use in coping with future hospital reimbursement policies. As mentioned earlier, the federal government,

through the Health Care Financing Administration (HCFA), has initiated several studies to evaluate hospital case mix. These projects are designed to group diagnoses in order to portray variances in treatment patterns among hospitals, such as differences in length of stay and the intensity of services being rendered, as a basis for limiting reimbursement by government and other third-party payors. One example is the "Diagnostic Related Grouping Methodology" developed at Yale University. Most authorities predict it will be several years before accurate case mix measures can be developed, but there is a risk one of the earlier measures will be prematurely adopted. Since university teaching hospitals care for the patients with the most complex conditions, it is crucial that the complexity and intensity of their services be accurately reflected in case mix measures and associated reimbursement. Only if this is done will the financial integrity of teaching hospitals be maintained under case mix reimbursement.

To address this problem, university hospitals must begin to evaluate the impact of case mix measures on their operations, participate in research to evaluate these measures, and take an active role in influencing how they are used, in order to avoid unnecessarily restrictive reimbursement programs. However, because teaching hospital charges presently bear the costs of extensive educational, research, new technology, and charity programs, as well as ambulatory care deficits, use of accurate case mix factors will not eliminate the need of teaching hospitals for further attention and consideration under price competitive types of national health insurance.

C. Section 223: Medicare Law Amendments of 1972

A related issue is Section 223 of the Medicare Amendments of 1972, which led to the imposition of a maximum allowable per diem cost for services defined as "routine services." Hospitals are classified into groups by bed size and location (urban and rural) and limits are calculated for each group based on the costs of the hospitals in the group. Over the past several years, modifi-

cations in these limitations have resulted in increasingly restrictive Medicare and Medicaid reimbursements. Major teaching hospitals have been especially hard hit by this regulation. Approximately 50% or \$84 million of the \$174 million savings to the Medicare program arising from the 1980 fiscal year curtailment is expected to be absorbed by such hospitals.<sup>31</sup> The recent HCFA proposal to add an "educational cost adjustment" may mitigate some of this effect in the 1981 fiscal year. However, HCFA is currently considering other reimbursement restrictions, such as per admission cost maximums, limits on all inpatient charges including ancillary services, and adjustments in limits for individual hospitals based on case mix.

Institutional planning related to these regulations has been limited to determining if the university hospital was properly classified and reviewing the hospital's cost allocation methodology. The latter review assists in assuring that excessive costs are not being allocated to "routine service" cost centers in order to minimize costs subject to the limits set under the regulatory formula. Future planning efforts must focus on the appropriateness of case mix data currently being supplied to the government through Medicare claims and other sources to assure its accuracy and completeness. If patient case mix is not accurately reflected in HCFA's reimbursement program for a given teaching hospital, the hospital's cash flow from the Medicare and Medicaid programs will be adversely affected.

#### D. Cost Per Patient Day Ranges

The disparity in comparative costs per patient day among teaching hospitals is also significant. The most recent (1978) data for university-owned teaching hospitals (See Table III) shows a range from \$123 to \$559 with the median approximating \$276.<sup>32</sup> These costs were derived from Medicare cost reports and thus should represent a consistent methodology for calculating per diem costs. While variable staffing ratios, scope and size of educational programs,

differential salary scales, and patient case mix partially explain these per diem variances, they do not fully account for the differences involved. Accordingly, the figures indicate a need for academic health centers to sponsor detailed analyses of the comparative data to determine areas that demand management attention prior to the arrival of more controlled or price competitive payment under national health insurance or other regulatory initiatives.

Table III

UNIVERSITY-OWNED TEACHING HOSPITALS  
COST PER PATIENT DAY FOR INPATIENT SERVICES IN 1978

<u>Cost Per Day for Inpatient Services</u>	<u>Number of University-Owned Teaching Hospitals</u>
\$123-149	1
150-199	5
200-249	13
250-299	27
300-349	9
350-399	4
400-449	2
450-499	1
500-559	1
Median: \$276	

Source: Medicare Data, 1978.

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E. State University-Owned Teaching Hospital Study

Another issue which directly impacts on future planning in academic health centers is the need to eliminate the present obscurity in many universities of mission, authority, accountability, and effective operating organization in the teaching hospital. Operating a hospital enterprise within the complexities of a university academic milieu is a challenge far too many universities further compound by not recognizing that a hospital is not a university and that different managerial problems, standards, and external accountabilities must prevail.

