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ILITARY MEDICAL PROGRAMS AND PROPOSED REVISIONS OF MILITARY MEDICAL PAY

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HEARING

BEFORE THE

SUBCOMMITTEE ON MANPOWER AND PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

S. 523

TO AMEND CHAPTER 5 OF TITLE 37, UNITED STATES CODE, TO REVISE THE SPECIAL PAY PROVISIONS FOR CERTAIN HEALTH PROFESSIONALS IN THE UNIFORMED SERVICES

S. 1100

TO AMEND CHAPTER 5 OF TITLE 37, UNITED STATES CODE, REVISE THE SPECIAL PAY PROVISIONS FOR CERTAIN LTH PROFESSIONALS IN THE UNIFORMED SERVICES

H.R. 5235

AMEND CHAPTER 5 OF TITLE 37, UNITED STATES CODE, REVISE THE SPECIAL PAY PROVISIONS FOR CERTAIN LTH PROFESSIONALS IN THE UNIFORMED SERVICES

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DECEMBER 5, 1979

Printed for the use of the Committee on Armed Services

U.S. GOVERNMENT PRINTING OFFICE
57-862 O WASHINGTON : 1980

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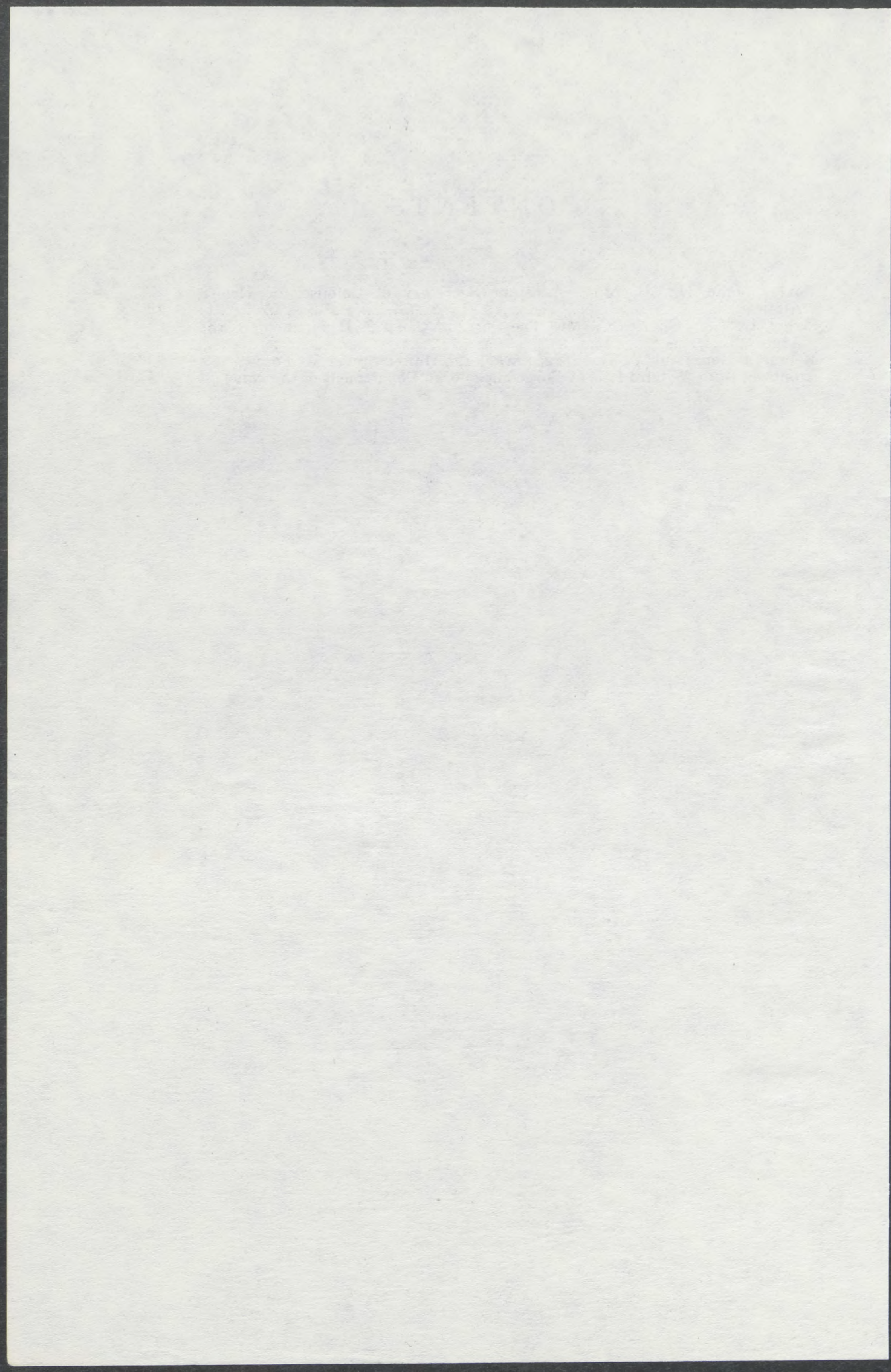

MILITARY MEDICAL PROGRAMS AND PROPOSED REVISIONS OF MILITARY MEDICAL PAY

DECEMBER 5, 1979

U.S. SENATE,
SUBCOMMITTEE ON MANPOWER AND PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 212, Russell Senate Office Building, Hon. Sam Nunn presiding.

Present: Senators Nunn, Hart, Exon, Thurmond, Jepsen, and Warner.

Committee staff present: George F. Travers, Ronald F. Lehman, Charles J. Conneely, professional staff members; John T. Ticer, chief clerk; Ralph O. White, research assistant; and Mary A. Shields, clerical assistant.

Also present: Gerald Stacy, assistant to Senator Culver; John Stirk, assistant to Senator Morgan; Christopher Lehman, assistant to Senator Warner; and Mike Donley, assistant to Senator Jepsen.

[The bills S. 523, S. 1100, and H.R. 5235 follow:]

[S. 523, 96th Cong., 1st sess.]

A BILL To amend chapter 5 of title 37, United States Code, to revise the special pay provisions for certain health professionals in the uniformed services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Uniformed Services Health Professionals Special Pay Act of 1979".

SEC. 2. (a) Chapter 5 of title 37, United States Code, relating to special and incentive pays for members of the uniformed services, is amended by striking out sections 302, 302a, 302b, and 303 and inserting in lieu thereof the following:

"§ 302. Special pay: medical officers

"(a)(1) Except as provided in paragraph (2), a commissioned officer who is an officer of the Medical Corps of the Army or the Navy, an officer of the Air Force designated as a medical officer, or a medical officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to primary special pay at the following applicable rate:

"(A) $1,200 per year, if the officer has less than five years of creditable service under subsection (c);

"(B) $7,000 per year, if the officer has at least five but less than eight years of creditable service under subsection (c);

"(C) $9,000 per year, if the officer has at least eight but less than fourteen years of creditable service under subsection (c); or

"(D) $11,000 per year, if the officer has fourteen or more years of creditable service under subsection (c).

"(2) A commissioned officer described in paragraph (1) who is serving in the pay grade of 07, 08, or 09 is entitled to primary special pay at the following applicable rate regardless of the number of years of creditable service such officer may have under subsection (c):

"(A) $6,000 per year if the officer is serving in a pay grade of 09;
"(B) $7,000 per year if the officer is serving in a pay grade of 08; or
"(C) $10,000 per year if the officer is serving in a pay grade of 07.

"(3) The annual rate of primary special pay to which an officer is entitled under paragraph (1) or (2) shall be increased by—

"(A) $9,000 for any period during which the officer is not undergoing medical internship or residency training, as determined under regulations prescribed under section 302d(a); and

"(B) $2,000 if the officer is board certified, as determined under regulations prescribed under section 302d(a).

"(b)(1) Subject to paragraph (2) and under regulations to be prescribed under section 302d(a), an officer who is entitled to primary special pay under subsection (a)(1) and who is not undergoing medical internship or residency training may be paid incentive special pay in an annual amount not to exceed $8,000.

"(2) No officer shall be eligible for incentive special pay under this subsection unless the Secretary concerned has determined that the officer is qualified in the medical profession.

"(3) To be eligible for incentive special pay under this subsection for any year, an officer must first execute a written agreement under which the officer agrees to remain on active duty for a period of not less than one year beginning on the date the officer accepts the award of such special pay.

"(4) In developing the budget for any fiscal year for transmittal to the Congress under section 201(a) of the Budget and Accounting Act, 1921, the President shall limit the amount to be paid during that year for incentive special pay under this subsection to an amount equal to not more than 10 per centum of the amount to be paid in that year for primary special pay under subsection (a).

"(c) For purposes of this section, creditable service of an officer of the Medical Corps of the Army or the Navy, an officer of the Air Force designated as a medical officer, or a medical officer of the Public Health Service, is computed by adding—

"(1) four years;

"(2) all periods which the officer spent in medical internship or residency training during which the officer was not on active duty; and

"(3) all periods of active service in the Medical Corps of the Army or Navy, as an officer of the Air Force designated as a medical officer, or as a medical officer of the Public Health Service.

"§ 302a. Special pay: dental officers

"(a)(1) Except as provided in paragraph (2), a commissioned officer who is an officer of the Dental Corps of the Army or the Navy, an officer of the Air Force designated as a dental officer, or a dental officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to primary special pay at the following applicable rate:

"(A) $1,200 per year, if the officer has at least four years of creditable service under subsection (c) and is undergoing dental internship training, as determined under regulations prescribed under section 302d(a);

"(B) $2,000 per year, if the officer has at least four but less than seven years of creditable service under subsection (c) and is not undergoing dental internship training, as determined under regulations prescribed under section 302d(a);

"(C) $7,000 per year, if the officer has at least seven but less than fourteen years of creditable service under subsection (c); or

"(D) $9,000 per year, if the officer has fourteen or more years of creditable service under subsection (c).

"(2) A commissioned officer described in paragraph (1) who is serving in the pay grade of 07 or 08 is entitled to primary special pay at the rate of $7,000 per year regardless of the number of years of creditable service such officer may have under subsection (c).

"(3) The annual rate of primary special pay to which an officer is entitled under paragraph (1) or (2) shall be increased by—

"(A) $3,000 for any period during which the officer is not undergoing dental internship or residency training, as determined under regulations prescribed under section 302d(a); and

"(B) $2,000 if the officer is board qualified in a dental specialty, as determined under regulations prescribed under section 302d(a).

"(b)(1) Subject to paragraph (2) and under regulations prescribed under section 302d(a), an officer who is entitled to primary special pay under subsection (a)(1) and who is not undergoing dental internship or residency training may be paid incentive special pay in an annual amount not to exceed $8,000.

"(2) No officer shall be eligible for incentive special pay under this subsection unless the Secretary concerned has determined that the officer is qualified in the dental profession.

"(3) To be eligible for incentive special pay under this subsection for any year, an officer must first execute a written agreement under which the officer agrees to remain on active duty for a period of not less than one year beginning on the date the officer accepts the award of such special pay.

"(4) In developing the budget for any fiscal year for transmittal to the Congress under section 201(a) of the Budget and Accounting Act, 1921, the President shall limit the amount to be paid during that year for incentive special pay under this subsection to an amount equal to not more than 5 percent of the amount to be paid in that year for primary special pay under subsection (a).

"(c) For purposes of this section, creditable service of an officer of the Dental Corps of the Army or the Navy, an officer of the Air Force designated as a dental officer, or a dental officer of the Public Health Service is computed by adding—

"(1) four years;

"(2) all periods which the officer spent in dental internship or residency training during which the officer was not on active duty; and

"(3) all periods of active service in the Dental Corps of the Army or Navy, as an officer of the Air Force designated as a dental officer, or as a dental officer of the Public Health Service.

"§ 302b. Special pay: veterinary officers

"(a) A commissioned officer who is an officer of the Veterinary Corps of the Army, an officer of the Air Force designated as a veterinary officer, or a veterinary officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to special pay at the following applicable rate:

"(1) $1,800 per year, if the officer has less than three years of creditable service under subsection (b);

"(2) $2,400 per year, if the officer has at least three but less than six years of creditable service under subsection (b);

"(3) $3,000 per year, if the officer has at least six but less than ten years of creditable service under subsection (b); or

"(4) $4,200 per year, if the officer has ten or more years of creditable service under subsection (b).

"(b) For puposes of this section, creditable service of an officer of the Veterinary Corps of the Army, an officer of the Air Force designated as a veterinary officer, or a veterinary officer of the Public Health Service is computed by adding—

"(1) all periods which the officer spent in veterinary residency training during which the officer was not on active duty; and

"(2) all periods of active service in the Veterinary Corps of the Army, as an officer of the Air Force designated as a veterinary officer, or as a veterinary officer of the Public Health Service.

"§ 302c. Special pay: optometry officers

"(a) A commissioned officer who is an officer of the Army, Navy, or Air Force designated as an optometry officer or who is an optometry officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to special pay at the following applicable rate:

"(1) $1,800 per year, if the officer has less than three years of creditable service under subsection (b);

"(2) $2,400 per year, if the officer has at least three but less than six years of creditable service under subsection (b);

"(3) $3,000 per year, if the officer has at least six but less than ten years of creditable service under subsection (b); or

"(4) $4,200 per year, if the officer has ten or more years of creditable service under subsection (b).

"(b) For purposes of this section, creditable service of an officer of the Army, Navy, or Air Force designated as an optometry officer or of an optometry officer of the Public Health Service is computed by adding—

"(1) all periods which the officer spent in optometry residency training during which the officer was not on active duty; and

"(2) all periods of active service as an optometry officer.

"§ 302d. Special pay: health professionals; general provisions

"(a)(1) The Secretary of Defense, with respect to the Army, Navy, and Air Force, and the Secretary of Health, Education, and Welfare, with respect to the Public Health Service, shall prescribe regulations for the administration of sections 302, 302a, 302b, and 302c.

"(2) For purposes of sections 302, 302a, 302b, and 302c, the terms 'board eligible', 'board qualified', and 'initial residency training' shall have such meanings as shall be prescribed in regulations issued by the Secretary of Defense.

"(b) Special pay authorized under sections 302, 302a, 302b, and 302c is in addition to any other pay or allowances to which a member is entitled, and the amounts set forth in such sections shall not be included in computing the amount of any increase in pay under any other provision of this title or in computing retired pay, severance pay, or readjustment pay.

"(c) Special pay under sections 302(a), 302a(a), 302b, and 302c shall be paid monthly.

"(d) An officer who voluntarily terminates his service on active duty before the end of the period for which a payment was made to such officer under section 302(b) or 302a(b) shall refund to the United States an amount which bears the same ratio to the amount paid to such officer as the unserved part of such period bears to the total period for which the payment was made.

"(e) The special and incentive pays to which an officer of the health professions of the uniformed services is entitled under sections 302 through 302c are to be adjusted each year by the same percentage rate that the monthly basic pay and allowances of members of the uniformed services is adjusted pursuant to section 8 of the Act of December 16, 1967 (Public Law 90-207; 81 Stat. 654).".

(b) Sections 311 and 313 of title 37, United States Code, are repealed.

(c) Section 306(e) of such title, relating to exclusions from special pay for officers holding positions of unusual responsibility, is amended by striking out "302 or 303" and inserting in lieu thereof "302, 302a, 302b, or 302c".

(d) The table of sections at the beginning of chapter 5 of such title is amended—

(1) striking out the items relating to sections 302, 302a, 302b, and 303 and inserting in lieu thereof the following:

"302. Special pay: medical officers.
"302a. Special pay: dental officers.
"302b. Special pay: veterinary officers.
"302c. Special pay: optometry officers.
"302d. Special pay: health professionals; general provisions.";

and

"(2) by striking out the items relating to sections 311 and 313.

Sec. 3. Unearned amounts received by officers under the provisions of sections 311 and 313 of title 37, United States Code, on the day before the effective date of this Act shall be recouped by the United States from the officer concerned on a pro rata basis. An officer receiving pays under the provisions of any of the sections amended or repealed by this Act shall continue, under regulations prescribed by the Secretary of Defense, to be entitled under the amendments made by this Act to an annual amount of special pay equal to not less than the annual amount to which such officer would have been entitled had such sections not been amended or repealed by this Act.

Sec. 4. This Act shall become effective on October 1, 1979.

[S. 1100, 96th Cong., 1st Sess.]

A BILL To amend chapter 5 of title 37, United States Code, to revise the special pay provisions for certain health professionals in the uniformed services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Uniformed Services Health Professionals Special Pay Act of 1979".

"Sec. 2. (a) Chapter 5 of title 37, United States Code, relating to special and incentive pays for members of the uniformed services, is amended by striking out sections 302, 302a, 302b, and 303 and inserting in lieu thereof the following:

"§ 302. Special pay: medical officers

"(a)(1) A commissioned officer who is an officer of the Medical Corps of the Army or the Navy, an officer of the Air Force designated as a medical officer, or a medical officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to primary special pay at the following rates:

"(A) $1,200 per year, if the officer has less than one year of creditable service under subsection (c).

"(B) $7,000 per year, if the officer has at least one but less than four years of creditable service under subsection (c).

"(C) $9,000 per year, if the officer has at least four but less than ten years of creditable service under subsection (c).

"(D) $11,000 per year, if the officer has ten or more years of creditable service under subsection (c) and is serving in a pay grade below O–7.

"(E) $8,000 per year, if the officer is serving in pay grade O–7.

"(F) $6,000 per year, if the officer is serving in pay grade O–8.

"(G) $4,000 per year, if the officer is serving in pay grade O–9.

"(2) The annual rate of primary special pay to which an officer entitled to primary special pay under paragraph (1) is entitled—

"(A) shall be increased by $9,000 for any period during which the officer is not undergoing medical internship or residency training, as determined under regulations prescribed under section 302d(a) of this title; and

"(B) shall be increased by $2,000 if the officer is board certified, as determined under regulations prescribed under section 302d(a) of this title.

"(b)(1) Subject to paragraph (2) and under regulations prescribed under section 302d(a) of this title, an officer who is entitled to primary special pay under subsection (a), and is not undergoing medical internship or residency training, may be paid incentive special pay in an annual amount not to exceed $8,000.

"(2)(A) An officer may not be paid incentive special pay under this subsection unless the Secretary concerned has determined that the officer is qualified in the medical profession.

"(B) An officer may not be paid incentive special pay under this subsection for any year unless the officer first executes a written agreement under which the officer agrees to remain on active duty for a period of not less than one year beginning on the date the officer accepts the award of such special pay.

"(3) In developing the budget for any fiscal year for transmittal to the Congress under section 201(a) of the Budget and Accounting Act, 1921, the President shall provide that the amount to be paid during that year for incentive special pay under this subsection shall not be more than 10 percent of the amount to be paid in that year for primary special pay under subsection (a).

"(c) For purposes of this section, creditable service of an officer of the Medical Corps of the Army or the Navy, an officer of the Air Force designated as a medical officer, or a medical officer of the Public Health Service is computed by adding—

"(1) all periods which the officer spent in medical internship or residency training during which the officer was not on active duty; and

"(2) all periods of active service in the Medical Corps of the Army or Navy, as an officer of the Air Force designated as a medical officer, or as a medical officer of the Public Health Service.

