

OFFICE OF THE FIRST LADY  
BOX 6 OF 8

LISTING OF MELANNE'S FILES  
HEALTH CARE

koop  
leg. strategy  
long term care  
lux memos  
mammogram  
managed competition  
mayo clinic  
medical savings accounts  
medicare malpractice reform  
medicare seniors  
mental health  
mercy health corp.  
merk  
minority  
mittell plan  
mongan  
moynihan  
nbc special  
nea  
nickles bill  
nih- health research  
nixon  
norway  
nurses  
nutrition  
occupational medicine  
ohio group meeting  
omb memos  
pharmaceuticals  
plans comparisons  
pku  
physicians  
pizza hut  
population

leg. strategy



population

ENCLOSURES FILED OVERSIZE ATTACHMENTS

6203

KOOP

PHOTOCOPY  
PRESERVATION

PHOTOCOPY  
PRESERVATION

K007

MELANNE VERVEER

DEPUTY ASSISTANT TO THE PRESIDENT, AND  
DEPUTY CHIEF OF STAFF TO THE FIRST LADY

(202) 456-6266

E WHITE HOUSE

WASHINGTON

THE WHITE HOUSE

January 3, 1995

MEMORANDUM FOR CAROL LANCASTER  
DEPUTY ADMINISTRATOR  
USAID

FROM: MELANNE VERVEER  
DEPUTY ASSISTANT TO THE PRESIDENT  
DEPUTY CHIEF OF STAFF TO THE FIRST LADY

Attached is correspondence from Dr. Koop concerning Noel Vietmeyer and his status working under contract for USAID. Over the last several months, Dr. Koop has mentioned this issue directly to the President, the Vice President and the First Lady. We have been asked to follow up. Please advise. Thanks for your help.

*The C. Everett*

# Koop Institute

at DARTMOUTH

**C. Everett Koop, M.D.**

*Senior Scholar*

September 15, 1994

Ms. Melanne Verveer  
Deputy Chief of Staff  
To the First Lady  
THE WHITE HOUSE  
2nd Floor, West Wing  
1600 Pennsylvania Avenue  
Washington, DC 20500

Dear Melanne:

When I was last with you I spent a little time with the President and then a little time with both he and the First Lady discussing the wonderful contributions of a man named Noel Vietmeyer who works for the National Research Council but is funded by the Agency for International Development. AID has cut off his income and though his wonderful work has continued, I am afraid he cannot go without a salary forever.

The enclosed letter has to do with this and I would appreciate it if you would be certain that the First Lady sees it, reads it and understands it is a continuation about this gentleman which we had in the Oval Office.

All the best to you.

Sincerely yours,

*Chick*

C. Everett Koop, M.D.

CEK/fen

Enclosure

Dictated by Dr. Koop but signed in his absence.

*The C. Everett*

# Koop Institute

at DARTMOUTH

C. Everett Koop, M.D.

*Senior Scholar*

September 15, 1994

First Lady Hillary Rodham Clinton  
THE WHITE HOUSE  
Old Executive Office Building, Room 100  
Washington, DC 20500

Dear Hillary:

When we last met I mentioned to you the plight of the extremely creative scientist, Noel Vietmeyer. He is the one who showed me how staple foodstuffs can be turned into liquids that babies can drink.

Vietmeyer is on the staff of the National Research Council. He investigates and publicizes innovations that could help the world's poor countries. In 20 years he has produced almost forty books describing such things as:

- trees that grow ten feet a year while rejuvenating soil
- highly nutritious grains, fruits and vegetables
- natural methods for halting soil erosion and land degradation
- animals that fit the small-scale needs of villagers
- safe and non-toxic pesticides that come from a tree
- corn with twice the usual protein

From what I've seen this is one of the country's most effective and creative small scientific activities. Thousands of people all over the world have taken up ideas and put them into practice. It is a program that is truly helping the most needy parts of the world.

From the beginning, Vietmeyer has been supported by the Agency for International Development (AID). The funds were transmitted through the science office in AID's Global Bureau. But about a year ago that bureau cut off all Vietmeyer's funding.

Many eminent scientists, including three Nobel Prizewinners, have appealed to AID to reverse this decision. Vietmeyer has copies of about eighty letters containing hundreds of glowing comments on the program and its successes in the field.

First Lady Hillary Rodham Clinton  
September 14, 1994  
(continued)

Page Two

Many testimonials were sent to the AID Administrator, but unfortunately without effect. Even White House staffers have been unable to reverse the decision. Vietmeyer tells me that during the past year Jack Gibbons, Robert Watson, and Katie McGinty have all expressed their view that the project deserves continued support.

It is Vietmeyer's baby food idea that most interests me. The key ingredient is malted barley flour, which he calls Power Flour. This material turns a porridge or pabulum into liquids babies can drink from a bottle. It is cheap and available in any country that makes beer - and they all seem to make beer. I have arranged for some to be carried to Rwanda in the recent past weeks. It should help the refugees who are too weak to eat solid foods.

All in all, Power Flour seems like an important breakthrough. I believe Aid should get Vietmeyer back in business so he can put out one of his inspirational books on it. That will propel the concept into world consciousness. Probably nothing could benefit the world's undernourished children more quickly or more easily.

With a success like that and with some of Vietmeyer's other breakthroughs, the Administration would have a great story to tell the world. I'm afraid, though, that it will take a direct intervention on your part or the President's to get AID to support Vietmeyer's program again. No one else has yet been able to get the agency to budge.

Sincerely yours,

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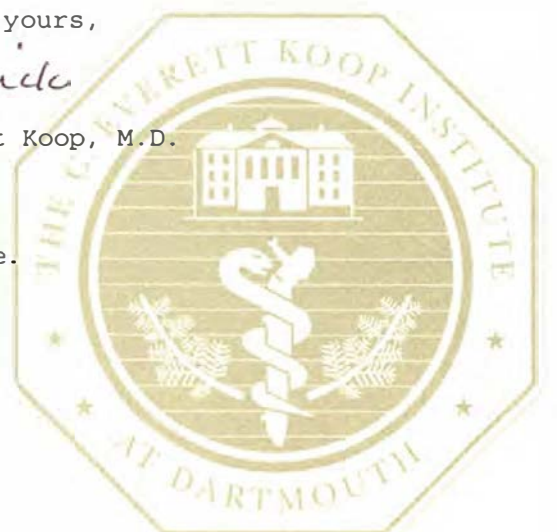
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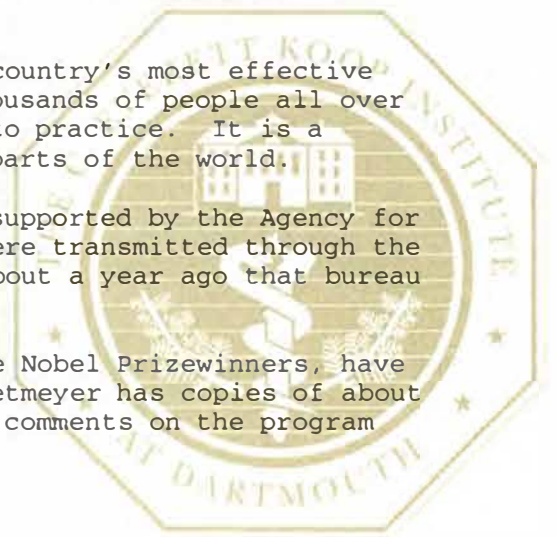
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*file Koop*

## Don't Just Say No

*The question is no longer if we will have major health reform in the United States, but how. It's time for physicians to join the rest of the country in a constructive debate.*



TIM CARROLL

**“W**HAT WERE YOU doing there, sitting next to her? You've sold us out!”

That's the drift of most of the letters I have received from physicians since I accepted Hillary Rodham Clinton's invitation to sit between her and Tipper Gore during President Clinton's speech to Congress on his health care reform proposals. That negative response, while not unexpected, was discouraging. I hope that in this case, as in many others, it's the small disgruntled minority who write the letters. I hope most physicians don't think I've sold them out. I hope most physicians have not dug themselves in to oppose health care reform.

Our track record on health care reform proposals is not one to be proud of. Physicians have been noticeably absent from past efforts to rebuild the American health care system, even though physicians proved to be among the beneficiaries of innovations like Medicare. This time, doctors cannot allow themselves to be cast in the role of naysayers. I don't imagine that any one of us will agree with all the proposed changes. I don't, and I suspect that even the president has his own reservations about some points. But our objections to some provisions cannot give us the excuse to say no to everything.

The question is no longer *if* we will have major health care reform, but *how*. The reform effort in the United States is already moving more quickly than at any time during my 50 years in medicine. During the last several months, in anticipation of the president's proposals, the various players in the health care game—physicians, nurses, hospitals, insurance companies, pharmaceutical companies, state governments—have begun to reform themselves. That's good; we can benefit from the variety and the imagination of these initiatives. But real change requires all the players to act in coordination, as in a football play. If one player fails

to move when the ball is snapped, the play fails. Right now the various factions are yelling at each other like football players in the huddle during the fourth quarter of a losing game. Only the coach can call the play; only the White House can provide that kind of leadership.

But presidential leadership does not mean presidential dictatorship. President Clinton says he views his health care proposals not as a take-it-or-leave-it package but as the foundation for a constructive national debate that will bring about the best in health care for the American people.

For this reason I have accepted the president's invitation to serve, not as a salesman for the administration, nor as an endorser (as some have reported), but as a moderator in the discussion between policymakers and the medical community. In the spirit of constructive debate I have agreed to preside at a series of regional panel discussions that will combine the views of national health care experts with those of local physicians and other health workers so they and the public can thrash out the issues both in local and national terms.

I have accepted this role because I want the health care reform proposals to reflect the best the medical community has to offer. I hope to see—and hear—readers of HIPPOCRATES at these forums around the country.

This time physicians know reform must come. More than anyone else they have seen patchwork efforts at cost control result merely in cost shifting, squeezing the balloon in one place, only to have it bulge out in another. Physicians have seen their patients' lack of health insurance go from being just an economic inconvenience to being a medical risk factor, not because they have been refused treatment but because their inability to pay has made them reluctant to seek treatment. Uninsured Americans are sicker than other patients when they finally find their way to a doctor's

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not as a salesman  
but as a moderator.

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#### Brief Summary:

**Contraindications:** Patients who have had allergic reactions to NAPROSYN® (NAPROXEN) or ANAPROX® DS or in whom aspirin or other NSAIDs induce the syndrome of asthma, rhinitis, and nasal polyps. Because anaphylactic reactions usually occur in patients with a history of such reactions, question patients for asthma, nasal polyps, urticaria, and hypotension associated with NSAIDs before starting therapy. If such symptoms occur, discontinue the drug.

**Warnings:** Serious GI toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAIDs. Remain alert for ulceration and bleeding even in the absence of previous GI tract symptoms. In clinical trials, symptomatic upper GI ulcers, gross bleeding or perforation occur in about 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year. Inform patients of signs and/or symptoms of serious GI toxicity and what steps to take if they occur. Studies have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious GI events and other risk factors associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well and most spontaneous reports of fatal GI events are in this population. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of GI toxicity.

**Precautions:** DO NOT GIVE NAPROSYN® (NAPROXEN) CONCOMITANTLY WITH ANAPROX® OR ANAPROX® DS (NAPROXEN SODIUM) SINCE THEY CIRCULATE IN PLASMA AS THE NAPROXEN ANION. Acute interstitial nephritis with hematuria, proteinuria, and nephrotic syndrome has been reported. Patients with impaired renal function, heart failure, liver dysfunction, patients taking diuretics, and the elderly are at greater risk of overt renal decompensation. If this occurs, discontinue the drug. Use with caution and monitor serum creatinine and/or creatinine clearance in patients with significantly impaired renal function. Use caution in patients with baseline creatinine clearance less than 20 mL/minute. Use the lowest effective dose in the elderly or in patients with chronic alcoholic liver disease or cirrhosis. Borderline elevations of liver tests may occur in up to 15% of patients. Elevations of SGPT or SGOT occurred in controlled trials in less than 1% of patients. Severe hepatic reactions, including jaundice and fatal hepatitis, have been reported rarely. If liver disease develops or if systemic manifestations occur (e.g., eosinophilia or rash), discontinue therapy. If steroid dosage is reduced or eliminated during therapy, do so slowly and observe patients closely for adverse effects, including adrenal insufficiency and exacerbation of arthritis symptoms. Determine hemoglobin values periodically for patients with initial values of 10 grams or less who receive long-term therapy. Peripheral edema has been reported. For patients with restricted sodium intake, note that each tablet contains approximately 25 or 50 mg (1 or 2 mEq) sodium. Use with caution in patients with fluid retention, hypertension or heart failure. The drug may reduce fever and inflammation, diminishing their diagnostic value. Conduct ophthalmic studies if any change or disturbance in vision occurs. **Information for Patients:** Side effects can cause discomfort and, rarely, more serious side effects, such as GI bleeding, may result in hospitalization and even fatal outcomes. Physicians may wish to discuss with patients potential risks and benefits of NSAIDs, particularly when they are used for less serious conditions where treatment without NSAIDs may be acceptable. Patients should use caution for activities requiring alertness if they experience drowsiness, dizziness, vertigo or depression during therapy.

**Laboratory Tests:** Because serious GI tract ulceration and bleeding can occur without warning symptoms, follow chronically treated patients and inform them of the importance of the follow-up. **Drug Interactions:** Use caution when giving concomitantly with coumarin-type anticoagulants, a hydantoin, sulfonamide or sulfonylurea; furosemide; lithium; beta-blockers; probenecid; or methotrexate. **Drug/Laboratory Test Interactions:** May decrease platelet aggregation and prolong bleeding time or increase urinary values for 17-ketogenic steroids. Temporarily stop therapy for 72 hours before adrenal function tests. May interfere with urinary assays of SHIAA. **Carcinogenesis:** A 2-year rat study showed no evidence of carcinogenicity. **Pregnancy:** Category B. Do not use during pregnancy unless clearly needed. Avoid use during late pregnancy. **Nursing Mothers:** Avoid use. **Pediatric Use:** Single doses of 2.5-5 mg/kg (as naproxen suspension), with total daily dose not exceeding 15 mg/kg/day, are safe in children over 2 years of age.

**Adverse Reactions:** In a study, GI reactions were more frequent and severe in rheumatoid arthritis patients on 1650 mg/day naproxen sodium than in those on 825 mg/day. In children with juvenile arthritis, rash and prolonged bleeding times were more frequent, GI and CNS reactions about the same, and other reactions less frequent than in adults. Incidence Greater Than 1%, Probable Causal Relationship: GI: The most frequent complaints related to the GI tract: constipation; heartburn; abdominal pain; nausea; dyspepsia, diarrhea, stomatitis. CNS: headache; dizziness; drowsiness; light-headedness, vertigo. Dermatologic: itching (pruritus); skin eruptions; ecchymoses; sweating, purpura. Special Senses: tinnitus; hearing disturbances, visual disturbances. Cardiovascular: edema; dyspnea; palpitations. General: thirst. \*Incidence of reported reaction 3%-9%. Where unmarked, incidence less than 3%. Incidence Less Than 1%: Probable Causal Relationship: GI: abnormal liver function tests, colitis, GI bleeding and/or perforation, hematemesis, jaundice, melena, peptic ulceration with bleeding and/or perforation, vomiting. Renal: glomerular nephritis, hematuria, hyperkalemia, interstitial nephritis, nephrotic syndrome, renal disease, renal failure, renal papillary necrosis. Hematologic: agranulocytosis, eosinophilia, granulocytopenia, leukopenia, thrombocytopenia. CNS: depression, dream abnormalities, inability to concentrate, insomnia, malaise, myalgia and muscle weakness. Dermatologic: alopecia, photosensitive dermatitis, skin rashes. Special Senses: hearing impairment. Cardiovascular: congestive heart failure. Respiratory: eosinophilic pneumonitis. General: anaphylactoid reactions, menstrual disorders, pyrexia (chills and fever). Causal Relationship Unknown: Hematologic: aplastic anemia, hemolytic anemia. CNS: aseptic meningitis, cognitive dysfunction. Dermatologic: epidermal necrolysis, erythema multiforme, photosensitivity reactions resembling porphyria cutanea tarda and epidermolysis bullosa, Stevens-Johnson syndrome, urticaria. GI: non-peptic GI ulceration, ulcerative stomatitis. Cardiovascular: vasculitis. General: angioneurotic edema, hypoglycemia, hypoglycemia.

**Overdosage:** May have drowsiness, heartburn, indigestion, nausea, vomiting. A few patients have had seizures. Empty stomach and use usual supportive measures. In animals 0.5g/kg of activated charcoal reduced plasma levels of naproxen. **Dosage and Administration for Mild to Moderate Pain, Dysmenorrhea and Acute Tendinitis and Bursitis:** Recommended starting dose is 550 mg, followed by 275 mg every 6 to 8 hours. Total daily dose should not exceed 1375 mg. **Dosage and Administration for Rheumatoid Arthritis, Osteoarthritis and Ankylosing Spondylitis:** Recommended dose in adults is 275 mg or 550 mg twice daily. In patients who tolerate lower doses well, the dose may be increased to 1650 mg per day for limited periods when a higher level of anti-inflammatory/analgesic activity is required. At this dosage, physicians should observe sufficient increased clinical benefits to offset potential increased risk. **Caution:** Federal law prohibits dispensing without prescription. See package insert for full Prescribing Information.

#35

Revised 9/91

SYNTEX  
SYNTEX PUERTO RICO, INC.  
HUMACAO, PR 00861

250 MG TABLETS  
**Anaprox DS** Anaprox®  
(NAPROXEN SODIUM)  
275 MG TABLETS

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## Koop

office or emergency room, and their illnesses cost the system more to treat. It is no coincidence that their lack of insurance bears a direct correlation to poor health outcomes.

Too much of the intensifying debate on health care reform focuses on the political and economic dimensions, on the questions of who will pay, and how. But before we can enact the sweeping changes we need, we must agree on the basic values and ethics on which our health care system—and our society—is based and from which it draws its moral power.

Physicians are understandably proud of what they can do for their fellow citizens, because in so many ways the American system, in spite of its many flaws, offers the best health care in the world. But while our system may function with compassion, competence, and excellence for many Americans, for others it is a tyranny.

The next decade will force us to do some hard thinking—and deciding—about the basic purpose of medicine. We haven't done much of that. For most of human history medicine really couldn't do very much, really couldn't cure very much, so at best it offered some comfort, some relief from symptoms. Then with the application of science and technology to medicine, we saw the age when medicine could cure many problems and could prolong life for millions. Now, as we come to grips

with the failings of our health care system, as we come to grips with the limits of curative medicine, another new age may be dawning.

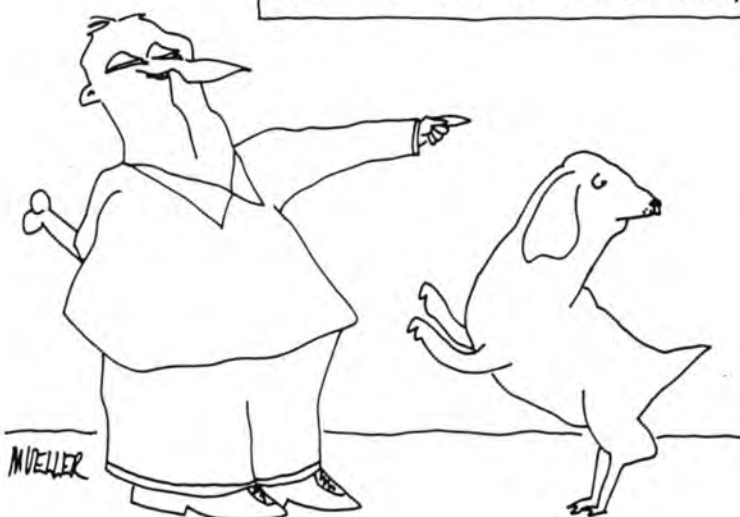
Many doctors are understandably anxious about what the president has in mind. Physicians and patients alike are worried that the president's plan will mean fewer choices and more bureaucracy. Physicians are especially concerned about the possibility that medical decisions will be made by insurance companies or government bureaucrats.

I share these concerns. But merely being concerned, just saying no, won't accomplish anything. It's time to get involved, to do what we can to shape the proposals that eventually win congressional approval. I know that many physicians became discouraged when the medical community was largely excluded from the initial discussions of the health reform task force. I also know the president now genuinely desires a constructive dialogue. Let us in the medical profession accommodate him in the spirit of our high calling, in the Hippocratic tradition that requires us to do nothing but the best for our patients.

—C. Everett Koop

C. Everett Koop, M.D., Sc.D., is a professor of surgery at Dartmouth Medical School and senior scholar with the C. Everett Koop Institute at Dartmouth.

### THE UGLY TRUTH ABOUT BONE LOSS.



The considerable savings to the health care system that could be realized through high tech communication of many varieties that is transmitted over telephone wires will never be realized until the government restrictions constraining the regional Bell companies are lifted The problem is the InterLATA long distance services. The savings are 36 billion dollars.

I have mentioned this to the President and the Vice-president. I do not think anything but legislation will accomplish the needed change.

*OK*

file  
Koop

# **Health Care Cost Reductions: The InterLATA Component**

Summary of Findings

**Arthur D Little**

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# **Health Care Cost Reductions: The InterLATA Component**

## **Summary of Findings**

### **Introduction**

Spending more than \$2 billion every day on health care services, America is grappling with a crisis in its health care system. From the Office of the President to state capitals to city halls across the country, plans to decrease costs while ensuring quality and access are being drafted and debated.

Last year, Arthur D. Little completed a study that alerted policymakers to the potential for significant health care cost containment through telecommunications. The study identified more than \$36 billion in specific annual cost reductions from several telecommunications health care applications. Local telephone companies have been vital partners in developing and deploying these applications—including home care, management and transport of patient information, claims processing, inventory control, video conferencing, and health care professional telecommuting—in communities across the country.

However, government restrictions significantly constrain the ability of seven key telecommunications providers, the regional Bell companies, to contribute positively in helping to solve the health care crisis.

Since the 1984 break-up of AT&T, the regional Bell telephone companies have been banned from providing any service (voice, text, data, image, and video) across the government-created service boundaries known as Local Access and Transport Areas (LATAs). There are 197 LATAs in the U.S., some of which have populations under 120,000. In addition to preventing the telephone companies from providing traditional long-distance services to their customers, the interLATA ban prevents them from linking hospitals, health care providers, and patients in any instance in which a LATA boundary would be crossed.

To help determine the impact of this interLATA ban on American health care, the Bell companies commissioned this study to determine how much of the original \$36 billion in health care cost reductions from telecommunications applications involves the use of interLATA long-distance services.

### **Health Care Cost Containment and InterLATA Services**

American health care could experience annual cost reductions of more than \$9.7 billion through the enhanced use of interLATA long-distance services. In other words, more than a quarter of the \$36 billion annual cost reductions identified in the previous study involves the use of health care applications that reach outside a single LATA boundary.

These findings are conservative—they are based on current technology and known applications. The cost reductions cited in the study could be achieved today if telecommunications providers facilitated their development. The interLATA long-distance restriction precludes the Bells, however, from developing applications which, to be most effective, need to be statewide, regional, or national in scope.

The Bell companies, in concert with the health care providers, can bring together elements necessary for achieving the potential health care cost reductions identified by this study only if the interLATA long-distance restriction is removed.

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### **Cost Reductions from Selected InterLATA Health Care Applications**

| <b>Applications</b>      | <b>InterLATA Annual Cost Reductions</b> |
|--------------------------|-----------------------------------------|
| Home Health              | \$5,032,383,611                         |
| Hospitals and Physicians | 1,465,715,330                           |
| Claims Management        | 2,716,779,748                           |
| Materials Management     | 447,690,168                             |
| Video Conferencing       | 78,033,139                              |
| Work at Home             | 6,377,485                               |
| <b>Total</b>             | <b>\$9,746,979,481</b>                  |

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**I. Home Health**—The drive toward providing patient care in the most cost-effective environment consistent with quality standards makes home health care an attractive alternative to institutional care. InterLATA home health services could help reduce American health care costs by **\$5 billion** annually.

- Supplying information through interLATA services can reduce annual costs by nearly \$4 billion through eliminating unnecessary emergency room and doctor's office visits.
- Patient self-help over interLATA facilities would lead to early intervention and cost reductions of approximately \$1 billion annually from preventable hospital admissions and outpatient visits.
- Supplying extensive diagnostic and educational information from a national or regional database and utilizing interLATA long-distance services would realize at least \$30.8 million in annual cost reductions through the elimination of numerous generic discussions with patients.

**II. Hospitals and Physicians**—Telecommunications offers several vehicles for the more efficient creation, transport, storage, and retrieval of computer-based patient records and administrative information for hospitals and doctors. InterLATA services can help reduce these costs by an additional annual **\$1.5 billion**.

- Updated, standardized, universal protocols of care transmitted over interLATA facilities would lead to malpractice premium reductions of \$1.3 billion a year, reducing fees passed on to consumers and decreasing the expensive practice of defensive medicine.
- Access via interLATA facilities to national databases on drug-drug and drug-allergy reactions and the redundant effects of medication would reduce the \$3 billion of medical administration errors by at least \$161 million each year.
- Improved efficiency in reviewing procedures through interLATA connections to on-line medical records can reduce annual hospital labor costs by \$14.3 million.
- The ability to send records, through interLATA services, over long distances reduces the need for specialists traveling to remote locations, meaning \$0.2 million reductions for radiologists alone each year. In addition, fewer records would be lost, reducing duplication of costly procedures.

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**III. Claims Management**—America's health care system each year processes four billion health care claims, mostly on paper. InterLATA telecommunications services offer reductions of at least **\$2.7 billion** in annual administrative costs for health care providers and insurers.

- Electronic claims submission and processing across interLATA boundaries will reduce health care providers' billing costs by \$116.8 million annually.
- Automating claims through interLATA services will reduce insurers' annual costs by \$2.6 billion, costs that the health care consumer otherwise pays for in premiums.

**IV. Materials Management/Inventory Control**—The traditional material supply chain involves substantial and expensive materials handling. Electronic ordering over interLATA facilities can reduce health care costs annually by **\$448 million**.

- InterLATA data links between hospitals and suppliers would allow hospitals to receive smaller but more frequent deliveries, translating into a \$361.2 million annual reduction in hospital storage costs nationwide.
- InterLATA services will allow buyers to spend less time on paper intensive tasks, such as counting inventory, calculating how much to reorder, and calling vendors to refill stocks, a labor cost reduction of \$69.4 million annually.

**V. Video Conferencing**—Real time, audiovisual, interactive discussion between two or more parties is beginning to be used in health care for remote consultations and education. InterLATA long-distance video conferencing for these purposes will contribute, annually, up to **\$78 million** in health care cost reductions.

- The \$13.2 million in annual cost reductions from using interLATA video conferencing services for remote consultations comes from reducing overhead costs and travel time for rotating specialists.
- Distance learning will reduce annual conference trips and expenses by roughly \$64.9 million.

**VI. Work at Home**—Telecommunications makes it possible for transcriptionists, computer programmers, and employees in information-intensive jobs to work full and part time from their homes. InterLATA long-distance services will contribute over \$6 million in annual cost reductions from this application.

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## **Impact of Future Trends**

*Marketplace and technological trends of the future will further enhance the possibility of controlling health care costs through interLATA telecommunications services. Although their exact monetary effect on health care is difficult to project, the inevitability and scope of these trends are important to recognize.*

*These trends make it clear that interLATA long-distance services will become increasingly important in containing health care costs in the future.*

- **Growth of health care promotion and preventive care**—The success of existing pilot programs indicates that these services can dramatically improve the general level of American health and reduce the demand for acute care and costly services. InterLATA communication of information will be essential to any large scale program.
- **Creation of national and regional data bases on treatment outcomes**—Numerous agencies and organizations are developing databases and standards of treatment outcomes. Ultimately, the health care industry and the patient will benefit. Data collection and retrieval over interLATA facilities is a critical component to any national or regional system.
- **Increased reliance on video conferencing and telemedicine**—These will become much more common tools of the health care provider, leading to more collaboration in general health care and medical procedures, and a significant reduction in inappropriate treatment. As these practices expand, the relative portion of them requiring interLATA services will increase.
- **Improved cost efficiencies of the material and supply chain**—The suppliers of products and pharmaceuticals, currently insulated from many factors ratcheting down hospital costs, have significant room to improve methods of communication, distribution, and warehousing. As economies of scale bring greater centralization, interLATA services will become more vital.

## **Conclusion**

Telecommunications technology and applications offer tremendous benefits to health care in the form of improved care and cost reductions. Many of these benefits depend upon the transfer of information—voice, data, text and video—across government-created LATA boundaries. As this study documents, interLATA long-distance services could contribute to more than \$9.7 billion in annual health care cost reductions from greater efficiency in medical care and administration.

