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RURAL HEALTH CARE CRISIS

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JUNE 2, 1990

SIOUX FALLS AND RAPID CITY, SD

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CONTENTS

SATURDAY, JUNE 2, 1990

(Sioux Falls, SD)

OPENING STATEMENTS

COMMITTEE PRESS RELEASE

PUBLIC WITNESSES

SATURDAY, JUNE 2, 1990

(Rapid City, SD)

OPENING STATEMENTS

PUBLIC WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

COMMUNICATIONS

RURAL HEALTH CARE CRISIS

SATURDAY, JUNE 2, 1990

U.S. SENATE,
COMMITTEE ON FINANCE,
Sioux Falls, SD.

The hearing was convened, pursuant to notice, at 10:11 a.m., in room 101, New South East Area Vocational School, Hon. Tom Daschle presiding.

Also present: Senator Kerrey.

[The press release announcing the hearing follows:]

[Press Release No H-35, May 29, 1990]

FINANCE COMMITTEE PLANS FIELD HEARINGS ON RURAL HEALTH CARE

WASHINGTON, DC—The Senate Finance Committee will sponsor two field hearings on Saturday, June 2, 1990, in South Dakota on the future of rural health care.

Senator Thomas A. Daschle (D., South Dakota) will chair the hearings, which will be in Sioux Falls and Rapid City, South Dakota.

The hearings will focus on innovative solutions to rural health care problems, specifically on increasing access to health care for rural citizens.

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. If I can have everybody's attention, I want to thank you for coming. This is the first opportunity I have had to hold a meeting in the new school, Sioux Vocational School, and I must say it is a fantastic facility. I had an opportunity to tour it sometime ago. At that time we saw how beautiful and functional it is, so we decided to have our hearing out here. I want to thank those who are responsible for hosting us—the coffee, the cookies, the room. It couldn't be any better. They are just wonderful hosts. My thanks to Sioux Vocational School for having us here this morning.

As you probably have heard, this is the second in a series of hearings that we are holding. These are official hearings sponsored by either the Senate Appropriations Committee or the Senate Finance Committee. It is an unusual opportunity for the two committees which have the most to do with health policy in the country, at least as far as the Senate is concerned, to get the kind of feedback and the kind of testimony that we will be receiving for the next couple of days.

Yesterday we were in Freemont, NE. Today we will be in Sioux Falls and Rapid City; and tomorrow we will be in Scotts Bluff, NE.

Senator Bob Kerrey is perhaps one of the fastest rising stars with regard to health care issues in the Congress. He has devoted

the first couple of years of his tenure in the Senate so far to health care issues. We found a natural allegiance in a number of issues and we find ourselves together once more on the whole question of health care policy in the country. We find ourselves in much the same philosophical point of view as well.

He has been a very dear friend of mine and we continue to work together and have become even closer friends as we work together on a number of issues directly affecting South Dakota and Nebraska. So it is a real pleasure for me to have someone of Senator Kerrey's stature involved in this hearing and with us throughout the day today.

We have a number of witnesses, and as you know, we will take formal testimony from those witnesses and then we expect to take open testimony from the floor as well.

I have had the good fortune of touring what I consider to be one of the finest hospitals in the country just this morning. I attended and toured Sioux Valley Hospital. I must say I was again moved by their dedication, by the quality and the caliber of people that I had the chance to visit with. I have had similar experiences with McKennan Hospital. I do not know that anybody in the country, perhaps in the world, has a better opportunity to get the finest health care to be found than people living right here in Sioux Falls.

So I really pay tribute to our two hospitals—their people, their health providers, and all of those who make it possible to say what I have just said.

I must say as I travel across the State I do not find the same optimism, the same kind of confidence about our health care that I find right here in Sioux Falls. Therein lies part of the problem. As I talk to people in Washington, and in particular as I talk to people when I come home, many more constituents are telling me that they are concerned about health care. Obviously, it has to be a concern for policymakers in Washington.

There have been no less than five different Commissions that have been organized to look at health care from a myriad of different perspectives. And as they look at this issue, they have come to many of the same conclusions with regard to categorization of the problems.

It is possible to put these problems in three categories. The first is cost. We spent about $660 billion last year for health care in this country. It comes out to about $2,500 a person. Medical costs have gone up dramatically, as this chart shows, over the last 30 years and it does not appear that the end is in sight. Experts who have analyzed cost trends indicate that we could see another 100-percent increase in health care costs in the next 10 years unless something is done soon.

Unfortunately, the health care cost issue is one that is largely one found within the United States. We have the single most expensive health care system in the country now, and it relates unfavorably to other countries. Canada pays less for health care. So does Germany, Japan, the United Kingdom, Ireland, and Greece.

The per capita health care in this country can be best shown as it relates to other countries by this chart, which indicates we are up here with number one; this is the trend line. Turkey is down

here. You have France up here and Canada above the line, right below the United States. And finally, if you look at the annual health care costs per capita as they relate to both per capita costs and costs as a percent of GNP you see that the United States is around $2,500—and these are 1987 figures, the 1989 figures are even higher. About 12 percent of our gross national product pays for health care versus Canada's $1,500 and 8.5 percent of the gross national product. Britain was $700 and 6.5 percent of the gross national product.

As we compare ourselves to other countries we see that costs are much higher today than they are elsewhere. Of course, that becomes a competitive issue, an economic issue as well as a health issue.

A recent study was done with regard to the impact of health on the manufacturer of automobiles. We find that in Canada health costs represent $223 of a car manufactured there. Health costs in the United States represent $700 of a car manufactured here within the United States. So cost is clearly a concern that people have expressed to me as I traveled across our State in the last 10 open-door meetings that I have held this week in addition to the meetings and the representatives that we have received from people in Washington.

The second issue is access. There are 35 million Americans who have no health insurance at any point during the year. We have 64 million Americans who lack health insurance at some point during a 28-month period. That lack of adequate insurance is more and more reflective of the inability that they have in getting the kind of care that they should have.

Access is becoming an increasing problem. Not only is it an insurance related problem, however; it is also a problem related to an inadequate number of adequate health care providers, especially in rural areas.

We have tremendous difficulty recruiting health care providers today. We have 40 vacancies for doctors in South Dakota right now. We have 220 vacancies for nurses. We have 16 counties with no hospitals. Obtaining access to health care become far more complicated without any medical facilities in 16 of the counties across the State today.

We also have a serious problem in certain areas with quality. Quality of care is inadequate in very rural and remote areas, while in other cases we have too much duplication of services. Joseph Califano, a former Health, Education and Welfare Secretary indicated that $155 billion of our health care costs go for duplicative or unnecessary medical procedures.

Arnold Relman, the editor of the New England Journal of Medicine, said 30 percent of all procedures are duplicative and unnecessary. In part, this may be due to defensive medicine. In part it may be due to other reasons. But in any case, as a result of access and quality, we have a problem in South Dakota with quality.

This chart—the one I will leave up—is the physician supply in South Dakota today. The blue area represents those areas in our State without any primary care physicians. The yellow area represents the area in South Dakota which represents counties with only one to three primary care physicians. So both the blue and

yellow areas are underserved by health care providers in South Dakota now.

As we look at all these issues, obviously we are looking for advice and direction. We are hoping to come to understand the complexity of these issues and, most importantly, their solutions. So that is the purpose of the hearing this morning—to look at cost; to look at quality; to look at access; to look at ways that we can improve the current system, and obviously to get suggestions for ways in which we can build upon what we have, provide new direction and solving the problems we have.

[The prepared statement of Senator Daschle appears in the appendix.]

Senator DASCHLE. Before I call our first witness, let me call on my colleague and good friend, the Senator from Nebraska, Bob Kerrey.

[Applause.]

OPENING STATEMENT OF HON. BOB KERREY, A U.S. SENATOR FROM NEBRASKA

Senator KERREY. Thank you, Tom. It is indeed a pleasure to be with Tom Daschle in these hearings. One of the things that I have noticed in my life is that I have been blessed to be around good friends and family who have been able to help me at times when I needed them the most. It is a very fortunate set of circumstances that I should arrive at the United States Senate in 1989 when Tom Daschle was there.

In addition, very specifically, we share a very deep-seated interest in trying to address problems that are faced today in American health care. He has laid out the generalized condition of health care very well. We are extracting an unacceptable, I think, and increasing amount of our gross national product for health care. It is estimated that we could be at a trillion dollars by the year 2000. We could be pulling 15 to 16 percent of GNP by that time; and the numbers show that we have at the same time increasing numbers of individuals who are not receiving care, who are uncertain about whether or not they have any coverage at all, or who are being provided care in what I would call very undesirable circumstances.

I should say to all of you, so that you have some sort of sense of where I come from, that I confess I am a product of my own experiences. I know how important health care is as a consequence of those experiences. I was wounded in Vietnam in 1969 and I was provided superb health care at the Philadelphia Naval Hospital for 9 months of that rehabilitation, as well as at the Veterans Administration Hospital in Lincoln, NE to which I returned after I was released from the Navy in 1969.

That environment—and it was free by the way—was an environment of intensely rationed health care. If I complained, as I did quite often, about the services that I was getting in that hospital, if I complained too much I could be court martialed. Now that has not happened to me today, but what I am suggesting to you is the fact that I was complaining about my health care does not mean that necessarily I was getting poor health care. In truth, the outcome was that my life was saved. Were it not for that Philadelphia

Naval Hospital and the other sorts of care I received, not only would I not be living, but I would not have been able to rehabilitate myself in the manner that I have been able to do in the past 20 years.

So the outcome was superb. I want to make it clear that the technology that we very often talk about as being very expensive was very important in my life.

Yesterday we heard a woman who was administrator of a 36-bed hospital in David City, NE, talking about the dilemma of the paperwork and the harassment that she receives from Medicare, through HCFA, all the things that she has to do, and the differential in Medicare reimbursement.

She had a long list of things that need to be corrected. No question about that. And she made two observations that I think are very appropriate. First, she said it did not seem to be very reasonable that we only control the cost of health care by decreasing the reimbursement to providers. That does not seem to me to be an altogether reasonable way to get the job done.

But she also pointed out that when her father had a heart attack 20 years ago he managed to live 2 years beyond it because that was the extent to which technology could assist her father. Her brother, on the other hand, who had a heart attack recently, has had his life extended for a long period of time with balloon angeoplasty and other sorts of procedures that were not available 20 years ago.

I look at health care from the vantage point of business; I've been in business before and I know what is going on there. I have been an employer as Governor of the State of Nebraska and I am very familiar with Medicaid and the rising costs of Medicaid and the difficulty of controlling costs. As much as I want to change the system, as unhappy as I am with the way that we finance it, and as concerned as I am about the way we are doing things, I think it is very important to acknowledge that in the United States of America we do have, most of us, access to superb care.

And therein lies part of the problem. I think particularly that is part of the problem with Congress. With all due respect for our ability to understand what is going on in the country, there are 535 of us in Congress, plus the President—that makes 536—that are in the position of having been elected to serve the people, and we get superb health care provided by the taxpayers.

The President gets socialized medicine at Walter Reed and all the rest of us get a superb health care plan through our site of employment. And as a consequence, it is difficult sometimes for us to understand what is going on with doctors, nurses, and other allied health care professionals. It is sometimes difficult for us to understand what it means to be working today in America at $12,000 a year and not have any health care, to wonder whether or not your children are going to be able to get the kind of baby care that they need, and to wonder whether or not they are going to be able to get the kind of care that most of us enjoy all the time.

It is difficult for us to appreciate what it is like to be in a small business getting out there day in and day out trying to compete, trying to survive, trying to pay off the notes with the bank, or what it is like to be self-employed as a farmer. What I feel most grateful for in having Tom Daschle as a friend, is that he has not

only the capacity but the willingness to come home, to listen, and to try to increase the sense of urgency about this problem and the understanding that is going to be necessary to wade through the complexities of health care in America today. It is enormously complex.

We very rarely think about health care until we need it. We very rarely approach it with any sort of sustained consistency because it is complicated and difficult for us to understand. We are heavily dependent upon others who understand not only the science of it, but increasingly the accounting of it that is needed to know the scope of the problems. It is a difficult subject for us to approach, particularly as we are from Nebraska and South Dakota and are worried about rural health care because unfortunately today we do not have the votes that we used to. We need to get another playing field to get good access to health care in our rural communities.

So I appreciate, Tom, your willingness to do the hearings here in South Dakota. I learned a lot yesterday in the hearing in Nebraska and I expect to learn as much here in South Dakota.

Thank you.

Senator DASCHLE. Thank you, Bob.

We have tried to provide an opportunity for people who are health providers, as well as those who are the users of our health system, to present testimony. The first witness today is one who certainly falls in the category of a patient who has had experiences in trying to acquire health insurance that she intends to share with us this morning.

So at this time, let me welcome Marlene Weinacht, who is working with the Census Bureau. Ms. Weinacht has had difficulty acquiring insurance. Marlene, we invite you to present your testimony at this time.

STATEMENT OF MARLENE WEINACHT

Ms. WEINACHT. Good morning, Senator Kerrey, Senator Daschle. It is a pleasure to be here with you today.

I was with a major corporation for 15 years and as such I was carried under their group insurance plan. During that time I had three separate medical problems which has prevented me from receiving any type of insurance today. I was told that I would be written by one company, but the premiums were almost $900 every 3 months and I just could not afford that. And there were riders on every one of the special problems that I had.

One of my problems was migraine headaches and a neurosurgeon in Omaha, NE prescribed Elavil. I had a sleep disorder and the Elavil would let me sleep. And the sleep disorder was contributing to the severity of the migraines and that did help considerably. But one of the reasons that I have been turned down by insurance companies now, they state as mental health problems because I understand Elavil is used in dealing with people who have mental health problems, although that was not the case with me and I have explained that to them, and they had access to my medical records.

Another problem was lumps. I have had two cysts, over 30 years ago, taken out of my breasts. Every time I have an examination they find a mass but after the mammogram they discover it is

nothing that is even closely related to anything malignant. That is another rider that has been put on all of the—the one insurance company that would take me.

A third problem was a disorder. It was a vaginal disorder that left untreated can turn into cancer. I had surgery for that and then a medication program afterwards. The last 5 years everything has been normal but still that is another reason why they will not accept me.

So those three problems right there. And the one company that would take me, I just could not afford the premium.

Senator DASCHLE. So are you going without insurance today?

Ms. WEINACHT. I have an AARP policy that pays me fifty some dollars a day if I go to the hospital; and that is all I have right now.

Senator DASCHLE. What does that insurance policy cost?

Ms. WEINACHT. It is $21 or $23 a month. I cannot remember exactly. But that is the most I can get.

Senator DASCHLE. But that is the limit, $50 a day?

Ms. WEINACHT. Right. Right.

Senator DASCHLE. Have you actually sought out other insurance companies to——

Ms. WEINACHT. Yes, I have.

Senator DASCHLE [continuing]. Request coverage?

Ms. WEINACHT. Yes.

Senator DASCHLE. And what have they told you?

Ms. WEINACHT. Well most of them just flat turn me down; and one of them did offer to write the policy for me but there was a rider on everything. If I fell and broke my leg they would pay for that, but that's—you know, something of that nature.. But anything else they would not cover.

Senator KERREY. Who is the major corporation you worked for?

Ms. WEINACHT. I worked for Marriott Hotels.

Senator DASCHLE. What would your recommendations be having had the experiences you have?

Ms. WEINACHT. Well I think that if my examinations now showed that I definitely had a problem, you know, I can understand. They are turning me down for mental problems, mental health problems, and I have not had a history of that. And like I say, every doctor that I have gone to, I have taken my taken records with me. I transferred several times when I was with Marriott Hotels and each time I took my medical records with me.

So the insurance companies have access to all those records, but still they have turned me down.

Senator DASCHLE. So if you were to recommend something to us, there may be others who are experiencing similar problems that you have had, what would it be? What would be the way to——

Ms. WEINACHT. Well I think that they should look at this in a way, like with the Dysplasia, for 5 years, it has been normal. I think that they should not use that against me any more.

The fact that I have had the cyst, that is shown over a 30-year span. It is not something that is malignant. It is part of me. That is the way I am made. And there has not ever been any hint of malignancy there at all.

And as far as the mental health problems, I have not had that. So I just think that they are being totally unfair.

Senator KERREY. Just for your information, there are a whole series of problems that are derived from our system which locates the responsibility for health care with the employer. I am leaving out the list of things that are associated with the employer themselves having to go out and spend a lot of time trying to figure out what sort of plan to get and the difficulty, particularly in a start up business, in paying for health care.

But any time you put a small group together you can end up, with just one individual with a health care problem that can throw the entire group off. I mean, it is not uncommon at all to find a small group of under 20 with $700, $800 a month for health care expenditures. I just talked recently to a Lincoln, NE business person with that particular dilemma.

In addition, from the employee standpoint it creates the kind of problem that you are talking about where you move from one job to another. I have frequently heard examples of individuals who say they have an opportunity actually to move up to a higher salary but can't take advantage of it. We have a welfare reform program in Nebraska. We have been working on areas where health care becomes a real barrier. Where people are trying to move up, and have the training, or have gone to a community college or something, but they have a preexisting condition either with themselves or with their child and they simply cannot afford to do it. They cannot afford to take a higher paying job because of the problem with health insurance.

The list is actually, I think, a bit longer than that. Though I am sure misery doesn't enjoy company in your particular case, I assure you you are not unique. I mean the problem you are identifying is not——

Ms. WEINACHT. I understand that.

Senator KERREY [continuing]. Just an anecdote all by itself.

Senator DASCHLE. Marlene, thank you very much.

Ms. WEINACHT. Thank you.

Senator DASCHLE. We appreciate your coming this morning.

Our second panel of witnesses includes Dr. Susan Johnson. Dr. Johnson is the Chairman of the Department of Nursing at the University of South Dakota. Dr. Dean is a Wessington Springs family practice physician who currently serves as the president of the National Rural Health Association.

Dr. Johnson, Dr. Dean, we are delighted that you could be with us.

STATEMENT OF DR. SUSAN JOHNSON, CHAIRMAN, DEPARTMENT OF NURSING, UNIVERSITY OF SOUTH DAKOTA

Dr. JOHNSON. Good morning, Senator Daschle and Senator Kerrey. My name is Susan Johnson. I am a certified pediatric nurse practitioner and chairperson of the department of nursing at the University of South Dakota. Except for the years I spent in school at the University of Minnesota, I have lived and worked in rural America all of my life. Therefore I have both a personal and a professional interest in this area.

From my written testimony I would like to highlight three areas that are of particular concern to me. Those are: One: the plight of children, two: the need for primary health care, and three: the role of nurses in the health care system.

A very high percentage of children live in rural areas. Unfortunately, a report by the Columbia Center for Children in Poverty estimated that 5 million children in this country live in families below the poverty level and more than half of the poor children live in suburbs or rural areas.

The 23 percent poverty rate for children under 6 is more than double the rate for adults and about twice that of the rate of Canada. Current figures suggest that 40 percent of children eligible for Medicaid are not receiving it.

As a pediatric nurse practitioner, I perform physical examinations for the Headstart programs in Vermillion, Elk Point, and Canton. During this past year I have seen many needy children. One little boy did not have stockings on. And I said well you forgot to wear your stockings today and he said, "No, I do not have any." He was very poorly nourished. I would not say malnourished, but very poorly nourished, and if it would not have been for the Headstart program, and the food that it offers, I believe that he would not have been growing properly.

Even though we live in a very rich country and it is the rural areas that supply much of its food, I am very concerned about what is happening with all the children. If you look at all the money we are spending on health care, my concern is that we are not spending enough on primary health care services. We need to shift some of the money that we are spending into preventing illness and promoting health.

And again, this relates back to the area of children, if we do not spend more money in keeping children well and healthy as they are growing up, we will pay for that over and over in increased costs later, plus they will be the workers that will be trying to support our system as our elderly population grows. So I would really urge you to focus your attention on the plight of children.

One problem we have in our health care system is that we are underutilizing nurses at this time. There are 1.6 million employed nurses in this country representing the largest number of health professionals, yet we consume only 8 percent of health care costs. A higher utilization of nurses would expand access to health care and increase the quality of care. Often when a consumer comes in to get health care, nurses are the first people they encounter. Better utilization of nursing skills, could better direct patient care.

Nurse practitioners are becoming increasingly important to the delivery of health services in rural areas. Recent documentation published shows that nurse practitioners can provide 80 percent of adult primary services and up to 90 percent of pediatric services; and the potential cost savings could be estimated at $.5 billion to $1 billion. They could provide 19 to 49 percent of primary health care services in this country.

Looking at South Dakota, we have 40 physician openings. A recent survey by the Physicians Assistants showed we have 28 unfilled nurse practitioner and PA positions in this State. And I would guess, as we look at trying to fill the 40 physician positions,

those that cannot be filled with physicians may be able to be filled with nurse practitioners or physicians assistants. But we have a problem of a shortage of nurse practitioners as well.

So we need to look at putting more Federal money into the education of nurse practitioners. In our experience in South Dakota with educating nurses, we have found that locating programs close to rural areas or within rural areas helped keep the graduates in the area. I would also look at funding nurse practitioner programs that are close to rural areas or within rural areas.

I would like to take this opportunity to look at three pieces of legislation that I think are of vital importance to rural areas. These are the Rural Nursing Incentive Act by Senator Daschle, Senate bill 1384, that provides for direct reimbursement under Medicare for nurse practitioners and clinical nurse specialists, and the Rural Health Improvement Act and the National Health Service Corps Act. All will be very helpful to us in rural areas.

In preparing this testimony your office asked me to look to the future, look to the year 2000. I would like to throw out some ideas that will help us get to where we want to be by the year 2000. One would be to educate an increased number of primary health care providers in this country, both nurses, physicians and others, with a focus on prevention and promotion activities.

I think we should look at rural health areas being linked more carefully to the academic centers and to the large health care centers of this country, maybe through computer, maybe through interactive video, so that rural health providers are not alone out there, that they have a better mechanism for communication with others.

I think also these academic communities or the major health center communities can do more of a circuit rider approach, where specialty providers actually go out into the rural communities rather than always the rural patients coming in. This starting to happen. I think more of it would help the patients in the rural areas.

We have to be very careful with our emergency medical services planning. Emergency care has to be available to every citizen and community in this country. I do not think we want to have pockets of areas that are left unserved. You do not want people to believe that they will go through pockets of this country where emergency services are not available. It affects tourism. It affects economic development.

I think communities might need some assistance in learning how to do a community assessment and how to facilitate interagency collaboration. Perhaps some demonstration models of communities that have learned how to sit down and talk to each other, talk to other surrounding communities, and how to work together, would be helpful.

We need better transportation support for the elderly and for children. If you are very old and you do not have transportation you cannot reach services; and if you are young you do not drive and you cannot reach services.

We should develop the community health center concept more fully. If we cannot have a hospital in a community or an undersized hospital, perhaps we could have centers that promote pri-

mary care. The provision of home care services in sparsely populated settings is of concern. When patients from a tertiary center like Sioux Falls, are sent back to their home communities, the services needed to help them stay out of the hospital do not always exist. So I think we need to look at developing home care services in rural areas.

I know that the debate over how to increase access to health care and reduce costs will be a long one; and I do hope that some of these ideas I have mentioned will be helpful to you.

[The prepared statement of Dr. Johnson appears in the appendix.]

Senator DASCHLE. That you, Dr. Johnson.

Dr. Dean?

STATEMENT OF DR. TOM DEAN, PRESIDENT, NATIONAL RURAL HEALTH ASSOCIATION

Dr. DEAN. Thank you. Good morning, Senators. As you indicated, I am a board certified family physician. I have been in practice in Wessington Springs for 11 years in a small community health center there. I did serve in the National Service Corps for 7 years; 3 years of those in the mountains of Appalachia and 4 years in my current location. Currently I serve as chairman of the Advisory Council to the South Dakota Office of Rural Health and as president of the National Rural Health Association.

I am extremely pleased to have the opportunity to be here today to comment on present and future issues in rural health. These are certainly issues that are of enormous personal and professional significance to me and I believe they are of fundamental importance to the future of South Dakota and Nebraska. Because of that I certainly want to take this opportunity to thank both of you for your support of programs in this area.

I think through your efforts on the Senate Finance, Agriculture, and Appropriations Committees, these issues certainly have come to the forefront of the Senate agenda. With regard to issues currently before Congress I would certainly put the highest emphasis on the reauthorization and expansion of the National Service Corps. I think you are well aware of these issues and certainly we have been very appreciative of the leadership that Senator Daschle has demonstrated in taking the lead and introducing National Service Corps legislation in the last Congress.

Other legislative issues of importance are continued and expanded support for community health centers, support for State office of rural health. The latter is currently included as part of the National Service Corps bill and I think would greatly assist our currently newly organized office of rural health.

I would certainly urge that the Congress continue to address inequitable reimbursement, both to rural providers and to rural hospitals, both by the rapid implementation of the resource based relative value scale and by acceleration of the schedule for elimination of rural, urban differential hospital payments. These provisions and several other important changes are included in Senator Packwood's Rural Health Improvement Act and I would certainly urge your support of this legislation.

Turning to future issues, I would like to address three. These are health professions education, quality assessment and health care and access to health care. With regard to health professions education, I would submit that our current system is producing the wrong types of professionals, instilling in them a distorted view of what constitutes high quality health care and is completely failing to respond to the desperate needs of the underserved as well as failing to respond to many of the wants and the needs of the middle class.

These problems have evolved from a value system and a reward structure in medical education which have emphasized research in basic science and biotechnology at the expense of primary care and bed side teaching. Bright students rapidly learn that advancement comes to those who garner Federal research grants and publish papers, whereas those faculty whose primary interest is patient care, particularly primary care, are the lowest paid and have the least opportunity for advancement.

I would submit that these forces coupled with the gross inequities in reimbursement that exist are responsible for the decline in interest in the primary care specialties which we have observed. I would urge that as the health professions legislation comes up for reauthorization that it be restructured to provide emphasis on primary care training, as well as support for those institutions who have shown that they have an interest and a willingness to adapt their programs to demonstrate the great personal and social rewards which can be obtained by promoting primary care practice.

The second issue I would emphasize is quality assessment in health care. We have assumed for many years that we did have the best of health care, even though we have acknowledged that we have had problems with distribution and equitable access. I think recent research is demonstrating that in fact we really have a poor understanding of what type of care brings the best outcome. Many of our assumptions on this issue are not being born out by the data.

Congress has wisely appropriated funds to support research and to health care outcomes and health care effectiveness. These are extremely important issues and deserve continued and expanded support if we are to come to rational conclusions about what care is appropriate. We have tended to assume that more sophisticated care is better care and that centralization of care in larger facilities with greater emphasis on technology brought about better care.

I believe that both these assumptions are open to serious question. And, in fact, the latter—namely that centralization is an effective way to ensure quality—is in fact grossly erroneous. I believe we need to broaden our concept of quality and that it must include concepts of easy access and acceptability to patients. Technically correct care that is inaccessible, either because of geographic barriers or financial barriers, or that is delivered in a manner that is not acceptable to the patient is not good care.

Finally, and most importantly, is the overall issue of access to care. As you indicated earlier, we are all too aware of the 35 to 40 million people in this country without health insurance and that we have many more who either are poorly covered or who have re-

sources to pay for care, but have difficulty obtaining care simply because it is not available in their area.

All indications are that, as costs rise, this problem is getting worse, rather than better. Some would suggest that all we need to do is add more resources to the system. I believe, however, that that is not a viable option; and that even if we did have those resources available the current system would consume any amount we are able to put in without any guarantee of better access or improved quality.

In an era when Federal resources are extremely limited, where the American consumer has indicated reluctance to pay more for health care as evidenced by the recent rejection of the catastrophic care provision, and at a time when American business is increasingly telling us that health care costs are forcing their goods to be noncompetitive on a world market, I believe it is essential that we completely restructure our approach to public financing of health care services and that we rethink the social contract that underlies that financing.

I believe it is neither fair, nor responsible, to pretend that we can provide complete health care services to all of those who could benefit from them. What we have done, typically, as health care resources have been restricted is two things. We have either made eligibility requirements more stringent—that is we have redefined who is poor strictly for budgetary reasons or we have racheted down the reimbursement to providers.

Public programs no longer even pay the cost of providing those services and thus have to be subsidized from the private sector. I would submit that the former action, that of redefining the poor, is unethical and that the latter, reimbursing below cost, weakens the entire system and further restricts access to the services as facilities turn away patients in order to preserve their financial survival.

In this context I would submit that we need to redefine our goals. Instead of covering an essentially unlimited range of services for a limited number of people, leaving many needy without coverage as we currently do in existing Medicaid programs, I would suggest that we would be better served by a system which prioritized the value of services and provided everyone with access to at least a basic range of health services.

The down side of such a plan is that some services would not be covered. That is rationing—pure and simple. And that is objectionable to some people. What most critics fail to acknowledge, however, is that in fact we have always rationed health care. But instead of doing so openly and explicitly and hopefully on an ethically defensible means, we have done so implicitly and irrationally.

I believe that the system developed by the State of Oregon, which is certainly not perfect, deals with many of the fundamental inequities that exist. I would urge that Congress examine this proposal carefully and grant the Medicaid waivers which are necessary to allow it to proceed to implementation.

As we move to a national health plan—and I believe we are in fact doing that—I believe that we must find a way to guarantee access to at least a basic range of services for all people in need, regardless of their income or geographic location. Only through

such an approach will we ever be able to deal with such unacceptable health status parameters as an infant mortality rate which ranks us 16th in the world.

Thank you very much for your attention. I certainly appreciate your efforts to improve the status of rural health and I look forward to your continued input.

Thank you.

Senator DASCHLE. Thank you, Dr. Dean, Dr. Johnson.

As you look to the future and the options that we have available to us, we have obviously the option of fixing the current system in various ways. Some people have advocated limits on malpractice and trying to put more effort on prevention but nonetheless retaining the current system. Others have suggested what we ought to do is to mandate that everybody have health insurance, maybe through the employers and combined with a much more expansive Medicaid system that will solve the problem. A third group, the American College of Physicians, others have become a little more public in support of a single payer system.

Do either of you have any—you said that you thought a single payer system in this country was likely inevitable. I think that was your word. Does that mean that you feel that that's the most advantageous system or do you think that while it may not be the most advantageous it is the most inevitable?

Dr. DEAN. I never intended to imply that I supported a single payer system. I think we clearly need some sort of national policy which would allow us to provide coverage for the broad numbers of people that are not currently covered. I think that in order to do that we have to get a handle on the range of services that we are going to cover.

So I think first of all the whole issue of determining which types of services have the greatest return for the investment we put in. We have to define those and we have to develop a package that we can afford to provide. I think that in our attempt not to deprive people of things, we have tried to determine those people that needed services and then say we will give you everything that is appropriate. I think that has not worked and what we have done is provide extensive care for a few and we have let many, many people drop through the gaps.

I think we have to turn that around. The fair way to do it is to provide a more limited range of services and guarantee that that is available across the board and then try to add to that as our resources provide.

Now I think that to some degree that can be done through a multiple source system. I don't know that it necessarily has to be a single payer. But I think we have to prioritize our services and I guess that is what appeals to me about the Oregon system. Even though the Oregon system clearly is very provocative and very controversial I think what they have done is bite the bullet and say, "We cannot provide everything to everybody. We want to develop a socially responsible system for determining which things are going to be the greatest return."

And, you know, there are lots of arguments about the system they are putting together. But, at least they have tackled that tough issue. When they say what they do provide then they are

going to provide it to everybody in the State. It is not going to be just a few. The State is responsible for everybody below the Federal poverty level and employers are responsible for providing at least that package of benefits for those above the Federal poverty level.

To me that is the most equitable system I have seen. I think that we simply have to get a handle on cost and it ties in very closely with the effectiveness research because we have to have better data about which things provide us the most return.

Senator KERREY. That, of course, is the dilemma. I like what Oregon has done. In addition to the two things you have mentioned, they have also created a high risk pool.

Dr. DEAN. Yes, right. To allow small employers to——

Senator KERREY. Right. Which is the third element. The problem I have with the Oregon plan, even though I support what they are doing is that they are controlling only the cost of Medicaid. If I am living in Oregon, if I am either Packwood or Hatfield, they are not controlling my costs.

Senator KERREY. Right. I can still buy whatever I want and get whatever I want because I have essentially first dollar coverage as a consequence of being employed in the U.S. Senate.

So the Oregon plan, it seems to me, opens up the need to do what I hear you talking about doing for everyone. If I was living in Oregon, I would advocate doing the kind of outcome assessment that they have publicly done.

Dr. DEAN. Right.

Senator KERREY. They had lots of hearings and the public had an opportunity to change the list anyway they want. As I looked at the 1,700 procedures that they had it was interesting to me that they did not conform to this almost mythical concept that I hear an awful lot about that you have to choose between very expensive life-saving, high technology procedures, on the one hand, and preventative measures on the other. In fact, that did not appear to be the choice at all. It was just a choice between those procedures that actually worked and those that did not.

Dr. DEAN. Right.

Senator KERREY. But like all States, Oregon only controls Medicaid. They do not control the cost on the private side, other than their ability to increase costs by mandating that insurance policies have coverage for different sorts of things; States certainly do not have any control over Medicare reimbursed expenditures.

So all the State politicians can do is deal with those things in front of them. It seems to me that what you are talking about is the rationalization of everyone, having an outcome analysis for everyone, whether it is Medicaid, private insurance, or private pay. Private pay, by the way, is still out there to the tune of 15 to 20 percent, mostly with pharmaceuticals or Medicare.

Is that a fair statement? I mean are you talking a rationalization of outcomes for all of us?

Dr. DEAN. My concern is that if we are ever going to attack our outcome problems in this country—our infant mortality and the things that we hear about all the time—we have to get a basic level of services to everybody in the country.

The concern that I have is that even though people are concerned about services being denied to Medicaid patients in Oregon,

those people are better off than most of my patients right now who are neither eligible for Medicaid or can afford health insurance. And even though if a patient in Oregon is denied a liver transplant, at least that patient has the basic level of services to get to that point. Whereas, most of my patients who are working poor do not even have access or have very restricted access to even basic vital services.

Senator KERREY. Although interestingly on the liver transplant issue, they do not deny all liver transplants. They only deny those where they expect the outcome to be not worth the investment. What is interesting about the Oregon plan is that it seems to permit a much more local rationalization of health care distribution. Whereas, now HCFA has the power. I do not know what Senator Daschle's experience is but people that come to me and talk about health care, say they go to HCFA first.

Dr. DEAN. Right.

Senator KERREY. He is not the person that has been elected to represent the people. So the issue of centralization that you have referenced is very important issue.

Senator DASCHLE. Don't you really face the same problem with the Oregon plan that you do with the Medicare, and that is sort of a balloon effect? That by squeezing one end of the balloon you just make the other end larger.

Dr. DEAN. Yes.

Senator DASCHLE. And that is the concern that I think we have with health costs. We may not solve any health problems as far as cost goes if all we have done is shifted more of it onto the insurance companies in the private sector.

Dr. DEAN. Because we are actually making access harder for those people that are paying out of their pockets.

Senator DASCHLE. That is right.

And actually could argue accelerating costs in doing that.

Dr. DEAN. Absolutely.

Senator DASCHLE. Because if nothing else, you are creating more bureaucracy—25 percent I am told—of all health care costs that they are bureaucratic related.

Dr. DEAN. Absolutely.

Senator KERREY. And you haven't changed the fundamentally hostile relationship between the provider and the patient that exists in Medicaid as a consequence of the way we pay. Medicaid says "we are going to pay the provider less than it takes to provide the care," and so the patient is going to feel abused, and the doctor is going to feel put upon. That is not a healthy environment to create between the patient and the doctor.

Dr. DEAN. Absolutely. Absolutely.

Senator KERREY. How do you feel about Dr. Johnson's suggestions that nurse practitioners and physician's assistants could do more primary care?

Dr. DEAN. I am probably the strongest supporter of that concept in this State.

Senator KERREY. Does that mean it is popular or unpopular with other physicians?

Dr. DEAN. Well, both. No, I have strongly supported the practice of nurse practitioners and physician's assistants and have worked

with them over the last 15 years that I have been in medicine. We employ three in my current practice. So I think they can do a tremendous amount.

In fact, my current practice in Wessington Springs would not be possible if it were not for those people. I have been by myself. We have been recruiting for nearly 2 years now. If it had not been for those folks being there, I could not have survived in that community.

Dr. JOHNSON. I would like to add that I think an ideal practice would be a family practitioner or a family physician with collaborativ arrangements with geriatric nurse practitioners and pediatric nurse practitioners, so they can be supportive of each other in call and in care, and reach out to provide more of the health promotion, health prevention activities so greatly needed.

I think collaborative practice, utilizing nurse practitioners and nurses and other health professionals is really a way to provide better services for less cost; and in the long run I think reduce the long-term costs in health care.

Dr. DEAN. Absolutely.

Dr. JOHNSON. But at some point we have to take a leap of faith because we know preventing and promoting health reduces costs, but we are not putting very much money there. If we put more money into health promotion and health prevention activities, we will save money in the long run. We just have to start to focus there. And it is hard to do that because the money is wanted for other things. But we just have to start to do that; and I think we have to start to do it for our children.

We are just setting up a time bomb by having all these children who are not getting adequate care. We are really going to pay for that in 10 to 20 years. We just have to make the commitment that if you are born in this country you will get a certain level of care at least until you are 18 and that care will be provided to everybody whether you are rich or poor, black or white, or urban or rural. That will be the gift of this country to its children.

Senator DASCHLE. Dr. Dean, Dr. Johnson, thank you very much.

[The prepared statement of Dr. Dean appears in the appendix.]