As previously indicated, the financial constraints within which university hospitals operate are becoming increasingly restrictive. There is a growing potential for a competitive model of national health insurance which would place the teaching hospital in a weakened position. An intimate relationship of the university hospital to external groups such as health planning agencies, referring physicians and their patients, community hospitals, government and third-party payors is becoming crucial to the survival of the academic health center we know today.

Universities must recognize that teaching hospitals are now at a crossroads of success and survival or failure and erosion. The university teaching hospital can no longer be viewed as a "laboratory" of the health sciences colleges, but rather it must be recognized as an enterprise providing high-quality patient care with education as a byproduct of these responsibilities. If university hospitals are to compete successfully in our changing health care system, while maintaining their educational mission, they must continue to offer the public a unique service of the highest quality. Perpetuation of long waiting times in ambulatory clinics, impersonal service, inferior communication with referring physicians, and outmoded facilities prevalent in many of our university hospitals, if uncorrected, will contribute to deterioration of their competitiveness. In some of our academic health centers, all of these features of teaching hospital management are now in need of review and refinement. If teaching hospitals are to retain their tertiary care role, attract the patient referrals essential for health science education and research, retain high-quality faculty, and concomitantly maintain a sound financial base, vigorous remedial action must be initiated.

To the end of conceptualizing solutions to these problems in state university-owned hospitals, the AAMC is presently reviewing a request to sponsor formal study of these issues. It is hoped that a multi-disciplinary steering committee

composed of university hospital directors, deans of medicine, and representatives of the Association of Academic Health Centers and the Association of American Universities will participate in this study.

F. Experimentation with New Forms of Health Education Modeling

Another element of academic health center operations which will require greater future attention from university and academic health center administrators is the funding of training for new health professional roles. Increasing cost containment initiatives, third-party resistance to reimbursing for educational costs reflected in patient charges, and a growing interest in competitive or other models of national health insurance will place pressure on academic health centers to limit experimentation with new forms of health education. Prior to nationwide or even limited implementation of a new health education program, evaluations should be conducted in a small number of academic health centers to assess the cost effectiveness of the program's future product.

G. Multi-Hospital Systems

Multi-hospital systems present an added challenge for the academic health center by providing, as they do, not only centralized corporate management and other support service, but also broad clinical specialty expertise. While multi-hospital systems are in an early state of development, they can potentially pose significant threats to continuation of established teaching hospital patient referral patterns. As they develop a stronger clinical, financial and political base with which to compete with academic health centers, the potential exists for diversion of significant numbers of patients into their own networks. If this occurs, the broad array of disease entities necessary to health science education will no longer be present in the teaching hospital, which will have its patient mix focused on tertiary level care to the detriment of a comprehensive educational experience for all health science students. Accordingly, university administrators should closely monitor developments in the multi-



hospital movement to determine if avenues of alignment with such systems are appropriate and beneficial to the goals of the academic health center.

H. Broadened Orientation of University-Federal Government Liaison Efforts

The federal government is closely linking the educational side of the health professions with health service responsibilities of the academic health center. For example, the Health Professions Educational Assistance Act ties the capitation funding of medical schools to the size and types of residency programs in teaching hospitals, thereby aligning health science education with federal patient care goals. Accordingly, congressional and federal agency liaison staff of universities must be given increasingly broader information and background regarding the health service sector of the academic health center, as well as the educational sphere, in order to represent the needs of the total center within the changing structure and goals of the federal government.

Projected Nature and Timing of National Health Insurance in the U.S.

You do not need a Washington insider to tell you that passage of any legislation this year that will create increases in the federal budget or increases in taxes is unlikely. It is also probably safe to assume that Congressional efforts to trim government spending will be an objective that will be with us for much of the 1980's.

Most of the Congress perceives the Senate Finance Committee to be the key committee for national health insurance. Its chairman, Senator Russell Long, has long been an advocate of catastrophic insurance and appears to be the individual best able to negotiate the political compromises needed to send an acceptable bill to the full Senate. Senator Long is in a particularly significant position because his committee is responsible for tax policy as well as program implementation. At this time, his tax compromise appears to favor added excise taxes on tobacco and alcohol products, rather than general or payroll tax increases.

