association of american medical colleges

AGENDA

FOR

COUNCIL OF TEACHING HOSPITALS

ADMINISTRATIVE BOARD MEETING

June 20, 1985
8:00 a.m.
Washington Hilton Hotel
Jackson Room

one dupont circle, n.w./washington, d.c. 20036

COTH ADMINISTRATIVE BOARD MEETINGS

September 11-12, 1985	Shoreham Hotel, Washington, DC
October 28, 1985	AAMC Annual Meeting Washington Hilton Hotel Washington, DC

COTH SPRING MEETINGS

May 7-9, 1986	Franklin Plaza Hotel Philadelphia, PA
May 13-15, 1987	Fairmont Hotel Dallas, TX

AAMC ANNUAL MEETINGS

October 26-31, 1985	Washington Hilton Hotel Washington, DC
October 25-30, 1986	Hilton Hotel, New Orleans, LA
November 7-12, 1987	Washington Hilton Hotel Washington, DC

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

June 19-20, 1985
Washington Hilton Hotel

WEDNESDAY, June 19, 1985

6:00pm	JOINT AAMC ADMINISTRATIVE BOARDS MEETING Military Room (Agenda - Page 1)
7:00pm	JOINT AAMC ADMINISTRATIVE BOARDS RECEPTION Map Room
7:45pm	JOINT AAMC ADMINISTRATIVE BOARDS DINNER Caucus Room

THURSDAY, June 20, 1985

8:00am	COTH ADMINISTRATIVE BOARD MEETING Jackson Room (Agenda - Page 17)
Noon	JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON Hemisphere Room
1:00pm	AAMC EXECUTIVE COUNCIL BUSINESS MEETING Military Room

JOINT ADMINISTRATIVE BOARDS MEETING

"The Direction of National Science Policy"

Guest Speaker

Representative Don Fuqua
Chairman, Committee on Science and Technology
U.S. House of Representatives

Wednesday, June 19, 1985
6:00 p.m. in the Military Room
Washington Hilton Hotel

To be followed by Cocktails in the Map Room
and
Dinner in the Caucus Room

The House Committee on Science and Technology Policy has established a bipartisan Science Policy Task Force to conduct a two-year study of national science policy. The Task Force is the first major Congressional review of American science policy in nearly twenty years and will focus on the significant changes which have occurred in the science-government relationship and the overall environment for scientific research. Specifically, the Task Force is undertaking an indepth review and examination of government policies in 1) conducting and supporting basic and applied research, and 2) science and engineering education and manpower issues as they are related to graduate and postdoctoral education. An indepth ten-point agenda for the Science Policy Task Force was published in December 1984.

The eighteen member Task Force is under the leadership of the House Committee on Science and Technology Policy Chairman, Don Fuqua (D-FL) and Committee ranking minority member Manuel Lujan, Jr. (R-NM). A long term objective of the Task Force is to achieve a deeper understanding of science policy issues and to examine such issues outside of the conditions of crisis which so often force policy changes. To facilitate this long term objective a number of studies, evaluations of existing programs, and bibliographies have been requested from the Congressional Research Service, the Office of Technology Assessment, and the General Accounting Office. The Task Force has also scheduled an exhaustive series of hearings in 1985 and early 1986. Following the hearings Task Force staff will compile and write a draft of the final report, copies of which will be circulated to the scientific community for comment before the final report is published at the end of September 1986.

The Task Force will examine all of the sciences, including the life sciences. However, since the jurisdiction and background of the parent committee is focused on the physical sciences, space, energy, and environmental research and the National Science Foundation, they have had less contact with the biomedical milieu and policies relevant to the NIH and the medical school environment. Thus the Association, as well as other segments of the biomedical/biobehavioral research community, may have a useful role to play in identifying key policy issues as well as providing resources and data to the Task Force.

The AAMC will be forming an ad hoc Research Policy Committee under the chairmanship of Dr. Edward Brandt, Chancellor of the University of Maryland, to assist it in examining federal biomedical research policy in the context of the work of the Task Force on Science Policy.

Further background information on the Task Force is provided on the following pages:

MEMBERSHIP OF THE SCIENCE POLICY TASK FORCE

DEMOCRATS:

Don Fuqua (FL-2), chairman
George E. Brown (CA-36)
Doug Walgren (PA-18)
Stan Lundine (NY-34)
Norman Y. Mineta (CA-13)
Harry M. Reid (NV-1)
Richard Stallings (ID-2)
Frederick C. Boucher (VA-9)
Harold L. Volkmer (MO-9)
Timothy E. Wirth (CO-2)

REPUBLICANS:

Manuel Lujan Jr. (NM-1)
Claudine Schneider (RI-2)
Ron Packard (CA-43)
Tom Lewis (FL-12)
Robert S. Walker (PA-16)
Sherwood L. Boehlert (NY-25)
James Sensenbrenner (WI-9)
Sid Morrison (WA-4)

AGENDA FOR THE HOUSE SCIENCE POLICY TASK FORCE

I. The Goals and Objectives of National Science Policy

Purpose: To examine the goals and objectives of American science policy, the assumptions underlying these goals, and how well they are being achieved.

A. Goals of Federal Science Policy
B. History of American Science and U.S. Science Policy
C. The Future of U.S. Science
D. The Pay-off from Scientific Research
E. Accountability in Research

II. The Institutional Framework of National Science Policy

Purpose: To review the adequacy of research universities, industrial firms, and governmental agencies to meet the future needs and demands of science.

A. The Role of Research Universities
B. The Role of the Governmental Laboratories
C. Basic and Applied Research in Industry
D. Government Responsibility for the Research Infrastructure
E. International Cooperation in Big Science
F. Coordination and Management of Federal Research Programs
G. Role of the National Academies

III. Education and Manpower

Purpose: To examine the issues associated with and the relationships between scientific research, the education and training of scientists at the graduate and post-doctoral levels, and the demands for scientific manpower.

A. The Past, Present, and Future Government Role in Science Education
B. Effects of Long-Range Population Trends on Science Manpower Policy (Including Physicians)
C. The Government's Role in Professional Education (Including Physicians)
D. Equity of Opportunity
E. How Should the Education of Scientists, Doctors, and Engineers be Paid For?
F. Engineering Education
G. New Educational Technologies

IV. Impact of the Information Age on Science

Purpose: To examine the widespread introduction and use of modern information technologies such as telecommunications, electronically stored data bases, and computers on the conduct and scope of sicentific research.

V. Role of the Social and Behavioral Sciences

Purpose: To address the importance of the social sciences, particularly the question of future government support for research programs in these disciplines.

VI. The Regulatory Environment for Scientific Research

Purpose: To consider the relationship of societal values and scientific research, focusing on the conflict between the aims of society and the aims of research, the manner in which these conflicting aims are accomodated, and the development of principles to achieve balance.

VII. Funding Levels

Purpose: To explore the manner in which funds are allocated for scientific research, thus establishing national priorities, by both the government and by other providers.

A. History of Science Funding Since 1945
B. Is There an Optimum Level of Federal Support for Science?
C. The Financial Health of Universities and Medical Research Centers
D. Priorities for Science Funding

VIII. Support of Science by the Mission Agencies

Purpose: To examine the science programs, conducted both in government laboratories and through grants and contracts, of agencies such as the departments of Defense, Energy, and Agriculture, and the National Aeronautics and Space Administration.

IX. Funding Mechanisms

Purpose: To examine the array of funding mechanisms and instruments, such as peer review and grants, used to provide the government's research funds to organizations and individuals.

A. Alternative Systems of Funding Scientific Research
B. The Selection Process and the Role of Peer Experts
C. Styles of Research Support in Different Fields of Science
D. Secondary Effects of Present Funding Mechanisms
E. The Cost of Research

X. The Role of the Congress in Science Policy Making

Purpose: To review the processes of the Congress for dealing with the formation of science policy.

A. Science in the Political Process
B. Priority Setting by the Congress
C. Oversight and Evaluation of Federal Science Programs
D. Multi-Year Funding of Science Programs
E. Review of Science Policy Reports to the Congress
F. Background Materials for Members

PROPOSED SCHEDULE FOR THE HOUSE SCIENCE POLICY TASK FORCE

1985

February	Task Force Organizational Meeting Hearing on Goals of Federal Science Policy	(2/28)
March	Hearings on Goals of Federal Science Policy	(3/7, 21, 28)
April	Hearing on the Role of the Research Museum Hearings on Industry's View of Federal Research Policy Hearing on Big Science: High Energy Physics	(4/17) (4/23-24) (4/25)
May	Hearing on the Future of U.S. Science Hearing on the Nobel Prizes and Science Policy Hearing on Government and the Research Infrastructure	(5/2) (5/14) (5/21-22)
June	Hearings on International Cooperation in Science Hearings on Science in the Political Process	(6/18, 19, 20) (6/25/26)
July	Hearings on Science and Engineering Education and Manpower	(7/9, 10, 11) (7/23, 24, 25)
September	Hearings on the Impact on Science of the Information Age Hearings on the Role of the Social Sciences	(9/10, 11, 12) (9/17, 18, 19)
October	Hearings on Science in the Mission Agencies Hearings on Science in Goverment Laboratories Field Visits to Research Universities, Government Laboratories (tentative)	(10/2, 3, 4) (10/22, 23, 24)

1986

February	Hearings on Effects of Long Range Population Trends in Manpower Policy Hearings on the Regulatory Environment for Research
March	Hearings on the Pay-Off from Scientific Research
April	Hearings on Funding Mechanisms
May	Hearings on Funding Levels FIRST DRAFT OF FINAL REPORT DUE
June	Hearings on (combined) First Draft of Final Report Goals of Federal Research Policy The Role of the Congress in Science Policy Making
July	Hearing on the Role of the National Academy of Science TASK FORCE MEETINGS TO EDIT FINAL REPORT
August	STAFF REWRITE OF FINAL REPORT
September	TASK FORCE MEETINGS TO REVIEW AND EDIT FINAL REPORT FINAL REPORT TO GOVERNMENT PRINTING OFFICE: 19 SEPTEMBER PUBLICATION OF FINAL REPORT: 31 OCTOBER

LIST OF STUDIES COMMISSIONED BY THE SCIENCE POLICY TASK FORCE

Study	Agency	Due Date in 1985
Expertise in the Political Process	CRS	Draft Received
Nobel Prizes as Indicators of National Strength in Science	CRS	Draft Received
Compilation of International "Big Science" Facilities	CRS	Late May
Bibliography of National Academy Reports	CRS	Late May
Impact on Science of the Information Age	CRS	Late June
Social and Behavioral Sciences and their Contributions to Society	CRS	July
Support of Scientific Research by the DOD	CRS	July
History of Science Policy Since 1945	Staff Fellow	
Alternate Mechanisms of Research Support	GAO	September

GAO is asked to examine the array of federal funding mechanisms for science. For example, a preliminary review shows that the diversity of instruments and methods of funding research have been gradually narrowed, and the individual project grant is now the dominant mechanism. GAO is asked to study the relative merits of various funding mechanisms.

The Regulatory Environment for Scientific Research	OTA	September

This study will explore controls on scientific research and their effects on the quality of science. Recent controversies over research on recombinant DNA, research on humans and animals, and constraints on disclosure of research findings are examples of such controls. The study will outline contemporary attempts to regulate science. It will analyze how the effects of regulation on the quality of science might be measured and how current legislative actions reflect the regulatory climate.

Analysis of Demographics and Manpower	OTA	October

This study will examine demographic trends and manpower needs over the next 40 years, with particular emphasis on the outlook for U.S. research universities and their students and faculty.

Science Funding as an Investment	OTA	November

A traditional justification for federal support of science rests on the principle that the search for knowledge is intrisically valuable. More recently the justification has emerged that science funding is an investment. OTA is asked to examine models for funding high risk long term investments in other contexts and the relevance these have to funding science.