Local telephone companies—vital partners in providing the telecommunications services necessary to support health care needs—could help to bring these benefits and cost reductions to American health care today, using currently available technology and applications. The interLATA long-distance restriction, however, precludes the regional Bell companies from independently providing these applications on a wide-area basis.

The Bell companies, in concert with the health care providers, can bring together elements necessary for achieving the potential health care cost reductions identified by this study only if the interLATA long-distance restriction is removed.

## Processor Perspective

# Why Regional Bell Operating Companies Contend Their Processing Hands Are Tied

On paper, the seven regional Bell operating companies are capable of becoming the automated medical payments industry's most powerful information processors. Collectively, the regional Bell operating companies—Ameritech, Bell Atlantic, Bell South, NyNex, Pacific Telesis, U.S. West and Southwestern Bell—already switch more than a billion pieces of information annually over their regional telecommunications networks.

But when it comes to processing on-line health care transactions, regional Bell operating companies are still on the outside of the market looking in. Since Harold Greene, the federal judge who oversaw the break up of AT&T in 1984, ruled that regional telephone companies can only be limited players in the information services market, regional Bell operating companies have been prohibited from switching information—including on-line health care transactions—across regional Local Access and Transport Areas, which are federal government created service areas.

In the 197 LATA zones nationwide, telephone companies are permitted to move information within the zone, but are prohibited from switching information between zones. In Wisconsin, for example, the Wisconsin Health Information Network—the joint venture health care information switch owned by Ameritech Health Connections Inc. and Aurora Health Care—can process transactions between payers and providers in Green Bay, but is prohibited from switching transactions between Green Bay and Milwaukee.

"To this day, the consent decree's long distance ban prevents Ameritech from itself providing WHIN throughout Wisconsin or across our entire Midwest service territory or the United States," Joseph Sullivan, president of Ameritech Health Connections, told the Senate Committee on Commerce, Science and Transportation on Aug. 5. "Ameritech is between a rock and a hard place whenever we are developing an information services product

that contemplates the delivery of information across service boundaries."

To end the grid lock preventing telephone companies from providing information services between regional LATA zones, Ameritech is pursuing a controversial proposal now pending before the Federal Communications Commission.

### A Health Care Argument

In exchange for letting Ameritech offer long distance telephone service within its six state service area, Ameritech promises to open up its local network to outside competitors. "Ameritech proposes to open its local network fully to outside competitors in exchange for certain pricing and earnings regulatory reforms," Sullivan told the Senate Committee. "This quid pro quo will yield the products and services our customers demand and deserve at competitive prices."

Ameritech argues that if regional Bell operating companies were allowed to offer long distance service and pro-

cess transactions between regional LATA zones, they could save the U.S. health care system more than \$9.7 billion in administrative expenses. In a June 1993 report done for the regional Bell operating companies by Arthur D. Little, the accounting firm contends that lifting the inter LATA restrictions would reduce the cost of claims processing nationwide by \$2.7 billion and reduce provider electronic claims submission costs by \$116.8 million annually.

Since Ameritech filed its Federal Communications Commission proposal, reaction has been mixed. A host of information service companies remain opposed to lifting the long distance service band, but other trade associations contend Ameritech's plan will work if Congress or the federal courts establish pricing or other regulatory safeguards. "My prediction is that Congress or the courts will eventually lift the long distance service restriction, but that won't happen this year or maybe even next," says Hank Levine, a long-time regional Bell operating company observer and an attorney with the Washington, D.C. law firm, Levine, Lagapa and Block. "Regional Bell operating companies will be given the means to compete, but only with certain regulatory safeguards that still aren't defined." ☐

FROM : ALLEN KOOP

PHONE NO. : 603 526 6107

P01

ONE OF THE MOST IMPORTANT WAYS THE NEW TELECOMMUNICATIONS SYSTEM WILL BENEFIT EVERY AMERICAN IS IN OUR HEALTH CARE SYSTEM, A HEALTH CARE SYSTEM THAT ALMOST EVERYONE AGREES MUST SEE DRAMATIC REFORM IN ORDER TO MEET THE HEALTH CARE NEEDS OF AMERICAN SOCIETY IN THE TWENTY-FIRST CENTURY. NO MATTER WHICH REFORM PLANS ARE ADOPTED BY THE CONGRESS AS WELL AS ON THE STATE LEVEL, WHATEVER WE DO IN HEALTH CARE REFORM WILL DEPEND OUR OPENING UP A TELECOMMUNICATIONS SYSTEM UNCLUTTERED BY OBSTACLES AND INEFFICIENCIES. BY IMPROVING OUR ABILITY TO TRANSMIT VITAL HEALTH INFORMATION, WE WILL BE ABLE TO INCREASE ACCESS TO THE HIGHEST QUALITY HEALTH CARE, AND ALSO REDUCE COSTS.

WE ALL COMPLAIN ABOUT THE HIGH COST AND HIGH FRUSTRATION LEVEL OF HEALTH CARE INSURANCE PAPERWORK, BUT WE WON'T BE ABLE TO REPLACE ALL THOSE FORMS AND FILES WITH AN UP-TO-DATE ELECTRONIC SYSTEM OF PROCESSING CLAIMS, UNLESS WE PROVIDE ACCESS TO A NATIONAL HEALTH DATA INFORMATION SYSTEM TO EVERY HOSPITAL AND DOCTOR'S OFFICE IN THE COUNTRY.

OUR NEW TELECOMMUNICATIONS SYSTEM CAN IMPROVE THE HEALTH CARE AVAILABLE TO EACH AMERICAN BY BRINGING US CLOSER TO THE PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS WHO CAN BEST PROVIDE THE CARE WE NEED. IT IS CLEAR THAT ONE OF THE MOST IMPORTANT IMPROVEMENTS WE CAN MAKE IN OUR HEALTH CARE SYSTEM IS TO INCREASE THE NUMBER OF PRIMARY CARE PHYSICIANS AVAILABLE TO AMERICAN CITIZENS. MOST MODERN SOCIETIES HAVE ABOUT HALF THEIR

FROM : ALLEN KOOP

PHONE NO. : 603 526 6107

P02

PHYSICIANS IN PRIMARY CARE, WHILE WE HAVE ONLY ABOUT 29 PER CENT. IF WE ARE GOING TO INCREASE THE NUMBER OF PRIMARY CARE DOCTORS, WE NEED TO MAKE PRIMARY CARE MORE ATTRACTIVE TO THE YOUNG WOMEN AND MEN GRADUATING FROM MEDICAL SCHOOL. ONE REASON SO FEW MEDICAL SCHOOL GRADUATES CHOOSE PRIMARY CARE IS THE ISOLATION PRIMARY CARE DOCTORS FEEL, A SENSE OF BEING CUT OFF FROM THE LARGER WORLD OF MEDICINE. THIS PROBLEM CAN BE ELIMINATED BY MAKING EACH PRIMARY CARE DOCTOR PART OF A MODERN HEALTH COMMUNICATIONS SYSTEM IN WHICH DESK-TOP COMPUTERS, VIDEO SYSTEMS, AND TELEVISION WILL ENABLE EVERY FAMILY PHYSICIAN --WHETHER IN THE SUBURBS, THE INNER CITY, OR THE MOST REMOTE CORNER OF RURAL AMERICA-- TO HAVE AT HER OR HIS FINGERTIPS THE RESOURCES OF ANY MEDICAL CENTER IN THE UNITED STATES.

PRIMARY CARE PHYSICIANS, EVEN THOUGH THEY ARE OFTEN PAID THE LEAST, ARE EXPECTED TO KNOW THE MOST, SINCE THEY ARE EXPECTED TO DIAGNOSE AND THEN TREAT OR REFER ELSEWHERE, ANY AND EVERY HEALTH PROBLEM A PATIENT BRINGS INTO THEIR OFFICE. WITH MEDICAL KNOWLEDGE EXPANDING EVERY DAY, NO PHYSICIAN CAN KEEP UP WITHOUT HELP. BUT NOW THAT HELP IS AVAILABLE THROUGH A TELECOMMUNICATIONS NETWORK THAT ALLOWS DOCTORS NOT ONLY TO SEEK INFORMATION ON A PUZZLING CASE BEFORE THEM, BUT ALSO WILL GIVE THEM A WAY TO PURSUE LIFELONG LEARNING.

THIS MODERN HEALTH TELECOMMUNICATIONS SYSTEM WILL OFFER AS MUCH TO PATIENTS AS IT DOES TO THEIR PHYSICIANS, BECAUSE IT WILL BRING

FROM : ALLEN KOOP

PHONE NO. : 603 526 8107

F03

PATIENTS THE BEST IN AMERICAN MEDICINE AT REAL SAVINGS TO THEM. WHEN YOUR FAMILY DOCTOR WANTS YOU TO HAVE A CONSULTATION WITH A SPECIALIST, PERHAPS IN A DISTANT CITY, INTERACTIVE TELEVISION CAN LET YOU CONSULT DISTANT SPECIALISTS AND EXPERTS WITHOUT LEAVING YOUR OWN CITY OR TOWN. THAT WILL SAVE TIME, MONEY, AND, IN AN EMERGENCY, COULD EVEN SAVE LIVES.

EVEN NOW, ALL ACROSS THE COUNTRY WE HAVE HEALTH AND COMMUNICATIONS EXPERTS WORKING ON NETWORKS TO MAKE DRAMATIC IMPROVEMENTS IN HEALTH CARE. FOR EXAMPLE, IN NORTHERN NEW ENGLAND, FORMER SURGEON GENERAL C. EVERETT KOOP IS WORKING TO PUT TOGETHER A TRI-STATE HEALTH COMMUNICATIONS NETWORK IN MAINE, NEW HAMPSHIRE AND VERMONT, WHICH COULD SERVE AS A MODEL FOR THE REST OF THE NATION.

BUT RIGHT NOW THESE IMPORTANT PROJECTS ARE BEING FRUSTRATED BY OBSOLETE REGULATIONS THAT BLOCK THE TRANSFER OF VITAL HEALTH INFORMATION. OUR PROBLEMS ARE WITH RULES AND REGULATIONS, NOT WITH TECHNOLOGY. WE HAVE THE TECHNOLOGY, RIGHT NOW, TO GET THIS HEALTH TELECOMMUNICATIONS NETWORK IN PLACE, BUT THE EASY AND EFFICIENT EXCHANGE OF INFORMATION IN OUR TELECOMMUNICATION SYSTEM IS CURRENTLY BLOCKED BY REGULATIONS LEFT OVER FROM THE BREAK-UP OF THE BELL SYSTEM YEARS AGO. IT IS TIME WE REMOVE THESE OBSOLETE AND ARTIFICIAL BARRIERS, SO WE CAN GIVE THE AMERICAN PEOPLE THE TELECOMMUNICATIONS SYSTEM THEY DESERVE TODAY AND WILL DEMAND TOMORROW.

*NH  
addressing  
these*

Perm copy This front page for me  
Melanne will pick up package

Current regulations (OBRA '90, section 4752(e)) published by HCFA Aug. 6, 1993 prohibits osteopaths from providing Medicaid services to pregnant women and children under 21. This was not the intent of the legislation and in typical HCFA fashion undermines the very care it was intended to provide. Osteopaths are the backbone of primary care in many parts of the country.

Following Enclosures:

- ✓ ① OBRA Regs re Osteopaths prohibited from Medicaid services to PG & children
- ✓ ② Uniform Services Univ. of Health Sciences
- ✓ ③ High tech / info. highway
- ④ possible evolving support from internists
- ⑤ Koop's piece on Hippocrates
- ⑥ 12/17/93 Koop letter to POTUS re PATR

PHOTOCOPY  
HRC HANDWRITING

file Koop

The National Performance Review has recommended the closure of the Uniformed Services University of the Health Sciences (USUHS). That would be tragic and the university would soon have to be reinvented. Don't think of it as a medical school for the armed forces alone; it is the seat of Federal Medicine and should be utilized as such by the administration.

There are bureaucrats in government that get their kicks from obstructing certain institutions or programs. OMB is no exception and houses one such whose mission is to close USUHS.

Please see short report--tagged in orange--submitted by a member of the Gore task force who was charged to survey USUHS. His favorable report was ignored by OMB.

**At a time when the medical profession and the President are on divergent paths re health care reform, the action to close USUHS would further alienate the medical profession.**

Most of this material is background information. But please read the ~~two~~ pages at the orange tag. You might also be interested in the supporting letter from the AMA, the AAMC, and the Association of Academic Health Centers.

A handwritten signature or set of initials, possibly "CSU", in dark ink, located in the lower right quadrant of the page.

FROM RED TAPE TO RESULTS

# CREATING A GOVERNMENT THAT WORKS BETTER & COSTS LESS

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Report of  
the National  
Performance Review

Vice President Al Gore

throughout many states, so the facilities cannot easily be sold to a local entity. APA, on the other hand, is unique: Its facilities and customers are located in a single state. Various public agencies have already urged the federal government to sell the APA facilities. APA signed purchase agreements to do so before 1993.

The sale is supported by state and local officials, Alaska's congressional delegation, the Energy Department, the Office of Management and Budget and the House Appropriations Committee. But Congress has yet to pass the necessary authorizing legislation. We urge it to do so. The sale would bring \$52.5 million into the U.S. Treasury and save millions more in yearly operating costs.

**Action: *Terminate federal grant funding for Federal Aviation Administration higher education programs.***<sup>18</sup>

Success has rendered two FAA federal subsidies obsolete. They have met the objectives for which they were established and can now be terminated. For example, in 1982, the Federal Aviation Administration (FAA) launched a program to improve the development and teaching of aviation curricula at universities and other post-secondary schools. The goal was to produce graduates better prepared for jobs in the industry.

So far, the FAA has spent about \$4 million on consultants to upgrade schools' programs and another \$100 million was appropriated—most at Congress' insistence not at FAA's request—to be given out in grants so that the schools could buy better facilities and equipment. Many schools now offer high quality aviation training programs without support from the FAA. Since \$45 million of the appropriation remains unspent, stopping the program now can save this money.

Another program we no longer need is the Collegiate Training Initiative for Air Traffic Controllers. It was set up to determine whether other institutions could offer the same quality training for

controllers as the FAA Academy does. If they could, it would save the government the \$20,000 it costs to train each new controller at the academy. The answer is clearly yes. Five schools participating in the program are producing well-qualified controllers, although only two are receiving government subsidies. It is now time to phase out these remaining subsidies.

**Action: *Close the Uniformed Services University of the Health Sciences.***<sup>19</sup>

The Department of Defense once faced shortages of medical personnel, particularly of physicians. So, in 1972, Congress created the Uniformed Services University of the Health Sciences (USUHS). Today, USUHS provides less than 10 percent of the services' physicians at a cost much higher than other programs: USUHS physicians cost the federal government \$562,000 each, while subsidies under the Health Professionals Scholarship Program cost only \$111,000 per physician. Closing the facility and relying on the scholarship program and volunteers would save DOD \$300 million over five years.

**Action: *Suspend the acquisition of new federal office space.***<sup>20</sup>

Over the next 5 years, the federal government is slated to spend more than \$800 million a year acquiring new federal office space and courthouses. Under current conditions, however, those acquisitions don't make sense.

The federal workforce is being reduced, the Resolution Trust Corporation is disposing of real estate once held by failed savings and loans at 10 to 50 cents on the dollar, commercial office vacancy rates are running in the 10 to 25 percent range, and U.S. military bases are being closed. All of these factors suggest that the government has many potential sources for office space without buying any more buildings.

The GSA administrator will place an immediate hold on GSA's acquisition—through construction, purchase, or lease—

Issue: DoD Medical School. Duplication of commercially available activity? Is it needed? Who are its customers? Can it generate revenues?

### Background

Historically, the Department of Defense has faced shortages in medical personnel, particularly physicians. To alleviate this situation, DoD has developed various programs to provide a supply of these personnel. One such program is the Health Professionals Scholarship Program (HPSP), which pays tuition and a stipend to people attending medical school and other health-related programs in return for a military service obligation. Another example is the Uniformed Services University of the Health Sciences (USUHS), a medical school operated by DoD.

Congress created the university in 1972 to train physicians committed to long-term military careers. The school provides a full education for its participants, graduating about 165 physicians a year. USUHS currently trains physicians for both the military and public health services; however its primary emphasis has been on military needs.

To meet the mandates of legislation and required standards for accreditation as a medical school, USUHS must produce the following: continuing medical education for serving medical officers; support for military residency training programs; special military/public health education programs; graduate education in the biomedical sciences; applied and basic science research; and medical care for military beneficiaries provided by the USUHS clinical faculty in the course of teaching. All of these products are paid for as part of the approximately \$85 million operating cost (including military salaries) of USUHS.

From the perspective of the DoD budget, USUHS is the most expensive source of physicians at \$562,000 per person; HPSP costs \$111,000, and other sources, such as the Financial Assistance Program and the Volunteers Program, range in cost from \$55,000 to \$13,000. This direct cost comparison does not reflect the indirect cost of federal subsidies to other medical schools nor does it reflect the effect of USUHS-trained physicians longer service commitment and even longer effective retention rates (estimated at 90% by USUHS). USUHS graduates must pay back seven years of active duty, whereas HPSP recipients must pay back roughly one year of active duty for each year of health professional training. [source CBO] USUHS has estimated that the true cost to the taxpayer is \$88 thousand per year of obligated service for HPSP but only \$80 thousand per year of obligated service for USUHS using 1991 data in JAMA. The comparison would favor USUHS even more if actual service

was used rather than obligated service. Because of the rough comparability in true cost to the taxpayer, the university should be evaluated based on its unique capability to train physicians for the military and public health service missions, and its other educational and research products.

USUHS is the only medical school in the country to train all of its graduates in population medicine, how to plan for medical care in national or natural disasters, refuge medicine, and mobilizing and organizing medical resources.

Today the shortage of physicians in the Public Health Service is greater than in the military. Public Health Service scholarship recipients resist pay back service in rural areas and inner cities. USUHS graduates that are Public Health Service physicians are at USUHS because of a desire to serve in those areas, are trained for those areas, and consequently do not resist their obligation.

#### **Recommendations and Options**

**Direct USUHS to increase training of Public Health Service physicians.**

USUHS should logically become an academic center for the advancement of national health care. The mission of USUHS needs to be expanded. In a time of complicated international relationships and low intensity conflicts, there is continued need to graduate a cadre of military physicians. Concurrently, the demand for Public Health Service physicians to meet the needs of the under-served could be addressed by increasing the number of Public Health Service graduates from USUHS. The government needs to retain flexibility to redirect graduate output to the highest priority area as this shifts.

**To empower employees to serve its customers:**

**Alternative 1: Convert the USUHS to a quasi-government corporation thereby increasing the university's flexibility to meet its customers' needs.**

This would be the most entrepreneurial alternative; however it would require some time for all the details to be worked out to permit USUHS to raise sufficient revenues to function.

- o The PHS or DoD would pay a fee for each graduate going to them. Payment would be made over four years based on the number of years of obligated service. (For example, \$85 thousand times 7 years of obligated service = \$595 thousand) It could eventually be set at a rate comparable to the true federal cost per year of obligated service for the HPSP scholarship program. Because tuition only covers about 4 percent of medical school costs according

to the Association of American Medical Colleges. (p. 4)  
Provision would have to be made to compensate the USUHS  
for those income streams that private and public medical  
school have that cover the majority of costs. USUHS could  
also be given authority to contract with Health  
Maintenance Organizations to provide physicians; however  
this should be considered a low priority.

- o The Public Health Service currently pays the salary of  
the DHS students who attend USUHS and also provides some  
faculty members. The cost of increasing the number of PH  
students could be adjusted as the relative needs of the  
DoD and PHS change.
- o Requires legislation
- o Provision would have to be made for some unique services  
such as AFPRRI which obtains its security services from  
DoD.

Alternative 2: Revise Title 10, section 2113 to clarify and  
simplify the chain of command.

A number of minor changes in the governing language is  
necessary to reflect the realities of USUHS if it is to be  
efficiently administered under the Department of Defense. DoD could  
then increase USUHS flexibility consistent with the Model  
Installations Program in DoD 2000. This would empower its  
employees to serve its customers without making USUHS independent

Congress should provide legislation that would permit USUHS to  
grant associates and bachelors degrees for various health science  
professions such as physicians assistants.

The hospital accreditation associations will soon require  
degrees for these technical support staff in accredited hospitals.  
At present the military departments train these personnel and then  
contract with schools such as George Washington University to  
provide the degrees based on the military departments' training.  
The universities charge large fees for this service that exceed the  
costs the USUHS would incur to grant the degrees. In addition  
USUHS would be able to provide a quality assurance review of the  
military departments' training that would include the unique  
military considerations that the private universities cannot. (need  
to get the cost of degrees paid by the departments)

The President should issue an executive order that revises the  
complex and bureaucratic process of grant charge backs between NI  
and institutions such as USUHS.

Grant charge-backs for new grants should be flexible to  
reflect cost revisions on an annual basis without requiring the

## UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

### ROLES AND RESPONSIBILITIES

### IN NATIONAL HEALTH CARE REFORM

The National Performance Review's recommendation to close the Uniformed Services University of the Health Sciences (USUHS) did not consider its current and future roles in national health care reform. The recommendation did not reflect the many contributions made by USUHS that perhaps transcend its primary mission to produce military physicians.

The recommendation for closure was presumably based upon the cost to the Federal Government for procurement of military physicians through USUHS compared to those attained from civilian medical schools through the Health Professions Scholarship Program (HPSP). The National Performance Review's analysis was misleading in that only the Department of Defense's direct contribution to civilian medical school costs was used, and it did not consider differences in the service obligation of the two sources, nor differences in training or other benefits of USUHS. When all Federal expenditures are included in the calculations and physician-years of obligated service are compared, a USUHS graduate costs the Federal government about \$66,000 per year of service compared with a cost of about \$98,000 per year for military physicians who enter through the HPSP. The cost of producing a M.D. graduate at USUHS is about one-third lower than the average cost at U. S. civilian medical schools. The USUHS cost also includes salary and benefits for its students, which is not an expense for civilian medical schools.

### USUHS IS THE PRESIDENT'S MEDICAL SCHOOL

USUHS is the only Federal medical school. It provides opportunities for highly qualified medical students including underrepresented minorities and women to attend school in exchange for service rather than financial indebtedness. The commitment to national service is made by each student at entry to medical school. USUHS maintains strong ties with all other Federal health care delivery systems. These linkages enable USUHS to perform coordinating and collaborating functions between Federal health care systems and State, local and private entities. This relationship provides a unique environment to implement, test and evaluate novel, cost-effective approaches to health care delivery and access. USUHS is ideally suited to develop specific curricula for undergraduate and graduate medical education that addresses the specialized needs of populations in and out of government.

The Departments of Defense, Health and Human Services, and Veterans Administration operate the largest HMOs in the country. USUHS could serve as a "laboratory" where programs can be tested and outcomes measured in pilot studies or full scale clinical or community trials. USUHS is also in a unique position to

measure cost benefits and patient outcomes resulting from changes in procedure, practice or policy.

### THE SHORTFALL OF PRIMARY CARE PRACTITIONERS

The shortage of primary care services in our country creates serious problems. Two groups are most adversely affected by the lack of access to primary care, the poor living in inner cities and rural populations, poor and affluent alike. Many with health insurance or Medicaid eligibility are unable to locate a provider. Our nation's inner city emergency rooms are inundated by patients who lack a regular source of care. A recent study in a large city showed that only 13% of patients coming to a typical hospital emergency room had medical problems that required emergency services. Higher costs and poorer health outcomes result from patients not being able to access primary clinical and preventive services.

Only about one third of all U.S. physicians provide primary care services, compared with over 50% of physicians in the United Kingdom, Australia, Germany and France. In 1991, more than 40% of available U.S. residency slots in family practice, general internal medicine and general pediatrics were unfilled. More than one third of those currently in such residencies plan to subspecialize. The mix of physicians produced in our country is incongruent with our health care needs. Even if the nation's medical schools were immediately able to increase the production of primary care physicians to 50% of graduates, it would be well into the 20th century before our country's primary care needs were met. USUHS has focused its attention on primary care.

### SUPPORT OF MANAGED CARE

The President's proposal to reform the nation's health care system greatly emphasizes managed care based on the selection of the most cost-effective health care interventions. For cost containment to happen, physicians must have the ability to efficiently establish a correct diagnosis and predict the effect of available interventions on the course of the disease. Physicians must possess the epidemiological and quantitative skills necessary to select appropriate diagnostic tests and make referrals and choose interventions of most benefit to the patient. Many clinicians have not acquired these skills because their medical training has been principally qualitative and has not focused on risk-benefit at individual and community levels. The successful implementation of the managed care agenda critically hinges on the training of new physicians and the retraining of those currently in practice.

### SUPPORT OF HEALTH CARE SYSTEM OVERSIGHT

Health care reform will require expanded oversight responsibility at State and National levels to assure that economic and administrative reforms do not impair the quality of the care provided. Accountable Health Plans, the State Quality Improvement Foundations and the National Health Board will need trained and experienced professional staffs who are able to apply epidemiological methods and understand the biological sciences, new

measure cost benefits and patient outcomes resulting from changes in procedure, practice or policy.

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technologies and the practice of medicine. These practitioners will need to be able to assess patterns of care, outcomes and the health status and trends of populations.

### **THE ROLE OF USUHS IN HEALTH CARE REFORM**

USUHS is an example of the principles embodied within the President's Health Care Reform Initiative. Indeed, its mission is to train physicians whose principal responsibilities are primary care and the management of health care services. The following is a brief outline of the current and potential contributions of USUHS to health care reform.

### **TRAINING OF PRIMARY CARE PHYSICIANS**

USUHS provides medical education to students that is directly linked to a guaranteed, long-term, public service commitment. Its graduates have honored this commitment by serving the most needy of our nation in assignments often viewed as less than desirable. Medical students trained at USUHS demonstrate their interest in volunteerism and service through participation in community activities that are student initiated and largely student-coordinated. They demonstrate commitment to deliver compassionate, primary care to underserved populations even when recipients are not Department of Defense beneficiaries.

USUHS graduates approximately 165 medical doctors each year. The majority of today's USUHS graduates fill Army, Navy and Air Force billets and will serve in military medical facilities. Nine students are sponsored each year by the Public Health Service (PHS) and serve civilian populations upon completion of residency training. Seventy percent of all USUHS graduates choose to serve in primary care or transitional programs during the first year of post graduate medical education. USUHS is well on its way to meeting the President's goal of 50% of medical school graduates in primary care by the year 2000.

The University's medical school graduate retention rate after payback of obligated service is estimated to be greater than 92%. Its curriculum, 25 weeks longer than that of the average civilian medical school, provides skills in leadership, expanded and enhanced courses in public health, biostatistics, epidemiology, health promotion and disease prevention, tropical medicine, and provision of services in a managed care setting. By focusing on health promotion and disease prevention, USUHS graduates are prepared to take actions to maintain the health of military or civilian populations anywhere in the world.

### **ADVANCED PRACTICE NURSES**

The nation faces a serious shortage of advanced practice nurses (APNs). An assessment was made this summer that focused on just two categories of APNs, certified registered nurse anesthetists (CRNAs) and Nurse practitioners (NPs). Data collected from the three DoD services—Army, Navy, and Air Force—revealed that to fill all vacant positions and to replace current losses would require 302 new

**APNs.** Annual enrollments of 268 CRNAs and 100 NPs would be required in educational programs to eliminate the DoD shortage by 1997. In addition, the Indian Health Service (IHS) currently has a total of 42 unfilled APN positions.

Various options exist for meeting future needs for APNs in the military and PHS including improving retention through increased pay and other incentives and providing funded, long term education for individuals who in so doing will incur a service obligation. Due to the national shortage of APNs, the chief nurses of the Air force, Navy and Army concluded that without producing its "own" these services would make little progress in meeting a serious shortfall that is growing more acute with time. In one IHS service area the cost of contracting for one CRNA is \$180,000 per year, while if the IHS had a CRNA to assign the cost would be between \$50,000 and \$60,000 annually. The contract CRNAs in that area alone cost IHS more than one million dollars each year, which illustrates the unnecessary expense resulting from the uniformed services inability to recruit and retain adequate numbers of APNs.

There will be a growing need for APNs in the PHS. Increases in ratios of nurses to population are expected to occur. The National Health Service Corps will need additional APNs in the future since attracting these cost effective practitioners to underserved areas is expected to have high priority in national health care reform. While "downsizing" of active duty personnel in DoD may occur, need for APNs will probably not be reduced for many years.

USUHS, responding to requests from the PHS and the military services, inaugurated a Graduate School of Nursing in August 1993. The initial class included 3 students who are preparing to be family nurse practitioners. USUHS plans to expand the school in July 1994 by admitting 25 CRNA students and 12 family nurse practitioner students. The school plans to prepare other APNs such as certified nurse midwives.