"§ 302a. Special pay: dental officers

"(a)(1) A commissioned officer who is an officer of the Dental Corps of the Army or the Navy, an officer of the Air Force designated as a dental officer, or a dental officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to primary special pay at the following rates:

"(A) $1,200 per year, if the officer is undergoing dental internship training, as determined under regulations prescribed under section 302d(a) of this title.

"(B) $2,000 per year, if the officer has less than three years of creditable service under subsection (c) and is not undergoing dental internship training, as determined under regulations prescribed under section 302d(a) of this title.

"(C) $7,000 per year, if the officer has at least three but less than ten years of creditable service under subsection (c).

"(D) $9,000 per year, if the officer has ten or more years of creditable service under subsection (c) and is serving in a pay grade below O–7.

"(E) $7,000 per year, if the officer is serving in pay grade O–7 or O–8.

"(2) The annual rate of primary special pay to which an officer entitled to primary special pay under paragraph (1) is entitled—

"(A) shall be increased by $3,000 for any period during which the officer is not undergoing dental internship or residency training, as determined under regulations prescribed under section 302d(a) of this title; and

"(B) shall be increased by $2,000 if the officer is board qualified in a dental specialty, as determined under regulations prescribed under section 302d(a) of this title.

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"(b)(1) Subject to paragraph (2) and under regulations prescribed under section 302d(a) of this title, an officer who is entitled to primary special pay under subsection (a), and is not undergoing dental internship or residency training, may be paid incentive special pay in an annual amount not to exceed $2,000.

"(2)(A) An officer may not be paid incentive special pay under this subsection unless the Secretary concerned has determined that the officer is qualified in the dental profession.

"(B) An officer may not be paid incentive special pay under this subsection for any year unless the officer first executes a written agreement under which the officer agrees to remain on active duty for a period of not less than one year beginning on the date the officer accepts the award of such special pay.

"(3) In developing the budget for any fiscal year for transmittal to the Congress under section 201(a) of the Budget and Accounting Act, 1921, the President shall provide that the amount to be paid during that year for incentive special pay under this subsection shall not be more than 5 percent of the amount to be paid in that year for primary special pay under subsection (a).

"(c) For purposes of this section, creditable service of an officer of the Dental Corps of the Army or the Navy, an officer of the Air Force designated as a dental officer, or a dental officer of the Public Health Service is computed by adding—

"(1) all periods which the officer spent in dental internship or residency training during which the officer was not on active duty; and

"(2) all periods of active service in the Dental Corps of the Army or Navy, as an officer of the Air Force designated as a dental officer, or as a dental officer of the Public Health Service.

"§ 302b. Special pay: veterinary officers

"(a) A commissioned officer who is an officer of the Veterinary Corps of the Army, an officer of the Air Force designated as a veterinary officer, or a veterinary officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to special pay at the following rates:

"(1) $1,800 per year, if the officer has less than three years of creditable service under subsection (b).

"(2) $2,400 per year, if the officer has at least three but less than six years of creditable service under subsection (b).

"(3) $3,000 per year, if the officer has at least six but less than ten years of creditable service under subsection (b).

"(4) $4,200 per year, if the officer has ten or more years of creditable service under subsection (b).

"(b) For purposes of this section, creditable service of an officer of the Veterinary Corps of the Army, an officer of the Air Force designated as a veterinary officer, or a veterinary officer of the Public Health Service is computed by adding—

"(1) all periods which the officer spent in veterinary residency training during which the officer was not on active duty; and

"(2) all periods of active service in the Veterinary Corps of the Army, as an officer of the Air Force designated as a veterinary officer, or as a veterinary officer of the Public Health Service.

"§ 302c. Special pay: optometry officers

"(a) A commissioned officer who is an officer of the Army, Navy, or Air Force designated as an optometry officer or who is an optometry officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to special pay at the following rates:

"(1) $1,800 per year, if the officer has less than three years of creditable service under subsection (b).

"(2) $2,400 per year, if the officer has at least three but less than six years of creditable service under subsection (b).

"(3) $3,000 per year, if the officer has at least six but less than ten years of creditable service under subsection (b).

"(4) $4,200 per year, if the officer has ten or more years of creditable service under subsection (b).

"(b) For purposes of this section, creditable service of an officer of the Army, Navy, or Air Force designated as an optometry officer or of an optometry officer of the Public Health Service is computed by adding—

"(1) all periods which the officer spent in optometry residency training during which the officer was not on active duty; and

"(2) all periods of active service as an optometry officer.

"§ 302d. Special pay: health professionals; general provisions

"(a) The Secretary of Defense, with respect to the Army, Navy, and Air Force, and the Secretary of Health, Education, and Welfare, with respect to the Public Health Service, shall prescribe regulations for the administration of sections 302, 302a, 302b, and 302c of this title. Such regulations shall include standards for determining whether an officer is undergoing medical internship or residency training for purposes of sections 302(a)(2)(A) and 302(b) of this title, whether an officer is board certified for purposes of section 302(a)(2)(B) of this title, whether an officer is undergoing dental internship or residency training for purposes of section 302a, and whether an officer is board qualified in a dental specialty for purposes of section 302a.

"(b) Special pay authorized under sections 302, 302a, 302b, and 302c of this title is in addition to any other pay or allowance to which an officer is entitled. The amount of special pay to which an officer is entitled under any of such sections may not be included in computing the amount of any increase in pay authorized by any other provision of this title or in computing retired pay, severance pay, or readjustment pay.

"(c) Special pay under sections 302(a), 302(a), 302b, and 302c of this title shall be paid monthly.

"(d) An officer who voluntarily terminates service on active duty before the end of the period for which a payment was made to such officer under section 302(b) or 302a(b) of this title shall refund to the United States an amount which bears the same ratio to the amount paid to such officer as the unserved part of such period bears to the total period for which the payment was made.

"(e) The amounts of special pay provided by sections 302, 302a, 302b, and 302c of this title shall be adjusted annually by the same percentage as the overall average percentage increase applied to basic pay and allowances of members of the uniformed services pursuant to section 1009 of this title.".

(b) Sections 311 and 313 of title 37, United States Code, are repealed.

(c) Section 306(e) of such title, relating the exclusions from special pay for officers holding positions of unusual responsibility, is amended by striking out "302 or 303" and inserting in lieu thereof "302, 302a, 302b, or 302c".

(d) The table of sections at the beginning of chapter 5 of such title is amended—

"(1) by striking out the items relating to sections 302, 302a, 302b, and 303 and inserting in lieu thereof the following:

"302. Special pay: medical officers.
"302a. Special pay: dental officers.
"302b. Special pay: veterinary officers.
"302c. Special pay: optometry officers.
"302d. Special pay: health professionals; general provisions.";

and

(2) by striking out the items relating to sections 311 and 313.

Sec. 3. After September 30, 1979, or the last day of the month in which this Act is enacted, whichever is later, any individual who on such date—

(1) was entitled to special pay under section 302, 302a, 302b, or 303 of title 37, United States Code; or

(2) was participating, or had been accepted for participation, in a program under which the individual has an obligation to serve on active duty in the Army, Navy, Air Force, or Public Health Service upon successful completion of such program and under which the individual, upon performing such active duty, would have been entitled to special pay under section 302, 302a, 302b, or 303 of title 37, United States Code, as in effect on such date;

shall be entitled, if otherwise qualified therefor, to be paid special pay under such section, and under section 311 or 313 of such title, if applicable (as such sections were in effect on such date), in lieu of special pay under section 302, 302a, 302b, or 302c of title 37, United States Code (whichever is applicable), as in effect after such date, at any time that it is more favorable to the individual to be paid special pay under such sections.

Sec. 4. The amendments made by section 2 apply to special pay payable for months beginning after September 30, 1979, or after the date of the enactment of this Act, whichever is later.

[H.R. 5235, 96th Cong. 1st sess.]

AN ACT To amend chapter 5 of title 37, United States Code, to revise the special pay provisions for certain health professionals in the uniformed services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Uniformed Services Health Professionals Special Pay Act of 1979".

SEC. 2. (a) Chapter 5 of title 37, United States Code, relating to special and incentive pays for members of the uniformed services, is amended by striking out sections 302, 302a, and 302b and inserting in lieu thereof the following:

"§ 302. Special pay: medical officers

"(a)(1) An officer who is an officer of the Medical Corps of the Army or the Navy, an officer of the Air Force designated as a medical officer, or a medical officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to special pay in accordance with this subsection.

"(2) An officer described in paragraph (1) who is serving in a pay grade below pay grade O–7 is entitled to variable special pay at the following rates:

"(A) $1,200 per year, if the officer is undergoing medical internship training, as determined under regulations prescribed under section 302c(a) of this title.

"(B) $5,000 per year, if the officer has less than six years of creditable service under subsection (c) and is not undergoing medical internship training, as determined under regulations prescribed under section 302c(a) of this title.

"(C) $10,000 per year, if the officer has at least six but less than eight years of creditable service under subsection (c).

"(D) $9,500 per year, if the officer has at least eight but less than ten years of creditable service under subsection (c).

"(E) $9,000 per year, if the officer has at least ten but less than twelve years of creditable service under subsection (c).

"(F) $8,000 per year, if the officer has at least twelve but less than fourteen years of creditable service under subsection (c).

"(G) $7,000 per year, if the officer has at least fourteen but less than eighteen years of creditable service under subsection (c).

"(H) $6,000 per year, if the officer has at least eighteen but less than twenty-two years of creditable service under subsection (c).

"(I) $5,000 per year, if the officer has at least twenty-two or more years of creditable service under subsection (c).

"(3) An officer described in paragraph (1) who is serving in a pay grade above pay grade O–6 is entitled to variable special pay at the rate of $1,000 per year.

"(4) An officer entitled to variable special pay under paragraph (2) or (3) is entitled to an additional payment of $10,000 for any twelve-month period during which the officer is not undergoing medical internship or initial residency training, as determined under regulations prescribed under section 302c(a) of this title.

"(5) An officer who is entitled to variable special pay under paragraph (2) or (3) who is board certified, as determined under regulations prescribed under section 302c(a) of this title, is entitled to additional special pay at the following rates:

"(A) $2,000 per year, if the officer has less than ten years of creditable service under subsection (c).

"(B) $2,500 per year, if the officer has at least ten but less than twelve years of creditable service under subsection (c).

"(C) $3,000 per year, if the officer has at least twelve but less than fourteen years of creditable service under subsection (c).

"(D) $4,000 per year, if the officer has least at fourteen but less than eighteen years of creditable service under subsection (c).

"(E) $5,000 per year, if the officer has eighteen or more years of creditable service under subsection (c).

"(b) An officer may not be paid special pay under paragraph (4) of subsection (a) for any twelve-month period unless the officer first executes a written agreement under which the officer agrees to remain on active duty for a period of not less than one year beginning on the date the officer accepts the award of such special pay.

"(c) For purposes of this section, creditable service of an officer of the Medical Corps of the Army or the Navy, an officer of the Air Force designated as a medical officer, or a medical officer of the Public Health Service is cumputed by adding—

"(1) all periods which the officer spent in medical internship or residency training during which the officer was not on active duty; and

"(2) all periods of active service in the Medical Corps of the Army or Navy, as an officer of the Air Force designated as a medical officer, or as a medical officer of the Public Health Service.

"§ 302a. Special pay: dental officers

"(a)(1) An officer who is an officer of the Dental Corps of the Army or the Navy, an officer of the Air Force designated as a dental officer, or a dental officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to special pay in accordance with this subsection.

"(2) An officer described in paragraph (1) who is serving in a pay grade below pay grade O–7 is entitled to variable special pay at the following rates:

"(A) $1,200 per year, if the officer is undergoing dental internship training, as determined under regulations prescribed under section 302c(a) of this title.

"(B) $2,000 per year, if the officer has less than six years of creditable service under subsection (c) and is not undergoing dental internship training, as determined under regulations prescribed under section 302c(a) of this title.

"(C) $5,000 per year, if the officer has at least six but less than eight years of creditable service under subsection (c).

"(D) $7,000 per year, if the officer has at least eight but less than ten years of creditable service under subsection (c).

"(E) $9,000 per year, if the officer has at least ten but less than twelve years of creditable service under subsection (c).

"(F) $8,000 per year, if the officer has at least twelve but less than fourteen years of creditable service under subsection (c).

"(G) $7,000 per year, if the officer has at least fourteen but less than eighteen years of creditable service under subsection (c).

"(H) $5,000 per year, if the officer eighteen or more years of creditable service under subsection (c).

"(3) An officer described in paragraph (1) who is serving in a pay grade above pay grade O–6 is entitled to variable special pay at the rate of $1,000 per year.

"(4) An officer entitled to variable incentive pay under paragraph (2) or (3) is entitled to an aditional payment for any twelve-month period during which the officer is not undergoing dental internship or residency training, as determined under regulations prescribed under section 302c(a) of this title, to be paid at the following rates:

"(A) $6,000 per year, if the officer has at least three but less than twelve years of creditable service under subsection (c).

"(B) $8,000 per year, if the officer has at least twelve but less than eighteen years of creditable service under subsection (c).

"(C) $10,000 per year, if the officer has eighteen or more years of creditable service under subsection (c).

"(5) A commissioned officer who is entitled to variable special pay under paragraph (2) or (3) who is board qualified, as determined under regulations prescribed under section 302c(a) of this title, is entitled to additional special pay at the following rates:

"(A) $2,000 per year, if the officer has less than twelve years of creditable service under subsection (c).

"(B) $3,000 per year, if the officer has at least twelve but less than fourteen years of creditable service under subsection (c).

"(C) $4,000 per year, if the officer has fourteen or more years of creditable service under subsection (c).

"(b) An officer may not be paid special pay under paragraph (4) of subsection (a) for any twelve-month period unless the officer first executes a written agreement under which the officer agrees to remain on active duty for a period of not less than one year beginning on the date the officer accepts the award of such special pay.

"(c) For purposes of this section, creditable service of an officer of the Dental Corps of the Army or the Navy, an officer of the Air Force designated as a dental officer, or a dental officer of the Public Health Service is computed by adding—

"(1) all periods which the officer spent in dental internship or residency training during which the officer was not on active duty; and

"(2) all periods of active service in the Dental Corps of the Army or Navy, as an officer of the Air Force designated as a dental officer, or as a dental officer of the Public Health Service.

"§ 302b. Special pay: optometry officers

"(a)(1) An officer who is an officer of the Army, Navy, or Air Force designated as an optometry officer or who is an optometry officer of the Public Health Service and

who is on active duty under a call or order to active duty for a period of not less than one year is entitled to variable special pay at the following rates:

"(A) $3,000 per year, if the officer has less than six years of creditable service under subsection (c).

"(B) $2,500 per year, if the officer has at least six but less than twelve years of creditable service under subsection (c).

"(C) $2,000 per year, if the officer has at least twelve but less than sixteen years of creditable service under subsection (c).

"(D) $1,000 per year, if the officer has sixteen or more years of creditable service under subsection (c).

"(2) An officer with at least three years of creditable service under subsection (c) who is entitled to variable special pay under paragraph (1) is entitled to an additional payment of $1,000 for any twelve-month period during which the officer is not undergoing optometry residency training, as determined under regulations prescribed under section 302c(a) of this title.

"(b) An officer may not be paid special pay under paragraph (2) of subsection (a) for any twelve-month period unless the officer first executes a written agreement under which the officer agrees to remain on active duty for a period of not less than one year beginning on the date the officer accepts the award of such special pay.

"(c) For purposes of this section, creditable service of an officer of the Army, Navy, or Air Force designated as an optometry officer or of an optometry officer of the Public Health Service is computed by adding—

"(1) all periods which the officer spent in optometry residency training during which the officer was not on active duty; and

"(2) all periods of active service as an optometry officer.

"§ 302c. Special pay: health professionals; general provisions

"(a) The Secretary of Defense, with respect to the Army, Navy, and Air Force, and the Secretary of Health, Education, and Welfare, with respect to the Public Health Service, shall prescribe regulations for the administration of sections 302, 302a, and 302b of this title. Such regulations shall include standards for determining—

"(1) whether an officer is undergoing medical internship or residency training for purposes of sections 302(a)(2)(A), 302(a)(2)(B), and 302(a)(4) of this title;

"(2) whether an officer is board certified for purposes of section 302(a)(5) of this title;

"(3) whether an officer is undergoing dental internship or residency training for purposes of section 302a(a)(2)(A), 302a(a)(2)(B), and 302a(a)(4) of this title;

"(4) whether an officer is board qualified in a dental specialty for purposes of section 302a(a)(5) of this title; and

"(5) whether an officer is undergoing optometry residency training for purposes of section 302b(a)(2) of this title.

"(b) Special pay authorized under sections 302, 302a, and 302b of this title is in addition to any other pay or allowance to which an officer is entitled. The amount of special pay to which an officer is entitled under any of such sections may not be included in computing the amount of any increase in pay authorized by any other provision of this title or in computing retired pay, severance pay, or readjustment pay.

"(c) Special pay payable to an officer under paragraphs (2), (3), and (5) of section 302(a), paragraphs (2), (3), and (5) of section 302a(a), and paragraph (1) of section 302b(a) of this title shall be paid monthly. Special pay payable to an officer under section 302(a)(4), section 302a(a)(4), and section 302b(a)(2) of this title shall be paid annually at the beginning of the twelve-month period for which the officer is entitled to such payment.

"(d) An officer who voluntarily terminates service on active duty before the end of the period for which a payment was made to such officer under section 302(a)(4), 302a(a)(4), or 302b(a)(2) of this title shall refund to the United States an amount which bears the same ratio to the amount paid to such officer as the unserved part of such period bears to the total period for which the payment was made.

"(e) The Secretary of Defense shall conduct a review every two years of the special pay for health professionals authorized by sections 302, 302a, 302b, 303, and 303a of this title. A report of the results of the first such review shall be submitted to the Congress not later than September 30, 1982, and the results of each subsequent review shall be submitted to the Congress not later than September 30 each second year thereafter.".

(b) Section 303 of such title is amended by striking out subsection (c).

(c) Chapter 5 of such title is further amended by inserting after section 303 the following new section:

"§ 303a. Special pay: podiatry officers

"(a) An officer who is an officer of the Army, Navy, or Air Force designated as a podiatry officer or who is a podiatry officer of the Public Health Service and who is on active duty under a call or order to active duty for a period of not less than one year is entitled to special pay at the rate of $100 per month, if the officer has three or more years of creditable service under subsection (b).

"(b) For purposes of this section, creditable service of an officer of the Army, Navy, or Air Force designated as a podiatry officer or of a podiatry officer of the Public Health Service is computed by adding—

"(1) all periods which the officer spent in podiatry residency training during which the officer was not on active duty; and

"(2) all periods of active service as a podiatry officer.".

(d) Sections 311 and 313 of such title are repealed.

(e) Section 306(e) of such title, relating to exclusions from special pay for officers holding positions of unusual responsibility, is amended by striking out "302 or 303" and inserting in lieu thereof "302, 302a, 302b, 303, or 303a".

(f) The table of sections at the beginning of chapter 5 of such title is amended—

(1) by striking out the items relating to sections 302, 302a, and 302b and inserting in lieu thereof the following:

"302. Special pay: medical officers.
"302a. Special pay: dental officers.
"302b. Special pay: optometry officers.
"302c. Special pay: health professionals; general provisions.";

(2) by inserting after the item relating to section 303 the following:

"303a. Special pay: podiatry officers.";

and

(3) by striking out the items relating to sections 311 and 313.