Financial Health of the Universities GAO December

GAO is asked to study how scientific research is funded at U.S. research universities, including their medical research centers. The purpose of this analysis is to provide "the broadest possible picture of how Federal funding for research fits into the total financial situation of this group of institutions." The study includes, "an analysis of the total sources of income for these institutions by major categories and includes resources being provided both in the form of money and in kind, an analysis of the extent to which research funds are used to fund both research activities and other institutional activities through various direct and indirect costs and reimbursements, and, conversely, the extent to which other funding sources, i.e., tuition, endowment income, and gifts, are used to support research activities, directly or indirectly." Data will be collected through a questionnaire, which is expected to sample 30 randomly selected universities on the NSF list of the top 100 research universities.

[COMMITTEE PRINT]

AN AGENDA FOR A STUDY OF GOVERNMENT SCIENCE POLICY

REPORT

PREPARED BY THE

TASK FORCE ON SCIENCE POLICY

TRANSMITTED TO THE

COMMITTEE ON SCIENCE AND TECHNOLOGY U.S. HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

Serial MM

DECEMBER 1984

Printed for the use of the Committee on Science and Technology

U.S. GOVERNMENT PRINTING OFFICE

40-860 O WASHINGTON : 1985

CONTENTS

INTRODUCTION

The last major Congressional review of American science policy took place in the mid-sixties, almost twenty years ago. Since that time, the relationship between science and government has undergone a number of significant changes, and there is every indication that further changes in that relationship are in prospect. In addition, the wider environment in which both government and science must function is expected to change in ways that will affect both science and the science-government relationship.

It is therefore timely that the Science and Technology Committee conduct a careful review of American science policy. Such a review will enable the members of the Committee, and the wider membership of the House of Representatives, to discharge their legislative and oversight responsibilities on the basis of a deeper understanding of past policies, present problems, and future needs and choices.

The proposed agenda presented in this report by the Science Policy Task Force represents our recommendations about the ground such a science policy study should cover. In our view, all of the individual items and questions we propose for consideration and study are closely related and together form the fabric of our science policy. We realize that the list of agenda items is long and may be difficult to cover in depth even with the expected two-year duration planned for the study. Nevertheless, the importance of this subject for the future of the country compels us to recommend that the entire subject be given the most careful and thoughtful study so that we can emerge with a deeper understanding and enhanced wisdom about the Federal Government's role in keeping America strong in science.

Science Policy and the Congress

The Federal Government's role as the principal source of the resources needed to advance science is comparatively new. Prior to 1945 it was limited to peaks of effort in support of major wars and specialized activities by those agencies of government which saw science as a way to acomplish their primary missions such as the Department of Agriculture. This limited role for the Federal Government gave way to a much stronger, ultimately dominant, role in the years following the end of World War II.

During the war years large numbers of scientists performed research directly related to the war effort. Funds were provided through the Manhattan Project for work on the atomic bomb, through the Office of Scientific Research and Development for work on a wide range of other military weapons, techniques, and medical problems, and through the military services to the universities for both training and R&D activities. This resulted in the de-

velopment of a spectacular array of science-based technologies which contributed significantly to the winning of the war. They included, in addition to the atomic bomb, the proximity fuze, radar, mass-produced penicillin, scientific techniques for anti-submarine warfare, and psychological methods for the selection and training of personnel.

As a result, public and Congressional support for the continuation of government support of science was strong, and the view that it should be broadened to include research with potential applications to the civilian sector of society was introduced. A number of new government agencies were created to continue and strengthen the close relationship with the universities. They included the Office of Naval Research and the National Science Foundation. Other established departments and agencies such as the National Institutes of Health and the Department of Agriculture also saw their science programs expanded and strengthened.

In the late Fifties, the launch of the Soviet earth satellite Sputnik, provided further impetus for public and Congressional support of science leading to rapidly growing budget allocations for science. A new emphasis on science education at all levels emerged, based on the need to train more scientists and engineers.

The resulting series of annual budget expansions lasted into the mid-seventies when a period of uncertainty and abrupt changes, began a period that is still with us. After a series of annual budgets in which the science component was essentially level, there has been a resumption of budget growth. That growth in science expenditures has been at rates equivalent to a doubling time of less than six years. It is unlikely that such rapid increases can be sustained, especially in view of the urgent need to close the deficit gap in the Federal budget.

The shift from a limited government role in providing support for science to a dominant role has of necessity meant a heavier involvement by the Congress in all aspects of that process. The Congress early recognized the importance of science to improved health, technological advance, and economic growth. The Congress has provided the institutional framework of new or augmented government agencies to administer those programs, and has responded to international developments, Executive Branch initiatives, and scientific opportunities with the allocation of substantial and frequent budget increases.

Yet, as in numerous other areas, there has been a strong tendency to make extensive changes in policy only under the conditions of crisis. Absent such conditions, debate on questions of resource allocation is normally restricted to the incremental increases proposed by the President in the annual budget. In our view the Science Policy Study offers a welcome opportunity to stand back in a non-crisis atmosphere and take the measure of our federal science policy in terms of both its relevance to national goals and its effectiveness in allocating sufficient resources to support science.

Scope of the Study

The scope of a study of science policy could vary widely, and would be interpreted quite differently depending on the time, the

circumstances, and the interests of the individuals involved. The term "science policy" itself is subject to differing interpretations, but in common practice is frequently used to cover policies for government support and encouragement of science and technology, ranging from basic research through applied research, advanced development, concept demonstration, and product development. When interpreted to encompass that broad range of activities, science policy includes such issues as patent policy, anti-trust policy, tax policy, and industrial innovation policy generally.

After a careful consideration of the appropriate scope for the Science Policy Study, and an evaluation of the advantages and disadvantages of a wide scope versus a more circumscribed scope, the Task Force recommends that the scope be limited to the issues of science policy in the narrow sense of government policies for the support of basic and applied research. This means excluding from the present study the issue of technology policy and the many policy questions which fall into that broad category. Our conclusion in this matter of the scope of the Science Policy Study is based on the following considerations.

We believe that any study to be done by the Committee should be of the highest quality. To achieve this will require extensive data gathering, careful probing of many issues and their correlated subjects, and in-depth analysis of each issue. Such a study can only be done if the scope is limited to a manageable number of issues, all of which preferably are related to each other. Science policy in the narrow sense constitutes, we conclude, such a group of issues. Furthermore, many of the issues in the wider interpretation of science policy are themselves as large, or larger than, the more narrowly defined study contemplated here and could therefore easily divert attention from the focus on basic and applied research policy. Consequently, we recommend that the Science Policy Study be limited to the role of the Federal Government in conducting and supporting basic and applied research.

Similar considerations were brought to bear in considering the extent to which the Science Policy Study should cover education and manpower issues in the area of science and engineering. While the Task Force fully recognizes the importance which mathematics and science education have at the high school and undergraduate college levels, it was concluded that only those aspects of science and engineering education which are directly related to research activities should be covered in the Study. In part this is due to the fact that several recent reports have dealt with the issues related to pre-graduate science education. In part this is also due to the great scope which a study of all science and mathematics education would entail, and the desire of the Task Force to keep the proposed Study within manageable boundaries. We therefore recommend that the Science Policy Study include science and engineering education and manpower issues as they are related to graduate and post-doctoral education in these fields.

Bipartisan Approach of the Task Force

From the time that the idea for a comprehensive science policy study first emerged, there was wide agreement that it should be

done on a fully bipartisan basis. That was the view of the several members who proposed the initiation of such a study as well as of the Chairman and the Ranking Minority Member of the Science and Technology Committee. We all share the view that the importance of science to the nation's future is high, and the need, therefore, to provide a strong leadership role by the Federal Government is not in dispute. The composition of our Task Force reflects that view.

A bipartisan approach to the work of the Task Force, and subsequently to the Science Policy Study itself, will not preclude that differences will arise on individual issues which form part of this study. Nevertheless, we recommend that the Science Policy Study be conducted in the same bipartisan manner as the work of the Task Force, an approach that proved workable and which we believe to be in the best interest of the nation.

The Past and the Future

We recognize that science policy is dynamic, ever-changing, and has a past and a future. That past, although comparatively short, is replete with changes that range from adjustments in the nuances of policy to major redirections in program orientation. Similarly, the future of science policy calls for sensitivity to important, but hardly detectable, emerging developments as well as the anticipation of major trends in the factors affecting science and science policy. In the conduct of the Science Policy Study an awareness of historical developments coupled with an acute sensitivity to emerging future needs will be crucial to the achievement of both wise judgments and sensible relevance. The Task Force recognizes that, in designing and conducting the Science Policy Study, a balance should be sought between attention to historical developments in American science policy over the last forty years and awareness of potential developments in science, in science policy, and in society as a whole.

Longer Term Objective

The Task Force is well aware that studies of important policy issues frequently have as their only result the drafting and publication of a huge report which is read by few and which accomplishes little. We urge therefore that, in the conduct of the Science Policy Study, the longer term objective of achieving a deeper understanding by members of the Committee should be a major objective.

This is not to suggest that an over-all report should not be produced, bringing together the conclusions and recommendations arising from the Study. But rather than a voluminous final report written without the active participation of the members of the Committee, we recommend that the Committee's final report be short and succinct and that it be considered only one of the several end products of the Science Policy Study.

Data Based Study and Analysis

A prominent anomaly of past and current science policy making has been the very limited use of quantitative information. In neither the evaluation of past programs nor in the development of new initiatives has the arena of science policy formulation seen the use, to any significant extent, of hard data and quantitative analysis. In this respect science policy differs in a noticeable way from policy-making in such fields as defense policy, social security policy, and many others.

The Task Force believes that in many areas of science policy the data is available and the policy making process could potentially benefit from its use in the associated analysis. We recommend therefore that in the conduct of the Science Policy Study, particular attention be given to the definition of the issues, the formulation of the questions, and the enunciation of the recommendations in a manner which will permit quantitative approaches to be brought to bear when possible. Equally important, a concerted effort should be made to evaluate existing programs with the prominent assistance of such quantitative methods.

We are conscious of the limitations of such quantification, especially in a field of public policy which is characterized by a high degree of uncertainty and a noticeable degree of reliance on individual insight and creativity. Nevertheless, we believe that the time has come to supplement, although certainly not replace, the traditional science policy process with a strong component of quantitative analysis, an approach which has proven so successful in science itself.

Structure of Agenda

In considering the wide range of topics which must be included in the agenda, even under the agreed narrow scope for the Science Policy Study, we have sought to arrive at a reasonable degree of coherence. The topics have therefore been organized under major subject categories and subheadings. However, some duplication was found unavoidable. For example, the focus on accountability in research will be found both in the initial chapter on goals and objectives and in the concluding chapter on the role of the Congress. Where it occurs, such repetition is intentional.

IX. Funding Mechanisms

An array of particular funding mechanisms and instruments, such as peer review and grants, are used to provide the government's research funds to organizations and individuals. These mechanisms have a profound effect on all aspects of the scientific enterprise, and are the focus of continuing discussion and debate. The Task Force recommends that the funding mechanisms used to support science be examined as part of the Science Policy Study.

A. ALTERNATIVE SYSTEMS OF FUNDING SCIENTIFIC RESEARCH

A cursory review of the funding mechanisms used by Federal agencies over the last 20-30 years shows that the diversity of instruments and methods of funding scientific research has been gradually narrowed. The variety of these funding instruments included Senior Investigator Grants, formula grants of various types, and block grants of many varieties. In their place, the project grant has achieved growing prominence as the principal method of providing funds for reseach.

1. To What Extent Should the Present Dominance of the Project Grant System for the Support of Scientific Research Be Gradually Replaced with a More Pluralistic Form of Support?

The project grant approach has many advantages, chief among which is that it maintains a strong degree of competition. This helps ensure that the available resources are expended on the best projects and that the system is open to new ideas and all researchers. But the system is also under considerable strain. There has long been complaints from scientists that the associated practice of basing project grants on unsolicited proposals involves a disproportionate amount of effort and paperwork. It is also claimed that the practice of judging the relative merits of the proposed projects by means of peer review does not ensure an open system, but introduces instead a strong degree of conservatism and reluctance to support unconventional research ideas. Recently, it has been claimed that the workload required to review proposals and the requirements for disclosures about personal finances have increased to the point that a growing number of scientists, especially among the leading, mature investigators, are declining to serve as reviewers. These points all serve to suggest that the time has come to ask if the trend toward sole reliance on project grants should be reversed in favor of a system which increasingly uses a greater diversity of funding mechanisms that more closely meet the needs of scientific research.