### **PRIMARY CARE PRACTITIONERS**

USUHS is capable of responding to our country's immediate, critical need for primary care physicians **and advanced practice nurses**. Through the cooperation of the Departments of Defense and Health and Human Services, the mix of medical and graduate student billets can be flexibly adjusted to reflect the changing need to support the military's mission in national defense and the responsibilities of the Indian Health Service (IHS) and the National Health Service Corps (NHSC). If the services of all USUHS graduates are not immediately required to serve the military, these physicians **and nurses** could be detailed to key, underserved inner city and rural areas. Alternately, military billets at USUHS could be replaced by PHS billets and graduates assigned to underserved populations through the IHS and NHSC.

All future USUHS graduates could be required to serve as primary care physicians for some or all of their 7 year service obligation. Those desiring to specialize could do so at the end of their pay back period. PHS graduates who resign after filling their service obligation could carry commissions in the reserves thereby assuring their long term availability for mobilization during national emergencies.

### TRAINING OF HEALTH CARE MANAGERS

USUHS is uniquely able to provide the training needed by physicians serving as primary care case managers who are responsible for directing and coordinating patient care. USUHS can also train medical epidemiologists who can assure that the health care system provides effective and efficient services. As a Federal entity, USUHS has already establish working linkages with Federal and State agencies. This provides it with stable sources of health data from which to develop assessments of trends, patterns of services and outcomes. It also provides a mechanism for the continuous flow of assessments from USUHS back to the operational agencies.

Existing models of collaboration and assessment include (1), responsibility given USUHS by the Assistant Secretary of Defense (Health Affairs) to provide scientific and technical support to the Civilian External Peer Review Program of the Department of Defense, and (2), a memorandum of agreement being negotiated with the Health Care Financing Administration for USUHS to train their Peer Review Organization staff, provide support in the development of "patient care algorithms" and assess the adequacy of their peer review procedures.

### SUMMARY

USUHS is able to undertake the following health care reform programs immediately:

1. Respond to the critical need for additional primary care providers **including physicians and advanced practice nurses** in underserved areas. USUHS is an important part of the answer to providing health services to those who most need care.
2. Prepare physicians with expanded and enhanced public health training who can act to maintain the health of military or civilian populations stationed anywhere in the world. These physicians are also trained to support contingency responses to natural and manmade disasters.
3. Provide training to practitioners to better equip them to identify and select the most cost-effective interventions for their patients. Elements that focus on the application of epidemiological principles to diagnostic test and treatment selection must be made more broadly available, especially to primary care physicians. This effort is critically needed and will have an immediate effect on health care reform.

4. USUHS, through the Department of Defense, has already been tasked by Congress to provide training to military medical officers to qualify them to become health care managers and executives.
5. Provide residency training to medical officers who will be responsible for the epidemiological oversight of health services that will be required under health care reform.
6. Develop medical school curricula that will be essential in the managed care environment to integrate the epidemiological and quantitative approaches to patient assessment and management.
7. Provide an environment where the nation can implement, test and evaluate the outcomes and cost benefits of new technologies and approaches to health care delivery.

The worth of USUHS to the nation must be measured in terms of its contributions to both military medicine and national health care reform. It is strongly positioned to meet the Department of Defense's needs in the post cold war international environment. It is also uniquely prepared to contribute to the enormous needs of national health care reform.

#### OTHER UNIQUE RESPONSIBILITIES OF USUHS

The following functions and responsibilities of USUHS contribute so significantly to the nation's well-being that mention of them is appropriate.

The unique research interests and capabilities of USUHS do not exist in civilian universities or research institutions and are necessary to protect troops and civilians in peace and war. This research is directed at the prevention and treatment of disease and wounds associated with natural and man made disasters and the adverse consequences of exposure to chemicals, biologicals, radiation and directed energy (lasers).

USUHS is at the forefront of telemedicine research and development. This rapidly advancing technology has relevancy for both military and civilian populations. Applications being developed are directed toward:

Improving the quality and access to care in pre hospital military and civilian environments. This has direct application to care of disease and injury in rural and remote areas.

Linking and improving consultation and access to care between regional medical centers and outlying clinics and personnel.

Educating and training a full spectrum of health providers, including emergency medical technicians, paramedics, nurse practitioners, physician assistants and physicians.

# UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

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## BACKGROUND INFORMATION

**USUHS was created as one of two complementary programs to develop military physicians**

- Established by Congress in 1972 to educate men and women for careers in public service as medical officers in the Army, Navy, Air Force and the commissioned corps of the U.S. Public Health Service.
- USUHS provides a cadre of trained military medical physician-leaders educated in military medical issues and leadership; the nation's only Federal medical school complements the Armed Forces Health Professions Scholarship Program (HPSP) which provides large numbers of physicians whose number can be easily regulated depending upon service needs.
- Maintaining two complementary pathways for physician accessions (USUHS and HPSP) has assured the right mix of active duty military medical officers ... leading to the impressive military medical force of today. Further, it provides flexibility to defense planners as the military services are *right sized* to match the nations defense needs.

**USUHS has a mission to serve the nation**

- The purpose of the University is to provide the nation with medical officers and scientists of character who serve the common good.
- The University's F. Edward Hébert School of Medicine graduates active duty physicians who are deeply committed to service to the Nation.
  - They willingly accept operational assignments often viewed as less than desirable by civilian medical graduates, they understand the military organization and mission, and they fully appreciate the unique discipline of military medicine.
  - They are well founded in the guiding principles of the military and are prepared to assume leadership in military medicine.

**Curriculum is focused on mission needs and national priorities**

- In addition to such subjects as combat casualty care, nuclear, biologic and chemical warfare, deployment medicine, disaster medicine, tropical medicine, and the study of man in extreme environments, the curriculum provides focused emphasis on primary care medicine, public health, preventive medicine, mental health and wellness, all within the context of an organized system of medical care.
- More than 97% of matriculants graduate, 70% begin their graduate medical education (GME) in a primary care specialty or a transitional program, and over 40% of all USUHS graduates beyond the first year of GME are serving as primary care physicians.
- The University's F. Edward Hébert School of Medicine is the Nation's only Federal medical school and should be used as a valuable national resource in implementing the President's plan for health care reform.

**USUHS fulfills many  
mandates**

- USUHS was mandated by its establishing legislation to graduate not less than 100 medical students annually, by no later than September 1982. The first class graduated in May 1980, and more than 100 students have graduated annually since 1982, for a total of 1,836.
- USUHS meets its Congressional mandate to "establish programs in continuing medical education for military members of the health professions to the end that high standards of health care may be maintained within the military medical services.
- USUHS is dedicated to meeting DoD and Congressional mandates to retain military medical officers on active duty who will provide stability and leadership to the force while demonstrating a dedication to national service ... medical officers who can honor our nation's moral obligation to care for those our country sends into harm's way.

**USUHS maintains full  
academic accreditation**

- In 1993, USUHS received full reaccreditation from the Commission on Higher Education of the Middle States Association.
- In 1993, the F. Edward Hébert School of Medicine received full reaccreditation from the Liaison Committee on Medical Education.
- The Accreditation Council for Continuing Medical Education has reaccredited USUHS as a sponsor of continuing medical education (CME).
- During the past two decades, in fulfillment of its founding legislation, the University has developed into a diverse and dynamic health sciences university that trains a variety of health care professionals.

## **STUDENTS AND GRADUATES**

**USUHS receives 15 appli-  
cants for each opening**

- The School of Medicine received 2,417 medical school applications from all fifty states for the 165 openings in the Class of 1997, entering in the Fall of 1993.
- The Class of 1997 has a mean science grade point average of 3.40, and a mean Medical College Admission Test score of 9.6 in each of the three subtests, both of which are above the national average of students entering U.S. medical schools.

**Students serve on active  
duty while in school**

- Students enter the School of Medicine as active duty commissioned officers of their respective services, and then spend their next four years in an environment which fosters jointness among the military services where interservice teamwork is practiced each and every day.
- Graduates incur a basic obligation of seven years active duty, to be served in addition to time served in graduate medical education.

**USUHS graduates remain on  
active duty longer, as career  
Federal physicians**

- USUHS offers a proven program of medical education directly linked to the guaranteed, long-term public service of its graduates. Its students demonstrate, both at matriculation and graduation, the sensitivity, commitment and selflessness necessary for a lifetime of national service.

- Currently, 96% of the 1,836 USUHS medical school graduates are still on active duty, and of those graduates who have completed their initial seven-year obligation, 87% continue to serve today.

## COST COMPARISONS

**USUHS costs less than HPSP in terms of cost per year of physician service**

- The cost to the Federal government per HPSP student, in FY1992, averaged \$393,586 ... including direct costs to the DoD and indirect Federal support of medical education through Medicaid, etc.; HPSP physicians are obligated to serve only four years.
- The annual cost to operate USUHS, per medical school graduate, is \$463,483; USUHS physicians are obligated to serve seven years.
- Cost per physician-year of obligated service:
  - HPSP graduate: \$98,396.
  - USUHS graduate: \$66,212.
- The recent *Report of the National Performance Review* ("Gore Commission" report) compares the per capita Defense Department expense of the HPSP graduate to the total cost of operating USUHS divided by the number of its graduates; this attempt to contrast the *unit price* of each military physician source ignores the difference in value of each, and ignores the broader contributions made by USUHS.

## GRADUATE SCHOOL

**USUHS provides graduate education in basic and applied health sciences**

- USUHS offers doctoral degree programs in Medical psychology, Clinical psychology, Anatomy and Cell Biology, Biochemistry, Pharmacology, Pathology, Physiology, and Neuroscience.
- USUHS offers masters degree programs in Public Health, in Tropical Medicine and Hygiene, and in basic medical sciences on a limited basis.
- In 1993, at the behest of Congress, USUHS began offering masters degree programs in Advanced Nurse practice.
- Since the first graduate students were admitted, 124 have completed study and received the Doctor of Philosophy; 27 received the Master of Science; 139 completed the Master of Public Health; and 14 completed the Master of Tropical Medicine and Hygiene.

## ADDITIONAL VALUE

**The value to the nation includes those components of military medicine that would have to be acquired from other sources at a higher cost**

- USUHS graduates medical officers who remain on active duty to become senior clinicians and medical department leaders. USUHS remains the most economical source for these career physicians.
- USUHS graduates medical officers who have been exposed to all the unique aspects of military and disaster medicine throughout their medical education and training. They also receive a thorough indoctrination in the history, organization, mission and values of each of the uniformed services with special emphasis on joint military service.

**Continuing Medical Education  
(CME)**

- USUHS is the major DoD resource for required CME, which is especially cost effective for physicians and other health care professionals deployed overseas.
- In FY1992, 273 USUHS-sponsored programs were approved for accredited CME credit; the total number of attendees at USUHS-sponsored CME activities was 4,138. In FY1993, more than 8,000 health care professionals participated in 250 ACCME-approved, USUHS-sponsored programs:
  - USUHS sponsored CME programs for more than 1,000 medical personnel in Europe during FY1993, saving the 7th Medical Command \$1.3 million.
  - USUHS sponsored CME programs for over 300 personnel deployed in the Western Pacific, saving the Navy over \$700 thousand in FY1992.
- Since 1990, USUHS has trained 684 military surgeons in laparoscopic surgery techniques, at an estimated tuition savings of \$2.05 million. In addition to tuition expenses saved, the ability of the services to provide these video endoscopy procedures in-house avoided additional expenses to the military health program.

**Graduate Medical Education  
(GME)**

- The USUHS GME Office provides DoD-wide consultation, affords oversight for ten USUHS sponsored-cosponsored GME programs and performs various DoD studies relating to GME in the military.

**Military Training Network  
(MTN)**

- The USUHS MTN supported 471 military programs in basic, advanced and cardiac life and trauma support medicine, training 243,335 personnel with an estimated cost savings of \$9 million in FY1992.

**USUHS provides unique  
training for civilian law  
enforcement agencies**

- The University reaches into communities throughout the country working with governmental agencies at the Federal, state and local levels to provide specialized medical support training to law enforcement, fire and rescue workers.
- The University's COUNTER NARCOTICS TACTICAL OPERATIONS MEDICAL SUPPORT (CONTOMS) program has trained more than 1,000 personnel in 18 Federal agencies, 208 non-Federal agencies and one non-U.S. agency ... a total of 227 agencies in 37 states plus D.C., Puerto Rico and Canada.
- University staff provides rapid response medical consultation and support to a number of law enforcement agencies involved in hostage or other tactical operations.
- The USUHS CONTOMS program was commended by the U.S. Senate Judiciary Committee and the International Narcotics Control Caucus as an "important success" which "should be expanded."

**USUHS is a major medical  
research center**

- USUHS scientists are involved in 344 active research projects in basic and applied science, many of which directly support a military requirement.
  - Intramural grants are valued at more than \$1.6 million.

- Extramural grants are valued at more than \$24 million. Extramural grant funding has increased by more than 100% in the last five years.
- USUHS scientists have been awarded eight patents, with an additional 28 patents pending and six disclosures filed.

## AN ANALYSIS OF USUHS COSTS VS. OTHER MEDICAL SCHOOL COSTS

**USUHS cannot be directly compared with other accession sources**

- Initially it might appear that determining the cost of educating medical students for military service would be straight forward ... simply divide the amount DoD spends for medical education by the number of M.D. graduates.
- However, the inequity of comparing the direct cost between USUHS and other sources of physicians was recognized by the Congressional Budget Office in its February 1992 report entitled, *Reducing the Deficit: Spending and Revenue Options*. The report states:  
Finally, direct cost comparisons between USUHS and other sources of physicians may be unfair to USUHS because of indirect subsidies that the federal government provides to medical schools, which in effect raise the true governmental cost of physicians from sources other than USUHS.

**Government already supports medical education by \$234k per student**

- The Federal contribution to U.S. medical schools comes in several forms: educational funding, research funding, and payment for medical services through Medicare, the Federal portion of Medicaid, etc.
- Direct Federal contributions (excluding research) to medical schools are estimated conservatively at over \$3.6 billion per year ... some \$234,000 per M.D. graduate.
- Other Federal support ... through student loan programs and scholarships, Veterans Administration hospital affiliations with medical schools, clinical clerkships at Federal agencies (e.g., NIH, the CDC, and AFIP) ... drive the Federal government's per student cost even higher.

**JAMA provides baseline data for evaluating medical school costs**

- Costs and revenues for U.S. medical schools are compiled annually by the Association of American Medical Colleges (AAMC) and published in the *Journal of the American Medical Association (JAMA)*.
- JAMA lists several revenue categories: Medical Services, Federal (non-medical), Tuition & Fees, State & Local, and Other. For this analysis, Medical Service revenue is subdivided between private sources and the Federal contribution to MediCare/Medicaid ... estimated to be 1/3 the total medical service revenue.
- Federal research revenue has been excluded from the following analysis due to differences in cost recovery procedures between USUHS and other medical schools. In most instances USUHS can not recover salaries of investigators who are Federal employees from Federal research grants.

**Figure 1. – SOURCES OF SUPPORT FOR U.S. MEDICAL SCHOOLS**

[FY 1992, excluding federal research]  
**SOURCES OF REVENUE\*** in \$millions

|                                    | <u>ALL<br/>U. S. SCHOOLS</u> | <u>U.S. SCHOOLS PLUS<br/>AFHPSP STIPEND</u> | <u>FEDERAL COST<br/>AFHPSP</u> | <u>DOD COST<br/>AFHPSP</u> | <u>TOTAL COST<br/>USUHS</u> |
|------------------------------------|------------------------------|---------------------------------------------|--------------------------------|----------------------------|-----------------------------|
| FEDERAL (Excl. Medical Svs.)       | \$589                        | \$589                                       | \$589                          | \$0                        | \$0                         |
| MEDICAL SERVICES (FEDERAL) [1]     | \$3,593                      | \$3,593                                     | \$3,593                        | \$0                        | \$0                         |
| STATE/LOCAL GOVERNMENTS            | \$2,896                      | \$2,896                                     | \$0                            | \$0                        | \$0                         |
| TUITION & FEES                     | \$955                        | \$955                                       | \$0                            | \$0                        | \$0                         |
| MEDICAL SERVICES (Non-federal) [2] | \$7,186                      | \$7,186                                     | \$0                            | \$0                        | \$0                         |
| OTHER SOURCES                      | \$3,455                      | \$3,455                                     | \$0                            | \$0                        | \$0                         |
| FEDERAL AFHPSP (Student Stipend)   | \$0                          | \$54.2                                      | \$54.2                         | \$54.2                     | \$0                         |
| FEDERAL AFHPSP (Tuition & Fees)    | \$0                          | \$0                                         | \$61.4                         | \$61.4                     | \$0                         |
| FEDERAL USUHS                      | \$0                          | \$0                                         | \$0                            | \$0                        | \$82.5                      |
| <b>TOTAL</b>                       | <b>\$18,674</b>              | <b>\$18,728</b>                             | <b>\$4,298</b>                 | <b>\$116</b>               | <b>\$82.5</b>               |

\*Ref: JAMA 270:1089(1993) & OASD(HA) STAFF PAPER

[1] Represents Federal MediCare cost calculated as 1/3 of total medical services.

[2] Exclusive of Federal MediCare cost

**Medical school revenue sources are detailed in Figure 1., to give a picture of real Federal costs**

**Figure 2. demonstrates that USUHS physicians cost the U.S. government less per year of service**

- FY1992 total medical school revenues (excluding Federal research) of \$18.7 billion are broken out by source in the first column of Figure 1.
  - It is conservatively assumed, here, that the Federal (Medi-Care/Medicaid) component of medical school *Medical Services* revenue is 1/3 of the total *Medical Services* revenue reported by the schools. Since various authorities estimate the Federal component to be 40% or greater, the 1/3 portion is used with confidence.
  - This Federal component of *Medical Services* revenue is critical to understanding the full Federal cost of the HPSP program.
- Column two adds the DoD cost of HPSP student stipends.
  - Note that HPSP tuition values were already accounted for under Tuition & Fees revenue in column one.
- Column three deletes non-Federal revenue sources for schools participating in the HPSP program, leaving the net Federal support for HPSP.
- Column four lists only the DoD contribution to the HPSP program costs.
- Column five lists the total Federal outlay to USUHS (through DoD).
- Figure 2 considers the cost of medical education on a per-student basis.
- Costs are then adjusted for years of obligated service comparing USUHS and HPSP graduates.
- The USUHS graduate is required to serve seven years (plus at least one year of internship) while an HPSP graduate will serve two to four years in one of the uniformed services depending on how long he/she was in the HPSP program.

- For this comparison, the cost-per-physician-year has been determined by using seven- and four-year obligations respectively. Seven and four are the nominal service obligations of physicians completing four-year medical educations in government sponsored programs.
- DoD costs and Total Federal costs are computed for the HPSP program, where hidden Federal costs (see Figure 1, above) mask the true expense of accessing such a physician. For USUHS, the DoD cost is the Total Federal cost.
- Total program costs (HPSP, USUHS) are divided by the number of graduates to produce the per-graduate cost.
  - Since HPSP had a total of 3,797 students enrolled during FY1992, it is assumed that 25%, or 949, graduated.
- Per-graduate costs are divided by the respective service obligations to produce the Cost Per Year Of Obligated Service numbers.
- Since the USUHS graduating class of 1992 produced 178 physicians, 13 higher than nominal, the last column in Figure 2. looks at the average cost of USUHS divided by the average size class.
- Although, on a Per Year Of Obligated Service basis, the cost to DoD is higher for the USUHS graduate than for the HPSP graduate, the Total Cost to Federal Government is just the opposite. HPSP physicians cost over \$30,000 more per year spent on active service.

**Figure 2. – COST PER GRADUATE**

[FY1992, excluding federal research]  
in \$

| SOURCES OF REVENUE**                         | U.S. SCHOOLS | U.S. SCHOOLS PLUS<br>AFHPSP STIPEND | FEDERAL COST<br>AFHPSP | DOD COST<br>AFHPSP | TOTAL COST<br>USUHS 1992 | TOTAL COST<br>AVERAGE USUHS<br>CLASS |
|----------------------------------------------|--------------|-------------------------------------|------------------------|--------------------|--------------------------|--------------------------------------|
| FEDERAL (Excl. Medical Svs)                  | \$38,282     | \$38,282                            | \$38,282               | \$0                | \$0                      | \$0                                  |
| FEDERAL (Medical Svs)                        | \$233,524    | \$233,524                           | \$233,524              | \$0                | \$0                      | \$0                                  |
| STATE/LOCAL GOVERNMENTS                      | \$188,223    | \$188,223                           | \$0                    | \$0                | \$0                      | \$0                                  |
| TUITION & FEES                               | \$62,069     | \$64,683                            | \$0                    | \$0                | \$0                      | \$0                                  |
| MEDICAL SERVICES (Non-federal)               | \$467,048    | \$467,048                           | \$0                    | \$0                | \$0                      | \$0                                  |
| OTHER SOURCES                                | \$224,555    | \$224,555                           | \$0                    | \$0                | \$0                      | \$0                                  |
| FEDERAL AFHPSP (Student Stipend)             |              | \$57,098                            | \$57,098               | \$57,098           | \$0                      | \$0                                  |
| FEDERAL AFHPSP (Tuition & Fees)              |              |                                     | \$64,683               | \$64,683           | \$0                      | \$0                                  |
| FEDERAL USUHS                                |              |                                     |                        |                    | <u>\$463,483</u>         | <u>\$500,000</u>                     |
| TOTAL (Total Revenue/Number<br>of graduates) | \$1,213,701  | \$1,273,412                         | \$393,586              | \$121,780          | \$463,483                | \$500,000                            |
| COST PER YEAR OF OBLIGATED SERVICE           |              |                                     | \$98,396               | \$30,445           | \$66,212                 | \$71,429                             |

Total Physician Graduates (all medical schools, FY1992) = 15386\*\*

Total USUHS Physician Graduates (FY1992) = 178; Average USUHS Physicians Graduates = 165

Total AFHPSP Physician Graduates = 949 (25% of Total AFHPSP 3797)

\*\* Ref: JAMA 270:1064(1993)

PREPARED STATEMENT  
FOR THE  
SENATE APPROPRIATIONS COMMITTEE  
SUBCOMMITTEE ON DEFENSE

June 1993

James A. Zimble, M.D.  
President  
of the  
Uniformed Services University of the Health Sciences

NOT FOR RELEASE UNTIL  
AUTHORIZED BY THE COMMITTEE

## Introduction

Mr. Chairman, distinguished Members of the Committee, I am very honored to be here today. I thank you for the opportunity to review the current status and accomplishments of our nation's fully accredited medical school at the Uniformed Services University of the Health Sciences (USUHS).

Two years ago, I had the honor of being sworn in as the third president of the university. Since that time, we conducted a national search for a new dean at the F. Edward Hébert School of Medicine, and appointed Dr. Nancy E. Gary in August 1992.

The reaccreditation process for both the university and the School of Medicine has been in the forefront for much of the past year. Faculty, staff and students have been engaged in institution-wide self-studies in preparation for survey team visits by the Commission on Higher Education of the Middle States Association (MSA) and the Liaison Committee on Medical Education (LCME). I am pleased to announce that the university was informed in April that the LCME has fully re-accredited your federal medical school for the maximum period allowed of seven years. We expect to hear that the university has also been reaccredited by the MSA within the next few weeks.

These re-accreditations attest to the educational quality of the university's academic programs. Our faculty includes many nationally and internationally respected scientists and scholars, and is committed to supporting the university's educational and research missions. Our federal medical school stands ready and fully accredited to serve the nation.

As I report this pleasant news, I want to acknowledge the wisdom of the Congress for the establishment of our relationship with the Assistant Secretary of Defense for Health Affairs. Under Health Affairs' guidance and support, USUHS has enjoyed new stature in the Department of Defense. USUHS has participated to a greater extent in the development of programs and budgets which provide the resources necessary to carry out the mission that has

been assigned to USUHS: To provide the nation with medical officers and scientists of character who serve the common good in war and peace. Dr. Martin, the Acting Assistant Secretary of Defense for Health Affairs, has provided USUHS with invaluable support throughout the past five months.

Established by the Congress on September 21, 1972, as a part of the Uniformed Services Health Professions Revitalization Act, the Uniformed Services University's mission is to educate men and women for careers in public service as medical officers in the Army, Navy, Air Force and the Public Health Service and to conduct other formal educational programs such as graduate education, continuing education and research in the health sciences. The university is dedicated to academic excellence, scientific rigor, humanism and professionalism. Our graduates must be ready for the challenges that confront the nation's health care community and the uniformed services in peace and war. USUHS graduates are prepared for a lifetime of learning and service as members of the uniformed services health care systems.

The USUHS F. Edward Hébert School of Medicine was mandated by congressional legislation to graduate "not less than 100 medical students annually, with the first class graduating not later than September 21, 1982." The first class graduated in May of 1980, and more than 100 medical officers have graduated each year since 1982. On May 15, 1993, the F. Edward Hébert School of Medicine graduated its 14th class, bringing the total to 1,841 physician alumni. In addition to graduating medical doctors, the university offers fully accredited graduate programs in the basic medical sciences. Doctoral degrees are awarded in anatomy and cell biology, biochemistry, medical psychology, microbiology, pathology, pharmacology, physiology, medical zoology and neuroscience. Master's degrees are offered in public health, tropical medicine and hygiene, and in other basic sciences on a limited basis.

USUHS graduates are currently serving in the following uniformed services: Army, Navy, Air Force, and Public Health

Service. Many now occupy key leadership positions in each of the uniformed services. Approximately 10% of all physicians currently on active duty in the military are USUHS graduates. At this time, the number of graduates who are beyond their period of obligated service is too small to provide meaningful retention data. However, USUHS anticipates a retention rate as high as 90%.

The School of Medicine received 2,417 medical school applications from all fifty states for the fall 1993 entering class. The applicant per space ratio is 15:1, which allows for the selection of highly qualified applicants. Also, over the last two years, the School of Medicine has enjoyed a low average declination rate of 26%. The entering students will have an approximate mean science grade point average of 3.40 and Medical College Admission Test mean score of 9.3 in each of the three subtests, both of which are above the national average for students entering U.S. medical schools. USUHS is one of 45 medical schools which requires students to pass Step 1 and Step 2 of the United States Medical Licensing Examination in order to graduate.

The university is unique in its mission and ownership. USUHS is our nation's only federal medical school. To meet the mandates of legislation, required medical school accreditation standards, and our vision as the capstone of federal health sciences academia, USUHS must produce the following: continuing medical education for serving medical officers; support for military residency training programs; special military/public health education programs; graduate education in the biomedical sciences; applied and basic research; and medical care for military beneficiaries provided by USUHS clinical faculty in the course of teaching. To fulfill these missions effectively, USUHS must become an academic center for the maintenance and advancement of military and disaster medicine. All of these products are paid for as part of the operating cost of USUHS, and all are part of USUHS' value to the nation. USUHS represents a

blending of traditional medicine, military training and character development. Our objective is to produce a doctor who not only practices medicine in the military, but who can practice military medicine.

Let me describe the vital statistics of our current freshman class: 38 members of the class are from minority groups, including 16 from groups classified as underrepresented; 23 percent are women; all have B.S. or B.A. degrees; nine hold Master's degrees and three have been awarded doctorates; 56 percent of the students had prior military experience of some kind; and 52 percent were also accepted at one or more other U.S. medical schools.

According to data supplied by the Association of American Medical Colleges (AAMC), USUHS is in the 95th percentile of all medical schools for number of course contact hours per week. The USUHS medical curriculum is distinct from that of the other 125 U.S. medical schools in several aspects. Prior to reporting to USUHS, each new medical student receives four to six weeks of military orientation at the medical service school of the individual's service. These schools present service specific instruction on subjects such as administration, customs, leadership, and officer responsibilities. Class cohesiveness develops even before formal school begins.

In addition to the usual medical school curriculum, USUHS has a uniquely integrated curriculum in military medicine which extends across the four years of medical school. First year students take Military Studies I, comprised of an Overview of Military Medicine, Combat Medical Skills, Military Applied Physiology, Leadership, and Field Skills. At the conclusion of the first year's curriculum, just prior to a short authorized summer leave, all students participate in the Military Medical Field Studies course, which includes a two-week field exercise plus a 3-4 week assignment to an operational unit of their parent service. During that assignment, they participate as officers in various aspects of unit training and operations. Another unique

USUHS requirement is that all students must be certified in Basic Life Support (BLS) during their first year, and must be recertified each year thereafter.

In the second year, all students take Military Studies II - Introduction to Combat Casualty Care, which includes coverage of the nature of combat operations, conventional and non-conventional weapons effects, operational medical support for the Army, Navy, Air Force and Marines, and case studies in operational medicine. Much of the content of this course is preparation for a later course in preventive medicine which requires students to deal with the medical problems confronting a hypothetical joint task force deployed to Southwest Asia.

