Staats

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by

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"GAO AND THE PUBLIC HEALTH"

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It gives me great pleasure to participate in your annual meeting this year. This is particularly so in light of the frequent occasions in recent times during which activities of the GAO have intimately concerned areas in which you have a vital interest.

It may be useful, at the outset to give you a general overview of the General Accounting Office and how it functions.

The GAO is a part of the legislative branch of the Government, and as such responsible directly to the Congress. One of its most important functions is to review programs which Congress legislates or for which it appropriates funds in order to determine how those programs are meeting congressional intent and whether or not they are being operated successfully and economically. Upon completion of our review, we prepare a written report of our findings and recommendations which usually incorporates the views of the Federal agency whose activities we reviewed. The agency's comments are included in the report which I sign and transmit to the Congress for its consideration.

Approximately one-third of our activities result from congressional mandate or requests for our services. The other two-thirds are self-initiated reviews of problem areas where we believe we can make a significant contribution. In most cases, we make contact with appropriate congressional committees to determine the extent of their interest.

The professional staff which performs our reviews is located here in Washington, in regional offices located throughout the country, and in branch offices overseas. While our staff, in bygone years, consisted primarily of accountants and attorneys we have placed increasing emphasis, in recent years, on building an interdisciplinary staff with a variety of academic and experience backgrounds such as economics, engineering, education, energy, systems analysis, and, of course, health. It was just 7 years ago that we secured the services of a physician on our staff to assist us in our health program evaluations.

Your theme at this meeting concerns itself with the allocation of medical resources and services. Accordingly, it may be appropriate to mention some of the recent activities of the GAO which have related to this area.

For some time, questions have been raised as to whether we are training too many surgeons and perhaps too few primary care physicians. In an attempt to examine these issues, the GAO visited 16 medical schools and 33 teaching hospitals with graduate medical training programs. We also contacted 85 medical organizations and interviewed 225 graduate medical training directors to secure their views on the number and types of physicians needed and the ways by which these needs could be met. We found that whether or not we have an adequate supply of physicians in the United States is really unknown and that although there appears to be general

agreement that more primary care physicians are needed there is by no means any concensus on whether or not we have too many specialists.

As you know, in an effort to increase the number of primary care physicians, legislation was enacted which required that after fiscal year 1977, in order to be eligible for capitation grants, medical schools must have certain specified percentages of first year graduate training positions in primary care training programs.

We found that no system currently exists for ensuring that the number and type of physicians being trained is consistent with or related to the number needed. Rather, decisions on the number and type of physicians being trained are made by individual medical schools and hospital program directors with no real consideration of national needs. These decisions are influenced by funds available, the need to provide balanced training within a medical school and the patient care needs of training institutions.

As a result of considerable interest in the geographic distribution of health manpower and congressional interest in ensuring that physicians are located so as to be accessible to the entire population, GAO recently reviewed a number of Federal and State programs which are endeavoring to increase access to medical care in underserved areas. For example, we examined the progress being made by the National Health

Service Corps in increasing the availability of physicians in communities designated as having a critical shortage of health manpower. We also reviewed the Federal loan repayment program for physicians, the area health education centers and the preceptorship and family medicine training program. We also explored a number of State activities which are using alternatives such as physician extenders to the use of physicians in rural areas.

We found that distribution of health manpower and particularly physicians is clearly uneven and that the New England, Mid-Atlantic and Pacific regions rank almost 20 percent above the national average in physicians per 100,000 persons while the East South Central region is almost 30 percent below the national average. We found also that newly graduating physicians, like their predecessors, are tending to enter practice predominately in urban areas and that the factors influencing their location decisions have remained virtually unchanged over the last several years. We learned that loan repayment was not an important factor in the selection of practice location and therefore recommended that Congress reconsider whether that program should be continued.

After our examination of the area health education center program, we felt that this activity has useful long-term potential for improving geographic health manpower

distribution. We noted, particularly, that certain of the programs have established rather close linkages between the medical school and the health delivery system within the communities in the States. These linkages have resulted from training of medical students in community hospitals and in physicians' offices, from an increase in the number of medical residencies within the State, and as a result of the establishment of continuing education courses in areas remote from the medical school.