2. What Lessons Can Be Learned from the Mechanisms of Science Support Used in Other Advanced Industrial Countries?

In addition to reviewing alternative funding mechanisms used by various agencies at various times in the United States, it might well be highly useful to determine what funding methods are used in other advanced, industrial countries. While none of these methods may be directly transferable from the particular circumstances found elsewhere, there may be elements of such systems that would be highly useful. We frequently have heard mention, for example, of the Max Planck Institutes in Germany as a form of organizational arrangement outside the university setting which permits high quality research to be conducted. Other modes and practices may be of equal interest and they should all be studied as part of the Science Policy Study.

B. THE SELECTION PROCESS AND THE ROLE OF PEER EXPERTS

Underlying much of the present grant system is the belief that the best results are obtained through competition based principally on potential scientific merit. Because such judgments frequently can be made only by other scientists who are experts in the same field of science, the peer review method of deciding project competitions has become prevalent. But this system also appears to be biased against radical, high-risk research project proposals and against younger investigators. It also suffers from a high degree of centralization and much paperwork. We therefore recommend that the Science Policy Study include on its agenda a careful review of the presently used selection processes for scientific research projects, their advantages and disadvantages, and their relative merits in comparison with other possible selection methods.

1. Should the Present System of Peer Review and Competition Be Modified?

The peer review system operates differently from agency to agency and even within some agencies. Under some operating modes the peers provide their comments by mail and thus never meet face to face, while other systems involve formal meetings and discussions in Washington or elsewhere. As indicated previously, occasional complaints have surfaced to indicate that the workload of those serving as peer reviewers is trending toward a level where some of the better scientists are reluctant to continue their service as reviewers. On a more general level, concern has been expressed that while this system works well in periods of rapid growth, it may be less well suited to periods where a particular field of science is not growing. On the other hand, many have noted the very great advantage which some form of competition yields in comparison with systems in other countries which involve less, or no, competition. We are also cognizant of the strong attachment which many, but not necessarily all, scientists have to the peer review system. Thus we recommend that one approach to the reduction of the undesirable aspects of the present project selection method that should be considered is the evolution of changes which would [illegible] the system to reduce its weaknesses without eliminating its ba[illegible] strengths.

2. What Are the Advantages and Faults of Alternative Systems?

A more far-reaching way of rectifying the known problems of the present project selection system would be the adoption, wholly or partly, of quite different methods of providing research support. Such methods might include junior investigator grants and career development grants, involving support for individuals rather than projects, various forms of block or formula funding which would support institutions or groups, or, alternatively, project awards made on the basis of program manager judgments, geographic distribution criteria, or cost considerations. Any of these alternatives are likely to have distinct advantages as well as faults, and we urge that each be carefully weighed on its own merits and in comparison with the present methods as part of the review of the support selection process.

C. STYLES OF RESEARCH SUPPORT IN DIFFERENT FIELDS OF SCIENCE

A review of the variety of modes or styles in which government support for scientific research is provided, suggests that the degree of centralization or decentralization varies greatly. For example, a high degree of decentralization is found in some parts of agricultural research. The Department of Agriculture supports a comprehensive system which involves, in addition to research, extension and teaching activities. Funds for this system are provided through formula grants to the land grant colleges, the so-called "Hatch Act funds". At the other end of the spectrum, the National Institutes of Health and the National Science Foundation support research chiefly through project grants to individuals. Projects are selected on the basis of nationwide competition and peer review. In recent years, however, competitive grants have been introduced into the agricultural research system to supplement the formula grants. At the National Science Foundation and the National Institutes of Health, small but significant programs of support for limited areas of science such at materials research is being provided in the form of block grants. We recommend that these widely varying styles of research be compared and evaluated as part of the Science Policy Study.

1. Are Differing Styles of Research Support Optimum for Particular Fields of Science?

While we note the wide spectrum of styles used for the support of research in different agencies, little is available to explain why these different styles are being used. Apart from the historical evolution of the program, it is not clear whether certain types of research, for example basic or applied, or certain disciplines, for example biological or physical, thrive better under one style of support or another. In the event a correlation of support style with productivity exists, that should be ascertained and applied more widely.

2. Should Future Funding Systems for Research Mix the Two Styles of Funding?

It appears possible that the optimum mode of supporting scientific research may be a mix of formula or block grants a[illegible]mpeti-

tive project grants. The instances where experience with this mixed style of support has been developed should be included in the examination of the effectiveness of the different research support modes.

3. Has One Mode of Research Support a Higher Chance of Yielding Technological Pay-Off?

A basic question in evaluating the various modes of research support is how the different modes contribute to the transfer of research to the users who can apply them in the form of technology or cures for disease. For example, it has long been recognized that the agricultural research system has been highly successful in providing the results of research to the farmer. Whether this is due to the formula mode of research support is not clear. Conversely, the recent lag in technological innovation often is viewed as occurring in areas where research in the physical sciences might have been expected to make major contributions, and these fields of science are largely supported through project grants. The Science Policy Study's review of research support styles should attempt to determine if a relationship exists between such styles and the level of practical application.

D. SECONDARY EFFECTS OF PRESENT FUNDING MECHANISMS

The presently used mechanisms for providing support of scientific research may, on the whole, be achieving the primary aim of advancing science. However, it is becoming evident that these mechanisms also have significant secondary effects on scientists and the institutions in which they do their research. In our view, these secondary effects can not be neglected. They should be identified, both in terms of the effects produced by the existing support mechanisms and in terms of any proposed new or altered support mechanisms that may energy from the Science Policy Study.

1. Should the Federal Government Be Concerned about These Secondary Factors?

Many of the secondary effects arising from the presently used research funding mechanisms occur wholly or partly within the research institutions. As such their impact is chiefly a matter of concern to those institutions. At the same time the funding mechanisms are established by the government, and the government in the long run has an interest in assuring that the research institutions are healthy and viable. The balance between institutional autonomy and government interest should be carefully observed in the view of the Task Force. The cooperative spirit between the government and the research community should, in our view, be preserved and enhanced, and the development of an adversarial relationship should be avoided.

2. Is "Getting Research Grants" Replacing the Actual Conduct of Research as an Incentive for Some University Scientists?

One suggested effect of the present project grant system in its interaction with the universities and their system for rewarding and promoting individual scientists on their faculties is said to be

that it has become more important to obtain research grants than to conduct actual research work. The prevalence of this practice should be determined, if feasible, along with its good and bad effects, and the desirability of making adjustments in the funding mechanisms.

3. To What Extent Do the Present Funding Mechanisms Provide Incentives and Disincentives for Research Fund Raising, Industrial Cooperation, Patient Care, and Undergraduate Teaching?

The scientists who are engaged in research at universities, medical research centers, and other institutions have a number of other duties such as patient care and undergraduate teaching. The institutions similarly have duties other than raising research funds from the Federal agencies. These include fund raising from private donors, and cooperation with industrial firms and many other functions. It has been noted that the present mechanisms of providing Federal research funds may in some cases serve as disincentives for carrying out these other activities. This should be reviewed as part of the Science Policy Study, and, if possible, corrective measures should be recommended.

4. Would Growing Institutional Funding Lead to Growing Government Influence in Research Institutions?

Any shift in the use of funding mechanisms which would increase the reliance on funding mechanisms that provide support to institutions rather than to individuals might potentially lead to expanded government influence on the institutions. Past experience with such funding mechanisms should be carefully reviewed in designing new approaches to institutional support research funding.

E. THE COST OF RESEARCH

To a considerable extent the discussions about government funding of university research activities have become centered on a group of technical issues. These are issues having to do with what it costs to carry out research in an institutional setting and how many of the costs less directly related to such research should or should not be borne by the government. Because of their impact on both the financial health of the universities and on the costs to the government, we recommend that these technical issues be included within the scope of the Science Policy Study.

1. What Accounts for the Gradual Increase in Indirect Cost Rates, and Is This Growth Desirable or Undesirable?

For most grants and contracts the direct costs, consisting of salaries, materials, publication costs, etc., are supplemented by the so-called indirect or overhead costs. These presumably pay for such associated costs as building maintenance, heating, and shared clerical support. A slow but steady growth of the indirect cost rate has been noticeable over the last five years. This growth has meant that for every dollar provided to a research institution a smaller and smaller fraction goes to the direct cost of doing research, while a mounting fraction goes to defray general institutional costs. The nature of this shift, if in fact it is widespread, should be

ascertained and its longer term implications should be carefully examined.

2. Is It Possible to Replace the Present Complex Indirect Cost System with a Better System?

The present system by which government agencies pay the research institutions for their indirect costs involve the careful and detailed audit of the institution's books after the costs have been incurred. The government auditors must determine whether a given expenditure is allowable under the current rules and how much is allocable to a particular grant. Frequent disagreements occur between the university officials, who seek to recover as much of their costs as possible, and government auditors, who seek to include only those cost items reasonably chargeable to the government projects. Because of differences in institutional accounting practices, the overhead rates vary from institution to institution. It has occasionally been suggested, most recently in a 1984 study by the General Accounting Office, that a fixed overhead be established for all research grants at all institutions. This would eliminate the need for the complex and controversial accounting rules and the extensive auditing needed to ensure compliance with them. However, the research institutions have resisted such an approach, in part because they feel that if the rate were set too low, it would mean a substantial loss of revenue to cover many of their administrative costs. In more general terms, the underlying question is how much of the institutional operating costs should be borne by the agency sponsoring individual research projects at research institutions. Institutional grants for this purpose also have been considered to deal with this question, and we recommend that this entire question be examined as part of the Science Policy Study.

3. Has Cost Sharing Worked in the Past and Is It Feasible in the Future?

In the early postwar years when the Federal Government embarked on an expansion of support for science at American universities, there was a strong belief that this should be done in the form of partial assistance to such research, rather than complete funding. There were concerns that complete funding could lead to undue government interference in the research being done and in the internal operation of the university. There was also a feeling that, while the research being done would benefit the government, it also would benefit the institution and the professor in charge by providing training of graduate students, professional growth for the scientist, and some measure of enhanced status to the university. Based on such considerations, the principle of cost sharing between the government and the university was established for the funding of research. In practice, however, this principle is not widely used. In some cases cost sharing is less than one percent, and it may well have lost both its actual and symbolic effects. We recommend that the principle and practice of cost sharing be reviewed as part of the Science Policy Study and that a clear-cut policy for this practice be sought.

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

June 20, 1985
Washington Hilton Hotel
Jackson Room
8:00am-Noon

I.	CALL TO ORDER	
II.	CONSIDERATION OF MINUTES April 4, 1985	Page 18
III.	MEMBERSHIP	
	The Institute for Rehabilitation and Research, Houston, TX	Page 51
IV.	SPRING MEETING REVIEW	Page 56
V.	1984 NEW CHALLENGES PAPER REVISITED	Page 57
VI.	AAMC FACULTY PRACTICE SURVEY	Executive Council Agenda - Page 70
VII.	HEALTH PLANNING	Executive Council Agenda - Page 55
VIII.	REVIEW OF THE AAMC MCAT PROGRAM	Executive Council Agenda - Page 60
IX.	REPORT OF THE AAMC AD HOC COMMITTEE ON THE IOM STUDY OF THE STRUCTURE OF NIH	Executive Council Agenda - Page 12
X.	PROPOSED CHARGE FOR THE AAMC RESEARCH POLICY COMMITTEE	Executive Council Agenda - Page 51
XI.	INFORMATION ITEMS	
	Special Healthcare Financial Management Association (HFMA) Session for Teaching Hospital CFOs	Page 61
XII.	OTHER BUSINESS	
XIII.	ADJOURNMENT	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
April 4, 1985

PRESENT

Sheldon King, Chairman
C. Thomas Smith, Chairman-Elect
Haynes Rice, Immediate Past Chairman
Robert J. Baker
J. Robert Buchanan, MD
Jeptha W. Dalston, PhD
Gordon M. Derzon
Spencer Foreman, MD
Gary Gambuti
Glenn R. Mitchell
James J. Mongan, MD
Eric B. Munson
David A. Reed
Thomas J. Stranova
Nancie Noie, AHA Representative

GUESTS

Robert M. Heyssel, MD

STAFF

James D. Bentley, PhD
Melissa Brown
Richard M. Knapp, PhD
Karen L. Pfordresher
James Schofield
Nancy E. Seline
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD
Meeting Minutes
April 4, 1985

I. CALL TO ORDER

Mr. King called the meeting to order at 8:00am in the Hamilton Room of the Washington Hilton Hotel.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the January 24, 1985 COTH Administrative Board meeting.