Sec. 3. (a) The Secretary of Defense shall conduct a comprehensive evaluation of various alternatives for addressing the existing maldistribution of medical and dental specialties within the Armed Forces. Such evaluation may include a test of the effectiveness of paying an increment of special pay in addition to the special pay authorized by title 37, United States Code (as amended by this Act), to officers in special categories determined by the Secretary of Defense for the purposes of such test. Such evaluation shall focus on—

(1) the future requirements of each Armed Force for physicians and dentists, by specialty and by years of service; and

(2) the efficiency, effectiveness, and fairness of the various alternatives considered.

(b) The Secretary shall submit to the Congress—

(1) not later than six months after the date of the enactment of this Act, a formal plan for conducting the evaluation required by subsection (a);

(2) not later than eighteen months after the date of the enactment of this Act, an interim report on the progress of such evaluation; and

(3) not later than two years after the date of the enactment of this Act, a final report of such evaluation.

(c) To carry out the purposes of this section, there is authorized to be appropriated the sum of $3,000,000 for fiscal year 1981.

Sec. 4. Notwithstanding any provision of the amendments made by this Act, and in accordance with regulations to be prescribed by the Secretary of Defense, with respect to the Army, Navy, and Air Force, and the Secretary of Health, Education, and Welfare, with respect to the Public Health Service, any officer who at any time before the effective date of the amendments made by this Act was entitled to special pay under any of sections 302, 302a, 302b, 303, 311, or 313 of title 37, United States Code, and any officer who after such effective date would have become entitled to special pay under any of such sections (as in effect on the day before such effective date) had such sections continued in effect, shall be paid basic pay and special pay under sections 302, 302a, 302b, and 303 of such title (as in effect on and after the effective date of the amendments made by this Act) in a total amount not less than the total amount of the basic pay (as in effect on the day before such date) and special pay applicable (or which would have been applicable) to such officer under such sections 302, 302a, 302b, 303, 311, and 313 (as in effect on the day before such date and computed on the rates of basic pay as in effect on the day before such date).

Sec. 5. The amendments made by section 2 apply to special pay payable for periods beginning after September 30, 1979, or after the date of the enactment of this Act, whichever is later.

Passed the House of Representatives November 13, 1979.
Attest:

EDMUND L. HENSHAW, Jr.,
Clerk.
By BENJAMIN J. GUTHRIE,
Assistant to the Clerk.

OPENING STATEMENT BY SENATOR NUNN

Senator NUNN. The subcommittee will come to order.

The Subcommittee on Manpower and Personnel meets today to consider legislation to revise special pays for military physicians and other military health professionals.

The All-Volunteer Force is facing increasing difficulties in recruiting sufficient numbers of people, particularly technical and skilled personnel. Recruiting a sufficient number of military physicians has been a chronic problem over the past few years, under the All-Volunteer Force.

The shortage of Active and Reserve doctors means we will have a serious deficit in the event of a mobilization. Testimony before this subcommittee indicates that these shortages of doctors, nurses, and enlisted medical specialists are so severe that in case of war, substantial numbers of our young men will die or be permanently disabled because of the lack of medical attention.

This is an intolerable situation. Should such a situation ever develop, I believe the American people would demand an inquiry and the identification of those responsible for such shortages.

The shortage of doctors has also resulted in a reduced peacetime medical benefit available to military families. When I talk to military members and their families, health care benefits is the most frequently raised concern about overall benefits. Unfortunately, many people seem to think that Congress has reduced the number of doctors. In fact, Congress has not reduced the number of doctors.

Congress has authorized various incentive pays, authorized a scholarship plan, increased the payment ceiling for the CHAMPUS program, and recommended the reinstitution of training of physician assistants. Over the objections of the administration, Congress has kept the Uniformed University of Health Sciences open so that another source of physicians will be provided and also increased the number of support personnel in military medical programs.

We have several bills now pending on this overall subject. There are now four proposals on revisions of doctor's pay, all of which we will talk about today.

Under current law, a military doctor is eligible for $4,200 per year in special pay plus an additional bonus of up to $13,500 for those who have completed intern and residency training for a total bonus of $17,700.

The Department of Defense proposal would increase the total bonus level to $18,000 and add a new bonus of $8,000 for doctors in skills where there was more than a 10-percent shortage. The Department of Defense proposal would not change current law for other health professionals.

H.R. 5235, which recently passed the House, uses several components for a revised special pay system:

Doctors in residency training would receive a bonus of $5,000 compared to $4,200 under the Department of Defense proposal and current law.

All doctors who complete initial residency training would receive a bonus of $10,000.

Doctors with less than 6 years service would receive an additional bonus of $5,000. Those with 6 to 8 years service would receive an additional bonus of $10,000. This additional bonus would then decline with years of service to a level of $5,000 after 22 years.

In addition to the above levels, doctors would receive a bonus based on board certification. This payment would be $2,000 per year for those with less than 10 years service and increase to $5,000 per year for those with over 18 years service.

We also have the Hart and Thurmond bills. Both Senators Hart and Thurmond are members of this committee, and Senator Hart, I am glad that you are here this morning.

S. 523, introduced by Senator Hart, and S. 1100, introduced by Senator Thurmond, provide a similar bonus system that is different from either the House or the Department of Defense proposal:

Doctors in residency would receive a $7,000 bonus instead of the $4,200 in current law.

All doctors not in training would receive an additional $9,000 bonus.

Doctors who were board certified would receive a $2,000 bonus.

In addition, doctors with 4 but less than 10 years service would receive another bonus of $9,000 which would increase to $11,000 for those with 10 or more years of service.

In sum, current law provides bonuses of up to $17,700. The Department of Defense proposal would provide a bonus of up to $18,000 with an additional payment of $8,000 for doctors in shortage skills.

The House-passed bill provides a total bonus of $15,000 to $22,000, depending on length of service and board certification. The peak level of $22,000 would apply to those doctors board certified with between 6 to 8 years of service.

The Hart and Thurmond bills would provide a bonus of $18,000 to $20,000 for those who had completed residency with under 10 years service; $20,000 to $22,000 for those with over 10 years service with the higher bonus going to those who were board certified. Another $8,000 bonus could be paid to some doctors but the total amount of this additional bonus would be limited to 10 percent of the total amount of the primary special pay.

In its report on H.R. 5235, the House emphasized two points that are very important once a doctor has joined the military service. The first is at the end of the average 6-year obligation period of health professional scholarship physicians. Current retention at the end of obligation is 10 percent, yet the bulk of physicians on active duty will enter through the scholarship program.

The second point is at the end of the 2-year obligation of volunteers.

So the philosophy behind the House bill is to emphasize the bonus at those points and to provide a total bonus that declines after 8 years service, as well as an increasing payment for those board certified. In addition, more senior doctors receive higher basic pay.

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The Defense proposal does not distinguish among doctors not in training by length of service. In addition, the Defense proposal would pay lower bonuses to doctors with obligated service.

The Hart and Thurmond bills increase the bonus for doctors with over 10 years of service.

The Department of Defense proposes changing the bonus for military physicians. The House-passed bill provides an increased bonus for doctors, dentists, optometrists, and podiatrists. The Hart and Thurmond bills provide increased bonuses for doctors, dentists, optometrists and veterinarians.

We are very pleased to have with us Dr. John H. Moxley III, the Assistant Secretary of Defense for Health Affairs; and we welcome back to the subcommittee the Surgeon General of the Army, Gen. Charles C. Pixley; the Surgeon General of the Navy, Adm. Willard P. Arentzen; and the Surgeon General of the Air Force, Gen. Paul W. Myers.

After other statements that members of the subcommittee wish to make, Dr. Moxley will present his statement.

First, I will call on Senator Warner for any opening remarks he might have.

Senator WARNER. Thank you, Mr. Chairman.

I am going to ask that Mr. Jepsen's remarks be included in the record.

Senator NUNN. Without objection.

[The prepared statement of Senator Jepsen follows:]

Prepared Statement of Senator Roger Jepsen

Mr. Chairman, we are all aware of the severe consequences of the existing shortage of military physicians. Not only are we faced with declining morale of our military personnel and their families as they experience difficulty in obtaining medical care quickly, but we have seen in exercises such as NIFTY NUGGET, that medical support in projected combat situations will be insufficient. In addition, because much of the medical attention which would normally be provided in-house in military hospitals and clinics is now provided through the troublesome and expensive CHAMPUS program, the shortage of military physicians results in still greater costs.

Today, the military services are faced with the difficulty of both recruiting and retaining adequate numbers of doctors in the proper mix of specialties. Many administrative steps have been taken to try to reduce the decline in the number of military physicians, and I believe that this Committee should investigate to insure that even more vigorous administrative steps are taken to improve the working climate of military physicians as an added incentive to remain in military service. Likewise, I believe we should look at ways to exploit the Armed Forces Health Professions Scholarship Program (AFHPSP) on a broader scale and perhaps even expand the Uniformed Services University of Health Sciences. These are only a few of the possible steps which this committee has examined and will continue to examine in the future. This Hearing will focus on a much narrower subject, what monetary compensation in addition to a military salary is necessary to recruit and retain physicians for the military services.

Several basic questions will have to be answered before this committee begins mark up of any bill providing special pay for health care professionals:

To what degree should special pay be based on specific skill shortages rather than across-the-board bonuses?

What health care specialists other than physicians—for example, dentists, optometrists, podiatrists, or veterinarians—should receive special pay?

Should obligated medical officers receive the same bonuses that non-obligated officers receive?

What bonuses should physicians in training receive?

What bonuses should be made available to flag and general officer physicians?

Should "board certification" of military physicians result in an additional bonus?

This committee will be considering the Administration proposal (H.R. 4076), the House bill (H.R. 5235), Senator Thurmond's bill (S. 1100), and Senator Hart's bill (S. 523). The action taken by this committee will be determined in large measure by the answers to the questions I have just set forth. I look forward to working closely with our witness and the other members of this committee in an effort to expedite consideration of special pay legislation. Thank you.

Senator WARNER. I will not prolong my observations except to say that every minute we sit in this room with the clock ticking away, we must address this problem and find a solution.

Thank you, Mr. Chairman.

Senator NUNN. Thank you.

Senator Exon, do you have an opening statement?

Senator EXON. Mr. Chairman, I want to defer to Senator Hart who is a producer of one of the bills. I wish to thank the chairman for calling this meeting. We have been very much concerned about this problem and, as Senator Warner said, time is ticking away.

I am here seeking information from the expert witnesses that we have before us today, with an eye for moving the bill along. We are still hopeful that we might be able to get this passed even before the Christmas recess.

In any event, I just wanted to add my word of encouragement to those who had been providing leadership in this area.

I would agree that we must move very expeditiously on this matter. I will defer at this time to Senator Hart, who I recognize as an expert in this field.

Senator NUNN. Senator Hart, we are delighted to have you here and will be delighted to hear from you. You have taken a real lead in this area. You recognize the crucial need and have been out in front proposing options to be considered by the committee, so we would be delighted to hear from you.

Senator HART. Thank you very much, Mr. Chairman.

I want to thank you, also, with Senator Exon, for calling this hearing expeditiously, facing and recognizing the problem that we will hear from the surgeons.

As you know, Mr. Chairman, nearly 2 years ago I personally introduced legislation which would provide permanent and stable pay incentive programs for military physicians and other health care professionals.

On March 1 of this year, I introduced S. 523, which is entitled Uniformed Services Health Professionals Special Pay Act of 1979, and this bill has received the endorsement of the three Surgeons General and many of our colleagues have sponsored it.

You have accurately described the principal provisions of those bills. I will not repeat those.

Enactment of this legislation this year, I think, for a permanent special pay incentive program of some kind, is essential to our Nation's ability to maintain a viable and effective military corps.

The deteriorating state of the military health care system is clearly evident by the severe shortage of qualified military health care professionals. Currently the Army, Navy, and Air Force are short over 3,000 physicians. This shortage raises serious questions about the ability of the military medical corps to provide adequate wartime medical support for the Armed Forces.

In addition, Mr. Chairman, shortages of military medical personnel severely limit the military health care system's ability to fulfill

its secondary mission of providing medical service to active duty dependents and retired beneficiaries.

A recent General Accounting Office report found that of the 128 military hospitals examined, nearly 60 percent either closed some medical services or curtailed them for up to 6 months because they lack qualified physicians to staff those services.

Beneficiaries of the military health care system who are turned away from military hospitals or clinics are forced to turn to the private sector for medical treatment. Civilian Health and Medical Programs for the Uniformed Services—CHAMPUS—not only costs eligible beneficiaries more, but also results in additional costs to the taxpayer, since such medical services are provided by civilian hospitals and physicians who are more expensive than the military facilities.

CHAMPUS costs have risen from $76 million in 1966 to an anticipated level of $754 million in this fiscal year. Some experts predict that, due to the physician shortage in the military, CHAM PUS costs may well break the $1 billion mark this year.

In addition to the increased CHAMPUS costs, the physician shortages forced the medical departments of the armed services to hire civilian contract physicians to meet essential medical services. A recent example of this problem can be found in the advertisement in the bulletin of the American College of Radiology. The U.S. Army offers $120,000 annually, plus benefits, for one civilian radiologist who worked at Brook Army Medical Center in San Antonio.

Without the enactment soon, immediately, of some improved compensation measure for military health care professionals, the high rate of attrition will continue to increase at even more alarming rates, and the conditions of the military health care system will continue to deteriorate.

The military medical health system is becoming a crisis. We cannot afford to delay finding a solution to this problem any longer.

Mr. Chairman, I want to emphasize that while our permanent pay program is esential to slowing the high attrition rate of qualified military health care professionals, pay alone will not solve all the problems facing the military medical corps. Clearly the environment in which the medical corps practices its profession has also deteriorated in recent years. Poor medical facilities, inadequate or nonexistent ancillary support staff, equipment shortages, and management deficiencies all play a significant role in the system's ability to recruit and retain qualified physicians and other health care professionals.

I think these issues also have to be addressed in our examination of this overall problem. Today's hearings will not allow that kind of comprehensive review.

Mr. Chairman, I think we all understand, particularly those who serve on the Armed Services Committee, that we can solve, either through a volunteer force or a draft, the problem of having the best qualified manpower to man our services.

We can provide that manpower with the best equipment in the world, but if we get into conflict or hostility or hopefully not a shooting war, if those military personnel know that going into that

conflict or war they are not going to receive adequate medical care, then I think that is going to have a serious detrimental effect on the morale of our forces.

If there is anything we can do, I think it is absolutely urgent that the Senate and Congress act on this measure, whether by adopting the proposal that I put forward, or some other, as quickly as possible.

I thank you again for this hearing today.

Senator NUNN. Thank you very much, Senator Hart.

I will be delighted for you to participate in the hearing as much as you have time to.

Our first witness is Dr. John Moxley, Assistant Secretary of Defense for Health Affairs.

Dr. Moxley, we are glad to have you with us this morning. It sounds like we have a vote. Approximately how long is your opening statement?

Dr. MOXLEY. Mr. Chairman, I submitted a 10-page statement for the record. I intend to summarize it. I would say certainly 3 or 4 minutes, probably, I would imagine.

Senator NUNN. We have approximately 10 minutes now before we have to depart for the vote. Why don't we proceed with your opening statement, and then we will take a brief recess and go vote.

[The prepared statement of Dr. John H. Moxley III follows:]

PREPARED STATEMENT OF HON. JOHN H. MOXLEY III, M.D., ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

I appreciate the opportunity of appearing before you today to discuss various aspects of special pays for military health professionals.

Our most urgent problem is the shortage of military physicians. Our projections indicate that shortages will be reduced over the next few years. It is emphasized, however, that these projections are base on the optimistic assumptions that:

The Armed Forces Health Professions Scholarship Program will remain filled in the coming years.

Recruitment efforts will result in at least 600 active duty volunteers being recruited each year.

Active duty retention rates will be improved.

Many efforts have been, and continue to be, made to alleviate the shortage of military physicians. Long-term efforts have included the current Variable Incentive Pay, the Armed Forces Health Professions Scholarship Program, construction of new facilities and malpractice legislation.

The following short-term steps have been undertaken:

Nonpersonal civilian service contracts for radiology reading services and other special procedures.

Implementation of a 60-day basic radiology course for nonradiologists.

Increased emphasis on recruitment and retention and the use of allied health care practitioners.

Temporary waivers of officer indoctrination and other military schooling for physicians.

Exceptions to mandatory retirement.

The following steps are in the planning stage:

Procuring the equipment requested by military physicians on an expedited basis outside normal supply operations.

Increasing the funds available to military physicians for attendance at professional meetings, seminars, and short courses.

Increasing the clerical and other support personnel required in order to free physicians for the fulltime performance of their professional duties.

While the foregoing actions can be expected to have some value in reducing the scope of the physician shortage problem, we have concluded that a long-term legislative solution is necessary if we are to finally overcome the shortage problem. This involve revising the special pays programs for military physicians in order to

narrow the gap between their income levels and that of their civilian contemporaries in private or group practice and provide long-term stability for the program.

Special pay is critical to the efforts of the Department of Defense in maintaining an adequate force of volunteer physicians.

In view of other factors which enhance the attraction of military service, the Department of Defense does not believe that complete income comparability is necessary or desirable. The overall objective is to meet the health manpower goals which include the total number physicians authorized and a proper mix of skills, grades, and experience.

The Department of Defense has proposed legislation which would provide for the first major restructing of our medical special pay program in the past six years and would provide for a long-term special pay structure as opposed to the one and two year "quick fixes" of the recent past. We believe that, if enacted, it would satisfy all of the following objectives:

A long-term solution.

Stability of eligibility and entitlements.

A single special pay system.

Easy to understand.

Pay levels sufficient to obtain the desired forced structure.

Pay levels that recognize the significant civilian earnings differential in medical specialties.

The achievement of these objectives should provide a system which will allow the DoD to meet authorizations by the end of Fiscal Year 1983.

COMPARISON OF LEGISLATIVE PROPOSALS

The Administration's proposal (H.R. 4076) includes provisions which are intended to remove pay inequities in the present system and provide ascending amounts to physicians in the following categories:

Those who are interns.

Those who are initial residency training.

Those who are obligated.

Those who are not obligated.

Those who are not obligated and are trained in selected specialties.

The Administration's proposal does not provide for any increase in compensation above the levels currently paid to Interns and Residents as there is no problem at present or expected in the foreseeable future in filling these positions.

For physicians who are not obligated to serve, a set amount ($18,000) is provided to help narrow the gap between the total compensation received by military physicians as opposed to that which they could receive in the nongovernment sector.

A final provision of the Administration bill addressed the near term problem of obtaining scarce physician specialists by providing a temporary (2 year) authority to enter into contracts with physician specialists and pay an entry bonus (in the case of a volunteer), or continuation bonus (in the case of the member eligible to leave the service), of $8,000 for each additional year of service (up to a maximum of three years). In order to make this provision more attractive, it may be paid in a lump sum of up to $24,000 or in annual installments of $8,000 for each year of service. This provision has been limited to a two year period with contracts expiring over a four year period ending in Fiscal Year 1984. It is anticipated that our needs for scarce specialists will then be satisfied primarily through fully trained specialists entering the work force via the Armed Forces Health Professions Scholarship Program and subsequent intern and residency training either in military hospitals or in civilian hospitals while in a deferred status.