Senator DASCHLE. Our third panel, comprised of Doug Reker, who is the administrator and CEO for Flandreau's Municipal Hospital; Frank Drew, who is the president of the South Dakota Hospital Association; and Loren Amundson. Dr. Amundson is the director of the South Dakota Office of Rural Health. Will those three people please come forth?

Gentlemen, we are pleased to have you before us this morning. Thank you very much for coming. Why don't we start with Dr. Amundson and then we will go to his right.

STATEMENT OF DR. LOREN AMUNDSON, DIRECTOR, SOUTH DAKOTA OFFICE OF RURAL HEALTH, SIOUX FALLS, SD

Dr. AMUNDSON. Good morning, gentlemen. I am Dr. Loren Amundson, a family physician from Sioux Falls with roots and practice in rural South Dakota; and now director of the South Dakota Office of Rural Health. It is a pleasure to be here and I thank you for the invitation to testify.

In March of this year I was appointed as the first director of the South Dakota Office of Rural Health. During the past several months we have been organizing the office and working closely with communities to examine and promote their health care delivery systems. In the course of this dialogue discussions with health policy makers and consumers have helped to define some of the State's health care concerns and needs.

As we concern ourselves with health care in the rural areas, we must be cognizant that if effective solutions are to be found, we must address rural health on two plains. One is the technical issue oriented level. The other is the level of our values. We must concern ourselves with what our values are concerning rural health. Our values tell us what should be, how we see the world collectively and individually.

To us in the Office of Rural Health, the philosophical underpinning of rural health lies in access to affordable, quality health care. Without a shared belief that rural South Dakotans and all Americans are entitled to access, both geographically and financially, the technical issue-oriented information is meaningless.

Governor George Mickelson has a keen interest in rural health, as witnessed by the creation of our Office of Rural Health, focusing on access, quality and cost as the primary issues which concern most South Dakotans. The office has refined a myriad of rural health issues into a manageable set of topics that form the basis for an action agenda on rural health in South Dakota.

On June 26 and 27, the Governor will host a rural health strategy meeting in Pierre. Among the policy issues to be discussed are mid-level practitioners, people who are uninsured and underinsured, recruitment and retention of physicians and nurses, emergency medical services, rural ambulatory care, rural mental health, rural hospitals, farm injuries, long-term care and the impact of the rural economy on health care.

He has invited health care providers, professionals, institutions, insurers, leaders and other interested citizens from throughout the State to come together to identify specific opportunities to improve the delivery of health services in rural South Dakota.

The involvement of our office with local communities in the State is paramount; and this process holds a unique opportunity to heighten awareness of problems and to solidify a spirit of collaboration on possible solutions. This is to be an action- oriented meeting to solicit individual perspectives and to develop a rural health agenda for the 1990's.

During plenary sessions at that meeting there will be presentations by several leading national rural health experts, including Dr. Tom Dean. In addition, each participant will be assigned to one of several work groups to discuss health care issues and to prioritize the concerns they have.

The previously mentioned issues papers for discussion at that strategy meeting are being developed at this time. After discussing the issues in the workshops, participants will be asked to prioritize the key rural health concerns facing South Dakota.

As a result of this meeting and four subsequent regional rural health meetings to be held throughout the State later this summer, we believe resultant administrative and legislative policies will pro-

vide potential solutions. Let me emphasize that how these solutions will occur is as important as what they will be.

These topics will cover issues which are economic in nature, such as the effect cur agricultural based economy has on its people and health care. They are affected by population changes, such as the process of urbanization and higher proportions of elderly residing in rural areas; and challenged by the organization and delivery of health services, such as the pursuit of technology and resultant specialization on the one hand and the need for access to quality, community-based services in rural areas on the other.

Finally, these issues are related to our system of reimbursement. These changes have personally and directly affected the lives of rural Americans. Physicians no longer practice in rural areas in the proportions they did years ago. Many rural hospitals are having difficulty staying open and nursing shortages are prevalent.

Clearly, the future holds a role for creative thinking and action at all levels. We need to address geographic and financial access to care in a manner that assures all rural Americans a certain basic level of service. At the Federal level we support the formulation of a national rural health policy and will work with the Office of Rural Health Policy at an upcoming meeting in Washington, DC, on June 13 and 14, providing input towards such an outcome.

A national institute of primary care would be helpful. The current Agency for Health Care Policy and Research, called AHCPR, is a start and provides funding for appropriate primary care and clinically based research.

At the State level we believe that the development of successful models of care is the key. We believe that States must be used as laboratories for rural health care and that offices of rural health, such as ours, play a facilitative role in helping to find solutions. Our office is committed to the health care team concept and offers support for both regionalized and local services to solve problems.

Most important, we believe that the key to many rural health related challenges lies within each community. Community leadership is critical to the success of any Federal or State policy.

In conclusion I would like to say that we share common values regarding rural health care. Access to health care in rural areas is vital. Our crystal ball reveals that many rural health care issues will be resolved through communication, cooperation, understanding, experimentation and most of all community leadership.

I personally was most pleased recently to hear Dr. Bob Harmon, the new administrator of HRSA, stress the key issues in his agenda for the 1990's. I think they are why we are here today. His stresses were the three P's—primary care, public health and prevention.

Senator DASCHLE. Dr. Amundson, thank you very much for an excellent statement. Mr. Reker?

[The prepared statement of Dr. Amundson appears in the appendix.]

STATEMENT OF DOUG REKER, ADMINISTRATOR AND CEO, FLANDREAU'S MUNICIPAL HOSPITAL

Mr. REKER. Senator Kerrey, Senator Daschle, thank you for inviting us today. I am pleased to be here with you today. My re-

marks I will keep rather spartan this morning. I think that what I have had in mind has been said at least two or three times this morning already.

I believe perhaps one of the single most concerns of the future will be access. As you mentioned before we are spending about $2,000 per capita in the United States or about 12 percent of our GNP. And we still are not, by far, the healthiest nation.

Many individuals do not have insurance. They cannot afford insurance. They cannot afford primary care. And as a result, health care facilities therefore are providing more and more free health care. This problems becomes magnified when we consider the tremendous technological advances that have been made in the last 15 years. This is frightening to me to look ahead.

Technology has greatly outpaced what we can legitimately afford. I think the future of health care in the United States will include rationing of care. I also think we as a State and a nation can and should examine models objectively. Two of these models can be the Canadian system and the Oregon model for Medicaid.

The future will also see increased personnel problems, shortages, both in terms of physicians, nurses, medical technologists, respiratory therapists and the list goes on and on and on. These problems has become more complex as technology becomes much more exaggerated. Personnel problems will stem from the need to satisfy both governmental policy type needs and the special interests of professional organizations.

Thank you.

Senator DASCHLE. Thank you, Doug.

Frank?

STATEMENT OF FRANK DREW, PRESIDENT, SOUTH DAKOTA HOSPITAL ASSOCIATION

Mr. DREW. Thank you, Senator Daschle. Senator Kerrey, welcome to South Dakota.

I think what I was going to say in the introductory portion of my remarks or what I had planned to say have already essentially been given also. I was particularly interested in the exchange with Dr. Dean because I very strong agree with most of what he said.

Doug has just mentioned the word "rationing" and I think clearly if we look to the long-term future of the health delivery system in South Dakota we have got to come four square up against the issue of rationing. Whether it is a partial solution—and I agree with Senator Kerrey that the Oregon model is only a partial solution because it only affects one piece of the puzzle—whether it is a British or Canadian system which I know has been receiving additional attention in this State or in this country, unfortunately I think sometimes we get caught up in the good news from those systems, that is the cost figures, and tend not to look at the bad news in those systems, which I think are there in terms of the tradeoffs on access to certain kinds of care, and what I believe at least are systems of rationing, perhaps again not explicit.

But in any event, we have to make, I think, in the long term serious changes in our thinking and we have to come to grips with rationing and all its implications. I point out that the provider

community, at least at the present time, while perhaps beginning to sign on to some degree to those concepts, are absolutely constrained by both the court system and Federal law and regulation.

If we even edge in that direction we are both in trouble from the tort system in the courts and we are in trouble from various State and Federal agencies for declining or refusing care or giving it in not a timely fashion or in not a complete fashion. The inspector general of HCFA, for example, with the anti-dumping regulations which you may be familiar with. So that we have built in now, I think, these kind of contrary dilemmas.

We are all thinking about if we have to move in the direction of rationing, yet both the legal and the legislative system are presently set up to absolutely punish those who would even begin to move in that area.

With the kind of conceptual thing on rationing out of the way, let me I guess maybe be a little more optimistic in the short term. We certainly recognize the realities of governmental budget problems at all levels. The demographics of rural health care, which perhaps none of us in the health delivery system can do very much about, the changes in technology and medical practice. But even with those forces of change, I think with local community support, with the involvement of health professionals and government at all levels, we can sustain an effective rural health delivery system.

Let me comment then briefly on what I see as the role of the Federal Government in that respect. You folks play a role as a provider of health services, certainly through the VA and the Indian Health Service and others. But closer to the rural provider you are a payer for services. You are a regulator of the facilities and professionals in terms of trying to maintain public health and safety and you certainly have the potential of playing a tremendous role as a facilitator, both in terms of bringing resources to bear in problem areas and in terms of providing the resources to fund a model or innovative demonstration type projects.

A quick word about those roles. It is absolutely fundamental, I believe, until we collectively have the will and the ability to change the rules of the game, that the Federal Government provide adequate payment for the services that it promises to its beneficiaries.

I am not going to get bogged down in detail, but let me give you three numbers. We have worked closely with Senator Daschle's office, and I know in other States, to address some of the problems of the rural urban differential. We have greatly appreciated his support and his influence in the Senate Finance Committee in that respect.

Yet with all that work the Health Care Financing Administration has just published proposed rules for hospital payment starting October 1, 1990. I would point out to Senator Kerrey that the net effect of all that is going to be a decrease of 2 percent in payment to rural Nebraska hospitals. Our sister State to the north, it decreases 0.9 percent in payment to rural hospitals. The good news is that South Dakota hospitals, in the aggregate, will achieve a 1.8 percent increase.

Senator KERREY. That is good news?

Mr. DREW. That is the good news. Yes, Senator, that is the good news. [Laughter.]

The principal reason for that is an issue which has not gotten a lot of attention but I think we are becoming increasingly aware, is a really perverse kind of thing, it's the area wage index. And while the standardized amounts were raised, the Congress and particularly the Senate, and particularly the Senate Finance Committee insisted that rural hospitals receive a higher update than the urbans. You factor that into the area wage index and you get the kind of numbers that I just recited.

And the reason for it, I guess when you think about it, is pretty simple. Those wage increases are based on what rural hospitals pay their employees. And if they do not pay them very much, they do not get much reimbursement. And if they do not get much reimbursement, they cannot raise their pay. If you do not raise the pay, your wage index does not go up. So it is an original kind of a vicious circle that I think rural hospitals are particularly stuck in.

Out-patient services are receiving a great deal of attention lately, and both lab and x-ray and other payment to rural hospitals are being driven down. You have already heard from Dr. Johnson and Dr. Dean some of the problems and issues in attracting professionals to rural areas, and I think those also need attention.

You regulate hospitals and in some respects I think do a good job, and other respects we get very frustrated. The "swing bed" program has been a God sent for rural hospitals. I commend all of those in the Congress who have supported that and we hope that that program will continue to be nurtured and will not fall a victim of overregulation.

The initiative of Senator Daschle and others in trying to set up model arrangements for alternative rural health facilities, be they called MAF's or EACH's or PEACH's or whatever the latest acronym is, is clearly a step in the right direction. We commend the Congress; we commend researchers for attempting to provide models in that respect.

And again, caution policy makers to let them be truly innovative. Do not overregulate the innovative because I think you then wind up and in fact stifle the innovation. You have to provide the demonstration authority for truly innovative and flexible types of new programs.

Only to echo Dr. Johnson and Dr. Dean's comments about rural health professionals, our association strongly supports nurse practitioners and physician's assistants in their practice and use in rural areas. National Health Service Corps has been mentioned, and various kinds of State and Federal incentives.

I heard, I believe, on a news report, Senator Daschle, you commenting on perhaps we should be providing financial incentives for health professionals to practice in rural areas. You do need to know through hospital reimbursement mechanisms and through professional reimbursement mechanisms the Federal Government now provides significant disincentives to rural practice on the part of both health professionals and allied health professionals.

I do think that saving rural health care in our State and throughout the country should be a serious national goal. I think we adequate reimbursement policies, flexible and responsible regulation, and targeted assistance through demonstration projects that

we can accomplish that. And we have appreciated your interest and support.

Senator DASCHLE. Frank, thank you very much.

Let me just ask you, you talked about rationing a good deal in your opening remarks. A lot of people across the State as we talk about the whole problem of rationing from various perspectives have argued that to a certain extent we are rationing care on ability to pay today. If you do not have health insurance, in some cases you do not get to a hospital, you do not get prenatal care, you do not get preventative care in some cases.

To what extent do you see rationing as a problem of health care based upon the ability to pay today?

Mr. DREW. Let me answer for South Dakota hospitals and perhaps someone is going to argue with me. I believe for—in this State at least, and in most rural areas—I believe that essential and emergency hospital services are made available to individuals regardless of their ability to pay. I cannot comment on, because I frankly do not know, I suspect that some of the non-emergent or non-urgent preventive sorts of care are not provided.

But I am simply not aware, from working with our State Legislature, our Department of Social Services, our Department of Health, the court system in this State, I do not believe that necessary hospital services are being denied to South Dakotans based on their inability to pay.

Senator DASCHLE. Emergency care.

Mr. DREW. No, I would go beyond emergency care.

Senator DASCHLE. Go beyond emergency?

Mr. DREW. I would go beyond. I would include elective surgery, all sorts of procedures that you would not categorize as technically an emergency in that they are life threatening in 24 hours. They are routine kinds of hospital services.

We have a County poor relief system in this State. We have a Medicaid program. And hospitals through, frankly, the manipulation of private dollars and the cost shifting phenomenon through those three mechanisms, I believe that most people receive necessary hospital services.

Senator KERREY. Frank, I would be curious to see if your observations agree with some of what I have seen in Nebraska. Based on their experiences, I would answer the question the same way you did but I would add a qualifier to say that the rules require people to make behavioral adjustments that I find often conflict with other values.

For example, a person in Nebraska that wants to receive first dollar health care coverage—and does not happen to work for someone who provides it—can do one of two things in order to get the health care that you are describing: (a) They can go to work for the government which provides first dollar coverage. So you have the private employer sitting out there saying, "gee, I am trying to compete and trying to hold onto my employee and my employee can go to work for the damn government and get better health care than I can afford to provide; or (b) The person can quit their job and get first dollar coverage through Medicaid.

And as I said to the earlier panel, this is provided in an environment that creates great hostility between both people. So yes the

care is there, but it seems to me that the rules that we have in place foster behavior that is in conflict with other and I think higher values.

Mr. DREW. I agree with you to a great extent, Senator. My dilemma is that the Oregon model itself, and if that concept was applied to all patients and all providers, I think you set up the same kinds of conflicts. I do not understand how the citizen that needs or is able to purchase something which is not on the minimal list then deals with the health delivery system.

Do you say, "I am a millionaire and I can pay for it and by golly I want it." And you say, "No, you cannot have it." It simply is illegal for you to receive that service or do you say, "Well, yeah, you can have it if you go over to the specialty or the rich people's hospital or whatever." I am not sure how you deal with those dynamics if you try to do what we all agree needs to be done. And conceptually I agree. I am not sure of the dynamics you create when you try to move the whole system to that sort of program.

Senator KERREY. I am not sure either, by the way. I am very cautious about this because I am very much aware that there is a law of unintended consequences. I have to abide by what the old docs used to say which is, "The first rule is, make sure you do not make the patient any sicker." It is possible for us to make it worse.

I would start off by recognizing that it is not the other guy that is the problem, but that I am at least part of the problem. I do not know if anybody saw the movie "The Tinman" but I think I am often much like Richard Dreyfuss when he was buying the Cadillac. The guy said, "how much do you want to pay, the truth is nothing."

If you ask me what I want in health care, I want no pain. I do not want to die. I would like to stay like I was when I was 18. I would rather not age at all; and I want it all for nothing.

Mr. DREW. Sure.

Senator KERREY. And that is just for me. My kids, I have even higher requirements. I mean God help the person that does not take care of my child in the way I want him taken care of.

I don't think we are ever going to eliminate that conflict. We are never going to eliminate complaints. We are never going to eliminate pain, and the problems associated with pain: the frustration, and the loneliness, and all the sorts of things that accompany people that are sick, that want more than they can ever get.

I do apply the "doctrine of relative rights" when I say I think health care is a right. It is not an absolute right. There are limits. If it is an absolute right you can never deliver what you say you are trying to deliver. Nonetheless, what I am trying to arrive at is some point, where we can rationalize at a bit more at the local level. I am very uncomfortable with the HCFA arrangement and the top down method of regulation we have in place. I cannot, by the way, promise that I can deliver on the two areas for which you said, "do not overregulate" because I am not in charge of that.

And very often what we find ourselves needing to pass a new law in the House and the Senate to deal with a problem created by the regulators. We then do not have as much influence over it as we would like. I am trying to come up with a health care system that

permits people to live with the American dream, to become all they are meant to be.

The current systems often penalizes someone for seeking higher employment. You are penalized if you try to educate yourself. You are penalized very often for doing things that we consider to be good in America. Those are the sort of things I would like to address. I am not trying to iron out all the conflicts. I think those conflicts are always going to be there. I would like to get them out in the open more and more then down to the local level.

Mr. DREW. Sure. And I agree with you again, Senator. I think many of those are problems of the interplay between public and private insurance programs.

I know the lady who testified earlier, there have been bills in our South Dakota Legislature for 5 years to create a risk pool for medically uninsurable individuals. And everybody in Peer is in favor of it—everybody—but nobody will pay for it. The insurance companies do not want to increase their premium tax to pay for it. The patients understand that they cannot afford the premium because of the very nature of the condition. The providers do not want to pay for it by simply even paying 50 cents on the dollar. For a dollar of care pay me 50 cents. And State government says, "Gee, we cannot pay for it because we are kind of busy over here with Medicaid and building roads and bridges."

That issue is again, unfortunately, I think comes down to one of financing. Like the moving from one insurance vehicle to another from one employment to another is the same type of thing.

Senator KERREY. The high risk pool is a terrific example of how you never eliminate conflict. We have a high risk pool down in Nebraska. I think it works very well, but it is a long way from perfect. We get lots of terrific examples where employers are without question dumping off risk into the pool. They measure it as high risk only because it costs them more than they want to pay, which is nothing.

Senator DASCHLE. Gentlemen, thank you. We appreciate your presence.

Mr. DREW. Thank you, Senator.

Senator DASCHLE. We are actually out of time as far as the schedule goes for additional testimony, but I know a lot of people want to be heard. So I am going to make some additional time to ensure that people who have come to express themselves will have the opportunity to do so.

If you would do two things: First of all, if you would identify yourself and where you are from so our official recorder can be sure that we have the names of those who wish to express themselves. And then secondly, if we could keep it somewhat brief. We want to be sure that we can afford everybody an opportunity to have some say.

So if there are those who wish to express themselves, there is a microphone there or there is a microphone down here.

STATEMENT OF TED BLAIR, PRESIDENT, UE, LOCAL 1128, SIOUX FALLS, SD

Mr. BLAIR. My name is Ted Blair. I am president with Local 1128 here in Sioux Falls. I am about to say that I am somewhat disappointed today because I do not think I heard enough testimony from the people that we should be hearing it from, and that is people that need the health care. That is where the problem is.

I can tell you that it is a nightmare for the people who do not have insurance or who are underinsured; and I can say it from first-hand experience because I have had some bad problems with it. Back about 8 years ago my daughter started having seizures. She had to have a battery of tests. I did not have insurance at the time. And each test she had to have had large price tags on them and I became seriously in debt.

And between my wife and I both working we barely had enough money to pay for our living expenses. We had nothing left over. And we could not pay for these tests. We had bill collectors coming after us. We tried to pay them a little bit, but when we would give them a little bit, then we would get behind on our other bills and I ended up to the point where I had 13 judgments against me. I had my wages garnished. And I finally, it took me a long time because I couldn't have the money to go bankruptcy like I wanted to, but finally my wife got a book and she went bankrupt, we went bankrupt. She did it herself.

But my credit is just completely ruined because of this and it is not because I went and borrowed money that I didn't pay back or I charged things that I didn't need. It is because my daughter was sick and we could not afford the health care for her.

Also I think I just recently heard him say that the problem with people getting the care. I think the gentlemen sitting right up here said that there isn't that much of a problem. Well I am going to have to disagree, there is a serious problem on that.

Two years ago my wife broke her ankle. We do have health insurance now. It is not good, but we do have it. And 2 years ago my wife broke her ankle. She went to the emergency room at the hospital. They put a temporary splint on her ankle and told her that she had to the doctor and get a cast put on. Well she never did get a cast put on because they told her we had to have the money up front before they would do it and we do not have that kind of money. She went to three or four different doctors here in Sioux Falls and she did not get a cast put on her leg because we did not have the money up front to do it.

And then for our health care the cost is getting seriously out of hand, I believe. As president of Local 1128 I have negotiated two contracts with our union and it is getting to be the thing where you are negotiating harder for health coverage and health insurance than you are for your wages. And because of it your wages are going down. Because the company, you know, if they provide health insurance they are not going to give you as much on wages.

I know it is not only here in Sioux Falls, but it is a nationwide problem. With the UE we have two unions on strike right now strictly over health insurance.

That is all I have to say. You wanted it to be brief. I could probably go on for another 10 minutes.

Thank you.

Senator DASCHLE. Thank you.

STATEMENT OF LLOYD WAGNER, PATHOLOGIST, SIOUX FALLS, SD

Dr. WAGNER. I am Dr. Lloyd Wagner, a pathologist in Sioux Falls. Until last year I was director of McKennan Laboratories and at present I am president of the College of American Pathologists.

I am here as a private citizen, but I would imagine that some of my statements might reflect the views of my organization as well. I think some of the things that have been said here this morning are very appropo; and that is the implied or alluded to statement that we need to have a health care policy in this United States. I think one of the problems today is we do not have that health care policy. We have a politically, fiscally driven sick care policy.

I think that because of that we have things that are done, perhaps inadvertently, by Congress and by the regulators that make the situation worse. I would like to call attention to two issues that I think will have not only a long range, but a short range, very negative impact on health care in South Dakota.

In late 1987 there was publicity about adverse cytology preparations and interpretation and some bad publicity about the quality of laboratory care. This led to a good deal of media attention and in the Congress in 1988 there were a series of hearings, at three of which I testified, on regard to laboratory quality.

In August of 1988 the Health Care Financing Administration published a set of regulations for laboratories that applied to 12,000 Medicare labs in the country. And later that year Congress passed the Clinical Laboratory Improvement Amendments of 1988, which extended control to all laboratories in the United States, including physician's office laboratories for the first time.

The August 5, 1988 regulations were finally published in final form on March 14, with a 60-day comment period as a result of extensive lobbying because of the adverse and onerous provisions of that particular set of regulations on the accessibility of patients to laboratory services in this country.

On May 21 of this year the proposed regulations for CLIA 1988—the Clinical Laboratory Improvement Amendments—were published. These regulations have some provisions which will do exactly the opposite of what is intended—that is, the intentions of the regulations and of legislation was to improve quality in laboratories and to provide quality service to all patients access and at an affordable price. I pose it to you that these regulations will have exactly the opposite affect.

In the final regulations published March 14, our provisions for cytology, for instance, which will make it virtually impossible for many pathologists now doing cytology to continue to do so. One pathologist in South Dakota who handles some 6,000 to 8,000 cytology preparations a year has stated that he will not be able to continue that service because he cannot find the people to do it and the reg-

ulations are so onerous that he will not any longer provide that service.

Senator KERREY. Are you saying cytology?

Dr. WAGNER. Cytology, yes—pap smears.

Senator KERREY. I thought you said psychology and I was trying to figure out what you pathologists were doing in psychology.

Dr. WAGNER. Pardon?

Senator KERREY. I thought you said psychology. I wrote down psychology.

Dr. WAGNER. No, not psychology. We would like to use some psychology once in awhile. [Laughter.]

Anyway, that provision is scheduled to go into effect. We do not know whether we can get that changed or not.

In the proposed regulations for CLIA 1988, there are three levels of laboratories proposed. One is a waivered list of tests for which no requirements for quality, efficiency testing or anything else be required. Based on what I consider an oxymoron in the legislation, and that is that if the test has no risk to the patient, that can be waivered if it is incorrectly performed.

I would propose to you that a fecal accult blood, if it is incorrectly done, can miss the opportunity to diagnose and treat a carcinoma of the colon. A hemoglobin or immadacrit, if incorrectly done, can have the same effect. It is really illogical in this regard. The other regulations in this proposed rule will make it virtually impossible for small hospital laboratories in South Dakota and physician's office laboratories to comply, which means that there will be decreased access to laboratory services, that costs will go up. And it is the opinion of the medical community involved in laboratory examinations that quality will not be improved.

Thank you.

Senator DASCHLE. Thank you.

STATEMENT OF CHARLES ROSE, REPRESENTATIVE, SOUTH DAKOTA MEDICAL GROUP MANAGERS ASSOCIATION

Mr. ROSE. My name is Chuck Rose. I am here representing the South Dakota Medical Group Managers Association. We are the folks that are in the trenches daily dealing with the financial conflicts amongst our physicians, the patients they treat and the people who pay for their services. We have submitted some prepared remarks.

I would like to merely call your attention to one major issue for us, and I think for South Dakota in terms of rural health care. That is the current treatment of the Medicare fraud and abuse provisions and safe harbour regulations.

No two individual medical groups can cooperate to provide better services under these proposed regulations. As we look at them today our group in Sioux Falls could probably not provide a locum tenus legally without being prosecuted by the Department of Justice for trying to solicit Medicare patients. We would have to have a 1-year contract in order to provide a weekend's worth of service.

Down the track we think this is going to further delay and injure any attempts to involve urban providers and larger groups in the

support and cooperation of independent smaller groups throughout the State.

We would appreciate your looking at that. The legislation was drafted when the Medicare Act was passed when medical organization was substantially different, when larger medical groups were not really that part of the scene as they are today, approximately 20 years later.

We would like to ask you to review it, to look at redrafting it with some new congressional intention to allow the medical groups of South Dakota and the United States to be able to cooperate in this effort.

Thank you.

[The prepared statement of Mr. Rose appears in the appendix.]

Senator DASCHLE. Thank you, Chuck.

STATEMENT OF FRANK BRADY, VERMILLION, SD

Mr. BRADY. Good morning. I am Frank Brady from the medical school in Vermillion. I am really here as a private citizen. I am a medical educator and a scientist and my wife is a nurse educator. She is here today. She is actually teaching and working in Nebraska. So it is nice to Senator Kerrey here today.

About 6 weeks ago I had the pleasure of participating in a Kelloggs Foundation seminar in Boston on ethical rationing of health care. When I first saw that title I thought, "What are we doing these days?" I would like to emphasize three main points that came out of that seminar which was joined in with many people from around the country from many different disciplines.

Two of the things we have heard today—and that is health care—and I think what we learned in Boston that week was that we are really involved in medical care costs. We are not involved in health care costs. We are involved in response to serious illness. We are involved in hospital driven—physician in-hospital driven health care provisions. We are not really focusing enough attention on how to provide health care at probably a much cheaper cost to this country.

And in many of the countries in which we have lower costs, you will find that there are lots of health care provisions going on, rather than medical care—response to injury and illness types of things.

The second one that has been mentioned here today is the major group of people in this country who are seriously underserved in terms of the types of systems we have. We just heard an eloquent personal comment a few minutes ago about that sort of thing.

I think what we learned in Boston at the time was that this large group of 30 to 40 million people are really not unemployed people. They are really not people who are out there not working. They are really what you might say the working poor in a sense, and their dependents—their children, their families. And they really do not have the access. We have heard that said very eloquently today.

But one thing I do not think we have really talked about today, and that is expectations. What are the expectations of U.S.A. citi-

zens, South Dakota citizens, Nebraska citizens, in regard to what they want to see.

I work in an environment in which daily new advances are being made in the ability to do things of a medical nature, in the ability to come up with new machines and equipment to prolong life. But the question that really has not been raised here, and I think really has to get into these discussions is: What do people want and expect?

Senator Kerrey says they want free care because, you know, they do not want to pay anything. But they also want perfect care. They want perfect outcomes. I think that is an unrealistic expectation. I think with all the publicity and all the television and all the medical advances that get lots of play on TV time that we expect too much. And just because we have the technical ability, usually a very high rate of reimbursement to prolong life, to do things, to do medical types of care, doesn't necessarily mean that that's what people want and expect to have for their own outcomes.

Because as we have an aging society, especially in mid-Western America, we are going to have more and more people who need more and more types of medical health care. They do not necessarily get a quality of life that they really would appreciate. I think we really have to look at expectations.

Thank you.

Senator DASCHLE. Frank, thank you. That was an excellent statement.

STATEMENT OF DANIEL STROH, SIOUX FALLS, SD

Mr. STROH. Senator Kerrey and Senator Daschle, I am Dan Stroh, ex-small businessman from Sioux Falls. I think a lot of people are not aware of what started this rising insurance cost. Back in the early 1970's I was quite involved in small business management and small business organizations. But in the early 1970's real estate got to be a good investment. All insurance companies invested in real estate. A few years later the real estate market went all to pieces, insurance companies lost lots of money.

They blamed it on malpractice suits, hospitalization and all this. And actually, it was just their faulty investments. I had four employees when I sold out and my insurance, Blue Cross/Blue Shield, went from $350 a month to over $1,000 a month at the time I sold out. I got good coverage for my employees because employees keep you in business. Good employees keep you in business.

My liability insurance went from $2,500 a year to $12,000 a year. Insurance companies were recovering the losses they had in real estate, but blaming it on malpractice and excessive hospital expenses. And this is not true. The Nation's Business carried a five-page article on this actual fact. I showed it to my insurance friends. They said, "That is the truth, Dan. That is the truth."

That is all. Thank you.

Senator DASCHLE. Thank you, Dan. [Applause.]

It looks like somebody agrees with us.

Mr. STROH. I think so.

STATEMENT OF DARRELL E. JEPSON, LINCOLN COUNTY COMMISSIONER, LINCOLN COUNTY, SD

Mr. JEPSON. Senator Daschle, Senator Kerrey, welcome to South Dakota. I am Darrell Jepson, Lincoln County commissioner. I would like to talk to you a little bit today. I have heard a lot of theories and strategies and programs. But I would like to talk to you a little bit about the costs of this health care.

As a county commissioner and as the county commissioners across the State of South Dakota, last year in health care alone we expended over $2.5 million just for indigent and health care. In the State of South Dakota, your local governments are mandated by South Dakota codified law 2813 to provide this care to anyone that is unable to provide it for themselves.

It is becoming a greater and greater burden on the taxpayers. You know, in this State we only have real property taxes to support our county government operations and it is becoming a greater burden all the time on the people. You figure that out, 700,000 people, we are looking at approximately $3.50 for every person in the State of South Dakota, just to provide indigent health care for those that cannot afford it.

One of the problems we face here in South Dakota is that more and more of our employers are going to a status of permanent part-time, whereby they just pay a wage to the person without any benefits. What this does, particularly it involves a lot of single parent families. And what this does, the people whenever they have an illness—the last thing they are going to buy is health care coverage. And whenever they have an illness they come to the County and we are burdened with this load. And it is a very difficult load.

It is a difficult program to budget for, to manage, because there are so many unknowns. We never know. Most counties in the State of South Dakota never budget enough for health care. The reason is, we do not know how much to budget. And, therefore, we have to go into reserves each year.

And in turn when people tell you in South Dakota, well, I was lucky I didn't have any health care costs, if they own any real property, gentlemen, I assure you that they did pay health care costs through their tax dollars.

I am a strong supporter of a national health care program. I think it is high time that we get on with this program. We need it. In South Dakota our wages were the lowest average earnings in the nation. Certainly our hospital costs are much less than in New York or the bigger cities, but yet our wages are much lower too. We need help and we need help in this area.

I think that a national health care policy should also take a hard look at incorporation on the VA health care programs, as a veteran I am well aware of that. And also the BIA programs that are offered. I think it should be combined, tied together. But really, Senators, this is a problem and it isn't going to go away. It is only going to get worse.

So with those comments I would like to present a couple of bulletins or packages of information that was put together by the South Dakota Department of Social Services with the cooperation of the County Association of County Commissioners and at this time I

would like to thank you for your kind attention and if you have any questions I will try to handle them.

Senator DASCHLE. Thank you, Darrell. We appreciate it very much.

STATEMENT OF CINDY STUDSDAHL, R.N., SIOUX FALLS, SD

Ms. STUDSDAHL. My name is Cindy Studsdahl. I am a registered nurse here in Sioux Falls. We have heard a lot today about the cost of health care, but we really are not addressing another issue, and that is the nursing shortage.

I know here in South Dakota it is not as major of a problem as it is in other areas of the country, but I think that is an issue that we need to look at also. I agree with Dr. Johnson that more money needs to be put into education for our health care providers.

Senator DASCHLE. Thank you for your comments.

Perhaps we can take two or three more and then we will probably have to go. We have a hearing over in Rapid City that we are going to have to get to. So we will probably finish this at about noon.

Go ahead.

STATEMENT OF JIM COTE, PRESIDENT-ELECT, SOUTH DAKOTA ACADEMY OF PA'S

Mr. COTE. I will be brief. Thank you.

My name is Jim Cote. I am a physician's assistant, over in Plainington, that works with Dr. Dean. I am president-elect of South Dakota Academy of PA's. I just returned from a week in New Orleans for the American Academy of Physician Assistants National Meeting. I spent a lot of time in committees and hearings and everything else.

I think the one thing that came out there that gave me a big boost is the resource based relative value system that is being considered. I think it is imperative that you pay particular attention to what comes out of that committee. On two different occasions—I have been out in rural South Dakota for 11 years and am not considered one of the high paid people around the nation. On two different occasions I have said, hey, I have people come and say, "Jim, we are looking for people like you with much experience and we will pay you about twice as much as what you are worth." Or twice as much as what you are getting. [Laughter.]

Twice as much as what you are being paid right now. What it basically boils down to is that why, if I can put in a half an hour of doing an excellent preventive care, am I not getting the same payment as somebody that is doing surgery or something along that line. So the relative value system is very important. I urge you to pay particular attention to that committee.

Thank you.

Senator DASCHLE. If you are a PA in a rural area, nobody can pay you twice what you are worth. [Laughter.]

Mr. COTE. Thank you.

Senator KERREY. You would have to be a Senator to get that. [Laughter.]

STATEMENT OF JEAN HINES, EMPLOYEE, ORTHODIC AND PROSTHETIC CENTER, SIOUX FALLS, SD

Ms. HINES. I am Jean Hines and I work for Orthodic and Prosthetic Center in Sioux Falls here. We make all types of body braces and artificial limbs. We do quite a bit of work with people with foot deformities, arch supports, corrective shoes. This is one thing that is not covered by Medicare. If Medicare denies it, Medicaid will deny it also in the State of South Dakota. Most insurances do not cover arch supports.

We have made several types of inserts for people's feet to clear up diabetic ulcers. We fit people with certain kinds of shoes that do heal these diabetic ulcers and also do help the poor circulation. Medicare will cover the cost of a leg amputation and artificial limbs, but they will not cover the preventative to prevent this, such as the arch supports in shoes.

Since we have been in Sioux Falls this is just really on the increase, these type of orthotics. I guess I would like to see something trying to be done about covering these items. I do not know if Medicare would cover them if other insurance companies would go and cover them in the future then or not.

The State of Minnesota and Nebraska, if we get prior authorization, they will cover corrective shoes or the custom molded, like for the rheumatoid arthritis, where the feet are so severely deformed. But South Dakota has not been covering these unless they are attached to a leg brace.

I guess I would like to see something more done to help this area.

Senator DASCHLE. Thank you very much.

Ms. HINES. Thank you.

Senator DASCHLE. We appreciate that, Jean.

STATEMENT OF DR. LOREN TSCHETTER, SECRETARY, AMERICAN SOCIETY OF INTERNAL MEDICINE AND THE AMERICAN COLLEGE OF PHYSICIANS

Dr. TSCHETTER. I am Dr. Loren Tschetter. I am a practicing oncologist in Sioux Falls, which is a cancer specialist. I am Secretary of the American Society of Internal Medicine and the American College of Physicians, that are two internal medicine organizations.

But what I am going to say is just a personal comment. Dr. Dean made this point, and I think it is very important, that to have access to health care you have to have physicians. It is my perception that there are many students not going (a) into medicine; and (b) certainly not going into the primary care specialty based largely on government policies for reimbursement that are not fair.

Now I am not quite convinced that the Harvard relative value scale will correct this. I think there is a lot of lip service to this by HCFA. But when the figures come down as Frank Drew said, in terms of hospital reimbursement, they are not much different for primary care reimbursement, in South Dakota under the new rules either. In fact, many of the things that we cover are reimbursed at a lesser rate under the new program.

For example, just daily hospital visits. I have no economic complaints with my current salary. I make an adequate amount of

money to live. But it does not fit that the Harvard relative scale may correct the things that it was planned to correct. I think this really will influence access to care if you do not have those kinds of physicians down the road. I think you should think about that one.

Senator DASCHLE. Thank you, Loren.

[The prepared statement of Dr. Tschetter appears in the appendix.]

Senator DASCHLE. We will take one last comment if somebody wishes to come to the microphone.

STATEMENT OF DALE CLYDON, TREASURER, UE, LOCAL 1128

Mr. CLYDON. Yes, my name is Dale Clydon. I am treasurer of Local 1128. I had an automobile accident on December 1, 1988. The medical expenses on it really weren't bad—$2,100. But that accident, because of that accident, I had the group insurance that my plant carries, denies me any insurance at all. I have none, because of one accident—$2,100.