We were impressed by the WAMI program which has attempted to place physicians in areas of need in the States of Washington, Alaska, Montana and Idaho (from which the acronym derives) and to increase the number of primary care physicians being trained. We were also impressed with the extent to which Eastern Kentucky has tackled the problem of rural health care delivery by establishing a number of innovative programs including extensive use of physician extenders, mobile health care units and computerized medical and management information systems.

The allocation of medical resources and services obviously requires careful and thoughtful planning. A number of years ago, the GAO evaluated on comprehensive health planning as carried out by State and areawide health planning agencies in three States.

More recently, we reviewed the status of the implementation of the 1974 National Health Planning and Resources Development Act which sought to build on the experience of the Hill-Burton regional medical and comprehensive health planning programs and to combine their best features in the latest health planning effort. The basic purpose of the act was to achieve equal access to quality health care at reasonable cost but we found many delays in implementing the provisions of the act and many organizational problems within the Department of Health, Education, and Welfare which have impeded the timely development of health systems agencies.

In addition, we found that health systems agencies had little data available on the existing health care system and the status of the health of their residents and that no approved national standards or criteria were available regarding the appropriate supply, distribution and organization of health resources and services. We also found that controversy exists over the compatibility of the objectives of the act and that health systems agency board members and local health professional groups, as well as public officials were not optimistic about meeting the goals of restraining health care costs and improving accessibility to health care. Furthermore, many officials questioned the authority and the ability of areawide health systems agencies to accomplish

the goals. While it is perhaps too early to render any final judgment on the ability of health systems agencies to bring some order to the system, our review does not supply a particularly hopeful note in an area which is of great importance if national objectives aimed at the appropriate allocation of health resources and services are to be achieved.

Because of the fact that many hospitals with federally assisted loans have been experiencing serious financial probblems, the GAO sent a questionnaire to 380 hospitals participating in this program. Forty-four of these hospitals said that their financial condition was poor. Clearly, their financial problems could lead to defaults and closure of facilities; six hospitals had already defaulted on their loans. We recommended that the Department of Health, Education, and Welfare should make comprehensive risk assessments to identify the chances of loan defaults and that the Department should increase its vigilence in monitoring the program.

We recently reported on a review that we made of the work of the Joint Commission on the Accreditation of Hospitals and a comparison of its accreditation activities with those of the State health agencies which are required to perform hospital validation surveys under contract from the Department of Health, Education, and Welfare. We found that the Commission reported more deficiencies and more significant ones. We also found that the State accreditation process

was not reliable and we proposed consideration of a number of alternative approaches in order to revitalize the Medicare certification process. One of the important alternatives that we proposed for consideration would require that the Department of Health, Education, and Welfare contract with the Joint Commission on Accreditation of Hospitals for all hospital certification surveys.

Last year we reported on a review that we had performed of the neighborhood health centers program. These centers, which were first established by the Office of Economic Opportunity, serve areas of the country in which some 45 million Americans live under conditions which apparently have not proven attractive to health care providers. Our objectives in examining these centers, were to determine whether the centers continued to serve a useful purpose, whether they were duplicative of already existing services and whether health manpower was being effectively used in the centers. A previous GAO report, issued in 1974, had raised some questions concerning the utilization of physicians and dentists in neighborhood health centers.

We found that the neighborhood health centers were generally overstaffed for the number of patients being treated and that patient demand has not reached the level on which staffing was based; nor do we believe that demand for health services from these centers is likely to significantly increase

in the forseeable future. We also felt that there was considerable uncertainty as to whether, in fact, the centers were serving residents of medically underserved areas. Some centers, in an effort to obtain revenues, have dropped boundary and residency requirements to attract patients who have the means to pay for these services. We believe that this duplicates care available in already existing facilities. We also determined that most patients use the centers for treatment of illness and very little for prevention even though this has been one of the stated purposes of these centers.

Our recommendations were geared to bringing about changes in most of the areas in which we had voiced some criticism; for example, we suggested that staff be reduced at some centers to levels consistent with demand for services and that criteria be developed for measuring the productivity of dentists. We also recommended that funding for centers which primarily serve people who do not live in medically underserved areas be stopped, particularly when the residents have access to other health care providers.