H.R. 5235—which was passed by the House—is similar to the Administration proposal; however, there are some basic differences. While the rates of special pay for interns are identical in both proposals, H.R. 5235 but is not included in the Administration proposal. In the civilian community, board certification usually results in increased income; and at the time H.R. 5235 would permit payment of $5,000 per year during initial residency training, while H.R. 4076 would maintain the level of payment during residency training at the present rate of $4,200. Before the Department of Defense considered limiting the scope of military residency training, the $5,000 payment possessed merit in that it would help to fill the then increasing numbers of residency positions. The concept of limiting the number of residencies removes the need for any additional compensation above the amount currently paid.

A payment of $2,000 to $5,000 per year in recognition of board certification is included in H.R. 5235 but is not included in the Administration proposal. In the civilian community, board certification usually results in increased income; and at

the time H.R. 5235 was prepared, it was believed that it would be beneficial to recognize this professional achievement within the military setting. Since that time, however, the Department of Defense has determined that residency training is sometimes delayed, and consequently board certification. Therefore, it was determined that further inequities could result.

The remaining differences deal with the method of managing a "bonus" or "incentive" payment in the case of scarce specialists and in the total level of special pay. Contained in H.R. 5235 is a provision for the development and evaluation of an experimental program to award additional special pay in FY 1981 to selected categories for this program. The Administration's proposal has a provision for an "Entry or Continuation Bonus" in the amount of $8,000 per year for up to three years. Authority for this "Entry or Continuation Bonus" is temporary, commencing on 1 October 1979 and expiring on 30 September 1981.

Both the "experimental program" and the "Entry or Continuation Bonus" pays are intended to alleviate the near term (next 3 or 4 years) problem of attracting and retaining scarce specialists until such time as the physicians obtained through the Armed Forces Health Professions Scholarship Program enter on active duty, become fully trained, and available in sufficient numbers and specialties to provide a permanent solution to this problem.

S. 1100—the Thurmond bill—and S. 523—the Hart bill—would maintain the current pay level for interns. S. 1100 and S. 523 contain a provision for the payment of $7,000 per year during initial residency training while the Administration's proposal would maintain the current level of payment.

A payment of $2,000 per year in recognition of board certification is included in S. 1100 and S. 523.

A provision for incentive special pay is contained in S. 1100 and S. 523 which would provide a payment of $8,000 per year (regardless of length of service) to scarce specialists. There is, however, a limitation on the dollar amount that could be expended in this area. For flag officers, S. 523 would permit payment of up to $29,000 for an O-7, $26,000 for an O-8, and $25,000 for an O-9.

H.R. 4076, the Administration's proposal, as in effect recently modified by the Congress with respect to certain obligated officers, is preferred by the Department of Defense. To the extent that the House bill exceeds the Administration's bill in total costs, scope, and personnel covered, we are opposed to it. Examples of the foregoing are increases of up to $8,800 annually for physicians beyond the Administration's bill, the addition of dental, optometry, and podiatry officers, and the inclusion in the House bill of certain members of the Commissioned Corps of the Public Health Service. In conclusion, the Department of Defense supports the Administration's bill in this matter.

That concludes my statement. I will be pleased to answer any questions you may have regarding these subjects or any other aspects of our medical operations.

STATEMENT OF JOHN H. MOXLEY III, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. MOXLEY. Thank you, Mr. Chairman.

I appreciate very much the opportunity to appear before you today to discuss various aspects of special pays for military health professionals.

I have with me Lieutenant Commander Mooers, MSC, USN, from our Office of Planning and Policy Analysis who has been a part of the development of this pay bill as it has moved along.

I would immediately underline that our most urgent problem is the shortage of military physicians. Our projections indicate that shortages will be reduced over the next few years. It is emphasized, however, that these projections are based on the optimistic assumptions that:

The Armed Forces health professions scholarship program will remain filled in the coming years.

Recruitment efforts will result in at least 600 active duty volunteers being recruited each year.

Active duty retention rates will be improved.

I would underline vigorously what Senator Hart has said about the need to improve the professional environment if, in fact, those retention rates are going to increase. Special pay is critical to the efforts of the Department in maintaining an adequate force of physicians.

We agree that we need to move ahead as expeditiously as possible to adopt a new pay bill.

In view of other factors which enhance the attraction of military service, the Department of Defense does not believe that complete income comparability is necessary or desirable. The overall objective is to meet the health manpower goals which include the total number of physicians authorized and a proper mix of skills, grades, and experience.

The Department of Defense has proposed legislation which would provide for the first major restructuring of our medical special pay program in the past 6 years and would provide for a long-term special pay structure as opposed to the 1- and 2-year "quick fixes" of the recent past. We believe that, if enacted, it would satisfy all of the following objectives: A long-term solution. Stability of eligibility and entitlements. A single special pay system. Pay levels sufficient to obtain the desired force structure. Pay levels that recognize the significant civilian earnings differential in different medical specialties, particularly the surgical subspecialties.

The achievement of these objectives should provide a system which will allow the DOD to meet authorizations by the end of fiscal year 1983.

The administration's proposal—H.R. 4076—includes provisions which are intended to remove pay inequities in the present system and provide ascending amounts to physicians in the following categories: Those who are interns. Those who are in initial residency training. Those who are obligated. Those who are not obligated. Those who are not obligated and are trained in selected specialties.

The administration's proposal does not provide for any increase in compensation above the levels currently paid to interns and residents as there is no problem at present or expected in the foreseeable future in filling these positions.

For physicians who are not obligated to serve, a set amount, $18,000, is provided to help narrow the gap between the total compensation received by military physicians as opposed to that which they could receive in the nongovernment sector.

A final provision of the administration bill addresses the near term problem of obtaining scarce physician specialists by providing a temporary 2-year authority to enter into contracts with physician specialists and pay an entry bonus, in the case of a volunteer, or continuation bonus, in the case of a member eligible to leave the service, of $8,000 for each additional year of service, up to a maximum of 3 years.

In order to make this provision more attractive, it may be paid in a lump sum of up to $24,000 or in annual installments of $8,000 for each year of service. This provision has been limited to a 2-year period with contracts expiring over a 4-year period ending in fiscal year 1984. It is anticipated that our needs for scarce specialists will then be satisfied primarily through fully trained specialists entering the work force via the Armed Forces health professions schol-

arship program and subsequent intern and residency training either in military hospitals or in civilian hospitals while in a deferred status.

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Since that time, however, the Department of Defense has determined that residency training is sometimes delayed, and consequently board certification.

Therefore, it was determined that further inequities could result.

The remaining differences deal with the method of managing a bonus or incentive payment in the case of scarce specialties and in the total level of special pay. Contained in H.R. 5235 is a provision for the development and evaluation of an experimental program to award additional special pay in fiscal year 1981 to selected categories for this program.

The administration's proposal has a provision for an entry or continuation bonus in the amount of $8,000 per year for up to 3 years. Authority for this entry or continuation bonus is temporary, commencing on October 1, 1979, and expiring on September 30, 1981.

Both the experimental program and the entry or continuation bonus pays are intended to alleviate the near term—next 3 or 4 years—problem of attracting and retaining scarce specialists until such time as the physicians obtained through Armed Forces health professions scholarship program enter on active duty, become fully trained, and available in sufficient numbers and specialties to provide a permanent solution to this problem.

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area. For flag officers, S. 523 would permit payment of up to $29,000 for an O-7, $26,000 for an O-8, and $25,000 for an O-9.

H.R. 4076, the administration's proposal, as in effect recently modified by the Congress with respect to certain obligated officers, is preferred by the Department of Defense. To the extent that the House bill exceeds the administration's bill in total costs, scope, and personnel covered, we are opposed to it.

Examples of the foregoing are increases of up to $8,800 annually for physicians beyond the administration's bill, the addition of dental, optometry, and podiatry officers, and the inclusion in the House bill of certain members of the commissioned Corps of the Public Health Service. In conclusion, the Department of Defense supports the administration's bill in this matter.

That concludes my statement. I will be pleased to answer any questions you may have regarding these subjects or any other aspect of our medical operations.

Senator NUNN. Thank you very much.

I think the more orderly way for us to proceed now would be for us to take a 10-minute recess and go vote.

[A brief recess was taken.]

Senator NUNN. The subcommittee will come to order.

We have our three Surgeons General who are here this morning. We are delighted to have you.

I know each of you have statements. We have a good many questions this morning, and in the interest of time, if there is a way that each of you could more or less summarize your statement and put the full statement in the record, which will be carefully examined, we would appreciate it.

I will leave it up to Dr. Moxley to decide who goes first.

Dr. MOXLEY. General Pixley.

[The prepared statement of Lt. Gen. Charles C. Pixley, MC, follows:]

PREPARED STATEMENT OF LT. GEN. CHARLES C. PIXLEY, MC, THE SURGEON GENERAL, DEPARTMENT OF THE ARMY

INTRODUCTION

Mr. Chairman and members of the Subcommittee, I am Lieutenant General Charles C. Pixley, the Surgeon General, Department of the Army. It is my privilege to provide you a brief report on the Army health care system and comment on certain items of interest to you.

MISSION

The provision of Army health care is a military mission, and the objectives of the Army Medical Department are as follows.

Maintain a physically and mentally fit, combat and operationally ready military force.

Ensure timely availability of trained health manpower and other health resources required to provide support to approved combat, mobilization and contingency plans.

Provide a program of health services to all eligible beneficiaries.

Maintain a challenging environment that attracts and retains health care professionals.

Assure effective, efficient and complete utilization of Army health resources.

THE ARMY HEALTH CARE SYSTEM

The Army health care system is technical and complex, involving highly professional personnel, specialized training, vitally important research and development,

use of the most sophisticated equipment and maintenance of facilities which must meet the highest standards. The demand for perfection is high because of the nature of the services rendered and the system is unique in that it must meet not only military standards but also those of the various civilian health care regulating bodies. It is important to remember that a change to any element of this system may cause interactions having profound effects on accomplishment of the Army's health care mission.

PERSONNEL REQUIREMENTS

Since this hearing is in large part related to military personnel matters, I would like to briefly reiterate some items presented in several other House and Senate hearings this year.

Our major personnel problem, which effects almost all facets of the Army health care system, is the shortage of military physicians. There is a shortage of uniformed doctors, measured by our need to respond to the Army's contingency, mobilization and wartime missions. Indeed, we have shortages in several other categories of professional and ancillary personnel, all of whom are critical to a full program of health and combat readiness.

Prior to 1971, the military departments obtained the bulk of their physicians through the draft induced Berry Plan, which allowed deferral of induction until the individual had completed residency training in a medical or surgical specialty. This arrangement satisfied two of our needs—a sufficient number of physicians, and physicians specialty trained. In 1973, when induction was terminated and the All-Volunteer concept initiated, our primary source of physicians was immediately severed except for individuals still obligated following their deferment for training.

Congress anticipated the shortage of health professionals following cessation of the draft and enacted two significant pieces of remedial legislation—the Armed Forces health Professions Scholarship Program (HPSP) in 1972 and authority for a special pay referred to as Variable Incentive pay (VIP) in 1974. By 1977, however, Berry Plan resources were virtually depleted, volunteers were not being obtained in sufficient numbers, retention rates were low and the scholarship program had just started to provide health professionals for the active force. Army physician strength had dropped to slightly over 4,000 against a requirement of 5,896. Moreover, a qualitative shift occurred as specialty trained Berry Plan physicians, who could rapidly assume military duties after a short training period, were replaced for the most part by medical school graduates. The latter group requires internship and, in most cases, residency training prior to full utilization in the force.

The total number and types of physicians we must have is determined by mobilization and contingency requirements, and those requirements do not change because of reduced availability. There are 5,896 military physicians required to staff our tactical medical units as well as our fixed medical treatment facilities and research activities. We know, however, that to have this number in peacetime would engender inefficiencies; for example, many physicians in tactical units would have little professionally satisfying patient care responsibility. We have carefully studied this problem and determined that during peacetime, with acceptable risk, we can set our military physician requirements at 5,273. This would allow efficient and economical operation of the peacetime Army health care system, while providing physician resources to satisfy contingency missions short of national mobilization and accomplish rapid and orderly transition to a mobilization posture should the need arise. It is this figure—5,273—from which we calculate the shortfall in military physicians. This is an important point. Much of the discussion of our physician shortage and its impact deals with peacetime delivery of health care in our established medical treatment facilities within the United States. To be sure, this is an important part of our task, but to base the measurement of physician shortages on peacetime requirements focuses on the wrong reason for having uniformed physicians, resulting in proposed solutions which run counter to the real problem.

Although requirements remain relatively constant from year to year, end strength authorizations are based on the best information available at the time we project our future strength. Therefore, authorized levels are continually revised consistent with results actually achieved from our procurement and retention efforts.

RECRUITMENT AND RETENTION

Our two main sources of health professionals are the scholarship program and volunteer recruitment. I would like to cover those programs briefly and then discuss other means used to create and environment conducive to retention.

SCHOLARSHIP PROGRAM

Under the Armed Forces Health Professions Scholarship program, we provide full tuition, educational expenses (e.g., books and laboratory fees), and a monthly stipend. By law, the participant agrees to serve one year on active duty in his profession for each year of support; however, our policy requires a minimum active duty term of three years. Upon graduation, the students are commissioned in an appropriate corps of the Army Medical Department and normally enter active duty, although some physicians are deferred to attend civilian Graduate Medical Education (GME) programs.

Initial response to the scholarship program was satisfactory. However, the Army has experienced difficulty during the past two years in recruiting a sufficient number of scholarship applicants to meet projected physician requirements. We are optimistic that scholarship recruiting will improve due to a provision in the DOD Authorization Act which increased the student's stipend and will provide for automatic future increases.

VOLUNTEER RECRUITMENT

In regard to volunteer accessions, we now have a nationwide organization of 54 non-physician officers working on recruitment of health professionals for the active duty force. These officers also recruit applicants for the scholarship program and for Army programs which allow commissioning of physicians while in civilian residency training. In addition, every officer in the Army health care system, including myself, has a secondary mission of supporting the procurement effort through continual contact with prospective volunteers, professional societies and educational institutions.

We have also recently accepted responsibility for recruitment of health care officers, excepting nurses, for the U.S. Army Reserve and a recommended procurement ogranization is under review within the Army staff. Procurement of nurses and medical enlisted personnel for the active Army and Reserves is a function of the U.S. Army Recruiting Command. Due to an intensive recruiting effort during the last fiscal year, we were able to obtain a record 332 volunteer physician accessions. We are not certain at this time how productive our efforts will be for fiscal year 1980.

RETENTION

The other side of the coin concerns our efforts to retain health professionals once they enter the active force. This is not a simple proposition as we must consider the entire spectrum of experiences which any officer and his or her family experience in a military career environment, plus those unique to the health care community. Therefore, all of the factors relating to other officers apply, such as housing, benefits, retirement options and so on, but for health professionals there are two additional dimensions which are difficult to satisfy professional satisfaction and level of income. In satisfying professional needs, we work within the system to provide incentives such as the following:

Increased opportunities for continuing health education experiences recognized by the American Medical Association, sponsored by health care facilities and professional organizations.

Personalized career management, with particular emphasis on assignment preferences.

Enhanced promotion opportunities.

Minimizing non-clinical duties.

Modernization of facilities and equipment.

Increased availability of ancillary personnel.

Finally, and most important, maximum opportunity for participation in graduate medical education programs.

MILITARY GRADUATE MEDICAL EDUCATION (GME)

Experience gained during the past few years indicates that the most effective program in attaining the required numbers and specialty mix of physicians is military Graduate Medical Education (GME). I consider this program to be of such major importance to fulfillment of the Army's health care delivery mission, and to the purpose of these hearings, that I would like to discuss it in some detail.

There are a number of dimensions to the necessity for maintaining programs of military Graduate Medical Education.

First, nearly every physician graduating from an American medical school wishes to become fully trained. This means that regardless of what speciality he leans toward, such as family practice, medicine or surgery, he seeks to master the body of knowledge and skills associated with that field. To accomplish this normally requires a period of three to five years of Graduate Medical Education, and even more in certain specialties. If the Army wants to be attractive to this great majority of physicians, it must offer quality, competitive GME programs.

The second dimension is the role GME plays in recruiting and retention. Of the direct civilian volunteers who are recruited for active duty, a large number are attracted by our military GME programs. Those individuals provide care to our beneficiaries while they complete their training and also incur an obligation for further service in the process.

Next, GME is a major consideration of many physicians making initial retention decisions. Doctors completing intership or initial tours as General Medical Officers have insight into medical practice in the Army, but have the goal of becoming fully trained. Army GME programs are needed to attract these individuals to a further career in the Army.

There are other significant factors. The attractiveness or competitiveness or our scholarship program is greatly influenced by GME availability. Medical students who talk to us about a scholarship invariably ask about GME availability. We have been able to respond by demonstrating the opportunities. We cannot guarantee GME to any individual but we do demonstrate that for individuals completing internship or a tour as general medical officer, there is opportunity to apply and a favorable possibility of selection. This circumstance is absolutely necessary for the scholarship program to succeed.

Finally, many of our senior clinicians remain with us because the practice they are in brings them in frequent contact with training and the challenges a training environment brings. Some of these nationally recognized clinicians would leave us if they did not have reasonable affinity to training settings. They cannot be replaced to the satisfaction of civilian accrediting agencies.

We have recently been directed to reduce our military GME programs, purportedly to place more physicians in direct patient care positions. In fact, such a move would ultimately have the reverse effect through long-term inability to recruit and retain military doctors.

Our teaching facilities, in addition to their education mission, have a significant patient care responsibility. Fifty percent of all inpatient care is performed at the teaching hospitals. Statistical data compiled by the U.S. Army Health Services Command indicates that 80 percent of seriously ill patient care and 40 percent of outpatient care is performed at the medical centers, primarily by the house staff of interns and residents.

The impact of a "cap" or limit to the number of individuals that could be put into GME would be a disaster to our scholarship program recruiting. It would also reduce the number of DOD beneficiaries that could be treated in Army facilities and cause more of them to use alternatives which are more costly to the individual and to the government. Finally, it would reduce our mobilization capability in that a military resident is immediately deployable for national emergencies, whereas it would take 90 days or longer to deploy a physician in civilian residency.

COMPENSATION

The second unique dimension to our problem of attracting and retaining military health professionals is compensation. Since being appointed The Surgeon General of the Army, I have visited almost every medical facility in our department and personally contacted at least 3,000 physicians and other health professionals. My Corps Chiefs have made similar visits. We are aware of the feelings of these health professionals and their problem. In relation to the interests of the committee, these health professionals are very concerned over their compensation level relative to potential earnings in the private sector. Many feel that the present special pay system is inequitable and has lost much of its value through inflation. A large number have told me that they are looking for improvement in the special pay system as the key to their decision as to whether or not to remain in the service. The ultimate use of compensation authorities is to enable us to achieve the most effective health care force, both in size and specialty composition. Improvement of the special pay system is a critical link, in combination with the other programs I have discussed, in achieving that goal.

RESERVE COMPONENTS

In a situation related to our experience with the active force, termination of the draft in 1973 drastically reduced the number of health professionals entering the reserve components as volunteers or as a follow-on to active duty service.