Before moving directly to the agenda, the Chairman indicated that Dr. Knapp had three items to share with the Board. Dr. Knapp distributed a publication entitled, "Recalibration & Updating: A Means to Healthcare, Cost Control and Quality." This is a document that has been produced by the Health Industry Manufacturers' Association which makes a significant contribution to the debate concerning possible changes in the Medicare Prospective Payment System. Board members were urged to share this document with their staff responsible for activities in this area. Dr. Knapp then distributed copies of the Council of Teaching Hospitals Executive Salary Survey which had recently been mailed to the membership. He made the point that a special analysis had been prepared of the 115 member hospitals in which the majority of the chairmen in the medical school departments are also hospital chiefs of service. Increasingly in the COTH surveys, special analyses will be done for this set of institutions. He reminded the Board of the way in which these institutions were selected and distributed a memorandum of March 27, which was accompanied by the Executive Salary Survey to those 115 institutions. A copy of this memorandum is included in these minutes as Appendix A. At this point, Jim Bentley followed up on an item discussed at the January Board meeting. He reported on the results of his informal effort to identify hospitals interested in participating in a pilot study of resident staffing patterns. While several CEOs have expressed interest in study findings, little interest has been found in participating in the study. CEOs with concerns about the study have also expressed several concerns about the study: (1) reducing housestaff is a political issue and data from other hospitals is only of marginal value, (2) the study is not sufficiently detailed and precise that the results can convert a political issue into a quantitative issue, (3) areas of significant overstaffing are already known, and (4) data showing a hospital below the average could be used by some chiefs of service to argue for increases. Given these discussions, plans are to send a letter inviting participation to the CEOs of all 115 academic medical center hospitals. If sufficient interest is generated, the effort will go forward.

III. MEMBERSHIP

A. Following discussion and appropriate consideration, the following action was taken:

ACTION: It was moved, seconded, and carried to approve:

(1) CITY OF FAITH HOSPITAL, Tulsa, OK for full membership;

(2) ST. ELIZABETH HOSPITAL MEDICAL CENTER, Youngstown, OH for full membership;

(3) ST. MARY'S HOSPITAL, Waterbury, CT for full membership;

(4) SAN FRANCISCO GENERAL HOSPITAL, San Francisco, CA for full membership.

B. For-Profit Participation in the Council of Teaching Hospitals

A general discussion was held concerning formal action by the Administrative Board to recommend that the AAMC Bylaws be amended to permit individual for-profit hospitals to join the AAMC Council of Teaching Hospitals provided they meet the membership requirements that apply to all other hospitals. Dr. Dalston raised the question of whether or not this action can be done without changing the legal structure of the organization. It was agreed that the action needs to be taken as a policy matter and the legal issues will then be reviewed. A letter is being prepared by the Williams, Meyers, and Quiggle law firm requesting permission from the IRS to move ahead in this direction. Mr. Smith pointed out that there never has been a statement of responsibility and commitment that a given institution must specify in order to maintain its membership in the Council of Teaching Hospitals. In other words, it may be desirable to require that for certain surveys members be required to participate in order to maintain their membership in good standing. This is an issue that may have to be pursued if the move to change the Bylaws comes to pass.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board recommend to the AAMC Executive Council that the AAMC Bylaws be amended to permit individual for-profit hospitals to join the Council of Teaching Hospitals provided they meet the membership requirements that apply to all other hospitals. Eleven individuals voted in favor; two individuals, Dr. Foreman and Mr. Rice, voted "no."

The Chairman asked the staff to prepare a fact sheet setting forth the action taken by the Administrative Board as well as the pros and cons of moving ahead with this proposal that should be included in the registration packet for the COTH Spring Meeting in San Francisco. He indicated that at the Business Session of that meeting he would raise

this question and ask all who wished to make presentations on the issue. However, he did not anticipate specifically calling for a vote at that meeting.

IV. FINANCING GRADUATE MEDICAL EDUCATION

The Chairman asked the Board to move directly to this item and asked Dr. Buchanan to report on his testimony before Senator Quayle on March 25. Dr. Buchanan reviewed briefly the testimony he presented and indicated that this testimony had been distributed to the AAMC membership. He stated that he was asked about the matter of a physician surplus and responded that he wasn't quite so sure that there will be a physician surplus given the fact that the number of women in the physician workforce has increased substantially and there is currently much reorganization taking place with regard to the provision of medical services. Given these major changes along with the fact that the population is aging rapidly, he wasn't so sanguine about a physician surplus in the future. He stated that Senator Quayle listened carefully, asked intelligent questions, and his own impression was that there is a growing sense that we are certainly producing too many specialists.

Dr. Buchanan also indicated that he had made presentations of the Statement of Issues paper completed by the Committee on Financing Graduate Medical Education at the recent spring meetings of the Council of Deans and the Council of Academic Societies. A survey was distributed at each of these meetings addressing three issues with the following questions:

- Teaching hospitals are facing an increasingly price sensitive market. Can your hospital compete on a price basis with non-teaching hospitals, and continue to support graduate medical programs at current levels?

- Currently 18% of the residents in this country are foreign medical graduates. Approximately half of the FMGs are U.S. citizens and the other half are aliens. Should the AAMC take a clear position opposing Medicare funding of residents who are foreign medical graduates?

- Which of the three options do you believe the AAMC should favor if there is to be separate funding of graduate medical education?

  1. Fund residents for a fixed number of years (e.g.; three) regardless of the length of their training and impose no explicit manpower constraints;

  2. Fund residents for the training necessary to attain initial board eligibility and possibly have some manpower constraints imposed on the number of residency slots to be funded in each specialty;

  3. Fund residents in all accredited programs for initial and subspecialty training and accept the manpower planning constraints which will be imposed.

Dr. Buchanan indicated that he would be making a similar presentation at the San Francisco COTH Spring Meeting and that the Committee on Financing Graduate

Medical Education will have a meeting in July to discuss the composition of its final committee report.

At this point the Chairman described his experience testifying before Congressman Waxman's Health Subcommittee of the House Energy and Commerce Committee. The first two witnesses were Henry Desmarais and Bob Graham on behalf of the Administration. They were, in the Chairmans view, "raked over pretty well" for taking a policy initiative without any idea what the implications of that initiative would be. Specifically, a 50% reduction in the indirect medical education adjustment and a freeze on the direct medical education passthrough were not well received by either Republican or Democratic congressman, nine of which were present at this point in the hearing. Testimony was presented by Dr. Will Deal, the Dean at the University of Florida; and Stuart Marylander, President, Cedars-Sinai Medical Center, Los Angeles, on behalf of the AMA and AHA respectively. They were reasonably well received in their views. Dr. Heyssel made a presentation and set forth his view that it would not be an unacceptable request that the Medicare passthrough be limited to only three years of graduate medical education. He also talked at length about the control of graduate medical education and the wide range of organizations involved in this control. Following these presentations, a number of individuals representing primary care residency programs testified and made the point that they would be the first to be hurt in any reductions in hospital revenue. All these witnesses were well received. Bob Sillen, Director of the Santa Clara Medical Center, testified on behalf of the National Association of Public Hospitals. He made an effort to tie together the graduate medical education issue and the indigent care issue, but the result did not come across in that fashion. There was a desire to separate those two issues by the Committee. The Chairman indicated that he presented the AAMC policy positions that were ratified by the Administrative Board and the Executive Council at the meetings in January. He indicated that he received a generally positive reception and was impressed with the fact that the entire Committee seemed to be much more positive than he expected them to be. He stated that he had spent the previous day with the Stanford lobbyist visiting various staff members of committees and California congressmen and once again felt that he had received a good reception. He was surprised to find that the DRG freeze was not as much a given as he expected it to be. He urged other members to take the opportunity when they visit Washington to stop by and see their congressmen and express their views on subjects important to the AAMC and their institutions. Finally, he indicated that Dr. Mongan would be testifying before the Health Subcommittee of the Committee on Ways and Means on behalf of the AAMC on April 15.

The Chairman asked for comments or questions concerning the Statement of Issues document drafted by the Committee on Financing Graduate Medical Education or any of the reports on testimony that had been given thus far. Dr. Foreman raised the question of the matter of funding fellows. He indicated that the AAMC needs to exercise care in approaching this subject, and should begin to develop arguments for generating other sources of funding in this area. Mr. Rice raised the question of social responsibility if a recommendation were to be brought forward opposing funding for foreign medical graduates. He and Mr. Gambuti indicated that they understood the need to separate the issue of indigent care from graduate medical education. However, in a practical sense, it is a fact that graduate medical education is being used as a method of providing services to those who cannot afford to pay. To the extent that foreign medical graduates are providing these services, that issue needs to be underlined and understood. Mr.

Rice reiterated his view that this subject needs to be raised specifically in the discussion of financing graduate medical education at the Spring Meeting and in other settings. Dr. Mongan indicated that he felt that we shouldn't just address the need for special funding but also the wisdom of changing this system. He advocated an incremental approach to any policy changes.

V. COTH GENERAL SESSION AT THE AAMC ANNUAL MEETING

The topics for the COTH General Session since 1972 were reviewed briefly. The following individuals were identified as individuals who might speak:

Richard Davidson - Maryland Hospital Association;

Drew Altman - The Robert Wood Johnson Foundation;

Bob Blendon - The Robert Wood Johnson Foundation;

Ewe Reinhardt - Princeton University (in particular, his recent article on indigent care in the Princeton University alumni magazine was cited as a useful article to review);

John Cogan - Office of Management and Budget;

Richard Egdahl, MD - Boston University.

The possibility of identifying someone to describe the Florida proposal to finance indigent care or identifying a "futurist" who might give us a preview of general views as well as views specific to the health care environment were suggested.

Mr. Smith stated that he felt the Council should be careful and not allow this meeting to take on the "Rotary Club" luncheon attributes. In other words, this is a nice lunch and this is an interesting topic. He recommended that we think in terms of a speaker(s) who is directly related to a policy issue(s) concerning the future of this organization and its members. This suggestion was well received and there was agreement that the Chairman and Chairman-Elect should work with the staff to identify an appropriate program and inform the Board of their decision at the June Administrative Board meeting.

VI. UPDATE ON CONSORTIUM ACTIVITIES

Three members of the Board were asked to provide a synopsis of the activities of the consortia to which their hospitals belong. Mr. Baker was asked to provide information on the University Hospital Consortium, Mr. Reed on Associated Healthcare Systems, and Dr. Foreman on the Consortium of Jewish Hospitals. These consortia were of particular interest since large numbers of COTH members belong to these organizations. Mr. Baker began by describing the history of the University Hospital Consortium. UHC is a new organization which evolved out of the Consortium for the Study of University Hospitals. The hospitals were organized in order to help them face price competition from physician groups and multi-hospital groups. The UHC began by putting together data on governance and linkages with other types of providers. By 1984, UHC had 20 members and was looking to achieve recognition of their unique qualities, which included a dedication to teaching, the provision of indigent care, a similarity of missions,

a strong research base, and the need for new technology. UHC currently has 40 hospital members, which totalled approximately 25,000 beds and $3.2 billion in revenue each year. When the Council of Teaching Hospitals elected not to participate in economic services, the Consortium took on this role. UHC has begun to move into areas of capital, pharmaceutical, and medical supply group purchasing programs. It also has engaged in a strategic planning process which is to be completed by the end of May and is intended to identify other functions which UHC might pursue.