I would like now to turn for a few moments to discuss the field of research with emphasis on Federal research grants. The importance of research has been clearly recognized by the Federal Government. The President's budget for fiscal year 1980 proposed $30.6 billion for research and

development. Of this amount, $3.9 is proposed to support the conduct of research and development in colleges and universities, including medical schools. Approximately half of the Federal research and development funds that colleges and universities receive goes to conduct basic research; approximately 40 percent to conduct applied research, primarily of a medical nature, and; the remainder to undertake development activities. When one considers that about two-thirds of the direct support of research and development in these institutions is provided by the Federal Government, it is apparent that government and academia have become dependent on each other.

However, there are signs of strain in this relationship. Last November, Jerome Wiesner, then President of MIT expressed "grave concern that the basic Federal-academic relationship is floundering". In recognition of the importance of these tensions, an independent National Commission on Research created in October 1978 is taking an in-depth look at the issues involved. The problem is how to achieve adequate accountability for public funds without imposing excessive controls, direction, and administrative burdens on research grantees, which would inhibit freedom of intellectual inquiry and efficient performance of research. The keystone of the research process is the individual researcher. It is he who conceives, directs, performs and publishes his

work. As a consequence, the researcher will be particularly sensitive to any externally imposed constraints on his time and investigative effort.

On the other hand, the Government, as the steward of public monies entrusted to it, is accountable to the public for supporting high quality efforts. Peer review appears to be the best method to account for the substance of scientific research as opposed to other aspects, such as finances. Recently, public pressure for accountability in Government has substantially increased, in part, because of increased inflation, partially because there appears to be public mistrust of large institutions, and partly because there has been increased tightening of Federal spending with greater competition for increasingly scarce funds. The key issue here is how to ensure proper stewardship for funds spent in research without imposing control, direction and administrative burdens on research grantees.

The GAO has great interest in the issues relating to basic research and has a considerable amount of related work in progress or being planned including a review of the adequacy of HEW audits of the 20 academic institutions that received the most Federal support during fiscal year 1975; a review of indirect costs of health research, how they are computed, and why they are increasing so rapidly; a study of research proposal review and monitoring of grants to

universities by the National Science Foundation and National Institutes of Health; and a study which will examine Federal policies and institutional relationships affecting Government-industry-university cooperation in the area of basic research.

As a result of congressional concern at the large proportion of health research funds spent for indirect costs and the wide range in those costs among different institutions, the GAO asked the National Institutes of Health 1977 grantees what caused the greatest increase in their indirect research costs. Most blamed utility bills and compliance with Government mandated requirements.

Finally, I would like to discuss a few GAO efforts currently underway which may be of considerable interest to your organization.

In recent years, the Nation's health care bill has increased at a rate much faster than growth in the overall economy. In 1978 health care expenditures in the United States increased to nearly $180 billion. The percentage of the gross national product spent on health care has almost doubled in the last 29 years from 4.6 percent in 1950 to nearly 9 percent in 1979. This spiraling inflation in health care expenditures has been fueled by spending for hospital care. Hospital costs account for the largest single share of health care costs and currently represent about 43 cents of the health care cost dollar.

It is difficult to place specific responsibility for the cost increase since the hospital industry does not tend to respond to normal market forces. Decisions regarding hospital spending are highly decentralized; patient choices of when and where services are provided are usually restricted and payment comes primarily from third party payors. Some economists contend that since hospitals are removed from the normal marketplace economic factors, much of the incentive for hospital managers to run hospitals efficiently are not present. These economists also argue that the traditional cost-based retrospective payment method has eroded any remaining incentive by paying for essentially all costs of medical care deemed appropriate by physicians and hospitals. In an effort to provide incentives for cost savings, an increasing number of States and insurance companies are paying hospitals for patient care on the basis of rates established before the services are provided. The underlying principle of this prospective payment method is that these preestablished rates may provide financial rewards and penalties and will cause hospital managers to operate more efficiently without compromising the quality of the services provided. In theory, this payment methodology places hospitals at financial risk and encourages them to keep actual expenditures below the prospectively established rates, puts increased emphasis on identifying and controlling

costs and encourages them to examine the financial implications of any new facilities and services.