During the fourth year, all USUHS students complete a four-week course in Military Contingency Medicine (MCM) that includes the American College of Surgeons-sponsored course in Advanced Trauma Life Support (ATLS), the American Heart Association-sponsored Advanced Cardiac Life Support Course (ACLS), and a variety of military, disaster and emergency medicine topics. This course culminates in a one-week field medicine exercise called Operation Bushmaster. During this exercise, the USUHS student must demonstrate a capacity to practice medicine and to exercise medical officership in a military field situation. The students establish and operate multiple mobile field medical treatment facilities which operate 24 hours a day, and treat simulated patients representing the full spectrum of casualties seen in combat units. Following completion of MCM, students participate in the four-week Military Emergency Medicine (MEM) course, consisting of an on-site experience in any one of a number of busy civilian or military hospital emergency departments and trauma centers.

The Department of Defense encourages all military medical officers to receive ATLS training and complete the Combat Casualty Care Course. The USUHS-trained medical officers receive this training as part of the basic curriculum and as a prerequisite to graduation.

USUHS-trained medical officers receive unequalled training in the management of medical situations most likely to occur in the combat or civilian disaster environment. At the same time, the USUHS curriculum sets clinical practice standards for students in all areas of medicine which meet or exceed the requirements set by civilian peer review organizations, accrediting organizations, and regulatory agencies. Clinical rotations in civilian institutions during the fourth year allow students to experience, and to understand, the civilian medical care system. Elective clerkships in the fourth year provide an international perspective on patient care. USUHS is closely affiliated with 16 military teaching hospitals where most clinical teaching of students occurs. These hospitals and medical centers offer programs in major medical specialties, have sizable outpatient workloads and together have more than 5,500 teaching beds.

At the onset of Desert Storm, USUHS graduates filled nine of 14 medical officer positions in the Army Special Operations Forces. USUHS graduates helped to provide backfill and continuity during the initial deployment period. We are proud of the operational readiness evidenced by our medical school graduates. Currently, and for the foreseeable future, U.S. military forces will be increasingly CONUS-based, requiring high levels of readiness for rapid overseas deployment. The USUHS medical school curriculum is specifically designed to train students to meet the attendant medical support requirements.

It is my opinion that USUHS medical graduates are essential to the effective accomplishment of the military medical mission. Graduates of USUHS, by virtue of specialized training and longer commitments, form a cadre of career medical officers who make a significant contribution toward the leadership and continuity so important to our armed forces.

#### Administrative Issues

The Inspector General, Department of Defense (IG, DoD)

completed an inspection of USUHS in April 1990. The inspection report outlined corrective actions that needed to be taken for USUHS to be in compliance with DoD requirements. The Office of the Director, Review and Evaluation at USUHS is responsible for tracking those corrective actions and reporting progress on them to the IG/DoD every six months.

The IG, DoD inspection report outlined specific areas of concern at USUHS. Thirty-six recommendations, of which 27 are closed, ranging from personnel management to international agreements, were made to the management of USUHS in order to improve operations at the university. The most important of these recommendations addressed the need for more oversight of university activities and the development of internal management control procedures at USUHS. The position of the Director, Review and Evaluation has been filled. This office will ensure adequate visibility, credibility, formal recognition of responsibilities, and appropriate review, oversight and internal management control.

#### Expansion of the USUHS Mission

The USUHS administration has worked closely with the Assistant Secretaries of Defense for Program Analysis and Evaluation (ASD/PA&E) and Health Affairs (ASD/HA) on the issue of cost effectiveness. Initial efforts outlined expanded responsibilities for USUHS in the areas of medical consultative services, research, curriculum development, and worldwide continuing medical education. DoD Directive 5105.45, which charters USUHS, was updated, accepted and approved by the Secretary of Defense in April 1991. The USUHS strategic planning and Continuous Quality Improvement (CQI) programs have been underway for over a year. Mission, vision, and guiding principles have been developed, circulated and approved by faculty, staff and students. Strategic goals consistent with those documents and the recently completed accreditation self-

studies are now being finalized. These goals are being developed to expand the role of USUHS, increase its cost-effectiveness, and guide us toward our stated vision.

Under Title 10, U.S. Code (Section 2113), USUHS is mandated by Congress to "establish programs in continuing medical education for military members of the health professions to the end that high standards of health care may be maintained within the military medical services." The Accreditation Council for Continuing Medical Education has reaccredited USUHS as a sponsor of continuing medical education (CME). In FY 1992, 273 programs were approved for continuing education credit; the total number of attendees at USUHS-sponsored CME activities was 4,138. The USUHS CME programs facilitate and support the professional development of faculty members and military physicians serving throughout the world.

The university is accredited by the American Nurses' Association Council on Continuing Education in Nursing as an approved provider of nursing continuing education. In FY 1992, 14 programs were approved for continuing education in nursing; a total of 616 attendees were taught at USUHS-sponsored nursing activities.

In response to the Defense Medical Guidance, USUHS is planning an expanded role in graduate medical education. In 1986, the position of the Assistant Dean for Graduate Medical Education (GME) was established to provide consultation on GME programs (internship, residency and fellowship training for physicians) for program directors and OASD(HA). The mission of the office expanded to provide DoD-wide consultation and oversight for 10 USUHS and School of Medicine sponsored and cosponsored GME programs in General Internal Medicine, Pediatric Endocrinology, Pediatric Gastroenterology, Neonatal-Perinatal Medicine, Pediatric Infectious Disease, Clinical Pharmacology, General Preventive Medicine, Occupational Medicine, Radiation Oncology, and Immunodermatology. USUHS stands ready to participate in the development and implementation of the overall

office of the Assistant Secretary of Defense for Health Affairs' plan to integrate GME programs and faculty and to have an intra-DoD resident matching system.

USUHS is very much aware of its primary mission of readiness. On May 15, 1993, the USUHS commencement address was delivered by the distinguished Chairman, Defense Subcommittee of the Senate Appropriations Committee, the Honorable Daniel K. Inouye, the United States Senator from Hawaii. Senator Inouye presented an inspiring case for the importance of military and medical readiness when addressing our graduating class. He emphasized the significant contribution of military medicine in operational roles such as disaster relief, humanitarian assistance and peace-keeping operations during his fifty years of distinguished service to the nation.

Within hours of Hurricane Andrew's devastation, military medical personnel were providing assistance. They focused on evacuation and treatment, dental, veterinary and preventive medicine services, logistics, mental health, and communications. Military medicine's response was designed to support and assist community medical resources and personnel until they were able to resume their previous functions. The first large deployment of the National Disaster Medical System (NDMS) Disaster Medical Assistance Teams (DMATs) occurred following Hurricane Andrew. The USUHS Department of Military and Emergency Medicine trained the initial DMATs and USUHS faculty members continue to advise and participate in DMAT operations such as these.

Negotiations with the United States Public Health Service (USPHS) have resulted in an increase of three medical student matriculants per year beginning this fiscal year. The number of USPHS students is expected to increase to 12 within the next two years. To date, USUHS has graduated 71 USPHS medical officers who serve in the Indian Health Service (IHS), National Health Service Corps, the Food and Drug Administration, and the Centers for Disease Control and Prevention. The IHS has also committed two training positions to the graduate programs on an annual

basis. In this way, USUHS assists in producing medical officers to serve the health care needs of the underserved within the continental U.S.

On September 22, 1992, the Deputy Secretary of Defense transferred the Armed Forces Radiobiology Research Institute (AFRRI) to the management of USUHS beginning in FY94. AFRRI has provided a unique capability for DoD to study the effects of radiation on biologic systems, and is about to become the only organization in the country to possess a reactor dedicated to radiobiology research.

A Transition Team from AFRRI, Defense Nuclear Agency (DNA), and USUHS has been appointed. Working groups are reviewing opportunities to consolidate, or share, administrative and support functions between AFRRI and the university. Emphasis is being placed on cost-effective plans which will maintain quality services for both institutions. A scientific working group is looking for opportunities for university faculty and staff to contribute to the research programs of the institute, and opportunities to utilize AFRRI personnel and resources in support of university research and teaching programs.

### **Academic Activities**

The F. Edward Hébert School of Medicine of USUHS continues to operate fully accredited academic programs in the health sciences. These programs grant degrees in Doctor of Medicine (M.D.), Doctor of Philosophy (Ph.D.), Master of Science (M.S.), Master of Public Health (M.P.H.), and Master of Tropical Medicine and Hygiene (M.T.M. & H.). During FY 1993, the numbers of graduates from these programs were: 155 M.D.; 13 Ph.D.; 20 M.P.H.; and 1 M.T.M. & H.

The USUHS Office of Minority Affairs was established in 1991 with the appointment of Lieutenant Colonel Jeannette South-Paul, M.D., as the Vice President for Minority Affairs. In order to increase the number of traditionally underrepresented minority

medical and graduate students at USUHS, the second "Get Acquainted with USUHS Weekend" was held from 1-3 April, 1993. Attendees included 50 pre-health advisors and professors of military science and 50 students from universities with a high enrollment of minority students. Our goals are to increase the awareness in minority communities of what USUHS can offer its students in the biomedical sciences and further understanding of our commitment to quality, diversity, and government service.

The Student National Medical Association (SNMA) meets monthly at USUHS and quarterly in a faculty or student home to discuss common interests and concerns facing minorities in uniformed medicine. The SNMA has several ongoing community projects: monthly meetings at the Birney Elementary School (Southeast, Washington, D.C.) to role model and mentor minority students; and weekly visits to the Shepherd's Table Homeless Soup Kitchen and two other clinics in Montgomery County to shadow volunteer physicians working there.

The Office of Minority Affairs has made considerable progress toward establishing programs that will lead to successful participation in the Association of American Medical Colleges project to increase total minority enrollment in medical schools to 3000 by the year 2000 (Project 3000 by 2000). The USUHS community is aware of and has utilized the support of the newly established office.

In early 1993, USUHS hosted a successful International Telemedicine/Disaster Medicine Conference in coordination with NASA and the American Institute of Aeronautics and Astronautics. During the conference, a live, two-way video conference with Moscow, Russia, was held via satellite transmission. The conference convened key policy makers and planners from the areas of disaster medicine and telemedicine from the U.S. and other countries. The primary objective of the conference was to review the present and future role of telemedicine in disaster medicine, aerospace medicine in supporting space crew health and research, remote health care delivery, and public health.

A rapidly developing segment within the university's School of Medicine is the Casualty Care Research Center, staffed by military and civilian physicians and scientists in the Department of Military and Emergency Medicine. Created in 1989, the Casualty Care Research Center is a national center for research on all aspects of injury control and combat casualty care. The goal of the Casualty Care Research Center is to establish a national center of excellence for research on issues relating to injury control and casualty care, including acute care, epidemiology, biomechanics, prevention and rehabilitation. The Center provides research and resource information, technical assistance and community service to USUHS and other federal, state, and local agencies which share common interests in casualty care and operational medicine.

The faculty of the Casualty Care Research Center, USUHS and the Department of Interior, United States Park Police (USPP) developed the Counter-Narcotics Tactical Operations Medical Support (CONTOMS) program to train personnel to medically support tactical law enforcement operations related to the counter narcotics effort. The relationship between USUHS and the USPP has demonstrated that medical input in mission planning is beneficial and that medical support for tactical operations requires a unique expertise. Through this relationship, the university has accessed unique training and development opportunities for students, physicians, and faculty, while federal, state and local police have been able to take advantage of a unique national resource which has directly enhanced their mission effectiveness. The CONTOMS program has trained more than 900 personnel from the Drug Enforcement Administration, the Federal Bureau of Investigation, the United States Marshals Service, the United States Secret Service, the National Park Service (Department of Interior), the Federal Law Enforcement Training Center (Department of Treasury), and police and sheriffs' departments from over 34 states.

Current research efforts of the Casualty Care Research

Center include: development of a casualty data basis for medical system modeling and planning; assessment of doctrine and equipment for naval special warfare medical support; development of training programs for triage instruction; assessment of penetrating injury severity; medical response to terrorism, management of combined trauma and hypothermia; application of military casualty care methodologies to support federal law enforcement operation; and emergency medical care in austere environments.

The Military Stress Studies Center serves as a focal point for special studies and seminars on stress, combat, stress reactions, long-term consequences of hostage situations, and prisoners of war. Created in 1985, the Stress Center's mission is to establish a center of excellence for research on issues related to stress, psychiatric illness, and treatment. Currently areas of research and consultation by center staff include disaster medicine, trauma, chronic stress, and other issues of particular relevance to the military that will be added as they arise.

#### Status of the Program for Training Psychologists to Prescribe Drugs

This congressionally mandated demonstration project is intended to train clinical psychologists to prescribe certain psychotropic drugs. The Army Surgeon General was charged as executive agent to develop a demonstration project that would prepare uniformed clinical psychologists to prescribe a limited formulary of drugs within the military health care system. In 1991, four military clinical psychologists (two from the Army and two from the Navy) were assigned to participate in this demonstration project. The first phase of this project evaluated the feasibility of using unmodified courses from the medical student curriculum of the F. Edward Hébert School of Medicine to be accompanied by a clinical practicum at Walter Reed Army

Medical Center (WRAMC). To further develop this program, WRAMC has primary responsibility to develop the curriculum and manage the two-year training program to achieve this aim. USUHS is assigned to support WRAMC in this task by developing and instituting the first year didactic portion of this program with a newly designed curriculum. The Surgeon General of the Army has been tasked to appoint an advisory committee to oversee the entire demonstration program. The American College of Neuropsychopharmacology (ACNP) serves as external evaluator of this program.

Three of the original clinical psychologists continue in the training project. The participants completed their didactic requirements in May 1993, and began their nine-month clinical practicum full time. A new one-year didactic curriculum at USUHS required to support this program has been developed. Where possible, these courses will be used to support the development of other USUHS programs. The curriculum plans have been approved by the Evaluation Committee from the ACNP.

#### Steps Taken to Institute the Clinical Psychology Program

The Assistant Secretary of Defense for Health Affairs (ASD/HA) tasked USUHS on December 9, 1992, to establish a Ph.D. program in Clinical Psychology for the 1993-94 academic year. The students are to be drawn from qualified applicants in the uniformed services and in the private sector.

One Army captain is currently attending USUHS on an outside training billet from the Army Medical Service Corps. The Medical Psychology billeted faculty is providing the basic science component of the program. The one clinical course and practicum in the first year is being taught by the Army Clinical Psychologist who is an adjunct member of the faculty. The practicum is being carried out at the Psychology Service of the Walter Reed Army Medical Center.

The recruitment of a senior, full-time faculty member to

serve as Director of Clinical Training has been initiated and all aspects of the program have been coordinated with the Service Specialty Advisors. Contact has been made with the Indian Health Service to elicit their participation. Two students, one Navy and one Air Force, are expected to matriculate this August.

#### Steps Taken to Institute a Nurse Practitioner Program

In the FY 1993 budget, the Congress provided \$1M to begin the planning and implementation of a Nurse Practitioner Program at USUHS. The key feature of this program is the education of nurses who will practice in advanced nursing roles in the uniformed services. Nurse Practitioners prepared in this program will provide the uniformed services with additional professional nurse leaders who have demonstrated skills in reasoning, analysis, research, and decision-making relevant to health care delivery in the uniformed services.

A mission statement is in refinement stages; a curriculum has been proposed for a Master of Science in Nursing program; and monthly reports will be sent to the Surgeons General and uniformed nursing chiefs. The program's development is progressing. State agencies and certifying bodies have been contacted as a part of the accreditation process.

#### Research Administration and Support

Currently in FY 1993, USUHS has 318 active research grants. While these grants cover a wide area of biomedical research interests, the faculty members at USUHS are conducting 59 research projects supported by other DoD agencies. USUHS is on the forefront of basic biomedical and applied health services research. This research covers such areas as infectious diseases, combat casualty care, wound healing, factors which affect military performance, and responses to the stresses of military life. In addition, USUHS investigators maintain an

approved funding rate of 34% from the National Institutes of Health, versus a national average of 29%.

The current status of USUHS' patent activity continues to be very encouraging, as evidenced by the diverse nature of the technology and its commercial potential. Our patent portfolio consists of 37 invention disclosures, 8 pending patent applications and 8 patents issued to date. Nearly 100% of our patent portfolio is being licensed.

### Summary

This past year has been an exciting time of growth and change within the university. I am committed to continuing the high standards upon which USUHS was founded. Despite the fact that federal funds allocated to the Department of Defense are diminishing, we will continue to focus on the most efficient, effective, and creative utilization of those resources available to us.

The Uniformed Services University of the Health Sciences houses talented and dedicated faculty and staff that, on a day to day basis, ensure and exemplify educational excellence. The graduates of this university will continue to be of the highest caliber. I am dedicated to the university and believe that with the continued support of the Congress and the commitment of the university staff and faculty, this federal institution will continue to serve our great nation.

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

RETENTION OF USUHS GRADUATES  
ON ACTIVE DUTY

In May 1993, USUHS' F. Edward Hébert School of Medicine graduated its 14th class of physicians, producing a total of 1,836 M.D. degrees awarded.

In July 1993, the four services (Army, Navy, Air Force and U.S. Public Health Service) reported that 1,780 graduates of the USUHS medical school were still serving on active duty ... for a retention rate of 97%.

USUHS medical school graduates incur active duty service obligations of seven years, to be served after completion of graduate medical education. Graduate medical education can range from a one-year transitional internship up to a six-year residency in a medical specialty ... with the typical being a four-year residency/internship package. Consequently, typical USUHS graduates will remain on active duty for eleven or more years before completing their basic service obligations.

Only graduates of USUHS' earliest classes have reached points in their service careers where they are making meaningful choices about remaining in federal service. As expected, retention rates for these early classes show a strong commitment to federal service:

| Class<br>Year | On Active Duty |      |      |       |              | Total<br>Grads | Retention |
|---------------|----------------|------|------|-------|--------------|----------------|-----------|
|               | Air<br>Force   | Army | Navy | USPHS | A/D<br>Total |                |           |
| 1980          | 5              | 14   | 6    | 1     | 26           | 29             | 89.7%     |
| 1981          | 16             | 22   | 21   | 2*    | 61           | 66             | 92.4%     |
| 1982          | 27             | 38   | 30   | 6     | 101          | 103            | 98.1%     |
| 1983**        | 33             | 42   | 37   | 3     | 115          | 122            | 94.9%     |

\* Status of one '81 USPHS graduate unknown; if still on AD, retention would be 93.9%.

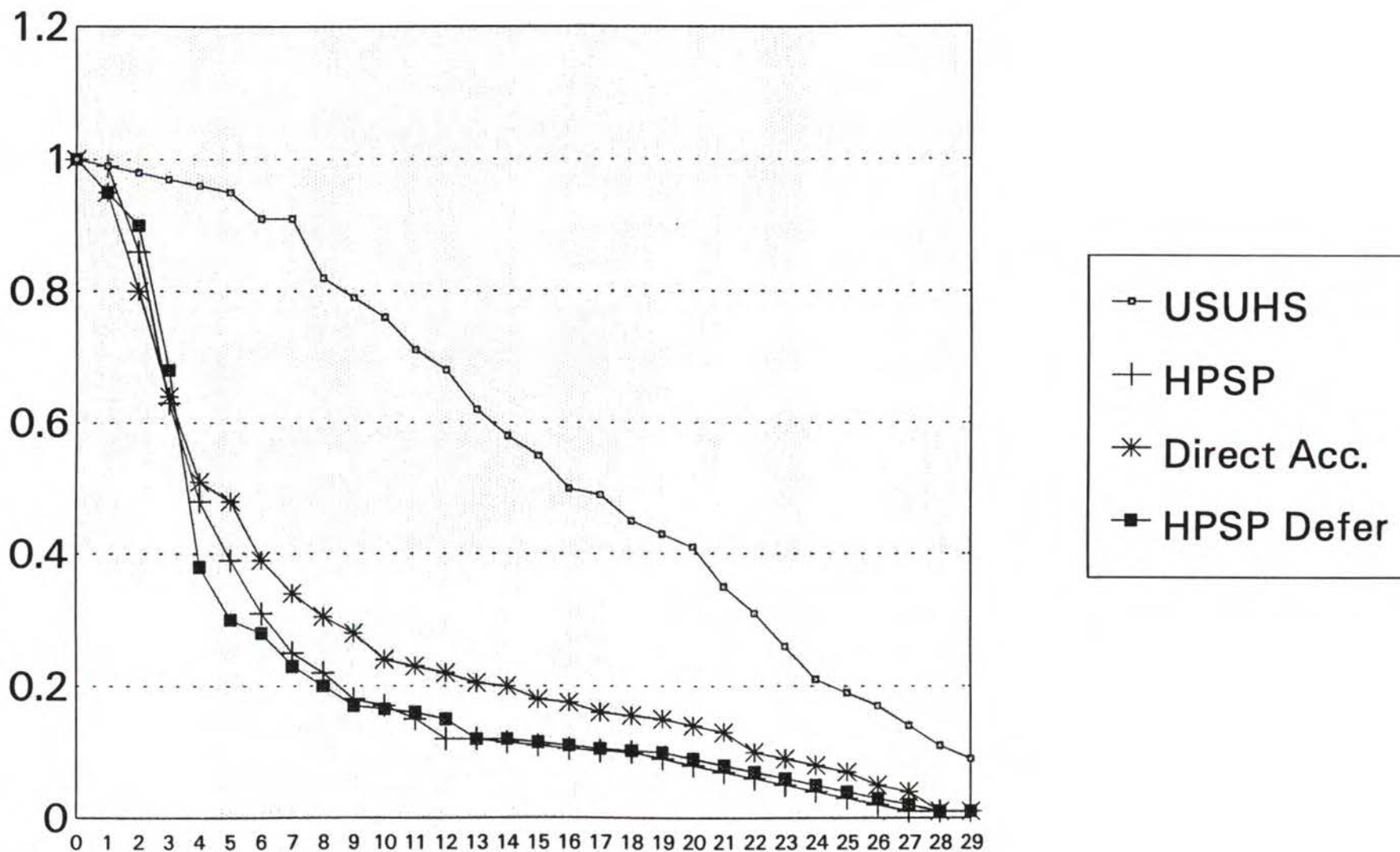
\*\* One '83 USPHS graduate subsequently transferred to the Navy.

September 1993

# CUMULATIVE RETENTION

## Specialties with 1-2 Years of GME

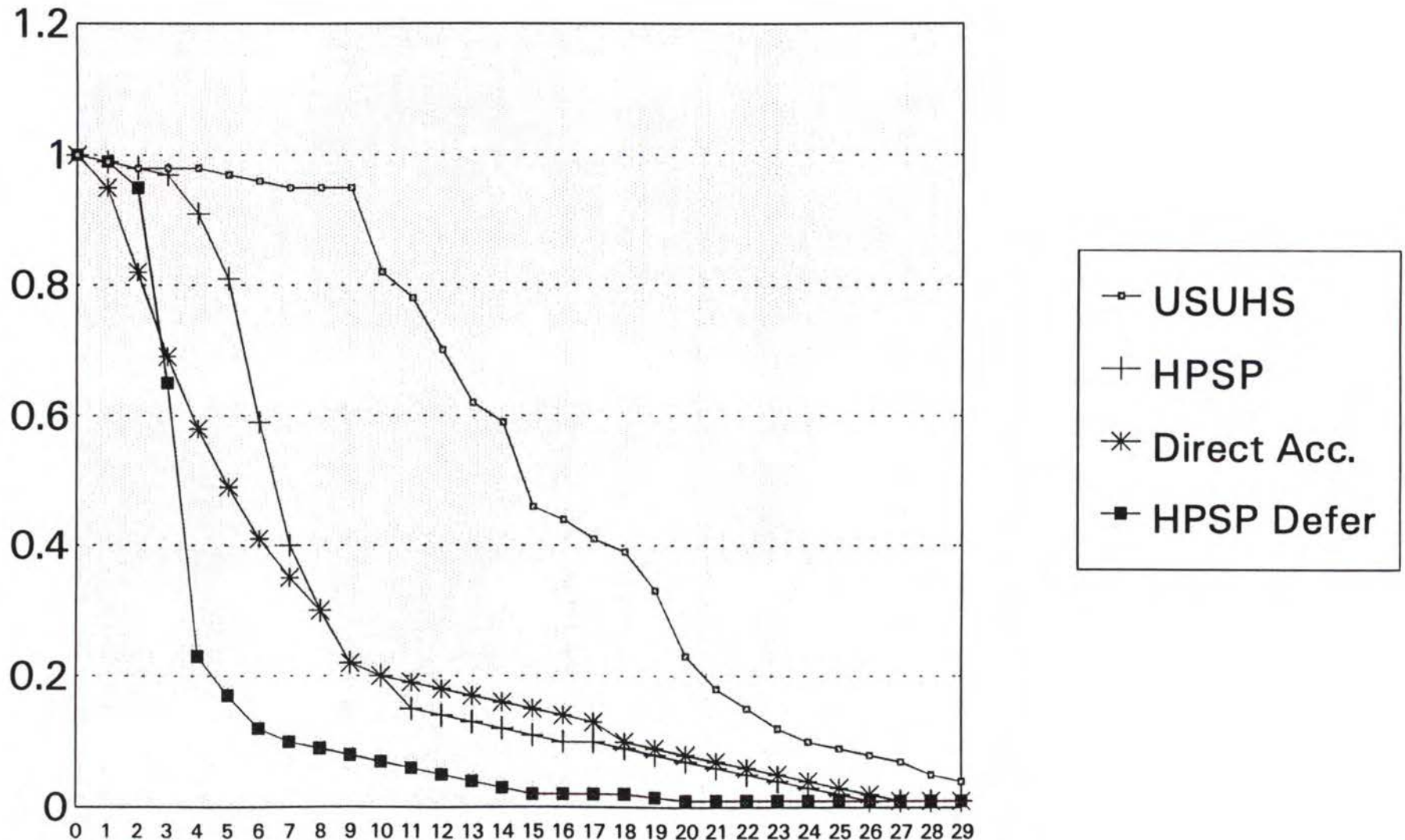
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# CUMULATIVE RETENTION

## Specialties with 3-4 Years of GME

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Robert G. Petersdorf, M.D.  
President

ASSOCIATION OF  
AMERICAN  
MEDICAL COLLEGES

2450 N STREET, NW  
WASHINGTON, DC 20037-1126  
TELEPHONE (202) 828-0460

September 28, 1993

The Honorable Les Aspin  
Secretary of Defense  
The Pentagon  
Washington, DC 20301

Dear Mr. Secretary:

As President of the Association of American Medical Colleges, which represents the nation's 126 accredited medical schools as well as 400 major teaching hospitals and 90 academic and professional scientific societies, I write to comment on the proposal in the Report of the National Performance Review to close the Uniformed Services University of the Health Sciences (USUHS).

The Uniformed Services University has a unique mission among this country's medical schools: to train men and women to assume careers as medical officers in the military and the United States Public Health Service. While many medical schools train physicians who serve for a limited time in the armed forces, USUHS educates those individuals for whom military medicine will be a career. It is these individuals that form the backbone of this nation's military medicine establishment as senior physicians and administrators.

USUHS graduates have demonstrated a commitment to serving their country in numbers and to a degree that is unrealistic to expect from civilian physicians. At a time when this nation's military operations are diverse and changing, we need a corps of dedicated individuals who are trained and willing to respond to these challenges. Also, we need a program such as USUHS to develop the next generation of military medical leaders. USUHS graduates average between 8 and 14 years of service to complete their active duty obligation and are much more likely to continue a career in military medicine; physicians trained through the Health Professionals Scholarship Program (HPSP) average only 4 to 8 years to complete their service requirement.

USUHS serves a significant role in the continuing medical education for military physicians by providing specialized courses in such areas as combat casualty care, tropical medicine, combat stress, disaster medicine, and medical responses to terrorism, which are not available through civilian medical schools. USUHS also benefits communities across the country and local, state and federal government agencies by providing specialized medical support training to law enforcement and fire and rescue personnel.

The National Performance Review raises the issue of whether USUHS is cost-effective. It is difficult to measure the cost of medical education at any institution; moreover, we believe that such an evaluation must extend beyond a simple comparison of the cost of educating physicians through USUHS and through the HPSP. What should be decided is

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Page Two--The Honorable Les Aspin  
September 28, 1993

whether the incremental cost of USUHS is justified by the value of the program's output. The Uniformed Services University of the Health Services is the nation's only program of medical education that is directly tied to guaranteed, long-term public service of its graduates. The value of USUHS, to both the Department of Defense and the nation as a whole, must take into account both its unique mission of training the career military physician and its diverse education programs to support both military and civilian personnel.

The AAMC supports the Uniformed Services University of the Health Sciences and believes that it is the best and most effective mechanism to meet this nation's needs related to military medicine.