Mr. Baker reported the UHC has no interest in assuming an advocacy role, but it will continue to provide economic services of benefit to its members. If there is an overlap in the functions performed by UHC and COTH, it will be in the area of information sharing. UHC has begun to identify some areas for data collection and dissemination. The UHC will continue its interest in and commitment to research of interest to its membership and since its members are also COTH members, there is some potential for duplication between the COTH or academic medical center surveys and surveys of the UHC. He indicated every effort would be made to avoid such duplication.

The UHC is viewed as a unique multi-hospital system whose membership has a commonality of missions. They might attempt to market themselves as a national referral network.

Mr. Reed stated that American Healthcare Systems was formed in 1984 from two already existing multi-hospital networks, formerly known as the Associated Hospital Systems of Phoenix and United Health Care Systems of Kansas City. These two systems and the other systems that have joined them in this corporation were brought together by the problems of access to capital and the hope of obtaining a better competitive advantage. By working together they hope to assure high quality hospital and health care services. In addition, AHS will continue to strengthen the competitive position of its shareholders and help them to realize the economic advantages of size while maximizing their long term economic value. AHS members maintain local and regional control of the hospitals. Specifically, the goals of AHS are:

- To develop a national network of health care delivery systems which is both vertically and horizontally integrated and represents all geographic regions of the U.S.
- To maintain and stengthen the systems in their respective markets and identify creative forms of increasing market share through joint venture arrangements among the systems.
- To engage in healthcare policy making through advocacy of policies which will benefit the shareholders of the company.
- To develop educational programs for improved governance and management of its members.
- To identify cooperative methods of meeting capital requirements for member hospitals.
- To engage in new health care delivery and financing programs both for the members and as investment opportunities.

- To develop cooperative relationships with either physician groups or with businesses that have major health care components.

The membership of the AHS consists of 26 multi-hospital systems. Together they own or manage 233 hospitals and 650 affiliates. They have a sum of 45,000 hospital beds and approximately $6 billion in revenue in 1984. In order to become a member, a system must have: a reputation for high quality; two or more hospitals that are owned, leased or managed; at least $100 million minimum annual revenue; a separate corporate office; non-profit status; a strong management and financial position; and minimum market overlap with an institution already in the corporation.

AHS has four divisions: (1) American Health Care Institute, located in Washington, DC and directed by Monte DuVal, MD, which has the primary pupose of developing and transmitting policy positions and concerns of AHS regarding federal initiatives; (2) a venture division, headquartered in Chicago, which is designed to organize joint ventures that will enhance the health care delivery or financial strength of AHS; (3) a shared services division with more than $1 billion in purchasing power, which is currently examining a joint venture in durable medical equipment purchasing; and (4) a capital division which is seeking new ways of accessing capital.

Dr. Foreman described the Consortium of Jewish Hospitals as a group that grew out of informal meetings of chief executive officers who had known each other through the years. This informal group began a group purchasing program in 1977, and as the organization became more formal, it defined its purpose as primarily for economic objectives. The Consortium would like to grow to approximately 30 hospitals. The organization offers programs "a la carte" to its members.

The members were characterized by Dr. Foreman as being hospitals with a large resident staff, length of stay, occupany rates, costs, and numbers of full-time equivalent employees which are all higher than those of the average hospital. The Consortium is involved in equipment purchases, cash management, and an advisory service for its member institutions. It is exploring access to the capital issue. The Consortium is interested in HMO and PPO arrangements. It is attempting to establish a case mix data base in order to do product line analysis and physician by physician analysis of utilization patterns. It has consultants online and is interested in exploring arrangements for clinical trials with health industry manufacturers. Initial capitalization for new members in the Consortium consists of $75,000 of which $40,000 is for base fees.

These presentations were followed by a brief board discussion in which members questioned Mr. Baker, Mr. Reed, and Dr. Foreman about the various aspects of their consortium activities. Several Board members stated that when such organizations mature to a certain point they begin to take on a life of their own. At this point Voluntary Hospitals of America appears to be at this stage of development. There is the potential for the organization to come into conflict or competition with the COTH. However, Mr. Mitchell pointed out that it may be impossible for institutions to survive in the current economic environment if they do not have a national organization supporting their economic needs.

There was consensus that the staff should review the 1984 "New Challenges...," paper and summarize it so that it can be discussed at the June COTH Administrative Board meeting in light of the presentations about the four

consortia. It was agreed that every effort should be made to avoid duplication of effort and and to promote harmony.

VII. LCME FUNCTIONS AND STRUCTURES OF A MEDICAL SCHOOL

Dr. Buchanan presented the proposed new LCME standards for accreditation of medical schools. The final version of the proposed standards is the thirteenth draft of work begun in 1980 to correct deficiencies in existing standards that did not address recent changes in medical education. Earlier draft versions had been circulated at large for comments and this final version incorporates appropriate comments. Dr. Buchanan stated that the Department of Education has an interest in the progress of this document concerning the delegation of authority to assess the process leading to the award of the MD degree.

ACTION: It was moved, seconded, and unanimously carried to approve the final version of LCME standards for accreditation of medical education programs.

VIII. ADDITION TO THE GENERAL REQUIREMENTS FOR GME

Dr. Cooper stated that the changes in essence require that each residency program assess the clinical competence of residents in the early part of the PGY-1 year. Dr. Cooper reported that this requirement is in fact a restatement of the language in the general essentials and in effect is redundant. He reported that the Association favors a hands-on examination of foreign medical graduates.

Dr. Foreman agreed that this additional requirement is a restatement of what is already required by the ACGME. He also questioned whether those required to perform the evaluation wouldn't have a self-interest in maintaining the resident in the program. Mr. Rice stated that this is an attempt to protect the public from inadequately trained physicians, a problem that is greater in scope in the foreign medical graduate cohort. Dr. Buchanan pointed out that the housestaff years are a time for the development and refinement of skills and techniques that were only introduced during the medical school years. At good institutions, Dr. Buchanan believes, there is an assessment of each individual. He concurred with Dr. Cooper that the Board should reaffirm the Association's earlier position favoring a hands-on review.

ACTION: It was moved, seconded, and carried that the Board recommend the Executive Council not ratify the addition of this statement to the General Requirements, and that the Council request that the ACGME develop a hands-on clinical skills examination by which graduates of non-LCME accredited schools are evaluated for adequate competence to undertake residency training.

IX. CERTIFICATION AND GME

Dr. Heyssel was called upon to introduce discussion of the AAMC proposed amendment to the American Board of Medical Specialties (ABMS) bylaws to require ABMS approval of any changes to requirements set by specialty boards which have a significant impact upon the resources that must be provided by teaching hospitals for their graduate programs, or that impinge upon the education resources of programs in other specialties. He reported that the ABMS tabled the proposal in

September 1984 and subsequently sponsored an invitational conference on the Impact of the Certification Process on Graduate Medical Education. Dr. Heyssel stated that he believed the discussion was valuable and realistic, especially considering the changing, cost competitive national environment. Dr. Cooper agreed that although the discussion did not result in the actions preferred by the AAMC, great strides were taken in the recognition that the current process by which the length of training programs is decided may need to be re-evaluated. No Administrative Board action was taken.

X. FOLLOW-UP ON MEDICARE POLICY DECISIONS

Dr. Bentley briefly summarized the present status of legislation and regulation to change Medicare's hospital payments. He noted that the proposed Senate budget resolution incorporated all of the President's recommendations and that the resolution would likely be considered in late April. Dr. Bentley then reviewed each of the substantive issues involved in the President's budget and suggested "best case/worst case" alternatives presently under consideration by various congressional committees. AAMC activities in several areas were discussed: (1) the AAMC is working with a coalition of associations to freeze the phase-in; (2) the AAMC distributed draft copies of the regulation to freeze direct medical education payments to the membership and urged members to lobby against a regulatory approach; (3) the AAMC is working to hold the resident-to-bed adjustment at 9%.

Following Dr. Bentley's presentation, Mr. Rice distributed copies of a Privacy Act notice published in the Federal Register. The notice is a procedural step required to collect data necessary for Medicare to pay the resident-to-bed adjustment. Mr. Rice was particularly concerned that the required reporting could lead to overtime payments for residents. Dr. Bentley reported that staff continues working with HCFA personnel to find a less intrusive and less burdensome reporting requirement.

XI. ADJOURNMENT

The meeting was adjourned at 12:00noon.

association of american medical colleges

March 27, 1985

To: Members of the Council of Teaching Hospitals

From: Richard M. Knapp, Ph.D.

Subject: COTH Executive Salary Survey

Enclosed is the sixteenth annual COTH Executive Salary Survey. This document contains the traditional analyses of the compensation, benefits and characteristics of COTH chief executive officers, as well as data on the salaries and benefits of departmental executives. In addition, this year a special analysis has been completed using just the data received from those members which are under common ownership with a university, or are public or private hospitals in which the majority of chairmen of the medical school departments are the chiefs of service. These hospitals are those that are in the first three categories described on page 5 of the April, 1984 document New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals. A memorandum describing these hospitals more completely and lists of the hospitals in each category are attached for your review. There are 115 hospitals in this group, 79 of which submitted responses to the 1984 Executive Salary Survey.

This Special Analysis is being distributed only to the 115 hospitals who are in this group. In addition to the aggregate information, the data have been provided for the six categories: (1.) public hospitals, (2.) private hospitals, (3.) university-owned public hospitals, (4.) university-owned private hosital s, (5.) private hospitals not owned by a university (those on the second list), and (6.) public hospitals not owned by a university (those on the third list). An analysis of the university-owned hospitals (those on the first list) is already included in the data provided in the traditional Executive Salary Survey report, and it has not been replicated in this Special Analysis.

We sincerely hope you find both the COTH Executive Salary Survey report and the new Special Analysis useful. If you have questions, comments, or suggestions as to how these reports can be improved, please contact me or Nancy Seline of my staff at (202) 828-0496. We look forward to hearing from you.

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

association of american medical colleges

SPECIAL ANALYSIS

1984 EXECUTIVE SALARY SURVEY

Department of Teaching Hospitals

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

SPECIAL ANALYSIS

TABLE 1

CHIEF EXECUTIVE: 1984 GROSS ANNUAL SALARY

Hospital Category	Number of Responses	Mean	Percentiles		
			25th	50th	75th
Public	42	$85,896	$72,000	$80,000	$99,000
Private	33	122,760	98,975	119,000	138,000
Public, University-Owned	30	87,160	75,000	82,500	99,000
Private, University-Owned	14	107,282	86,824	114,720	123,175
Public, Not University-Owned	12	82,738	65,110	70,500	94,578
Private, Not University-Owned	19	134,165	106,000	132,000	158,000
Aggregate	75	102,117	75,156	97,000	123,175

SPECIAL ANALYSIS

TABLE 2

ESTIMATED CASH VALUE OF FRINGE BENEFITS

Hospital Category	Number of Responses	Mean	Percentiles		
			25th	50th	75th
Public	33	$14,133	$9,697	$12,578	$17,179
Private	20	19,852	10,000	15,000	22,000
Public, University-Owned	25	14,633	10,000	14,000	17,000
Private, University-Owned	9	17,554	9,000	18,103	18,550
Public, Not University-Owned	8	12,572	4,000	5,500	19,760
Private, Not University-Owned	11	21,732	10,000	15,000	40,350
Aggregate	53	16,291	10,000	14,600	19,760

SPECIAL ANALYSIS

TABLE 3

CHIEF EXECUTIVE OFFICER: CASH VALUE OF DEFERRED COMPENSATION

Hospital Category	Number of Responses	Mean	Percentiles		
			25th	50th	75th
Public	11	$5,413	$3,307	$5,000	$7,500
Private	8	34,341	8,000	16,875	30,000
Public, University-Owned	7	4,456	3,307	5,000	6,000
Private, University-Owned	1	**	**	**	**
Public, Not University-Owned	4	7,087	1,800	7,050	7,500
Private, Not University-Owned	7	38,532	14,000	30,000	50,854
Aggregate	19	17,593	5,000	7,500	16,875