Senator DASCHLE. Dale, thank you for your comments.

It takes a little courage for somebody who is not used to microphones and public meetings to come up and express themselves. I want to thank all of those who have done so. I am especially grateful to you. You have given eloquent and compelling testimony, and I appreciate that. Hearings like this are extremely helpful because often times people who have come to this microphone do not always have the opportunity to come to Washington to express themselves to Senators out there.

So we are particularly grateful to all of those who have come to make this hearing especially successful.

That concludes the hearing. We are going to keep the record open for a week's time. If anybody wishes to add to what they have said, if they believe there are others who are out there who ought to express themselves and may not have come today, by all means encourage them to present testimony.

We want to provide as balanced and as open an opportunity for everybody to be heard as we can or these things are not worth the time or the paper they are written on. So it is very important. So let me again reiterate my thanks to all those who have participated. Let me thank the South East Vocational Technical Institute for use of their fantastic facility here. They have made us feel very much at home.

And let me thank my colleague, Senator Bob Kerrey, who as you can see from his presentation this morning has a lot to contribute to this whole debate.

Thank you all very much. [Applause.]

[Whereupon, the hearing recessed at 12:01 p.m., to be reconvened in Rapid City, SD.]

RURAL HEALTH CARE CRISIS

SATURDAY, JUNE 2, 1990

U.S. SENATE,
COMMITTEE ON FINANCE,
Rapid City, SD.

The hearing was convened, pursuant to recess, at 4:08 p.m., at 353 Fairmont Boulevard, Rapid City Regional Hospital, Hon. Tom Daschle presiding.

Also present: Senator Kerrey.

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. This is a hearing sponsored by the Finance Subcommittee. We are honored to have Senator Kerrey from Nebraska with us today representing the Appropriations Committee. Appropriations, of course, has a major responsibility in paying for much of the health care the government provides; and the Finance Committee is charged with the responsibility of setting a lot of that policy. So it is a rare opportunity for a member of the Appropriations and Finance Committees to work together to conduct some hearings and to gain a better appreciation of the state of health care in rural America.

We have a number of witnesses who will be presenting formal testimony, but then we are going to leave some time at the end for any oral testimony that some of you may wish to present. The hearing record will be kept open for at least a week after the close of the hearing this afternoon. So anybody who may wish to contribute following today is certainly encouraged and welcome to do that.

Bob and I have conducted a couple of hearings already. From here we go to Scotts Bluff, NE tomorrow for the last of what will be four hearings. It is a real pleasure for me to conduct these with Bob. He has already established a reputation and real leadership credentials with regard to health care policy.

He has devoted the first 2 years of his career in the Senate largely to health policy and as we have talked, as we have considered our options, as we consider our States, we find that we have a lot in common; and a common interest in pursuing health care policy to address some of the challenges and concerns that we face, not only in our two States but across the country today.

As I travel around South Dakota I find that there is a tremendous diversity in health care. We are in what I consider to be one of the finest health care facilities in the upper Midwest if not the country. I do not think health care gets much better than we find right here within Rapid City Regional. It is the best.

Unfortunately, as I travel across the State I do not find Rapid City Regional caliber quality in all the locations that I visit, just even in the last week. So we have a disparity in health care and as I look at the different options that we have and the different challenges that we face in addressing health care today, I find that we really have three challenges. Those challenges are related largely to cost, access and quality to a certain extent.

The cost question is the one that most people bring up as I travel across our State today. People are concerned about the cost of health insurance. They are concerned about their inability to pay. And as we look at this chart their concerns are legitimate. We have seen a 100-percent increase in the cost of health care in the last 10 years. But as this chart indicates we now spend around $2,560 each for health care costs in the United States.

These overall health care costs compare somewhat unfavorably to other countries. The United States is here at the bottom. These are 1987 dollars. The graph goes all the way up to one of the cheaper countries, Greece, where people pay $337 per capita. Obviously in some cases people will rightfully say you get what you pay for. This is certainly true when it comes to technology; we have some of the finest technology in the country.

But when it comes to infant mortality and life expectancy, we really do not fair as well as other countries. We are twentieth today in infant mortality; and that infant mortality statistic is one that is based on reasons other than, obviously, the technology that we have in this country.

This is another graph which shows where we stand with regard to other countries. We are up here—we have the single most expensive health care system in the world. Canada is second. And it goes all the way down, at least as far as this chart goes, to Turkey, which is eighth, down here to around $200 per capita per year.

The costs per capita, of course, are one way to look at it. The cost as a percent of our gross national product is another. Britain is 6.2 percent; Canada is 8.5 percent; the United States is about 12 percent of the gross national product. Life expectancy, of course, is about the same—75, 77, and 75. The percent of those people not covered by health insurance is one of the biggest concerns that people have as they address cost—14 percent in the United States. Of course, everyone has health insurance in Canada and Britain.

It is not just a health issue any longer. It is a competitive issue. A recent study was done as to what health care costs are as they relate to products that we manufacture. As they relate to automobiles I think the comparison is somewhat striking—$700 of every automobile we purchase today goes to health care costs. In Canada, it is $223; in Germany, it is $337. So cost is a problem that policy makers are looking at within the United States.

That question of cost relates directly to the second issue and that is access. We have about 35 million Americans—14 percent of the population—who have no health insurance; 64 million Americans who have no health insurance at some time during a 28-month period. But health insurance is only one aspect of access.

Access is also defined by the availability of facilities and personnel. And this chart shows where we are within South Dakota in terms of the access to a primary care physician. The blue area rep-

resents those counties in South Dakota that currently have no primary care physician. The yellow area represents those counties where we only have one to three primary care physicians. It is only in the white area where we have more than three primary care physicians per county in South Dakota today.

So access to primary care, and access to facilities, is a problem. Sixteen counties in South Dakota currently have no hospital. That does not mean they are not getting health care. Because we have transportation and because we have adequate clinics in some areas, access is not simply a factor of the availability of hospitals.

But clearly as we look at national problems, both in rural areas as well as in urban, cost and access are the two issues that most concern the Congress at this point.

The quality question also now is coming to become more of a question of policy. Joseph Califano, a former Secretary of Health and Education and Welfare, indicated that of the $660 billion that we currently spend on health care, about $155 billion is spent on unnecessary medical procedures. The England Journal of Medicine said about 30 percent of all procedures today may be unnecessary.

Perhaps some of this is due to defensive medicine. There may be many reasons why duplicative and unnecessary procedures take place. But nonetheless, due to unnecessary procedures, due to the lack of access, due in some cases to the lack of adequate health care providers in some of these blue and gold areas, we do not have the quality of health care, especially in rural America, that we ought to have.

So that is really our purpose today, to talk about these issues, to talk about the relevance of these issues to rural America, and to gain a better appreciation of these issues, both from providers as well as from those who are users of our health care system.

As I indicated, Senator Kerrey has been one who has spent a tremendous amount of effort since he has come to the Senate and before as Governor of the State of Nebraska on the issue of health care and it has been a great opportunity for me as we have traveled through our two States the last couple of days to talk about these issues and to learn from him.

So let me ask him for any opening comments that he would have to make and then we will ask our first witness to come to the table.

OPENING STATEMENT OF HON. ROBERT KERREY, A U.S. SENATOR FROM NEBRASKA

Senator KERREY. Thank you, Tom. I would just say that it is a pleasure to be here. Not just to be in South Dakota, but to be with Tom Daschle. He is an extraordinary public servant and an awful good friend. I have been fortunate in my lifetime to have good friends along the way that have helped me out, that have been fun to go into battle with. It is fun to go into battle with Tom Daschle.

This particular topic is a pretty formidable battleground in my judgment. I can see that simply by the anecdotal stories that I hear from patients who are not getting the coverage that they ought to get, from patients who are confused about the complexity of Medicare forms, from patients who are confused about the complexity even of private health insurance forms, from patients who wonder

whether or not they are going to be able to afford the care, and from patients who have fathers or mothers that need long- term care or a whole range of other things.

I am hearing from individual citizens who are worried about health care in the United States of America. I am hearing from business people who are facing at least double digit increases in their costs, who are finding themselves dropping people from their rolls, increasing the deductible or co-payments, or essentially decreasing the coverage to their employees. I am talking to providers who are increasingly harassed with analyses of what it is that they are doing, finding themselves confused by the complexity of the forms they have to fill out in order to be able to get reimbursed.

I look at trend lines and see rising costs in the United States of America—$650 billion this year and expected to be close to $1 trillion by the year 2000—and right along side of that I see a trend line going up with individuals who are either uninsured or underinsured.

So I see that the trend line for cost is moving up to the right. Through a variety of mechanisms people have been able to control some of that. But it is still a double digit increase and it still exceeds the inflation rate by 6 or 7 percent. The number of people that are covered is also unfortunately going up to the right.

I see some good trends in that people are decreasing their use of tobacco; they are decreasing their use of alcohol; they are involved more in "wellments," in taking care of their own selves, in trying to prevent themselves from getting sick in the first place. But I still see an alarming number of individuals who are not doing that. I am still seeing an alarming number of individuals who are finding themselves with medical problems that in fact were preventable, that I find myself, as a taxpayer, and a citizen not too happy about.

I must tell you as well that I have had an awful lot of experience with health care and most of it has been good, even when I have complained. I was a patient in a Philadelphia Naval Hospital in 1969, received health care through the U.S. Navy for a period of about 9 months. I complained almost every single day I was there, right up to the edge of being court martialed most of the time that I was in that hospital.

If you listened to me at that time you would have thought I was getting lousy care. But if you looked at me a few years after that, you had to judge I got pretty terrific care. And if you talk to me today I would concur that I got absolutely excellent care in 1969.

I say that because I am very much aware that it is impossible under any circumstances to eliminate all the complaints. Because if I am hurting, I am going to complain about it. And if I get a bill, no matter what that bill is, I would rather not pay it. I would rather get it for free, if the truth be known.

So I am not looking for some solution that is going to iron out all the complaints or make this thing perfect. But I do not like the way the current system is operating. There are significant problems with it that I have observed. I am also very much aware that as a politician I need to follow the advice of the old doc whose first rule is, try not to make the patient any sicker.

I am very much aware it is possible for me to do something in an effort to make health care better and actually make it worse. So I appreciate, Tom, the opportunity to come to South Dakota to listen to all of you. I hope that whatever it is that I do as a U.S. Senator in fact makes things better for people who receive and provide health care. I think it is a very important objective for all of us in the United States today.

Senator DASCHLE. Thank you, Bob.

As I indicated we have a number of witnesses that represent as broad an array of providers as we could put on an agenda of this kind. We also have someone who is a person who has attempted to utilize the health system, Mel Jutting.

Mel, would you come to the table and present your testimony at this time.

STATEMENT OF MEL JUTTING

Mr. JUTTING. Thank you, Senator. It is a pleasure to be here this afternoon. All I have to say is that I am a candidate for a heart transplant. I found out December 1988 that I had a heart problem. I went through the hospital. My insurance, of course, was dropped and SSI picked me up for 5 months and they turned me over to Social Security. Now Social Security will not pay one dime for 2 years that I have to wait.

Well I went through the hospital, Abbott Northwestern in Minneapolis, and they found out that I had only 10 percent of my heart working and that I would have to have a new heart within 1 year or I will die. Well so far I have tried everything I could in the way of trying to get some help and nothing but a dead end street, no matter which way I go. So I am just—if I can hold out until July 1991 I will get Medicare. But until then, I just live day to day with the pills I take.

Now my only income is Social Security and out of that I have my regular monthly household bills; and around $300 a month medication bills that I have to take. I am taking 22 pills a day right now to stay alive. If I can live long enough to outlive the government, I guess maybe then I will be all right. But until then, I just live on a daily basis and the pills that I live on is all.

Now the doctors have all been good. The hospitals here have been good. Like Senator Daschle says, we have a very good hospital facility right here in Rapid City with very good doctors. But they can only do so much and it is just a matter of getting a near heart and the help to get that I am hoping for, that I will outlive the government to make that Medicare come true for me.

But it is just a chance that I take. Other than that, there is no hope, you know. I guess probably—you will have to excuse me because my breath leaves me all the time. I should have taken some oxygen, but I did not. Anyhow, this is where I sit.

Senator DASCHLE. Thank you.

Let me ask you, you have no health insurance today?

Mr. JUTTING. None whatsoever. It was canceled off. It would have cost me, if I could have afforded it, $487 per month. But they dropped me as soon as I had to quit working because I was on a workmen's comp, you know, is what it was, a group insurance

policy. And when I had to quit working I had 30 days which I recovered by myself and after that I was on, like I say, SSI and then after that why Social Security took over, then I lost that. So I don't have anything.

Senator DASCHLE. So are you eligible for Medicaid?

Mr. JUTTING. Well, no, because they tell me I get too much money from Social Security, that they can't even give me Medicaid. Now what the reason for that is, I never did get an answer. I have asked, but there is no answer except that, "Well that is the law. That is the law." And the same way with Medicare. I have asked why when SSI dropped me and Social Security picked me up, being disabled, that I should have been eligible right there for Medicare but they say no, I have to wait 2 years. And that will be 1991 July that I will be eligible for that. If I live that long. I don't know whether I can, you know.

Senator DASCHLE. Are you currently seeing a doctor?

Mr. JUTTING. Oh, yes, every 3 weeks or so.

Senator DASCHLE. Every 3 weeks?

Mr. JUTTING. Yes.

Senator DASCHLE. And so when you see him, whatever payments are made come out of your pocket; is that it?

Mr. JUTTING. Right. That is right. And I just cannot stand anymore. I have exhausted all my money for what I have had so far. I have one big one in Minneapolis of $10,000 to worry about.

Senator DASCHLE. Do you have a hospital bill?

Mr. JUTTING. A hospital bill in Minneapolis.

Senator DASCHLE. $10,000?

Mr. JUTTING. Yes, for 3 days.

They gave me all the tests down there and that is when they found out that only 10 percent of my heart was working. And right then and there I was a candidate for a heart transplant. But, they want $60,000 up front, which is what I do not have. And then after that we are still talking anywhere from $800 to $1,000 a month medication, even with a new heart. There is no hope, I guess.

So I am living on pills for that length of time. If I don't get any help, I will have to outlive that 2 years in order to get any help. And that is the answer that I want: Why did they drop me from Medicaid and make me wait 2 years for Medicare when I am permanently disabled? The answer is: "That is the law."

And there is no changing the law, I guess. So we will just have to sit and wait and see what happens.

Senator DASCHLE. Bob, do you have any questions?

Senator KERREY. Well, I will first of all tell you that if I were to take your case and try to work it through Medicaid, Medicare, or SSI or try to find out whether or not we could get some private pay coverage, which is essentially what we try to do, one of the first discoveries we make in that process is that democratic institutions are organized very poorly to enable us to make those decisions. I know because I have done it before, with veterans who weren't getting care, with individuals who need hospitalization and cannot get it, with individuals trying to get a doctor's care and cannot get it.

You know, it seems to me that what we need is some way to make that decision more often at the local level, rather than having to have Senator Daschle or Senator Kerrey introduce a spe-

cial piece of legislation to make the bureaucracy do what we think it ought to do. Now that is not to say that with a localized system that there are not going to be opportunities when the people are going to say, "No, we aren't going to make that expenditure." But we do not have that mechanism now.

We make everybody in this sort of situation go to welfare offices, go to hospitals, go from office to office trying to get an answer. Even if we do not change the way we finance health care in America—and I am increasingly of the opinion that we need to—it seems to me that we need to change the way we have organized the democratic decisionmaking process.

Most of the decisions now are being made in Washington, DC. They are being made in a thing called the Health Care Financing Administration, which controls both Medicaid and Medicare and sets the rules under which doctors and hospitals can provide the care, and under which they are going to get reimbursed.

Because that if we had a local mechanism to make that kind of decision, I suspect that you would have had that heart transplant long ago. I do not know if that is the case. It is entirely possible that there is an evaluation done at the local level and the heart transplant is not done.

What frustrates me, and angers me, is citizens getting the runaround from office to office to speak to local people without the authority to make the decision. So the runaround is understandable because they do not have the authority to make the decision in the first place.

Senator DASCHLE. Mel, thank you very much.

Mr. JUTTING. You're welcome.

Senator DASCHLE. Our first panel is comprised of Dr. Michael Pekas, the president of the South Dakota Medical Association; Dr. John Herbst, an internist who has directed physician networking for Rapid City Regional; and Allen Winchester, the past president of the South Dakota Chapter of the National Association of Social Workers. If those three witnesses could come to the table.

Dr. Pekas, thank you for coming. Since we call you to the stand first, we will invite your testimony at this time.

STATEMENT OF DR. MICHAEL PEKAS, PRESIDENT, SOUTH DAKOTA MEDICAL ASSOCIATION

Dr. PEKAS. Thank you, Tom. On behalf of the State Medical Association I would really like to thank you for inviting us here today.

Our concerns in rural health care in the State of South Dakota are the same as yours. We are very concerned about costs, access and quality. We are very concerned about the viability of our rural hospitals and how to keep them in these communities, keep them functioning with what is going on in increasing regulation that causes increase in their costs of operation and ultimately causes a lot of those hospitals to have to close their doors.

This not only affects the ability to deliver health care to the rural communities, but it causes a lot of problems in trying to keep, of course, physicians in those communities without a place to practice their art; and it also causes a lot of economic distress on the rural communities themselves. Because many times the largest

employer in a small town will be the hospital and the nursing home. And when those close it is like driving a stake right into the heart of the small community. They have a lot of difficulty surviving.

We are also very concerned about how we are going to put physicians in these communities because of the geographic maldistribution of reimbursement that goes on, you know, with the Medicare system. You know, why is it that physicians are reimbursed over twice as much in California, for instance, for the same examination that they receive from a physician in South Dakota? It has gotten to the point to where the lines have crossed for a lot of physicians in that it costs them more just in overhead costs alone to see the patient than they are reimbursed for.

They lose revenue on every single Medicare patient, for instance, that they see. And it becomes very, very difficult for those physicians to stay in practice in a situation like that.

We are also very concerned about recruitment of physicians into rural communities because of the cost of medical education. The average medical student will finish his medical education with I think it is almost an average of $70,000 in debt; and how are they going to be able to pay that back when they would like to go practice, for instance, in a rural setting and they know they cannot make a living there.

So it is a very, very difficult problem. We do not have any answers. We have suggestions. We would love to work with you in trying to solve these problems. But it is going to take, I think, a cooperative effort on the part of business, government, organized medicine and the insurance interests in this country to come up with some way to try to get a handle on all this.

But as far as we are concerned in South Dakota, we have the same concerns as you do. It is just that it is very, very difficult for us to do anything proactive when we are faced with a government bureaucracy that we are faced with.

Senator DASCHLE. Thank you, Dr. Pekas.

Dr. Herbst?

STATEMENT OF DR. JOHN HERBST, DIRECTOR, PHYSICIAN NETWORKING, RAPID CITY REGIONAL HOSPITAL

Dr. HERBST. Thank you, Tom.

My purpose today is not to present another litany of what the problems are and what is wrong with the rural health care system in our country. It is my first belief that this issue has been studied enough and that the time has come for very strong, bold, decisive and innovative decisionmaking on these issues.

Even as we speak rural hospitals are closing across our Nation. Projections continue to show that 600 or more hospitals will close within the next 5 years and once they are closed they will never reopen. Unless bold action is taken immediately—and I emphasize immediately—this situation of rural health care demise in our country most likely will reach a point from which it cannot be resuscitated.

The future productivity of our country is in large part based on the institutions of education and adequate health care for its citi-

zens. Across the Nation people are standing up and speaking out on the education issue. But all too few are willing to stand up and speak out on the demise of our health care system.

Senator Daschle, Senator Kerrey, I wholeheartedly thank you for being here today and being some of the insightful few who are willing to take a bold stand concerning this national crisis.

In the May 1, 1990 Annuals of Internal Medicine, the American College of Physicians presented what I consider to be just such a bold and innovative stance in proposing drastic changes in our health care system. I believe the stance is a landmark for a multiplicity of reasons. For the first time a group of organized physicians have stood up in mass and offered to contribute to the solution of this problem rather than to be once again against any change in the status quo of the system.

Secondly, this proposal by the American College of Physicians, again proposed by organized physicians, is an attempt to address these issues which are on the best interests of national health care and not just the issues that are best for physicians.

This proposal by the ACP will not be without its critics and I, myself, indeed having reviewed it intensively have some misgivings about the issues proposed. Nevertheless, I believe that this is a frame work and a foundation upon which a future plan for health care in our country can be based. The Laudus Christianous issue will state that this is "socialized medicine."

To date, few physicians or powers to be in political office have dared to bring this issue to the forefront. I, as a physician, am here to state that if we as physicians fail to contribute to the solution of this problem we will only ourselves be to blame when the solution comes to be without our input.

The nationwide over review of these issues which has brought us to this present crisis in health care clearly show that the same problems come up time and time to the forefront. These include adequate access to health care which is just another way to state that adequate financing is available for adequate health care for all of our citizens.

A second problem is that inadequate health insurance protection is both equitable and uniform to all of our citizens.

Thirdly, the continued and dramatic upward spiraling of health care costs to which administrative costs of present day health care insurance systems are overburdening to the point of being prohibitive.

Lastly, the current health care system in our country is involved into an incredible ineffective and burdensome system for patients, their families, and the physicians which undermines the access to adequate health care, as well as a patient/physician relationship as we have traditionally known.

In the short period of time allotted to me today it is impossible to discuss in detail all of the ramifications and provisions of the proposed ACP universal health care access proposal. A national health care program is needed to assure access of all Americans to an appropriate health care program and this access must be provided irrespective of age, sex, race, financial status or place of residence.

The existing program is growing ever more expensive and ever more ineffective. A new approach is required. I would like to state

that the health care system in the United States, to date, in my mind is undoubtedly the best that there is on the face of the earth. However, with the spiraling costs and the rocketing technology of modern health care a new approach is needed to assure citizens of this country are able to afford health care and to take advantage of the health care technology which is evolving.

In establishing universal access to a health care program, such as is available in virtually all other industrial nations of this world, all Americans would have specific health insurance benefits and financial access to health care. Administrative costs of current health care programs most likely would be lower because there would be elimination of the duplication and costs of excess billing, processing the claims, et cetera.

A reduction of only 1 percent of the total amount of administrative costs would save an estimated $5.5 billion annually in health care dollars. The obvious and logical question is how such universal health care program is to be financed. Costs can be paid from a multiplicity of areas, including tax revenues or by some combination of individual/employer premiums, supplemental insurance programs and governmental subsidies. Likewise, different peer levels could be individualized for payment between Federal and State funding.

Projected savings of administrative costs under such a program could be as high as $60 billion per year and these savings obviously could be shifted toward funding of such a program. Financing could be from general tax revenues, surcharges on income taxes, payroll taxes, or if we choose to attempt to keep President Bush happy in not having to say the "T" word, we could label it a user fee.

Cost containment and controls to avoid excessive and unwise use of such medical services obviously would be an integral part of such a program. Financing the implementation of such a program could hopefully be built on some strengths of learned experiences of existing health care mechanisms today. Again, time constraints preclude me from going into details of such a complex program.

As I have already alluded to, there certainly will be detractors from such a program. Certainly some of the loudest detractors again will be my fellow colleagues in the medical profession. Physicians are increasingly concerned today over the intrusion into medical care by outside forces. These outside forces have drastically changed clinical mechanisms as we have traditionally known it.

In the recent Medicare and most recently the DRG disasters have only worked to deepen the suspicions of physicians as to any other governmental interference into the health care industry. Any system which further diminishes physician autonomy in my mind is most likely doomed to failure. Nevertheless, once again physicians are for the first time willing to look at drastic changes.

In summary, the American college of physicians has presented what I perceive to be a bold, innovative and challenging proposal from nationwide health care. I think that without a doubt such a system is on the horizon and the American College of Physicians is asking by their proposal to be part of the decision making in this bold new venture.

I present it not as the ultimate answer to health care problems that we have today, but as a possible frame work and foundation upon which to build. Certainly major reforms today are necessary.

Senator Daschle, at the last hearings on rural health care I stated in my testimony that South Dakotans are extremely fortunate to have you representing them in these dilemmas. This statement is more true today than ever.

Over the last year I have written to you on a multiple occasions concerning these issues and each time you have personally replied to me and my correspondence. Today I wish to personally thank you once again for your continuing concern and efforts on behalf of all South Dakotans who are fearful of what the future holds for ourselves and our families in these areas of rural health care concerns.

Thank you.

[The prepared statement of Dr. Herbst appears in the appendix.]

Senator DASCHLE. Thank you, Dr. Herbst. That was an excellent statement.

Allen Winchester?

STATEMENT OF ALLEN WINCHESTER, M.S.W., PAST PRESIDENT OF THE SOUTH DAKOTA CHAPTER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Mr. WINCHESTER. Thank you for inviting me to participate in today's hearing on rural health care. I am a member of the National Association of Social Workers. The NASW represents 127,000 professional social workers and there are approximately 200 members in South Dakota. I am President of the State Chapter of Social Workers for another 30 days, actually.

NASW believes that the future of rural health care and the nation's health care as a whole lies in development of a national health care program. We have all heard the alarming statistics which point to the need for fundamental restructuring of our health care delivery systems and we have heard those today already.

These statistics are even more alarming in rural communities where a higher percentage of the rural population is uninsured at every income level. Rural poverty and unemployment rates are disproportionately higher than those for urban areas and only one-quarter of the rural poor qualify for Medicaid coverage.

The health care crisis is further compounded in rural communities by the shortage of primary care providers and services, particularly severe for obstetrical care and the growing numbers of rural hospitals which face financial strain and at times are forced to close.

NASW has a longstanding history of support for a national health program through which all Americans may receive equitable quality care. The Association believes that our current systems of health care and delivery are in a state of crisis and that we need to direct our attention to the development of a simplified single-payer national health program.

I would like to share with you an outline of a national health care proposal which was recently developed by NASW and ap-

proved by our national board of directors in April. I wish to warn you in advance that I am not a health policy expert. So I may have to defer specific questions on the plan to NASW's health staff at our national office.

I would like to outline this proposal because I believe that the health crisis in rural America and the Nation as a whole point to the need for a national health program which offers flexibility to meet the special needs of rural communities.

In the interest of time I will highlight a few features of the plan and request that my written testimony be submitted for the hearing record. The NASW national health care proposal fundamentally restructures our current fragmented and costly health care system. The plan is designed as a Federal/State partnership. The Federal Government maintains overall administrative control through strict Federal guidelines and taking authority. The State assumes the responsibility for delivery of health services and payment to all providers.

Principal features of the NASW national health care plan include coverage and enrollment. All persons residing in the United States would be covered through the national health plan. Coverage through employers or other privately purchased health insurance will be discontinued, although private insurance plans may provide coverage for services not covered under the national health plan.

Benefits: The NASW plan provides coverage for comprehensive health and mental health benefits. This includes disease prevention and health promotion services. Care coordination services, mental health services, substance abuse treatment programs, rehabilitation services, hospital services, in-patient and out-patient professional services, laboratory and radiology services, long-term care, including home and community-based services, hospice care, prescription drugs, dental care, hearing and speech services and vision care. Certain health services, such as cosmetic surgery, are excluded from our plan.

The NASW national health plan is intended to be more than a mechanism for ensuring access to health care. It provides a frame work for the delivery of quality health care. This includes primary prevention and health promotion services for everyone and emphasizes well baby care, prenatal care and school- based health programs.

Care coordination services that will ensure cost effective comprehensive coordinated care for individuals with multiple and costly health problems, comprehensive health delivery plans that promote integrated health services, and improved access to health and mental health services for underserved, intercity and rural population, increased support for community-based and mental health services and a reduction in costly in-patient care, and state screening and care coordination systems for the delivery of long-term care.

Cost sharing: Under this plan, there will be no deductibles. We also believe there should be no co-payments, although provision is made for co-payments, if necessary, to control utilization. Residents of nursing homes and other residential facilities would be required to pay a modest room and board fee.

Administration: The NASW plan seeks to streamline the chaos of our present health system into a single administratively simple and cost efficient system.

The plan calls for creating a national health board that would administer the plan nationally. This board provides the States with an annual lump sum or global budget for all covered State health care expenditures. The States will, in accordance with Federal guidelines, ensure the implementation of all State health services, determine the distribution of all health care funding, and provide for payment of all health care providers.

Payment to providers: Under the NASW plan, payment to providers will be carefully regulated to ensure reasonable payment while reducing administrative waste. Hospitals will receive a set annual global budget for operating expenses.

Other health care facilities, such as community clinics, nursing homes or rehabilitation facilities, will be paid either on the basis of a global budget or a per capita fee as determined by the State. Health care practitioners and group practices will in general be reimbursed on a fee-for-service basis. The reimbursement rate will be based on a national fee schedule for each classification of practitioner.

A newly established National Council on Quality Assurance and Consumer Protection is responsible for determining guidelines and monitoring the quality assurance systems. Peer review organizations extended to cover all types of health care providers and services will be responsible for utilization review and quality control.

Planning: The national health plan requires local, State and regional health planning efforts to ensure equitable distribution of all health resources and to target essential health needs of given jurisdictions.

Financing: The NASW plan could be financed primarily from a dedicated Federal tax on personal income and an employer-paid payroll tax. Additional sources of revenue could include a State contribution that requires each State to pay its fair share, a dedicated estate tax, and an increase in the cigarette and alcohol tax.

Small businesses would be protected by a cap on the amount they must contribute and new firms facing financial hardships would be protected by a reduced payroll tax for the first 3 years of operation.

Training and education: The health plan provides Federal support for [illegible]e existing and new programs that will, for example, increase the supply of needed health care personnel, encourage more health practitioners to work in underserved areas, and support new approaches to continuing education programs in rural areas.

Regarding research, while only touching on this briefly, the proposal provides funds for a range of research efforts that include support for continued biomedical research and the need to develop practice guidelines that can assist physicians and other health care providers.

NASW believes that a unified national health program can achieve enormous savings, savings which may be redirected toward truly comprehensive health and mental health services for all, including those of us who live in rural communities.

Thank you.

[The prepared statement of Mr. Winchester appears in the appendix.]

Senator DASCHLE. Thank you, Allen.

Let me just ask, Dr. Herbst, since the announcement of the College of Physicians—and I guess I would ask Allen the same question—what kind of reaction within the health care community have you received? Has there been much discussion? Has there been just an avalanche of criticism, concern, support? How would you describe what kind of reaction there has been so far?

Dr. HERBST. I was at the South Dakota Rural Health Care Conference about a week ago and the issue came up there after discussion by a physician from Oregon when he was presenting a Statewide health program for Oregon which is obviously being watched very closely by a lot of people.

A lot of people in the hallways and stuff that I talked to were discussing these proposals. I have been amazed at the support there has been for it. One thing I touched on is, more and more physicians are again saying we really want to be a part of this. In the past lots of physicians tended to say, you know, things are working fine. To be blunt about it, we did not want anything changed.

There is definitely criticism out there. But more and more physicians are saying, look, we did not participate in the DRG decisions and they have been a disaster for physicians. More and more physicians realize that what is going on now is not working and that something is going to change and physicians I am talking to are more and more saying, I would like to be a part of that change. They know it is inevitable. We would like to be part of it is what I am hearing.

Senator DASCHLE. Allen, what have you heard?

Mr. WINCHESTER. I haven't heard a great deal. Our proposal is just hot off the presses. It was passed by our national board in April and it was sent out via a newsletter to members within the last couple of weeks. So I quite frankly have not heard what the reaction is.

Senator DASCHLE. Would you say it is the severity of the situation that has caused these plans to be proposed or is it a change in the internal politics of the organization? What is it that has changed, in your view, in the last few years that have triggered these things to happen?

Mr. WINCHESTER. I think that the high cost of health care is part of the problem. And I think the fact that there are a number of individuals who simply do not receive the health care they need, are not eligible for insurance. Mr. Jutting talked earlier today. I think that that is a good indication that there are, I think, 27 to 37 million people who are not eligible or do not have health care insurance.

It is my understanding that our national health care system is in chaos. We believed we needed a complete new system to handle the problem, rather than doing piecemeal changes in the system.

Dr. HERBST. Yes. I think multiple scenarios have brought it around for physicians that I have talked to. First off we see the disasters of the DRG type program and now physicians were not allowed to participate or did not participate in that and it crashed. Over the last several years the watch word on the Reagan years in

our country or one of them was deregulation. In most industries deregulation was rampant, except in the medical care industry where in the last 8 to ten years regulation has been absolutely incredible. Physicians, again lost of autonomy, loss of control, loss of their ability to practice medicine as they were trained to as come to the forefront.

Physicians, I think, are seeing more and more that that is not all going to go away, that it is the old story of work with the system or it is going to break you. What is going on now will destroy health care as we have known it. The physicians I am talking to—and certainly there are critics who are still saying, we do not want any part of this socialized medicine. But there are more and more saying again it is going to change. We are beginning to see more and more that that is most likely. If it is going to change, we want to be part of the decision making so health care is not hurt more, so physicians are not hurt more.

Senator DASCHLE. Dr. Pekas, has the South Dakota Medical Association had much of an opportunity to discuss these or other proposals? What would your membership say about something like this at this point?

Dr. PEKAS. Well we certainly do discuss this a lot. The AMA has a plan, as you are aware—Health Access America. It is a way to try to cope with the problems we have been discussing here.

But I think there is a general feeling on the part of the physicians that they are willing to see the health care system change. But we are extremely concerned about the quality of the health care delivery system that would result and extremely concerned about access. We do not want to see a problem instituted that would ration medical care. And we do not want to see a problem that would allow poor quality Medicare care to be dispensed.

And when we look at, for instance, other countries and their health care programs, we find that a lot of that does go on. We are extremely concerned about that.

Senator KERREY. Can I follow on your statement that you do not want to ration? We just had a man up here who needs a heart transplant and is not getting it. Certainly we are rationing to him.

Dr. PEKAS. Exactly.

Senator KERREY. So we do have a rationing system in place. If you do not want to ration, how do we deal with that?

Dr. PEKAS. We are just going to have to try to come up with a plan that will allow enough control of cost, I guess, in order to afford, you know, the quality of health care that we need to have in this country. Now I am not quite sure just exactly how that is going to occur or how that can happen.

You gentlemen are the ones that are going to have to come up with the answer to that question.

Senator KERREY. If you knew my knowledge about health care that fact would frighten you. [Laughter.]

Dr. PEKAS. But basically that is one of the reasons why the three of us up here are so concerned, because we have a health care system right now that is beginning to fall apart.

Senator DASCHLE. Do you think that it is possible—and, like Bob, I'm still learning. But the sense I get from Allen and John and the groups they represent is they have come to the conclusion that if

you are going to control costs and provide access that a single payer system is really the only way to do both. That you can provide access by mandating health insurance, but as long as you have third party payer you really cannot control cost.

Is there a way of controlling cost in a third party payer concept?

Dr. PEKAS. Well, you know, I would like to—I would like to see a system that could function with the existing payment sources that we have in this country. The reason I feel that way is because I am suspicious or I guess I do not, from seeing what the Federal Government has done in the past, I do not think that it could really get a good handle on providing good quality at the expenditure level that is available.

Because one of the problems is overhead. I mean the overhead costs.

Senator KERREY. Let me try to give a rather quick summary of 50 years of health care and the Federal Government's involvement. One of the first steps was saying that we were going to provide tax deductibility in order to encourage people to purchase insurance. Then somewhere along the line we began to intervene directly with the construction and hiring of physicians directly. In some cases it was people like me in the Armed Services; in some cases it was through the Veterans Administration; in some cases it was for the poor.

We intervened more dramatically in the 1960's with Medicaid and Medicare—in the one case for the poor and the other case for the elderly. It seems to me that in almost every one of those cases is we have had only a partial intervention and tried to fix only one piece of the system.

One of the things that is very difficult is that in the political world, the incentive is to say yes. If you have somebody coming to you asking you for something it doesn't matter whether they are conservative or liberal, by the way. I am always amused that I get far more conservatives than liberals coming to me asking me for money.

But nonetheless, the incentive is there for the politician to answer the question yes. And it seems to me that in health care we need to establish some democratic way for the people to occasionally say no. For the people occasionally to be able to look back to the patient now and say, "look, if we are extracting $50 billion of our health care expenditures as a consequence of people who smoke cigarettes, I for one do not enjoy subsidizing that kind of behavior." And there are other examples that are similar to that.

I for one am not thrilled about the possibility, particularly now that I hear your proposal. The problem that I hear with your proposal is that there is no checkpoint. There is no check against you. I am quite serious when I say that my health requirements are far greater than anybody's.

There is not a health professional in the world that can give me what I want because I never want to get sick. And if I do I want it cured just like that. I don't want any pain. I don't want to get old and I want it all for nothing. In truth, if you ask me what I would like in a dream world, I want perfect health and I want it free.

Maybe some of you are different than I am. Maybe some of you do not have that base line sort of desire to get more than you are

entitled to. I am concerned that unless we create some kind of check that we are going to drive the cost of this clear off the charts. We are going to end up with more bureaucracies in Washington, DC, trying to control costs than we have right now, more paperwork than we have right now, and even greater deterioration between the patient and the care giver then we have right now.

It alarms me that we do not have doctors and patients anymore. We have consumers and providers in this country in an adversarial relationship. I think it is possible for practically every solution that I have heard thus far for us to make that worse, unless we have some way to establish a check on the natural appetite for health care that is there.

Senator DASCHLE. Dr. Herbst or Allen, is it possible, from your experience and from the conversations you have had with others in the field, to devise a way through third party payer for us to control costs? Can we do it effectively?