Very sincerely yours,

A handwritten signature in black ink, appearing to read "Robert G. Petersdorf". The signature is fluid and cursive, with the first name "Robert" and last name "Petersdorf" clearly legible.

Robert G. Petersdorf  
President

# American Medical Association

Physicians dedicated to the health of America

**James S. Todd, MD**  
Executive Vice President

515 North State Street  
Chicago, Illinois 60610

312 464-5000  
312 464-4184 Fax

December 3, 1993

The Honorable Les Aspin  
Secretary of Defense  
The Pentagon  
Washington, DC 20301

Re: The Uniformed Services University of the Health Sciences

Dear Mr. Secretary:

On behalf of the membership of the American Medical Association, I am writing to express our strong support for the Uniformed Services University of the Health Sciences (USUHS). The F. Edward Herbert School of Medicine at USUHS has been identified by Vice President Gore's National Performance Review as a candidate for closure. Closing this national asset would be a grave mistake.

Training men and women to assume careers as medical officers in the military and the United States Public Health Service is a noble and unique mission, a mission that must be continued. The 1,836 graduates of USUHS, more than 97% of whom are still serving the nation, are a testimonial to the wisdom of Congress, who in 1972, recognized the public need to train and educate its own medical officers and provided funding for USUHS. The university each and every year graduates active duty physicians from the Army, Navy, Air Force and the Public Health Service. These physicians are uniquely qualified to meet the medical needs that arise in the course of the military's mission, and those graduates who serve in the Public Health Service are deeply committed to health service and providing care for the most needy citizens of our nation.

Graduates of the program can receive doctoral degrees in anatomy, medical psychology, clinical psychology, biochemistry, physiology, neuroscience, pharmacology, microbiology, pathology, and medical zoology. In the course of a very diverse training program, the USUHS's curriculum provides a focused emphasis on primary care medicine, public health, preventive medicine, mental health and wellness. USUHS data indicates that 70% of all USUHS graduates serve in primary care or transitional programs during the first year of postgraduate medical education. 43% of the school's graduates are in practice or training in a primary care specialty beyond their internship year.

Changing global and military conditions suggest that this emphasis on primary care is well placed. The nation's interest in addressing the needs of the underserved and uninsured also puts a premium on providing primary care in coordinated care systems. USUHS is well positioned to serve as a valuable resource in developing the seasoned cadre of long-term professional medical leaders needed to manage as well as provide health care for our uniformed forces.

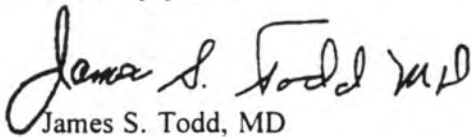
When global conflicts do occur, the country can be assured that USUHS graduates are prepared and committed to accept operational assignments often viewed as less than desirable by civilian medical graduates, are responsive to military education, are more understanding of the military missions, and are more knowledgeable about military medicine.

USUHS not only helps to educate its own graduates but also provides a significant national service through continuing medical education for military physicians by providing specialized courses in combat casualty care, tropical medicine, combat stress, disaster medicine, and medical responses to terrorism. These specialized courses simply are not available through civilian medical schools. The USUHS also provides education programs geared to military medical missions for thousands of reserve physicians. The research program at USUHS is another important benefit to the military as well as to the civilian population. Citizens everywhere have benefited from advances developed by military physicians in numerous fields, including tropical medicine, blood preservation and vascular surgery.

The issue of cost effectiveness raised by the National Performance Review must take into consideration the much longer retention on active duty of the USUHS physician (8-14 years) compared to the Health Professions Scholarship Program physician (4-8 years). In addition, Senator Daniel Inouye recently indicated that it was \$30,000 cheaper (on a per year of obligated service basis) than the cost for physicians trained under the Department's scholarship program. Surely the lower per year costs plus the retention of highly qualified USUHS medical officer graduates makes the institution worthy of the Administration's continued support.

The American Medical Association strongly supports the Uniformed Services University of the Health Sciences. Its mission and goals are consistent with the national interests and should be continued.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "James S. Todd MD". The signature is fluid and cursive, with the "MD" at the end being more distinct.

James S. Todd, MD



September 9, 1993

**ROGER J. BULGER, M.D.**  
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SENIOR VICE PRESIDENT AND  
VICE PRESIDENT FOR HEALTH AFFAIRS  
HOWARD UNIVERSITY  
*Associate Chairman for Public Health*

Vice President Albert Gore, Jr.  
Executive Office of the President  
1600 Pennsylvania Avenue, N.W.  
Washington, D.C. 20500

Dear Mr. Vice President:

I would like to congratulate you on the general thrust of your effort to reconfigure our government. All of our institutions need such efforts from time-to-time. I am moved to write, however, to protest the recommendation to close the Uniformed Services University of the Health Sciences (USUHS). People of good will can differ upon many important issues, but this one is clouded with misinformation, and your report perpetuates some of the current myth about the "military medical school." I am the president of the Association of Academic Health Centers and was, in fact, one of the two candidates for the deanship of USUHS when it opened in the 1970s. I spent a lot of time then trying to understand the possibilities for this institution, and I have watched with great interest over the years as each of those potentials has been fulfilled and others have emerged.

In brief, it is not true that USUHS costs more than other medical schools; the opposite is true. I will be glad to review why that is true with any of your staff. It is true that the maturity, personal character, commitment to the military, and the seven-year contract of the students differentiate them from other medical students. Experience shows that the vast majority of these physicians have made their careers in the military or public health service, extending their stay well beyond the original seven years. They have become the backbone of the health care delivery corps and if absent would leave us with a body without a spine, making it difficult to stand up and move when the need suddenly becomes acute.

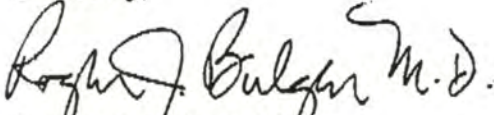
In its two decades, this institution has made innumerable connections and contributions on a wide variety of fronts, including technology transfer. I believe the faculty at USUHS should become even more important in the transfer of important new technologies developed originally for military purposes that can be further developed for civilian use in the health field.

Vice President Albert Gore, Jr.  
September 9, 1993  
Page Two

The Uniformed Services University of the Health Sciences has taken a major lead in international health in a wide variety of ways, and they present the President with the institution I would think he might want to have at his command, able to develop human resources to meet an international need somewhere, or a public health disaster somewhere else--an elite corps of physicians linked by a military background and spirit of discipline to which most of the medical profession is not disposed.

In short, I strongly object to the idea of closure and believe that it is tantamount to closing West Point, or Annapolis, or the Air Force Academy on the grounds that the ROTC can make officers cheaper.

Sincerely,

  
Roger J. Bulger, M.D.

RJB/hls

**NEED FOR CONTINUATION OF THE  
UNIFORMED SERVICES UNIVERSITY  
OF THE HEALTH SCIENCES**

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**REPORT  
OF THE  
SUBCOMMITTEE ON INVESTIGATIONS  
OF THE  
COMMITTEE ON ARMED SERVICES  
HOUSE OF REPRESENTATIVES  
WITH DISSENTING VIEWS  
NINETY-FIFTH CONGRESS  
FIRST SESSION**



**JUNE 15, 1977**

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(II)

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ARMED SERVICES,  
ARMED SERVICES INVESTIGATIONS SUBCOMMITTEE,  
Washington, D.C., May 16, 1977

HON. MELVIN PRICE,  
*Chairman, Committee on Armed Services,*  
*House of Representatives,*  
*Washington, D.C.*

DEAR MR. CHAIRMAN: Attached is a report entitled "Need for Continuation of the Uniformed Services University of the Health Sciences," approved by the members of the Armed Services Investigations Subcommittee, with dissenting views by Mr. Dellums. This report is based on hearings which were held March 16, 24 and 29, 1977.

I shall appreciate your early approval of the report so that it may be printed.

Sincerely,

SAMUEL S. STRATTON,  
*Chairman, Armed Services Investigations Subcommittee.*

Approved for printing:  
MELVIN PRICE, *Chairman.*  
Date: June 2, 1977

## CONTENTS

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|                                                 | Page |
|-------------------------------------------------|------|
| Introduction.....                               | 1    |
| Findings and conclusions.....                   | 2    |
| Recommendations.....                            | 3    |
| Discussion.....                                 | 4    |
| Staff-year cost of medical education.....       | 4    |
| The dubious assumption of 1,000 volunteers..... | 6    |
| Problems of the scholarship program.....        | 6    |
| Volunteers are not the answer.....              | 7    |
| Construction costs.....                         | 8    |
| OMB witnesses and documents.....                | 8    |
| Proposed subcommittee study.....                | 9    |
| Dissenting views of Hon. Ronald V. Dellums..... | 11   |

## THE NEED FOR CONTINUATION OF THE UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

### INTRODUCTION

On February 22, 1977, Secretary of Defense Harold Brown announced that the Uniformed Services University of the Health Sciences (USUHS), an institution authorized by the Congress in 1972, and funded in the Military Construction Authorization and Appropriations Acts for Fiscal Years 1975 and 1976, would be closed. The Department of Defense, in its amended budget submission to the Congress, stated that, "Physician needs of the military services can be satisfied more economically by direct recruitment or through the Armed Forces Health Professional Scholarship Program. Therefore, the University is to be closed."

The Armed Services Committee was concerned about the impact that decision might have on the ability of the military services to provide quality health care for military personnel. It also was concerned about the authority of the Secretary to unilaterally terminate an activity which the Congress had authorized and funded. To examine the authority for the Secretary's edict and its impact, the Investigations Subcommittee held hearings on March 16th, 24th and 29th. The Subcommittee sought to determine (1) the processes by which the Secretary arrived at the decision, (2) the soundness of the information upon which he acted, and (3) the extent to which the Secretary considered the impact of the decision on quality health care of our armed forces, as well as its effect on the careers of students and faculty of the University.

In an effort to develop that information, the subcommittee took sworn testimony from Dr. Robert N. Smith, Assistant Secretary of Defense for Health Affairs; VAdm. Donald Custis, USN (Ret.), former Surgeon General, U.S. Navy; Hon. David Packard, Chairman of the Board of Regents and Acting President of the USUHS; Dr. Anthony Curreri, former President, USUHS; Dr. Francis J. Haddy, Chairman, Department of Physiology, USUHS; 2nd Lt. Maceo Braxton, U.S. Army, Class President, Charter Class, USUHS; 2nd Lt. Margaret Diapoulis, USAF, Charter Class, USUHS; Lt. Gen. R. R. Taylor, Surgeon General, U.S. Army; VAdm. W. P. Arentzen, Surgeon General, U.S. Navy; Maj. Gen. Garth B. Dettinger, Deputy Surgeon General, U.S. Air Force; RAdm. A. R. Marschall, Commander, Naval Facilities Engineering Command; Mr. Thomas Corcoran; and, Mr. John Flinn, Staff Analyst for Program and Budget, Office of the Assistant Secretary of Defense, Comptroller.

#### *Background of the USUHS*

Retention of physicians in the armed services has been a problem since World War II. While the Selective Service Act was operative, it permitted the services to satisfy their need for doctors by ordering them to active duty. Since 1954, the so-called Berry Plan also satisfied

a large portion of the military's requirements for physicians by providing draft deferments to medical students during the time of their graduate medical training in exchange for a two-year period of obligated military service. The Berry Plan, whose impact continues at a rapidly decreasing rate, will produce its last six doctors for the Armed Forces in 1980.

With the resort to an all-volunteer force, the Congress, in 1972, sought to provide a substitute for the doctor draft. In furtherance of that objective, it passed the Uniformed Services Health Professions Revitalization Act of 1972 (P.L. 92-426). That legislation provided a dual approach to the problem of bringing doctors into the military and to increasing the period they would remain on active duty. The Act established the USUHS as the long-term solution. The University, when fully operational, after 1980, will provide 175 graduates annually, each with an initial service obligation of 7½ years to constitute a nucleus of career-oriented physicians. Additional obligated service will be incurred through postgraduate training which could result in as many as 12 years of obligated service. The purpose of the medical school is twofold, first to provide a nucleus of career physicians in the armed services, and in the Public Health Services as well; and second, to provide a unique curriculum which, in addition to the traditional courses, would include those essential for military medical training, such as trauma, mass casualties, combat surgery, medical logistics, nuclear medicine, etc.

Public Law 92-426 also established the Armed Forces Health Professions Scholarship Program (HPSP) as the short-term solution for bringing a large number of medical professionals into the armed services for shorter periods of obligated service. That program provides 5,000 full scholarships at any one time, of which 3,744 are for physicians. Graduates of the scholarship program incur an active duty obligation of one year for each year of participation in the program with a minimum two-year obligation.

Funds were appropriated by the Congress for construction of the USUHS buildings in fiscal year 1975. Construction was begun in July 1975 on the grounds of the National Naval Medical Center at Bethesda, Maryland. At present, the first building, a basic science building containing laboratories, research facilities, and classrooms, is approximately 80 percent complete, while approximately 17 percent of the second building has been completed.

In September 1976, the Charter Class of 32 students was admitted to the USUHS. Until completion of the first University building, students are attending classes in temporary facilities at the Armed Forces Institute of Pathology, Walter Reed Army Medical Center. Each succeeding class will be enlarged by approximately 35 students until the enrollment capacity of 175 first-year students is attained in 1980.

#### FINDINGS AND CONCLUSIONS

1. Following the recommendation of a junior budget analyst, the Secretary of Defense decided to discontinue funding of the USUHS without consulting the Congress or any of the civilian or military officers of the Department who are responsible for medical care of the armed forces.

2. The Secretary's decision was based solely on a speculative economic analysis without any weight being given to its impact on the quality of medical care to be provided to the armed services.

3. The analysis, upon which the Secretary acted, projected that "military physician strength can be increased by 20 percent over current requirements." It assumed the military departments can recruit 1,000 volunteers per year. That assumption had no basis in reality, as the services' best efforts have never come close to recruiting 1,000 volunteers in any year.

4. A General Accounting Office report of June 15, 1976 concluded that, when the total Federal funding to State-supported and private medical school is considered, the cost per staff-year of service under the scholarship program would be \$32,068, whereas the cost per staff-year of service for a graduate of the USUHS is \$26,236.

5. The Surgeons General of each of the military departments testified that they have been, and will continue to be, unable to recruit enough physicians to satisfy the requirements of their services.

6. The USUHS is essential since it will provide the military services with a nucleus of physicians, with special training in military medicine, who are expected to average 16 years of active military service. That is twice the period of active duty which can be anticipated from doctors educated in the scholarship program. Moreover, there are positive indications that many USUHS graduates will make a career of military medicine. Such long-term service will have a stabilizing effect on the military medical services which heretofore have experienced an average annual turnover of one-third of their physicians.

7. The USUHS will provide military physicians with an opportunity to participate in academic medicine. Experience has demonstrated that many highly qualified doctors have left military service because of the lack of such an opportunity.

8. No significant saving could be realized from termination of construction of the University buildings. One building is substantially completed. To abandon construction of the other would cost \$39 million, while completion in accordance with the contract would cost approximately \$56 million. To adapt the building to suit some other use could cost \$60, or more, per square foot.

9. Since the organization and administration of the service academies are controlled in great part by detailed statutory provisions, the subcommittee will study the feasibility of amending the law which established the Uniformed Services University of the Health Sciences (Public Law 94-246), to reduce the policy control vested in the Secretary of Defense to give Congress a stronger hand in the overall operation of the medical school, and to obviate any further attempt in the Department of Defense and the OMB to close the school through the appropriations process.

#### RECOMMENDATIONS

The subcommittee recommends:

1. That before deciding to terminate a military activity authorized and funded by the Congress, the Secretary of Defense should submit to the Armed Services Committees of the House of Representatives and the Senate a detailed justification for his decision.

2. That in evaluating any action which will affect the health care programs of the military services, the Secretary of Defense should give paramount consideration to its impact on the quality of that care, and should consult with the Surgeons General of the military departments before taking any action.

#### DISCUSSION

The decision to terminate funding for the Uniformed Services University of the Health Sciences was based solely on budget considerations. Testimony established that Secretary of Defense Harold Brown had not consulted any of the civilian or military officials of the Department who are responsible for health care before deciding to close the University. In fact, each of those officers, the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the military departments, testified that his first knowledge of the decision was obtained from the news media after the Secretary's decision. The record established that, instead of consulting those informed doctors, the Secretary relied upon the recommendation of a junior budget analyst. That recommendation was predicated upon some assumptions which are more wishful than factual.

#### *Staff-Year Cost of Medical Education*

While basing his decision exclusively on economic considerations, it appears that Secretary Brown failed to consider all the consequences of this decision. As Mr. David Packard, Chairman of the Board of Regents and Acting President of the University, testified, "he did not include in his analysis the cost of the scholarships which would be necessary to provide an equivalent number of doctors for the military." The General Accounting Office report concluded that if the University should be terminated, the scholarship program would have to be enlarged to permit graduation of an additional 379 students annually to compensate for the years of service which could be anticipated from the 175 graduates of the University each year.

When one focuses exclusively on the government costs of educating a doctor, the University appears to be a questionable alternative. However, when the benefits derived by the government are measured against those educational costs, the University compares favorably with the scholarship program. The General Accounting Office provided such a calculation. It did so by dividing the educational costs by the years of military service which could be anticipated from graduates of both programs and came up with a "cost per staff year of service." Since the University graduates will have almost twice the period of obligated military service, and since it is estimated that more than half of them will make a career of military medicine, as compared with an estimated 15 percent of the scholarship graduates, the University's cost per staff year compares most favorably.

When only the direct costs of the scholarship student are included, the cost per staff year for a scholarship graduate is \$21,444 as compared with \$26,236 per staff year for a University graduate. In a subsequent report, however, the General Accounting Office included all Federal subsidies to civilian medical schools in its calculation of the staff year cost of the scholarship program. On that basis the cost per staff year of educating a doctor in the scholarship program is increased

to \$32,068. Thus, the staff year cost of educating a doctor in the University is \$5,832 less than the staff year cost of his scholarship counterpart.

The intangible benefits provided by the University were stressed by several of the witnesses. One of the most important is the opportunity for military physicians to participate in academic medicine. That possibility was pointed out by the Surgeons General as a very important item in retaining highly qualified doctors who are interested in teaching. They cited examples of wholesale losses of doctors who have left the service since the military has offered them no opportunity for academic medicine.

Col. Bernhard Mittemeyer, Chief of Surgery at Walter Reed Army Medical Center and Professor of Surgery at the University, expressed the importance of this opportunity:

This has been a tremendous stimulus for us to have the opportunity to participate in the academics. We have published papers and made exhibits and movies. We have gone to meetings. But we have never had the opportunity to be members of a true academy or a university program. This has been a tremendous stimulus, not only to myself and other senior officers within the Armed Forces, but also to the junior officers, those in the 10- to 15-year period who aspire to become teachers. They aspire toward a career in military medicine. The loss of the University in this regard would be a very severe blow to all of us \* \* \*.

The unique location of the USUHS in proximity to the National Institutes of Health, National Naval Medical Center, Walter Reed Army Medical Center and the National Library of Medicine, provides facilities which are unmatched at any other medical school.

Another of the unique benefits of the University is the specialized education it provides in military medicine. In addition to the regular medical curriculum, students at the USUHS will have courses which are not available at any other medical school. Colonel Robert Joy, Chairman of the Department of Military Medicine and History, gave some examples when he testified concerning that training:

They get many hours of education in medical defense against special weapons of war, such as chemical, biological, and nuclear war. The Armed Forces Radiobiology Research Institute provides a 10-man faculty to give 10 hours of instruction on mass casualties and about patients hit by the atomic weapons and the blast. They get a good number of hours and lectures on what happens to ordinary people when they join the military and what does the military do \* \* \*. They will have over 30 hours of military applied physiology \* \* \*. The course I am about to describe, no civilian school teaches—we give them 30 hours, using military and civilian senior scientists from Department of Defense laboratories on heat exhaustion, frost bite, altitude sickness, decompression system, translocation—which means jet lag—seasickness; there are noise problems which are pretty bad in the service.

It is impossible to assign dollar values to those benefits, and many other intangibles, in measuring the worth of the USUHS. Yet each of those items contributes to the quality of the medical care available to armed services personnel. The Department of Defense budget analyst who had recommended termination of the University in November 1976 testified that he didn't incorporate any quality factors in his recommendation. Unlike that analyst, the subcommittee believes that the quality of military health care is the item of paramount importance. If the University can produce a doctor who is better trained in military medicine, or if it can induce well qualified doctors to remain in the military longer than they might otherwise serve, the additional cost of educating a doctor there will be well worth it.

### *The Dubious Assumption of 1,000 Volunteers*

The record of the subcommittee hearings reflected that the Secretary had very little information available at the time of his decision, and that which was available was based on an optimistic assumption which had no basis in reality. A search of the Department's files produced only one document which would have been available to the Secretary at the time of his decision. That document, an Issue Paper, prepared by the transition team of the new administration, concluded "military physician strength can be increased to 20 percent over current requirements by continuing the Armed Forces Health Professions Scholarship Program and the military doctor bonus."

The subcommittee hearings revealed that optimistic conclusion was based on the assumption that the Department of Defense "will continue to obtain 1,000 volunteers per year plus our other accessions as now planned." If the military services had been able to recruit 1,000 physician volunteers<sup>1</sup> annually, proceeding on that assumption would have been valid. In reality, however, the services have fallen far short of that optimistic goal. Their combined efforts have never been able to approach recruiting 1,000 volunteers in any year; in fact, fiscal year 1976 was their most successful recruiting year when a total of 658 volunteers were recruited. The Surgeons General testified that the fiscal year 1977 goal of 1,010 volunteers probably will not be achieved. They testified that as of March 29, 1977, almost halfway through the fiscal year, they have succeeded in recruiting only 212 of those 1,010 volunteers.

### *Problems of the Scholarship Program*

Testimony during the hearings also raised a serious question about the ability of the scholarship program to attract a sufficient number of medical students to satisfy the needs of the Armed Services. The Surgeons General testified that the Armed Forces Health Professions Scholarship Program has lost some of its attractiveness because of another scholarship program established by Public Law 94-484, the Health Professions Educational Assistance Act of 1976, 90 Stat. 2243. They testified that the Public Law 94-484 scholarship program offers advantages which the Armed Forces program does not, i.e., a cost of living increase in the stipend, an opportunity to "buy out" of the obligated service, and an opportunity to practice in a civilian community rather than a remote military base at some overseas location. The witnesses also expressed the fear that the Armed Forces scholarship program has been rendered less attractive as a result of the Internal Revenue Service ruling that the scholarship benefits, i.e. tuition and stipend, are taxable to the student as income.

The Air Force Deputy Surgeon General noted that last year his service had only 371 applicants for its 350 scholarships and that he does not expect there will be enough applicants for the Air Force allocation of scholarships this year. He also referred to a study by Rand Corporation which predicted that in future years the Air Force will not be able to fill 40 percent of its scholarship quota.

<sup>1</sup> A volunteer physician is a medical school graduate who has incurred no obligated military service in return for his education as distinguished from doctors who have received all or part of their medical education at Federal expense in scholarship programs.

The Department of Defense projection of its accessions plans on more than 1,100 doctors annually coming from the scholarship program. In view of the doubts of the Surgeons General about the future of that program and the failure of the Department to meet its accession goals in the past, one finds little or no support for the Department's optimistic prediction.

*Volunteers Are Not the Answer*

Testimony of the Surgeons General also surfaced problems connected with the physician volunteers. They noted that a large portion of the volunteer physicians they have recruited are graduates of foreign medical schools, and many of those are aliens. For example, of the 658 volunteer physicians recruited during fiscal year 1976, 237, or 36 percent, were graduates of foreign medical schools. And during the transition quarter, i.e., between July 1st and September 30, 1976, of the 304 volunteers recruited, 136, or 45 percent, were foreign medical graduates. While some of those foreign graduates are United States citizens, in fiscal year 1976, 27 percent were aliens.

Vice Adm. Arentzen, Surgeon General of the Navy, testified that aliens accounted for 123, or 68 percent of the 181 foreign medical graduates recruited by the Navy during 1976 and 1977. Major General Dettinger, Deputy Surgeon General of the Air Force, testified that 91 percent of the foreign medical graduates recruited by the Air Force during fiscal year 1976 were aliens. Such a preponderance of aliens among the volunteer physicians is disturbing. If that trend should continue, the military medical services would, within a few years, contain a disproportionate number of alien doctors.

The Surgeons General further testified that the alien medical officers have caused some problems. Since the law requires that officers of vessels of the Navy shall be citizens of the United States, the Navy Surgeon General testified that he is unable to assign alien doctors to shipboard duty. Alien doctors are also ineligible for assignment to medical officer billets which require very high level security clearances.

The record further reflects that many of the alien doctors have proven unsatisfactory in the service. The Air Force Deputy Surgeon General testified his service has been required to discharge many of them for such varied reasons as shoplifting, drugs use and alcoholism. He also stated the Air Force has recruited many doctors who are 50, or more, years old. Since all of those doctors must be discharged upon reaching age 60, he testified "our shortfalls will be very, very real in 1980 and thereafter."

The enactment of Public Law 94-484, the Health Professions Educational Assistance Act of 1976, will greatly reduce the number of alien doctors eligible to enter the United States. That Act contains a congressional finding "that there is no further need for affording preference to alien physicians and surgeons in admission to the United States under the Immigration and Nationality Act". Title VI of that Act, which went into effect in January 1977, places limitations on the immigration of foreign medical graduates into the United States. As a result of those limitations, there will be fewer foreign doctors available for recruiting by the armed services. In view of the predominance of alien doctors among the recent volunteers, some reduction in volunteers must be anticipated.

### *Construction Costs*

Secretary Brown, at his press briefing on February 21st, estimated that the USUHS "would cost at least \$100 million to complete. So not completing it does not incur that cost, and I would call that a saving." That figure is another example of the misinformation upon which the Secretary's decision was based. Mr. Packard, the Acting President of the University, testified, "I want to point out there is not that much money in the building program all together."

The construction program for the University calls for two buildings. Those buildings, totalling 543,392 sq. ft., will be adequate to accommodate the full 700-student enrollment of the University. Both have already been authorized and a total of \$85.5 million has been appropriated for their design and construction. The construction contracts for the two buildings total \$72.6 million, that is a cost underrun of \$13 million, a welcome contrast to the cost overruns which have plagued the Department of Defense in recent years. At the time of our hearing the first building was approximately 80 percent completed. According to Rear Admiral A. P. Marschall, Commander, Naval Facilities Engineering Command, who is responsible for the construction of the University buildings, "The only course is to complete it. We could not get a red cent out of this thing at this point." The second building is approximately 17 percent complete. To tear down the construction and restore the site would cost \$39.3 million according to Admiral Marschall. He testified that the other alternatives and their costs would be: termination at the plaza level—\$39.4 million; completion of a building shell—\$46.1 million; completion in accordance with the contract—\$55.8 million. He also testified that those buildings are very specialized and do not readily lend themselves to usage other than a medical school. While he was unable to specify what modifications to suit another user would cost, he said it would be expensive. He also said that modifications could cost more than \$60 per square foot. For purposes of comparison, the Architect of the Capitol advised that the construction cost of the Rayburn House Office Building, in 1964, was \$34 per square foot.

### *OMB Witnesses and Documents*

During the hearings of the subcommittee Mr. James Fish, a budget analyst at the Office of Management and Budget, was identified by several witnesses as an individual who was responsible for the initial recommendation to terminate funding of the University. When Mr. Bert Lance, the Director of the Office of Management and Budget, declined to make Mr. Fish available to testify, the subcommittee authorized the issuance of a subpoena for his attendance. In an effort to avoid issuance of the subpoena, Mr. Lance advised the Chairman he would make Mr. Fish available for interview by the subcommittee staff. During the ensuing interview Mr. Fish identified several documents he had prepared, or reviewed, in the preparation of the Program Budget Decision. He was directed by the staff to submit those documents to the subcommittee. When Mr. Lance informed the Chairman that the documents would not be produced, he was directed by the Chairman to appear before the subcommittee on April 27 with the documents.

On April 21, however, the House of Representatives voted to adopt the Conference Report on the Supplemental Appropriations Bill of 1977, H.R. 4877. In its adoption of the Conference Report, the House, by a vote of 250 to 162, approved a Senate amendment which provided an appropriation of \$12.5 million for operation and maintenance of the University during fiscal year 1978. In view of that vote, the subcommittee concluded that Mr. Lance's testimony and the production of the documents were no longer necessary. Consequently, the Chairman, on April 22, sent Mr. Lance the following letter:

As you know, the House yesterday, by a vote of 250 to 162, supported continued funding for the Uniformed Services University of the Health Sciences.

In view of that vote, I believe there is no further need to continue the hearings of the Subcommittee on the University. Accordingly, you are hereby excused from your scheduled appearance before the Subcommittee on April 27, and you are also excused from the production of the various records of the Office of Management and Budget relative to the decision to terminate the school, which the Subcommittee had requested.