**Too few respondents to report data.

SPECIAL ANALYSIS

TABLE 4

CHIEF EXECUTIVE: FRINGE BENEFITS PROVIDED IN 1984

AT NO PERSONAL COST

Type of Fringe Benefits	Hospital Categories						
	Public (n=45)	Private (n=34)	Public, Univ.-Owned (n=33)	Private, Univ.-Owned (n=15)	Public, not Univ.-Owned (n=12)	Private, not Univ.-Owned (n=19)	Aggregate (n=79)
Hospitalization Ins. - Individual	67%	59%	73%	53%	50%	63%	63%
Hospitalization Ins. - Family	44	62	49	33	33	84	52
Major Medical - Individual	62	65	67	67	50	63	63
Major Medical - Family	47	62	52	40	33	79	53
Dental Services - Individual	51	53	52	40	50	63	52
Dental Services - Family	36	35	42	20	17	47	35
Professional Liability	69	74	70	47	67	95	71
Life Insurance	56	77	58	47	50	100	65
Disability Insurance	49	77	52	53	42	95	61
Travel Insurance	11	44	15	47	0	42	25
Automobile Insurance	16	29	9	7	33	47	22
Automobile provided	64	68	61	40	75	90	66
Prof'l Dues and Memberships (not specified)	49	82	58	80	25	84	63

SPECIAL ANALYSIS

TABLE 5

AGGREGATE

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

			Percentiles		
NON-M.D. POSITIONS					
Title	(n)	Mean	25th	50th	75th
Associate	72	$73,854	$58,528	$68,836	$80,300
First Assistant	78	62,974	49,922	60,240	67,122
Second Assistant	74	56,941	45,300	53,650	63,000
Third Assistant	65	49,281	41,904	47,637	53,500
Chief Fiscal Officer	73	69,516	56,850	66,585	81,500
Controller	57	50,848	42,720	47,285	57,000
Director of Outpatient Services	37	40,615	30,400	38,555	46,647
M.D. POSITIONS					
Director of Medical Education	11	81,461	57,782	74,022	90,120
Medical Director	28	87,696	75,000	86,076	101,085
Director of Emergency Room	36	74,933	65,642	82,000	91,506

SPECIAL ANALYSIS

TABLE 5 (continued)

AGGREGATE

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

Non-M.D. Departmental Executives	(n)	Mean	Percentiles 25th	50th	75th
Data Processing	64	$51,959	$44,700	$51,290	$58,299
Dietary	55	39,632	33,590	39,252	44,036
Senior Engineer	63	47,710	40,788	46,000	54,000
Housekeeping	61	33,236	29,000	32,585	38,709
Laundry	39	33,025	23,670	29,910	36,055
Nursing School	8	48,401	42,640	44,500	48,794
Nursing Service	69	55,913	48,652	55,000	62,600
Personnel	61	48,745	41,000	45,500	58,000
Pharmacy	73	49,131	43,050	49,013	55,300
Medical Records	73	36,720	31,800	36,061	41,041
Public Relations	58	41,896	32,827	40,700	48,300
Purchasing	62	37,617	32,710	36,630	41,916
Social Service	74	38,678	31,574	38,300	43,600
Physical Therapy-Sr. Tech.	72	34,969	30,912	34,192	38,995
Clinical Lab-Sr. Tech.	65	37,057	33,528	36,818	40,000
Radiology-Sr. Tech.	71	37,535	30,132	36,300	41,419
Inhalation Therapy-Sr. Tech.	72	33,950	29,964	33,700	37,065
Hospital-Based Planner	50	48,442	35,897	45,000	56,000
Full-Time In-house Legal Counsel	25	51,570	40,020	50,000	62,000

SPECIAL ANALYSIS

TABLE 6

PUBLIC

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

			Percentiles		
NON-M.D. POSITIONS					
Title	(n)	Mean	25th	50th	75th
Associate	41	$62,085	$52,000	$62,700	$69,900
First Assistant	44	53,371	45,000	51,700	63,000
Second Assistant	41	47,507	40,428	48,996	54,200
Third Assistant	38	43,683	39,228	44,000	48,006
Chief Fiscal Officer	43	60,917	51,003	62,000	70,000
Controller	30	45,335	40,400	43,500	47,285
Director of Outpatient Services	23	40,618	30,400	39,000	46,980
M.D. POSITIONS					
Director of Medical Education	7	70,218	57,782	73,000	87,600
Medical Director	21	80,553	58,218	85,000	95,000
Director of Emergency Room	25	75,090	65,642	85,000	91,506

SPECIAL ANALYSIS

TABLE 6 (continued)

PUBLIC

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

Non-M.D. Departmental Executives	(n)	Mean	Percentiles 25th	50th	75th
Data Processing	37	$46,388	$40,500	$47,037	$53,500
Dietary	32	36,581	32,686	36,000	40,216
Senior Engineer	32	45,268	38,538	45,864	51,000
Housekeeping	34	31,226	26,973	30,744	34,360
Laundry	25	33,255	22,387	25,251	32,300
Nursing School	4	54,140	44,500	48,794	51,168
Nursing Service	39	51,165	41,916	52,000	60,000
Personnel	34	42,228	36,857	43,000	46,800
Pharmacy	41	46,960	41,253	46,935	52,000
Medical Records	43	35,254	30,744	35,364	39,000
Public Relations	30	36,954	30,051	37,500	42,720
Purchasing	35	36,423	32,000	36,755	40,740
Social Service	43	36,291	30,888	36,428	41,556
Physical Therapy-Sr. Tech.	43	34,040	29,460	34,000	38,000
Clinical Lab-Sr. Tech.	39	35,713	31,700	35,246	38,856
Radiology-Sr. Tech.	43	35,691	30,000	35,410	39,900
Inhalation Therapy-Sr. Tech.	43	32,952	29,286	32,376	37,003
Hospital-Based Planner	30	42,067	35,000	40,000	47,000
Full-Time In-house Legal Counsel	10	42,651	36,040	38,000	48,250

SPECIAL ANALYSIS

TABLE 7

PRIVATE

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

			Percentiles		
NON-M.D. POSITIONS					
Title	(n)	Mean	25th	50th	75th
Associate	31	$89,420	$70,000	$80,276	$100,000
First Assistant	34	75,402	57,886	70,000	82,800
Second Assistant	33	68,662	53,650	63,315	75,332
Third Assistant	27	57,158	47,000	53,000	65,700
Chief Fiscal Officer	30	81,840	70,000	81,500	90,901
Controller	27	56,974	50,000	54,500	65,000
Director of Outpatient Services	14	40,609	29,500	34,500	46,647
M.D. POSITIONS					
Director of Medical Education	4	101,136	56,547	83,000	100,000
Medical Director	7	109,125	81,799	101,085	139,196
Director of Emergency Room	11	74,575	75,000	80,900	95,320

SPECIAL ANALYSIS

TABLE 7 (continued)

PRIVATE

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

Non-M.D. Departmental Executives	(n)	Mean	Percentiles 25th	50th	75th
Data Processing	27	$59,594	$50,958	$58,299	$68,000
Dietary	23	43,877	37,600	44,036	49,280
Senior Engineer	31	50,230	42,160	46,000	56,971
Housekeeping	27	35,768	30,000	35,479	40,608
Laundry	14	32,615	26,200	31,680	38,000
Nursing School	4	42,662	37,010	42,640	43,000
Nursing Service	30	62,086	52,700	58,475	69,000
Personnel	27	56,953	42,262	59,000	67,000
Pharmacy	32	51,913	47,100	51,300	56,547
Medical Records	30	38,822	32,171	38,000	46,000
Public Relations	28	47,190	36,139	47,662	55,000
Purchasing	27	39,164	33,000	36,630	45,800
Social Service	31	41,990	32,500	40,125	50,300
Physical Therapy-Sr. Tech.	29	36,346	32,750	35,028	42,000
Clinical Lab-Sr. Tech.	26	39,072	36,500	37,075	42,500
Radiology-Sr. Tech.	28	40,367	31,753	38,500	46,628
Inhalation Therapy-Sr. Tech.	29	35,429	31,803	34,570	38,500
Hospital-Based Planner	20	58,003	40,020	52,300	69,300
Full-Time In-house Legal Counsel	15	57,517	48,400	52,500	69,500

SPECIAL ANALYSIS

TABLE 8

PUBLIC, UNIVERSITY-OWNED

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

			Percentiles		
NON-M.D. POSITIONS					
Title	(n)	Mean	25th	50th	75th
Associate	30	$62,559	$55,000	$63,000	$69,900
First Assistant	33	54,113	45,052	54,000	63,300
Second Assistant	31	48,375	40,428	50,000	55,000
Third Assistant	29	44,376	40,000	44,195	49,290
Chief Fiscal Officer	31	62,070	55,000	62,700	70,000
Controller	22	47,452	41,500	43,706	50,849
Director of Outpatient Services	18	42,505	34,000	43,000	47,700
M.D. POSITIONS					
Director of Medical Education	3	68,268	******	73,000	******
Medical Director	15	84,420	58,218	86,076	104,700
Director of Emergency Room	20	79,364	66,380	86,467	93,200

SPECIAL ANALYSIS

TABLE 8 (continued)

PUBLIC, UNIVERSITY-OWNED

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

Non-M.D. Departmental Executives	(n)	Mean	Percentiles 25th	50th	75th
Data Processing	28	$47,937	$40,500	$48,136	$53,699
Dietary	24	36,990	32,686	35,400	40,300
Senior Engineer	21	46,030	38,947	43,307	51,000
Housekeeping	26	30,889	27,200	30,500	33,720
Laundry	15	37,452	20,116	26,100	32,300
Nursing School	1	72,100	******	******	******
Nursing Service	28	52,508	45,000	53,538	60,000
Personnel	22	43,954	38,300	43,140	47,700
Pharmacy	31	47,534	41,253	47,064	53,436
Medical Records	31	35,194	31,800	35,000	38,099
Public Relations	22	38,553	34,336	38,856	42,720
Purchasing	23	36,291	32,000	37,000	40,272
Social Service	32	36,491	30,700	36,912	42,705
Physical Therapy-Sr. Tech.	31	34,365	29,460	34,192	38,856
Clinical Lab-Sr. Tech.	27	35,484	29,941	35,090	38,856
Radiology-Sr. Tech.	31	36,224	30,000	36,000	40,441
Inhalation Therapy-Sr. Tech.	31	33,859	30,000	33,600	37,760
Hospital-Based Planner	21	41,567	35,000	42,566	47,000
Full-Time In-house Legal Counsel	8	43,834	36,040	38,000	48,250

SPECIAL ANALYSIS

TABLE 9

PRIVATE, UNIVERSITY-OWNED

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

			Percentiles		
NON-M.D. POSITIONS					
Title	(n)	Mean	25th	50th	75th
Associate	12	$78,060	$68,836	$77,500	$84,926
First Assistant	15	70,280	56,000	67,122	78,998
Second Assistant	14	63,191	51,000	58,300	73,000
Third Assistant	13	57,630	47,000	57,886	65,700
Chief Fiscal Officer	15	74,752	59,808	72,142	88,600
Controller	11	57,902	51,500	56,908	68,000
Director of Outpatient Services	6	45,203	32,000	38,912	46,647
M.D. POSITIONS					
Director of Medical Education	2	69,773	******	56,547	******
Medical Director	5	107,416	100,000	101,085	115,000
Director of Emergency Room	6	75,421	75,000	75,066	95,320

SPECIAL ANALYSIS

TABLE 9 (continued)

PRIVATE, UNIVERSITY-OWNED

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

Non-M.D. Departmental Executives	(n)	Mean	Percentiles 25th	50th	75th
Data Processing	11	$57,701	$50,958	$58,300	$63,000
Dietary	10	40,476	33,590	37,823	46,000
Senior Engineer	12	46,417	37,476	45,000	55,000
Housekeeping	11	37,824	28,596	37,460	43,050
Laundry	7	28,986	25,872	31,241	33,300
Nursing School	1	48,000	******	******	******
Nursing Service	13	57,877	49,003	55,000	68,135
Personnel	10	53,456	41,267	59,000	67,000
Pharmacy	14	52,978	48,021	49,920	60,000
Medical Records	14	39,022	33,488	38,000	47,099
Public Relations	12	49,710	32,827	47,662	63,000
Purchasing	9	38,476	33,000	38,000	42,000
Social Service	14	41,146	36,267	40,125	48,000
Physical Therapy-Sr. Tech.	13	37,012	31,950	35,171	42,324
Clinical Lab-Sr. Tech.	11	39,286	36,818	38,500	44,850
Radiology-Sr. Tech.	13	41,451	31,753	40,577	47,779
Inhalation Therapy-Sr. Tech.	12	35,796	28,848	34,026	40,477
Hospital-Based Planner	9	59,447	50,398	56,430	69,300
Full-Time In-house Legal Counsel	8	61,592	48,400	64,300	69,500