Dr. HERBST. I think it can be done.

Senator DASCHLE. What would be the three or four essential elements to cost control for the third party system?

Senator KERREY. Can I add an amendment to that?

Senator DASCHLE. Sure.

Senator KERREY. And improve the relationship between the care giver and the patient.

Dr. HERBST. That is where the difficult part comes in, obviously. You know, as far as giving you hard and concrete things right now, I cannot do it. It is a very difficult situation.

In the job I had before I took the position here with Regional, I worked in a situation where we attempted to control costs and it can be done. They are very complex, very complicated; and one of the big problems with them is that the administrative costs of such a program become intertwined to such an extent that the administrative costs become so prohibitive, again, taking and subtracting away from the health care dollar available.

That is what is going on at this point. So much of our health care dollar is being spent towards the administrative costs. When the dollar filters down to actual, honest to God, hard core health care dollar, it is not there. It is minimal.

Can you control costs? It can be done. They are very difficult. There is not an easy solution. It has to be done through utilization control, abuse control by the patient and the physician. When you talk about utilization programs or control programs, you usually talk about, well you have to control the physician usage of the program. You have to control both sides of it.

You have to control the patient utilization. You cannot be showing up at the emergency room at 3:00 in the morning for a back ache you have had for 7 years. Some back check controls like that have to be in place.

It is an uncomfortable type program when you are talking control of costs from both the provider and the utilizer standpoint and therein comes a rub. Unfortunately in our country the public has had the opinion, on two concepts that I think drastically need to change if you are going to have an efficient control program: (1) My health care, my doctor, my health care provider will always be there; (2) health care is my right.

Those concepts have got to change. Your doctor may not always be there anymore because you cannot afford him or he cannot afford to be there. And health care is not your right. It is a business and nobody wants to say that. What is your right in health care is that when you do seek medical care that you can get the best possible.

Nobody feels comfortable with saying, well health care is not really my right. Health care is a commodity, unfortunately.

Senator DASCHLE. Well thank you, gentlemen, very much. We appreciate your coming.

Our second panel is comprised of Dr. Robert Talley, the vice president and dean of the School of Allied Health Sciences and Medicine at USD; Dr. William McBreen, the head of the department of research and special services in the College of Nursing at South Dakota State University; and Gary Riedmann, the president and CEO of Rushmore Health System.

Dr. Talley, we are pleased that you have driven across, or flown, traveled in some way, all the way across the State to get here this afternoon. It probably would have been more easy to have you on the other side of the State, but we appreciate having you in Rapid City; and thank you for coming. We invite you to present your testimony as you see fit.

STATEMENT OF DR. ROBERT TALLEY, VICE PRESIDENT AND DEAN, SCHOOL OF ALLIED HEALTH SCIENCES AND MEDICINE, USD

Dr. TALLEY. Thank you, Senator Daschle and Senator Kerrey. I would like you to think that I traveled only for this meeting, but the truth was, I was here for a meeting for the past 3 days. So I just stayed a little longer. I am flattered, I think, to be here to testify. The reason I add the "think" is, it is flattering that many people believe educational institutions can answer problems as complex as health care in this country. While flattering, it is also a little frightening, to tell you the truth, to be put on the line to say what to do about those things.

One of the charges Danny gave me was to talk about my vision of rural health care in the year 2000. The truth is, I am not entirely sure of November yet, but I will do the best I can to look at 2000. I guess philosophy is really what you talk about when you end up talking about the future. My philosophy is that medical schools should train physicians to meet the needs of society.

In South Dakota, as we have heard today, I believe a school such as the University of South Dakota Medical School must prepare physicians to meet the needs of rural health in our State. My vision of the year 2000 is that we will have a system of hubs and spokes and that the hub will be the base of the health care personnel, especially physicians. It will be the hospital a base and it will be the center of acute and chronic care. The physician staff will depend upon the size of the hub, really, the number of spokes served.

For example, Hettinger, North Dakota, which I think is the best example of the hub-spoke model, a town of 1,800 has 15 physicians

in the community, but it serves 8 outlying areas on a daily basis for health care.

I believe most of the physicians in such a system will be primary care physicians and family medicine will dominate. I think we will have internal medicine, OB/GYN, perhaps pediatrics, and I believe we will have surgery for the needs of the dollar in order to keep such a system alive. Radiology will be necessary whether they will be in each hub or whether they will serve several hubs I am unsure for the future.

There will be allied health staff at the hub, OT/PT, et cetera. I believe that high tech data transfer systems will be part of the answer, rather than high tech always being the problem as we hear, because I think we will be able to transfer a tremendous amount of data from onsite to centers where they can evaluated with almost instant return of those results without having all the specialists at the hub necessary to do the interpretations.

I also believe that high tech systems will be the answer for onsite education in order to improve the health care and the quality of the physicians and other health personnel.

The spoke may be served by full-time individuals, either physicians or physician assistants or nurse practitioners. A team will travel out to the spokes and the makeup of the team will depend upon the needs of the community. If that community is heavily geriatric in population, then I think the team will be those who are specialists in that area or trained in that area—chronic illnesses, pediatrics, et cetera.

If this really is what is going to happen, if my vision is correct, then you have to ask what kind of physician should a medical school train in order to meet that need. I think the physicians are going to have to be very experienced in ambulatory care, experienced in continuity of care, experienced in working with teams of health care providers—and those teams would be nurses, allied health, nurse practitioners, PA's, social workers, et cetera—but experienced in working with those teams.

They are going to have to be self-learners and they are going to have to be computer literate because that is the way they will access their data and their data bases.

Where would the training take place? I believe the medical schools are going to have to train in the hubs and across the States rather than in specific tertiary care centers. I believe residency training will take place at those hubs as well if we expect to get physicians and other personnel to serve in them.

What will be necessary to facilitate such a medical school curriculum? We are going to have to do much better to convince our students to choose primary care. We have all said today that an answer, not only for some of our escalating health costs, but particularly rural health, will be primary care physicians. But the truth is, the number of students choosing primary care specialties is depressingly getting smaller and smaller every year until it is close to only 20 percent of the graduates at this time in the areas of family medicine, and general internal medicine.

Will medical school faculty be the problem? They are occasionally put forth as the problem, as being specialists, and as wishing to reproduce themselves. I think some of that will be true. But if we

move the teaching out into these hub areas, then the model will be a primary care physician.

We will have to change in some way our national view of who are heros in medicine. The heros that are asked sometimes to testify in front of your committees, but certainly who appear on television are not primary care doctors involved in the day-to-day care of individuals or in preventative medicines. They are the subspecialists who have a special procedure, perhaps a new mechanical heart to put in this week in same individual.

Rural populations are going to have to become intelligent about health care and the use of specialists; and they are going to have to have a major say into what is provided at their community. If, as now, 60 percent of the rural population drive by their nearest provider, the system will not work. Therefore, we have to train the provider to meet the needs of the community, and the community has to use that provider.

Medical schools currently use almost solely a hospital based education. Hospitals where the faculties has grown up are tertiary care, research oriented, institutions in general. Even in the community medical schools, such as South Dakota, the major part of our training is in Sioux Falls and in this hospital in this city, which is hardly the model of a rural hospital, Rapid City Regional.

We are going to have to make the transition. Monies for that transition are going to have to be present, not to sustain the program but to stimulate the initial changes. We are going to have to have support for students from rural areas to go to medical school; and we are going to have to continue some method of Federal support for residency training even though it is going to be outside of the hospital. Therefore such support probably cannot continue to come through hospitals as it does today.

Thank you.

Senator DASCHLE. Thank you, Dr. Talley.

Dr. McBreen?

STATEMENT OF DR. WILLIAM McBREEN, HEAD, DEPARTMENT OF RESEARCH AND SPECIAL SERVICES, COLLEGE OF NURSING, SOUTH DAKOTA STATE UNIVERSITY

Dr. MCBREEN. Thank you. I, like Dr. Talley, was given the mission of describing my vision of the future in regards to health care in rural South Dakota and rural areas across the nation. I, however, am going to talk about the future of rural health care from a nursing perspective, in terms of what nurses can do to help with the future of health care delivery in rural areas.

If we look to the future and we try to identify how we can improve health care delivery in rural areas of the nation, there are four basic considerations that come to mind. First of all, reimbursement of health services; secondly, coordination of scare resources in rural communities, health care personnel needs; and finally, the individual community resources and needs of each community within the State and across the nation.

In terms of reimbursement of health care services one of the obvious tasks that is ahead of us is to analyze which services are basic and essential to health care as we value it in the United

States. We also need to analyze which health care services are cost effective and can actually reduce the amount we spend on health care. A good example of health care services that can actually reduce health care costs are health care that we give to indigent mothers during pregnancy.

Study after study has indicated that if we give proper health care to indigent mothers during pregnancy for every dollar we spend on that prenatal care, we save $2 on the care of an ill infant. Those are the types of considerations we must make when talking about what we as a society are going to pay for in terms of health care.

Coordination of scarce services in rural communities are another essential component of the future of health care in rural areas. It is a basic principal that when resources are scarce we cannot afford to duplicate or to compete with one another. Coordination needs to occur between health care facilities—meaning hospitals, nursing homes, primary care clinics, and public health agencies—that are not only within one small community, but within a region of communities so that they are not competing with one another.

Examples of programs that have been developed that are addressing this competition and helping rural facilities survive are consortiums that are being developed through various projects from the Kellogg Foundation and the Robert Wood Johnson Foundation and other foundations as well, that help set up consortiums of regional facilities.

Examples of this are seen in northern Minnesota and also rural New York.

Another area that we need to address and is particularly suited to what I want to discuss today, and is suited to nursing education, is the personnel needs. Generally it is accepted when you are talking about health care delivery in rural areas you need health care providers that are generalists and are diverse in the types of services that they can provide.

Obviously I am biased towards nursing. That is my background. I am a Registered Nurse and that is the area that I have practiced in for the last 15 years. So that is the area that I am going to discuss primarily.

One of the areas of nursing that has already demonstrated their effectiveness for health care in rural areas is the nurse practitioner. Study after study has indicated that nurse practitioners deliver cost effective, as well as very high quality care, particularly in rural clinics.

In addition to the nurse practitioner, the nurse practitioner with a master's degree also has an additional component of a diversity. The master's degree enables the nurse practitioner to be a support person for area health care agencies—meaning hospitals and nursing homes. Nurse practitioners can not only diagnose and prescribe treatment for that 90 percent of very common health care problems that come into rural clinics, but they can also assist nursing homes and hospitals with developing strategies for improving patient care and also work with individuals and their families who are having particularly difficult times adjusting to an illness.

Another group, obviously, that needs to be involved when you are talking about health care in rural communities are nurses. The

role that nurses can play in rural health care includes: hospitals, clinics, and nursing homes but also health and individual health in the home.

For example baccalaureate prepared nurses are educated in health education, physician assessment, functional assessment and community health. This preparation gives these nurses a background to work with individuals and families who are experiencing chronic illness but are having trouble working with that chronic illness. And they are prepared to do it on a community basis and in the home.

Unfortunately, one of the problems with nursing practice is the restrictions placed on practice. These restrictions do not come from their nursing license, in other words, what they are legally empowered to do by their nursing practice description. The restrictions come from policies that regulate what kind of activities a nurse can take once a problem is identified.

An example of this was, a colleague of mine who is a community health, specifically a home-health nurse, who was working with an elderly woman in her home, identified after a functional assessment that all this woman needed was some basic homemaker services, with hygiene measures and some cooking measures, in order for her to stay out of a nursing home. But in order to implement those measures the nurse had to go through area physicians and other health care services to get reimbursement from the Medicare/Medicaid System.

If we are talking about rural America where access to different providers is going to be at a premium, it follows that the providers that are already in those areas should be allowed to practice within the defined law of their practice act.

The final area of consideration when we're talking about the future of health care is flexibility in the individual communities. Like Dr. Talley also indicated regarding recruiting physicians into rural areas. It is also difficult at times to recruit nurses into rural areas. One of our findings from the College of Nursing in trying to provide educational services to nurses around the State is that most of the nurses that go into our programs go back to their community of residence prior to entering the program.

In fact, 95 percent of the nurses who enter the master's program go back to their original community of residence after the program. So, therefore, if we are to provide flexibility and to develop a program that meets individual community needs, we need some flexibility in regards to how we deliver care.

Programs that have been developed by the Kellogg Foundation have gone beyond what we have seen as traditional health care. One program in a very small community educated grocery store clerks who know who usually comes into the grocery store to look for signs that there may be impending health problems so individuals can then be referred to a physician or a public health nurse in the area.

You know, programs like this need to be community centered and community developed that are based on those individual needs.

Thank you.

Senator DASCHLE. Thank you, Dr. McBreen.

Gary? I might mention for the record that Gary received his MBA at the University of Nebraska.

Senator KERREY. I wondered why he's running such a good place here.

Senator DASCHLE. He had difficulty getting into USD and they took him down south. [Laughter.]

STATEMENT OF GARY RIEDMANN, PRESIDENT AND CEO, RUSHMORE HEALTH SYSTEM

Mr. RIEDMANN. Thank you. I appreciate the opportunity to spend a few minutes to share my perspective about health care with you.

I am speaking on behalf of the 60,000 patients we cared for at our hospital, last year. In the past week—I visited with a grandmother who had three children who were born healthy here at the hospital, who was just ecstatic. I talked to a mother who gave birth to a 1 pound 3 ounce baby that is up in our special care nursery. I also visited with a professional associate who died of cancer. We have a variety of people who come and use the resources at our hospital.

I also have contact with the people who pay their bills at this hospital. In the last year at our hospital, we provided over $4 million in uncompensated care for services that people in the community need but could not afford to pay. I am deeply concerned about these challenges we have in health care today.

On the one hand I see the excitement and the enthusiasm of the new technology that we offer at the hospital and the quality care that we provide; but I also look out and see the people are trying to pay for these services. I also look at our medical staff, 165 individuals who provide top quality care to people in this region, but are often overwhelmed when they are trying to face the issues of insurance, reimbursement, and malpractice.

What I would like to do today is talk about three items in particular: (1) the need for a national health care policy; (2) the need to change the current maldistribution of medical professionals in our Nation; and (3) the need for strategies to strengthen rural community health care services through linkages between rural providers and regional medical centers.

Certainly a most fundamental deficiency in our current health care system is the absence of the clearly defined Federal policy. Frequently State and Federal health care policy makers are pursuing worthwhile but often divergent policies. This lack of a coordinated unified purpose has proven to be costly for many of our rural communities. It is absolutely vital that our decision makers in government and the private sector formulate a meaningful approach to rural health care.

It often appears that interest in rural health care has been profoundly eclipsed by this desire to cut costs. There seems to have been a silent agreement on the part of government to support the rationing of health care. We have seen cuts in Federal funding compromising the accessibility, availability, and quality in rural settings.

Instead of developing a national health policy, I see most efforts trying to focus on ways and cut more dollars, while meeting mini-

mal community needs I would like to see us back up and develop a new overall Federal strategy about what health care should be in our country today.

It would be helpful for the Federal Government to also develop a flexible national policy statement to support rural health care which would include the following issues: health manpower, primary health services, prevention and education, reimbursement, regulation, access to care, and the use of our limited resources in an efficient and effective manner to encourage quality, clinically effective health care services in our country.

One area that is certainly a paradox in our situation is having a surplus and yet a shortage of medical professionals in our country today. In essence what we really have is a maldistribution of medical professionals. A serious shortage of medical professionals, particularly physicians, occurs in many of our rural communities. Although many rural communities offer the prospect of substantial income to physicians, a variety of other variables conspire to prevent our physicians from reaching into the rural areas.

The Government has repeatedly vacillated on the issue of physician supply. In 1965 Congress passed a Health Professional Education Assistance Act to stimulate the increased production of physicians. Well, it worked. However, for a variety of reasons, the doctors have not gone out to the rural areas.

A new method of subsidizing medical education offers a potential solution to this maldistribution of physicians. Medical students are highly subsidized for their undergraduate and graduate education, but with minimal benefit for rural communities.

Although the perfunctory question of practice location is part of the admission ritual to medical schools, there is little control for these institutions over the eventual practice location of their students. Also, the entire medical education system needs to encourage specialization that is compatible with and offers incentives for these individuals to go to a rural practice.

I am convinced that the survival of health care in rural communities is largely contingent upon the establishment of strong incentives at a State and Federal level for medical graduates to locate in our rural communities.

My third suggestion is to encourage the development of linkages between rural health care providers and regional medical centers. There is ample evidence suggesting that health care is largely a regional phenomenon. Recognition of this fact will result in benefits for both larger and smaller communities. The smaller community health care provider can gain access to diagnostic, therapeutic, and management services from the larger community hospital while still maintaining local identity and local control.

The regional medical center can benefit from the referral of patients needing specialty care in an efficient and effective manner through this relationship with the smaller hospital. Efforts should be made to encourage a closer bonding between rural health care providers and their urban counterparts. The ultimate result would be a significant enhancement of our rural health care services.

The success of working together will result in improvement of our rural community, satisfying both physical and economic needs.

A recent study indicates that the death rate from trauma is more than two times higher in rural areas than in urban areas. This is only one example of how an enhanced rural health care system could offer improved results.

The economic health of health care providers is also a critical point to remember. Rapid City Regional Hospital and Black Hills Rehabilitation Hospitals are the largest employer in Rapid City, offering quality employment opportunities to persons in over 390 fields. It is typical throughout this rural region that the local health care providers are also one of the largest employers in their communities.

Research has indicated that when a local community hospital closes a significant number of main street businesses are going to follow shortly thereafter. A Federal policy directive encouraging successful, cooperative efforts will result in healthier rural communities throughout our Nation.

One additional comment I would make speaks to the cost issue. We deal with cost concerns daily at our hospital. It was my intent in preparing this testimony to offer some type of simple solution for implementing an effective program for cost control. Instead of a simple solution, all that came to mind was a sign that I saw at a doctor's office the other day—"An apple a day won't do it."

Obviously, there is no simple solution. But I would encourage you to look at some of the issues that we deal with here in the State of South Dakota. If you would talk to the 60,000 people in the last year who received a bill from our hospital. They are going to say, "That was very expensive. Thank God that I received the care I did, and that I am well today, but that bill was really tough to handle."

If you compared our hospitals in the State of South Dakota to the rest of the hospitals in the United States, you would discover our hospitals come in as 49th least expensive in the United States.

Here at Rapid City Regional, if you compared our hospital just in the State of South Dakota, you will find that three of the hospitals in this State provide in-patient care to over 50 percent of the patients in this State.

We are the least expensive of those three, in both cost per stay and cost per day. But I can tell you, I can show you all the ways we are being cost efficient, like so many other hospitals across the country and across our State, but I cannot find a single patient that is going to come back and say, "My that was a wonderful bill."

What I would really encourage is an effort on behalf of the Federal Government to try to bring together some of the interested parties, the patients, including the physicians, the hospitals, the other providers, and insurers, as a group, with our Federal representatives, to sit down and say what is good for quality patient care, and what are we willing to pay for.

Bringing together both the professionals and the people getting the care, is going to be the magic of what is going to make it work. Do not assume that there is going to be any point in our history when everybody is going to be happy with their health care bill. But I can assure you that when people feel that they have gotten the best care possible and they have gotten it in the most efficient

manner possible, that they had some input, we will have a better result.

In conclusion, I would like to thank you for this opportunity to comment on the need for national policy, the need for a good distribution of health care, and developing a good working relationship with both the large and the small hospitals to provide good quality health care.

[The prepared statement of Mr. Riedmann appears in the appendix.]

Senator DASCHLE. Gary, thank you for an excellent statement.

In fact, we thank each of the panel members. You have certainly given us a good deal of food for thought and some very constructive suggestions. And I appreciate it. We are running a little bit short on time and I do want to make sure we have an open mike to allow witnesses who have not been invited, but who wish to speak, to have the opportunity for a few minutes. So I am going to forego questions at this time and excuse the panel at this time.

Mr. RIEDMANN. Thank you.

Senator DASCHLE. Let me now invite people who have an interest in addressing the issue to come to the mike. I would ask two things, first that you identify yourself for our official transcriber; and secondly that we try to keep our remarks as succinct and as brief as we can only because there may be a number of people who want to speak and probably more importantly, perhaps, Senator Kerrey and I are supposed to be somewhere at 6:00.

We can be late, but nonetheless, we do want to invite people to come forward. So if anybody wishes to be heard at this time, we invite you to come to the podium.

Go ahead.

STATEMENT OF J.W. BAXTER, MEMBER, RURAL HEALTH CLINIC BOARD, FAITH, SD

Mr. BAXTER. My name is J.W. Baxter and I live in Faith, South Dakota. I am a board member of a rural health clinic that is staffed by one physician assistant. I guess one of my main concerns today, I heard a lot of problems and a lot of positive stuff, and I know you guys are going to work it out, but my concern right now is access. You used that word right off the bat and I drove 135 miles to use the same word.

Let me explain that a little bit. Being staffed by one person is not the best thing in the world when that person happens to have a sickness or whatever. We are in that right now. Our physicians assistant fell and broke his leg. He sees 20 patients a day. We are without any health care from probably 4 to 8 weeks.

Senator DASCHLE. You're talking the Faith Clinic, right?

Mr. BAXTER. Uh-huh.

Senator DASCHLE. And the physicians assistant broke his leg?

Mr. BAXTER. Uh-huh.

Senator DASCHLE. Bob, for your information it is just north of here, 135 miles north and east of here.

Mr. BAXTER. Northeast, right in the corner of Meade County. If you go 2 miles north you're in Perkins County and two miles east in Zeebok County up there.

Senator DASCHLE. What is the status of the clinic right now?

Mr. BAXTER. Well we are supervised by the Massabare Clinic out of Sturgis and they come up a half a day a week. They are going to extend that to a day. You have to realize, it is these physicians day off that they come to, you know, help us provide this care.

Also I have heard some good comments about Rapid City Regional today and I want to reconfirm them too, because they are truly getting to be a regional hospital. They, through one of their programs here, are going to provide us with a physician 1 day a week also. So in this process—some of these gentlemen talked about networking and consortiums and this is what rural South Dakota and western South Dakota is trying to do for ourselves.

You know, there are things I think probably you guys cannot do for us. Starting this last year, there is a lot of networking talk and meetings going on. I guess that is what I just wanted to tell you today in your process of whatever, new laws, new programs, or whatever, let's don't forget the access; and that deals with some money too.

Some of these new things come along the pike, like the Clinical Lab Improvement Act of 1988. The way it is looking it may prohibit us from having our lab tech and our lab up there because we cannot meet the requirements for our little primary care lab which has a registered lab tech.

Our EMS monies have been cut in the last year or so. That makes it possible for us to have an ambulance to get to this excellent care that is here.

So I guess I just want to encourage you to, you know, keep access in your mind. I know your cost and relations is probably an overshadowing problem. But for us people out there that choose not to live in the city, we still feel that, you know, through our efforts and yours we might can have still enough health care to get our heart attacks, you know, to here.

That was what I wanted to leave with you.

Senator DASCHLE. Thank you. I'll tell you, some of you may not have had the opportunity that I have had to visit the Faith Clinic. But I dare say I do not know that there is anybody, any group of people more dedicated and more popular among the people they serve than the Faith Clinic. I have used you as an example in so many speeches and in talking to so many people.

I am really disheartened to hear that your physicians assistant has broken his leg. So many people have put their total faith and confidence in that clinic and for you to be shut down now to 1 day a week is probably as good an example as I have heard about lack of access and lack of good quality in the 2 days that we have been holding hearings.

I really appreciate your coming 135 miles to talk about access. He used the word more effectively than I did.

Who else?

STATEMENT OF MARSHALL CURTIS

Mr. CURTIS. I might as well give it a shot. I attempted two times. Tom and Senator Kerney——

Senator KERREY. That is close enough.

Mr. CURTIS. Okay. I am sorry I do not know you. I know Tom Daschle.

Senator KERREY. That is fine.

Mr. CURTIS. Anyway, my name is Marshall Curtis. I have been kind of concerned about my medical needs as well as my children's; and they have—my children—we have no medical care. We have no insurance. We cannot afford it. I am on disability retirement and it is very difficult for my children to get the proper medical care that they need. Because the fact is that we just have to go right to the aspirins and whatever we have to do to try to use the old remedies however with the modern technology we have.

However, we do the best we can with the money that we have. Anyway, I, myself, have to have an operation come July 8, and I do not know if Medicare is going to take care of it or not. I have Medicare or will have come July 1. I do not know if they are going to cover it. Can you answer me? Are they? Will they cover for—I don't know what you call it—what I say, they're going to rotor-root my veins. Okay?

I do not know what it is called, but they are going to clean the veins out. The one vein is completely blocked off and all they can work on is the one side because the other one is completely blocked. But anyway, I am quite concerned about the costs that it costs for insurance.

You know, and I think there should be something done, some way that we can afford, that my family and all should have, we all should have some type of insurance. We have none—no life, no nothing. You know, just whatever my money that I get. It's a day-to-day or month-to-month. We live on month-to-month. That is exactly what it amounts to. And sometimes there's—when I say month-to-month that means sometimes I do not have that. You know, the dollar is done with and the bills are still coming in.

Or the doctor and hospital bills because I don't—I don't charge anything.

Senator DASCHLE. Are you seeing a doctor now, Marshall?

Mr. CURTIS. Yes. I am going to Montana for an operation. I don't know if they are going to cover it—if Medicaid is going to cover my doctor bill or not. I have no idea. I assume that they are. But another guy told me that, hey, don't count on it. Because I had to have an operation and they would not pay one red time on it.

So I don't know if they're going to cover this. I do know there's a $500 deductible that has to be met by myself if they cover whatever bill they're going to cover. So I don't know. I mean, I just realize that and know that there's—my children need some type of access.

We did have and the government was paying if children was sixteen years and young, the government had or we could get—we could go to the health care center and get medical and doctor care. And all of a sudden the State, when the government bowed out of paying for that, then the State would not.

I mean right now they say they haven't got any money appropriated for this type thing and our Governor has not—you know, that to me is something that they should have. I mean that is a priority over the other thing. I get quite angry when I realize he is doing so much for other things and the care of my children is more important than a lot of things that I hear him talking about. And I do

not appreciate him and our officials—I think I see one of them in here and I want to talk to him afterwards also. I do not see him now.

Senator DASCHLE. Thank you, Marshall. Let me have my staff talk to you about whether or not you may be Medicare eligible.

Mr. CURTIS. Okay.

Senator DASCHLE. And maybe we can help you prior to July 8 to get some of those answers.

Mr. CURTIS. Okay.

Senator DASCHLE. Very good. Thank you.

Mr. CURTIS. Thank you very much, Tom.

Senator DASCHLE. You bet.

STATEMENT OF BILL SNYDER, RAPID CITY, SD

Mr. SNYDER. Hi. My name is Bill Snyder. I live here in Rapid City. I am 25 years old and I have a heart problem. I cannot get any insurance whatsoever. I have tried a half a dozen in less than a week and I have been turned down from every one of them. I have even went to a place that would make me pay $250 a month; and I said, "Hey, I'll take it." But I cannot get it.

I have a family. I have a daughter. We're trying to make a living. We own a home. If anything were to happen to me, I do no. know what would happen. We would go bankrupt. I really do not know. I am in a really sticky situation. I have talked to you, Senator Daschle, before about it. And, you know, I really don't know.

I have been listening to—like Senator Kerrey's State has a health risk pool and Governor Milkenson does not want that. I am just in a really bad situation. You know, that is about it.

I have had two open heart surgeries. Luckily my folks were—my father was in the military which helped him out a lot. Now that I am older, I am not covered by the military. I have worked for a small company. Their group insurance has denied me. My wife's group insurance—she works for a small company—has denied me also. I need some help.

I mean right now I'm fine. I can't—well, put it this way, I can't even go see a—get my medication because, hell, we live day by day, check by check. I'm supposed to be taking blood thinners and I haven't taken them for over a month just because I can't afford it. It's really crazy. I mean, we need some help.

Senator DASCHLE. Thank you, Bill.

Mr. SNYDER. You bet.

STATEMENT OF JASON BLUMBERG, FIRE CHIEF, VOLUNTEER FIRE DEPARTMENT AND AMBULANCE SERVICE, SHANNON, SD

Mr. BLUMBERG. Senator Daschle, Senator Kerrey, my name is Jason Blumberg. I am the fire chief from the volunteer fire department and ambulance service in Oaklala in Shannon County, which is the poorest county in America. It has that dubious distinction.

I work with approximately 20 Indian volunteers. In terms of bureaucratic oppressiveness and abstinence, I sent you a report, Senator Daschle, on April 16 regarding the 3½-year difficulty we have had getting any compensation from Indian Health Service for the

services we have provided. We have responded to over 1,500 medical emergencies in this time.

And in essence, volunteers from that community, including myself, are giving welfare, being forced to give welfare to an agency of the U.S. Government. And there is no interest from that Agency to remedy the situation.

A similar report went to Congressman Tim Johnson who wrote to me recently and sent me a copy of his testimony before the Subcommittee of the Interior. He states, "I request the Subcommittee to address the pressing need of ambulance service on Pine Ridge Reservation. Specifically, the Aberdeen area office of IHS has yet to contract with the White Clay District Emergency Medical and Fire Protection Service. This outfit is a State chartered entity and is fully certified to perform EMT services. There are numerous statutes which oblige the Aberdeen area office to contract with an eligible entity."

The fact is that we have demonstrated, by putting an ambulance service where none existed previously, that there is a need and that lives can be saved and injuries can be reduced, which means overall reduction in cost by prevention and interaction. But this service cannot continue to exist on the energies and resources of volunteers who are basically indigent themselves or on my energies as a volunteer.

Unless this situation can be remedied, this service will cease to exist and that means 75 people a year will suffer from either death or permanent disability from the lack of available emergency medical services. And part of rural health care has to be delivery of a patient to a medical facility.

I am requesting a commitment from you to give testimony to the appropriate people regarding this matter before it is too late.

Senator DASCHLE. Jason, I hear you loud and clear; and I certainly intend to include among those priorities that we will present to the Interior Appropriations Committee emergency care on Pine Ridge. I appreciate your testimony.

Thank you.

Mr. BLUMBERG. Thank you.

Senator DASCHLE. Are there additional people who wish to be heard?

STATEMENT OF LAVERN NORMAN

Mr. NORMAN. Well I spent a little time last night when I heard about this and wrote up a few things that I think—some of the problems and some of the solutions. I am not exactly—my wife has been on dialysis for 7½ years and I probably logged more time sitting time around the hospital than anybody in this room. So I think I have some idea of what the problems are.

Now I will start with the terminal sick patients as those people on dialysis. Now these people should be taken care of in a group all by themselves. Their domestic lives are sad and evicted. Their medical bills and living expenses are much higher than families with no medical problems, yet their income limits are the same as the others before they can receive aid of any kind.

The person or persons taking care of them and their domestic lives are given no consideration. The condition of their domestic life has much to do with their physical and mental well being. The terminal patient should not be subject to lawsuits and collection agencies. I think it is a shame that our courts will send the sheriff out to seize property from these people. And worse yet is the sheriff takes a cut for himself for doing the job.

The doctors that will not take care of these people for what they can afford or the Medicare insurance should not accept them as patients. The Medicare payment needs to be changed. The family doctor does three-fourths of the work and gets one-fourth the pay. The specialists and the surgeons get far too much of the Medicare pie.

Equal pay for equal work has long been a goal of this country. It is not so with Medicare. My wife's doctor, while we were working with the dialysis unit in Omaha, got a check for $240 for Medicare and a check for $60 from the insurance. Her doctor here in Rapid City gets a check from Medicare for $105 and an insurance check for $26.

There is also a law in South Dakota that states all x-rays must be read by a specialists. This places another bill for the patient to pay. I know in our circumstances it is just another bill. I would hate to think that the biggest share of the doctors in Rapid City were not capable of reading an x-ray.

I think that the amount that Medicare pays doctors is adequate, the exception being the family doctors. Doctors who will not accept the assignment of Medicare could not get a Medicare check there would be a lot more of them accepting assignments on their cases. There are too many cases where the Medicare is just a downpayment. I know.

I have had surgeons that—we have been up here just 3 years now and the first two times the bill just doubled. My wife has been in surgery, I think, six times. And the bill has just doubled to what it was the first time that she went into surgery.

The medical needs of those that work for minimum wage has to be addressed. The Government and the employer are going to have to cooperate in getting some medical insurance program for these people. You have heard about people paying $5 to $7 for an aspirin in the hospital. The medical profession calls it cost adjusting. What is amounts to is that the patient lying in the hospital bed with the means to pay their bills are subsidizing the operations of those who pay a minimum wage. I mean that is just my opinion, but I believe it is so.

Malpractice insurance and malpractice lawsuits have long been a thorn in the side of the medical needs of the American people. The first thing we must make a distinction between making a mistake and negligence. To expect someone to practice medicine all his life and never make a mistake is just not being realistic.

I believe we should do away with malpractice suits. If we had a head tax of $5 a head for 250 million people in the United States, it would amount to $1,250 million; at $10 a head tax it would be $2,500 million. This money could be used to compensate patients for mistakes or negligence without having to sue the medical profession and also some realistic guidelines of what should be paid

out to a person that has suffered some kind of a medical problem in that respect. The lawsuits are getting so high that everybody—every article you read says that malpractice suits are the biggest one of the reasons that we have a rise in medical costs.

Now in order to do this I think all we would have to do is to, like this Rapid City community, we would have a five man board of knowledgeable people and somebody that has a medical problem, like malpractice, could go before the board and they could see whether he should be entitled to some compensation. And also this five man board could hold the medical profession accountable for its actions. I mean if a doctor is accused of malpractice, they could call the doctor in and get his side of it. But it shouldn't be between the patient and the doctor.

And the way it is now, if I sued a doctor and I got $100,000 settlement, I would be lucky when the dust settled if I had $50,000 left. Well that is $50,000 that the patient or the doctor are both out of.

Senator DASCHLE. I am going to have to ask you to summarize if you could. Thank you.

Mr. NORMAN. Well that is about what I have to say.

Senator DASCHLE. Great. Thank you. They were excellent comments. And if you could leave your notes I think the transcriber could use those as well. But thank you very much for your testimony.

[The prepared statement of Mr. Norman appears in the appendix.]

Mr. NORMAN. I sure hope—I don't think——

[Applause.]

Senator DASCHLE. No, that isn't taken as criticism. As you can tell from the applause, there are people who certainly agree with much of what you said.

This concludes the hearing. I want to thank all of those who prepared their testimony, and who came to the microphone to express themselves. Certainly coming to the microphone under circumstances like this to talk about personal experiences or to talk about your own thoughts about as difficult an issue as this is, takes a good deal. I appreciate all of those who have helped us this afternoon.

This has been an excellent hearing and I want to thank those who have participated for making it so.

Let me especially thank Rapid City Regional for hosting us, for giving us the opportunity to use this meeting room, and certainly for providing us with the warm hospitality they have.

Let me finally thank my colleague and friend, Senator Kerrey, for traveling all the way to Rapid City to be a part of this hearing this afternoon; and I thank him again for his commitment and his continued support in finding solutions to the problems we face today and the ones we have addressed this afternoon.

So, Senator Kerrey, if you have any final comments you would like to make, this is your last moment. The last opportunity.

Senator KERREY. This is it?

Senator DASCHLE. This is it.

Senator KERREY. Permanently silenced.

Senator DASCHLE. That's right.

Senator KERREY. Well the growing idea that I have, if you can talk about an idea growing, is to look for some way to not only increase access which I think has to occur, not only decrease paperwork which I think needs to occur, and not only to get some way to control the cost, but also to reverse what I think is an improper relationship at the moment between Federal local officials.

Gary, on a number of occasions you appeared to be using Federal and national interchangeably and I don't think you mean it quite that way. The last witness that we had up here, to my mind, as well as the individual from the Faith Clinic, are solid testimony as to why I think we need to reverse the current relationship that we have with the Federal Government, independently of whatever else we do with the financing.

Currently with both Medicaid and Medicare, the decisions are being made in Washington and they are extremely difficult to make in the great number of diverse communities that we have in this country, no matter how knowledgeable and smart we are, or how many hearings we hold. So the growing idea that I have in addition to all the other sorts of problems that need to be addressed is trying to reverse the current relationship that we have between Feds and locals.

Senator DASCHLE. Thank you for that. Thank all of you for coming. The hearing stands adjourned. [Applause.]

[Whereupon, the hearing was adjourned at 6:04 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF LOREN AMUNDSON

Good Morning. I'm Dr. Loren Amundson, a family physician from Sioux Falls, with roots and practice in rural South Dakota, and now Director of the South Dakota Office of Rural Health. It is a pleasure to be here, and I thank you for the invitation to testify.

In March of this year I was appointed as the first director of the South Dakota Office of Rural Health. During the past several months, we have been organizing the Office and working closely with communities to examine and promote their health care delivery systems. In the course of this dialogue, discussions with health policymakers and consumers have helped to define some of the state's health care problems and needs.

As we concern ourselves with rural health care, we must be cognizant that if effective solutions are to be found, we must address rural health on two planes. One is the technical, Issue-oriented level. The other is the level of our values. We must concern ourselves with what our values are concerning rural health. Our values tell us what *should be;* how we see the world collectively and individually. To us in the Office of Rural Health, the philosophical underpinning of rural health lies in *access* to *affordable, quality* health care. Without a shared belief that rural South Dakotans, and all Americans, are entitled to access, both geographically and financially, the technical, issue-oriented information is meaningless.