*Proposed Subcommittee Study*

Finally, the subcommittee will look into the possibility of tightening the law to diminish the likelihood, and discourage any further attempt, to close the school through financial strangulation initiated in the Department of Defense and the OMB.

The service academies are good examples of Federal institutions which are organized and administered pursuant to detailed statutory provisions initiated in the Congress. It may well be wise to provide a similar statutory structure for the military medical school, and that prospect will be studied by the subcommittee during this session of the 95th Congress.

## DISSENTING VIEWS OF HON. RONALD V. DELLUMS

MAY 16, 1977

I cannot agree with the substantive recommendation made by the Committee in favor of the Uniformed Services University. Numerous independent studies have shown that the University would be more expensive than the scholarship programs now being used to procure medical personnel. Furthermore, I do not believe it is desirable to establish yet another military academy, this one at the graduate level, to further isolate the military from society and perhaps train the students to be soldiers first and doctors second. The Administration's decision to close the University should be supported.

(11)

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Report of REFERENCE COMMITTEE C

Presented by: J. Regan Thomas MD, Chair

Mr. Speaker and Members of the House of Delegates:

Reference Committee C gave careful consideration to the several items referred to it and submits the following report:

(1) JOINT REPORT OF THE COUNCIL ON MEDICAL EDUCATION AND THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT - GUIDELINES FOR PHYSICIAN WORKFORCE PLANNING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education and Council on Long Range Planning and Development Joint Report entitled "Guidelines for Physician Workforce Planning" be adopted, and the remainder of the report be filed.

This Joint Report of the Council on Medical Education and the Council on Long Range Planning and Development reviews current initiatives and previous attempts at physician workforce planning, as well as American Medical Association policy related to the physician workforce, and makes the following recommendations: (1) planning which includes needs-analysis and incentives is in order; (2) the AMA should obtain relief from antitrust considerations and participate in physician workforce planning; (3) AMA participation in planning efforts should be guided by principles related to goals, planning infrastructure, and assumptions; and (4) implementation of a workforce plan should follow guidelines regarding use of incentives and disincentives and preservation of freedom of career choice.

Your Reference Committee heard very positive testimony regarding the guidelines for physician workforce planning and the need to proceed with its recommendations immediately. Both Councils were congratulated for their report and it was acknowledged that the Task Force on Physician Workforce Planning will continue with its deliberations and the preparation of subsequent reports.

(2) RESOLUTION 320 - NATIONAL PHYSICIAN WORKFORCE PLANNING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 320 be referred to the Board of Trustees.

Resolution 320 asks the American Medical Association to urge that the Council on Graduate Medical Education (COGME) or any equivalent national workforce planning body be solely Advisory in nature, and have both bipartisan and adequate physician representation.

1 Your Reference Committee was advised by the Council on Medical Education that a Task Force  
2 on Physician Workforce Planning with representatives from several Councils and Sections of the  
3 American Medical Association has been charged to analyze the issues raised in Resolution 320,  
4 and therefore proposes that this resolution be referred for further study by this Task Force.  
5

6  
7 (3) RESOLUTION 322 - MANAGEMENT OF GRADUATE MEDICAL EDUCATION  
8

9 RECOMMENDATION:  
10

11 Mr. Speaker, your Reference Committee recommends that Resolution 322 be  
12 referred to the Board of Trustees.  
13

14 Resolution 322 asks the American Medical Association to urge that any physician workforce  
15 guidelines developed to modify the composition of primary care and other specialty positions in  
16 graduate medical education be national while respecting regional needs.  
17

18 Your Reference Committee was informed that this complex issue, as well as several others related  
19 to workforce planning presented at this meeting, was currently being studied by a specially  
20 appointed task force, and therefore recommends that Resolution 322, which proposes the  
21 consideration of regional needs, be considered by this task force. Testimony presented to your  
22 Reference Committee was basically supportive of the need to plan on a national basis and to  
23 respect regional and local differences.  
24

25  
26 (4) RESOLUTION 303 - TITLE VII FINANCIAL ASSISTANCE FOR  
27 MEDICAL STUDENTS AND PRACTICE CHOICE LIMITATIONS  
28 RESOLUTION 317 - HEALTH PROFESSIONS STUDENT LOAN (HPSL) PROGRAM  
29

30 RECOMMENDATION:  
31

32 Mr. Speaker, your Reference Committee recommends that the following  
33 Substitute Resolution 303 be adopted in lieu of Resolutions 303 and 317.  
34

35 RESOLVED, That the American Medical Association encourage the  
36 federal government not to place additional conditions on Title VII  
37 financial assistance programs for students that narrow eligibility based  
38 on specialty choice, and not to divert funding from existing assistance  
39 programs; and be it further  
40

41 RESOLVED, That the American Medical Association study the impact  
42 of federal financial assistance programs on choice of a primary care  
43 specialty and develop recommendations for financial incentive programs  
44 for students to stimulate positively the choice of a primary care  
45 discipline.  
46

47 Resolution 303 proposes that American Medical Association Policy 200.983 be amended to include  
48 support for the development of incentives from new funds to meet workforce requirements for  
49 primary care physicians, rather than directing existing funds for the purpose.  
50

51 Resolution 317 asks the American Medical Association to work with other groups to stimulate  
52 choice of a primary care career and to develop less restrictive and discriminatory options for  
53 student financial assistance than the Primary Care Loan Program.

1 Testimony before the Reference Committee suggested consolidating the two resolutions. There is  
2 a need to have AMA policy at this time to protect against future diversion of federal funds into  
3 specialty-specific financial assistance programs and also to study how best to use financial  
4 incentives to encourage choice of a primary care specialty.

5  
6  
7 (5) RESOLUTION 316 - FINANCING OF CLINICAL EDUCATION UNDER HEALTH CARE  
8 REFORM

9  
10 RECOMMENDATION A:

11  
12 Mr. Speaker, your Reference Committee recommends that Resolution 316 be  
13 amended by insertion and deletion on line 17, to read as follows:

14  
15 Organizations to ensure that health ~~care~~ system reform proposals and  
16 ultimate legislation result in adequate

17  
18 RECOMMENDATION B:

19  
20 Mr. Speaker, your Reference Committee recommends that Resolution 316 be  
21 adopted as amended.

22  
23 Resolution 316 asks the American Medical Association to work with other professional  
24 organizations to ensure that health system reform proposals and subsequent legislation provide for  
25 adequate resources to enable medical schools to produce an adequate supply and appropriate  
26 specialty mix of physicians to deliver patient care services.

27  
28 Your Reference Committee heard testimony that medical schools face danger especially in the  
29 transition period as health system reform is being implemented. There should be guarantees that  
30 adequate resources are provided to support schools during this period.

31  
32  
33 (6) RESOLUTION 319 - SUPPORT FOR INVESTIGATOR-INITIATED MEDICAL  
34 RESEARCH

35  
36 RECOMMENDATION A:

37  
38 Mr. Speaker, your Reference Committee recommends adoption of the first  
39 Resolve of Resolution 319.

40  
41 RECOMMENDATION B:

42  
43 Mr. Speaker, your Reference Committee recommends that the second  
44 Resolved of Resolution 319 be referred to the Board of Trustees.

45  
46 Resolution 319 asks the American Medical Association to reaffirm its support for non-targeted  
47 investigator-initiated research and to urge funding agencies to monitor the impact of constrained  
48 resources on the ability of young investigators to pursue non-targeted research, and where  
49 appropriate to develop mechanisms to stimulate careers in biomedical research.

50  
51 Your Reference Committee heard strong support for the concept of non-targeted investigator-  
52 initiated research as the basis of the U.S. biomedical research enterprise. Because of the need to  
53 identify the appropriate agencies to carry out the monitoring function and to identify the fiscal

resources needed to evaluate the impact of constrained funds on the ability of investigators to pursue non-targeted research, your Reference Committee recommends referral of the second Resolve for further study.

(7) RESOLUTION 302 - HBV VACCINE FOR HEALTH CARE PROVIDERS  
RESOLUTION 304 - INFLUENZA VACCINE FOR HEALTH CARE PROVIDERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following  
Substitute Resolution 302 be adopted in lieu of Resolutions 302 and 304:

RESOLVED, That the American Medical Association strongly recommend that all medical schools include the cost of influenza vaccination and HBV vaccination, with subsequent antibody titers when medically indicated, in the preparation of the student budget, which may be used to determine eligibility for financial aid.

Resolution 302 proposes that the American Medical Association recommend that all medical schools provide HBV vaccinations for students until immunity is acquired, as a part of student fees, unless medically contraindicated. Resolution 304 proposes that the American Medical Association recommend that medical schools provide students with annual influenza vaccinations as a part of student fees, unless medically contraindicated.

Testimony before your Reference Committee indicated the importance of influenza and HBV vaccinations for healthcare professionals and noted the additional financial burden that this places on medical students. This burden would be eased if the costs could be borne through financial aid. In order to do this, the costs must be included in the student budget which is used to calculate the availability of eligible funds. Your Reference Committee believes that adoption of the Substitute Resolution would further promote implementation of existing AMA policy (440.958) which endorses the principle of universal immunization for the HB virus.

(8) RESOLUTION 301 - TRAINING PHYSICIANS IN NURSING FACILITIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolve 2 of  
Resolution 301 be amended by deletion on line 25, to read as follows:

RESOLVED, That the American Medical Association promote and support the training of ~~primary care~~ physicians in ...

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 301 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends the following new title  
for amended Resolution 301:

Training Physicians in Non-Traditional Sites.

Resolution 301 asks American Medical Association to develop a proposal for evaluating methods to reimburse the Medicare direct and indirect costs for physician training in non-traditional sites and to support the training of primary care physicians in non-traditional sites, including nursing homes.

The testimony heard by your Reference Committee strongly urged adoption and dissemination of this resolution. Several descriptions of successful educational programs in varied sites, including nursing homes, were offered to emphasize the importance of evaluating methods to reimburse direct and indirect costs for training physicians in such sites.

(9) RESOLUTION 306 - SUPPORT OF THE UNIFORMED SERVICES  
UNIVERSITY OF THE HEALTH SCIENCES  
RESOLUTION 318 - UNIFORMED SERVICES UNIVERSITY OF THE HEALTH  
SCIENCES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following  
Substitute Resolution 306 be adopted in lieu of Resolutions 306 and 318:

RESOLVED, That the American Medical Association vigorously support the continuance of the Uniformed Services University of the Health Sciences as vital to the continued strength, morale, and operational readiness of the military services and that our support be made known to the President and Vice President of the United States of America, to the Congress, and to the public.

Resolutions 306 and 318 propose that the American Medical Association support continuance of the Uniformed Services University of the Health Sciences and so inform the President and Vice President, the Congress, and the public.

Your Reference Committee heard extensive, unanimous, and overwhelming support for adoption of this resolution. The vital services provided by the Uniformed Services University of the Health Sciences, including the recruitment, training and retention of high quality physicians and support personnel was echoed by all who testified. Mention was made that costs associated with the operation of this school are not excessive and may be less than at other medical schools. Recognizing the urgency of the situation, members of the House of Delegates were encouraged to contact their senators to support continuation of the USUHS and to suggest that the administration of the USUHS be contacted as a valuable source of information.

(10) RESOLUTION 307 - NOMENCLATURE FOR MEDICAL STUDENTS  
AND POST-MD TRAINEES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 307 not  
be adopted.

Resolution 307 asks the American Medical Association to work to ensure that medical students are identified as graduate students and that residents are identified as postdoctoral or postgraduate trainees.

The Reference Committee heard testimony that changing the terminology would result in unnecessary confusion. For example, graduate students currently are defined as students enrolled in master's or doctoral programs. Also, there are combined BA/MD programs where students enter medical schools after high school and do not have a baccalaureate degree. While recognizing the worthy intent of the resolution, testimony did not support using this change in terminology as an appropriate mechanism to achieve greater respect.

(11) RESOLUTION 309 - GRASSROOTS PARTICIPATION IN PROJECT 3000 BY 2000

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 309 be amended by insertion and deletion on lines 29-30 to read:

RESOLVED, That the American Medical Association make known the ~~potential~~ mechanisms through which local medical societies, ~~local~~ physicians and medical students may work with medical schools in Project 3000 by 2000 and actively encourage...

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 309 be adopted as amended.

Resolution 309 proposes that the American Medical Association (1) ask the Association of American Medical Colleges (AAMC) to include local physicians in its Project 3000 by 2000; (2) develop ways for local participation, through its Advisory Committee on Minority Physicians, in conjunction with the AAMC; and (3) publicize the ways in which local medical societies, physicians and medical students can participate with medical schools in Project 3000 by 2000.

Testimony before the Reference Committee reflected unanimous support of the concept. Local physicians are a valuable resource as role models for minority medical students, and their participation in programs in support of Project 3000 by 2000 should be encouraged. Examples were given of effective ongoing programs, and data should be collected to document existing models. Medical societies and medical schools should communicate with each other to facilitate such programs.

(12) COUNCIL ON MEDICAL EDUCATION REPORT 3 - FACULTY/STAFF  
APPOINTMENTS AT MORE THAN ONE MEDICAL SCHOOL  
(Resolution 301, I-92)

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation contained in Council on Medical Education Report 3 be adopted in lieu of Resolution 301 (I-92) and the remainder of the report be filed.

Council on Medical Education Report 3 responds to the complex issues raised in Resolution 301 (I-92) and proposes that the American Medical Association encourage medical schools that do not permit volunteer faculty members to hold appointments at more than one school to review this policy to ensure that it is in the best interests of medical education and program integrity.

1 Testimony was in support of the recommendation in the report. It was reported that the majority  
2 of medical schools permit volunteer faculty members to have appointments at more than one  
3 institution. Most testimony maintained that it is inappropriate for the AMA to mandate medical  
4 school appointment policies. The recommendation encourages medical schools to review their  
5 policies, and make a decision based on the needs of medical education. While the contributions of  
6 volunteer faculty members to teaching was acknowledged, testimony emphasized that those who  
7 are appointed as faculty members should have sufficient time to contribute to the educational  
8 program.

10  
11 (13) COUNCIL ON MEDICAL EDUCATION REPORT 7 - GRADUATE MEDICAL  
12 EDUCATION FACULTY EVALUATIONS  
13 (Resolution 319, I-92)  
14

15 RECOMMENDATION A:  
16

17 Mr. Speaker, your Reference Committee recommends that the  
18 Recommendation of Report 7 of the Council on Medical Education be  
19 amended by insertion on page 2, lines 36 and 38, to read as follows:  
20

21 That the American Medical Association request its representatives to  
22 the ACGME to encourage the Residency Review Committees that do  
23 not have explicit procedures for the evaluation of faculty, including  
24 evaluation by residents, to develop procedures and implement them.  
25 The AMA recommends that evaluations should be done in a  
26 confidential manner, at least annually, and the areas evaluated should  
27 include teaching ability, clinical knowledge, scholarly contributions,  
28 attitudes, interpersonal skills, communication ability and commitment.  
29 Residency program directors should provide faculty members with a  
30 written summary of the evaluations.

31  
32 RECOMMENDATION B:  
33

34 Mr. Speaker, your Reference Committee recommends that the recommendation  
35 contained in Report 7 of the Council on Medical Education be adopted as  
36 amended in lieu of Resolution 319 (I-92), and the remainder of the report be  
37 filed.  
38

39 Council on Medical Education Report 7 responds to Resolution 319 (I-92) and recommends that  
40 the American Medical Association ask its representatives to the Accreditation Council for Graduate  
41 Medical Education (ACGME) to encourage Residency Review Committees that do not have  
42 explicit procedures for evaluation of faculty to develop and implement them annually, in a  
43 confidential manner, addressing specific areas of performance. Program directors should provide  
44 faculty members with a written summary of the evaluations.

45  
46 Your Reference Committee heard testimony that was uniformly in support of Report 7 of the  
47 Council on Medical Education. It was pointed out that it was more expeditious to modify  
48 practices through revisions of Special Requirements than through revision of the General  
49 Requirements.

(14) RESOLUTION 308 - STEP 3 SCORES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 308 be amended by insertion and deletion on lines 12 and 13, to read as follows:

RESOLVED, That the American Medical Association encourage the U.S. Medical Licensing Exam Composite Committee to report ensure ~~that~~ Step 3 Scores of the U.S. Medical Licensing Exam ~~be reported~~ directly and automatically to the examinee.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 308 be adopted as amended.

Resolution 308 proposes that the American Medical Association encourage the Composite Committee that oversees the U.S. Medical Licensing Exam to ensure that Step 3 Scores be reported directly and automatically to the examinee.

Your Reference Committee heard extensive testimony regarding Resolution 308, most of which supported its adoption. It was pointed out that the Step 3 exam has not yet been administered and there is no evidence that examinees will experience extensive delays receiving examination scores. However, the majority of state boards have agreed to have scores go to examinees at the same time they are sent to the boards. Those testifying emphasized that this practice should be followed by all state boards.

(15) BOARD OF TRUSTEES REPORT 13 - SELF-INCRIMINATING QUESTIONS  
ON APPLICATIONS FOR LICENSURE AND SPECIALTY BOARDS  
(Resolutions 302 and 303, I-92)

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Report 13 of the Board of Trustees be amended by insertion on page 5, line 24, to read as follows:

"...or professional misconduct be made at the time of application for licensure or reregistration only for causes that...."

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 of Report 13 of the Board of Trustees be amended by insertion on page 5, lines 31-32, to read as follows:

"The AMA will seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards."

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations contained in Report 13 of the Board of Trustees be adopted as amended in lieu of Resolutions 302 and 303 (I-92), and that the remainder of the report be filed.

Board of Trustees Report 13 is responsive to the concerns raised in Resolutions 302 and 303 (I-92), which opposed inclusion of questions about past treatment or referral for substance abuse and psychiatric problems on applications for licensure or board certification. The report reviews American Medical Association policy, which shows clear concern for the rights and interests of physicians on these issues as well as a concern for the welfare and protection of the public. These policies attempt to balance the need of physicians with the needs of their patients and the public in general. In lieu of adopting Resolutions 302 and 303 (I-92), Report 13 recommends that the AMA reaffirm Policy 275.970, which calls for state licensing boards to ensure confidentiality of sensitive information contained in licensure and reregistration applications. Secondly, the report recommends that Policy 275.978 be amended by insertion of the word "current" in describing the licensee's competence to practice medicine. The report asks that the AMA seek clarification of the application of the Americans with Disabilities Act (ADA) to the actions of medical licensing boards and encourage the American Board of Medical Specialties (ABMS) and the Federation of State Medical Boards (FSMB) and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities. Finally, the report asks the AMA to encourage the FSMB to standardize the definitions and nomenclature used in licensing and disciplinary proceedings. The report is intended to promote confidentiality, an emphasis on current competence, uniform definitions and nomenclature, and clarity about the ADA.

Extensive testimony was presented on the importance and sensitivity of asking physicians to report conditions that might affect their ability to practice. Comments related to the impact of the Americans with Disabilities Act on the legality of requesting information from physicians, especially about their past history of treatment and referral, included information that a suit filed by the Medical Society of New Jersey against the New Jersey State Board of Medical Examiners, is progressing very positively. A decision favoring the Medical Society of New Jersey was reported. The numerous organizations and individuals providing testimony and your Reference Committee believe that these recommendations will further the admirable policies and programs currently addressing discrimination against physicians who have any sort of impairment.

(16) RESOLUTION 312 - REAFFIRMATION OF POLICY AGAINST DISCRIMINATION  
TOWARD INTERNATIONAL MEDICAL GRADUATES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 312 not be adopted.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolved of Resolution 312 be amended by insertion to read as follows:

"That the AMA reaffirm its present policy which prohibits discrimination against any international medical graduate in matters of education, licensure, reciprocity, employment, promotions, hospital privileges, salary and reimbursement, academic appointments and professional society membership."

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 312 be adopted as amended.

Resolution 312 asks the American Medical Association to reaffirm its policy prohibiting discrimination against international medical graduates and to urge the Louisiana State Board of Medical Examiners and all other state licensing boards to adopt uniform licensing requirements for all medical graduates.

The first Resolved of Resolution 312 urged that the Louisiana State Board of Medical Examiners as well as other state licensing boards adopt uniform licensing requirements.

Your Reference Committee considered that this Resolve may not be in agreement with AMA Policy 275.973 "State Control of Qualifications for Medical Licensure" that supports the ability of individual states to determine the qualifications of physician candidates for licensure. On the other hand, the second Resolve of Resolution 312 prohibiting discrimination was fully supported by testimony.

(17) COUNCIL ON MEDICAL EDUCATION REPORT 8 - PHYSICIAN CREDENTIALING  
AND PRIVILEGING  
(Resolution 320, I-92)

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 2 of Report 8 of the Council on Medical Education be amended by insertion, page 7, line 10, to read as follows:

2. That the AMA reaffirm the position that clinical procedures be performed only by physicians with appropriate education, training, experience, and demonstrated current competence.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 3 of Report 8 of the Council on Medical Education be deleted, and all following recommendations be renumbered accordingly.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 4 of Report 8 of the Council on Medical Education be amended by insertion and deletion, page 7, lines 16-18, to read as follows:

4. ~~3.~~ That the AMA support the position that physicians ~~not~~  
~~credentialed by a JCAHO facility~~ be assessed on the basis of their  
education, training, experience, and documented competence.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Recommendation  
No. 5 of Report 8 of the Council on Medical Education be amended by  
insertion, page 7, line 20, to read as follows:

- ~~5.~~ 4. That the AMA, in coordination with national medical specialty  
societies, pursue the development and application of appropriate  
standards for continuing medical education that is directed toward  
procedural competence.

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Recommendation  
No. 7 of Report 8 of the Council on Medical Education be amended by  
insertion, page 7, lines 28-29, to read as follows:

- ~~7.~~ 6. That the AMA, in coordination with national medical specialty  
societies, develop a process to evaluate educational programs that  
educate physicians to perform new procedures or procedures which are  
new for that physician.

RECOMMENDATION F:

Mr. Speaker, your Reference Committee recommends that the  
recommendations in Report 8 of the Council on Medical Education be adopted  
as amended in lieu of Resolution 320 (I-92), and the remainder of the report  
be filed.

Council on Medical Education Report 8 responds to Resolution 320 (I-92) and thoroughly reviews  
the procedures used in credentialing and granting privileges to physicians by hospital medical  
staffs.

Your Reference Committee heard extensive testimony on this complex subject which uniformly  
praised the efforts of the Council on Medical Education in addressing these issues. Based on this  
testimony, your Reference Committee has added language to several of the recommendations to  
make them fully consistent with existing AMA policy. Testimony also suggested that references  
to credentialing mechanisms in JCAHO-accredited hospitals and healthcare organizations be  
omitted, and that the AMA coordinate the development of new standards for evaluation of  
educational programs with national medical specialty societies. It is anticipated that a national  
invitational conference will be an important initial step. The Council on Medical Education  
stressed that this is an intermediate report, and that timely reports on progress will be submitted to  
the House of Delegates. Of particular importance in the future will be the delineation of the role  
of proctoring, and the potential application of telemedicine to assist in this important process.

Your Reference Committee also heard testimony concerning the fiscal note attached to the Report.  
The Council on Medical Education explained to your Reference Committee that this report outlines  
a very extensive and complicated agenda. Following a feasibility study, a detailed budget will be  
presented to the Board of Trustees.

(18) COUNCIL ON MEDICAL EDUCATION REPORT 5 - RECOGNITION OF THOSE WHO PRACTICE ADDICTION MEDICINE (Resolution 308, A-93)

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 of Report 5 of the Council on Medical Education be amended by insertion on page 2, line 41, as follows:

4. That the AMA affirm that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance abuse, and for utilization review, and for other evaluation of such treatment, and should be entitled to compensation.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations of Report 5 of the Council on Medical Education be adopted as amended in lieu of Resolution 308 (A-93), and the remainder of the report be filed.

Council on Medical Education Report 5, in response to Resolution 308 (A-93), recommends that the American Medical Association (1) encourage all physicians to undertake education in treatment of substance abuse; (2) direct its representatives to Residency Review Committees to ask their respective committees to consider requiring appropriate instruction in the recognition and management of substance abuse; (3) encourage continuing medical education dealing with treatment of substance abuse; and (4) affirm that physicians in fields other than psychiatry have education and experience appropriate for the treatment of substance abuse.

Your Reference Committee heard praise for Council on Medical Education Report 5 as being responsive to issues raised in Resolution 308 (A-93). It was clearly pointed out that psychiatry had never asserted it was the only medical specialty prepared to treat addiction. Strong support was voiced for continuing cooperative approaches to the topic.

(19) COUNCIL ON MEDICAL EDUCATION REPORT 4 - DEFINITION OF A PHYSICIAN (Resolution 307, A-93)

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Council on Medical Education Report 4 be referred to the Board of Trustees.

Council on Medical Education Report 4 responds to Resolution 307 (A-93) and recommends that the American Medical Association affirm that a physician is an individual who has been awarded an MD or DO degree by an accredited medical school in the United States or Canada, or who has an equivalent diploma from a medical school listed in the World Directory of Medical Schools. This statement should supersede Policy 405.988, "Definition of 'Physician'."

Abundant testimony was presented to your Reference Committee on the difficulty of being more specific in the present definition of a physician than contained in Policy 405.988 (AMA Policy Compendium). Concern was still expressed about both the present and the proposed new definition of Report 4 of the Council on Medical Education. Your Reference Committee recommends referral of this report for further study.

(20) RESOLUTION 310 - VALUE OF COMMUNITY-BASED  
CONTINUING MEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 310 be amended by deletion on line 19, to read as follows:

RESOLVED, That the American Medical Association ~~ask that the~~  
~~ACCME~~ encourage the use of local consortia to plan local continuing  
medical education programs as a viable means of meeting education  
goals.

Resolution 310 proposes that the American Medical Association (1) advise the Accreditation Council for Continuing Medical Education (ACCME) of the need for expanding continuing medical education (CME) beyond acute care hospitals, and (2) ask the ACCME to use local consortia to plan CME programs.

Your Reference Committee heard testimony that the use of local CME consortia in rural communities in California and Illinois had resulted in better CME for practicing physicians. Testimony pointed out the fact that the ACCME was an accrediting agency, and could not encourage or stimulate use of any particular format for the provision of CME; it was believed that the AMA could play such a role. Your Reference Committee hopes that the AMA and State Societies will facilitate the development of such cooperative arrangements in order to support CME in remote areas for the overall improvement of patient care.

(21) COUNCIL ON MEDICAL SERVICE REPORT 4 - TELEMEDICINE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 4 be referred to the Board of Trustees.

Council on Medical Service Report 4 describes the work of the Council in studying the use of telemedicine and its role in improving access to healthcare services, particularly for rural populations. The Council on Medical Service will continue to study to the impact of telemedicine on the quality, accessibility, continuity and costs of care, as well as its role in continuing medical education. A report will be presented at the 1994 Annual Meeting of the House of Delegates.

There was extensive testimony before your Reference Committee about the rapid expansion of telecommunication technology to support both medical education and consultation for patient care. The Council on Medical Education submitted a report on the use of telemedicine at the 1993 Annual Meeting and is currently conducting a survey of all known providers and applications of this technology. The Council on Medical Service studied the role of telemedicine in improving access to quality care and the impact of the use of telemedicine on quality, costs, and continuity of

care. Your Reference Committee suggests a Joint Report from the Council on Medical Education and the Council on Medical Service, discussing both the educational and practice implications and potential of this technology.

(22) BOARD OF TRUSTEES REPORT 35 - ECONOMIC AND QUALITY OF CARE  
ISSUES WITH IMPLICATIONS ON SCOPES OF PRACTICE -- PHYSICIANS  
AND NURSES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report 35 of the Board of Trustees be referred to the Board of Trustees for decision.

Board of Trustees Report 35 focuses on the scope of practice of nurses and discusses the implications for cost and quality of care that would result from the unsupervised provision of services by nurses in advanced practice. Issues covered in the report include nursing education and preparation for practice, the education of nurses for advanced practice, extension of scope of practice of advanced practice nurses, delivery of care to underserved populations, and issues of costs and quality of care. The major issues addressed in the report are summarized as an addendum to facilitate public understanding of the bases for the differing roles of physicians and nurses.

Your Reference Committee heard high praise for the comprehensive Board of Trustees Report 35. However, representatives of the American Society of Anesthesiologists, Inc., indicated the need (1) to modify page 9 of the report by deleting lines 24-27 and substituting the following: "RNAs participate in the technical aspects of two-thirds of anesthesiology care, under the proximate medical direction of an anesthesiologist as members of the anesthesia care team. In rural areas where no anesthesiologist may be available, RNAs administer anesthesia under the supervision of a non-anesthesiologist physician"; and (2) to insert on page 10, line 53 following "responsible" the following: "The claim by nurse anesthetists that they can deliver primary care because they are the 'sole providers of anesthetics in 85% of rural hospitals' is questionable." These changes are needed to prevent the report from being easily quoted out of context.