The Army has taken several steps to improve reserve component recruiting and retention, such as:

Elimination of certain military education requirements for promotion.

Change in policy to allow unit assignments without regard to authorized grade.

Streamlining of application processing procedures.

Increased funds to support professional conferences and seminars.

Authority to attend professional conferences in lieu of drill periods.

Commissioning medical and dental students in the Reserve, with a commitment to serve upon graduation, and

Extension of age limits for reserve component service.

In addition, as I mentioned, my office was recently assigned the mission of recruiting health professionals for the Reserve. This will allow us to assist Reserve commanders in this effort and enhance our currently successful procurement effort for the active force. We will also be able, for the first time, to develop a data base on which to improve recruitment of health professionals for the reserve components.

MOBILIZATION

I would now like to discuss a subject related to the foregoing—our mobilization capability. Under present conditions, the Army Medical Department would be unable to meet its total, world-wide, mobilization requirements. However, we have improved our capability to support a NATO conflict in Western Europe even though the following problems still exist:

Non-divisional medical support units are organized at low levels.

The medical logistical support structure requires conversion and/or realignment to absorb expanded mobilization requirements.

There are insufficient numbers of medical units in-theater to support anticipated evacuation and treatment requirements.

There is a shortage of surgical specialties required to provide adequate medical treatment to the combat forces.

Initiatives are being pursued within theater and at Departmental level to improve the medical support posture in Europe. These include programming spaces to raise staffing levels, unit realignments within theater, prepositioning and forward stationing of additional medical units, and reconfiguration of the medical logistical support structure.

Recent analysis of active and reserve component physician strength in support of a NATO conflict in Western Europe indicated that total assets were sufficient to meet theater requirements, with certain qualifications.

If the United States were to go to war tomorrow in Western Europe, total physician assets are sufficient to meet theater requirements but there is a shortfall of critical specialties such as General Surgery, Thoracic Surgery, Orthopedic Surgery, and Neurosurgery. The shortfall occurs in these specialties even after substituting other or partially trained specialty assets against their requirements. For example, 312 OB/GYN surgeons and 78 general surgery residents were applied against general surgeon total requirements.

Shortages in theater would be reflected in United States medical facilities, which would then be virtually devoid of those specialties. Moreover, other specialties in the United States would become short as necessary assets were stripped out to satisfy theater requirements.

CONCLUSION

In my military career, I have served in nearly every role a medical officer can hold. I assure you, from personal experience during the Korean and Viet Nam conflicts, as well as from command of a major medical center in peacetime, that a comparison of military and civilian health professionals on the basis of professional duties or income alone falls far short of portraying the real differences between their practices. We are speaking of entirely different environments. When we consider job comparability, we should remember that the military competes for health professionals whose customary practice setting is a well-appointed private office, amply supported by receptionists, secretaries and personal assistants; practitioners who can regulate their workload and their practice location to satisfy their own financial, family, and professional development needs. By contrast, we offer austere settings, long hours, heavy case loads, shortages of support personnel that reflect

budget cuts and manpower ceilings, duty in isolated, rural stations, the turbulence of military rotation policies and periodic separation from family. That is not all. Our health professionals keep that silent vigilance of readiness by which they have agreed to lend their services, as needed, under tentage, in adverse places, under threat of their own destruction.

Despite these differences, we still manage to maintain a dedicated nucleus of career officers and I believe we are moving in the right direction to realization of an adequate, effective health care force. If all of our programs are successful, we will experience a steady input of health professionals through the scholarship program, the Uniformed Services University of Health Sciences, and our recruitment of health professionals from the private sector. I want to caution that all of these programs are dependent upon volunteers and, again, strongly emphasize that a change to any element of the military health care system may have a serious effect on the willingness of health professionals to enter the armed forces, either prospectively as subsidized students or as volunteers from the private sector.

What are the payoffs to improvement of our current situation? Foremost is readiness—our ability to meet obligations in the first few days of a "come-as-you-are" war. Readiness as seen by the ability to meet minimum force level objectives, and to be able to adequately handle assigned missions. Second, ability to turn around the perception of erosion of benefits and ability to reduce the volume of beneficiary complaints resulting from health manpower shortages. Third, with the attainment of minimum peacetime objectives, 5,273 physicians, for example, we obtain maximum use and efficiency of our medical resources because peacetime capability is sized to function most efficiently at this level.

Mr. Chairman, I appreciate the opportunity to appear before this subcommittee.

STATEMENT OF LT. GEN. CHARLES C. PIXLEY, MC, THE SURGEON GENERAL, DEPARTMENT OF THE ARMY

General PIXLEY. Mr. Chairman, I am Gen. Charles C. Pixley, the Army Surgeon General. I will submit for the record a formal statement.

I would like to make about 3 minutes worth of remarks.

Since termination of the draft, we have had a difficult time obtaining the numbers and types of health professionals needed, to provide a desirable level of peacetime care, and to satisfy mobilization requirements.

In resolving that problem, there are four major elements.

First, are subsidized education programs which provide health care officers obligated to serve 4 to 7 years;

Second, volunteer procurement programs;

Third, our retention efforts; and

Fourth, special pay.

The mechanism for the first three is already set up and operating. We have, thanks to Congress, the Armed Forces Health Professions Scholarship program and the Uniformed Services University of Health Sciences.

The Army has a nationwide recruiter network. We have initiated a number of measures to enhance professional opportunities and improve working conditions for career physicians.

However, revision of the special pay system is required to enable us to achieve maximum results from these programs. For example, our recruitment of students for the scholarship prorgrams is hampered by an inequity in the pay system which I will discuss in a moment.

Special pay also plays an important part in volunteer recruitment as it affects our ability to procure the full qualified specialists which we so critically need today, not the general medical officer.

Its value as a retention tool is obvious, but I am particularly concerned about keeping the senior physicians who are so vital to the tertiary care programs.

I certainly do not wish to infer that we seek dramatic increases in the amount of special pay or that complete income comparability with the private sector is desired.

I assure you, from personal experience in the Korean and the Vietnam conflict as well as command of a major medical center in the United States, that a comparison of military and civilian health professionals on the basis of professional duties or income alone falls far short of portraying the real differences between their practices.

We are speaking of entirely different environments. When we consider job comparability, we should remember that the military competes for health professionals whose customary practice setting is a well-appointed private office, amply supported by receptionists and secretaries and personal assistants. Practitioners who can regulate their workload and their practice location to satisfy their own financial, family, and professional development needs.

By contrast, the military offers often austere settings, long hours, heavy caseloads, shortages of support personnel that reflect budget cuts and manpower ceilings, duty in isolated rural stations, the turbulence in military rotation policies and periodic separation from the family.

That is not all. Our health professionals keep that silent vigilence of readiness by which they have agreed to give their services as needed, often in adverse places, under threat of their own destruction.

Despite these differences we still manage to maintain a dedicated nucleus of career officers. I believe, with your help, we can move in the right direction to realization of an adequate, effective health care force.

Returning specifically to the special pays, I understand the committee is considering three bills which have already been identified. I will not go over that any further.

In structure and concept, however, these bills are based on preliminary recommendations of a study group provided by the three Surgeons General starting in 1977 to consider improvements to the current military health professionals special pay system.

Aside from the technical and administrative changes, the group recommended the following measures to insure an effective system in the long term.

First, pay fixed in law. Major portions of the present special pay for physicians and dentists is subject to regulatory change. This causes apprehension among the recipients as they are unsure of future entitlement. It drastically reduces the pay's potential as a personnel retention tool.

All the bills essentially meet this requirement.

Second, equity for obligated officers. Individuals who volunteer for our subsidized education programs incur 4- to 7-year active duty obligations. Denial or reduction of special pay during that obligated period, as in the present system, offers the amount they received in subsidies, and ultimately, has led to lack of interest in our health scholarship program.

I am happy to see that all the bills provide complete equity for these obligors, which would enhance recruitment of scholarship participants and also provide a climate to improve their retention upon completion of obligation.

Third, and finally, this group recommended from the very beginning automatic annual increases in special pay in the same manner as basic pay.

The two Senate bills include this feature while the House bill provides for a review of the necessity for increases every 2 years.

Although the bills are similar, as I mentioned before, there are some desirable features in each, and amendments could be made. However, I believe that immediate passage of a bill is extremely important.

My officers are well aware of our long efforts to revise the special pay system and are now expecting action. In the Army alone I have 1,242 physicians who will complete their obligated service this next summer and must make the decision to stay in our get out.

In addition, there are hundreds more in mid-career who are attracted by increasingly lucrative offers from the private sector.

Passage of a bill at this time will not only provide these officers a tangible incentive to remain with us, but also furnish the last essential link in our programs to insure a positive recruitment and retention effort.

This concludes my general remarks, Mr. Chairman. Thank you.

Senator NUNN. Thank you very much, General. I will not get into detailed questions until we have all of our testimony. I would just ask you one question.

In your personal opinion, if you had to choose one bill or the other—the House bill, the DOD bill, the Hart bill, the Thurmond bill—which bill would come closest to meeting the needs of the Army and the military, as you see them?

General PIXLEY. All right, sir.

I must say that the Department of Defense position is to support the administration bill. You have asked me my personal opinion?

Senator NUNN. That is right.

General PIXLEY. I would say the Hart and the Thurmond bills would be more attractive, without any question, to the great bulk of Medical Corps officers. I personally, however, do not feel that a long debate on the merits of one versus the other would be particulary productive. What we need is a bill.

I personally would not object to the House bill, but I must tell you that a great bulk of Medical Corps officers feel the Hart and Thurmond bills would be attractive.

Senator NUNN. Thank you, General.

General Myers, would you like to go next?

General MYERS. Yes, Mr. Chairman. Thank you.

I have submitted a statement. I, like General Pixley, would like to highlight it, if I may.

[The prepared statement of Lt. Gen. Paul W. Myers follows:]

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Prepared Statement of Lt. Gen. Paul W. Myers, Surgeon General, U.S. Air Force

Mr. Chairman and members of the committee, I am Lieutenant General Paul W. Myers, USAF, MC, Surgeon General of the United States Air Force. It is a privilege to appear before you today to discuss some issues of major impact on the Air Force health care delivery system.

Mr. Chairman, on behalf of all the members of the Air Force Medical Service, I am grateful to you and the committee for your recognition of the criticality of the problems we face in recruiting and retaining our health care professionals and for your expeditious action in scheduling this session. I thank you.

Our prime mission is to maintain a healthy, combat ready force. The personnel required to meet this need in peacetime allows support of mission duality whereby we attempt to provide health care to beneficiaries of active duty, retired personnel and their dependents.

Our continued ability to support the Air Force mission and to provide comprehensive health care depends on the availability of manpower, money, and facilities. There are inadequacies in all three areas. These problem areas were addressed in detail before this committee earlier this year, so I will only highlight the manpower area in this report.

The physician is the hub of our health care delivery system. The recruiting and retention of physicians, especially certain specialists is of major concern.

During the past 10 years, there has been approximately a 21 percent decrease in the number of active duty Air Force physicians. The number of eligible beneficiaries has increased 1.6 percent. The trend for the near future is an even greater increase in beneficiaries. With that in mind, let's look at our projected physician staffing for the next few years:

PROJECTED PHYSICIAN STAFFING

	Fiscal year						
	1979	1980	1981	1982	1983	1984	1985
Authorized	3,526	3,542	3,529	3,476	3,476	3,476	3,476
Assigned	3,310	3,316	3,275	3,309	3,276	3,326	3,326
Number of shortfalls	−216	−226	−254	−167	−200	−150	−150
Shortfall (percent)	−6	−6	−9	−5	−6	−4	−4

Now, let's look at our projected requirements for the various disciplines of our health care team under discussion:

PROJECTED REQUIREMENTS

	Fiscal year						
	1979	1980	1981	1982	1983	1984	1985
Physicians	4,775	4,775	4,775	4,775	4,775	4,775	4,775
Dentists	1,606	1,612	1,602	1,576	1,575	1,569	1,569
Veterinarians	292	292	291	287	287	287	287
Optometrists	139	139	136	133	133	133	133
Podiatrists	32	33	32	31	31	31	31

The number of physicians authorized do not necessarily equate to the numbers required. Active duty peacetime physician requirements represent that number of physicians needed on active duty during peacetime to meet early war mobilization requirements. The portion over and above current authorizations could be effectively used in peacetime to recapture CHAMPUS workload.

With an assigned physician strength of 3,316 projected for the end of this fiscal year, we are nowhere near our authorized strength much less our required strength. This is of great concern to us because it reflects on our readiness capability and limits significantly the amount of care which can be provided to Air Force families. This year, we met only 47 percent of our physician recruiting goal. Fifty percent of

the volunteers this year were foreign medical graduates (FMGs). Seventeen percent of our total physician force is made up of FMGs.

Currently, of the 2,404 fully qualified physicians (this excludes those in training), 994 (or 41%) are eligible to leave service this next year. Without additional pay incentives, it appears that a significant part of that number will do so. We cannot survive a major exodus and maintain a posture of preparedness for readiness or meet the needs of our Air Force families.

For new accessions we rely primarily on volunteers and sponsored education program graduates. The Health Professions Scholarship Program (HPSP) is our most successful program for gaining new physicians.

The Uniformed Services University of Health Sciences, another source of physicians, will begin to have a positive impact in the mid-1980s. Eventually, 50 physicians will join us each year. They will have an active duty obligation of 7 years.

We have made an assumption that by the mid-1980s, our authorized and assigned strengths would begin converging. But there are problems ahead. This assumption was based on our Recruiting Service recruiting 350 physicians a year and the fact that we would begin to reap the benefits of the HPSP. However, only 206 physicians were accessed this fiscal year against a recruiting goal of 434. As we get further into the 1980s, HPSP will assume greater importance as far as total numbers. However, recruiting will become more difficult as efforts will have to be directed toward meeting specific specialty needs. This is already a problem because we have major shortages in specialty areas which are critical to the operation of our medical facilities, such as general surgeons, orthopedic surgeons, radiologists, ear, nose and throat specialists, and obstetricians and gynecologists.

The dissatisfactions voiced by our physicians are primarily pay, continuing medical education, support staff shortages and acquisition of current technologies. Money is the key factor in resolving all of these areas of dissatisfaction.

Most of their complaints are valid and that is one of the reasons we are before you today. We need to rectify as many of the situations as we can which work against our efforts to recruit and retain physicians and other scarce health care personnel.

The inability to successfully compete in the civilian health care market is the major problem in recruiting new physicians and retaining those now on active duty. Our incomes are in malalignment. We believe that all physicians should receive some special pay based on qualification rather than an obligated/nonobligated status. The fact that we have been unable to offer variable incentive pay to such qualified physicians as Berry planners and scholarship graduates has precipitated the exodus from service of many of these members.

A Department of Defense (DOD) Physicians Compensation Study was completed in April 1979. The study concluded that military physician pay and other benefits are below that of their counterparts in the non-Federal sector.

The Air Force Dental Corps is experiencing a shortage of specialists and anticipates a shortage of general dentists in the future. In the past, dentists were gained through volunteers and the HPSP. In fiscal year 1977, the Air Force was no longer permitted to offer scholarships to dental students.

Active duty peacetime dental officer requirements are based on the needs of active duty Air Force personnel. The method of computing such requirements is currently under revision. Listed below is our projected dentist staffing for the near future:

PROJECTED DENTIST STAFFING

	Fiscal year						
	1979	1980	1981	1982	1983	1984	1985
Authorized	1,563	1,575	1,569	1,545	1,545	1,545	1,545
Assigned	1,509	1,445	1,436	1,417	1,419	1,418	1,423
Number of shortfalls	−54	−130	−133	−128	−126	−127	−122
Shortfall (percent)	−3.5	−8	−8	−8	−8	−8	−8

The Dentist shortfall may decrease as a result of a recent initiative to offer continuation pay to Dentists in pay grade 0-3.

Peacetime requirements over and above current authorizations have not been determined for veterinarians and optometrists. These are in process of being updated. It should be noted that authorizations for both of these groups have been

consistently reduced, and drastically so for optometrists (from 216 in FY 1973 to 133 beginning in FY 1982). We have only 32 podiatrists and the requirement is projected to remain fairly constant.

The continuing efforts to reduce a significant number of veterinarians causes much concern. Veterinarians have many unique preventive medicine and research abilities which make them indispensable to a flexible and mobile readiness mission and there is an absolute requirement for them in a combat environment. The final decision regarding the extent of veterinary service to remain with the Air Force is still in joint House-Senate Conference.

Readiness has been a subject of major debate in the nation. The circumstances which have precipitated our current international crisis reinforces our concern for military preparedness and our ability to continue to operate from a position of strength.

The physician shortage impacts on our state of readiness by decreasing the number of theater hospital patients released to duty. It increases morbidity and mortality of our airmen by denying them necessary care. Early this year, we completed a systematic, indepth analysis of wartime medical readiness requirements. Our personnel requirements are classified; however, our analysis produced many initiatives which are specifically directed to resolving deficiencies which may exist. For example, we can increase theater medical capability by prepositioning medical facilities and equipment. We can reconfigure present tactical medical units to enable them to more capably respond to projected requirements. Other initiatives require coordination with the various elements of the DOD, such as changing the approved evacuation policy to reflect the optimum mix of air evacuation and theater medical support for planning and programming. But the success of all depend upon adequate physician staffing.

Just two weeks ago, we completed a new wartime training exercise called Medical Red Flag at Keesler AFB, Mississippi. For one week, we had both academic and real time practice in battlefield medicine, operating from an air transportable hospital. We trained more than 240 Air Force physicians in various types of combat related health services. We plan to extend this training to our other medical centers in the coming months.

The shortage of physicians and other selected health care personnel has created problems in the peacetime delivery of health care. These include curtailment and closure of some services and long waiting times for appointments to see health care providers. It also increases the use of CHAMPUS, which is more expensive to the beneficiary and to the Government.

The extent to which the Air Force Medical Service "takes care of its own" reflects directly on the CHAMPUS program and appropriation. The Air Force and our sister services have a tremendous impact on the dollar cost of that program. We influence CHAMPUS costs by reducing demand for CHAMPUS. At present, the demand for CHAMPUS is increasing and we do not have the inhouse resources to temper that demand. I would like to note that both DOD and Air Force studies have shown that inhouse care is the most economical and satisfactory means of providing health services to military families.

Inhouse, we have expanded our training programs for physicians and other scarce health professionals, and have continued to make major use of physician assistants and nurse practitioners in meeting the needs of our people. This has helped but is only part of the solution. In addition, we established a program called KEEP, Keep Each Eligible Person. This program individualizes career plans and personalizes relationship at the grass roots level. It is helping also. But it is urgent that we provide a realistic, equitable and permanent special pay package for physicians and other scarce health care providers.

The current special pays system is a combination of several separate pieces of legislation requiring annual or biennial approval for continuation. The temporary nature of these pays is disturbing to those eligible to receive them. Further, the variable incentive pay ceilings were established in 1974 and special pay ceilings at an even earlier date. Dollar values have decreased markedly with economic inflation. The lack of provisions to adjust these pays accordingly has greatly eroded their value as an incentive to remain in service. Further, experience has clearly shown that physicians who are otherwise qualified and receive less than their peers leave the service; thus, we must eliminate any obligated/unobligated conditions for award of special pays.