It is worthy of note that more committee time has been spent on extensions of benefits than on the taxes required to pay for them.

How these differences of opinion will be resolved is difficult to predict, but it is clear that external factors, such as the state of the economy, will play a key role. As long as the inflation forecast for the nation remains bleak, congressional enthusiasm for new programs will be dampened and attention will be focused on legislation that will decrease rather than increase the size of existing programs.

As my historical review indicated, national health insurance seems to be an issue that periodically waxes and wanes, but never gains quite enough momentum to be enacted. This past year was no different. Last spring, there were even some suggestions that a fairly comprehensive plan might be adopted. Last fall, it appeared that catastrophic insurance might be accepted. This spring, we are not close to either of these approaches. If the circumstances are right, Congress may move quickly next year, but it would not surprise me if this latest cycle of activity has run its course.

There are, however, two developments which might alter congressional interest in national health insurance. First, if the Federal Reserve Board's tight money, policy and the Carter administration's balanced budget dramatically increase unemployment, large numbers of presently insured persons will lose their employer provided health insurance coverage. With large numbers of newly unemployed eligible for Medicaid, state expenditures for health care will grow while revenues are decreasing. This will lead states to join employee groups seeking relief. When this combination arose in the mid-70's, there was a movement to have the federal government underwrite coverage for the unemployed and their families as the initial step in implementing national health insurance and, in part, to remove financial pressure from the states. In the early 80's, this problem and a proposed Federal solution may once again arise. A second development on

the immediate horizon is a congressionally mandated study of the Social Security system being conducted by the National Commission on Social Security. While the Commission's preliminary report has received limited circulation, the final report, due in January, 1981, is intended to make recommendations on the long-range future of the Social Security program. Because of the significance of health expenditures among the aged, the disabled, and the poor, the Commission's report is to address publicly financed health care. Certainly the recommendation it will make on the future role of Social Security will influence, and perhaps dramatically alter, the national health insurance debate.

It is apparent that we hear less talk today about health care as a right for all Americans and more discussion about protection of citizens from catastrophic financial expense, and then only if additional savings in present health care expenditures can be achieved. It is not evident where these savings can be found. As a result, I would speculate that Senator Kennedy's legislation, or any other proposal that mandates comprehensive health insurance benefits, clearly will not be passed in the foreseeable future. Catastrophic health insurance is the only form of national health insurance that will receive serious consideration, but Congress is not willing to act on even a catastrophic bill this year. There is a possibility that catastrophic national health insurance may pass next year, particularly if there are some assurances that cost containment measures, whether mandatory or induced through competition, will offset the additional federal expenditures created by catastrophic coverage. But even Senator Long appears to see the need for new excise taxes on cigarettes and alcoholic beverages to support catastrophic insurance and this may delay the enactment of any legislation in 1981 or the years immediately beyond.

Concluding Statement

While I have outlined a host of substantial challenges facing academic health centers in the years ahead, I would hope that none of you conclude that operating an academic health center is a "price too high to pay" for your respective universities. These centers, which are of critical importance to society as a whole, have been built through huge investments in capital and human resources, particularly over the past several decades, and now represent tremendous national resources. Speaking from the perspective of one functioning within a university academic health center, I will close with the following thought: If we are to meet the challenges ahead, we must have the thorough understanding and vigorous support of University Presidents in order to succeed. For this reason, I am especially grateful for the opportunity to share these thoughts with you this afternoon. I hope they have been helpful. Thank you.

Footnotes

<sup>1</sup>Department of Health, Education and Welfare, Health-United States, (Washington, D.C., U. S. Government Printing Office, 1978), pp. 401-403.

<sup>2</sup>Marjorie Smith Carroll, "Private Health Insurance Plans for 1976: An Evaluation," Social Security Bulletin, 41 (Sept., 1978), p. 7.

<sup>3</sup>David A. Stockman, "Modifying Consumer Alternatives," Hospital Management Quarterly, (Winter, 1980), p. 27.

<sup>4</sup>John J. Moscato, "Federal Health Legislation: Overview and Assessment," in Health Management for Tomorrow, ed. by Samuel Levey and Thomas McCarthy (Philadelphia: J. B. Lippincott Co., 1980), p. 35.

<sup>5</sup>Richard Knapp, (COTH Staff) "Toward A More Contemporary Public Understanding of the Teaching Hospital," (Washington, D.C., Council of Teaching Hospitals, A.A.M.C., Spring Meeting, May, 1979), p. 42.