Governor George Mickelson has a keen interest in rural health, as witnessed by the creation of our Office of Rural Health. Focusing on *access, quality* and *cost* as the primary issues which concern most South Dakotans, the Office has refined a myriad of rural health issues into a manageable set of topics that form the basis for an action agenda on rural health in South Dakota. On June 26 and 27 the Governor will host a rural health strategy meeting in Pierre. Among the policy issues to be discussed are mid-level practitioners, people who are uninsured or underinsured, recruitment and retention of physicians, nurses, emergency medical services, rural ambulatory care, rural mental health, rural hospitals, farm injuries, long-term care, and the impact of the rural economy on health care. He has invited health care providers, professionals, institutions, insurers, leaders and other interested citizens from throughout the state to come together to identify specific opportunities to improve the delivery of health services in rural South Dakota. The involvement of our Office with local communities in the state is paramount and this process holds a unique opportunity to heighten awareness of problems and to solidify a spirit of collaboration on possible solutions.

This will be an action-oriented meeting to solicit individual perspectives and to develop a rural health agenda for the 90s. During plenary sessions there will be presentations by several leading national rural health experts. In addition, each participant will be assigned to one of several workgroups to discuss health care issues and prioritize the concerns they have. The previously mentioned Issues Papers are being developed at this time. After discussing the issues in the workgroups, participants will be asked to prioritize the key rural health concerns facing South Dakota.

As a result of the Governor's Rural Health Strategy meeting, and four subsequent regional rural health meetings to be held throughout the state later this summer, we believe resultant administrative and legislative policies will provide potential solutions. Let me emphasize that how those solutions will occur is as important as what they will be.

These topics will cover issues which are *economic* in nature, such as the effect our agricultural-based economy has on its people and health care. They are affected by *population* changes, such as the process of urbanization and higher proportions of elderly residing in rural areas, and challenged by the organization and delivery of *health services,* such as the pursuit of technology and resultant specialization on the one hand and the need for access to quality, community based services in rural areas on the other. Finally, these issues are related to our system of *reimbursement.* These changes have personally and directly affected the lives of rural Americans. Physicians no longer practice in rural areas in the proportions they did years ago; many rural hospitals are having difficulty staying open, and nursing shortages are prevalent.

Clearly the future holds a role for creative thinking and action at all levels. At the Federal level, we support the formulation of a national rural health policy and will work with the Office of Rural Health Policy, providing input toward such an outcome. We are also pleased to work with Dr. Tom Dean, a Wessington Springs, SD family physician, who is the new President of the National Rural Health Association and Chairman of our Office of Rural Health Advisory Council. We need to address geographic and financial access to care in a manner that assures all rural Americans a certain, basic level of service.

At the state level we believe that: the development of successful models of care is the key. We believe that states must be used as laboratories for rural health care and that Offices of Rural Health, such as ours, play a "facilitative" role in helping to find solutions. Our office is committed to the "Health Care Team" concept, and offers support for both regionalized and local services to solve problems. Most important, we believe that the key to many rural health-related. challenges lies within each community. Community leadership is critical to the success of any Federal or state policy.

In conclusion, I would like to say that we share common values regarding rural health care. Access to health care in rural areas is vital. Our crystal ball reveals that many rural health care issues will be resolved through communication, cooperation, understanding, experimentation and most of all, community leadership.

Thank you.

PREPARED STATEMENT OF SENATOR TOM DASCHLE

Health care in America is in a crisis. The cost of health care has been increasing at a rate more than four times the rate of general inflation; we have approximately 37 million uninsured; our infant mortality and longevity statistics are a national disgrace; and public confidence in the medical profession has never been lower.

These facts stand in marked contrast to the fact that we have, *at the very same time,* the finest health care delivery system in the world, and that we provide the best medical care money can buy for those who have the money to buy it. Our leadership in medical research and development is unquestioned; the National Institutes of Health are the finest research institutions in the world; our doctors and nurses receive superb educations; and it is common for ill citizens of other countries to come to the United States seeking the best available medical care.

How can these two sets of facts be reconciled? How can it be that we know so much, spend so much, and still acknowledge that a child born in Haiti or Bulgaria has a better chance of living to see his first birthday than a child born two blocks from the nation's capital.

I'm concerned about this, and I'm concerned because the rate of health care spending in the United States doesn't show any signs of abating. It's clear to me that as a nation we can't continue paying more and more of our GNP for health, and I'm not at all sure we're getting top value for the money we spend.

I have some charts that forcefully and graphically illustrate our problems. The first [CHART 1] shows the rapid rate of *medical inflation.* Keep in mind that these figures reflect per capita expenses expressed in constant *1990 dollars* so the effect of general inflation is not included. You can see that the average family is spending over *four times* what it did in 1960 for health care.

The next chart [CHART 2] illustrates the marked disparity between health care spending in the United States and almost every other nation. It is interesting to note that the average American spends almost *six times* as much on health care as the average Greek citizen, yet on average *dies more than a year and a half earlier.*

You can argue that we should spend more than other countries because we are one of the richest countries in the world, and this is probably true [CHART 3]. However, even when adjustments are made for per capita wealth, we still spend far and

away more than any country, and more than we should. This excess spending would be justified if we were producing a nation of bionic men and women, but we're not. At least 16 other countries have better longevity statistics, and at least 20 have better infant mortality figures.

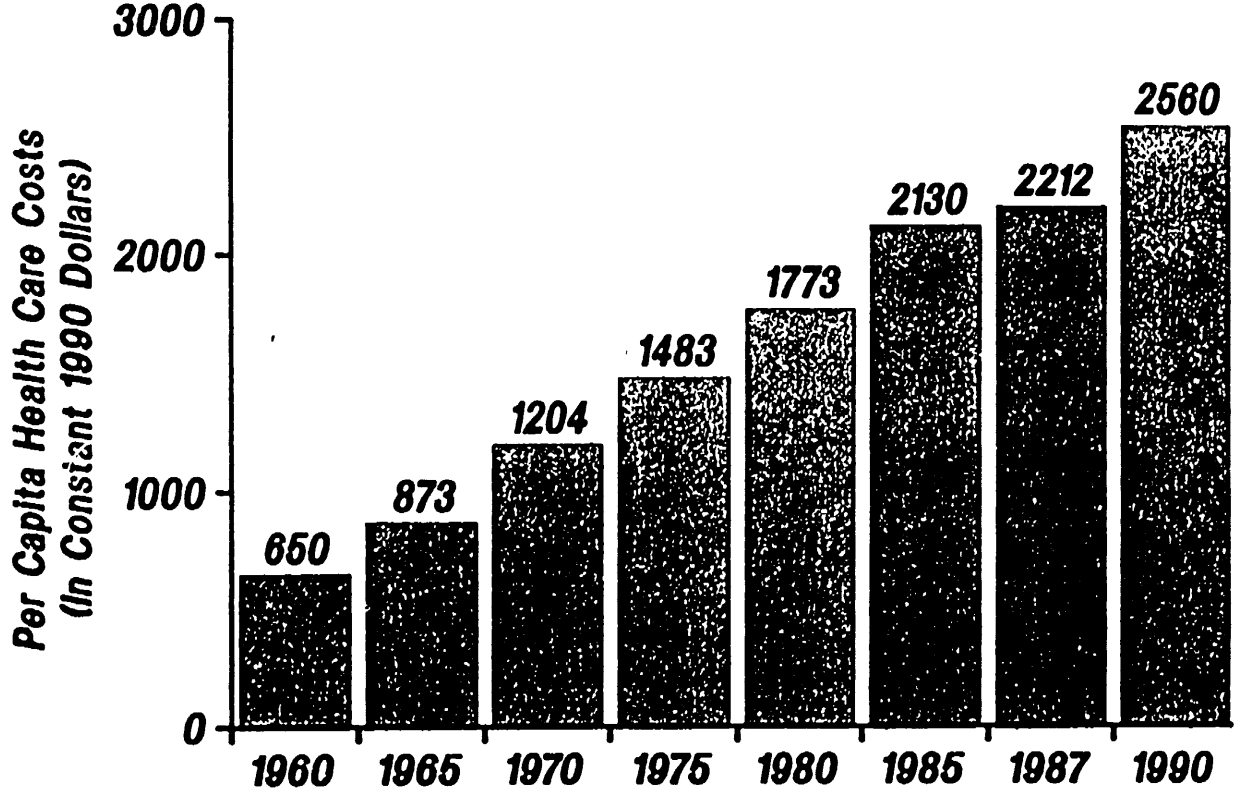
I'm especially troubled that we cannot manage to insure all our citizens [CHART 4]. Countries similar to ours in culture and language manage to achieve universal access to health care, and do it spending far less per person than the U.S. There is something embarrassing about the fact that in all the industrialized world, only the U.S. and South Africa lack some sort of universal health plan.

There is a great deal of concern now about *competitiveness*, and I think this chart [CHART 5] illustrates why we have to get a handle on health care costs. We can never hope to be competitive with the Japanese if every Toyota is priced $500 less than every Chrysler when it rolls out of the plant, just because of health care costs.

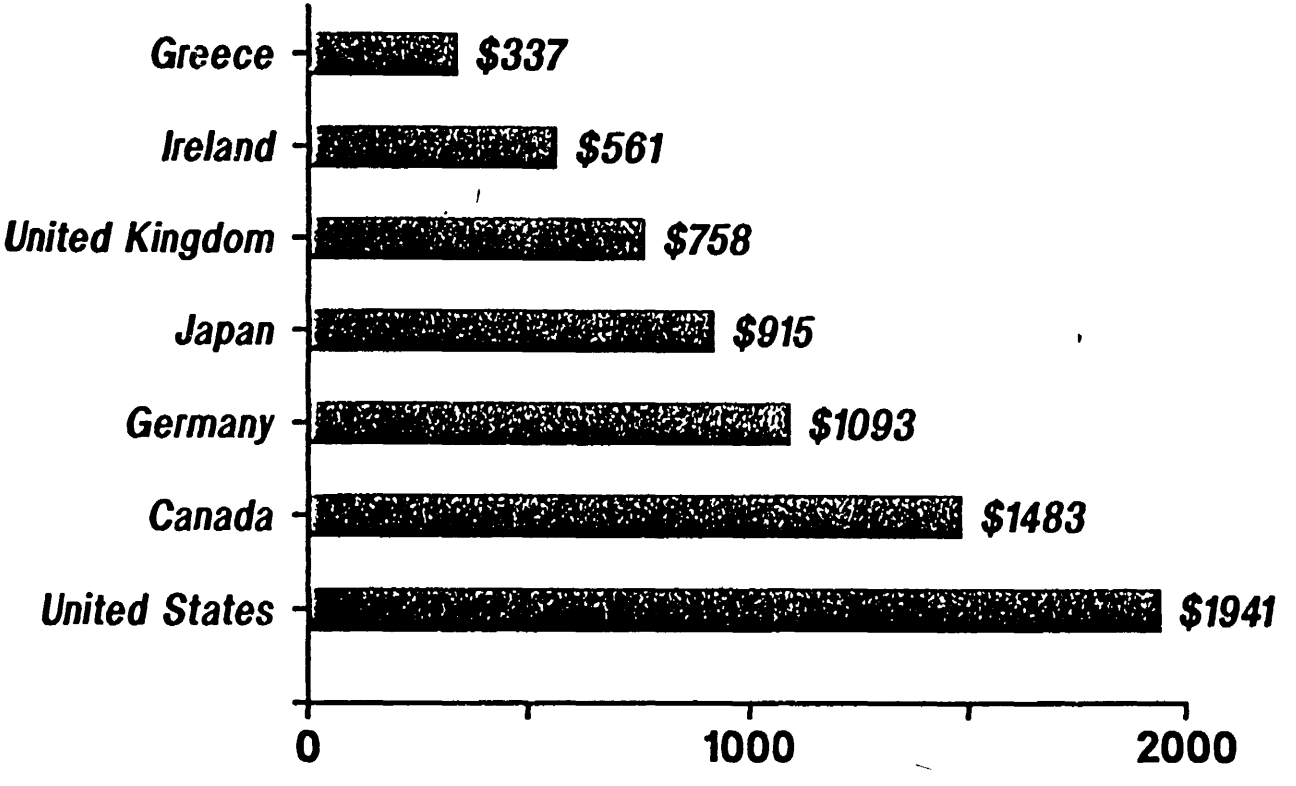
We have to insure that whatever solution we adopt is good for rural America, and this is my primary concern. There are *14* counties in South Dakota that don't even have a primary care doctor, and many more that are underserved [CHART 6]. Whatever we do to fix the problems of health care access and delivery in this country has to provide for those Americans who live outside the metropolitan areas where most of our hospitals and doctors are found.

Senator Kerrey and I want your help as we look for innovative solutions to the health care needs of this country. We clearly need to be cautious in what we try, but just as clearly *we need to be bold in what we think*. People have compared our health care system to a tattered, crazy patchwork quilt that is falling apart. No matter how much time and energy we spend patching it up, it just keeps getting more and more tattered. We are here today to discuss what might be done about this dilemma.

The Relentless March of Health Care Costs

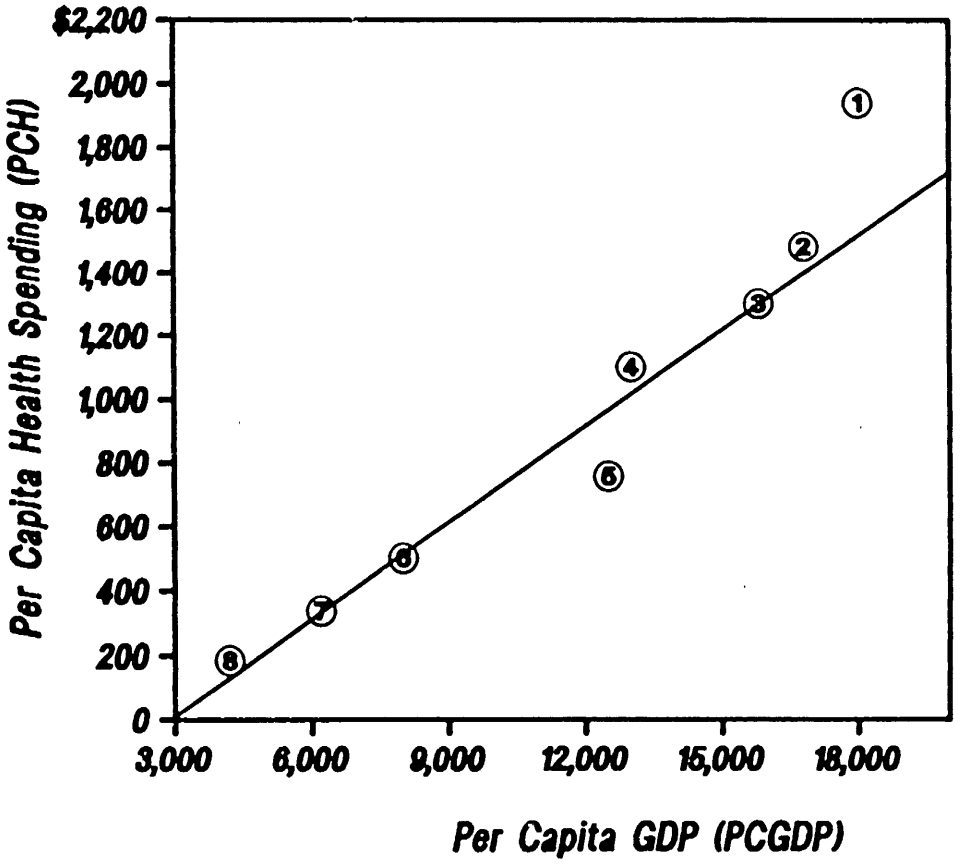


Do We Spend Too Much for Health Care?



Comparative Per Capita Health Care Costs (1987 Data)

Per Capita Health Spending and Per Capita GDP, 1987



Rank (PCH)

1.– U.S.
2.– Canada
3.– Sweden
4.– France
5.– U.K.
6.– Spain
7.– Greece
8.– Turkey

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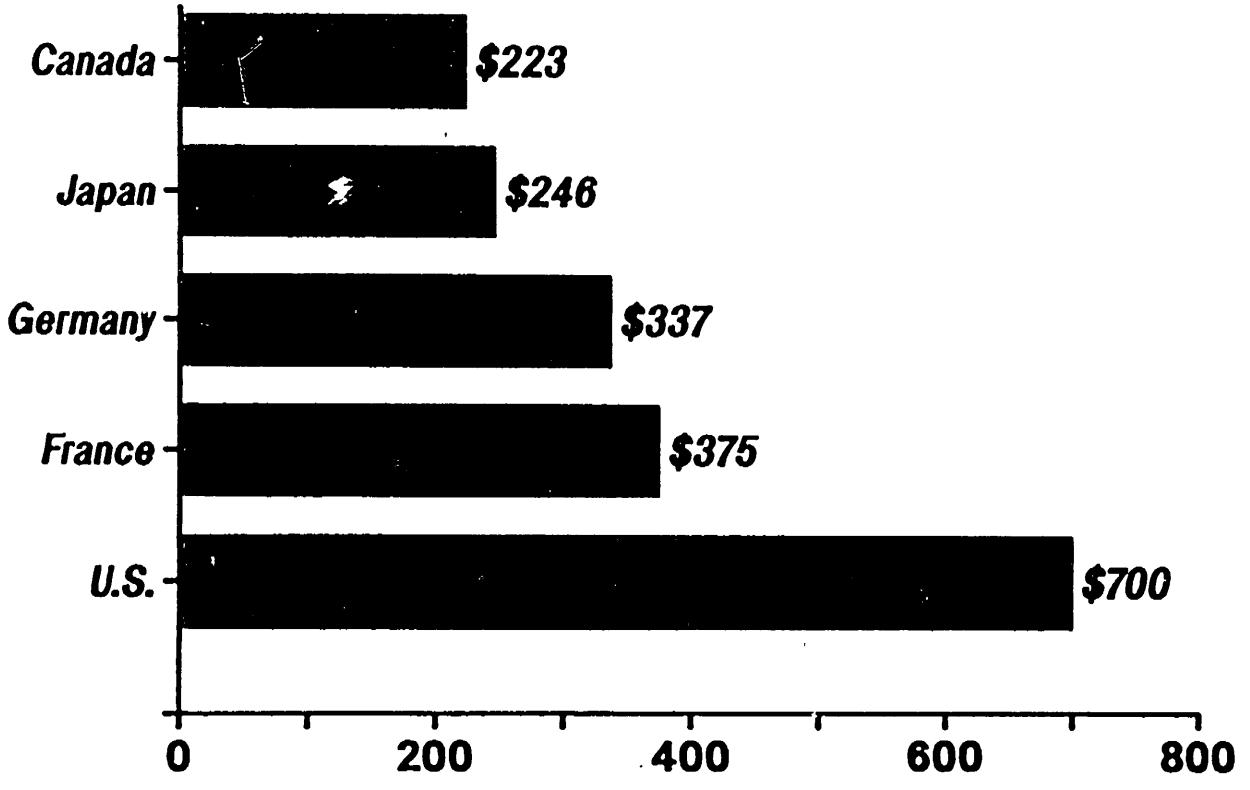
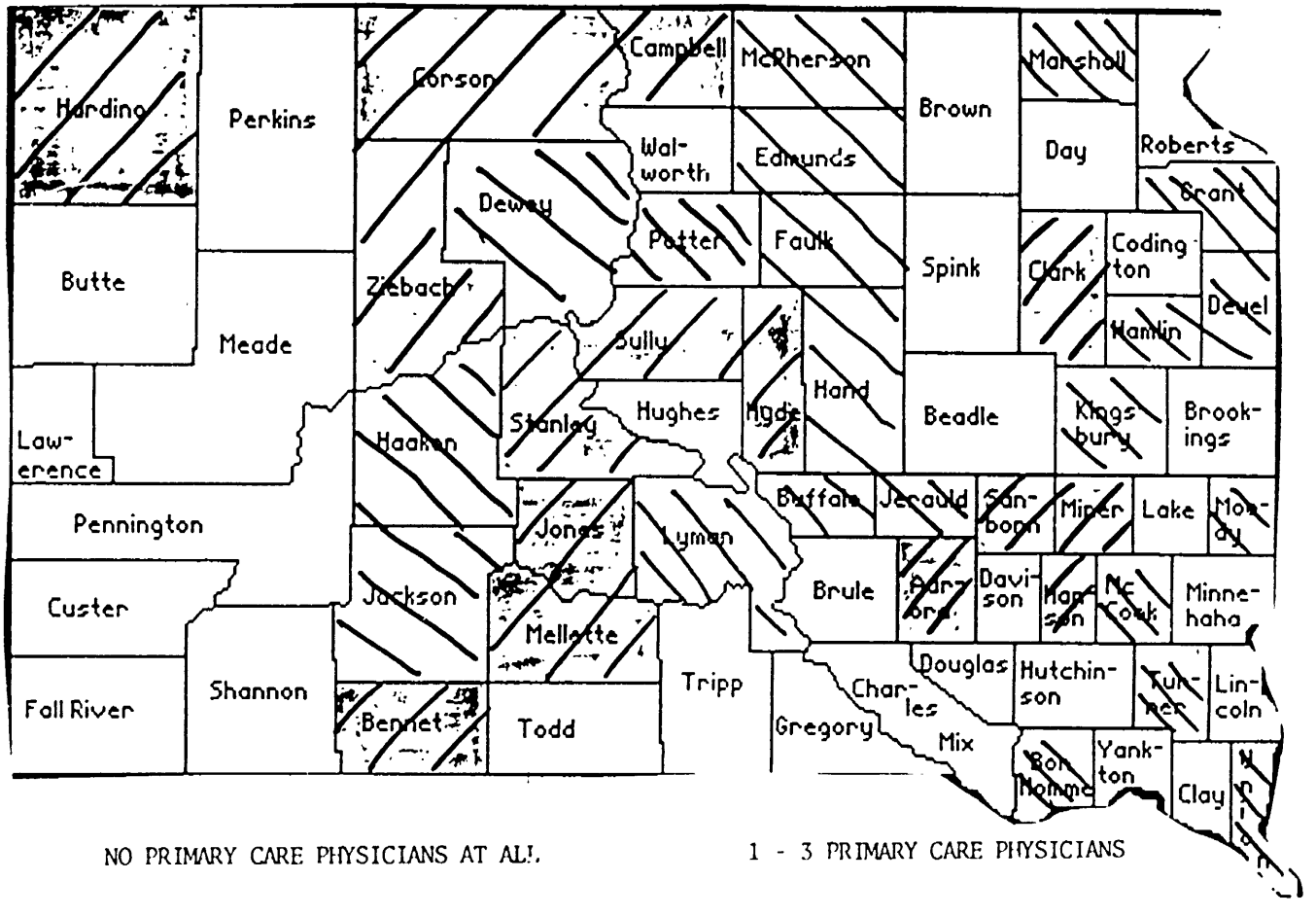
	U.S.	Canada	Britain
Annual health costs per capita	$1,926	$1,370	$711
Health costs as a % of GNP	11.1%	8.5%	6.2%
Life expectancy	75	77	75
Infant mortality, deaths per 1,000 births	11	7	9
% of population not covered by health insurance	14%	0	0

Health Care Expenses Per Vehicle



SUPPLY OF PRIMARY CARE PHYSICIANS IN SOUTH DAKOTA



NO PRIMARY CARE PHYSICIANS AT ALL

1 - 3 PRIMARY CARE PHYSICIANS

PREPARED STATEMENT OF THOMAS M. DEAN

My name is Tom Dean. I am a Board Certified family physician and have been in practice for eleven years in Wessington Springs. I was in the National Health Service Corps for 7 years—3 in the mountains of Appalachia and 4 years at my current location. Currently I serve as chairman of the Advisory Council for the South Dakota Office of Rural Health and as President of the National Rural Health Association.

I am extremely pleased to have the opportunity to be here today to comment on current and future issues in rural health. These are issues which are of enormous personal and professional significance to me and which I believe are of fundamental importance to the future of South Dakota and Nebraska. Because of that, I want to take this opportunity to thank you both for your support of programs to improve health care in rural areas. Through your efforts on the Senate Finance, Agriculture and Appropriations Committees, rural health issues have been at the forefront of the Senate agenda.

With regard to issues currently before Congress, I would put the highest emphasis on reauthorization and expansion of the National Health Service Corps. As I indicated, I served in the Corps for seven years. It was a valuable professional experience for me and one which I believe would broaden and benefit the perspective of all health professionals. As you are aware, Senators Kennedy and Hatch have introduced Senate 2617, the National Health Service Corps Revitalization Act of 1990. This proposed Corps legislation contains a number of important provisions to improve the recruitment and retention of health profession students. In addition, however, it is important that sufficient funding be obtained through the Appropriations process. The National Rural Health Association has requested that 55 million dollars be allocated for the NHSC Field Program and 75 million for the loan repayment scholarship program. This would represent a substantial increase over the 50 million dollar total funding level of last year; however, it is an increase that we feel is vitally important if we are to even begin to respond to the desperate need for physicians and other health providers in underserved areas. I know you are well aware of this issue and we are deeply appreciative of the leadership Senator Daschle demonstrated in taking the lead in introducing National Health Service Corps legislation in the last Congress.

Other legislative issues of importance are continued and expanded support for Community Health Centers and support for state offices of rural health. The latter is included as part of the NHSC bill and would greatly benefit our newly organized South Dakota Office of Rural Health.

I would also urge that the Congress continue to address inequitable reimbursement, both to rural physicians and rural hospitals, by rapid implementation of the Resource Based Relative Value Scale and by acceleration of the schedule for elimination of the rural-urban differential in hospital payments. These provisions and several other important changes are included in Senator Packwood's Rural Health Improvement Act of 1990 (Senate 2214). I would urge your support for this legislation.

Turning to future issues, I would like to address three. These are: (1) health professions education, (2) quality assessment in health care, and (3) access to health care. With regard to *health professions education,* I would submit that our current system is producing the wrong types of professionals, instilling in them a distorted view of what constitutes high-quality health care, and is completely failing to respond to the desperate needs of the underserved as well as failing to respond to many of the wants and needs of the middle class. These problems have evolved from a value system and reward structure in medical education which have emphasized research in basic science and biotechnology at the expense of primary care and the bedside teaching. Bright students rapidly learn that advancement comes to those who garner Federal research grants and publish papers, whereas those faculty whose primary interest is patient care—especially primary care—are the lowest paid and have the least opportunity for advancement. I would submit that these forces, coupled with the gross inequities in reimbursement that exist, are responsible for the decline in interest in the primary care specialties which we have observed. I would urge that as the health professions legislation comes up for reauthorization that it be restructured to provide emphasis on primary care training. Such training must be increased if we are to have any chance of responding to the desperate needs we have for primary care providers in our rural and underserved areas. I am heartened by reports that there is an increasing level of interest on the part of health professions students in responding to the needs of the underserved. I believe this could be greatly assisted by changes in Federal legislation to provide

support to those institutions who have shown that they have an interest and a willingness to adapt their programs to demonstrate the great personal and social rewards that can be obtained from primary care practice.

The second issue I would emphasize is *quality assessment in health care.* We have assumed that we had the best of health care, even though we have acknowledged that we have had problems with distribution and equitable access. Recent research is demonstrating that in fact we have a very poor understanding of what type of care brings the best outcomes. Many of our assumptions on this issue are not being borne out by the data. Congress has wisely appropriated funds to support research into healthcare outcomes and healthcare effectiveness These are extremely important issues and deserve continued and expanded support if we are to come to rational conclusions about what care is appropriate. We have tended to assume that more sophisticated care is better care, and that centralization of care in larger facilities with a greater emphasis on technology brought about better care. I believe both of these assumptions are open to serious question and in fact the latter, namely that centralization is an effective way to insure quality, is in fact grossly erroneous. I believe that we need to broaden our concept of quality and that it must include concepts of easy access and acceptability to patients. Technically correct care that is inaccessible either because of geographic barriers or financial barriers, or that is delivered in a manner that is not acceptable to the patient, is not good care.

In summary we must greatly expand our understanding of the effectiveness of interventions, we must maintain accessibility to them and we must learn to deliver them in a way that is acceptable to the population being served. Anything less than this cannot claim to constitute quality health care.

Finally, and most importantly, is the overall issue of *access to care.* We are all too aware that we have 35-40 million people in this country without health insurance and that we have many more who either are poorly covered or who have the resources to pay for care but who have difficulty obtaining it simply because it is not available in their areas. Morbidity and mortality rates are substantially higher in rural and underserved areas, even among those who have resources to pay for it. All indications are that as costs rise this problem is getting worse rather than better.

Some would suggest that all we need to do is add more resources to the system. I believe, however, that that is not a viable option and that even if we did have those resources available, the current system would consume any amount we put in without any guarantee of better access or improved quality.

In an era where Federal resources are extremely limited, where the American consumer has indicated reluctance to pay more for health care as evidenced by the recent rejection of the Catastrophic Care Provision and at a time when American business is increasingly telling us that health care costs are forcing their goods to be less competitive on a world market, I believe it is essential that we completely restructure our approach to public financing of health care services and that we rethink the social contract that underlies that financing. I believe it is neither fair nor responsible to pretend that we can provide complete healthcare services to all of those who could benefit from them. What we have done, typically, as healthcare resources have been restricted and costs have gone up, is two things. We have either made eligibility requirements more stringent—that is we have redefined who is poor strictly for budgetary reasons—or we have ratcheted down the reimbursement to providers. Public programs no longer even pay the cost of providing those services and thus have to be subsidized from the private sector. I would submit that the former action, that is redefining the poor, is unethical and that the latter reimbursing below cost, weakens the entire system and further restricts access to services as facilities turn away patients in an attempt to preserve their financial survival.

In this context I would submit that we need to redefine our goals. Instead of covering an essentially unlimited range of services for a limited number of people leaving many needy without coverage as we currently do in existing Medicaid programs, I would suggest that we would be better served by a system which prioritized the value of services and provided everyone with access to at least a basic range of health services. The downside of such a plan is that some services would not be covered. This is rationing pure and simple, and that is objectionable to some people. What most critics fail to acknowledge is that in fact we have always rationed care but instead of doing it openly and explicitly and hopefully by an ethically defensible means we have done it implicitly and irrationally. I believe that the system developed by the State of Oregon, while certainly not perfect, deals with many of the fundamental inequities that exist. I would urge that the Congress examine this proposal carefully and grant the Medicaid waivers which are necessary to allow it to proceed in implementation. As we move toward a national health plan—which we are in fact doing—I believe we must find a way to guarantee access to at least a

basic range of services for all people regardless of their income or geographic location. Only through such an approach will we ever be able to deal with such unacceptable health status parameters as an infant mortality which ranks us 16th in the world.

Thank you very much for your attention. I certainly appreciate your efforts to improve the status of rural health and I look forward to your continued support on these issues.

Thank you.

PREPARED STATEMENT OF JOHN W. HERBST

It is a great honor for me to have been asked today to present to you in this forum some of the ongoing issues of the rural healthcare situation in 1990.

My purpose today is not to present another litany of what the problems are and what is wrong with the rural healthcare system in our country. It is my firm belief that this issue has been studied enough and that the time has come for very strong, bold, decisive and innovative decision-making on these issues. Even as we speak, rural hospitals are closing across our nation. Projections continue to show that 600+ hospitals will be closed within the next five years, and once they are closed, never will they open again.

Unless bold action is taken immediately, and 1 emphasize immediately, this situation of rural healthcare demise in our country most likely will reach a point from which it cannot be resuscitated. The future productivity of our country is, in part, based on the institutions of education and adequate healthcare for its citizens. Across the nation, people are standing up and speaking out on the education issue, but all too few are standing up to speak out on the demise of our healthcare system. Senator Daschle and Senator Kerry, I wholeheartedly thank you for being two of the bold and insightful few who are willing to take a stand concerning this ongoing national crisis.

In the May 1, 1990 Annals of Internal Medicine, the American College of Physicians, presented what I considered a bold and innovative stance in proposing drastic changes in our nationwide healthcare system. I believe this stance is a landmark for several reasons: For the first time a group of organized physicians have stood up and in mass offered to contribute to the solution of this problem rather than to be once again against any change in the status quo of the system. Secondly, this proposal by the American College of Physicians, again proposed by organized physicians, is an attempt to address the issues which are in the best interest of nationwide healthcare and not just what issues are best for physicians. Lastly, this issue of national healthcare is not just one of an issue of healthcare, per say, but the stance taken by the ACP is also a political statement.

This proposal by the ACP will not be without its critics, and indeed, I myself, after having reviewed it intensively, have some misgivings of the issues proposed. Nevertheless, I believe that this a framework and foundation upon which a future plan for the healthcare of our country can be based. The loudest critics in this issue will state this "socialized medicine." To date, few physicians or powers to be in political office have dared to bring this issue to the forefront. I, as a physician, am here to state that if we physicians fail to contribute to the solution of this problem, we will only have ourselves to blame, when the solution has come about without our input.

The nationwide overview of these issues which have brought us to this present crisis in healthcare show clearly that the same problems come time and time to the forefront. These include inadequate access to healthcare which is just another way to state that inadequate financing is available for adequate healthcare for all of our citizens. A second problem is that of inadequate health insurance protection which is both equitable and uniform to all of our citizens. Thirdly, the continued and dramatic upward spiraling of healthcare costs to which administrative costs of present day healthcare insurance systems are overburdening to the point of being prohibitive. Lastly, the current healthcare system in our country has evolved into incredibly ineffective and burdensome system for patients, their families, and physicians which undermines the access to adequate healthcare, as well as the patient-physician relationship as we have traditionally known it.

In the short period of time allotted to me today, it is impossible to discuss in detail all of the ramifications and provisions of the proposed ACP universal healthcare access proposal. A national healthcare program is needed to insure access of all Americans to an appropriate healthcare program and this access must be provided irrespective of age, sex, race, financial status, or place of residence. The existing pro-

gram is growing expensive evermore ineffective, and a new approach is required. I would like to state that the healthcare system to date in the United States of America, in my mind is undoubtedly the best that there is on the face of the earth. However, with the spiraling costs and the rocketing technology of modern healthcare, a new approach is needed to assure the citizens of this country are able to afford healthcare and to take advantage of the healthcare technology which is evolving.

In establishing a universal access to a health insurance program, such as is available in virtually all other industrial nations of this world, all Americans would have specific health insurance benefits and financial access to mainstream healthcare. Administrative costs of current healthcare programs, most likely would be lowered because of the elimination of the duplication and costs for excess billing and processing of claims etc. which is ambiguous to today's system. A reduction of only 1% of the total amount of administrative costs would save an estimated $5.5 billion annually in healthcare dollars.

The obvious and logical question is how would such a universal healthcare program be financed. Costs could be paid from tax revenues, or by some combination of individual/employer premiums, supplemental insurance programs and government subsidies. Likewise, different tier levels could be individualized for payment between Federal and state funding. Projected savings from administrative costs under such a program could be as high as $60 billion/year and these savings obviously could be shifted toward the funding of such a program. Financing could be from general tax revenues, surcharge on income taxes, payroll taxes, or if we choose to attempt to keep President Bush happy in not having to say the "T" word, he could label it a users fee. Cost containment and controls to avoid excessive and unwise use of such medical services obviously would be integral part of this program. Financing, as well as implementation of such a program could hopefully be built on the some of the strengths of learned experiences of existing healthcare mechanisms in place today.

Again, time constraints today preclude me from going into details of such a complex program, and indeed, certainly all of the details certainly have not been worked out.

As I have already eluded to, there certainly will be detractors to such a nationwide healthcare program. Certainly some of the loudest detractors, will be my fellow colleagues in the medical profession. Physicians are increasingly concerned today over the intrusion into medical care by outside forces. These outside forces have drastically changed clinical medicine as we have traditionally known it and the recent Medicare, and most recently the DRG disasters have only worked to deepen the suspicions of physicians as to any other government interference in the medical care industry. Any system which further diminishes physician autonomy in mind is most likely doomed to failure. Nevertheless, once again physicians are, for the first time, willing to look at drastic changes in our healthcare system for the good of the healthcare delivery system itself, and ultimately the final product—quality patient care.

In summary, Senators Daschle and Kerry, the American College of Physicians has presented what I perceive to be a new bold, innovative and challenging proposal for a national healthcare system. I think that, without a doubt, such a system is on the horizon and the American College of Physicians is asking by their proposal to be a part of the decision-making in this new bold venture. I present this, not as the ultimate answer to the healthcare problems that we have today, but as a possible framework and foundation upon which to build. Certainly major reforms today are necessary. Piecemeal, superficial and political stopgap measures may offer short term solutions, but at a tremendous and I feel unwise risk for the future of our healthcare in our country. Therefore, I feel such daring innovative and comprehensive reform, such as proposed by the ACP deserves serious discussion and consideration.

Senator Daschle, at the last hearings on rural healthcare, I stated in my testimony that South Dakotans are extremely fortunate to have you representing them in these healthcare dilemmas. That statement is more true today, than ever. Over the last year I have written to you on multiple occasions concerning these issues and each time you have personally replied to my correspondence. Today I wish to personally once again thank you for your continuing concern and efforts on behalf of all the South Dakotans who are fearful of what the future holds for ourselves, and our families in these areas of rural healthcare concerns. Thank you very much.

PREPARED STATEMENT OF SUSAN J. JOHNSON

Good morning, Senator Daschle and Senator Kerrey. My name is Susan Johnson, RN, CPNP, MPH, Ed.D. I am a Certified Pediatric Nurse Practitioner and chairperson of the Department of Nursing at The University of South Dakota in Vermillion, South Dakota. I would like to thank you for the opportunity to address the issue of the future of rural health care. Except for the years spent in school at The University of Minnesota in Minneapolis, I have lived in rural America all of my life. It grew up on a farm in central Minnesota that has been in my family for over 100 years. I have both a personal and professional interest in addressing the problems facing rural citizens.