It was also pointed out that on page 24, in the second paragraph, "11 years" should be changed to "7 years after college." Your Reference Committee believes that if these three changes are made, Report 35 could be widely circulated.

CONSENT CALENDAR:

RECOMMENDED FOR ADOPTION:

- (23) RESOLUTION 311 - PRIMARY AND CONSULTATIVE CARE
- (24) COUNCIL ON MEDICAL EDUCATION REPORT 6 - OVERSEAS MEDICAL EDUCATION DEVELOPED BY U.S. MEDICAL ASSOCIATIONS
- (25) RESOLUTION 305 - HEALTH EDUCATION LOAN EXCHANGE PLAN
- (26) RESOLUTION 321 - OBSTETRICS AND GYNECOLOGY TRAINING IN TERMINATION OF PREGNANCY

(27) COUNCIL ON MEDICAL EDUCATION REPORT 1 - 25TH ANNIVERSARY OF THE  
AMA PRA

(28) RESOLUTION 313 - PROMOTING PHYSICIAN ACCESS TO QUALITY  
CONTINUING MEDICAL EDUCATION PROGRAMS

RECOMMENDED FOR REFERRAL TO BOARD OF TRUSTEES:

(29) RESOLUTION 314 - RETRAINING PHYSICIANS IN PRIMARY CARE

(30) RESOLUTION 315 - SUPPORT FOR DEVELOPMENT OF CONTINUING  
EDUCATION PROGRAMS FOR PRIMARY CARE PHYSICIANS IN NON-  
ACADEMIC SETTINGS

Mr. Speaker, this concludes the report of Reference Committee C. I would like to thank Stephen  
W. Bayles, Michael F. Collins, MD, Seymour R. Stall, MD, Robert E. Windom, MD, Edmund  
W. Jones, MD, and Kenneth N. Buchi, MD, and all those who testified before the Committee.

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Stephen W. Bayles (Medical Student Section)

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Michael F. Collins, MD, Massachusetts

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Seymour R. Stall, MD, New York

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Robert E. Windom, MD, Florida

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Edmund W. Jones, MD, Ohio (Alternate)

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Kenneth N. Buchi, MD, Utah (Alternate)

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J. Regan Thomas, MD, American Academy of Facial Plastic  
and Reconstructive Surgery, Chair



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*file-loop*

October 22, 1993

President William J. Clinton  
The White House  
Washington, D.C. 20500

Dear Mr. President:

On October 5th and 6th we had the pleasure of co-chairing a National Research Council (NRC) workshop on the subject of "National Information Infrastructure and Health Care Reform." The workshop was organized jointly by the Computer Science and Telecommunications Board of the NRC and by the Institute of Medicine's Division of Health Care Services. A diverse group of individuals from both public and private sectors met in Georgetown to discuss the National Information Infrastructure (NII), its role in support of health care reform, and the possibility of undertaking a major study in this general area.

Despite the diversity of the participants (ranging from health professionals, computer scientists, and telecommunications experts to representatives from federal and state agencies and leaders in health policy), we were struck by the unanimous appreciation of the importance of information infrastructure for health care delivery and health reform. We also heard a resounding plea for urgent attention to the issues raised in the two days of discussion.

Because of the perceived urgency of the situation, we decided to bring to your attention the workshop, and the recommendation for a major NRC study on the NII and Health Care beginning early in 1994. We have enclosed for your information a brief summary of the workshop, including a list of the attendees. Because several of the suggestions that arose during the meeting could influence some of the detailed planning for health care reform in the months ahead, even this informal workshop report may be helpful in stimulating discussion of how the NII can enhance health care and how the federal government can facilitate the penetration of the NII into health care and public health settings.

We will be pleased to provide further information if you would find that useful.

Yours sincerely,

C. Everett Koop, M.D., Sc.D.  
Senior Scholar  
The C. Everett Koop Institute at Dartmouth

Edward H. Shortliffe, M.D., Ph.D.  
Professor of Medicine and of Computer Science  
Associate Chair of Medicine for Primary Care

cc: First Lady Hillary Rodham Clinton  
Mr. Ira Magaziner

# THE ROLES OF INFORMATION INFRASTRUCTURE IN HEALTH AND HEALTH CARE

## Abstract

Intending to conduct a study on roles for national information infrastructure in support of health and health care, the Computer Science and Telecommunications Board and the Institute of Medicine of the National Research Council (NRC) hosted a meeting on October 5-6, 1993, to advise the NRC on the issues that such a study should address. This meeting was chaired by C. Everett Koop, former Surgeon General, and Edward H. Shortliffe, Professor of Medicine and of Computer Science at Stanford University. Meeting participants were drawn from both the health care community and the information technology community so that each community could learn from the other. Meeting participants endorsed the notion of an NRC project to articulate a vision of how information infrastructure can help to reduce the cost of health care, increase its quality, and improve access to it; to identify critical barriers to the realization of that vision; and to develop strategies for how those barriers might be overcome.

**The Clinical Context** Dr. Koop presented the clinical context that frames the issue of information infrastructure for health care purposes. He noted that health care reform is inevitable. The details will evolve, but in any case information infrastructure will play a key role in supporting reform. Apart from the obvious applications (such as speeding the flow of administrative information), information infrastructure will have important roles in supporting health education (e.g., for health care professionals engaged in lifetime learning and for the public in teaching them how to pursue healthy lifestyles and make informed medical choices), in improving the connectedness of primary care providers to mainstream medicine, and in supporting outcomes research that will enable clinicians and consumers to make better decisions and choices regarding health and health care.

**National Information Infrastructure** Information infrastructure refers to the hardware needed to connect information systems, the architecture for arranging these components, and the software, services, support, and operating procedures, policies, and regulations that make this hardware useful. A national information infrastructure (NII) refers to information infrastructure that is accessible on a national basis. NII is an evolving concept; today, certain elements of an NII are operative, though these elements operate independently and incompatibly with one another. Components of the NII of the future will be integrated in what appears to users as one seamless web.

**Roles of NII in Health and Health Care** National interest in the use of NII for health care and health maintenance is substantial. Health-related uses of NII discussed at the meeting included:

- Distribution of and access to health-related information (e.g., medical literature, distribution of practice guidelines and outcomes management advice) among care providers;
- Public access to health-related information through personal health information systems;
- Simultaneous sharing of computer-based patient records;
- Telemedicine to connect primary care providers with decision-making support at a distance;
- Rapid transport of financial and administrative information;
- More timely, more consistent health data for policy makers; and
- Better support for clinical trials and clinical reporting to federal agencies and manufacturers.

**Enabling Activities to Facilitate Use of NII for Health Care** Meeting participants agreed that with only a few exceptions, the obstacles to widespread use of an NII for health care are largely logistical, political, and financial, rather than technological. Meeting participants discussed activities that must be undertaken if the potential of NII for health care is to be fully realized:

- Establishing a policy framework for health-related applications of NII. Participants noted that there is no governing focal point of responsibility for coordinating policy for health-related NII issues across federal agencies. Meeting participants believed that as a result, federal policy and leadership in this area has been lacking. Particularly underscored was the need for federal policy to be concerned with issues in addition to collecting and managing the data necessary for assessing health

care reform. A coherent policy framework would address issues such as:

- the need for and possible roles of a national chief health information architect;
  - potential incentives for the health-related use of an NII;
  - options for information policy regarding matters such as data collection, use, comparability, accuracy, completeness, security, and privacy;
  - possibilities for pre-emptive federal legislation to coordinate state actions; and
  - possible roles of government in promoting NII for health.
- Developing standards. Stakeholders (e.g., vendors, users) have not accepted standards that will enable all health-related applications to communicate with each other, and the pace of applications development has slowed as a result. Establishing standards is essential for widespread use of NII for health-related purposes.
  - Adopting an open-systems philosophy. The history of computing suggests that open systems encourage the development of very large numbers of different applications.
  - Developing a system of universal patient and provider identifiers. Such identifiers are necessary to obtain many of the advantages achievable with an NII (e.g., simplification of administrative information requirements, better matching of patients and their records, construction of databases with longitudinal records for individuals).
  - Providing training and education for those involved in health care (e.g., providers, consumers, payers). These individuals must be shown how their health-related needs could be better met through the use of information infrastructure and trained in how to use this technology.
  - Undertaking demonstration projects to illustrate the impact of health-related NII applications on cost-effectiveness and quality, thereby educating policy makers and care providers about the value that NII could have for health care and helping to build public support for other health-related applications of NII.
  - Establishing a clearinghouse on NII and health. A clearinghouse would provide information on relevant past activities (so that the lessons of previous experience could be accommodated in present efforts), present activities (so that duplication of effort could be reduced), and funding opportunities (so that researchers and developers could seek support for their efforts).

**Issues Affecting the Implementation of an NII for Health-related Purposes** Meeting participants discussed many issues that must be resolved for health-related NII activities to gain acceptance and grow. These include:

- Sharing information (data, notions of system architecture, analytical methodologies);
- Assuring data quality and appropriateness for use;
- Defining the appropriate role of computer-based patient records within an NII;
- Developing local, regional, and state information infrastructure to feed an NII.
- Resolving questions of access to patient data;
- Clarifying rights to published research information and other intellectual property;
- Integrating health-related services supported by NII with other social or educational services;
- Developing interfaces that provide users with enough utility to make it worthwhile to change their routines and that reduce or eliminate the need to perform unpleasant tasks; and
- Defining metrics of success for the health-related use of NII.

**An NRC Study on Information Infrastructure and Health** Meeting participants expressed a certain sense of urgency about moving forward in ways that would advance public awareness and support appropriate government action on information infrastructure issues that are related to health care reform. They collectively endorsed the proposition that the NRC should undertake a project that would articulate a vision of how information infrastructure can help to reduce the cost of health care, increase its quality, and improve access to it. The project would address the benefits of using information infrastructure for health care that would accrue to individual clinicians, patients and consumers, and society-at-large. In addition, the project would identify critical barriers to the realization of that vision and develop strategies for how those barriers might be overcome. Also stressed was the need for a interim product that would focus especially on the identification of key problem areas early in the project. Finally, an essential component of this project would be an intensive dissemination effort through a multitude of channels.

SUMMARY OF DISCUSSIONS AT A PLANNING MEETING ON

**THE ROLES OF INFORMATION INFRASTRUCTURE  
IN HEALTH AND HEALTH CARE**

NATIONAL RESEARCH COUNCIL

OCTOBER 5-6, 1993

**Chairs:**

**C. Everett Koop, The Koop Institute  
Edward H. Shortliffe, Stanford University**

**Rapporteurs:**

**Herbert Lin, Computer Science and Telecommunications Board  
Jane Durch, Institute of Medicine**

*This white paper summarizes the discussions of a planning meeting sponsored by the National Research Council (NRC) on October 5-6, 1993. It has not been reviewed by the National Research Council, and does not reflect the institutional views of the NRC in any way.*

Meeting of October 5-6, 1993 on

## **The Roles of Information Infrastructure in Health and Health Care**

### **THE ROLES OF INFORMATION INFRASTRUCTURE IN HEALTH AND HEALTH CARE**

Intending to conduct a study on roles for national information infrastructure in support of health and health care, the Computer Science and Telecommunications Board and the Institute of Medicine (IOM) of the National Research Council (NRC, described in Appendix A) hosted a meeting on October 5-6, 1993, to advise the NRC on the issues that such a study should address.

This meeting was chaired by C. Everett Koop, former surgeon general, and Edward H. Shortliffe, professor of medicine and of computer Science at Stanford University. Meeting participants (Appendix B) were drawn from both the health care community and the information technology community so that each could learn from the other. The meeting agenda is given in Appendix C.

Meeting participants endorsed the concept that the NRC should undertake a project that would articulate a vision of how national information infrastructure could help to reduce the cost of health care, increase its quality, and improve access to it. In addition, the project would identify critical barriers to the realization of that vision and develop strategies for how those barriers might be overcome.

#### **1 - The Clinical Context**

Dr. Koop reviewed the clinical context that frames the issue of using information infrastructure for health and health care in the United States. He focused on four main themes:

- Health care reform is inevitable. There is so much dissatisfaction across the nation with the current health care system that the only real questions on health care reform are when we will have it and how much of it we will have. Regardless of the details of the reform package that is ultimately adopted, an information infrastructure will have to be in place to support health care reform.
- Health education is central to health care reform. Health education involves two components:
  - education of health professionals. Medical education is much more than medical school. It involves premedical education and college; science education for junior high and high school students; teaching teachers at all grade levels how to seek out and nurture the aptitude for science, medicine, and the health professions; internships and residencies after medical school; and continued learning throughout a provider's lifetime. Each of these phases of education provide opportunities for health care professionals to learn how to use information technology to improve the quality of the care they deliver. For example, many residents and interns are learning to use a hand-held computer to retrieve information when needed rather than relying on memory or journal articles. For lifetime learning, information technology should be used to bring the expertise of the medical center to the setting where providers are caring for patients.
  - education of the public. A major opportunity to reduce the costs of health care lies in preventing disease and promoting health. Prevention of disease is key to the future of American health and U.S. health care. Health care providers must learn to instruct the public in the techniques of behavioral change necessary to promote healthful practices

Meeting of October 5-6, 1993 on

## **The Roles of Information Infrastructure in Health and Health Care**

and appropriate lifestyle changes. These efforts must be directed not only at individual patients but also at whole communities. National information infrastructure can be used to deliver this information to the public using the same channels that will be used for other educational purposes.

- Primary care is the backbone of U.S. medicine. The primary care physicians and other health professionals who serve the forty percent of the U.S. population outside of major urban areas are perhaps the most important target of the communications system that a national information infrastructure can support. Such communication will provide continuing education, contact with specialists, and access to the most current medical information, all of which will reduce some of the disincentives for providers to practice in smaller communities.
- Outcomes research is needed to support intelligent choices about health care. National information infrastructure offers the opportunity to assemble data needed for outcomes research of various types. The effectiveness of treatments and diagnostic techniques must be established. The success rates of individual doctors and hospitals in treating specific diagnoses and performing certain surgical procedures should be assessed. Utilization patterns can be compared across different regions. Perhaps the most important research needed is examining patient values as they are reflected in measures of patient preferences for and satisfaction with various medical procedures. Indeed, when patient values are taken into account, patients may be more satisfied by low-cost, low-technology medicine and surgery than by more expensive services.

## **2 - The National Information Infrastructure**

Dr. Shortliffe reviewed the origins of the national information infrastructure and its suitability for health-related applications. The concept of information infrastructure refers to the hardware needed to connect information systems (e.g., cables, switches, computers, and other components needed to route and manage traffic), the architecture for arranging these components, and the software, services, support, and operating procedures, policies, and regulations that makes the hardware useful for acquiring, transporting, managing, and processing information. A national information infrastructure (NII) refers to such resources and services that are accessible on a national basis.

NII is an evolving concept. Certain elements of an NII exist today (e.g., the Internet,<sup>1</sup> the telephone system, broadcast media such as radio and television, cable television), but for the most part they operate independently. NII in the future is expected to include not only the hardware used to transmit, store, process, and display voice, data, and images, but also a multitude of technologies for handling or processing information (computers, telephones, video, fiber optics, satellites, and so on) that will be integrated in what appears to users as one seamless web.

The notion of connecting a wide range of health-related computer applications has been evolving for about 20 years. In 1973, the first non-defense-related computer connected to the Arpanet (an early component of the Internet) was a system in the area of health care and health care research. A

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<sup>1</sup>The Internet is a highly decentralized but world wide "network of networks" connecting some 2 million computers and tens of millions of users. It is used for academic, research, government, and commercial purposes.

Meeting of October 5-6, 1993 on

## **The Roles of Information Infrastructure in Health and Health Care**

variety of health-related applications of information infrastructure have been demonstrated; however, with few exceptions, these applications have been site-specific solutions that cannot be generalized to other settings.

More recently (in 1986), the National Library of Medicine (NLM) sponsored a Long Range Planning Panel on Medical Informatics, which noted that "widely disseminated medical information systems will require high-bandwidth communications to allow access to the computational, data, and information resources needed for health care and research."

Furthermore, it articulated the goal that

by the end of the next decade, there will be a national computer network for use by the entire biomedical community, both clinical and research professionals. The network will have advanced electronic mail features, as well as capabilities for large file transfer, remote computer log-in, and transmitted graphics protocols. It will either be part of a larger national network . . . or will have gateways to other federally sponsored networks.

In 1986, these statements were mostly of academic interest. They generated some enthusiasm within the NLM, but in the absence of a congressional mandate, the NLM had no way to act on the Panel's ideas. More recently, the confluence of two major trends has dramatically increased the level of national attention to health-related information infrastructure. First, the pressure for health care reform—specifically, the desire to restrain health care costs, to improve quality, and to increase access—puts a great premium on making more effective use of health-related information. Second, the number of parties using the Internet has grown remarkably and the technologies that support the Internet and other electronic networking enterprises have developed rapidly. Both trends have attracted attention in the Congress<sup>2</sup> and the Administration<sup>3</sup>, as well as other important work undertaken in the private sector.<sup>4</sup>

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<sup>2</sup>For example, Senate Bill S-4 (*The National Competitiveness Act of 1993*) and House Bill HR-1757 (*High Performance Computing and High-Speed Networking Applications Act of 1993*) both single out health care as an important application area for national information infrastructure.

<sup>3</sup>For example, in April 1993, the Working Group on Computerization of Patient Records submitted to the Secretary of the U.S. Department of Health and Human Services a report entitled *Toward a National Health Information Infrastructure*.

<sup>4</sup>Examples of work undertaken in the private sector on health-related applications of information infrastructure include a white paper by the Computer Systems Policy Project on health care (*Information Technology's Contribution to Healthcare Reform*), which identified five generic barriers to the widespread use of information technology in health care, including commercial viability of health-related applications, professional adaptation to the use of information technology, the need to re-engineer business and clinical practices established in a paper-based environment, the lack of standards, and the lack of certain enabling technologies; the Institute of Medicine report on *The Computer-Based Patient Record: An Essential Technology for Health Care* (1991), which articulated the many advantages of a computer-based patient record and successfully advocated the creation of an institute to encourage the adoption of such records; the Arthur D. Little consulting firm report *Can Telecommunications Help Solve America's Health Care Problems?*, which estimated a possible annual

Meeting of October 5-6, 1993 on

## **The Roles of Information Infrastructure in Health and Health Care**

### **3 - Roles of National Information Infrastructure in Health and Health Care**

Meeting participants discussed a number of health-related uses for an NII that build on capabilities for communication, data collection, and access to data and other forms of information. They emphasized that applications must respond to the information needs of health professionals, consumers, and policy makers. Identifying those needs and articulating how to meet them through an NII may require assistance from technologists, but technological solutions crafted in ignorance of these needs may not be readily accepted by their intended users.<sup>5</sup> Health-related uses of an NII discussed or referenced at the meeting include:

- Distribution of and access to health-related information: Health professionals are finding it difficult to keep up with the rapid growth of knowledge in their fields. Computer-mediated interactions with databases of health-related research and literature could help health care professionals find relevant information as needed. More sophisticated applications would enable health professionals to use intelligent "agents" to monitor the expanding literature and call out articles on specified topics of interest. Other applications could support electronic distribution of practice guidelines and outcomes management to care givers and their automatic integration into providers' information systems devoted to patient care.
- Public access to health-related information through personal health information systems: Consumers have a key role to play in reducing the cost and increasing the efficacy of the health care system by taking responsibility for maintaining personal health through preventive measures and making informed decisions about when and how to seek direct medical attention. To do their part, however, consumers need appropriate information. An NII has a major role to play in delivering to consumers easy-to-obtain and easy-to-understand health information that can help them live in a healthy manner and interact with the health care system as well-informed customers.
- Support for public health surveillance and assessment: At the local, state, and national levels, public health agencies have a responsibility to collect, analyze, and disseminate information on the health status of the population and the health needs of the community. The resources offered by an NII can assist with all of these tasks and may be particularly valuable for transferring data between the local level and state or national agencies.
- Access to computer-based patient records: A recent IOM study (*The Computer-Based Patient Record: An Essential Technology for Health Care*, National Academy Press, Washington, DC, 1991) noted that computer-based patient records could help to ensure the completeness of

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savings of \$36 billion through the use of four health-related telecommunications applications; and the forthcoming IOM report on *Health Data in the Information Age: Use, Disclosure, and Privacy*, expected in January 1994, which will address many data policy issues.

<sup>5</sup>The cultural differences between technologists and health care professionals are quite profound. For example, terms such as "network" and "standards" have entirely different connotations to these two groups. For technologists, "health care network" might refer to the physical, wired connections between different sites for health care delivery, whereas to health care providers, "health care network" may well refer to a formal or informal association between providers.

Meeting of October 5-6, 1993 on

## **The Roles of Information Infrastructure in Health and Health Care**

information available to providers at the time of interaction with patients because they could be made sharable with the appropriate parties under the appropriate circumstances. An NII would be the means through which such records could be shared among provider institutions and clinicians—a clear need for our highly mobile society.

- Telemedicine: Health professionals (e.g., physicians, nurse practitioners, social workers) in remote or underserved areas (e.g., rural and inner city areas) are often isolated from the support that providers in better-served communities and in academic health centers take for granted. An NII could facilitate access to information resources and consultative services for isolated health care providers, thereby enhancing patient access to state-of-the-art health care in the communities they serve. Network-based multimedia conferencing and consultation may also be valuable for any practitioner, regardless of practice setting, when specialized services are needed.
- Financial and administrative transactions: Billing and insurance claims for health care services account for the vast bulk of the administrative information associated with health care. A 1991 study asserted that some 25 percent of the U.S. health care budget is spent on administration and that a large fraction of this amount was attributable to the multitude of health care payers, each making different demands on health care providers.<sup>6</sup> To the extent that the same administrative procedures, information, and data formats could be required, costs could be much reduced. Administrative burdens could be dramatically reduced, and patient information could be transmitted, processed, and reviewed in a matter of minutes rather than weeks.
- Support for health policy analysis: At present, the health care system and policy makers lack adequate data to make good judgments about the quality and cost of health care or the health of the public. Comprehensive information is not available on providers, patients, or the population as a whole. In many cases, the available policy-relevant data are administrative (e.g., data derived from Medicare or Medicaid reimbursement claims) rather than clinical data on a patient's condition, treatment, and functional outcome. Other datasets that rely on voluntary submission of data by providers are often incomplete and generate information of questionable value. These limitations make it difficult or impossible for analysts to determine if individual providers are giving safe, appropriate, and effective care or to document the most efficacious and cost-effective treatments for various clinical conditions (the focus of outcomes research). An NII could greatly facilitate compilation of population-based data or patient-level clinical data from patient records (with information identifying individuals removed as appropriate) into policy-relevant databases, thus minimizing inconsistencies, errors, and delay in assembling data to make such assessments.
- Support for clinical trials and submission of clinical reports to federal agencies and manufacturers: New medical procedures should be tested for clinical efficacy and cost-effectiveness (outcomes research). For drugs and medical devices, manufacturers must undertake extensive pre-market clinical trials of their products as well as post-marketing surveillance to monitor the emergence of adverse reactions associated with their products. Certain diseases and adverse drug reactions are also reported to federal agencies (e.g., the

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<sup>6</sup>Steffie Woolhandler and David Himmelstein, "Administrative Costs of U.S. Health Care", New England Journal of Medicine, Volume 324(18), 1991, pages 1253-1258.

Meeting of October 5-6, 1993 on  
**The Roles of Information Infrastructure in Health and Health Care**

Centers for Disease Control and the Food and Drug Administration, respectively). An NII could greatly facilitate the communication of clinical results and the identification of adverse reactions and side effects from patient records, thus eliminating the additional manual reporting required of clinicians today, increasing the speed with which such information is passed on to the appropriate parties, and ensuring greater completeness of that information.

- Support for information needs under health care reform: The Administration plan for health care reform calls for timely access to reliable data that can be used to assess the health status of the population and the state of the health care system through "report cards" for health plans. Such data will provide feedback to health care providers on their performance. The information transfer and analytic capabilities enabled by an NII may be an essential resource.

#### **4 - Activities To Facilitate Use of NII for Health**

Meeting participants generally agreed that the obstacles to widespread use of an NII for health are more logistical, political, and financial than technological (though new technologies could well reduce the cost and increase the usability of health-related applications). A variety of health-related applications that could build on an NII have been demonstrated, thus suggesting the potential benefits of such applications. But the lack of a common information infrastructure has meant that these applications have been custom-designed and individually constructed to solve only the problems at the particular installations where these applications operate; these applications have, for the most part, been unable to take advantage of other work, and their mutual incompatibility and lack of interoperability has meant that no synergistic effects have been possible.

To promote the development and use of a common information infrastructure on which health-related (and other) applications can build, a number of activities must be undertaken by appropriate parties, notably government and vendors. Meeting participants discussed a number of activities that would help to overcome the logistical, political, and financial impediments to using NII for health purposes:

- Establishing a policy framework for health-related applications of an NII: A coherent policy framework is a pre-condition for widespread use of an NII for health purposes. A key point noted by meeting participants is that *there is no governing focal point of responsibility for coordinating policy for health-related NII issues across federal agencies*. Meeting participants believed that as a result, federal policy and leadership in this area has been lacking. They particularly underscored the need for federal policy regarding health-related applications of an NII to go beyond collecting and managing the data necessary for assessing health care reform. A consistent, coherent, and comprehensive policy framework would address issues such as:
  - the need for and possible roles of a national chief health information architect. Such an official would have resources and institutional influence to coordinate federal policies relating to health-related information across agencies. Such a person would need to consider government data needs as well moving information out to provider institutions and practitioners.
  - potential incentives for the health-related use of an NII. "Non-market" incentives may be necessary to create a degree of connectivity sufficient to make it worthwhile for users to use NII routinely and for developers to work on new applications. For example, at a

Meeting of October 5-6, 1993 on

## **The Roles of Information Infrastructure in Health and Health Care**

time when few users transmit claims or payment data via electronic data networks, financial incentives to do so could increase connectivity to such networks. Once large numbers of users have such connections, applications developers would find it worthwhile to provide other services and any individual user could have reasonable confidence that another potential user was also connected.

- possible options for information policy. Matters related to data collection, use, comparability, accuracy, completeness, security, and privacy will need attention before an NII will be used extensively for health-related purposes.<sup>7</sup>

- possibilities for pre-emptive federal legislation. At present, health care is governed by a patchwork of different state laws and regulations. However, the concept of national information infrastructure for health presupposes some uniformity from state to state. Matters related to compensation, accountability, and liability (among others) will need attention.<sup>8</sup>

- possible roles of government in promoting NII for health. Some meeting participants noted that a government role may be appropriate when the private sector does not find it financially viable to be involved in research and development. Government may have an important role to play in the continuing support of a testbed that is several years ahead of the commercial infrastructure. Other participants, citing early federal support for the Arpanet that has led to an Internet now used increasingly for commercial purposes,<sup>9</sup> argued that government support for an initial infrastructure can result in a critical mass upon which the private sector can then build.

- Developing standards: Many existing health-related applications of information technology are unable to exchange information with each other. The promulgation and acceptance of appropriate standards are a pre-requisite for "plug-and-play" applications that will operate in many environments and communicate with one another. These standards cover a variety of domains: codes, knowledge/logic, terminology, descriptors, and connectivity. (As one concrete example, there are no technological barriers in principle to transporting entire computer-based patient records over a network, but ensuring that a sent record is actually usable when it is received is a matter of in-place standards that specify the format of such a record.) In some cases (e.g., medical or nursing terminology), consensus on standards remains remote, while in others (e.g., connectivity or the transport of medical laboratory data), standards are relatively well developed. Even in the case of relatively well developed standards, however, the relevant stakeholders (e.g., vendors, users) have not accepted a set of standards governing the products they sell and use, and the pace of applications development has slowed as a result.

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<sup>7</sup>The IOM report, *Health Data in the Information Age: Use, Disclosure, and Privacy* will address matters related to the accuracy, completeness, security, and privacy of data contained in large-scale health databases.

<sup>8</sup>Three problem areas stand out as particularly important. State laws vary greatly with respect to the legal acceptability of electronic signatures, the acceptability of electronic vs. paper records, and the penalties for failure to respect patient confidentiality. These matters are discussed (though not resolved) in Appendix B of the IOM report on the computer-based patient record.

<sup>9</sup>While definitive data are not available, one participant estimated that the current federal investment in the Internet accounts for less than 3% of total expenses.