We have recently become involved in examining the reasons for spiraling hospital costs and for reviewing both the retrospective and prospective reimbursement systems. As part of this study, we have spent some time reviewing systems in operation in some of the provinces of Canada and we have explored the issues with a number of State review commissions. We have submitted a questionnaire to 3,300 hospital administrators in an effort to determine which type of management techniques could help constrain the rise in hospital costs. We also submitted questionnaires to a number of health care experts to obtain their opinions on the potential for containing hospital costs and the ease with which selected management techniques could be implemented. In addition, we visited 55 hospitals to obtain detailed information on how techniques are being applied and what, if any, effect they had on costs. We recognize, however, that the solutions for containing health care costs are not easy to come by. However, work on this review is continuing and we expect to issue our report early next year.

As somewhat of a followup on this review, we have recently become interested in examining how physicians are trained during their undergraduate days, and as part of continuing education, to be aware of the cost of procedures and items they order when diagnosing and treating patients

medical conditions. In addition to determining the extent to which they are trained in these areas, we are also interested in learning how widely this information is used in every-day work with patients. We are also exploring the extent to which physicians are aware of techniques and drugs which may be used to treat the same patient problems as effectively but perhaps more economically. This review is in its infancy but we believe will supply some useful information on a subject we feel is of some current interest.

I am sure that everyone in this room is aware of the recent proliferation of medical schools that has occurred--particularly in the Carribbean and to some extent in Mexico--apparently to attract United States students who have failed to gain admission to medical schools in this country. We have recently undertaken, as a result of a congressional request, a detailed study of this situation with a view to making an effort to address a number of issues including questions concerning the number of American medical students currently enrolled in foreign medical schools who are receiving guaranteed student loans or Veterans Administration benefits and what is the current annual cost to the United States for this assistance. We are endeavoring to learn what attempts have been made by the Department of Health, Education, and Welfare and the Veterans Administration to determine whether foreign medical schools have standards

fairly comparable to our institutions. We also hope to learn the current position of the Department of Health, Education, and Welfare concerning the possible impact that returning physicians will have on the total supply of physicians and on medical costs. We would like to know whether financial gain plays a role in the establishment of some of these new medical schools and to what extent United States students studying abroad are able to pass the requisite examinations to receive licensure and post-graduate training in the United States. We are also interested in determining what happens to United States students who are unable to secure post-graduate education or pass examinations which would enable them to practice in this country. And finally, we are studying the extent to which United States students studying abroad can avail themselves of clinical training in the foreign country and the extent to which training is being made available within hospitals in the United States.

As part of this study, we have alredy spent considerable time reviewing the programs of the Office of Education and the Veterans Administration and have spoken with a number of professional medical organizations. We are in the process of visiting a number of medical schools located in foreign countries with emphasis on those schools which have a large number of American students. We are also visiting hospitals

in the United States to which some of these students are referred for at least part of their cliniical training and expect to meet with a number of State licensing boards and other authorities with a view to exploring any problems that have occurred or are on the horizon with regard to questions of licensure and post-graduate education. Our report on this most interesting subject should be forthcoming fairly early in the coming year.

Lastly, a word or two concerning an interesting review which we have been performing of the Food and Drug Administration's procedures for licensing drugs. For several years, the Food and Drug Administration has been accused by some for promoting a so-called "drug lag" by which was meant a bureaucratic inertia through which licensing of new drugs was being delayed.

In response to a congressional request, we initiated a review of the drug approval process, not only in this country but in Canada and eight countries in Europe. We wanted to determine how the systems varied and whether the procedures carried out in other countries led to more rapid licensure of effective drugs while still safeguarding the public's safety.

Although this review is still underway, we qave preliminary testimony on June 19 before the House Subcommittee on Science, Research and Technology in which we pointed out that important drugs do seem to take a long time to be approved in the United

States. We also noted a number of very useful drugs which had been licensed in various European countries long before licensure was effected in this country.

Our report on this topic will be available fairly early in the new year, at which time we expect to testify at hearings on the Administration's Comprehensive Drug Reform Bill.

From my remarks, you can readily grasp the number of, and complexity of, health care problems challenging GAO auditors and of concern to all of us.

We can all agree that people in the health care system--both in and out of Government--continue to strive for the goal of ready access to quality health care at a reasonable cost.

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