It has been a widely held belief that living the country life was a preferred life style that offered relaxation, enjoyment, and health . . . the best place to grow up or to raise a family was on a farm away from the problems of the city. However, over the last ten years there has been a growing awareness that all is not well in rural America. Unfortunately for the millions of Americans who live in rural areas, the issue of access to affordable health care is one they must live with on a daily basis. The problems: rural hospital closures, health manpower shortages, reimbursement system inequities, inadequate health insurance, high accident rates, economic instability, and mobility concerns have all been identified. What needs to be implemented is a comprehensive system of health care that will provide a framework to address these problems on a long-term basis. We need a rural health care plan. A band-aid approach will no longer suffice as our rural areas are hemorrhaging badly.

RURAL DEMOGRAPHICS

We have an aging population. The percentage of rural elderly is greater than the percentage of urban elderly. Since the elderly are less mobile and tend to need more health care, a responsive health care system must address the complicated needs of the geriatric patient. There is also a high percentage of children living in rural areas. Unfortunately, a recent report by the Columbia Center for Children in Poverty estimated that 5 million children in this country live in families below the poverty level and more than half of the poor children live in suburbs and rural areas. The 23 poverty rate for children under six is more than double the rate for adults and about twice the rate of Canada. Current figures suggest that 40 of the children eligible for Medicaid are not receiving aid.

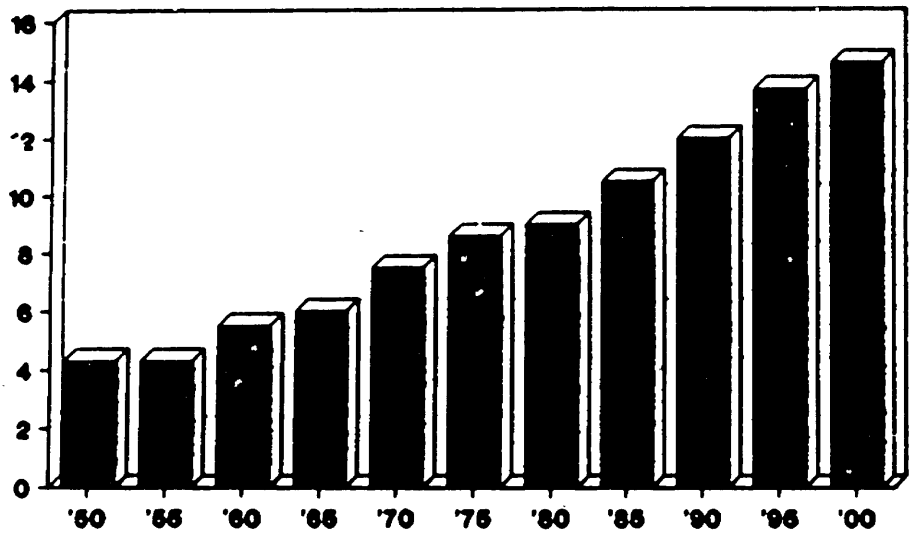
It is generally accepted that prevention of health problems in children will dramatically reduce future health care costs in the adult. Furthermore, to a nation concerned about the education of its youth, the skills of future workers, and competition in a global economy, it is truly an investment in America to invest in our children.

COST

As you are well aware, the amount of money spent on health care every year in this country is rising at an alarming rate. It is estimated in 1990 we will spend 12% of the Gross National Product on health care expenditures. By the year 2000, expenditures for health care are projected to use up nearly 15% of the GNP.

HISTORICAL AND PROJECTED HEALTH

[Expenditures as a Percent of GNP]



Source: NACDS Resource Guide

Despite the fact that we spend the most per capita of any industrialized country in the world, 37 million Americans have no health coverage, ½ of whom are children, and our infant mortality rate is appalling. The question needs to be asked: "What are we doing wrong?"

WORLD HEALTH ORGANIZATION GOAL

More than 15 years ago, the World Health Organization (WHO) set as the global objective "Health for all by the year 2000." The strategy chosen to achieve the highest level of affordable care for the most people was primary health care. Primary health care as defined by WHO includes:

—health promotion and disease prevention
—community determined and community based care
—use of appropriate health care technology
—use of appropriate health care personnel
—collaboration among health professions and between the health sectors such as social welfare, utilities, environment, housing, transportation, and so forth.

Even though we are a wealthy country by world standards, we are not doing an adequate job in the five areas of primary health care as defined by WHO. We have not focused our attention or our money in the provision of basic health care services.

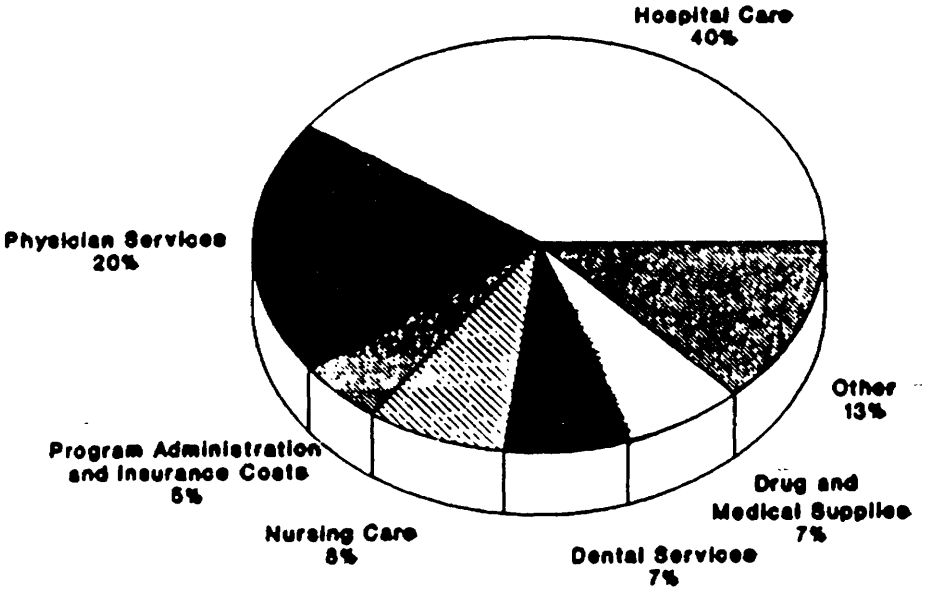
—For the most part, the four Federal payors do not cover health promotion and disease prevention services or case management services in health care settings in rural areas.
—Rural communities have not gathered together their constituents to discuss community health care needs and solutions.
—The use of appropriate health care and communication technology is vastly different from community to community.
—Collaboration among health professions and between the other health sectors is a rarity.
—Health care personnel are not always utilized in the most efficient manner.

IMPROVING ACCESS TO HEALTH CARE

Nurses are essential and often underutilized members of the health care team. The 1.6 million employed nurses in this country represent the largest number of any of the health professions, yet they consumed just 8% of all health care expenditures in 1989.

1989 HEALTH CARE EXPENDITURES

[Total $550 billion]



Source: Health Care Financing and Administration

Appropriate use of nursing services expands access to health care, increases the quality of care and is cost effective. Nurses are often the first point of contact between the consumer and the health care system.

Nurse practitioners are becoming increasingly important to the delivery of health services in rural areas. The American Academy of Nurse Practitioners published documentation on the cost effectiveness of nurse practitioners which includes data stating that 80% of adult primary services and up to 90% of pediatric services could be performed by nurse practitioners. Potential cost savings with the use of nurse practitioners was estimated at 0.5 billion to 1.0 billion dollars or 19 to 49% of primary care provider costs.

The 1986 Office of Technology Assessment Study (OTA) concluded that coverage by Federal third party payors would remove barriers to practice and in some settings improve health care for segments of the population that are not being served adequately.

Nurse practitioners are important to the delivery of health services in rural areas. Yet demand is currently exceeding the supply with rural areas competing with urban for these professionals.

A recent survey by the South Dakota Academy of Physician Assistants in the spring of 1990 revealed 28 unfilled nurse practitioner or physician assistant positions in South Dakota. As some rural hospitals consider alternative delivery options and rural health clinics expand, the demand for nurse practitioners will only continue to rise. If supply is to keep up with demands, we need to increase the number of nurse practitioner programs in this country and locate programs near rural areas. We have learned in South Dakota that students who come from rural areas are more likely to return to rural areas to live and work. We have also learned that rural students need and appreciate Federal financial support to go to school.

While the problems of access and cost will not be solved overnight, current steps being taken by Congress will help to relieve some of the pressure experienced by rural Americans. In particular, three pieces of current legislation are of vital importance. The Rural Nursing Incentive Act (S. 1384—Senator Daschle) provides for direct reimbursement under Medicare for nurse practitioner and clinical nurse specialists who provide services in rural areas. The Rural Health Improvement Act (S. 2214—Senator Packwood) and The National Health Service Corps (S. 2617—Senator

Kennedy) will also help provide incentives for health professionals who choose to practice in the neediest of rural areas.

FUTURE DIRECTIONS

For the future, we need to build a rural health delivery system which is centered around primary health care. This approach would include:

1. The education of an increased number of primary health care providers and the creation of incentives (such as tax incentives) for these providers to locate and stay in rural underserved areas.
2. Rural health care facilities of the future must be linked to academic health care centers through computer setups and in some cases, interactive video. Patient data then can be transferred for consultation and advice. Rural providers could also access library and nutritionists, pharmacy, nursing and other consultative services.
3. Outreach consultative specialty services provided by academic health care professionals in rural communities. Such services offered in a collaborative manner enhances the technical skill of rural providers and fosters understanding by academic health professionals on rural health care issues.
4. Emergency medical services available in every rural community. In addition, every rural state should have an elaborate air transport system which includes ground transport, helicopters and fixed wing aircraft all outfitted as mobile intensive care units with health care teams.
5. Establishment of a new demonstration program to help assist rural communities in learning the mechanism of community assessment and interagency collaboration.
6. Transportation support for the elderly and for children.
7. Agricultural health and safety services. Health care providers are needed who are knowledgeable about the diseases, illnesses, and injuries related to farming and ranching.
8. Rural health initiatives must include mental health concerns including depression, suicide, abuse, and alcoholism.
9. Rural minority populations face special access problems to health care services. New creative strategies must be developed including the education of more minority health professionals and the understanding of all health professionals of the special health problems facing minority communities.
10. Explore options such as the community health center concept designed to provide preventative services, primary care, and long-term care services. Nursing would have a critical role in services provided in these centers.
11. Expansion and restructuring of the Medicaid program for mothers and children with standard eligibility requirements, uniform benefits and minimum payment guidelines.
12. Innovative alternatives for the provision of home care services in sparsely populated settings. Nurses as case managers could train and assist families identify community resources.

Senator Daschle and Senator Kerrey, the debate over how to increase access to health care and reduce costs will be a long one. I hope the ideas I've mentioned will be helpful to you and other members of Congress as you restructure our rural health care system to better serve the needs of rural America.

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PREPARED STATEMENT OF LAVERN NORMAN

I believe we should do away with malpractice suits. If we had a head tax of $5 a head for 250,000,000 people in the United States it would amount to $1,250,000,000, at $10 to $2,500,000,000.

This money could be used to compensate patients for mistakes or negligence without having to sue the medical profession.

Some realistic sums to be paid out could be established. A five man board could be appointed to review each case to see if a patient would be entitled to be compensated and also make sure the medical profession was accountable for its actions.

The way it is now a patient could sue a doctor and get a $100,000 settlement. When the dust settles the patient would have maybe $50,000 left. That leaves the doctor and the patient both out $50,000.

The terminal sick patients such as dialysis patients should be in a group by themselves.

Their domestic lives are sadly neglected. Their medical bills and living expense are much higher then families with no medical problems, yet their income limits are the same as others before they can receive aid of any kind.

The person or persons taking care of them in their domestic lives are given no consideration. The condition of their domestic life has much to do with their physical and mental well being.

The terminal patient should not be subject to lawsuits and collection agencies. I think it is a shame our courts will send the sheriff out to seize property of these people and worse yet the sheriff takes a cut for himself too. The doctors that won't take care of these people for what they can afford or Medicare and insurance should not accept them as patients.

The Medicare payment system needs to be changed. The family doctor does three-fourths the work and gets one-fourth the pay. The specialists and surgeons get far to much of the Medicare pie. Equal pay for equal work has long been a goal for this country, not so with Medicare. My wife's doctor we were working with in Omaha got a check from Medicare for $240 and an insurance check for $60. Her doctor here in Rapid City gets a Medicare check for $105 and an insurance check for $26. That is by the month.

There is a law in South Dakota that states all x-rays must be read by a specialist. This places another bill for the patients to pay which for the most part is unnecessary. I would hate to think that most of the doctors here in Rapid City are not capable of reading x-rays.

I think that the amount that Medicare pays doctors is adequate. The exception being the family doctor. If doctors that won't accept assignment of Medicare couldn't get a Medicare check, a lot more of them would accept assignment.

It doesn't take long for things to get out of hand when the person signing the check can't fill in the amount.

The medical needs of those who work for minimum wage has to be addressed. The government and the employer are going to have to cooperate in getting some medical insurance program for these people. You have heard stories of patients paying $5 to $7 dollars for an aspirin in the hospital. The medical profession calls it cost adjusting. What it amounts to is that patients lying in the hospital beds with the means to pay their bills are subsidizing the operations of those who pay minimum wages.

Malpractice insurance and malpractice law suits have long been a thorn in the side of the medical needs of the American people. First we must make a distinction between making a mistake and negligence. To expect someone to practice medicine all his life and never make a mistake is not being realistic.

PREPARED STATEMENT OF GARY P. RIEDMANN

Good afternoon, Senators Daschle and Kerry. I am Gary Riedmann, President of Rapid City Regional Hospital and Black Hills Rehabilitation Hospital.

It is a pleasure to speak with you this afternoon about the future of rural healthcare. Although the present status of rural healthcare is certainly troubled, I am confident that this important segment of the healthcare continuum can be, and, should be revitalized. I will be restricting my comments to three interrelated issues.

1. The need for a national rural healthcare policy.
2. The need to change the current maldistribution of medical professionals.
3. The need for strategies to strengthen rural community healthcare services through linkages between rural providers and regional medical centers.

NATIONAL HEALTHCARE POLICY

Certainly a most fundamental deficiency in the current rural healthcare delivery system is the absence of a clearly defined national policy. Frequently, state and Federal healthcare policy makers are pursuing worthwhile, but often divergent objectives. This lack of a coordinated, unified purpose has proven to be costly for many rural communities. It is absolutely vital that decisionmakers, in government and the private sector, formulate a meaningful approach to rural healthcare.

It often appears that interest in rural healthcare has been profoundly eclipsed by a desire to cut costs. There seems to have been a silent agreement to support the rationing of healthcare. We have seen cuts in Federal funding compromising the accessibility, availability, and quality in rural settings.

The following mission statement and corporate goals identify our local efforts to develop appropriate direction and leadership as a provider of rural healthcare services:

The Mission Statement

The Mission of Rapid City Regional Hospital and Black Hills Rehabilitation Hospital is to provide leadership in maintaining and improving the healthcare of all people in this region by providing quality services through innovative programs, comfortable and convenient facilities, and a staff of caring physicians and employees.

We will act for the benefit and on behalf of our affiliated organizations to ensure a financially viable healthcare system.

Goals

1. To develop mutually beneficial relationships with other local, regional and national healthcare organizations.
2. To be recognized and utilized by physicians in the region as a referral center provider, and partner in providing primary, secondary tertiary and specialty healthcare services.
3. To operate in an efficient and effective manner under policies which ensure preservation of the economic value of our hospitals and provide sufficient financial flexibility to implement our corporate objectives.
4. To provide efficient healthcare services through continually improving management and employee performance, quality of work life, and productivity.
5. To recognize the importance of education in the provision of quality services.
6. To maintain state of the art technology in those areas in which the technology shows a demonstrated need supported by patient utilization and adequate reimbursement.

This is an example of how a local board of trustees has set their direction for the future. It would be helpful for the Federal Government to also develop a flexible national policy statement, to support rural healthcare efforts including the following issues: health manpower, primary health services, prevention and education, reimbursement, regulation, access to care, and the use of limited resources, in an efficient and effective manner, to encourage quality, clinically effective healthcare services.

MEDICAL PROFESSIONAL

The United States is currently confronted with the paradoxical situation of having a surplus and shortage of medical professionals. In essence, what we really have is a maldistribution of medical professionals. A serious shortage of medical professionals, particularly physicians, occurs in many rural communities. Although many rural communities offer the prospect of substantial income to physicians, a

variety of variables conspire to prevent physician levels reaching a market equilibrium in rural areas. The government has repeatedly vacillated on the issue of physician supply. In 1965 Congress passed a Health Professional Education Assistance Act to stimulate the increased production of physicians. This ultimately resulted in a rapid rise in the physician/population ration. However, for a variety of reasons, physicians continue to consolidate in urban areas.

A new method of subsidization of medical education offers a potential solution to the maldistribution of physicians. Medical students are highly subsidized for their undergraduate and graduate education, but with minimal benefit for rural communities. Although the perfunctory question of practice location is part of the admission ritual to medical school, there is little control over eventual practice location. The entire medical education system needs to encourage specialization that is compatible with, and offers incentives for a rural practice.

I am convinced that the survival of healthcare in rural communities is largely contingent upon the establishment of strong incentives at a state and Federal level for medical graduates to locate in rural communities.

RURAL/REGIONAL LINKAGES

The encouragement of linkages between rural healthcare providers and regional medical centers offers a concrete model for strengthening our rural healthcare system. The current fiscal environment of large deficits, efforts to reduce government expenditures, and emphasis on competition has done little to foster cooperation between healthcare providers. This is unfortunate. My experience in the states of South Dakota, Nebraska and Iowa has led me to believe there are tangible improvements in efficiency and quality of patient care when healthcare providers recognize the benefits of working with one another. State and Federal governments should encourage the sharing of resources to encourage both efficiency and effectiveness.

There is ample evidence to suggest healthcare is largely a regional phenomenon. Recognition of this fact can serve to be mutually beneficial to both the smaller and larger communities. The smaller community healthcare provider can gain access to diagnostic, therapeutic, and management services while maintaining local community identity and control. The regional medical center benefits from the referral of patients needing specialty care in an efficient and effective manner. Efforts should be made to encourage a closer bonding between rural healthcare providers and their urban counterparts. The ultimate result would be the significant enhancement of rural healthcare services.

The successes of working together will result in improvement of our rural communities satisfying both physical and economic needs. A recent study indicates that the death rate from trauma is more than two times higher in rural areas. This is only one example of how an enhanced rural healthcare system could offer improved results in healthcare. The economic health of healthcare providers is also a critical point to remember. Rapid City Regional Hospital and Black Hills Rehabilitation Hospitals are the largest employer in Rapid City, offering quality employment opportunities to persons in over 390 career fields. It is typical throughout our region that the local healthcare providers are also one of the largest employers in their communities. However, a research study has shown that when a local community hospital closes, a significant number of main street businesses do likewise very soon afterwards. A policy directive encouraging successful cooperative efforts in rural healthcare will result in stronger and healthier rural communities throughout our nation.

In conclusion, we appreciate your efforts to find innovative means to strengthen rural healthcare services. Your efforts in the United States Senate to encourage a strong national policy on rural healthcare, the encouragement of medical professionals to practice in rural areas, and strengthening locally coordinated leadership in healthcare services will be a benefit to millions of Americans.

STATEMENT OF CHARLES ROSE

My name is Charles Rose, and I am presenting this testimony on behalf of the South Dakota Medical Group Manager's Association. We are an organization of more than 100 in South Dakota and 8,000 nationally. Each of us is involved in the active management of physician practices ranging in size from a solo physician to several dozen. We are responsible for the day to day conduct of all management aspects of physician practices including finances, personnel, physical plant and any other non-medical needs. Our collective role is to guide our physician employers

through the increasingly complex structure of medical care reimbursement. We daily serve in the trenches dealing with financial conflict between our employers, the patients they serve and those who pay for those services. Today, I would like to share with you our perspective on rural health care.

We will present to you testimony to support the proposition that rural health care in South Dakota and nationally is continuing on an extended decline which cannot be arrested through current fiscal and legislative measures. Only through an explicit restructuring of rural health delivery and its financial support can we attain a stable and acceptable system of rural health services. Finally, we must integrate rural health needs with urban health resources to reverse the trend.

As you are aware, the characteristics of South Dakota's rural population generally reflect per capita income lower than urban, a lower proportion of health insurance coverage than urban and higher proportions of Medicare beneficiaries than urban. Further, the population density is substantially lower and continues to decline. This boils down to less money spread over the same geographic area to operate any type of health service regardless of its' configuration.

In spite of the obvious trends, we continue to attempt the delivery of rural health services by mimicking urban systems. Without regard to the economic facts of life, we finance small isolated hospitals and declare them to be equal to their urban counterparts in delivering care. Although we limit the comparison by declaring rural hospitals to be primary care hospitals, we find that primary care is usually more complex and complete in the urban facility. As a rule rural primary care physicians attempt to provide care equal to their urban peers without equal access to either technology or consultation with other medical specialists.

Inevitably, the existing system of rural health care must decline. It was created during an era when financial, technological and personnel factors were not nearly so complex. The technological base of a contemporary "hospital" cannot function without tremendous patient utilization to justify the capital cost and skilled support personnel. Further, contemporary primary care physicians train in major medical centers with faculty possessing routine access to technology and consultation that will never be available in most rural facilities. Because the necessary diagnostic and treatment resources are intensifying in urban areas, rural physicians are forced to refer their patients there with increasing frequency. Finally, rural physicians find their incomes reduced relative to their urban counterparts due to lesser rates of reimbursement for their more numerous Medicare, Medicaid and no insurance patients. We should not be surprised that young physicians trained to practice with the highest level equipment and personnel won't subject themselves to the risk of less adequate support and income

The ultimate factor is the changing attitude of rural citizens. Often perceiving differences in quality between rural and urban health care providers, they are more frequently opting to travel longer distances to the urban setting. Interestingly the trip to an urban physician is sometimes justified by a greater variety of retail shopping and services also available in that location. Perhaps, rural health care is subject to the same forces affecting other community services that have shifted to urban settings.

We do not believe that the decline and eventual collapse of rural health services is inevitable. We can act to realign our resources for the most effective results. However, reorganization must meet the dual criteria of financial feasibility and need.

Emergency care commands the highest priority of all medical activities. The public financing of a rural emergency medical care and transportation system maintained to a single standard should be a first priority. All citizens of South Dakota and additionally out of state travelers are potential beneficiaries. Financial feasibility is also great as cost can be spread over a large number of persons.

Beyond emergency medical services, we obtain the best medical results and, coincidentally, reduce costs most effectively through prevention and early diagnosis. These services do not require in-patient hospital stays. Further, modern equipment used for primary diagnostic care is usually portable and reasonably inexpensive. Thus we have the option of rotating the service location to meet the needs of more persons over a larger geographic area. This mobility allows us to simultaneously reduce cost through more efficient use of equipment and personnel.

Prevention and early diagnosis requires the support of many more technicians than physicians. Further, mid level practitioners, such as physicians assistants and nurse practitioners can be very effective in extending a supervising physician's reach. While cost effective in urban settings, justification for locating all necessary support personnel at one low intensity site is no longer possible. Again the mobile or circuit riding approach is financially responsible.

Mobile rotation is not new and, in fact, is being used today for a variety of high cost diagnostic services in South Dakota. Adapting more medical services to this model is actually nothing more than continuing current trends.

This non-hospital based ambulatory model is not new. Federally financed programs including the National Health Service Corps and Rural Health Centers deliver care in several sites in South Dakota using this format. However, we perceive the results are less than desired. Physicians do not seem to stay on location after their obligation expires. Private physician groups contracting to operate Rural Health Centers are experiencing a financial drain.

These mediocre results can be reversed by restructuring Federal support for rural health services to emphasize non-hospital based primary care and creating incentives for existing urban health care provider's to participate in rural health delivery. It is definitely in the power of yourselves as members of the Senate Finance committee to accomplish this.

If you agree that the greatest threat to the lives and health of rural citizens is inadequate emergency and preventive care, you should mandate more financing for these services and reduced support for inpatient facilities. The current marginal increases in Medicare reimbursement for both rural hospitals and rural physicians are inadequate.

Additional rural physicians will not be recruited and rural hospital facilities will continue to close. Instead of spreading your financial resources thin, focus them for maximum effect.

Besides improving financial incentives, encourage physician groups to develop innovative mechanisms to deliver on site rural services. Permit increased use of mobile facilities among several communities. Fund experimental applications of advanced technology to span the geographic barriers to cost effective service. In short, tap the creative energy of the most highly educated group of professionals in South Dakota who are also the most familiar with the specific problems of caring for our rural citizens.

We ask you to also remove the roadblocks and negative incentives created by Congress and the Federal establishment. Specifically, your revision of the fraud and abuse language in the Social Security Act is urgently needed to clarify how medical providers can interact to create the required delivery systems of the future.

Regulatory agencies have so broadly construed the prohibitions of the Social Security Act that it is difficult, if not impossible for two medical groups to legally cooperate to improve rural health care. The paranoia is so great that the Department of Justice will not even permit the Department of Health and Human services to give a legal opinion on request. Taxpayers routinely obtain these opinions from the Internal Revenue Service.

These prohibitions were drafted by Congress in a different era of health care. Please advocate their immediate review in light of the needs of our contemporary system. We will not be able to bring the full resources of South Dakota to bear on rural health needs unless you remove the roadblocks.

To summarize, the current decline in rural health care availability is reversible only through substantial modification of its structure. Financial resources should be directed towards innovative emergency and primary care, reserving high cost hospitalization for the urban setting where it can be most efficiently provided. Specific incentives for urban medical groups to participate directly in rural medical care should be established. Finally, remove the regulatory roadblocks to effective cooperation among medical groups for the benefit of their patients.

STATEMENT OF DR. LOREN TSCHETTER

My name is Dr. Loren Tschetter. I am in the practice of oncology (cancer medicine) in Sioux Falls, South Dakota. I am the secretary of the American Society of Internal Medicine and the American College of Physicians. These organizations represent internal medicine physicians in South Dakota.

I would like to make one personal observation regarding the question of access. In order for there to be access, there has to be the availability of physicians. I am concerned because I have observed over the past few years that fewer students are interested in medicine in general. I am also concerned that fewer students are interested in the very specialties that are needed, i.e. family practice, general internal medicine, etc. The reason for this relates in part to the faulty reimbursement system that has been developed by third party payers and HCFA. This payment system depends heavily on procedures and less so on cognitive thinking. The new direction of HCFA in relation to the Harvard Relative Value Scale may help correct

this in the long run; however, I am somewhat pessimistic that this will occur. I am concerned that simply heavily weighted procedures will be decreased in their reimbursement and that cognitive thinking reimbursement may remain stable or also decreased. I realize there is a phase-in period for the new system; however, in South Dakota physicians who do mainly cognitive type of practice are finding under the first year of the phase-in their cognitive values are actually being reimbursed at a reduced rate. I am fearful that there is a lot of lip service by the government and HCFA to cognitive thinking but very little real action.

As Mr. Drew pointed out in hospital reimbursement, while the rural differential was to be improved it actually in surrounding states has been decreased and that South Dakota has improved at a mere pittance of 1.5%. This is an example of lip service but no real action, in my mind.

I believe that all of this is socially irresponsible on the part of HCFA and the government, and I am concerned that this continuing social irresponsibility will decrease the number of qualified people going into medicine and specifically decrease the number going into the very specialties that are needed.

One last item that I would like to personally mention is that I believe it is fundamentally wrong for the Federal or State government (Medicare and Medicaid) to demand services at levels of payment that require physician subsidization. Certainly there is evidence that Medicare patients and especially Medicaid patients are receiving services at less than cost. I believe it is unfair to shift this to other payers, and I believe that government needs to accept the responsibility of their obligations, i.e. one cannot pass laws and guarantee services unless one is willing to pay for them and have revenues to pay for them.

PREPARED STATEMENT OF ALLEN WINCHESTER

Good afternoon. My name is Allen Winchester. I am a clinical social worker in private practice here in Rapid City, and I am President of the South Dakota Chapter of the National Association of Social Workers (NASW). NASW represents 127,000 professional social workers, approximately 200 of whom are located in South Dakota.

Thank you for inviting me to participate in today's hearing on the future of rural health care.

NASW believes that the future of rural health care, and the nation's health care as a whole, lies in the development of a national health care program.

We've all heard the alarming statistics which point to the need for fundamental restructuring of our health care delivery systems:

- 37 million Americans have no health insurance coverage, and an additional 50 million have inadequate coverage.
- 12 million of the uninsured are children, who from infancy are denied the benefits that medical technology has to offer.
- Health care costs are sky-rocketing, with 12% of our gross national product spent on health care costs. This figure is expected to reach 15% by the year 2000.
- Millions of Americans are afraid to change jobs because of pre-existing health conditions.
- Ever increasing numbers of employers are eliminating health coverage or cutting back on health benefits.

These statistics are even more alarming in rural communities—

- A higher percentage of the rural population is uninsured—at every income level.
- Rural poverty and unemployment rates are disproportionately higher than those for urban areas.
- Only ¼ of the rural poor qualify for Medicaid coverage.

The health care crisis is further compounded in rural communities by the shortage of primary care providers and services, particularly severe for obstetrical care, and the growing numbers of rural hospitals which face financial strain and, at times, are forced to close.

NASW has a long-standing history of support for a national health program through which all Americans may receive equitable, quality care. The association believes that our current systems of health care delivery are in a state of crisis, and that we need to direct our attention to the development of a simplified, single-payer, national health program.

I would like to share with you an outline of a national health care proposal which was recently developed by NASW and unanimously approved by our national Board of Directors in April I wish to warn you, in advance, that I am not a health policy expert, so I may have to defer specific questions on the plan to NASW's health staff at our national office I would like to outline this proposal because I believe that the health crisis in rural America, and the nation as a whole, point to the need for a national health program which offers flexibility to meet the special needs of rural communities

In the interest of time, I will highlight a few features of the plan and request that my written testimony be submitted for the hearing record

The NASW national health care proposal fundamentally restructures our current fragmented and costly health care system The plan is designed as a federal-state partnership The Federal Government maintains overall administrative control through strict Federal guidelines and taxing authority The states assume the responsibility for the delivery of health services and payment to all providers.

The principal features of the NASW national health care plan are as follow:

COVERAGE AND ENROLLMENT

All persons residing in the United States are covered through the national health plan. Each person has the freedom to choose from among any of the participating public and private providers facilities or care delivery options Individuals enroll in the national health plan in the state in which they reside. Coverage through employer or other privately purchased health insurance will be discontinued, although private insurance plans may provide coverage for services not covered under the national health plan

BENEFITS

The NASW plan provides coverage for comprehensive health and mental health benefits This includes disease prevention and health promotion services; care coordination services, mental health services, substance abuse treatment programs; rehabilitation services hospital services, inpatient and outpatient professional services laboratory and radiology services, long-term care, including home and community-based services hospice care prescription drugs, dental care; hearing and speech services, and vision care

Certain health services such as cosmetic surgery, are excluded from coverage under this plan

IMPROVED SERVICE DELIVERY PROVISIONS

The NASW national health plan is intended to be more than a mechanism for ensuring access to health care It provides a framework for the delivery of quality health care This includes

- Primary prevention and health promotion services for everyone, that emphasizes well-baby care, prenatal care, and school-based health programs;
- Care coordination services that will ensure cost-efficient comprehensive, coordinated care for individuals with multiple and costly health problems;
- Comprehensive health delivery plans that promote integrated health services, similar to the original concept of the health maintenance organizations;
- Improved access to health and mental health services for underserved inner city and rural populations, such as the expansion of primary care services, support for mobile health units and rural health and mental health clinics, and incentives for health professionals to serve in rural areas,
- Increased support for community-based health and mental health services, and a reduction in costly inpatient care; and
- State screening and care coordination systems for the delivery of long-term care, including home and community-based services.

COST-SHARING

Under this plan, there will be no deductibles. We also believe there should be no copayments, although provision is made for copayments if necessary to control utilization. However, limitations are imposed on the use of copayments, which would require that they not impede access to health care and must be collected in an administratively efficient manner.

Residents of nursing homes and other residential facilities will be required to pay a modest room and board fee.

ADMINISTRATION

The NASW plan seeks to streamline the chaos of our present health system into a single, administratively simple and cost-efficient system.

A new Federal National Health Board (NHB) will be established as an independent agency to administer the national health care plan. All responsibilities of the Health Care Financing Administration will be transferred to the NHB. Medicare, Medicaid, CHAMPUS, and other Federal health programs will be phased out under this national health care plan.

The NHB provides the states with an annual lump sum or global budget for all covered state health care expenditures. The states will, in accordance with Federal guidelines, ensure the implementation of all state health services, determine the distribution of all health care funding, and provide for payment of all health care providers.

PAYMENT TO PROVIDERS

Under the NASW plan, payment to providers will be carefully regulated to ensure reasonable payment while reducing administrative waste.

Hospitals will receive a set annual global budget for operating expenses. Separate funds for capital expansion and purchase of expensive, highly-specialized equipment will be subject to approval by the state.

Other health care facilities, such as community clinics, nursing homes, or rehabilitation facilities will be paid either on the basis of a global budget or a per capita fee as determined by the state.

Health care practitioners and group practices will, in general, be reimbursed on a fee-for-service basis. The reimbursement rate will be based on a national fee schedule for each classification of practitioner, similar to the resource-based relative value scale being implemented for payment to physicians under Medicare.

A newly-established National Council on Quality Assurance and Consumer Protection is responsible for determining guidelines and monitoring the quality assurance system. Quality assurance standards, certification and licensing criteria, and standards for all health care providers will be established by the NHB.

Peer Review Organizations (PROs), extended to cover all types of health care providers and services, will be responsible for utilization review and quality control. Each PRO is required to have a Consumer Board that will oversee the PROs.

A consumer advocacy program will be established on the Federal and state levels to administer ombudsman programs, hotlines for complaints, consumer information and education programs.

PLANNING

The national health plan requires local, state and regional health planning efforts to ensure equitable distribution of all health resources and to target essential health needs of given jurisdictions. Special attention will be given to rural areas.

FINANCING

The NASW plan will be financed primarily from a dedicated Federal tax on personal income and an employer-paid payroll tax. Additional sources of revenue will include a state contribution that requires each state to pay its fair share, a dedicated estate tax, and an increase in the cigarette and alcohol tax. All revenues will be placed in a National Health Care Trust Fund.

Small business will be protected by a cap on the amount they must contribute, and new firms facing financial hardships will be protected by a reduced payroll tax rate for the first 3 years of operation.

TRAINING AND EDUCATION

The health plan provides Federal support for some existing and new programs that will, for example, increase the supply of needed health care personnel, encourage more health practitioners to work in underserved areas, and support new approaches to continuing education programs in rural areas.

RESEARCH

While only touching on this briefly, the proposal provides funds for a range of research efforts that include, among others, support for continued basic biomedical research and the need to develop practice guidelines that can assist physicians and other health care practitioners.

MEDICAL MALPRACTICE REFORMS

Finally, we all recognize that medical malpractice reform is an essential part of restructuring our health care system. We cannot effectively contain costs until this issue is addressed. Our plan offers no specific solutions, but calls for a special commission to develop recommendations on this critical issue.

NASW believes that a unified national health program can achieve enormous savings—savings which may be redirected toward truly comprehensive health and mental health services for all, including those of us who live in rural communities.

Thank you.

COMMUNICATIONS

STATEMENT OF DR. JOHN S. CHICOINE

When the subject of rural health care is addressed, everyone in the rural community is affected but the most brutalized in the present health system is the elderly. When I see elderly patients in my office on a fixed income salary paying $200 to $300 per month for medications, it becomes evident that some changes are necessary.

Elderly patients ask why medications are so expensive? Why is medical care so costly? Why must Medicare and supplemental insurance continue to rise in cost but cover less? These are serious questions that deserve answers from our society and our government.

No one person, agency, association, committee or governmental body has all the answers. Input and ideas are necessary to solve these complex issues and I thank you for giving me the opportunity to address these issues as a representative of the South Dakota Chiropractors Association and as a rural health care practitioner concerned about the welfare of the rural community. My entire professional career of 21 years has been in a city of 1,000 people. In that amount of time things are perceived differently than my big city colleagues. A rural practitioner will not accumulate as much wealth, is more humble because everyone knows your strengths and weaknesses and finds If you're going to survive and live in a rural community, you must go the extra mile. Asking someone from a city over 3,000 about rural health is like asking someone who has never taken a shower to explain how it feels.

The following observations and comments are both mainstream ideas and distinctive. As the Jacksonian philosophy states, monopolies are the enemies of freedom. Perhaps that's where we're at in this country today. We've lost our freedom to pursue new directions in health care because the present system is monopolistic in its approach.

Rural health care, at least in South Dakota, and perhaps on a national level is wholly medical in nature. It is a medical mentality and bureaucracy that controls health care. Quite frankly, the monopoly like the telecommunications industry and airline industry, has been costly to the average consumer and the costs are continually escalating.

With the Rural Health issue fixed in a medical mentality, there seems to be no consideration for expanding beyond medicine to other health care disciplines. With the rise in the elderly populations, especially in the rural areas, shortages persist for health care practitioners in nursing homes and hospitals. Health care is needed for the elderly to assist them in remaining independent and functional as well as reducing pain and provide comfort, enhance mobility, and give much needed emotional and physical contact. Use should be made of all the resources available in a community whether medical, chiropractic, nurse practitioner, even EMT's. Everyone has an area of expertise that can be used.

Furthermore, to truly reduce medical costs, more competition is needed in the health field. More medical doctors are needed to reduce not only the cost of health care but also relieve the stress on current medical personnel. This is a theory debated hotly in the country. The medical societies believe there are enough medical doctors and an influx would cause a reduction in their current standard of living. Indeed, it probably would.