There are several bills before this committee, each of which provides increases at various levels and all of which have merit. The point I want to emphasize is that action is needed NOW to increase the special pays for our health professionals. The

subject has been under active debate for many months. Our people are getting progressively more restless with promises. We need to give them substance.

Again, I want you to know how appreciative we are of your scheduling this meeting in the midst of the major international issues with which you are involved. We pledge our support to you. I will attempt to answer any questions you may have.

STATEMENT OF LT. GEN. PAUL W. MYERS, THE SURGEON GENERAL, U.S. AIR FORCE

General MYERS. On behalf of all of the members of the Air Force Medical Service, Mr. Chairman, we are very grateful to you and the committee for the recognition of the criticality of the problem we are facing in recruiting and retention of health care professionals and for your expeditious action in scheduling this session. We thank you very much.

Our continued ability to support the Air Force mission and provide comprehensive health care depends on the availability of manpower, money, and facilities and there are inadequacies in all three areas.

But it is the physician who is the hub of our health care delivery system and the recruiting and the retention of physicians, especially certain specialists, is of major concern.

During the past 10 years, there has been approximately a 21-percent decrease in the number of active duty Air Force physicians as the number of eligible beneficiaries has increased by 1.6 percent. With an assigned physician strength of 3,316 projected for the end of this fiscal year, we are nowhere near our authorized strength, much less our required strength, and this is of great concern to me because it reflects on our readiness capability and limits significantly the amount of care that can be provided to Air Force families.

This year, we met only 47 percent of our physician recruiting goal. Fifty percent of the volunteers that we assessed were foreign medical graduates.

Currently of the 2,404 fully qualified physicians, and that number excludes those in training, 994, or 41 percent, are eligible to leave the service this summer, and without additional pay incentives, it appears that a significant part of that number will do so.

We cannot survive a major exodus and maintain a posture of preparedness or readiness or meet the needs of our Air Force families during peacetime.

Recruiting is becoming more difficult as we direct our efforts toward meeting specific specialty needs. This is already a problem, because we have major shortages in critical specialty areas.

The dissatisfactions voiced by our physicians are primarily pay, continuing medical education and the need for support staff.

I think, after talking literally with hundreds of them, that their complaints are valid and that is the primary reason we are before you today. We need to rectify the situation. The inability to successfully compete in the civilian health market is a major problem in recruiting new physicians and retaining them on active duty.

Incomes are in malalinement. The physician shortage will impact on the state of readiness by decreasing the number of theater hospital patients released to duty, it may well increase morbidity and mortality to our airmen.

The shortage of physicians and other selected health care personnel has created problems in the peacetime delivery of health care. Those problems include curtailment and closure of services and long waiting times for appointments to see health care providers.

It also increases the use of CHAMPUS which is more expensive to the beneficiary and to the Government. There are several bills before this committee, each of which provides increases at various levels and all have merit, but action is needed now to increase the special pay for these health professionals.

The subject has been under active debate for many months. Our people are getting progressively more restless with promises. We need to give them substance.

Mr. Chairman and members of the committee, I am most appreciative of your scheduling, as I said earlier, in the midst of pressing issues which you must debate. We pledge our support. I am ready to answer any questions you may have.

Senator NUNN. General, you used one phrase here which catches my attention. You said "increased morbidity and mortality."

What do you mean by that in layman's language?

General MYERS. Meaning that timeliness of care would make for longer hospitalization and even increase, perhaps, the number of deaths.

Senator NUNN. Which bill would you choose if you had to choose one today, just as it is?

General MYERS. Speaking personally?

Senator NUNN. Personally.

General MYERS. Yes, sir.

Senator Hart's bill and Senator Thurmond's bill are very attractive indeed to most of those to whom I have talked. My concern is about the timeliness and if, indeed, there was a debate on some of the points of those bills, I think that we would see many of our people leaving based on the timeliness required.

I think the House bill proposed by Mr. Nichols is the one I would support at this moment.

Senator NUNN. You fear that if we pass a different bill by the time we get out of conference, some of the decisions may already be made. Is that right?

General MYERS. Yes, sir.

As I pointed out, with this large number of over 900, they are poised and waiting, ready to make a decision. Most of those decisions of either to stay or leave will come in the summer or early fall.

If there is legislation on the books, I think it will be very attractive for retaining those very people who are threatening now to leave.

Senator NUNN. Thank you. Admiral Arentzen.

STATEMENT OF ADM. WILLARD P. ARENTZEN, THE SURGEON GENERAL, DEPARTMENT OF THE NAVY

Admiral ARENTZEN. In the interest of time, I will limit my remarks.

Reforms of the health professional pay system is critical. Three elements are esential to an effective compensation program.

The first feature is stability, entitlements set in law. This provision is necessary to overcome the uncertainties of periodic legislative renewal and administrative changes. Equity is the second essential component. This means that pay should be based upon education, training and experience, including full pay to obligated officers.

To recruit and retain health professionals, we cannot undervalue their services, or discriminate against particular procurement sources.

Finally, the pay system must provide some mechanism to help offset the continuing spiral of inflation and slow the growing income gap between military and civilian practice. Periodic adjustments are essential if the compensation system is to retain its long-term effectiveness.

These three features: Stability, equity and a provision for adjustments form the foundation for a fair and effective compensation package capable of sustaining adequate recruitment and retention.

The benefits of establishing such a pay system will significantly strengthen the Navy medical departments to perform assigned missions successfully.

All three recommended pay elements are contained within each of the health professional pay bills before this subcommittee. Our need is critical and I strongly believe that, with your assistance, we can achieve the necessary resolution of our manpower problems.

I appreciate the support this subcommittee has given the Navy and thank you for your time this morning.

Senator NUNN. Thank you very much, Admiral.

I will ask you the same question I asked our other two witnesses, that is, your personal view about which bill, at this stage, is preferable.

Admiral ARENTZEN. My personal view, Mr. Chairman, is the same as the other two Surgeons General: The Hart and Thurmond bills. Those are the bills my physicians prefer in my medical department but in the interest of time, it is so essential, as the other two have pointed out, that I will support the House bill.

Senator NUNN. Thank you very much. I am just going to ask a couple of questions. I have a great number of questions later, but I think with this number of Senators here we ought to have a 10-minute rule, and I have already used some of my time.

Dr. Moxley, there is no doubt that we have a critical medical shortage in the military services. There is no doubt that something has to be done. In my view, there is no doubt that we cannot wait for some kind of perfect theoretical remedy 2, 3, 4, years from now. But I am concerned that we must have some philosophy as we approach this.

If the Hart bill, for instance, is passed, you will have a colonel with 22 years service making $73,000 a year. That will be $2,000 less than the Vice President, $2,000 less than the Chief Justice of the United States.

More importantly, from a military point of view, it would be $10,000 more than the Chairman of the Joint Chiefs of Staff and also it would be—I do not know how much you make——

Dr. MOXLEY. It would be more, Mr. Chairman.

Senator NUNN. How much more than you make?

Dr. MOXLEY. $23,000 more.
Senator NUNN. $23,000 more than you make.
General Myers, what would be your salary?
General MYERS. It would be about $10,000 to $12,000.
Senator NUNN. $10,000 to $12,000 more than you make?
General MYERS. Yes, sir.
Senator NUNN. General Pixley, what is your salary?
General PIXLEY. The same.
Senator NUNN. Admiral, yours is about the same?
Admiral ARENTZEN. Yes.

Senator NUNN. We have to have some philosophy behind this and realize where we are going. I know you have crucial short term problems—hopefully they are short term. They may be long term unless some changes are made now in our overall philosophy. Nevertheless, you have crucial problems that have to be dealt with.

What happens to your chain of command when you have colonels with 22 years of service, becoming generals, and they start making less money—the higher you go up the less you make?

If they somehow or another quit being a doctor and became Deputy Secretary of Defense, they would take a big cut in pay. If for some strange reason we ever got into a situation where a doctor had unique talent in the military command area, which I am sure would not happen, but hypothetically, if they achieved the pinnacle of a military career and become the Chairman of the Joint Chiefs, they would have to take a $10,000 salary cut.

Where are we heading philosophically under these conditions through the chain of command? That is what I am speaking about.

Dr. MOXLEY. Are you addressing the question to me?

Senator NUNN. Yes, sir.

Dr. MOXLEY. I can draw comparisons to the life I have led in the last 20 years in the academic world where you have those sorts of differences. As a matter of fact, in some respects, you have those sorts of imbalances in the civilian community.

They are difficult to live with.

My judgment would be in the military where the chain of command is even more clear, they would even be more difficult.

I would defer to any one of the Surgeons General that would have far more experience in answering this question.

Senator NUNN. I will ask each of the Surgeons General. Admiral, you have your head lower than anyone else's now. That means you are ready to go.

Admiral ARENTZEN. No, sir. I really do not know what to say.

I think right now we have three Surgeons General making more than the CNO and Chiefs of Staff. It does not seem to bother them.

Senator NUNN. I am sure it does not bother those who are making more. What about those at the top?

Admiral ARENTZEN. The CNO is still in support of getting a very strong pay bill for the Navy.

Senator NUNN. No one likes for the whole medical corps to collapse while they watch. I know the CNO feels that way, I know you feel that way.

It is just natural that a commander does not want everything to deteriorate while he is there. At some point, we have to look at the long-range effect of where we are going. We have critical skill

shortages in the enlisted ranks now. I know the Navy, for one desperately needs more ships, but we cannot man the ships we have now. We have skill shortages at the petty officer grade.

At some point, it seems to me, the whole chain-of-command begins to come unraveled psychologically.

Do you see any danger along that line or is this something that is really not a problem?

Admiral ARENTZEN. I think there is probably a danger. I really could not say, Senator.

Senator NUNN. Has anyone done any thinking over in the Department of Defense? Has anybody done any philosophical thinking over there as to what happens to the chain of command? I assume that is still important to a military operation. Everyone is over here saying let's pass this bill. I hope we can pass something. General?

General PIXLEY. I do not believe there is a conflict in the chain of command. The medical department exists to support the combat arms, the combat service support elements.

Of course, the line commander is always in charge—at least I am speaking for the Army—in a theater of operations. The Medical Corps officers are in charge, or in command, of the health care facilities only where patient care is given in terms of a conflict with the conduct of war or operations.

Really, I do not believe there is one.

Senator NUNN. Maybe that is true in the medical field. You see this is just a symptom of an underlying disease. Shortages are not limited to the medical field. We have all sorts of critical skills shortages up and down the line. The medical shortage is perhaps the most crucial now.

We have a philosophy here of having people with higher ranks being paid less.

What do you do when a colonel in the Medical Corps with 22 years' service making $73,000, or $69,000 a year under the DOD proposal, basically does some things wrong, subject to discipline. What do you threaten him with? Making him a general and cutting his pay? If you do not do better, we are going to make you a general?

It seems to me that there is something missing here, and I would hope that someone has done some thinking about it and can come up with a way that we can philosophically have something other than just the typical Washington rescue mission throw money at it and hope in a few years somebody will be able to sort it all out because we got by on our watch.

That is the kind of approach we have going on right now.

Senator WARNER. Mr. Chairman, if I could interject, perhaps each of the services could advise us what is the highest amount that they paid out for contract services for a single physician in the last fiscal year and put that figure——

Senator NUNN. Oh, yes.

Senator WARNER. Do you have one of those figures? Would each of you put it in the record at this point?

Senator NUNN. I agree. That is very important.

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Senator HART. If the chairman would yield, I cited the fact in my opening statement that the Army was advertising for radiologists at $120,000 a year.

Admiral ARENTZEN. Our highest paid contract to date involving a single radiologist is $145,000.

Senator WARNER. General.

General PIXLEY. $120,000 is the highest I have ever heard.

General MYERS. $110,000 for a radiologist, Senator.

Senator NUNN. This makes the point even more vivid. Where do we go? Something is wrong with our system when we get to this point.

General MYERS. Mr. Chairman, there is some data. When we were looking at comparability of income, a very prestigious firm did a study for DOD and looked at the average incomes of physicians in various work arenas.

The physician based primarily in a hospital, the physician based in a medical school, those who worked in business, those who were clinic-based, and those who were self-employed were looked at.

It turns out that the average income in this Nation of physicians today is $70,000. For those who work in some structured organization, it runs about $20,000 less. The military is at the low point of all of those groups currently, which leads right in to a partial answer to your initial question.

There is an overall understanding that that kind of income exists in medicine in this country today and there is neither any covert or overt expression by the officers on the line about this disparity of income at all. We have had total support from the Chief of Staff of the Air Force, General Allen, the Vice Chief, the Air Council and the four star commanders who have appreciated this and have expressed total support for our desires to increase the incomes for military physicians.

Senator NUNN. I think it is quite natural that, the worse the problem gets, the more support you are going to have for curing it with money. That is the history of where we have been in the last 5 years.

I think we are just seeing the beginning of that in the future. I am out of my time at this point.

Senator Jepsen?

Senator JEPSEN. You are all in support, or have given evidence that you are in support of the House bill.

Is there anything in addition to the House bill that would be a more perfect solution to this that you would recommend by way of addition or amendments?

Dr. MOXLEY. Senator, I indicated that I was in support of the administration proposal as opposed to the House bill. I say that because I think, coming back to the earlier question for an expenditure which is the least of the bills before you, it provides a solution.

It corrects the situation in regard to obligated physicians versus unobligated, as pointed out by the Surgeon General, a major issue. It does make permanent the special pay situation for the services and I think that it would, with the least expenditure, do the job.

I think to come back for a moment to the chairman's question, the situation we are faced with is where we are now is intolerable.

I had some questions in the recess that indicated that some did not think that I felt it was intolerable. I do. I want that to be very clear.

It is intolerable, and something has to be done.

Quite clearly, we cannot match the civilian economy in terms of what we pay physicians. It is just not possible and not feasible within the constraints.

Really, it then becomes a judgment in that sense. There is not that much difference in these bills from a philosophical point of view. They are few and not major, in my judgment.

It really comes down in the final analysis, in my judgment, to an issue of how much money do we want to spend to correct this or what is the least amount of money that needs to be spent to correct the situation.

That approach can be taken, I think, because as has been indicated in other testimony and mine, physicians come to the military not to make money. Their capabilities would have to be greatly challenged if they thought they were coming into the military taking academic positions or entering any structured medical program to earn money. They come into it for other reasons.

I think if we can correct the pay situation and then go to work on improving the professional environment as first indicated by Senator Hart, which is important, and unfortunately will cost money to correct, but if we can improve the professional environment and make the changes that are really in any of these bills to various degrees—I happen to favor the administration bill—I think we will be taking a major step toward providing some stability for a situation that is extremely unstable at the present time.

Senator JEPSEN. As pointed out here, if you are going to advertise and pay doctors twice as much who are not in the military for service on a contract basis than those in service, and you couple that with the fact, as you say on page 3 of your testimony, General Myers, that 41 percent of your physicians are eligible to leave this year, couple that with the fact that you met only 40 percent of your recruiting goals this year, then, it goes without saying that we have a serious problem.

That is why I am getting back to this House bill.

Maybe I should ask the chairman, for my own edification, what bill is in the position to move the fastest and quickest on a realistic basis if we did not decide?

Senator NUNN. The easiest thing to do for time is to accept the House bill. The other alternative would be to pass the Senate bills in some form, or the DOD bill, and then go to conference.

Senator HART. As I understand the statements of the surgeons, they all support either my bill or Senator Thurmond's very close together, but in the interests of time, namely saving the conference, they would support the House bill. On the merits it seems clear which bill they support. Procedurally, in the interests of time, they support the House bill.

When my time comes, I want to get into the impressions they all have about how much time they are going to save if they pass the House bill, which they do not prefer.

Senator JEPSEN. I will wait for a second.

From what I have heard and read, it seems to me it might be well advised that you do put it in conference.

Thank you, Mr. Chairman.

Senator NUNN. Thank you, Senator Jepsen.

Senator Exon?

Senator EXON. Mr. Chairman, I would like to make a statement to follow up a little bit on the philosophy angle that you brought up. I would only say that my experience with the military goes back to those days of yesteryear and World War II.

I would suspect, and I believe that the testimony that has been given here probably does not support some of the concerns that the chairman has had with regard to rank. I would suggest that the average soldier today, if he were going into battle, he would like to follow somebody by the stars or the eagle or the oak leaf or the bar on his shoulder which would indicate that he has had some experience and training to properly lead him.

On the other hand, if that GI were stretched out on the operating table, I suspect that he would not care so much as to the decoration on the uniform, but he would like to have someone who is highly specialized in that particular area.

We did that. I do not think it ever went into the officer rank, but I know in World War II we did have what we called technical sergeants, technical corporals, which were recognized as not being line noncoms as such, but specialists in a certain area.

I would certainly believe—I am not concerned in the least by the fact that a surgeon might make more than the Chief of Staff because I suspect that their responsibilities are different and the training is different, so frankly, that does not concern me a great deal when I get into it.

Do you agree with what I just said, or do you tend to feel that there are some concerns as brought out in the line of questioning by the chairman?

General PIXLEY. I have encountered, as Surgeon General of the Army, absolutely no reservations in the Army staff and from the Army Secretary about any increase.

Senator NUNN. I think that is correct. However there is one thing I would add to that. My point was, if you could isolate the medical problem and say this is the only skill problem we have in the service, and we are going to solve this problem in a unique way—we are going to pay colonels more than generals—that is one thing.

But we have got critical skill shortages flowing through the whole military structure. This one just happens to be probably the most urgent, and I could not agree more with the fact that it is urgent and we are going to have to do something about it, but it is going to come up in many other areas in the 1980's.

The Navy cannot man the fleet now because of shortages in critical skills. Those are also special skills. At some point, you have to have a philosophy of what you are going to do in that area. Otherwise, at some point, you are going to have chief petty officers making more than captains of ships, if you carry this philosophy through.

Perhaps as a former enlisted man, that might be the right direction. We ought to know where we are going.

Senator EXON. I would like to follow up. Maybe I am looking down the road at least to where we are going on this. The statement was made in testimony before the vote that there were very attractive offers made in the private sector. I am sure that is true, not only in the medical skills but in the other skills that the chairman has referred to.

Getting back to the medical skills particularly, I would like to explore, if I could, a little bit briefly—could either one of you gentlemen tell me about the scholarship programs that we are offering?

I believe you testified that is where we are getting most of our medical practitioners today. When a person signs up for the scholarship program, how long does he obligate himself or herself for, under that, and what commitment are they making for the investment that we are making in them during their training period?

Dr. MOXLEY. They make a year-for-year commitment for every year they are on the scholarship. They have a year of obligated service after they get out of medical school.

That obligation, I believe it is correct, is not used up while they are in training. It is after their training that they have the obligation.

Senator EXON. I understand that if a student is on a scholarship program for 7 years then they would have 7 years obligation in the service.

Dr. MOXLEY. If they were on for 7 years. Usually they are not on beyond 4 years, 4 years of medical school.

Senator EXON. After the 4-year program, that is where we are right now on some 42 percent, one of you testified your strength would be up next year, they have to make the election whether they stay or leave.

General MYERS. That does not necessarily mean they all fall in that category.

What we have done is go through the numbers of active duty physicians we have to find out those who are eligible to leave. It turns out to be 900-plus.

Some of those have just finished their obligation or will be finishing while still others have finished their obligation long ago, but they are at that very critical point at the 12th to the 14th year where they are waiting to see which way things will swing.