<sup>6</sup>Ibid.

<sup>7</sup>Ibid.

<sup>8</sup>John W. Colloton and Richard Knapp, "Testimony on The Health Incentives Reform Act, S. 1968," to the Subcommittee on Health, Committee on Finance, U.S. Senate, (Washington, D.C., Association of American Medical Colleges, March 19, 1980), p. 3.

<sup>9</sup>Ibid., p. 4.

<sup>10</sup>Ibid.

<sup>11</sup>Ibid.

<sup>12</sup>Association of American Medical Colleges, 1979-80 AAMC Directory of American Medical Education, (Washington, D.C.: Association of American Medical Colleges, 1979).

<sup>13</sup>American Medical Association, 1979-80 Directory of Residency Training Programs, (Chicago: American Medical Association, 1980).

<sup>14</sup>Council of Teaching Hospitals, COTH Survey of University Owned Teaching Hospitals Financial and General Operating Data, (Fiscal Year Ending 1978), (Washington, D.C.: Department of Teaching Hospitals, Association of American Medical Colleges, April, 1980), Table 11.

<sup>15</sup>Association of American Medical Colleges, Computer Report on Medical Practice Plan Revenues, (Washington, D.C.: Association of American Medical Colleges, April, 1980).

<sup>16</sup>Carol M. McCarthy, Ph.D., "New York Study Shows Regulatory Costs Unreasonably High," Hospitals, 53 (January 16, 1979), p. 90.

<sup>17</sup>Group Health News, 21 (February, 1980), p. 1-5.

<sup>18</sup>Mark Freland, George Calat and Carol Schendler, "Projections of National Health Expenditures, 1980, 1985 and 1990," Health Care Financing Review, 2 (Winter, 1980), p. 2.

<sup>19</sup>Richard Knapp, Ph.D. and Peter Butler, "Financing Graduate Medical Education," The New England Journal of Medicine, 301(14) (October 4, 1979), p. 749; and "Part A Intermediary Letter No. 75-50, paragraph 27,492," Medicare and Medicaid Guide, Commerce Clearinghouse, Inc., (September, 1975), p. 10,089.

<sup>20</sup>Association of American Medical Colleges, Task Force on Graduate Medical Education, Graduate Medical Education: Proposals for the Eighties, (Washington, D.C.: AAMC, 1980), pp. 115-153.

<sup>21</sup>Ibid, p. 128.

<sup>22</sup>Association of American Medical Colleges, A Position Paper: The Expansion and Improvement of Health Insurance in the United States, (Washington, D.C.: Association of American Medical Colleges, August, 1979).

<sup>23</sup>John Alexander McMahon, Statement of the American Hospital Association on Health Insurance and Proposals to Restructure Incentives in the Private Health Care Sector, (Washington, D.C., A.H.A., February 11, 1980), p. 12.

<sup>24</sup>Ibid., p. 2.

<sup>25</sup>American Public Health Association, "Policies and Positions--Section 7809, National Health Insurance," American Journal of Public Health, 69(3) (March, 1979), p. 300.

<sup>26</sup>American Association of Dental Schools, "Statement on National Health Programs," Journal of Dental Education, 43(8) July, 1979, pp. 439-441.

<sup>27</sup>American Association of Colleges of Pharmacy, Priorities of Pharmaceutical Education in Response to National Health Needs, (Bethesda, Maryland, July, 1979).

<sup>28</sup>American Nurses' Association, Position Statement on National Health Insurance, (Kansas City, Missouri, Sept. 18, 1978).

<sup>29</sup>National League for Nursing, Position Statement on National Health Insurance, (New York, New York, April 29, 1979).

<sup>30</sup>American Pharmaceutical Association, "Government Insurance Programs (Medicare, Medicaid, Proposals for National Health Insurance)," Journal of the American Pharmaceutical Association, 17 (July, 1977), pp. 451-452.

<sup>31</sup>Conversation with Dr. James D. Bentley, Assistant Director, Department of Teaching Hospitals, Association of American Medical Colleges, April 7, 1980.

<sup>32</sup>Council of Teaching Hospitals, COTH Survey of University Owned Teaching Hospitals Financial and General Operating Data, (Fiscal Year Ending 1978), Table 25.

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