SPECIAL ANALYSIS

TABLE 10

PUBLIC, NOT UNIVERSITY-OWNED

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

			Percentiles		
NON-M.D. POSITIONS					
Title	(n)	Mean	25th	50th	75th
Associate	11	$60,792	$51,003	$57,000	$72,155
First Assistant	11	51,146	42,336	50,000	62,005
Second Assistant	10	44,817	37,850	42,254	51,000
Third Assistant	9	41,452	36,036	41,904	48,000
Chief Fiscal Officer	12	57,940	39,984	51,003	66,585
Controller	8	39,514	26,556	40,400	47,036
Director of Outpatient Services	5	33,824	29,515	30,400	38,555
M.D. POSITIONS					
Director of Medical Education	4	71,681	45,048	63,959	87,600
Medical Director	6	70,883	41,000	77,625	92,916
Director of Emergency Room	5	57,996	47,300	65,642	65,700

SPECIAL ANALYSIS

TABLE 10 (continued)

PUBLIC, NOT UNIVERSITY-OWNED

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

Non-M.D. Departmental Executives	(n)	Mean	Percentiles 25th	50th	75th
Data Processing	9	$41,567	$36,400	$41,900	$47,037
Dietary	8	35,354	29,016	36,000	38,520
Senior Engineer	11	43,812	38,538	45,324	51,709
Housekeeping	8	32,319	26,200	30,744	37,000
Laundry	10	26,959	22,387	24,800	32,576
Nursing School	3	48,154	******	48,794	******
Nursing Service	11	47,746	38,500	48,652	53,849
Personnel	12	39,063	31,450	40,200	43,104
Pharmacy	10	45,180	37,336	43,344	51,003
Medical Records	12	35,408	28,000	35,897	40,905
Public Relations	8	32,557	19,392	25,518	40,019
Purchasing	12	36,677	30,909	35,400	41,916
Social Service	11	35,709	31,574	34,860	39,590
Physical Therapy-Sr. Tech.	12	33,200	28,371	31,555	34,507
Clinical Lab-Sr. Tech.	12	36,228	32,256	35,639	38,600
Radiology-Sr. Tech.	12	34,313	29,100	33,852	36,250
Inhalation Therapy-Sr. Tech.	12	30,608	25,514	29,400	35,520
Hospital-Based Planner	9	43,234	32,490	36,828	51,615
Full-Time In-house Legal Counsel	2	37,918	******	30,825	******

SPECIAL ANALYSIS

TABLE 11

PRIVATE, NOT UNIVERSITY-OWNED

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

			Percentiles		
NON-M.D. POSITIONS					
Title	(n)	Mean	25th	50th	75th
Associate	19	$96,595	$70,000	$88,688	$118,000
First Assistant	19	79,447	58,000	75,000	97,000
Second Assistant	19	72,694	57,000	63,500	82,000
Third Assistant	14	56,720	50,000	53,000	57,801
Chief Fiscal Officer	15	88,927	75,000	83,000	104,600
Controller	16	56,335	47,125	54,000	61,673
Director of Outpatient Services	8	37,163	28,558	33,300	35,300
M.D. POSITIONS					
Director of Medical Education	2	132,500	******	100,000	******
Medical Director	2	113,400	******	80,500	******
Director of Emergency Room	5	73,560	78,300	80,900	82,500

SPECIAL ANALYSIS

TABLE 11 (continued)

PRIVATE, NOT UNIVERSITY-OWNED

DEPARTMENTAL EXECUTIVE: 1984 SALARY MEANS AND PERCENTILES*

Non-M.D. Departmental Executives	(n)	Mean	Percentiles 25th	50th	75th
Data Processing	16	$60,896	$49,600	$57,300	$68,000
Dietary	13	46,493	41,000	44,720	50,500
Senior Engineer	19	52,639	43,200	49,500	58,600
Housekeeping	16	34,355	30,000	34,850	39,200
Laundry	7	36,244	27,398	38,000	43,000
Nursing School	3	40,883	******	42,640	******
Nursing Service	17	65,305	53,685	65,000	69,000
Personnel	17	59,011	47,700	58,000	65,100
Pharmacy	18	51,084	47,100	51,300	55,355
Medical Records	16	38,647	31,500	38,000	41,700
Public Relations	16	45,301	36,139	47,000	51,000
Purchasing	18	39,509	33,155	36,600	46,000
Social Service	17	42,685	32,500	39,815	50,300
Physical Therapy-Sr. Tech.	16	35,806	32,750	34,200	36,000
Clinical Lab-Sr. Tech.	15	38,914	35,443	37,075	42,500
Radiology-Sr. Tech.	15	39,428	34,886	37,550	46,628
Inhalation Therapy-Sr. Tech.	17	35,170	31,976	34,700	36,880
Hospital-Based Planner	11	56,822	33,500	49,800	75,300
Full-Time In-house Legal Counsel	7	52,860	45,000	51,000	56,500

SPECIAL ANALYSIS

TABLE 12

DEPARTMENTAL EXECUTIVES: MEDIAN SALARIES IN 1984

Non-M.D. Departmental Title	Hospital Category						
	Public	Private	Public, Univ.-Owned	Private, Univ.-Owned	Public, not Univ.-Owned	Private, not Univ.-Owned	Aggregate
Associate	$62,700	$80,276	$63,000	$77,500	$57,000	$88,688	$68,836
First Assistant	51,700	70,000	54,000	67,122	50,000	75,000	60,240
Second Assistant	48,996	63,315	50,000	58,300	42,254	63,500	53,650
Third Assistant	44,000	53,000	44,195	57,886	41,904	53,000	47,637
Chief Fiscal Officer	62,000	81,500	62,700	72,142	51,003	83,000	66,585
Controller	43,500	54,500	43,706	56,908	40,400	54,000	47,285
Director of Outpatient Services	39,000	34,500	43,000	38,912	30,400	33,300	38,555
M.D. Positions							
Director of Medical Education	73,000	83,000	73,000	54,547	63,959	100,000	74,022
Medical Director	85,000	101,085	86,076	101,085	77,625	80,500	86,076
Director of Emergency Room	85,000	80,900	86,467	75,066	65,642	80,900	82,000

SPECIAL ANALYSIS

TABLE 12 (continued)

DEPARTMENTAL EXECUTIVE: MEDIAN SALARIES IN 1984

Non-M.D. Departmental Executives	Hospital Category						
	Public	Private	Public, Univ.-Owned	Private, Univ.-Owned	Public, not Univ.-Owned	Private, not Univ.-Owned	Aggregate
Data Processing	$47,037	$58,299	$48,136	$58,300	$41,900	$57,300	$51,290
Dietary	36,000	44,036	35,400	37,823	36,000	44,720	39,252
Senior Engineer	45,864	46,000	43,307	45,000	45,324	49,500	46,000
Housekeeping	30,744	35,479	30,500	37,460	30,744	34,850	32,585
Laundry	25,251	31,680	26,100	31,241	24,800	38,000	29,910
Nursing School	48,794	42,640	******	******	48,794	42,640	44,500
Nursing Service	52,000	58,475	53,538	55,000	48,652	65,000	55,000
Personnel	43,000	59,000	43,140	59,000	40,200	58,000	45,500
Pharmacy	46,935	51,300	47,064	49,920	43,344	51,300	49,013
Medical Records	35,364	38,000	35,000	38,000	35,897	38,000	36,061

SPECIAL ANALYSIS

TABLE 12 (continued)

DEPARTMENTAL EXECUTIVE: MEDIAN SALARIES IN 1984

Non-M.D. Departmental Executives	Hospital Category						
	Public	Private	Public, Univ.-Owned	Private, Univ.-Owned	Public, not Univ.-Owned	Private, not Univ.-Owned	Aggregate
Public Relations	$37,500	$47,662	$38,856	$47,662	$25,518	$47,000	$40,700
Purchasing	36,755	36,630	37,000	38,000	35,400	36,600	36,630
Social Service	36,428	40,125	36,912	40,125	34,860	39,815	38,300
Phys. Therapy-Sr. Tech.	34,000	35,028	34,192	35,171	31,555	34,200	34,192
Clinical Lab-Sr. Tech.	35,246	36,500	35,090	38,500	35,639	37,075	36,818
Radiology-Sr. Tech.	35,410	31,753	36,000	40,577	33,852	37,550	36,300
Inhalation Ther.-Sr. Tech.	32,376	31,803	33,600	34,026	29,400	34,700	33,700
Hospital-Based Planner	40,000	40,020	42,566	56,430	36,828	49,800	45,000
Full-Time In-house Legal Counsel	38,000	48,400	38,000	64,300	30,825	51,000	50,000

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: The Institute for Rehabilitation and Research

Hospital Address: (Street) 1333 Moursund Street

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

(Area Code)/Telephone Number: (713) 799-7030

Name of Hospital's Chief Executive Officer: William A. Spencer, 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): 128*

Average Daily Census: 90**

Total Live Births: -0-

Admissions: 712 (1983)

Visits: Emergency Room: -0-

Visits: Outpatient or Clinic: 4000 (1983)

*115 set up and staffed as of July 1984.

**We just opened a new 22-bed floor. Occupancy is increasing to new, higher capacity.

B. Financial Data

Total Operating Expenses: $ 19,252,852

Total Payroll Expenses: $ 13,222,178

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 115,000

Supervising Faculty: $ 25,000

C. Staffing Data

Number of Personnel: Full-Time: 510
Part-Time: 40

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 22
With Medical School Faculty Appointments: 22

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

Surgery

Medicine

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

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:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine			
Surgery			
Ob-Gyn			
Pediatrics			
Family Practice			
Psychiatry			
Other: PM&R	26	52	Required
Rehabilitation Medicine	6	6	Elective
Human Values in Medical Care (seminar)	75	75	Elective

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.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine				
Surgery	3	3	0	
Ob-Gyn				
Pediatrics				
Family Practice				
Psychiatry				
Other: PM&R	2	2	0	

[1]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.

[2]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: Baylor College of Medicine

Dean of Affiliated Medical School: Bobby R. Alford, M.D.
Vice President and Dean for Academic Affairs

TIRR is a primary affiliated hospital & research and educational institute. and is the site of three major medical school departments and their research endeavors in basic and clinical sciences. It is a focus of multidisciplinary post-graduate education for those persons engaged in medical rehabilitation.

Information Submitted by: (Name) Robert L. Baker

(Title) Administrator

Signature of Hospital's Chief Executive Officer:

William A. Spencer (Date) April 16, 1985

May 8, 1985

BAYLOR
COLLEGE OF
MEDICINE

One Baylor Plaza
Houston, Texas 77030

Bobby R. Alford, M.D.
Vice President and Dean
Academic and Clinical Affairs
(713) 799-6175

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

Dear Sirs:

The Institute for Rehabilitation and Research is one of our key affiliated institutions. It is the headquarters for our Departments of Rehabilitation and Physical Medicine. It plays an integral role in the teaching of medical students and residents and provides a special setting for members of our faculty, who have an interest in rehabilitation and who are engaged in medical rehabilitation, to carry out their duties in a special environment suited for the kinds of problems associated with rehabilitation. The Institue for Rehabilitation and Research is engaged in not only the medical educational and patient care process, but it is also heavily involved in research. We would appreciate your favorable consideration of The Institute for Rehabilitation and Research as a member in the Council of Teaching Hospitals.