They are incurring greater obligations as their children grow, thinking about their college education and wondering if they are going to make it as physicians in the Armed Forces or if their income predictions are less than what they perceive are required. They are ready, then, to make the move into civilian life.

Senator EXON. I believe you said that 4 years on a scholarship program is pretty much the norm, is that right?

Dr. MOXLEY. Yes, sir.

Senator EXON. Therefore, it follows that a student upon graduation serves 4 years and then has to make a decision whether they want to leave or stay in.

Dr. MOXLEY. Yes, sir. That is correct. Except the time that they are in additional training. Internship and residency does not go toward meeting their obligation.

Senator EXON. I understand that.

After that student who is in 4 years in a scholarship program and serves 4 years and leaves, does the Government have any hold on them at all as to calling them back in case of a national emergency?

Dr. MOXLEY. No, sir, no more than we have on any other physician.

Senator EXON. It seems to me that maybe there has to be some allowance for that kind of program. It seems to me that with anyone who has benefited from a scholarship program who serves 4 years, maybe not at fully equitable pay, that we should have a first call on those types of skills which we would need in case this Nation becomes involved in an international conflict.

Possibly, if we had that, we would not have any less people signing up for the scholarship program. But it seems to me, that with those who do benefit from the scholarship program, we ought to have some kind of a "hold" on them in the Reserve in case we need them.

Because if we get into war, we should take them out of the civilian population and put them back in the military to take care of our troops.

Maybe you do not care to comment on that now. Has that been considered?

Dr. MOXLEY. I cannot comment on whether that has been considered. I do not know. I do not believe it has. At least it has not been brought to my attention.

I would comment on the two other aspects very quickly.

It is possible, again, if you are looking at optimistic projections but exceptionally optimistic projections, that we will be able to fill up, if we get a pay bill and so forth, and there has begun to be looked at the possibility of having longer term Reserve commitments in lieu of year for year active duty and having, say, 3 years of Reserve in lieu of a year of active duty, or 4 years, or something like that. That aspect has been looked at.

In terms of physicians during an overall mobilization, I may be unique, but I do not believe so. I have always felt, since I graduated from medical school as a physician, possessing that skill of a physician, that I was going to be called if there was a national mobilization, that I would, in fact, be called and that I would go without any question.

I think that most physicians probably share that.

In terms of mobilization, the question would be tracking them, where are they, and making the sorts of contacts, which would take a fair amount of time.

I do not believe that there would be a great deal of resistance on the part of physicians to serve. I do not believe that was the case in the Second World War. I do not believe it would be that situation again.

Senator EXON. Thank you.

One last question, Mr. Chairman, that I would like to get into.

Looking down the road, of course, obviously we are going to have to have more physicians. What is the opinion of you gentlemen with regard to the productivity of physicians and surgeons from our medical schools?

Are they operating at peak efficiency?

Is there any holdback in the number of students being accepted into the medical schools?

Is there any difficulty with the American Medical Association or any other group with regard to the number of physicians that we are accepting into the medical schools and graduating, and should we be doing more in that area?

Dr. MOXLEY. I will try to give you a short answer to that question.

For the last 15 or so years, all of the drive in medical education has been to expand. This has been very much encouraged by the Congress and the administration both.

Because of that push, there has been an increase from approximately 7,500 in the entering class probably in the early 1960's to a point where there will be about 20,000 physicians entering the freshman class in about 1980, give or take a few, but those are fairly close.

There has been a dramatic increase in the last 15 years. That is just now being reflected in the output end, because physicians do take an average of 8 years before they are capable of practicing.

The decision that has been made now—and I believe has been pretty much concurred in across the Government, and certainly has been the position of HEW—as articulated before the Association of American Medical Colleges a year ago at their meeting in New Orleans, it is now concluded that we have enough physicians—as a matter of fact, may face a surplus of physicians in the late 1980's and 1990's and therefore all of the incentives to further expand medical education are being withdrawn.

My guess is that there will be no expansions of medical education over the next decade.

I do not make that as a judgmental statement, but I think it is a factual statement.

Senator EXON. Thank you for your candor in that and I suspect, Mr. Chairman, I do not agree with the statement which has just been made. We certainly do not have anything curtailing the output of other professionals today in our schools. Certainly it would be interesting, especially to those of us who come from rural communities where there is a very serious lack of qualified physicians to carry on the basic medical facilities in rural areas.

I would like to see a time where there is a surplus of physicians. I suspect that most Americans would not agree with the decision which has been made that we are going to have too many doctors by 1990.

If that is going to happen, maybe all we need, Mr. Chairman, is a short-term bill to keep doctors in now and maybe 10 years from now we will not need the incentive necessary now to bring more of these professionals into the service.

I thank you.

Senator NUNN. I agree with you about the terrible deficiency in rural areas. We have the same problem in my State. We are trying to get a medical school established that would cater to young people who want to go to rural areas. I think there is going to have to be a great deal of thought and emphasis given, not so much to the absolute numbers of physicians 10 years hence, but where they

are going to be located, both with regard to critical inner city needs and rural area needs.

Dr. MOXLEY. The conventional wisdom, Mr. Chairman, is that the problems in rural areas now are not a result of the overall number but a maldistribution, both in terms of where people are settling and also maldistribution in terms of the range of specialties that are reflected in the graduates, with not enough being in the primary care areas and too many being in the specialty areas.

Senator NUNN. Right.

Senator Hart?

Senator HART. Thank you, Mr. Chairman.

Dr. Moxley, Senator Nunn raised a pay for a hypothetical 22-year colonel. How much would that be in the administration bill?

Dr. MOXLEY. I believe that the chairman's figure of $73,000 was for a 22-year colonel who would also be getting the special supplement that goes to subspecialists. The figure I have for a 20-year person under your bill, Senator, is $67,400. The figure I have for the administration's proposal is $65,200; for the House, $61,900.

That does not include any of the various approaches to dealing with the very scarce specialties, which adds money on top of that.

Senator HART. I am not sure, in his absence, where the figure $73,000 came from.

Dr. MOXLEY. $67,000 plus the $8,000 or so, but I am not sure about that. I do not know.

Senator HART. Does the Department have any estimates as to what it is costing us now to contract out services plus the increased cost of CHAMPUS because of the doctor shortage?

Dr. MOXLEY. If the Department has them, sir, I do not have them at my fingertips.

Senator HART. Will you try to get those for our record, please?

Dr. MOXLEY. I can certainly get them for the record.

[The information follows:]

In fiscal year 1981 we estimate that contractural services directly resulting from the physician shortage will cost the Department approximately $17 million. As short specialties become more abundant, we are converting some functions back to an in-house operation.

We are convinced that the doctor shortage has diverted a certain amount of workload from the direct care system to CHAMPUS; however, due to an inherent lag in CHAMPUS data and other program changes that have caused fluctuations in CHAMPUS activity, we are unable to determine the dollar impact on the CHAM PUS program.

Senator HART. I might make the statement in regard to the contracting out of physicians and the very high figures you are hearing of $120,000 and so forth. There has been an implication, if that is the going rate, do we not have to come close to that?

Dr. MOXLEY. I think not. I think when we are contracting out for services, it is on a short-term basis. It is with the option to cancel within a year at the longest.

As I stated earlier, if we continued to keep the scholarship program full, we ought to be able to phase out those very high physician contracts. My guess would be some time in the mid-1980's. That assumes that we keep the scholarship program full and that has yet to be seen.

I do not think that the $120,000 for radiologists, which there is no question you have to pay on a short-term commitment, is neces-

sarily a benchmark for what we have to pay physicians in the services.

Senator HART. I understand that. That is not my point.

The chairman made the suggestion that we were throwing money at the problem again. All I am suggesting is that we are throwing money at the problem right now. It is just a question of which way you throw the money and how much.

It is not as if—we are throwing money at the problem now and losing doctors. If we are going to throw money at the problem, I would just as soon keep the doctors.

Dr. MOXLEY. Yes, sir.

Senator HART. If we could provide those, at least in round numbers so we could have some idea of what it is costing us now under the present system.

Dr. MOXLEY. Yes, sir.

Senator HART. Which I suspect is considerable, which I know is considerable and I suspect at least close to what it would cost under my bill if not drastically more.

Dr. MOXLEY. These figures would be in the military departments and it is possible that the Surgeons General have them. I do not have them DOD-wide.

On this end, $2.4 million now we have budgeted for contracting services. CHAMPUS has gone up by leaps and bounds this year, as you well know.

Senator HART. Yes.

General PIXLEY. I cannot give you the figure for the Army share of CHAMPUS, but the supplemental contracts for active duty and other beneficiaries is approaching $10 million a year.

General MYERS. $11.5 million for supplemental medical care in the Air Force last year.

Senator HART. Could you go service by service and tell us how many doctors you have, total numbers?

Senator THURMOND. Mr. Chairman, would you give me a half a minute to say a word? I have another engagement.

Senator HART. Certainly. I am late to an 11:30 appointment, but I would be glad to yield.

Senator THURMOND. I just want to say, I have a bill before the committee now, as you know, for doctors and health personnel. I am hoping the committee will act favorably on this bill, or some bill, promptly.

I have been told by many people that we are going to lose a lot of doctors and health people if we do not do something. I want to urge the subcommittee to please act as soon as possible.

If we do not act this year, I think it is going to be detrimental. The House has passed a bill and my bill goes further than the House.

But if we cannot get a bill like mine, I think we should pass the House bill. The point is that I think it is very urgent that we act, and act promptly this year.

Thank you very much, Mr. Chairman.

Senator HART. Thank you, Senator.

Back to my question. Service by service, how many doctors do you have and what do you project over the next 6 to 12 months to be the rate of attrition, given no action by Congress?

Admiral Arentzen?

Admiral ARENTZEN. The authorized level is 3,620. As of the 30th of November we have onboard 3,573.

Senator HART. What do you project as the rate of attrition in 6 to 12 months with no action?

Admiral ARENTZEN. 1,000 doctors, a little over 1,000, who are eligible to get out this coming year. Our retention rate will be about 15.5 percent, 16 percent.

Senator HART. Retention?

Admiral ARENTZEN. Sixteen percent of those, yes, sir. About 800 and some will be leaving.

If there is no action, yes, sir.

Senator HART. With no action.

General Pixley?

General PIXLEY. Yes, sir.

The authorization is meaningless in the Army because the authorization figure is based on what we think we can get at the end of every fiscal year. The Secretary of Defense's program directive decision memorandum to the Army says by 1985 you should have approximately 5,200 physicians during peacetime and maintain it at that.

We have today somewhere between 4,200 and 4,400; 400 of those are interns and therefore not productive.

They have a limited ability for utilization.

As I mentioned earlier, there are 1,242 physicians who are eligible to leave this summer. I could not predict a figure. I feel that it could vary from 30 to 50 percent, if a bill was not passed, those who might leave.

That is a guess.

Senator HART. General Myers?

General MYERS. Sir, we have a projected shortfall of 226 for this next year.

One must recognize the difference between authorizations and requirements. Measured against the budget authorization for us, the number is 226 short.

Our retention rate at the moment is 10.4 percent and with the 900-some people who are out there just waiting, breathing heavily, for the passage of a timely bill, my estimate would be that we would lose upward of 50 percent of those people. That might be even conservative.

Senator HART. You are 250-plus short now?

General MYERS. 226.

Senator HART. 226 now.

General MYERS. With 900 eligible to leave this coming year.

Senator HART. If you lost half of them?

General MYERS. Fifty percent of those.

Senator HART. All right.

Let's get to this question of time. As I explained to all of you in private meetings, I have no particular pride of authorship here. It is a peculiar situation when everybody testifies in favor of one bill but they will go with another one to save time.

We have all discussed the procedures. As you know, the only step that could be saved would be the conference step. If this committee reported this bill out and we managed with the cooperation of the

full committee and the leadership of the Senate to get that bill on the floor of the Senate before Christmas and got it acted on, which I think we could if we chose to, then the only issue that remains would go to conference with it either before Christmas or the first thing in January.

Having chaired conferences and participated in conferences, as all of my colleagues have, and Senator Nunn particularly, depending on the complexity of the issue and so forth, the conferences can take some time, or not very much time at all.

We usually wrap up the military construction conference having to do with $4 billion of expenditures and dozens and dozens of line items in a half a day, maybe a full day at most, and we usually spend half that day debating one or two points.

My own view is that you could have a conference between the Senate having adopted a Hart or Thurmond approach and the House adopting its bill and wrap it up in a half a day.

Is that the kind of delaying you think would cost you a lot of doctors?

I am a little unsure as to why you have all supported the House bill, I guess, if in fact all you save is 2, 3, or 4 weeks, if you really favor a stronger bill. That is what has gotten me perplexed, I guess.

What delay is fatal to your cause, I guess that is what I am trying to get at. Next May, April?

General MYERS. If I may answer that and I seek substantiation from my colleagues, I guess it is the trial balloons that have gone up and the intelligence that is coming back from the people who are involved in the preparation of this piece of legislation, especially on the House side, the perception that we have is that there would be difficulty in conference committee.

If one assumes that, and there is a drag-out perhaps in late winter, early spring, we are getting closer now to the time of commitment for these people who have been looking eagerly for some kind of relief in their incomes. We are reaching a point of criticality because those decisions are going to be made this summer when the major numbers of those people that we describe would finish their obligations or make some decision.

I think Dr. Moxley would certainly agree that summertime academically is a time when decisions and changes are made.

Senator HART. I do not know of a bill, in my memory, a conference, which has dragged on that long, including the natural gas deregulation bill which, by comparison, you know, is monstrously complex.

If this is what the House staff is saying to you, in fact they are blackmailing you to get your support. Frankly, I am outraged at that, that they are not going to accept any compromises with the Senate and in order to get their bill, they are going to drag this conference out for weeks and months. I think that is an outrageous situation and what they are presenting to the Senate is, through you, a fait accompli that we have to accept the House bill in order to get a bill.

I find that appalling.

We are not talking about major differences here and if some House staff member over there is saying to the armed services of

this country that to get the doctor problem solved, which is a critical problem to our readiness, the Senate has to go along with the terms of the House bill or they are going to delay this thing for weeks and months. I think that is an outrageous situation, and I would want that reported to the House.

Thank you Mr. Chairman.

Senator NUNN. Thank you very much, Senator Hart.

Dr. Moxley, would you like to respond briefly, then we will go directly to your question.

Senator EXON. On this point, I wish to associate my remarks with what Senator Hart just said. From your standpoint, I suspect you and others are looking at the House of Representatives record recently on a whole series of matters including abortion, including holding up the pay of people and not meeting the obligations of the Government.

I suspect, Senator Hart, these people's fears in this area might be well-founded.

Dr. MOXLEY. I would just comment as follows. I have not been involved in any discussions with anybody on the House side nor have I been involved with any of the conferences that have occurred over here.

As I have gone around and talked to military physicians and I have not been in the office long enough to have the experience of the Surgeons General, but I have visited close to 40-some bases at this point in time and at every one I have talked to physicians.

What I have heard in terms of pay is, No. 1, the instability, not knowing from year to year. That is always, in every conversation I have been involved in, that has been the most significant thing and all of the proposals before you correct that.

The second thing I have heard in regard to pay has been from the obligated physicians who are very sore that they are not receiving special pay during their period of obligation. They have been very vocal in that regard.

It has been rare when someone or any group has said that they feel that they ought to get a dramatic across-the-board pay raise. I am certain that they would like it. I would like it, we all would, but at least in terms of my conversations with them, once you get by the instability, once you get by the fact that the obligated physicians are not getting any special pay, usually then the conversation goes on to their unhappiness in regard to lack of clerical support, lack of technical support, difficulty in getting equipment and so forth.

It is for that reason that I think that, as I said, the one I would support is the administration bill. Any of the bills that correct those two things, and they all do, would be a major step in the right direction.

Senator NUNN. Thank you.

I would like to ask each of you a question about where we will go if one of these bills does pass.

I understand what you are saying, General Myers. You are saying that unless we pass this legislation, the present situation, which is already bad, regarding medical care will get worse. Is that what you are saying?

General MYERS. Yes, sir.

Senator NUNN. Are you saying, on the other hand, if we did pass this, the present situation, which is bad, will get better, or are you saying it will remain approximately the same, where are you saying we are going to be if we pass this a year from now compared to where we are now?

I am talking about the Air Force.

General MYERS. I speak for the Air Force only, Mr. Chairman.

Based on the talks that I have had with thousands of Air Force physicians, hundreds rather—we only have a little over 3,000—pay is of concern now—I reemphasize that.

Obviously, I cannot make some kind of very accurate prediction about retainability if something does or does not happen, but I know the mindset of those individuals now, and that mindset is now.

I think that there are certain forces at work in the civilian world that will work to our betterment as the months and years go by. The military will be more attractive as a result. My concern is magnified over and over again when I think of the readiness requirement, and the slow but substantial increase in the number of eligible beneficiaries. We must acknowledge that with an increased number of providers, we can get excellent health care during peacetime and war at a cost which is less than one would be able to get through some other means.

All of that is driving this.

Senator NUNN. I understand that, but I am asking very simply in your best judgment, if we passed one of these bills this year promptly, are we going to be better off next year in the Air Force with regard to doctors than we are now, are we going to be approximately the same, or are we going to continue to see a gradual deterioration?

General MYERS. I strongly believe, sir, we will be better off.

Senator NUNN. Thank you.

General Pixley, you and I have conversed on this subject several times now. I have a lot of respect for your opinion.

In 1978, I asked you before this subcommittee if you felt that we, at some point, were going to require compulsory service for medical personnel and you replied, and I quote you, "I would say that the signal that we are really in greater trouble than we are today would be the inability to provide military physician specialists for the military medical facilities in Europe and other overseas areas. We are not there at the present time. My view is optimistic."

In March of this year I asked you again if you have any form or could prescribe what was needed in terms of compulsory service. What would you do just for the physician problem, and you replied, and I quote again, "As a minimum, drafting into the Individual Ready Reserve."

I went on to say how that would work with doctors, what would they have to do, how long would they serve, and what would be the obligations in the Reserve? You said, again I quote you from the record, "I think I would have to supply for the record the precise number of years that would have to conform with the time required in the Individual Ready Reserve. It would have a positive impact in terms of motivation."

That was in March of this year.

My question now is, how do we stand at this point in time and will any one of the four we have outlined, make the situation better in regard to the Army than it is now, or are we just preventing the situation from deteriorating further?

General PIXLEY. I think it will make the Army better—the Active Army, not the Reserve components.

This bill is not going to have much of an impact on them. Remember that two-thirds of the total medical units in the Army are in the Reserve components, the Guard, and the U.S. Army Reserve, 40 percent of which have an early deployability.

Senator NUNN. The two-thirds in the Reserves have only one-third of what their requirements are, is that not right?

General PIXLEY. Yes, one-third.

Senator NUNN. A 60- to 70-percent shortfall in doctors in the Reserve.

General PIXLEY. A serious shortfall of physicians.

Senator NUNN. None of these bills address that problem?

General PIXLEY. No, sir.

Senator NUNN. None of these bills address two-thirds of the Army's overall physicians and mobilization?

General PIXLEY. That is correct.

Senator NUNN. All right.