Meeting of October 5-6, 1993 on

**The Roles of Information Infrastructure in Health and Health Care**

- Adopting an open-systems philosophy: Related to standards is a philosophy of open systems. Historical experience with computing suggests that when applications developers can count on the availability of a set of useful "operating system" services whose characteristics are widely known, a very large number of different applications will become available to the user community. Accordingly, a similar philosophy must guide the underlying design of an NII. Most meeting participants were encouraged that those involved in the design of NII appear to understand this point, although much remains to be done to translate this philosophy into practice.
- Developing a system of universal patient and provider identifiers: Without a system of public and provider identifiers, many potential advantages of an NII are not achievable; these include simplification of administrative information requirements, better matching of patients and their records, and construction of databases with longitudinal records for individuals. Any system of universal identifiers must, however, address the legitimate privacy and security concerns that such identifiers raise for the public.
- Providing education and training: Adoption of new technologies is often difficult to achieve. In some instances, implementations of new technology are not well suited to the needs of the user, but in other instances, potential users do not perceive how a new technology could help improve their routine practices. (This premise is at the heart of the "business practice re-engineering" that is receiving considerable attention in industry today.) Health care providers and the public may need to be shown how their health-related needs could be better met through the use of information infrastructure and must be trained in how to use this technology. Training in professional schools may be needed to introduce health care providers to new information technologies and prepare providers to use those technologies effectively.
- Undertaking demonstration projects: Such projects would illustrate the impact of health-related NII applications on cost-effectiveness and quality. They could help educate policy makers, administrators, public health officials, health care providers, and the public about the value that an NII could have for health matters. Successful development of high-payoff applications that can be implemented in a relatively short time would help build public support for further development and deployment of other health-related applications of information infrastructure. As importantly, high-payoff applications that can be implemented in the short term can help to promote wide acceptance of a particular choice of architecture. Two of many potential demonstration projects offered by meeting participants (as examples only) were the use of the health security card in selected large managed-care organizations and the development of a national immunization registry connected to an NII to stimulate the development of health-related infrastructure components.
- Establishing a clearinghouse on NII and health: Meeting participants were aware of a large number of activities, both past and present, that are relevant to health applications for an NII, and they expressed concern that future efforts not "reinvent the wheel." A clearinghouse could provide information on past activities (so that the lessons of previous experience could be accommodated in present efforts), present activities (so that duplication of effort today could be reduced), and funding opportunities (so that researchers and developers could seek support for their efforts).

Meeting of October 5-6, 1993 on

## **The Roles of Information Infrastructure in Health and Health Care**

### **5 - Issues Affecting the Implementation of an NII for Health-related Purposes**

Meeting participants discussed many issues that must be resolved for health-related NII activities to gain acceptance and grow. These include:

- Sharing information: The concept of sharing is the underpinning of an NII. Data must be shared as applications communicate with each other; a shared notion of system and network architecture will facilitate the development of "plug-and-play" applications; shared analytical methodologies will facilitate analysis of data contained in national databases; and shared metrics for evaluation will help establish consensus regarding the efficacy and utility of an NII.
- Assuring data quality and appropriateness: The people who generate and collect data should have incentives to ensure that those data are accurate and timely, and making data useful to those who collect them can be an incentive for ensuring data quality. Meeting participants were sympathetic to a premise of data collection stating that when clinical data are collected and recorded for a purpose other than patient care, those data are likely to be less reliable, accurate, timely, and complete than the patient care data themselves. At the same time, individuals reporting data may—for entirely legitimate reasons—be inclined to provide different data under different circumstances of data collection.
- Defining the appropriate role of computer-based patient records: While the IOM report on the computer-based patient record articulated many advantages of using computer-based patient records over paper records, the relationship of the computer-based patient record to an NII remains to be defined. The potential to distribute information to large numbers of recipients quickly raises important policy concerns. For example, this distribution ability may raise patient concerns about storing sensitive medical information (e.g., HIV status) in computer-based patient records. Reconciling patient sensitivities in this area with medical needs for complete information remains an outstanding issue.
- Developing local, regional, and state information infrastructure: Although a *national* information infrastructure will be critical for some health-related activities, much of the data collection, analysis, and use will take place on local, regional, and state levels. Information infrastructure at each of those levels linked through an NII may enable more effective use of the data collected.
- Resolving questions of access to patient data: To the extent that easy collection of data is facilitated by the existence and the availability of an NII for health-related purposes, demands for access to data may well increase. Those demands may, however, create disincentives for the comprehensive collection of data and could thus make records less useful. For example, a care provider may wish to collect certain data that he or she would not want to be shared with outside parties (e.g., an insurance carrier trying to make the provider more efficient, a lawyer investigating possible malpractice claims, a government regulator examining the provider's style of practice). Meeting participants generally agreed that not all parties have an equal right to obtain data about patients and provider practices. A framework must be established for deciding who will have access to what data and under what circumstances.
- Clarifying intellectual property rights to information: To the extent that NII is a means by

Meeting of October 5-6, 1993 on

## **The Roles of Information Infrastructure in Health and Health Care**

which information (e.g., published research) is disseminated electronically to clinicians and consumers, many intellectual property issues arise for those who would otherwise publish these materials in print. Furthermore, the "information" in question is not limited to articles that appear in journals; it also includes clinical guidelines and health-related software that may be useful to many clinicians or consumers across the nation. Such issues involve the appropriate degree and balancing of compensation and protection rights vs. fair use and broad access.

- Integrating health-related services supported by an NII with other social or educational services: A longer-term vision of health-related applications of an NII sees these applications integrated into the complete web of social and educational service applications that would also be supported through an NII. For example, the Department of Defense is supporting development of a workstation that is designed for community-based social workers who need access to information ranging from bus schedules to clinic schedules to local doctors' appointments. Pre-hospital emergency medical services offer another example of the need to integrate into the health information system data generated and collected by individuals and organizations in other sectors. Specifically, pre-hospital care may be provided by a fire department, a police department, a private company, or a volunteer service, but such entities are not a standard part of the health care environment where clinical information would be easily collected or where they would normally connect to health information systems. A third example might be health information systems that serve private homes directly.
- Developing good user interfaces: Regardless of the underlying technology, the interface to an NII needs to offer health care providers and consumers a critical mass of utility with a net benefit (taking into account the need to change routines) and reduce or eliminate the need to perform boring, repetitive, time-consuming tasks. These interfaces must initially require little or no change in the usual practices of users but also facilitate re-engineering of traditional practices as desired or necessary.
- Defining metrics of success for the health-related use of an NII: Metrics must be defined that enable decision makers to gauge the extent to which an NII is being used for health-related purposes and the success of these efforts. As importantly, these metrics should provide guidance and feedback on how to enhance applications and increase their use.

### **6 - An NRC Study on Information Infrastructure and Health**

Given these strengths, what special role could the NRC play in studying the above issues and providing recommendations to the government, the health care industry, the health professions, and the public?

*Meeting participants endorsed the notion that the NRC—specifically the Computer Science and Telecommunications Board and the Division of Health Services of the Institute of Medicine—should undertake a project that would articulate a vision of how the use of information could benefit clinicians, health care organizations, patients and consumers, and society at large (Box 1). In addition, the project would identify critical barriers to the realization of that vision and develop strategies for how those barriers might be overcome. Meeting participants placed special emphasis on developing a strategy to accelerate creation of standards critical to collecting and analyzing data in support of health care reform and on the need to coordinate government activities (internal and*

Meeting of October 5-6, 1993 on

## **The Roles of Information Infrastructure in Health and Health Care**

extramural) for efficient and appropriate sharing of data and information.

Finally, meeting participants stressed the need for an NRC project to produce results that would contribute in a timely manner to the national debate and deliberations on health care reform, focusing especially on the identification of key problem areas early in the project. An essential aspect of this project would be intensive dissemination efforts employing a multitude of channels for bringing the study's message to the appropriate parties. A variety of dissemination channels were discussed, including public service announcements, distribution through the Internet, video, and articles in professional and lay publications.

A formal NRC proposal that takes into account the insights developed at this planning meeting will be formulated in the near future. But for the project to become reality, funds will have to be raised. Suggestions for potential funders (and offers of assistance!) will be gratefully accepted.

**The Charge to the NRC:** To articulate a vision of how information infrastructure can help to reduce the cost of health care, increase its quality, and improve access to it.

### Key Questions

- What high-payoff public health and health care applications of information infrastructure can be implemented in a relatively short time?
- What are the social and behavioral impediments to implementing the vision?
- What are the policy and other roles of the federal government in facilitating the widespread use of information infrastructure for health-related applications?
- What are the fiscal implications of health-related information infrastructure?
- What technology issues are central to health-related applications of information infrastructure?

The initial task of the NRC project would be identify the most important issues within each of these questions that can be addressed within the resources available to the project. The committee would then develop recommendations for how these issues might be resolved.

### **Box 1: An NRC Study of Information Infrastructure, Health, and Health Care**

Meeting of October 5-6, 1993 on  
**The Roles of Information Infrastructure in Health and Health Care**

Appendix A

**On the National Research Council**

The National Research Council (NRC) is the operating arm of the Academy complex, which includes the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine (IOM). The NRC is generally regarded as a source of impartial advice to the federal government and other policy makers that is able to bring to bear the best scientific and technical talent in the nation to answer questions of national significance. In addition, it is able to act as a neutral party in convening meetings among multiple stakeholders on any given issue, thereby facilitating the generation of consensus on controversial issues. The NRC generally does not undertake original scientific research on its own, relying instead on the expert judgment of its committees and the existing literature and research. Projects are funded by the federal government, foundations, and industry, though NRC policy states that no funding in excess of 49% will be obtained from sources that may have a financial interest in the outcome of a project.

The Computer Science and Telecommunications Board (CSTB) of the NRC considers technical and policy issues pertaining to computer science, telecommunications, and associated technologies. The CSTB monitors the health of the computer science, computing technology, and telecommunications fields, pays attention as appropriate to the issues of human resources and information infrastructure, and initiates studies involving computer science, computing technology, and telecommunications as critical resources and sources of national economic strength.

The Division of Health Care Services of the IOM identifies important policy issues in the planning, organization, financing, and delivery of health care services—including issues of cost, quality, and access and related issues of health resources and health services research, and it oversees studies and other activities in these areas by the IOM that lead to greater understanding of these issues and contribute to productive policy decisions.

Appendix B

**PLANNING MEETING ON**  
**INFORMATION INFRASTRUCTURE, HEALTH, AND HEALTH CARE**  
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Appendix C

MEETING AGENDA

**INFORMATION INFRASTRUCTURE AND HEALTH CARE**

October 5-6, 1993  
National Academy of Sciences  
1055 Thomas Jefferson Street, N.W.  
Washington, D.C.

**Room 2004, Foundry Building**

**This agenda is subject to mid-course correction!**

Tuesday, October 5, 1993

8:30 - 9:30 Continental breakfast in meeting room, Foundry 2004  
9:30 - 9:40 Welcome and logistics (include brief review of NRC and how it works)  
9:40 - 10:00 Focus and context setting: C.E. Koop on clinical issues  
10:00 - 10:20 Focus and context setting: Ted Shortliffe on information infrastructure issues  
10:20 - 12:00 Round-robin of meeting participants (5 minutes per person)  
12:00 - 12:30 gather food for working lunch  
12:30 - 1:15 Round-robin continued  
1:15 - 1:30 CSPP work on health care  
1:30 - 1:45 Regional database organization presentation (strongly related IOM study)  
1:45 - 2:00 Pediatric EMS study; National Forum on Health Statistics (other related IOM work)  
2:00 - 2:15 Break  
2:15 - 3:15 Federal/State gov't issues and needs  
3:15 - 4:00 Needs of parties to health care: clinicians, consumers, carriers, researchers  
4:00 - 4:15 Break  
4:15 - 5:30 Needs continued  
5:30 - 6:45 Reception  
6:45 Dinner (Working groups to address what needs to be done in short, medium, and long term?)

Tuesday, October 5, 1993

7:30 - 8:30 Continental breakfast in meeting room, Foundry 2004  
8:30 - 9:45 Recap of previous day (including report of working groups)  
9:45 - 10:45 Impediments to adoption of information infrastructure for health care  
10:45 - 11:00 Break  
11:00 - 12:15 Impediments continued  
12:15 - 1:15 Lunch  
1:15 - 3:30 Elaboration of NRC proposal -- what issues should be addressed, and how  
3:30 Adjourn

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## **Clinton Presidential Records Digital Records Marker**

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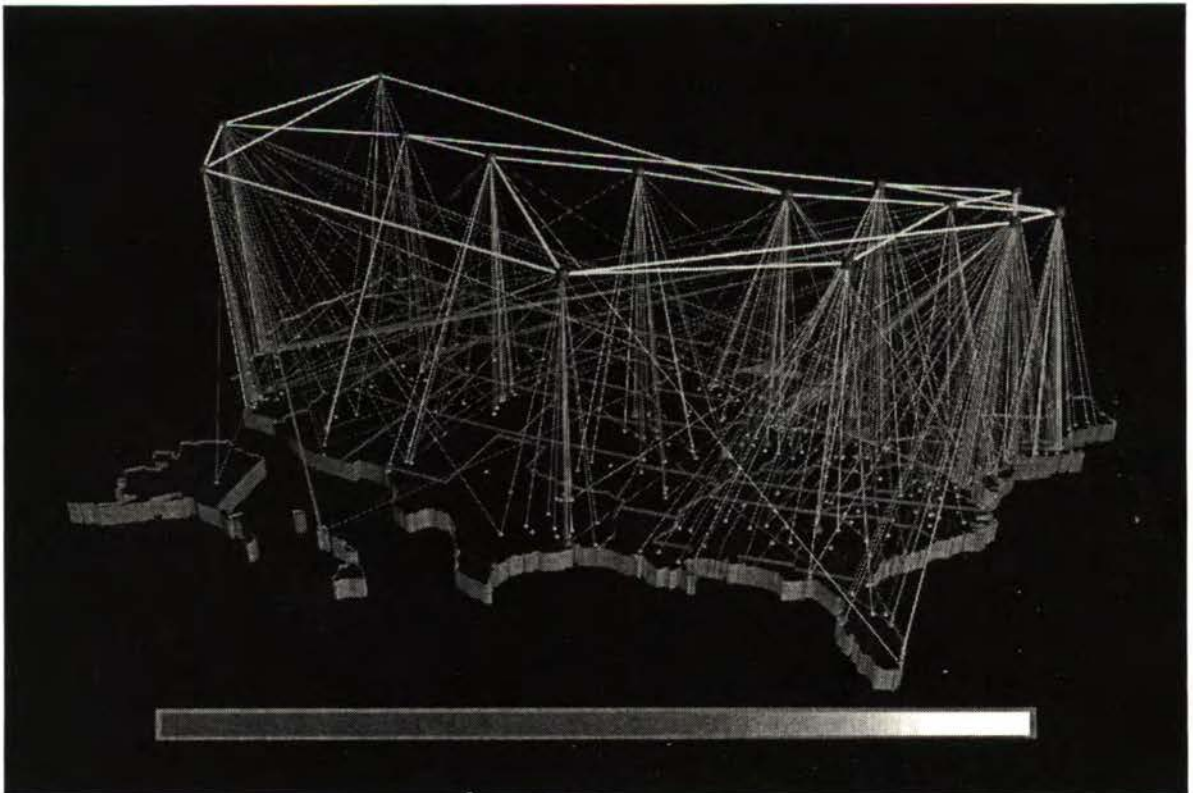
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# **THE NATIONAL INFORMATION INFRASTRUCTURE: AGENDA FOR ACTION**



Information Infrastructure  
Task Force  
September 15, 1993

THE WHITE HOUSE  
WASHINGTON

November 2, 1993

MEMORANDUM FOR

DPC (Bruce Reed)  
Media Affairs (Jock Gill)  
OFL (Melanne Verveer)  
OMB (Chris Edley, Sally Katzen)  
OPL (Doris Matsui)  
OSTP (Mike Nelson, David Lytel)  
OVP (Kumiki Gibson, Greg Simon)  
Staff Secretary (John Podesta)  
Commerce (Larry Irving, Arati Prabhakar, Johnathan Sallet)  
Council for Sus. Development (Johnathan Lash)  
Education (Linda Roberts)

FROM: Tom Kalil TAK

SUBJECT: Meeting with Foundations on NII

On Friday, November 12th, from 2:00 p.m. to 4:00 p.m., I would like to hold a meeting between Administration officials and foundation executives on the National Information Infrastructure (NII). The meeting will be held in Room 474, OEOB. Please RSVP with Sandy Mancini at 456-2801.

As you may know, foundations are increasingly interested in the NII and its applications in education, health care, government information, sustainable development, delivery of government services, and participatory democracy. Executives representing foundations with combined assets of \$22 billion (including Ford, Rockefeller, MacArthur, Pew, Bauman and Benton) have agreed to participate.

I would like to discuss:

1. The Administration's vision of the NII.
2. The NII and its impact on foundation missions.
3. Next steps.

Prior to the meeting, I will circulate a list of participants and a more complete agenda. Attached is a draft discussion paper on potential areas of partnership between the Administration and the foundations on the NII which I would like to circulate to the foundation executives prior to the meeting. Please call me at 456-2801 if you have any questions on the event or comments on the paper.

## **The NII and the Public Interest (Draft 11/2)**

### **1. The Information Technology Revolution**

The Clinton-Gore Administration believes that the emerging "National Information Infrastructure" will have an impact on virtually every impact on America's economic and social life. The NII will enable Americans to to access information and communicate with each other using voice, video, data, or images at any time, anywhere. The rate of technological change and the rapid diffusion of that technology is astounding:

- Productivity in the information technology sector is increasing at a rate of at least 25 to 30 percent per year, as opposed to the 1-2 percent rate of the U.S. economy as a whole. As a result, today's \$1,000 personal computer is more powerful than a 1970's mainframe.
- By the year 2000, U.S. companies will be able to manufacture semiconductors with hundreds of millions of transistors on a finger-nail-sized piece of silicon, leading to the advent of a "supercomputer on a chip."
- U.S. companies are developing fiber optic technology capable of transmitting terabits (trillions of bits) of information per second.
- The Internet now connects 10-20 million users and is growing at a rate of 7 percent per month.

### **2. Civic Applications of the NII**

Although the media has focused on entertainment and home-shopping as the major applications of the "information superhighway", the Administration believes that the NII can also be used as a tool for tackling some of our toughest economic and social challenges, including:

- Improving our education and training system;
- Reducing the administrative costs associated with our health care system while improving access and quality;
- Increasing public access to government information;
- Fostering economic development in distressed rural and urban areas;
- Monitoring the environment;
- Expanding opportunities for Americans with disabilities through

assistive technologies;

- Energy efficiency (telecommuting, demand-side management);
- Promoting participatory democracy at all levels of government; and
- "Reinventing" government and improving the delivery of government services.

### **3. Potential roles for the Foundation Community**

Recently, the President announced a partnership between the federal government and the auto industry to develop a "Clean Car" with three times greater fuel efficiency by the year 2000. To promote the civic dimension of the NII, the Administration believes that a partnership between the federal government, the foundation community, and public interest groups is necessary.

Below are some concrete ways in which foundations could promote the NII:

1. **NII pilot projects** in areas such as education, health care, libraries, civic networking, and government services/information, possibly in partnership with the federal government and other stakeholders.
2. **Research** (broadly defined) on the NII and its applications:
  - Policy development on issues such as universal service and privacy;
  - Evaluation and assessment of pilot projects; and
  - Strategies for "scaling up" pilot projects to the national level.
3. **Clearinghouses** for state and local NII initiatives so that practioners and policy-makers can learn from one another.
4. **Training** to enable end-user communities to use these technologies.
5. Formation of an **NII Foundation**, analagous to the Energy Foundation, to enable the foundation community to pool their resources.
6. **Distribution** of donated hardware.

**Potential next steps:**

1. Formation of **affinity group** to explore role of foundations in NII, and potential partnerships/common interests with federal government.
2. Further meetings on more specific topics (e.g. education, sustainable development).
3. Selection of topics for pilot projects.

**INFORMATION INFRASTRUCTURE & HEALTH CARE PLANNING MEETING**  
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**MEDICAID PAYMENT FOR OSTEOPATHS****BACKGROUND:**

OBRA 90 imposed restrictions on the qualifications of physicians treating pregnant women and children under 18. These restrictions were aimed at improving the quality of physicians serving particularly vulnerable Medicaid patients; sponsors believed that some States were not maintaining adequate standards for physician licensure. While any licensed physician may provide other Medicaid services, physicians serving these populations must have, under this amendment, one or more indicators of quality: they must be board certified, have admitting privileges at a hospital, etc.

The statute is narrowly drawn and does not explicitly include Doctors of Osteopathy (DOs).

Faced with the need for giving guidance to the States implementing the OBRA 90 provision, HCFA issued a notice of proposed rule making in the summer of 1993. This notice interpreted the statute strictly and would, if it became final without change, exclude DOs from Medicaid payment for serving pregnant women and children under 18.

**CURRENT STATUS:**

In the absence of a final rule, the OBRA 90 provision is not yet being enforced. States have been advised to operate under prior rules until a new final rule is published.

A technical fix to the statute is under active consideration on the Hill. It was included in the "Byrd drop" bill that was stalled in the Senate at the end of the last session. Since all concerned agree that Congress did not intend to exclude DOs who meet the other requirements, this amendment appears likely to pass in due course.

In the absence of an amendment, HCFA -- based partly on public comment on the notice -- has recently indicated in correspondence to the public that they will revise the final rule to insure continued payment to DOs that meet the other requirements of the statute.

file

## **Status of C. Everett Koop's Concerns**

### **1. The Uniformed Services University of the Health Sciences**

Under NPR, the Uniformed Services University of the Health Sciences was recommended to be closed, principally based on findings that it is cost effective to provide military scholarships for medical school for rather than keep USUHS in operation. Projected savings are \$350 million through FY 1999. Under the proposal, the university will be phased out over four years, so that the incoming class of 1993 will be the final medical class to graduate from USUHS. There will be no 1994 incoming class.

The projected savings from the closing of the university are included in the budget for FY 1995 being presented to Congress in the next few weeks.

Legislation (HR 3400), which incorporates NPR's recommendation for closing USUHS, passed the House just before recess and is now awaiting Senate approval. Senator Inouye has been vocal in his support of preserving USUHS and wrote letters to the President and to Leon Panetta to urge delaying the recommendation for closing the university until he holds full hearings.

OMB Director Panetta and Defense top brass both support the closing of the university, however the Surgeon Generals of the Army, Navy, and Air Force have, behind closed doors, have been vocally opposed to its closing. However, because of the defense budget short fall, there is general support for closing the program. It is in Congress' court. Jay Rockefeller will mention that to Koop when he sees him in the next few days.

### **2. Medical Technology, especially Telecommunications Deregulation**

We've had discussions with Gore's office and Gibbons' office and we are also doing a briefing on the scientific implications of our health care reform plan for the chief scientists in the administration. Also note, at our request, V.P. Gore mentioned Koop in his recent telecommunications speech. It was quite terrific for Koop.

### **3. Medicaid Coverage of Osteopathic Treatment**

HCFA's published regulations which would implement the provision of OBRA denying osteopaths coverage under Medicaid do not have the impact of law. Statutory language is necessary to clarify the regulation to ensure coverage for osteopaths. The administration is sympathetic to the concerns of osteopaths and as primary care physicians and will push for appropriate coverage under Medicaid. Also, there is sympathy on the Hill toward the concerns of osteopaths and there is mounting discussion. We hope for statutory clarification in the coming months.

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## United States Senate

COMMITTEE ON APPROPRIATIONS

WASHINGTON, DC 20510-6025

93 DEC 13

P1: December 9, 1993

Koop

The Honorable William Clinton  
 The President  
 The White House  
 Washington, D.C.

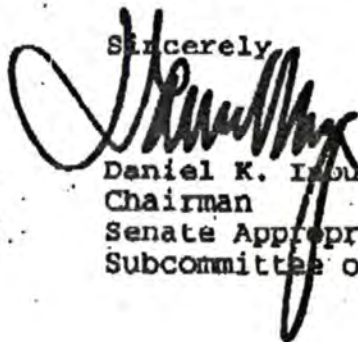
Dear Mr. President:

I would like to inform you of my request to the Secretary of Defense that he delay action to close the Uniformed Services University of the Health Sciences (USUHS). Even though closure of this federally-funded university is recommended by Vice President Gore's National Performance Review, I believe the Department's recent decision to proceed immediately with this action is both premature and ill-advised.

Congressional action on the fiscal year 1994 Defense program fully supports USUHS. The Fiscal Year 1994 Defense Appropriations Act funds all USUHS operations for the year, including the selection of a 1994 freshman class. In fact, our recent appropriations conference agreement approved language which was included in the Senate report and which fully supported the USUHS program. Thus, the Department's initiation of actions to close the university clearly contravenes Congressional intent for fiscal year 1994.

Mr. President, the future of the Uniformed Services University of the Health Sciences is a matter of deep personal concern to me. In my capacity as Chairman of the Senate Defense Appropriations Subcommittee, I intend to hold thorough and open hearings on this matter soon after Congress reconvenes. Most respectfully, Mr. President, I would ask you to intervene in this matter and delay any further action on the USUHS until my hearings are concluded and I have had an opportunity to discuss this matter with you.

Sincerely,



Daniel K. Inoué  
 Chairman  
 Senate Appropriations  
 Subcommittee on Defense

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# United States Senate

COMMITTEE ON APPROPRIATIONS

WASHINGTON, DC 20510-6028

JAMES H. ENGLISH, STAFF DIRECTOR  
 J. KEITH KENNEDY, MINORITY STAFF DIRECTOR

December 9, 1993

The Honorable Leon Panetta  
 Director  
 Office of Management and Budget  
 Washington, D.C.

Dear Leon:

After recently learning that the Department of Defense decided to initiate closure of the Uniformed Services University of the Health Sciences (USUHS) in 1994, I made a request to the President and the Secretary of Defense that such action be delayed. This letter is to inform you of that request and my personal concern on this matter.

Congressional action on the fiscal year 1994 Defense program fully supports USUHS. The Fiscal Year 1994 Defense Appropriations Act funds all USUHS operations for the year, including the selection of a 1994 freshman class. In fact, our recent appropriations conference agreement approved language which was included in the Senate report and which fully supported the USUHS program. Thus, DOD's initiation of actions to close the university clearly contravenes Congressional intent for fiscal year 1994.

Even though closure of this federally-funded university is recommended by Vice President Gore's National Performance Review, I believe proceeding immediately with this action is both premature and ill-advised. In my capacity as Chairman of the Senate Defense Appropriations Subcommittee, I intend to hold full and open hearings on this matter soon after Congress reconvenes. Thus, I have requested that any further action on the USUHS be delayed until my hearings are concluded and I have had an opportunity to thoroughly review this matter.

Sincerely,



Daniel K. Inouye  
 Chairman  
 Senate Appropriations  
 Subcommittee on Defense

2-11/94



EXECUTIVE OFFICE OF THE PRESIDENT  
OFFICE OF MANAGEMENT AND BUDGET  
WASHINGTON, D.C. 20503

*Nicole*

**FAX COVER SHEET**

NUMBER OF PAGES: 2  
(EXCLUDING COVER SHEET)

DATE: 12/5

TO: Nicole Rabner

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OFFICE NO.: \_\_\_\_\_

TELEFAX NO.: 66244

FROM: DONALD E. GESSAMAN

AGENCY: OMB/NSD

OFFICE NO.: (202) 395-3884

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**SPECIAL INSTRUCTIONS:**

Letters from Senator Inouye about  
the Uniformed Services University of the  
Health Sciences.

12/22/93

19:37

USUHS OFFICE OF THE PRESIDENT + 3814038150

NO. 721

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DEC 17 1993

1-4-94

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# of pages 5

|       |                 |         |                |
|-------|-----------------|---------|----------------|
| To    | Melanne Verreer | From    | Nancy Rittmann |
| Co.   | White House     | Co.     | Dr. Koop       |
| Dept. |                 | Phone # | 301-564-6146   |
| Fax # | 202-456-6244    | Fax #   | 301-897-0948   |



1/2/94

Hollay

This will be a disaster!  
If you close it now, it will  
have to be reinvented in time.

Chris

December 9, 1993

The Honorable Les Aspin  
Secretary of Defense  
The Pentagon  
Washington, DC 20301

Dear Les,

As you know, the National Performance Review (NPR) recommended closure of the Uniformed Services University of the Health Sciences (USUHS). I'm writing to underscore the importance of proceeding to implement that decision without delay.

The NPR recommendation was based on the fact that military physicians can be acquired and trained more economically through other means, including the Health Professionals Scholarship Program. By closing the USUHS, the Department will save \$350 million through FY 1999. For this reason the President recommended closure of the University to the Congress, and that recommendation is now embodied in H.R. 3400, the Government Reform and Savings Act of 1993, which passed the House on November 22, 1993.

I appreciate your efforts to promptly implement this important recommendation.

Sincerely,

Al Gore

AGJ/nae

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