Sincerely yours,

Bobby R. Alford, M.D.
Vice President and Dean
Academic and Clinical Affairs

BRA/rkt

cc: Dr. William Spencer

REVIEW OF COTH SPRING MEETING IN SAN FRANCISCO

All indications are that the meeting in San Francisco was very successful. In the interest of continued efforts to improve the meeting, the staff would appreciate suggestions and/or observations to consider for the 1986 SPRING MEETING in Philadelphia. Themes, speakers, logistics, amenities, and all other matters are open for review and discussion.

Additionally, thought should be given at this time to a timely meeting site for the 1988 SPRING MEETING. Listed below are the past cities in which this meeting has been held since its inception in 1978.

1978	St. Louis, MO
1979	Kansas City, MO
1980	Denver, CO
1981	Atlanta, GA
1982	Boston, MA
1983	New Orleans, LA
1984	Baltimore, MD
1985	San Francisco, CA

The 1986 SPRING MEETING as noted above is scheduled for Philadelphia, PA (May 7-9), and the 1987 meeting is scheduled for Dallas, TX (May 13-15). Staff recommends that consideration be given to the following cities for the 1988 COTH SPRING MEETING; other suggestions would be appreciated.

Chicago

New York City

Medical Education and Clinical Research in a Price Competitive Era: The Role for COTH/AAMC

In 1983 and 1984, the Administrative Board of the Council of Teaching Hospitals developed the paper entitled, "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals" to stimulate and focus discussion on the activities and initiatives of the Association of American Medical Colleges from a teaching hospital perspective. In the year since that paper was finished, changes in the environment have continued and perhaps accelerated. At its meeting in April, the Administrative Board heard presentations outlining activities of the Voluntary Hospitals of America, University Hospital Consortium, Associated Healthcare Systems, and the Consortium of Jewish Hospitals. In light of these presentations, the staff was asked to prepare a brief but similar paper so that the issues raised in 1984 could be discussed once again.

The Environment

For most of the first two decades that COTH was included in the AAMC, the teaching hospital's environment was relatively stable. Financial resources and organizational capabilities grew as public and private policies favored increasingly comprehensive, institutionally-based health services. Some new developments -- such as multi-hospital systems, health maintenance organizations, and state rate setting -- were initiated, but they remained relatively modest. Other developments -- such as national health insurance and comprehensive health planning -- disappeared or languished.

In contrast with the sixties and seventies, the mid-to-late eighties appears to be a dynamic, even frantic, period of change for the health system, teaching hospitals, and COTH. Five major trends impacting teaching hospitals are developing and perhaps colliding.

The Role of the Hospital in the Health System is Contracting

For over fifty years, the hospital has been an essential complement to the private practice of medicine. The hospital was the financial instrument for spreading the risk and sharing the capital needed as individual physician practices increased their technology base. It was the pooled labor market for skilled and semi-skilled personnel that enabled a physician to use less than a full-time equivalent. It was the information gathering system that monitored patient behavior and response in the absence of the physician. As medical practice evolves to a pattern of larger groups, the groups themselves are increasingly able to provide the financial and personnel services formerly provided by the hospital. In addition, portable monitoring equipment has increased the patient's mobility. As a result, the demand for hospital services is shrinking. This creates a temporary surplus of capacity which enables purchasers to command reduced prices. Prospective payment and negotiated prices are not a cause of the hospital's contracting role, they are a response to the opportunities created by the hospital's changing role and the rapidly increasing supply of physicians.

Health Plans are Reducing Risk Through Utilization Controls

Because illness is not evenly distributed, organized health care services always involve a significant risk management component. In the past, adverse financial risk was managed by enlarging the insurance pool of individuals covered and the range of services covered. By the late 1970s, these approaches to risk management had reached their financially feasible potential. New risk management approaches were needed and utilization controls were seized upon. Utilization controls included providing services on an ambulatory basis when possible, limiting the number of services per illness, and using providers with the lowest prices. Utilization controls may be implemented either by having the plan serve as a "gatekeeper" making direct choices or by increasing patient payments if they make choices adverse to the plan's goals.

Hospitals and Physicians are Collectivizing

The independent, free standing hospital and the solo practitioner are disappearing. Hospitals are forming or participating in alliances, networks, and chains. These may be either for-profit or not-for-profit. Physicians are increasingly working in organized groups and these groups are also forming linkages. For several years, these new arrangements can be expected to increase in number and diversity; eventually the arrangements will saturate the market and the weaker organizations will be eliminated.

The Medical Education System Will Change Slowly

Analytically, educational institutions exist to transmit the established values of a society. They tend to adopt new ideas relatively slowly, especially compared with market driven organizations. When the slow-to-change bias of an educational system is combined with the long educational pipeline for physicians, it is unlikely that medical education will change at a pace comparable to the changes being made by hospitals, practicing physicians, and other service providers.

New Databases Will Create National Information Markets

Historically, most medical care has been provided by local physicians and local hospitals to local residents. Except for a few data sets such as CPHA and HUP, utilization and treatment information remained local while financial information was aggregated nationally. The use of per case payment systems and the rise of plans concerned with utilization controls create a national market for information on treatment patterns and resource use. The rise of national linkages of providers and plans stimulates information sharing, at least within the group. It also gives those with information a prod to stimulate change in less responsive components of the system.

The AAMC/COTH Mission

To survive, teaching hospitals must confront and cope with these environmental changes and their derived impacts. Similarly, as an advocate for academic medical centers -- including their owned and affiliated hospitals -- the AAMC must continually review its teaching hospital activities to respond to both changes in the hospital environment and in the teaching hospitals themselves.

The mission of COTH and of AAMC staff concerned with hospital activities should have two foci. First, COTH/AAMC should represent the concerns, interests, problems, and contributions of providers conducting education and research in a clinical setting to organizations, agencies, and groups which influence the external environment. Secondly, COTH/AAMC should assist its members in balancing their multiple missions and preserving clinical education and biomedical research in the face of a price competitive market for medical services.

AAMC/COTH Activities

While a number of new hospital organizations have been created in the past few years which involve COTH members, the members and officers of these organizations have repeatedly stated that the new organization was not created to undermine or replace COTH. Nevertheless, the growth of new organizations suggests the need for COTH/AAMC to sharpen its focus and clearly articulate its mission. These clarified interests are discussed in the functional framework created for the "New Challenges" paper: advocacy, economic, information, education, and research services.

Advocacy

While AAMC/COTH should continue the primary emphasis of its advocacy on the federal government and on the traditional national hospital associations, advocacy could be expanded in two areas. First, because educational organization will respond more slowly to the new hospital environment than the hospitals themselves, the AAMC and COTH should advocate hospital concerns and problems to medical education organizations and academic organizations and societies that set policies that teaching hospitals must incorporate. Secondly, to avoid having new hospital organizations duplicate COTH/AAMC functions, AAMC and COTH should seek to establish a regular liaison relationship with for-profit corporations, not-for-profit chains, alliances, and networks through which the AAMC works with these organizations as the primary source of their clinical education and research funding information.

Economic

Moving beyond advocacy, it is increasingly clear that academic medical center hospitals are relatively disadvantaged in a price competitive marketplace. While COTH/AAMC could improve the competitive position of the membership by establishing a subsidiary for group purchasing, PPO development, and networking, a number of other groups already exist for these purposes and COTH members are included in such groups. The AAMC could help its hospitals economically, however, if it served as an impartial source of education and research as discussed below.

Information

The development of hospital alliances provides a natural framework for some of the information sharing activities that associations have previously offered. COTH/AAMC can avoid duplicating the efforts of hospital alliances by focusing its data collection efforts on three areas such as housestaff costs, benefits, and appointment policies; hospital-medical school-faculty financial relationships; and comparative performance and operating data for major academic medical center

hospitals. Historically, COTH/AAMC activities in these areas have examined issues from the perspective of the CEO. To ensure that information sharing in these areas remains relevant, COTH/AAMC might develop the capability to work directly with chief financial officers, institutional planners, market researchers, and those individuals responsible for medical education.

Education

Teaching hospitals and academic medical centers face a time of dramatic change. Many traditions are now being re-examined and questioned. This threatens local relationships, especially if the local change is not seen in its broader context. The AAMC can help its hospitals by developing educational programs, seminars, and conferences which communicate the national trends to its local members. Programs could be developed to explain the changing hospital situation to university officials, trustees, deans, faculty, and residents. The prior experience of the AAMC in its Management Advancement Program and in its seminars on TEFRA and PPS demonstrates the association's ability to pursue such efforts.

Major academic medical centers have been the primary force for basic clinical research and the initial introduction of technology. To maintain and enhance this distinction, the COTH/AAMC could organize an annual membership conference on new technology. The program objective would be to provide hospital CEOs, financial officers, and planners with an understanding of developments that are six-months to five years in the future.

Research

The "New Challenges" paper saw research as a relatively low priority area for COTH/AAMC. The changing environment is altering both the topics requiring attention and the priority of research itself. To assist COTH hospitals in remaining financially competitive, AAMC could sponsor or coordinate studies quantifying the impact of different residency training approaches on hospital costs, comparing total care costs (hospital plus physician) in teaching and non-teaching hospitals and the impact of tenure on hospital operations. The AAMC could also develop a set of case studies on joint venture relationships between hospitals and physicians in order to identify how different approaches impact the role of the dean, the department chairperson, and the hospital CEOs. This could be particularly important at a time when purchasers of care are seeking arrangements which include hospital and physician services as a single financial package. Most medical center providers are not in an organized position to respond swiftly to such requests. In addition as patient services increasingly move to ambulatory and other non-hospital sites, approaches to financing graduate medical education which developed in the hospital are less relevant. The AAMC could develop a major effort to identify, describe, evaluate and promote alternative institutional and financial arrangements which can expand training sites for residents.

. . . . .

This paper has been developed to stimulate discussion once again of the role and function of the AAMC on behalf of teaching hospitals, particularly in light of the growing presence and significance of consortia, alliances and similar organizations.

aamc association of american medical colleges

May 1, 1985

TO: Chief Financial Officers
Council of Teaching Hospitals

FROM: Richard Knapp, Director
Department of Teaching Hospitals
Association of American Medical Colleges

Michael Doody, President
Healthcare Financial Management Association

SUBJECT: Special HFMA Session for Teaching Hospital CFOs

For the second consecutive year, the Healthcare Financial Management Association is offering a special two-day course for teaching hospital CFOs. The course, BCD "Critical Issues for Teaching Hospitals CFOs," is listed on page 12 of the enclosed brochure for HFMA's Annual National Institute.

The specific course for teaching hospital CFOs will meet on June 18 and 19. Faculty and presentations already scheduled include:

Tuesday Morning

"The Environment and Outlook for Hospitals"
Gerald Bisbee
Vice President, Kidder Peabody & Co., Inc.

"Thinking About the Future of the Hospital"
Bruce Vladeck
President, United Hospital Fund of New York

Tuesday Afternoon

"Implementing a University Hospital Divestiture"
David Fine
President, West Virginia University Hospitals, Inc.

"Value Analysis for Acquistions and Divestitures"
Kenneth Kaufman
Kaufman, Hall and Associates

One Dupont Circle, N.W. /Washington, D.C. 20036 / (202) 828-0400

Wednesday Morning

"Current Medicare Developments"
James Bentley
Associate Director, Department of Teaching Hospitals
Association of American Medical Colleges

"Who Controls Graduate Medical Education?"
Richard Knapp
Director, Department of Teaching Hospitals
Association of American Medical Colleges

Wednesday Afternoon

"Hospital Involvement in Insurance Arrangements
Dale Thomas
Chairman of the Board, Voluntary Health Plans of America

"Developments in Hospital Cost Accounting"
Truman Esmond, President
Marilyn Plowman, Vice President
Truman Esmond and Associates

"Package Pricing and Medicaid Contracting"
Robert Hrudka, Director of Financial Services
Marianne Caringello, Assistant Director of Financial Planning
Northwestern Memorial Hospital

Last year's course for teaching hospital CFOs was a valuable addition to the Annual National Institute. We expect this year's course will be equally timely and useful. The enclosed booklet contains all necessary registration materials.

We look forward to seeing you in Philadelphia.