The insurance industry argues that more medical doctors will actually raise health costs because more treatment will be given that is not necessary, more surgeries would be performed and more expensive tests given to generate income to keep the current standard of living at its present level or even higher.

But on the other side of the issue, an increase in the present medical doctor population by at least four to five times the current level, even perhaps ten times the current numbers, would put more medical practitioners into rural areas.

The opportunities this could create could be phenomenal. With today's telecommunication systems, rural clinics could be connected to larger clinics or hospital systems so many costly diagnostic procedures done in hospitals and acute care clinics could be done on a local level at a fraction of the cost. A rural practitioner is more apt to treat conservatively initially instead of requesting sophisticated and often needless diagnostic procedures that a larger city medical facility would do. Acute care clinics, pseudo hospitals, could be developed that could give intermediate care to patients in a rural setting.

Competition is truly needed. There is a pediatric clinic in Sioux Falls, S.D. that charges an extra $10 to their already substantial fee for Saturday morning office appointments. Their reasoning being that they would keep the visits to emergencies only. But the Saturday schedule is completely full and unfortunately it is single family children and children of low wage earners who can't get off during the week to bring their children in. So those who can't afford the extra $10 are the ones stuck paying the extra fee.

If medical costs are to go down, then the doors to medical institutions need to be broken down to allow more people into medical schools. Standards often are set artificially high to make it an exclusive club. Many times B and even C students would make better doctors with comparable diagnostic skills and certainly better bedside manners than A students.

To increase the number of medical students, the curriculums need to be shortened. There are now at least 22 medical schools that have initiated a six-year program for the Doctor of Medicine degree. This program admits high school graduates without any college work for an average of 256 weeks to attain an M.D. degree. More of these programs are needed.

Small rural hospitals are fighting to survive. If these institutions are to continue innovative approaches to hospital care and usage are necessary. These institutions can no longer be for the exclusive use of the medical profession. To develop revenues necessary to survive they must open their doors to other healing arts practitioners. A new mentality is needed for sharing knowledge, facilities and technologies in the rural communities. Health teams need to be developed in rural communities using all available resources.

Mandated policies from the Federal Government will be necessary to change health care policy in the state governments. State health departments are political animals by nature with medical orientation, philosophy and mentality. If Federal funds are used in health care then the opportunities should exist for additional involvement of other primary health care providers other than medical physicians.

Paying more money to doctors and hospitals will not solve the problems. Patient loads will continue to rise because of the increase in the elderly population and AIDS. More money will make burnout more expensive. What is needed are more doctors and health care personnel, not only to reduce the patient loads of overburdened doctors but also to increase competition. Surprisingly enough, malpractice claims might go down because doctors may have more time to talk to their patients.

To further control costs, insurance companies and Medicare should develop mandatory second opinion programs for surgery and any type of long term care.

And finally, if a national health insurance is developed, reimbursement should be equal for all qualified health care providers. That will promote true health care competition and will lead to decreased costs.

COTEAU DES PRAIRIES HOSPITAL,
Sisseton, SD, May 30, 1990.

Senator THOMAS DASCHLE,
U.S. Senate,
Washington, DC.

Dear Senator Daschle: The board of directors, medical staff, administration, employees, and patients of Coteau des Prairies Hospital, Sisseton, South Dakota, would like to take this opportunity to express our appreciation to you for your strong interest and support of rural health care, especially here in South Dakota. There are many challenges facing not only rural health care, but the overall health care system in the United States. To successfully address these challenges will be no easy task however.

CURRENT ISSUES FACING RURAL HOSPITALS

The current system encourages inefficiency and discriminates against rural hospitals. The following issues need to be resolved as soon as possible:

1. DUPLICATION OF SERVICES: There are many expensive services duplicated due primarily to Medicare and Anti-trust regulations, and the competition of health care facilities. With Capital payment pass-thru, the incentives are for every hospital to buy equipment and build new additions rather than to work together to meet the health care needs of a community. Physicians must buy their own laboratory and X-Ray equipment instead of using the hospital's equipment because Medicare fraud and abuse rules are violated if they are shared. Here in Sisseton, there are two fully staffed and equipped acute care hospitals. A majority of the funds at both hospitals come from the Medicare and Medicaid program (primarily Federal dollars). Why is this duplication encouraged rather than discouraged, especially in light of today's environment of the shortage of professional staff?

2. RURAL HOSPITAL DISCRIMINATION: Rural hospitals in the past were very efficient and did not engage in large building and expansion projects like our urban counterparts did. Why is it then we are discriminated against under the DRG program. It would save the Federal Government a lot of money if it sent Medicare patients to rural hospitals for primary care than to have them at urban sites because our reimbursement rates are lower and our wage index (74% of the DRG amount is wage index based) is a lot lower than our urban counterparts. Regarding the wage index, is it fair that our employees have lower wages because we cannot afford to pay more? Yet, because our salary increases have not been as high as our urban counterparts, our rates in 1991 will decrease by 4.5%. We are attempting to keep our costs contained but yet we are penalized for doing so. The capital pass-thru expense to Medicare for rural hospitals is also a lot less than for urban hospitals because we have been conservative in our building and program expansions and our equipment purchases over the past several years. It seems the more we try to be efficient, the more we are penalized.

3. TPA REIMBURSEMENT. When a heart attack victim is brought to CDP Hospital and given the drug "TPA," if this patient is not transferred after administration of the drug, then CDP Hospital will only receive $1,900.00 for the total stay of the patient. The drug alone costs over $2,000.00! Is it efficient for Medicare to pay for a helicopter transfer to Fargo and then reimburse the Fargo hospital at the urban rates for the same care as we can provide here locally?

4. NO INCENTIVE FOR A WELLNESS LIFESTYLE: Why is society expected to pay for the health care costs of people who abuse their bodies through alcohol and drug abuse, smoking, poor dietary habits, etc.? The people who lead healthy lifestyles must share the financial burden of those who do not. There should be incentives for living a healthy lifestyle.

NEW HEALTH CARE SYSTEM

I believe that all parties involved in the current health care crisis need to work together to develop a solution to this crisis. However, a "game plan" needs to be developed which addresses the following issues:

1. ACCESS: Every person, regardless of income or ability to pay should have access to a "one tier system of health care;" not one which discriminates based upon ability to pay. The current Medicaid proposal in Oregon to fund only certain procedures is discrimination against Medicaid recipients, or ability to pay. This would then be a two tier system: one level of care for those who can pay and one for those who cannot. Access also means people everywhere have access to appropriate health care services. Every person should have access to a physician and a treatment center to treat emergency conditions. There are too many hospitals in some areas, but in other areas, people have to drive over 60 miles to deliver a baby because of OB malpractice rates or because of hospitals closing and physicians leaving the community.

2. RESPONSIBLE PAYERS: Insurance companies, the government, or self pay individuals should be expected to pay for the cost of providing health care services to their patients. Currently, because the government is not paying what it costs to treat its patients and there are many people who cannot or will not pay their hospital bills, hospitals have to cost shift the difference to those who do pay based upon charges (primarily insurance companies). Is is fair for those who buy insurance to have to subsidize those who do not buy insurance or those who do not pay their fair share?

3. EFFICIENCY REWARDED: Efficiency and cooperation should be rewarded. Providers should be encouraged to work together to improve the services provided in the community. Healthy lifestyles should also be rewarded and unhealthy lifestyles discouraged.

4. AFFORDABLE COVERAGE: Rationing of health care services is a must if we are to have an affordable system. However, I strongly believe that the poor or underprivileged must not be discriminated against. The current philosophy of "whatever care is needed at whatever cost for everybody" is not feasible any more. We must make some hard decisions to assure that everyone receives basic health care services, no matter where they live or what their income level or insurance status is. However, services beyond basic care are up for discussion. Several countries have age limits for certain procedures such as transplants. This is an option but it will face a lot of resistance.

Thank you for seeking input on these important issues from us here in Sisseton. We look forward to working with you in trying to develop options to improve our health care system. If you have any comments or questions, please do not hesitate to call.

Sincerely,

BILL NELSON, *Administrator/CEO.*

STATEMENT OF DR. ALAN P. JUEL

MEDICARE COMMENTS

The elderly population served by Medicare tends to suffer from degenerative conditions.

Chiropractic treatment is designed to minimize the progression of degenerative conditions and to promote repair and healing by using the person's recuperative powers.

Medicare would be well served by making Chiropractic treatment more easily usable—this would lead to a slower progression of degenerative conditions (which would reduce the demand for expensive hospitalizations and surgery).

The current Medicare regulations require examination and x-ray (but the patient is required to pay for them). This is unfair-similar services done by Hospitals and M.D.s are covered by Medicare.

It does not make sense to require something for all patients. Let the Dr. decide what is necessary.

We need consistent information from Medicare. (We get differing answers for the same question for different patients. Phone answers are sometimes different from the answers given in writing.)

The changes in your proposed bill are worth enacting.

STATEMENT OF DAVID SANDVIK, M.D.

As regulations now stand, we will be in trouble in South Dakota beginning in 1991.

Part of the relative value scale legislation passed last fall limits excess billing of Medicare patients to 125% of Medicare approved charges. In office and nursing home practices for most physicians, charges will fall within the new MAAC's (Maximum Allowable Actual Charges). However, in hospital practice, as far as I know all West River internists and internal medicine subspecialists will take dramatic cuts. The effects on my practice are outlined on the enclosed sheet.

I HAVE SEVERAL CONCERNS

(1) The PPRC has estimated only 5% of all physicians to be affected by these limits, and then only about a 5% decrease in the income of those physicians. In South Dakota, the effects for anyone caring mostly for geriatric patients will be much greater than those estimates. As I have communicated before, my office practice at present falls just short of paying overhead at $65 per hour. All take home income, investment for office equipment, loan repayment, etc., must come from hospital production. The above drop would decrease my income somewhere between 30-40%. If I were newly out of residency with $60,000 to $80,000 medical school debt and looking at another $50,000 to start practice, I certainly could not practice geri-

atrics in South Dakota without subsidy from either a hospital or the Medical School. I would also balk at considering a largely Medicare rural practice.

(2) Any physician who has the option will stop seeing Medicare patients, or move outside South Dakota. I know of friends considering both these alternatives. So, even if there are primary care providers willing to accept the above cuts, there will be great difficulty obtaining consults from specialists for Medicare patients.

(3) The relative value scale was meant to improve compensation for cognitive services to the tune of 30% overall increase to start in 1992 and be fully implemented by 1997. If we in South Dakota need to take a 30-40% cut for a year before the start of the new adjustments, by 1997 we will be much worse off than if the old system had been left intact.

(4) I am concerned about where the present Medicare approved charges originated. They are supposedly based on older data regularly revised upward. The Medicare "explanation of benefits" sent to patients and physicians ". . . is the prevailing charge for your area. This is the amount which is high enough to cover the customary charge in three out of four bills for the service. This charge limit can increase each year only by a percent set by the Government to reflect overall changes in the economy." I do not believe this explanation corresponds to reality. I do not believe that three out of four internists are family practitioners in South Dakota charge those "prevailing rates." I know of no internist who will not have to lower his charges. I really feel the basis for the present Medicare approved charges needs to be investigates. This investigation is particularly indicated when one considers that over the years millions of dollars have been paid by South Dakota Medicare recipients out of pocket because of cuts by our Medicare carrier from physicians MAAC's present Medicare approved charges. Those millions of dollars represent Federal funds which should have come to South Dakota's economy. Perhaps all has been done exactly according to Medicare procedure, but it has never made sense to me, particularly the explanation given above. I strongly fear that without some adjustment, the effect of this regulation will be disastrous in South Dakota.

I would be glad to meet with you further if you wish, at any time. Thanks again for your interest and help.

SOUTH DAKOTA

COUNTY POOR RELIEF REPORT

1989

Published By

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Statistical Analysis and Reports
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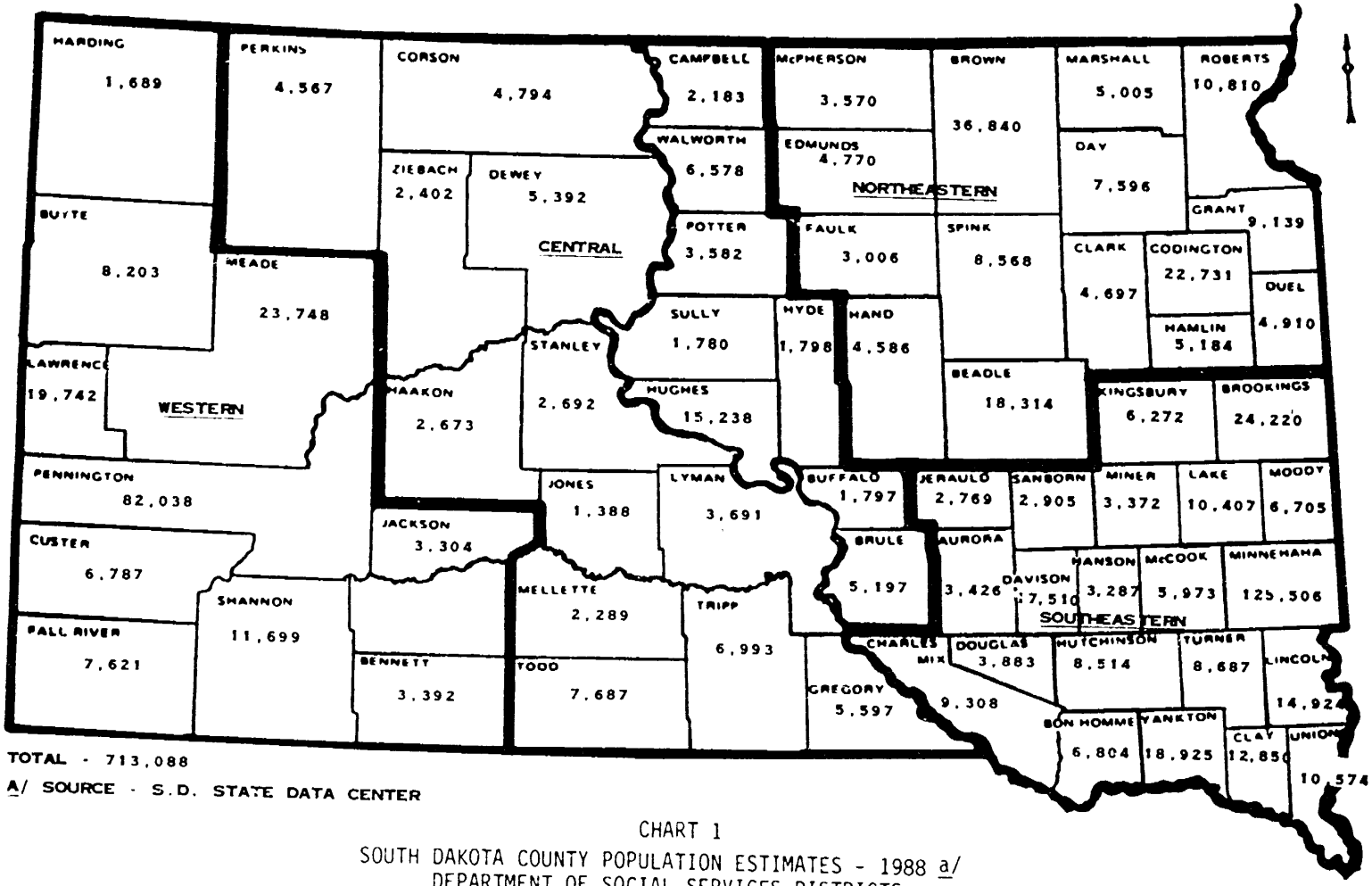
With Cooperation Of
County Auditors



TOTAL - 713,088

A/ SOURCE - S.D. STATE DATA CENTER

CHART 1

SOUTH DAKOTA COUNTY POPULATION ESTIMATES - 1988 a/
DEPARTMENT OF SOCIAL SERVICES DISTRICTS

TABLE 1

MEDICAL EXPENDITURES FROM COUNTY POOR RELIEF FUNDS
BY PROGRAM AND TYPE OF EXPENDITURE

CALENDAR YEAR 1989

PROGRAM	TOTAL	PRACTITIONERS' SERVICES	HOSPITALIZATION	DRUGS	SKILLED NURSING HOMES	INTERMEDIATE CARE FACILITIES	OTHER
TOTAL	$ 3,587,314	$ 507,832 a/	$ 2,293,099	$ 531,927	$11,953	$ 41,855	$ 200,648
SSI	109,744	7,406	28,885	63,578	--	--	9,875
ADC	26,828	3,471	18,416	2,413	--	--	2,528
Categorically Related Medical	145,609	10,207	6,820	122,460	--	5,030	1,092
County Aid	3,277,129	486,328	2,238,978	315,892	11,953	36,825	187,153
Nonallocable	28,004	420	--	27,584	--	--	--

a/ Includes $475,315 to physicians; $9,336 to dentists; and $23,181 to other practitioners.

TABLE 2

TOTAL EXPENDITURES FROM COUNTY POOR RELIEF FUNDS,
BY PROGRAM AND TYPE OF EXPENDITURE

CALENDAR YEAR 1989

TYPE OF EXPENDITURE	TOTAL	SUPPLEMENT TO SSI	SUPPLEMENT TO ADC	SUPPLEMENT TO CATEGORICALLY RELATED MEDICAL	COUNTY AID
TOTAL [a]	$ 5,042,154	$ 161,755	$ 137,744	$ 156,770	$ 4,557,881
Subsistence	431,077	16,888	88,142	930	325,117
Supervised Living Care	10,465	5,801	--	--	4,664
Medical Care:					
TOTAL	3,587,314	109,744	26,828	145,609	3,277,129
ICF	41,855	--	--	5,030	36,825
SNH	11,953	--	--	--	11,953
Other Medical [b]	3,533,506	109,744	26,828	140,579	3,228,351
Burial	143,080	21,630	2,314	9,813	109,323
Other	870,218	7,692	20,460	418	841,648

a/ Excludes Foster Care expenditures of $17,651.
b/ Includes $28,004 not allocable to any one program.

CHART 2

TOTAL COUNTY POOR RELIEF EXPENDITURES

CALENDAR YEAR 1989

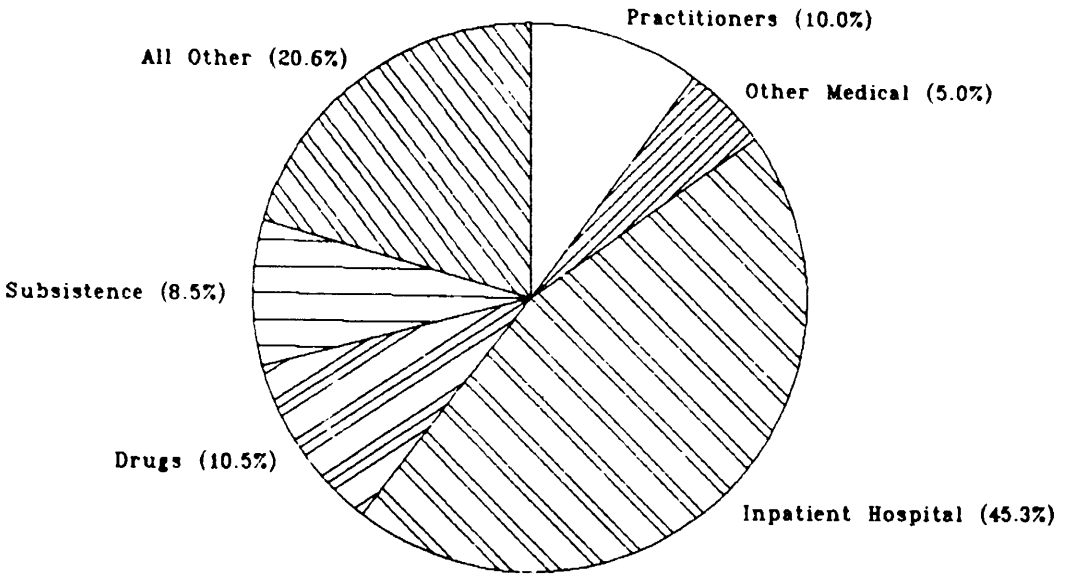


TABLE 3

TOTAL COUNTY POOR RELIEF EXPENDITURES a/

CALENDAR YEAR 1989

WESTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL	MEDICAL CARE	LONG TERM CARE: SKILLED NURSING HOMES	LONG TERM CARE: INTERMEDIATE CARE FACILITIES	LONG TERM CARE: SUPERVISED LIVING CARE	SUBSISTENCE	BURIAL	OTHER
Deadwood MSA	$ 488,481	$ 178,459	$ --	$ 381	$ --	$ 33,625	$ 8,684	$ 267,332
Butte	87,644	40,418	--	--	--	1,132	5,421	40,673
Harding	4,935	409	--	--	--	--	--	4,526
Lawrence	229,355	87,492	--	381	--	26,823	1,188	113,471
Meade	166,547	50,140	--	--	--	5,670	2,075	108,662
Pine Ridge MSA	6,349	5,076	--	--	--	16	1,175	82
Bennett	3,602	3,602	--	--	--	--	--	--
Jackson	1,556	1,474	--	--	--	--	--	82
Shannon	1,191	--	--	--	--	16	1,175	--
Rapid City MSA	504,309	329,275	--	--	5,801	133,504	4,811	30,918
Custer	49,588	15,854	--	--	--	2,816	--	30,918
Fall River	26,364	16,433	--	--	--	8,495	1,436	--
Pennington	428,357	296,988	--	--	5,801	122,193	3,375	--
TOTAL WESTERN DISTRICT	$ 999,139	$ 512,810	$ --	$ 381	$ 5,80	$ 167,145	$ 14,670	$ 298,332

a/ Does not include expenditures of $17,651 for Foster Care.

TABLE 3

TOTAL COUNTY POOR RELIEF EXPENDITURES

CALENDAR YEAR 1989

CENTRAL DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL	MEDICAL CARE	LONG TERM CARE			SUBSISTENCE	BURIAL	OTHER
			SKILLED NURSING HOMES	INTERMEDIATE CARE FACILITIES	SUPERVISED LIVING CARE			
Mission MSA	$ 45,320	$ 34,725	$ --	$ --	$ --	$ --	$ --	$ 10,595
Jones	10,674	8,287	--	--	--	--	--	2,387
Mellette	3,013	50	--	--	--	--	--	2,963
Todd	31,633	26,388	--	--	--	--	--	5,245
Mobridge MSA	98,402	60,578	--	--	--	2,583	10,362	24,879
Campbell	5,206	4,796	--	--	--	--	--	410
Corson	11,836	7,142	--	--	--	1,831	2,200	663
Dewey	279	279	--	--	--	--	--	--
Perkins	14,027	9,887	--	--	--	18	4,122	--
Potter	24,168	21,821	--	--	--	331	--	2,016
Walworth	40,019	15,953	--	--	--	403	2,800	20,863
Ziebach	2,867	700	--	--	--	--	1,240	927
Pierre MSA	86,277	55,256	--	3,716	978	11,359	2,660	12,308
Haakon	19,673	13,404	--	--	--	--	--	6,269
Hughes	55,709	36,954	--	3,716	978	11,275	2,660	126
Hyde	6,409	3,453	--	--	--	--	--	2,956
Stanley	1,529	1,445	--	--	--	84	--	--
Sully	2,957	--	--	--	--	--	--	2,957
Winner MSA	136,581	42,351	--	--	--	242	--	93,988
Brule	31,043	1,959	--	--	--	--	--	29,084
Buffalo	--	--	--	--	--	--	--	--
Gregory	14,894	14,662	--	--	--	232	--	--
Lyman	45,579	18,688	--	--	--	10	--	26,881
Tripp	45,065	7,042	--	--	--	--	--	38,023
TOTAL CENTRAL DISTRICT	$ 366,580	$ 192,910	$ —	$ 3,716	$978	$14,184	$ 13,022	$ 141,770

TABLE 3

TOTAL COUNTY POOR RELIEF EXPENDITURES

CALENDAR YEAR 1989

NORTHEASTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL	MEDICAL CARE	LONG TERM CARE			SUBSISTENCE	BURIAL	OTHER
			SKILLED NURSING HOMES	INTERMEDIATE CARE FACILITIES	SUPERVISED LIVING CARE			
Aberdeen MSA	$ 159,882	$ 119,414	$ --	$ --	$ --	$ 9,716	$ 12,901	$ 17,851
Brown	75,753	60,840	--	--	--	9,546	5,367	--
Day	40,050	29,877	--	--	--	170	2,692	7,311
Edmunds	18,815	13,973	--	--	--	--	4,842	--
McPherson	25,264	14,724	--	--	--	--	--	10,540
Huron MSA	344,058	218,953	6,538	5,078	1,639	20,473	11,330	80,047
Beadle	250,737	157,933	6,538	3,482	1,639	18,687	7,004	55,454
Faulk	3,096	2,387	--	--	--	--	--	709
Hand	46,623	38,487	--	--	--	107	3,188	4,841
Spink	43,602	20,146	--	1,596	--	1,679	1,138	19,043
Sisseton MSA	220,002	198,212	--	--	--	3,986	8,089	9,715
Grant	86,604	76,169	--	--	--	2,014	2,945	5,476
Marshall	35,480	30,248	--	--	--	--	993	4,239
Roberts	97,918	91,795	--	--	--	1,972	4,151	--
Watertown MSA	554,348	398,791	2,979	--	1,350	67,928	6,141	77,159
Clark	8,507	3,279	--	--	--	872	991	3,365
Codington	424,918	280,217	2,979	--	1,350	65,903	3,850	70,619
Deuel	103,131	101,731	--	--	--	100	1,300	--
Hamlin	17,792	13,564	--	--	--	1,053	--	3,175
TOTAL NORTHEASTERN DISTRICT	$ 1,278,290	$ 935,370	$ 9,517	$ 5,078	$ 2,989	$102,103	$ 38,461	$ 184,772

TABLE 3

TOTAL COUNTY POOR RELIEF EXPENDITURES

CALENDAR YEAR 1989

SOUTHEASTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL	MEDICAL CARE	LONG TERM CARE			SUBSISTENCE	BURIAL	OTHER
			SKILLED NURSING HOMES	INTERMEDIATE CARE FACILITIES	SUPERVISED LIVING CARE			
Brookings MSA	$ 383,806	$ 229,969	$ --	$ 30,121	$ --	$ 20,675	$ 10,379	$ 92,662
Brookings	159,773	70,565	--	--	--	10,446	--	78,762
Kingsbury	13,886	12,543	--	--	--	868	475	--
Lake	161,232	112,435	--	24,793	--	5,688	5,369	12,947
Miner	11,180	11,107	--	--	--	--	--	73
Moody	37,735	23,319	--	5,328	--	3,673	4,535	880
Mitchell MSA	313,820	262,536	2,436	--	482	18,400	13,086	16,880
Aurora	5,199	3,997	--	--	206	78	--	918
Davison	244,431	206,526	--	--	--	17,332	9,936	10,637
Hanson	36,310	33,538	2,436	--	276	--	--	60
Jerauld	15,641	12,079	--	--	--	--	1,200	2,362
Sanborn	12,239	6,396	--	--	--	990	1,950	2,903
Sioux Falls MSA	1,256,375	1,070,287	--	300	--	102,743	32,842	50,203
Lincoln	159,963	154,339	--	--	--	2,799	2,825	--
McCook	52,294	13,195	--	--	--	707	--	38,392
Minnehaha	984,441	849,882	--	--	--	97,788	28,017	8,754
Turner	59,677	52,871	--	300	--	1,449	2,000	3,057
Yankton MSA	444,144	329,624	--	2,259	215	5,827	20,620	85,599
Bon Homme	12,666	2,944	--	1,930	--	294	--	7,498
Charles Mix	51,425	48,084	--	--	215	309	2,817	--
Clay	61,653	54,314	--	--	--	3,165	1,400	2,774
Douglas	9,078	7,564	--	--	--	--	1,276	238
Hutchinson	67,809	67,372	--	--	--	437	--	--
Union	85,949	44,966	--	--	--	1,150	5,000	34,833
Yankton	155,564	104,380	--	329	--	472	10,127	40,256
TOTAL SOUTHEASTERN DISTRICT	$ 2,398,145	$ 1,892,416	$ 2,436	$ 32,680	$ 697	$ 147,645	$ 76,927	$ 245,344
STATE TOTALS	$ 5,042,154	$ 3,533,506	$11,953	$ 41,855	$ 10,465	$ 431,077	$ 143,080	$ 870,218

TABLE 4

MEDICAL CARE EXPENDITURES FROM COUNTY FUNDS, BY TYPE OF SERVICE

CALENDAR YEAR 1989

WESTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL [a]	PRACTITIONERS [b]	DENTAL	HOSPITALIZATION	DRUGS	OTHER
Deadwood MSA	$ 178,459	$ 8,431	$ --	$ 148,960	$ 14,067	$ 7,001
Butte	40,418	5,959	--	27,602	2,893	3,964
Harding	409	--	--	--	409	--
Lawrence	87,492	300	--	78,958	8,179	55
Meade	50,140	2,172	--	42,400	2,586	2,982
Pine Ridge MSA	5,076	--	65	--	4,815	196
Bennett	3,602	--	--	--	3,602	--
Jackson	1,474	--	65	--	1,213	196
Shannon	--	--	--	--	--	--
Rapid City MSA	329,275	158,780	60	95,842	45,709	28,884
Custer	15,854	23	--	2,990	11,288	1,553
Fall River	16,433	--	--	6,786	4,482	5,165
Pennington	296,988	158,757	60	86,066	29,939	22,166
TOTAL WESTERN DISTRICT	$ 512,810	$167,211	$ 125	$ 244,802	$ 64,591	$ 36,081

a/ Excludes payments to skilled nursing homes and intermediate care facilities.
b/ Includes payments for physicians and other practitioners.

TABLE 4

MEDICAL CARE EXPENDITURES FROM COUNTY FUNDS, BY TYPE OF SERVICE

CALENDAR YEAR 1989

CENTRAL DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL [a]	PRACTITIONERS [b]	DENTAL	HOSPITALIZATION	DRUGS	OTHER
Mission MSA	$ 34,725	$ 280	$ --	$ 31,488	$ 2,757	$ 200
Jones	8,287	130	--	5,400	2,757	--
Mellette	50	50	--	--	--	--
Todd	26,388	100	--	26,088	--	200
Mobridge MSA	60,578	2,732	--	36,916	16,402	4,528
Campbell	4,796	1,824	--	1,920	1,052	--
Corson	7,142	--	--	4,855	2,021	266
Dewey	279	--	--	--	279	--
Perkins	9,887	167	--	2,418	3,958	3,344
Potter	21,821	520	--	15,183	6,118	--
Walworth	15,953	221	--	12,540	2,974	218
Ziebach	700	--	--	--	--	700
Pierre MSA	55,256	1,687	--	44,415	7,194	1,960
Haakon	13,404	488	--	12,799	117	--
Hughes	36,954	1,014	--	28,445	5,535	1,960
Hyde	3,453	185	--	3,171	97	--
Stanley	1,445	--	--	--	1,445	--
Sully	--	--	--	--	--	--
Winner MSA	42,351	171	--	37,427	3,966	787
Brule	1,959	--	--	1,092	867	--
Buffalo	--	--	--	--	--	--
Gregory	14,662	--	--	12,397	2,265	--
Lyman	18,688	171	--	17,561	722	234
Tripp	7,042	--	--	6,377	112	553
TOTAL CENTRAL DISTRICT	$ 192,910	$ 4,870	$ --	$ 150,246	$ 30,319	$ 7,475

a/ Excludes payments to skilled nursing homes and intermediate care facilities.
b/ Includes payments for physicians and other practitioners.

TABLE 4

MEDICAL CARE EXPENDITURES FROM COUNTY FUNDS, BY TYPE OF SERVICE

CALENDAR YEAR 1989

NORTHEASTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL [a/]	PRACTITIONERS [b/]	DENTAL	HOSPITALIZATION	DRUGS	OTHER
Aberdeen MSA	$ 119,414	$ 5,694	$ --	$ 75,170	$ 37,441	$ 1,109
Brown	60,840	4,387	--	42,810	13,643	--
Day	29,877	524	--	21,424	6,820	1,109
Edmunds	13,973	174	--	4,036	9,763	--
McPherson	14,724	609	--	6,900	7,215	--
Huron MSA	218,953	82,374	--	102,070	29,971	4,538
Beadle	157,933	77,699	--	57,608	18,088	4,538
Faulk	2,387	--	--	--	2,387	--
Hand	38,487	2,486	--	32,860	3,141	--
Spink	20,146	2,189	--	11,602	6,355	--
Sisseton MSA	198,212	19,856	199	120,397	39,096	18,664
Grant	76,169	--	--	51,086	9,866	15,217
Marshall	30,248	1,437	--	18,768	8,969	1,074
Roberts	91,795	18,419	199	50,543	20,261	2,373
Watertown MSA	398,791	107,234	1,135	234,324	52,320	3,778
Clark	3,279	1,680	--	138	1,461	--
Codington	280,217	95,557	1,135	137,181	43,518	2,826
Deuel	101,731	6,799	--	90,599	3,381	952
Hamlin	13,564	3,198	--	6,406	3,960	--
TOTAL NORTHEASTERN DISTRICT	$ 935,370	$ 215,158	$ 1,334	$ 531,961	$ 158,828	$ 28,089

a/ Excludes payments to skilled nursing homes and intermediate care facilities.
b/ Includes payments for physicians and other practitioners.

TABLE 4

MEDICAL CARE EXPENDITURES FROM COUNTY FUNDS, BY TYPE OF SERVICE

CALENDAR YEAR 1989

SOUTHEASTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL [a]	PRACTITIONERS [b]	DENTAL	HOSPITALIZATION	DRUGS	OTHER
Brookings MSA	$ 229,969	$ 17,462	$ 1,484	$ 171,266	$ 37,721	$ 2,036
Brookings	70,565	2,728	89	47,653	19,904	191
Kingsbury	12,543	944	1,350	7,051	3,060	138
Lake	112,435	9,947	45	91,515	9,630	1,298
Miner	11,107	26	--	10,694	387	--
Moody	23,319	3,817	--	14,353	4,740	409
Mitchell MSA	262,536	17,959	148	213,659	21,674	9,096
Aurora	3,997	374	--	--	3,395	228
Davison	206,526	10,091	--	172,648	15,306	8,481
Hanson	33,538	5,830	--	25,610	2,098	--
Jerauld	12,079	--	--	11,676	403	--
Sanborn	6,396	1,664	148	3,725	472	387
Sioux Falls MSA	1,070,287	44,691	5,488	793,400	123,175	103,533
Lincoln	154,339	28,915	--	117,064	8,360	--
McCook	13,195	85	--	10,982	1,959	169
Minnehaha	849,882	15,340	4,788	636,548	92,820	100,386
Turner	52,871	351	700	28,806	20,036	2,978
Yankton MSA	329,624	31,145	757	243,892	39,492	14,338
Bon Homme	2,944	337	32	--	2,391	184
Charles Mix	48,084	55	--	44,295	3,734	--
Clay	54,314	3,982	725	44,672	2,562	2,373
Douglas	7,564	317	--	4,903	1,810	534
Hutchinson	67,372	25,702	--	31,639	8,471	1,560
Union	44,966	200	--	40,818	1,808	2,140
Yankton	104,380	552	--	77,565	18,716	7,547
TOTAL SOUTHEASTERN DISTRICT	$ 1,892,416	$ 111,257	$ 7,877	$ 1,422,217	$ 222,062	$ 129,003
STATE TOTALS	$ 3,533,506	$ 498,496 [c]	$ 9,336	$ 2,349,226	$ 475,800	$ 200,648

a/ Excludes payments to skilled nursing homes and intermediate care facilities.
b/ Includes payments for physicians and other practitioners.
c/ Includes payments of $475,315 for physicians, and $23,181 for other practitioners.

TABLE 5

MEDICAL CARE EXPENDITURES FROM COUNTY FUNDS - SUPPLEMENT TO OTHER ASSISTANCE

CALENDAR YEAR 1989

WESTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL [a/]	SUPPLEMENT TO PUBLIC ASSISTANCE	REGULAR COUNTY AID	NON-ALLOCABLE
Deadwood MSA	$ 178,459	$ 11,589	$ 166,870	$ --
Butte	40,418	6,202	34,216	--
Harding	409	--	409	--
Lawrence	87,492	537	86.955	--
Meade	50,140	4,850	45,290	--
Pine Ridge MSA	5,076	--	5,076	--
Bennett	3,602	--	3,602	--
Jackson	1,474	--	1,474	--
Shannon	--	--	--	--
Rapid City MSA	329,275	56,439	272,836	--
Custer	15,854	3,117	12,737	--
Fall River	16,433	9,633	6,800	--
Pennington	296,988	43,689	253,299	--
TOTAL WESTERN DISTRICT	$ 512,810	$ 68,028	$ 444,782	$ --

a/ Excludes payments to skilled nursing homes and intermediate care facilities.

TABLE 5

MEDICAL CARE EXPENDITURES FROM COUNTY FUNDS - SUPPLEMENT TO OTHER ASSISTANCE

CALENDAR YEAR 1989

CENTRAL DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL a/	SUPPLEMENT TO PUBLIC ASSISTANCE	REGULAR COUNTY AID	NON-ALLOCABLE
Mission MSA	$ 34,725	$ --	$ 34,725	$ --
Jones	8,287	--	8,287	--
Mellette	50	--	50	--
Todd	26,388	--	26,388	--
Mobridge MSA	60,578	7,498	53,080	--
Campbell	4,796	598	4,198	--
Corson	7,142	295	6,847	--
Dewey	279	--	279	--
Perkins	9,887	3,116	6,771	--
Potter	21,821	515	21,306	--
Walworth	15,953	2,974	12,979	--
Ziebach	700	--	700	--
Pierre MSA	55,256	4,664	50,592	--
Haakon	13,404	12	13,392	--
Hughes	36,954	3,563	33,391	--
Hyde	3,453	--	3,453	--
Stanley	1,445	1,089	356	--
Sully	--	--	--	--
Winner MSA	42,351	662	41,689	--
Brule	1,959	--	1,959	--
Buffalo	--	--	--	--
Gregory	14,662	662	14,000	--
Lyman	18,688	--	18,688	--
Tripp	7,042	--	7,042	--
TOTAL CENTRAL DISTRICT	$ 192,910	$ 12,824	$ 180,086	$ --

a/ Excludes payments to skilled nursing homes and intermediate care facilities.

TABLE 5

MEDICAL CARE EXPENDITURES FROM COUNTY FUNDS - SUPPLEMENT TO OTHER ASSISTANCE

CALENDAR YEAR 1989

NORTHEASTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL a/	SUPPLEMENT TO PUBLIC ASSISTANCE	REGULAR COUNTY AID	NON-ALLOCABLE
Aberdeen MSA	$ 119,414	$ 24,717	$ 94,697	$ --
Brown	60,840	5,567	55,273	--
Day	29,877	3,650	26,227	--
Edmunds	13,973	8,636	5,337	--
McPherson	14,724	6,864	7,860	--
Huron MSA	218,953	11,970	206,983	--
Beadle	157,933	7,660	150,273	--
Faulk	2,387	1,808	579	--
Hand	38,487	--	38,487	--
Spink	20,146	2,502	17,644	--
Sisseton MSA	198,212	19,498	178,714	--
Grant	76,169	4,897	71,272	--
Marshall	30,248	4,753	25,495	--
Roberts	91,795	9,848	81,947	--
Watertown MSA	398,791	42,412	356,379	--
Clark	3,279	680	2,599	--
Codington	280,217	35,119	245,098	--
Deuel	101,731	2,986	98,745	--
Hamlin	13,564	3,627	9,937	--
TOTAL NORTHEASTERN DISTRICT	$ 935,370	$ 98,597	$ 836,773	$ --

a/ Excludes payments to skilled nursing homes and intermediate care facilities.

TABLE 5

MEDICAL CARE EXPENDITURES FROM COUNTY FUNDS - SUPPLEMENT TO OTHER ASSISTANCE

CALENDAR YEAR 1989

SOUTHEASTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL a/	SUPPLEMENT TO PUBLIC ASSISTANCE	REGULAR COUNTY AID	NON-ALLOCABLE
Brookings MSA	$ 229,969	$ 23,478	$ 206,491	$ --
Brookings	70,565	14,458	56,107	--
Kingsbury	12,543	4,333	8,210	--
Lake	112,435	2,036	110,399	--
Miner	11,107	413	10,694	--
Moody	23,319	2,238	21,081	--
Mitchell MSA	262,536	11,638	250,898	--
Aurora	3,997	938	3,059	--
Davison	206,526	6,270	200,256	--
Hanson	33,538	--	33,538	--
Jerauld	12,079	--	12,079	--
Sanborn	6,396	4,430	1,966	--
Sioux Falls MSA	1,070,287	33,702	1,009,001	27,584
Lincoln	154,339	3,697	150,642	--
McCook	13,195	--	13,195	--
Minnehaha	849,882	18,592	803,706	27,584
Turner	52,871	11,413	41,458	--
Yankton MSA	329,624	28,884	300,320	420
Bon Homme	2,944	2,290	654	--
Charles Mix	48,084	1,549	46,535	--
Clay	54,314	8,111	46,203	--
Douglas	7,564	1,965	5,599	--
Hutchinson	67,372	6,363	61,009	--
Union	44,966	1,015	43,951	--
Yankton	104,380	7,591	96,369	420
TOTAL SOUTHEASTERN DISTRICT	$ 1,892,416	$ 97,702	$ 1,766,710	$ 28,004
STATE TOTALS	$ 3,533,506	$ 277,151	$ 3,228,351	$ 28,004

a/ Excludes payments to skilled nursing homes and intermediate care facilities.

TABLE 6

EXPENDITURES FOR LONG TERM CARE FROM COUNTY FUNDS - SUPPLEMENT TO OTHER ASSISTANCE

CALENDAR YEAR 1989

WESTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL a/	SUPPLEMENT TO PUBLIC ASSISTANCE	REGULAR COUNTY AID
Deadwood MSA	$ 381	$ 381	$ --
Butte	--	--	--
Harding	--	--	--
Lawrence	381	381	--
Meade	--	--	--
Pine Ridge MSA	--	--	--
Bennett	--	--	--
Jackson	--	--	--
Shannon	--	--	--
Rapid City MSA	5,801	5,801	--
Custer	--	--	--
Fall River	--	--	--
Pennington	5,801	5,801	--
TOTAL WESTERN DISTRICT	$ 6,182	$ 6,182	$ --

a/ Includes skilled nursing homes, intermediate care facilities, and supervised living care.

TABLE 6

EXPENDITURES FOR LONG TERM CARE FROM COUNTY FUNDS -
SUPPLEMENT TO OTHER ASSISTANCE

CALENDAR YEAR 1989

CENTRAL DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL a/	SUPPLEMENT TO PUBLIC ASSISTANCE	REGULAR COUNTY AID
Mission MSA	$ --	$ --	$ --
Jones	--	--	--
Mellette	--	--	--
Todd	--	--	--
Mobridge MSA	--	--	--
Campbell	--	--	--
Corson	--	--	--
Dewey	--	--	--
Perkins	--	--	--
Potter	--	--	--
Walworth	--	--	--
Ziebach	--	--	--
Pierre MSA	4,694	--	4,694
Haakon	--	--	--
Hughes	4,694	--	4,694
Hyde	--	--	--
Stanley	--	--	--
Sully	--	--	--
Winner MSA	--	--	--
Brule	--	--	--
Buffalo	--	--	--
Gregory	--	--	--
Lyman	--	--	--
Tripp	--	--	--
TOTAL CENTRAL DISTRICT	$ 4,694	$ --	$ 4,694

a/ Includes skilled nursing homes, intermediate care facilities, and supervised living care.

TABLE 6

EXPENDITURES FOR LONG TERM CARE FROM COUNTY FUNDS -
SUPPLEMENT TO OTHER ASSISTANCE

CALENDAR YEAR 1989

NORTHEASTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL a/	SUPPLEMENT TO PUBLIC ASSISTANCE	REGULAR COUNTY AID
Aberdeen MSA	$ --	$ --	$ --
Brown	--	--	--
Day	--	--	--
Edmunds	--	--	--
McPherson	--	--	--
Huron MSA	13,255	--	13,255
Beadle	11,659	--	11,659
Faulk	--	--	--
Hand	--	--	--
Spink	1,596	--	1,596
Sisseton MSA	--	--	--
Grant	--	--	--
Marshall	--	--	--
Roberts	--	--	--
Watertown MSA	4,329	--	4,329
Clark	--	--	--
Codington	4,329	--	4,329
Deuel	--	--	--
Hamlin	--	--	--
TOTAL NORTHEASTERN DISTRICT	$ 17,584	$ --	$ 17,584

a/ Includes skilled nursing homes, intermediate care facilities, and supervised living care.

TABLE 6

EXPENDITURES FOR LONG TERM CARE FROM COUNTY FUNDS -
SUPPLEMENT TO OTHER ASSISTANCE

CALENDAR YEAR 1989

SOUTHEASTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL a/	SUPPLEMENT TO PUBLIC ASSISTANCE	REGULAR COUNTY AID
Brookings MSA	$ 30,121	$ 3,840	$ 26,281
Brookings	--	--	--
Kingsbury	--	--	--
Lake	24,793	--	24,793
Miner	--	--	--
Moody	5,328	3,840	1,488
Mitchell MSA	2,918	--	2,918
Aurora	206	--	206
Davison	--	--	--
Hanson	2,712	--	2,712
Jerauld	--	--	--
Sanborn	--	--	--
Sioux Falls MSA	300	--	300
Lincoln	--	--	--
McCook	--	--	--
Minnehaha	--	--	--
Turner	300	--	300
Yankton MSA	2,474	809	1,665
Bon Homme	1,930	480	1,450
Charles Mix	215	--	215
Clay	--	--	--
Douglas	--	--	--
Hutchinson	--	--	--
Union	--	--	--
Yankton	329	329	--
TOTAL SOUTHEASTERN DISTRICT	$ 35,813	$ 4,649	$ 31,164
STATE TOTALS	$ 64,273	$ 10,831	$ 53,442

a/ Includes skilled nursing homes, intermediate care facilities, and supervised living care.

TABLE 7

EXPENDITURES OTHER THAN MEDICAL

CALENDAR YEAR 1989

WESTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL	SUBSISTENCE	BURIAL	SUPERVISED LIVING CARE	OTHER	FOSTER CARE
Deadwood MSA	$ 324,712	$ 33,625	$ 8,684	$ --	$ 267,332	$ 15,071
Butte	47,226	1,132	5,421	--	40,673	--
Harding	4,526	--	--	--	4,526	--
Lawrence	141,482	26,823	1,188	--	113,471	--
Meade	131,478	5,670	2,075	--	108,662	15,071
Pine Ridge MSA	1,273	16	1,175	--	82	--
Bennett	--	--	--	--	--	--
Jackson	82	--	--	--	82	--
Shannon	1,191	16	1,175	--	--	--
Rapid City MSA	175,034	133,504	4,811	5,801	30,918	--
Custer	33,734	2,816	--	--	30,918	--
Fall River	9,931	8,495	1,436	--	--	--
Pennington	131,369	122,193	3,375	5,801	--	--
TOTAL WESTERN DISTRICT	$ 501,019	$ 167,145	$ 14,670	$ 5,801	$ 298,332	$ 15,071

TABLE 7

EXPENDITURES OTHER THAN MEDICAL

CALENDAR YEAR 1989

CENTRAL DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL	SUBSISTENCE	BURIAL	SUPERVISED LIVING CARE	OTHER	FOSTER CARE
Mission MSA	$ 13,175	$ --	$ --	$ --	$ 10,595	$ 2,580
Jones	2,387	--	--	--	2,387	--
Mellette	5,543	--	--	--	2,963	2,580
Todd	5,245	--	--	--	5,245	--
Mobridge MSA	37,824	2,583	10,362	--	24,879	--
Campbell	410	--	--	--	410	--
Corson	4,694	1,831	2,200	--	663	--
Dewey	--	--	--	--	--	--
Perkins	4,140	18	4,122	--	--	--
Potter	2,347	331	--	--	2,016	--
Walworth	24,066	403	2,800	--	20,863	--
Ziebach	2,167	--	1,240	--	927	--
Pierre MSA	27,305	11,359	2,660	978	12,308	--
Haakon	6,269	--	--	--	6,269	--
Hughes	15,039	11,275	2,660	978	126	--
Hyde	2,956	--	--	--	2,956	--
Stanley	84	84	--	--	--	--
Sully	2,957	--	--	--	2,957	--
Winner MSA	94,230	242	--	--	93,988	--
Brule	29,084	--	--	--	29,084	--
Buffalo	--	--	--	--	--	--
Gregory	232	232	--	--	--	--
Lyman	26,891	10	--	--	26,881	--
Tripp	38,023	--	--	--	38,023	--
TOTAL CENTRAL DISTRICT	$ 172,534	$ 14,184	$ 13,022	$ 978	$ 141,770	$ 2,580

TABLE 7

EXPENDITURES OTHER THAN MEDICAL

CALENDAR YEAR 1989

NORTHEASTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL	SUBSISTENCE	BURIAL	SUPERVISED LIVING CARE	OTHER	FOSTER CARE
Aberdeen MSA	$ 40,468	$ 9,716	$ 12,901	$ --	$ 17,851	$ --
Brown	14,913	9,546	5,367	--	--	--
Day	10,173	170	2,692	--	7,311	--
Edmunds	4,842	--	4,842	--	--	--
McPherson	10,540	--	--	--	10,540	--
Huron MSA	113,489	20,473	11,330	1,639	80,047	--
Beadle	82,784	18,687	7,004	1,639	55,454	--
Faulk	709	--	--	--	709	--
Hand	8,136	107	3,188	--	4,841	--
Spink	21,860	1,679	1,138	--	19,043	--
Sisseton MSA	21,790	3,986	8,089	--	9,715	--
Grant	10,435	2,014	2,945	--	5,476	--
Marshall	5,232	--	993	--	4,239	--
Roberts	6,123	1,972	4,151	--	--	--
Watertown MSA	152,578	67,928	6,141	1,350	77,159	--
Clark	5,228	872	991	--	3,365	--
Codington	141,722	65,903	3,850	1,350	70,619	--
Deuel	1,400	100	1,300	--	--	--
Hamlin	4,228	1,053	--	--	3,175	--
TOTAL NORTHEASTERN DISTRICT	$ 328,325	$ 102,103	$ 38,461	$ 2,989	$ 184,772	$ --

TABLE 7

EXPENDITURES OTHER THAN MEDICAL

CALENDAR YEAR 1989

SOUTHEASTERN DISTRICT

DISTRICT, MSA, AND COUNTY	TOTAL	SUBSISTENCE	BURIAL	SUPERVISED LIVING CARE	OTHER	FOSTER CARE
Brookings MSA	$ 123,716	$ 20,675	$ 10,379	$ --	$ 92,662	$ --
Brookings	89,208	10,446	--	--	78,762	--
Kingsbury	1,343	868	475	--	--	--
Lake	24,004	5,688	5,369	--	12,947	--
Miner	73	--	--	--	73	--
Moody	9,088	3,673	4,535	--	880	--
Mitchell MSA	48,848	18,400	13,086	482	16,880	--
Aurora	1,202	78	--	206	918	--
Davison	37,905	17,332	9,936	--	10,637	--
Hanson	336	--	--	276	60	--
Jerauld	3,562	--	1,200	--	2,362	--
Sanborn	5,843	990	1,950	--	2,903	--
Sioux Falls MSA	185,788	102,743	32,842	--	50,203	--
Lincoln	5,624	2,799	2,825	--	--	--
McCook	39,099	707	--	--	38,392	--
Minnehaha	134,559	97,788	28,017	--	8,754	--
Turner	6,506	1,449	2,000	--	3,057	--
Yankton MSA	112,261	5,827	20,620	215	85,599	--
Bon Homme	7,792	294	--	--	7,498	--
Charles Mix	3,341	309	2,817	215	--	--
Clay	7,339	3,165	1,400	--	2,774	--
Douglas	1,514	--	1,276	--	238	--
Hutchinson	437	437	--	--	--	--
Union	40,983	1,150	5,000	--	34,833	--
Yankton	50,855	472	10,127	--	40,256	--
TOTAL SOUTHEASTERN DISTRICT	$ 470,613	$ 147,645	$ 76,927	$ 697	$ 245,344	$ --
STATE TOTALS	$ 1,472,491	$ 431,077	$ 143,080	$ 10,465	$ 870,218	$ 17,651

TABLE 8

FOSTER CARE

CALENDAR YEAR 1989

DISTRICT, MSA, AND COUNTY	TOTAL	IN FAMILY HOMES	IN INSTITUTIONS	MEDICAL CARE IN FAMILY HOMES	MEDICAL CARE IN INSTITUTIONS
WESTERN DISTRICT					
Deadwood MSA	$15,071	$ --	$15,071	$ --	$ --
Meade	15,071	--	15,071	--	--
TOTAL WESTERN DISTRICT	$15,071	$ --	$15,071	$ --	$ --
CENTRAL DISTRICT					
Mission MSA	$ 2,580	$ --	$ 2,580	$ --	$ --
Mellette	2,580	--	2,580	--	--
TOTAL CENTRAL DISTRICT	$ 2,580	$ --	$ 2,580	$ --	$ --
STATE TOTALS	$17,651	$ --	$17,651	$ --	$ --

TABLE 9

COUNTY POOR RELIEF - SELECTED AREAS

1980 - 1989

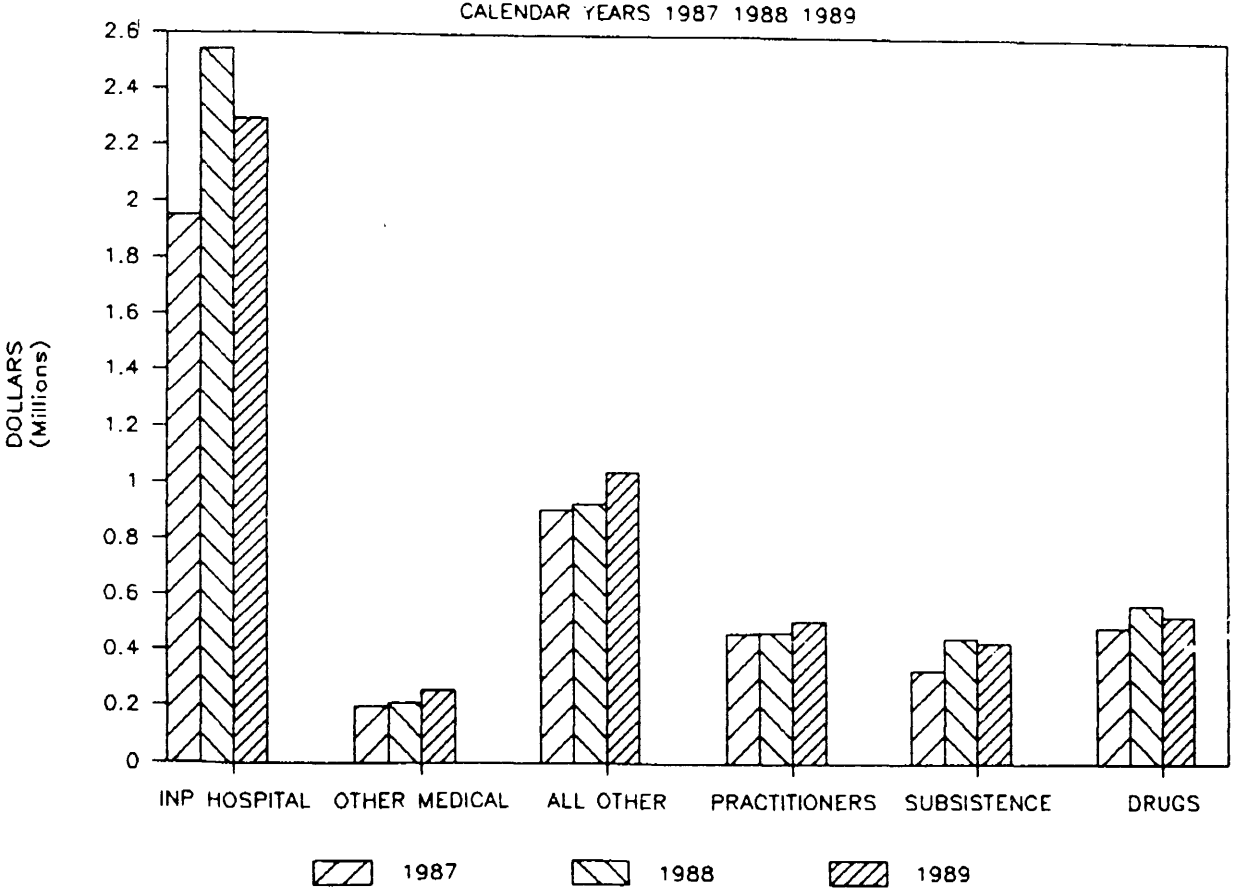
	GENERAL EXPENDITURES						MEDICAL EXPENDITURES							
Year	All Counties a/	Foster Care	Burial	Subsis-tence	Supervised Living Care	Other	Practi-tioners b/	Hospitals	Drugs	Skilled Nursing Homes	Intermediate Care Facilities	Other	Total	Medical Percent
1980	2,021,894	916	86,949	333,139	11,547	357,417	114,650	686,372	343,529	910	7,534	78,931	1,231,926	60.9
1981	2,408,244	1,900	79,074	351,680	5,371	325,501	157,732	1,016,101	376,787	5,321	11,656	77,121	1,644,718	68.3
1982	3,328,923	2,631	135,173	418,245	5,873	475,269	225,484	1,494,543	421,565	1,323	21,854	126,963	2,291,732	68.8
1983	3,782,208	1,328	111,501	346,966	4,084	496,190	303,857	1,945,769	437,323	4,167	6,850	124,173	2,822,139	74.6
1984	4,253,980	4,587	104,511	348,260	8,310	469,644	479,264	2,251,801	424,470	6,006	3,612	153,515	3,318,668	78.0
1985	4,086,388	16,209	140,781	385,588	11,963	510,468	460,889	1,958,830	465,082	7,290	15,944	113,344	3,021,379	73.9
1986	5,031,044	16,627	150,175	417,116	30,475	538,514	649,953	2,572,450	490,261	28,686	40,026	96,761	3,878,137	77.1
1987	4,341,499	5,246	135,729	331,683	30,548	735,692	464,124	1,951,523	488,593	7,987	57,549	132,825	3,102,601	71.5
1988	5,168,730	7,637	151,343	448,883	9,474	761,691	468,746	2,540,291	572,360	15,015	37,178	156,112	3,789,702	73.3
1989	$5,059,805	$17,651	$143,080	$431,077	$ 10,465	$870,218	$ 507,832	$2,293,099	$531,927	$11,953	$ 41,855	$200,648	$3,587,314	70.9

a/ Total does not include administrative costs to counties, such as salaries, office expense, etc.
b/ Includes physicians, dentists, and all other practitioners.

CHART 3

COUNTY POOR RELIEF EXPENDITURES

CALENDAR YEARS 1987 1988 1989



STATEMENT OF THE SOUTH DAKOTA SOCIETY OF INTERNAL MEDICINE (SDSIM) AND THE AMERICAN SOCIETY OF INTERNAL MEDICINE (ASIM)

The South Dakota Society of Internal Medicine (SDSIM) and the American Society of Internal Medicine (ASIM), representing physicians in the state of South Dakota and nationwide that are subspecialists in adult medical care, appreciates the opportunity to share with the committee its views on one of the most pressing problems facing this country: the inability of millions of Americans to have access to affordable medical care. This problem is particularly pronounced in rural areas throughout our state and country.

We commend the committee for its interest in the serious problems of access to care for the uninsured and for taking this national issue into the local community for debate. Obviously, the impact of a lack of health insurance for many Americans is most apparent in our own local communities. On the local level, physicians and policymakers can see first hand the adverse health consequences suffered by people without health insurance because they cannot afford to pay for needed care and delay seeking medical attention. Unfortunately, this lack of coverage often translates directly into unnecessary pain, suffering and premature death for the uninsured.

Let's make no mistake about it. America has two separate and unequal health care systems, one that provides access to a basic level of health insurance protection—and one that does not. Most Americans are fortunate to be under a system that allows them to obtain affordable health insurance through their employer. They can and do obtain the latest treatments and technology.

They have access to regular, comprehensive medical care through their own personal physicians. And they know they can get good care, when they need it, without fear of becoming impoverished. But more than 30 million Americans receive care, if and when they are able to obtain it at all, in a completely different world. For them, there is no health insurance protection. A major illness can mean personal bankruptcy. Even minor illnesses can represent an intolerably high expense. Delays in obtaining care are common and preventive care is virtually unknown. And, when they do get so sick that they can no longer go without professional care, treatment usually comes form chronically underfunded public clinics or hospital emergency rooms—or from physicians who donate their services on a charity basis.

Many other Americans—the underinsured—have insurance coverage that provides inadequate protection against the costs of a catastrophic illness. Even those Americans with good health insurance are at risk of joining the ranks of the uninsured. Unemployment or an illness followed by a change in jobs can lead to loss of coverage.

The problems of the uninsured are compounded in rural America. The scarcity of primary care physicians makes it difficult for people to get access to primary care even it they are insured—let alone the uninsured. This problem is particularly prevalent for Medicare and Medicaid beneficiaries who are often unable to locate an internist or family physician in the area. For the uninsured, hospital and clinic safety nets are simply not available to provide necessary health care. For those rural communities that do have hospitals, many are struggling to stay open due to financial problems attributable to the rising costs of uncompensated care. The time is rapidly approaching when the uninsured will no longer be able to get their care from the hospital emergency room in many of our local communities.

For these reasons, SDSIM and ASIM believe that it is time to put an end to separate and unequal health care. Our recommendations, which are fully detailed in the attached paper titled "Ending Separate and Unequal Health Care," closely parallel the approach put forth in the Pepper Commission report. *SDSIM and ASIM support requiring all employers to provide health insurance to their employees. We advocate reforming the insurance marketplace to reduce premium costs, avoid skimming, spread the cost burden more equitably, and to eliminate existing barriers to coverage. We believe that Federal subsidies and tax breaks should be provided to small businesses to make insurance more affordable and available to small businesses.*

We believe that Medicaid should be converted from a local welfare program to one that provides adequate, consistent coverage to any American, regardless of income or locale, who cannot obtain coverage through an employer. Simultaneously, increases in physician reimbursement under Medicaid, which most often does not even reimburse costs, are needed to improve access to primary care for our poorer citizens, specifically in rural areas.

Insurance reforms, the development of practice guidelines, reductions in the administrative costs of insurance, medical liability reform, and adequate levels of patient cost-sharing should be instituted to reduce the costs of care. Clearly, when mandat-

ing employers to provide insurance to their employees and their dependents, we must institute effective cost containment measures to reduce the costs of unnecessary medical care and administrative waste in the system thereby making the health care delivery system more efficient and cost-effective.

In the national debate, some have advocated that we scrap the current system of private/public insurance and adopt a single-payer system. Although the specifics of single-payer proposals vary, they have one common element—the creation of a national insurance program primarily funded by the Federal Government. *SDSIM and the American Society of Internal Medicine strongly oppose any effort to substitute the current pluralistic system of insurance with a single-payer approach.* The current private system provides coverage to 80 percent of employees and their dependents. Mandating employer coverage would provide insurance to all but one-fifth of the uninsured, with the remaining uninsured getting coverage through the public program.

SDSIM and ASIM believe that building on the current health care insurance system is what the American people want. To illustrate, a recent Gallup Poll reported that 80 percent of the American public favor employer-provided health insurance as long as tax breaks are given to small businesses. Only 17 percent said the government should not require employers to provide coverage. Only 34 percent supported a government-funded alternative.

Under a single-payer approach with the Federal Government paving the entire bill. Americans health care would be at greater risk to competing budget priorities. Congress would need to balance funding for medical care against such priorities as defense spending, deficit reduction, education and aid to farmers. Given that the new single-payer system would immediately become one of the largest spending programs, health care would be a natural target for arbitrary spending cuts to pay for other national priorities—or to reduce the deficit.

Clearly efforts to reduce costs, would inevitably lead to efforts to restrict benefits for needed services, to financially penalize physicians and hospitals that provide patients with the care they need and to limit access to technology. Multiple funding sources, as ASIM proposes, protect the public from too much power being concentrated in any single-payer.

Concentrating the financing of health care in the hands of one payer eliminates choices for patients as well as employers. Under the current pluralistic system of insurance, if employers and patients do not like the service they receive from an insurer, the benefits under the plan are inadequate or the managed care restrictions on the plan are unacceptable,they can simply purchase coverage from another plan. If the government-financed program is the only choice available, employers and patients have no choice to change coverage to another financing source.

SDSIM and ASIM believe that Americans want the freedom to choose their insurance plan, their physician and their hospital. A recent Gallup Poll survey reports that 83 percent of Americans surveyed would rather pay more and have a personal physician that they have chosen than pay less and have a physician assigned to them by government or a private clinic. Even if a single-payer system guaranteed "free choice of physicians," the freedom of patients and physicians to mutually decide the best and most appropriate care would inevitably be undermined and limited by the enormous monopoly power that a single-payer system would give to government to set limits on care available to patients.

Implementation of a single-payer system would cost the government more than $250 billion. *Obligating the Federal Government to a massive entitlement program, at a time when there is already a huge Federal deficit, is simply irresponsible.* Public opinion polls show that Americans are simply unwilling to pay for a new national health care program.

Expanding access to care by building on the strengths of the current system unquestionably will cost money. But the human and economic costs of not addressing the problem are far greater. We can no longer afford to take a "wait a minute" attitude and study the problem further, or expect someone else to pay the cost.

We know what the solutions are. We know that a combination of expanding employer-based health insurance and providing adequate public funding will work. We also know that if enough people want change, this country has the resources to make that change possible. And we know that the cost burden must be shared equally, so that no one segment of society is asked to pay the entire bill.

The time has come for Congress to move forward and enact comprehensive legislation. ASIM and 21 other medical organizations have formed a coalition to press for enactment this year of comprehensive access legislation, based on principles that are consistent with the Pepper Commission plan. Physicians stand ready to do ev-

erything we can to get such legislation enacted without further delay. We call upon business, labor, the administration, hospitals and consumers to do the same.

Millions of uninsured Americans are effectively being held hostage while those of us in Washington argue over whether now is the time to act. But the answer is simple. Just ask the uninsured in South Dakota. They want action—not next year or the year after, but now. SDSIM and ASIM recognize that expanding insurance coverage alone will not address all of the problems with access to care in rural America—namely the lack of primary care physicians in many of our local communities.

Without question, low levels of Medicare reimbursement in rural areas discourage primary care physicians from practicing in these areas thereby limiting access to needed services for the elderly as well as other patients. To address this issue, Congress, in 1989, enacted legislation to reform the Medicare physician payment system. The law mandates implementation of a new fee schedule, beginning in 1992, that would provide necessary increases in Medicare reimbursement for evaluation and management services, such as office, nursing home and hospital visits. Clearly, those primary care physicians practicing in rural areas will realize the greatest increases in reimbursement. SDSIM and ASIM urge Congress to preserve the intent of the physician payment reform package by rejecting significant cuts in the Medicare Part B budget. Substantial reductions in the Medicare Part B budget would significantly limit the funds available for payment increases for undervalued evaluation and management services and for care delivered in rural America. Additionally, Congress should provide appropriate oversight of the Health Care Financing Administration (HCFA) to ensure the agency does not take advantage of physician payment reform simply to cut overvalued procedures with little regard for the impact on future gains to undervalued services.

SDSIM and ASIM strongly encourage the Congress to correct flaws in the 1991 limits on balance billing. The requirement that 1991 actual charges to Medicare beneficiaries for all physician services be limited to no more than 125 percent of the Medicare-approved amount will result in a significant rollback in charges—and substantially decreased Medicare revenues—for the same undervalued evaluation and management services that the new physician payment reform package is intended to benefit. The rollbacks will be particularly pronounced in rural states, such as South Dakota. Several internists have reported that they will experience drastic reductions in their fees. One Rapid City physician—who will experience cuts of as much as 50 percent in his evaluation and management fees--states that "if these changes (the rollback) are introduced, I will be unable to tolerate them . . . It will lead to a dramatic crisis in medical practice in this state." The rollback in fees for evaluation and management services is a result of Congress mandating the balance billing limits a full year prior to implementation of the new Medicare fee schedule thus forcing reductions in charges for already undervalued services before the promised increases in reimbursement take effect. Congress should correct this flaw by allowing physicians to continue to charge their current fees in 1991 for undervalued evaluation and management services.

Congress must adequately fund the Medicaid program and provide sufficient increases in physician reimbursement. Medicaid reimbursement currently falls below costs for many primary care physicians, specifically those practicing in rural areas. Unfortunately, many states are financially strapped in terms of state Medicaid funding, making it critical that Congress provide the necessary funding.

In addition to these economic constraints on physicians in rural areas, studies demonstrate that the increasing administrative hassles of Medicare, Medicaid and other third-party payers are driving many physicians to early retirement and others away from the practice of internal medicine. Any policy or action that reduces the number of physicians particularly hurts access to care in rural areas. For these reasons, *SDSIM and ASIM urge the committee to support S. 2051, sponsored by Senator Max Baucus, to address a number of the most common problems physicians have with the administration of the Medicare program including confidential medical review screens, lack of precedent in denial reversals, and cross coverage prohibitions.* Specifically, this legislation would allow "attending" physicians to continue to bill Medicare for services provided to a patient by a professional colleague who is simply "covering" temporarily for the absent "attending" physician, require release of medical review screens, and establish a physicians' advisory council within HCFA to review proposed regulations to assess their proposed effect on physicians' ability to provide care. ASIM will be releasing a new white paper in the near future that provides further discussion of how the hassles of participation in Medicare are adversely affecting access to care—and our additional recommendations for resolving the problem. We would be pleased to provide a copy to the subcommittee.

In conclusion, ASIM and SDSIM believe that an agenda for assuring access to care for all Americans, particularly in rural states, must include enacting legislation, based on the Pepper Commission report, to expand health insurance coverage to all Americans; rejecting deep Medicare budget cuts that would undermine gains in Medicare payments for undervalued evaluation and management services in rural areas; correcting the 1991 rollback in Medicare fees for those undervalued services; providing adequate funding for physician services under the Medicaid program and reducing the hassles associated with the Medicare program. We stand ready to assist the committee in implementing this agenda.

NATIONAL HEALTH CARE FOR LIFE

A look at the crisis
in the
health care
and
its solutions.

United Electrical, Radio and Machine Workers of America (UE)
Local 1128,1180 and 1187
106 S. Indiana, Suite A,Sioux Falls SD 57103
Phone (605) 331-5078

"It's time to take the profit out of health care, It is our obligation to make decent health care the right of every citizen, not the privilege of those who can afford it."

--resolution adopted by 54th UE Convention

HEALTH CARE: WE'RE PAYING MORE, AND GETTING LESS.

Bigger bites taken out of our paychecks for health insurance and health care bills. Impossible bargaining over insurance costs for many union negotiators. Strikes by mineworkers, telephone workers and electrical workers.

These are some of the ways the health care crisis is showing up in the lives of America's working men and women.

And it doesn't stop there. One union study suggests we've been robbed of a 12 percent wage increase since 1980 as employers picked our pockets to pay skyrocketing insurance costs.

Then consider the fate of retirees or of workers victimized by layoffs or plant closings. More and more of them are joining the ranks of an incredible 37 million Americans who have no health insurance, or 50 million who are underinsured.

We're paying a heavy price, and so is our nation.

Spending on health care in the U.S. has reached an astounding *$ 2 billion a day* -- more per-person than any other country. Even so, our nation's health ranks near the bottom among all industrialized countries based on key measures such as infant deaths and adult life expectancy. We're paying more for health care and getting less for our money.

What's the Cause of Our Health Care Crisis?

Because the U.S. doesn't have a national health care program, we're stuck trying to meet people's needs through a crazy mix of private and public plans. The result is an administrative nightmare for consumers and providers alike.

There's few limits on what doctors charge or hospitals bill. Huge sums are going into the pockets of insurance companies, doctors, medical equipment manufacturers and for-profit hospitals. The average annual income (after taxes) for U.S. doctors is now near the $150,000 mark.

What's more, without national coordination of our health care system, inefficiencies abound. There are 1,550 different private insurance companies operating in the U.S. today,

with the result that 22 cents out of every dollar spent on health care is going to paper-shuffling costs. That's about twice what's spent in nearby Canada.

Congress is feeling the pressure and may act on health reform soon, possibly in 1990. But a real solution to the health care crisis won't come easily. For starters, it means winning a political fight with the $700 billion a year private insurance industry.

THE ANSWER IS NATIONAL HEALTH CARE.

The only meaningful solution to the health care crisis is a national health care program that will *control costs* and *guarantee decent care* for everyone.

The United States is the only industrial nation other apartheid South Africa which doesn't guarantee health care for all citizens. Canada, Great Britain, Sweden, Japan and West Germany (among others) all manage to provide better health care to their people -- and at less cost.

UE has long advocated a national health care program for our country, and today many other labor, religious and citizens groups -- and even some businesses -- have also begun speaking out for national health care.

One recent poll showed that 61% of Americans would prefer a national health care system like that in Canada.

How Would National Health Care Work?

Canada and Great Britain have quite different programs, but in both countries private health insurance is out. The government takes responsibility for paying health care bills and controlling costs.

HEALTH CARE:
U.S. vs. THE WORLD

	Cost	Life Expectancy	Infant Mortality
U.S.	11.2%	74	10.4
Canada	8.6%	75	7.9
Britain	6.1%	75	8.8
W. Germany	9.3%	75	8.5
Sweden	9.2%	77	5.9

COST: Percentage of GNP; INFANT MORTALITY: per 1,000 births

Some basic principles for an American program should be: 1) Cradle-to-the-grave coverage for all people; 2) Full coverage for all types of illness; 3) Freedom of choice in choosing doctors, dentists and other providers; 4) No out-of-pocket payments when health services are needed.

In many countries a card similar to a social security card is all you need to get health care. *No forms, no up-front cash, no bills.*

Who Would Pay for National Health Care?

To some extent it would pay for itself by reducing the cost of health care. According to one recent study, switching the U.S. to the Canadian system would mean an annual *savings* of roughly $60-70 billion in administrative costs, and elimination of another $5 billion in profits now collected by health-care providers and financial institutions. Another study estimates that switching to a British-style system would save more than $60 billion a year.

UE maintains that a portion of the "peace dividend" from cuts in the $300 billion-a-year U.S. military budget should be used to pay for national health care. Additional funds to support a national health care program could come from employer contributions and progressive taxation. (Money we now spend on insurance premiums could be renamed "taxes" and put in a national health care fund.)

How Do We Win National Health Care?

By making Congress answer to the majority of Americans who want a national health care program. (Members of Congress, by the way, already get free health care from the government.) Write, call or visit your senators or representatives. Organize marches, rallies or public hearings. Seek resolutions of support from your local and state governments. Most members of Congress must get re-elected this year. We need to turn up the heat and make national health care a ballot-box issue in 1990.

Every elected Official,UE member and
American must act on this issue now!!!
Lives depend on it!