Could I ask you again what you think about the route that we are going? Are we going down a road that has an optimistic kind of outlook, or are we going to have to take some other steps, including compulsion? Do you believe, as you did in March of this year, that compulsion in the medical area is going to be necessary?

General PIXLEY. I will have to address my personal opinion.

Senator NUNN. Yes, sir. I am asking for a personal opinion.

General PIXLEY. I will preface it by stating the position of the Department of Defense is not for draft, or even registration at this time. However, my testimony last spring was in consonance with the then Chief of Staff of the Army, General Rogers, who gave his personal opinion that a draft and registration, he would support that.

It is my personal opinion that this would be very helpful if we had first, registration and then, No. 2, classification, and then third, depending on what happened after that in terms of increased numbers of health professionals, specifically physicians who would sign up in the Reserve components, if that did not seem to help the Reserve components, then as a personal opinion, I believe the issue should seriously be addressed with reference to a certain number of years obligation to health professionals out of medical schools, dental schools, other schools, to the IRR.

Senator NUNN. Thank you. Secretary Alexander suggested earlier this year that civilian medical students who received substantial Federal aid for their education should assume some compulsory—I assume he said Reserve obligation.

Presumably, they would be placed in the Individual Ready Reserves. Their civilian medical practice would provide sufficient medical training, meaning they could be called in event of a mobilization.

Would you support that kind of proposal in your personal opinion?

General PIXLEY. In my personal opinion, yes, sir.

Senator NUNN. General Myers, let me ask you the question. Do you believe that we are going to approach a point where compulsion is necessary? I ask you first in your personal view as to the Air Force and then I am sure you have a view of all the other services, as to the other services.

General MYERS. Mr. Chairman, at the moment I am happy to report to you, sir, in the committee, that our Reserve strength is about 99 percent for physicians. We have actively recruited and done very well.

So that is not as much of a problem in the Air Force as it may be in our sister services.

Senator NUNN. As far as the Air Force is concerned, you see no need to return to any form of compulsion regarding doctors.

General MYERS. No, sir. I would support the position of our Chief of Staff, which was for registration.

Senator NUNN. All right, sir.

Admiral Arentzen, what is your view on those two questions, your personal view?

Admiral ARENTZEN. As far as the Reserves go——

Senator NUNN. Let me ask you the question again.

Are we going to be better off in the Navy with doctors a year from now than we are now by reason of passing one of these bills, are we fighting a battle to keep it from getting worse, or are we on a road that may lead to its getting better?

Admiral ARENTZEN. The key to our survivability is getting better, Mr. Chairman, and that means retention of our people. There are other sources of physicians with the scholarship program recruitment and the medical school out here in Bethesda, but the key to the whole thing is retention.

I think that if we get this pay bill passed, that it answers the three things that I mentioned in my statement. I think that we will be far better off next year.

Senator NUNN. Than we are now?

Admiral ARENTZEN. Yes, sir.

Senator NUNN. In the active forces?

Admiral ARENTZEN. Yes, sir.

Senator NUNN. What percentage of your doctors are in the Reserve? Nothing like the Army, are they?

Admiral ARENTZEN. Fifty-eight percent. That is all, sir.

Senator NUNN. Fifty-eight percent of your doctors?

Admiral ARENTZEN. No; I was thinking of the Inactive Reserve. You mean——

Senator NUNN. What percent of your doctors are in Reserve forces of one type or the other?

Admiral ARENTZEN. Thirteen percent.

Senator NUNN. Eighty-seven percent of your doctors are in the active force.

Admiral ARENTZEN. Yes.

Senator NUNN. General Myers, how many of your doctors are in the Reserves and Air Guard compared to the active force?

General MYERS. I have some numbers here, but I would want to review this before giving it to you, sir.

Senator NUNN. Do you have any idea? Are we talking about 10 percent? The Army has 66 percent of their doctors, the Navy has 10 percent. We have a bill here that does not address the Reserves. Two-thirds of the Army's problem is not even addressed here; 90 percent of the Navy problem is addressed and generally speaking—are you closer to the Army or the Navy?

General MYERS. 10,780 medical officers in the Reserve Forces and Guard.

In our Active Force authorization, about 3,400 to 3,500.

Senator NUNN. You have a large percentage of your doctors in the Guard and Reserve, then?

General MYERS. Yes, sir.

Senator NUNN. In the Air Force?

General MYERS. Yes, sir.

Senator NUNN. You are saying you have no real problem there. They do not need any additional pay now?

General MYERS. At this moment, things look very favorable, sir.

Senator NUNN. General, what is the great difference in the Army and in the Air Force in regard to Reserves? How is the Air Force able to have so many more percentagewise in their Guard and Reserve units than the Army?

Have you looked at that?

General PIXLEY. Yes, sir. We have looked at it and we have an intensive recruitment program. It has been given a tremendous amount of attention.

The track records show traditionally over the decades the motivating factor for health professionals to joint Army Reserve units is the draft. When that draft is taken off for a few years here and there, then it goes down.

Senator NUNN. Your medical personnel in the Reserves have always been heavily influenced by either the draft or the absence thereof.

General PIXLEY. Yes, sir.

Senator NUNN. General Pixley, what would happen in general terms, in your opinion, if we had a war today as far as medical care in the Army?

General PIXLEY. You are talking about a NATO-Warsaw Pact?

Senator NUNN. Let's say you had a 30-day conventional war in NATO, the Warsaw Pact.

General PIXLEY. Well——

Senator NUNN. I will not ask you for classified information. Just your general view.

General PIXLEY. I can make these comments.

First of all, the question is directed, are there enough physicians in the Active Army today for a short NATO-Warsaw Pact conflict, the answer would be yes, providing you would totally strip the continental United States base and even divert physicians who are with military units in the Far East, Alaska, and Panama.

Even if there were sufficient numbers for the first few hours of the first few battles, there is a terrible imbalance today for certain specialties. We have 40 percent of our requirements for orthopedic surgeons, neurosurgeons, general surgeons, neurology, and some of the other hard core surgical specialty skills.

Senator NUNN. That is precisely what is needed in a war, is it not?

General PIXLEY. Yes, sir.

I do not know how much further you want me to go. I think that tells a lot, what I just said.

Senator NUNN. In other words, you are in pretty bad shape.

General PIXLEY. We are certainly in bad shape regarding some of the specialty skills. We are in bad shape in terms of total numbers, in terms of that which has been authorized by the Secretary of Defense in the years 1981 to 1985.

We should be at, during peacetime, 5,200 physicians. We have today between 4,200 and 4,400 about a 17-percent shortage, just numberwise.

Senator NUNN. Active duty?

General PIXLEY. Yes, sir.

Senator NUNN. What is your shortage in the Reserves?

General PIXLEY. All right, sir. I can give you that specifically.

Specifically in the U.S. Army Reserve we are authorized 3,372 physicians with 885 assigned, for a 2,487 shortfall. In the Individual Ready Reserve, there are only about 757.

In the Guard, there is an authorization for 1,234 and we have assigned today 529. In essence, 50 percent of the requirements for the Guard are onboard today and between a fourth and a third of the requirements for the USAR.

Senator NUNN. You are saying none of these bills even address that problem at all in the Reserves and Guard?

General PIXLEY. No, sir.

Senator NUNN. What is the administration's response, Dr. Moxley?

We have two-thirds of the Army doctors in the Reserves. None of the legislation we have before us addresses that problem. The Army could not provide medical care for a war in Europe, which is what our entire planning force is based on.

What is the administration's position on this? You have been studying it for 3 years now. I have asked that question of your predecessors and others. Is there a plan for dealing with it in this administration?

Dr. MOXLEY. Yes.

Let me give you an answer. In my judgment, having now been in the DOD for 3 months, the most critical issue we face is the readiness issue. The first step I have taken as an individual is to view it at first hand, and I have done that.

The four of us at this table have discussed this matter on a couple of occasions and what I am going to do as a next step is bring together all of the key players to a conference in January with the following hope, Mr. Chairman, of getting a benchmark of, in fact, where we stand, not only in terms of reserves, but the readiness issue across the board and coming out of that with a series of steps that can be taken either in the Departments or in my office to bring the total readiness shortfalls—and they are significant—to the various service commands and to the Secretary within a period of months thereafter.

It is a serious problem. I do not have, off the top of my head, any immediate solutions, but certainly solutions have just got to be found. It is serious. No question about it.

Senator NUNN. Do you think Secretary Alexander's suggestion that civilian medical students who received substantial Federal aid for education should have some Reserve obligation? Would you think that that is something that should be considered seriously?

Dr. MOXLEY. It has been considered in some regard, Mr. Chairman, already. As a matter of fact, there have been discussions between DOD and HEW in regard to whether or not the HEW scholarship students who have a very similar scholarship to ours should not have some Reserve training and Reserve commitment in light of having the scholarships, since they do not have the military obligation afterwards.

I am told that these discussions did not meet with opposition from HEW but they have not been active for the last couple of months, in part because of my coming on and trying to get the pieces together. We can certainly pursue those. They have been undertaken in the past.

That clearly defines a group who are getting a significant Federal subsidy.

My problem now, with going further than that, having just come from a medical school, is in fact that all medical students get a subsidy because I think it is safe to say that no medical school in the United States could operate for very long without the moneys that come to them from the Federal Government, both in terms of educational support and in terms of research support and clearly in terms of the Federal portion of the payment for patients who are treated in university hospitals.

So that the thing that I would want to give some thought to is where do you draw the line, if you draw the line, or if you are going to do it, you just say, all medical students are receiving Federal subsidy, therefore, all medical students should do it?

I personally, at this moment in time am not prepared to immediately say I would like to go that route. I am not convinced that with a paybill and with some follow-on improvements in the professional environment that we cannot come out of this situation over the next 2 or 3 years in a much better position than we are now, one that would approach an acceptable level both of peacetime care and readiness. That may be initial naivete but I am not willing to throw in the sponge yet.

Senator NUNN. That is the advantage of turnover, having a new person who comes in, studies it for awhile, talks about it for awhile, realizes in horror how bad it is, tries a new initiative and then moves on to other fields. Then we go back through the same cycle.

I am just hoping that our would-be adversaries will be patient with us and make sure we have no war until we are prepared.

Senator Jepsen?

Senator JEPSEN. Out of curiosity, with the shortage that we have in the ground pounders, and the Air Force, are there any coordinated plans or thoughts of examinations of, in the event of an emergency, of sharing, or pooling medical facilities, people and personnel for the services?

General MYERS. The answer to that is yes, there are plans here to share services. As a matter of fact, on Friday of this week I will be going with a Navy colleague to the Western Pacific to look at that very thing. There is much sharing of service and much planning that is going on for even an increasing sharing of those facilities.

Senator JEPSEN. That is the Air Force-Navy combined?

General MYERS. In that part of the world. The Army is also involved, and we will be looking at the Army capability in the Western Pacific with General Pixley's full awareness and knowledge.

Senator JEPSEN. General Myers, I made a statement earlier based on some information, that had been presented. I wanted to make sure that if it is not correct, I do not want it to be left in the record that way.

When I said that the Air Force had met only 47 percent of its recruiting total this year, is that inaccurate?

General MYERS. No, sir, that is correct. 47 percent of its recruiting effort for physicians.

Senator JEPSEN. Yes. Yet you say that you have practically a full complement of physicians, so that 47 percent was enough to keep you?

I am confused.

General MYERS. May I review that?

I did submit a number in error. I said that our Reserve Guard fill was 99 percent. That is an error. It is 96.8 percent.

Of the numbers of active duty people we have authorized, we are short 226. The number of the high fill rate I gave you was in the Guard and Reserve, 96.8.

Senator NUNN. If the Senator would yield on that point for a minute, we must have some bad numbers here somewhere.

The Defense Resources Management Study shows that we can meet only 15 percent of the Air Force's stated requirement for general surgeons and 9 percent of the stated orthopedic surgeon requirement.

When you are talking about 96 percent in the Guard and Reserve, how can you not emphasize this point if it is accurate? Maybe it is not accurate.

General MYERS. Yes, sir.

Even though the numbers are filled, we are still shy on some of the proper distribution of specialists, which is also the reflection of the active duty force where we have such a high shortage of orthopedic surgeons, gynecologists, and so on.

Senator NUNN. What do you need in a war?

General MYERS. We need the surgical type, and part of our readiness planning is to use some of these other folks in a wartime role. The oral surgeon, for example, traditionally not necessarily a player, will be doing facial surgery. The pediatrician will be involved in taking care of that kind of medical problem that will be indigent to the part of the world we are in, the infectious disease problem.

Senator NUNN. Are you saying that you do not have a major problem, or you do?

General MYERS. No, sir. We do. We do have.

The only number, the good rate I gave you, was simply the fill, the number of authorized versus the size in the Guard and Reserve.

It does not necessarily follow that that is the right distribution of specialists.

Senator NUNN. Thank you.

Senator JEPSEN. Have you presented what could be considered to be a perfect solution for this to any committee or any individual in the legislative branch, a perfect solution or recommendation?

General MYERS. I am having a little trouble with the breadth of the question, sir.

Senator JEPSEN. With the semantics? With what it means?

I have found in my private business life that you try to arrive at what the perfect solution and answer would be, forgetting about where it comes from, whether there is money available or people available, just what the perfect solution would be.

Have you presented that? You must have some ideas of ideally in all of the services what ideally would bring your doctors up to strength, your specialists, your surgeons, your orthopedic surgeons, up to the ideal strength.

What do we need to make this thing perfect, if we are talking about national security and talking about a functional thing with the luxury of the times that we had when we had other emergencies in 1939 and 1941 and so on.

Why should we not get at and about the business of doing whatever is needed to be done to bring this to where it is supposed to be?

If we are to do that, then the perfect solution or recommendation, at least, to get us into that position should come from you. Have you ever presented that, or do you have that on a master chart?

General MYERS. In a piecemeal fashion, yes, sir, we do know what those requirements are that would be ideal. We have looked at that very, very carefully.

Senator JEPSEN. The requirements, how about the method of meeting those requirements?

General MYERS. We have tried to develop a methodology and go through our own services to get the necessary dollars for construction, for example, to work on the manpower authorizations for support personnel and bring those into a more realistic view to address the timely accumulation of modern equipment, to make our medical facilities far more productive.

Senator JEPSEN. Let me stop right there for a perspective of my own. Are there some doctors who may be specialists who have gotten discouraged because they really do not have the equipment they need to work with?

I have heard this.

General MYERS. Yes, sir. Some of that is very true. Some of it is exaggerated, but I think there is plenty of evidence to show there is a problem there.

Senator JEPSEN. Money is not the only thing, but there are a number of things.

General MYERS. Many things, but if one puts it in numerical order, in my perception, money is No. 1 at the moment.

Senator JEPSEN. Whatever is in second place is a little ways behind?

General MYERS. Yes, sir.

Senator JEPSEN. I see.

Senator NUNN. Senator Exon?

Senator EXON. I want to thank you again for calling this meeting. I am hopeful we can have a meeting of the subcommittee within a matter of hours or days, certainly. We have roughly 2 weeks before our scheduled adjournment.

It seems to me as though we could get this marked up and moved to markup in the full committee, it would be a step in the right direction, because there seems to be unanimous support here for doing something in this area.

I thank you again for calling this meeting.

One last question, gentlemen.

I am getting increasing questions from my constituents with regard to Agent Orange, and I guess you must have been looking into that as a result of the Vietnam conflict.

What can you tell us about that? How serious do you think it is, and what efforts are being made to correct the potentially serious situations that have arisen?

How long do you think, as professionals, it is going to be before we get a true handle on the facts of what appears to be a rather disturbing situation?

Dr. MOXLEY. I can give you a very general answer, Senator, that the primary DOD focus for looking at the question of Agent Orange has resided in two other parts of the Secretariat. One is the manpower area, one is the research and engineering portion, that they are working with representatives from the VA and HEW to try to answer the very questions that you are raising.

To the best of my knowledge, those answers are not available, and one of those studies that is in the development stage to look at what the results, what the effects might be, is to study the group called the Ranch Hand group which were, in fact, involved in the distribution of Agent Orange during the Vietnam conflict.

That study up until very recently was going to be carried out by the Air Force. The question has now been raised by Senator Cranston that since some of the reporting that DOD has done on this has not been as correct as he would like it that perhaps that study should not be done by the Air Force but should be done by the Department of Health, Education, and Welfare.

That is the end of the train as far as I know it, at this point in time. I suspect the study will be done. The protocol for the study has been submitted to a number of outside groups for criticism so that it will be a good, solid protocol.

Hopefully, it will begin to answer some of the questions for at least those people who are known to have been heavily exposed.

When that will lead to an answer of what effect are the varying levels of exposure to Agent Orange is, I would not be able to project, sir.

Senator EXON. Does the admiral, or any of the other generals, have anything to add to that?

General MYERS. The Air Force has been deeply committed to this, because the Air Force stepped forward some months ago to

come up with a Ranch Hand study. These were the individuals who operated the aircraft, loaded them and actually did the spraying.

The protocol that was developed by the Epidemiology Division of the Aerospace Medical Division at Brooks Air Force Base, as Dr. Moxley has described, was subjected to scientific review by three very prestigious bodies. The Armed Forces Epidemiology Board, the Air Force Scientific Advisory Group, and the University of Texas Medical School at Houston. The reason was, we wanted to insure that that study protocol left no doors open, that the Air Force, being the responsible agent, was doing this scientific study with the input from the best scientific minds in this country.

There still is some review to be done on that protocol. That review has not been as fast as we would have liked, necessarily. We cannot drive those units as rapidly as we wish.

We now have some expertise to detect the culprit, dioxin, the agent which is part of the production process which is the bad actor in all of this.

We can detect it in parts per trillion now, in the air and in water. It is difficult to say what the standard is or what the levels of exposure were.

Animal evidence showed damage, both carcinogenic and teratogenic but the human evidence is still lacking and there has been some very, very heavy infestations of this material in human beings.

As yet there is no firm evidence, and I think my colleagues will substantiate this, that there has been anything to the serious degree that has been alleged in the lay press.

Senator EXON. It is fair to say you do not know the answer, but you all feel we are doing everything we can under the present circumstances to seek the answers?

Is that a fair capsule of your testimony?

General MYERS. Yes, sir.

Senator EXON. Thank you, Mr. Chairman.

Thank you, gentlemen.

Senator NUNN. Thank you, Senator Exon.

I have gotten a lot of inquiries on that, too, and I am delighted you brought it up for our information.

Dr. Moxley, what is the position of the Department of Defense concerning increased special pay for health professionals other than physicians?

Dr. MOXLEY. The Department's position, sir, is that we do have some problems in those areas but that they are not of the magnitude or as urgent as those that we have with physicians, that we believe that we can take some more time to look at it and analyze it more quickly and come forward with a separate proposal to deal with it.

There are some changes that are now underway. For instance, in January 1980, optometrists and podiatrists will enter the services at the O-3 level as opposed to the O-2 level. There have been some changes in the continuation pay for dentists.

We think that these will go part of the way toward correcting the problems and that we can follow on, if necessary, with additional recommendations.

Senator NUNN. The Department of Defense does not have anything in their proposal regarding additional pay for dentists, optometrists, veterinarians, podiatrists, and others?

Dr. MOXLEY. That is correct.

Senator NUNN. Does the Hart bill, the Thurmond bill, as well as the House bill provide parity for those professionals with physicians?

Dr. MOXLEY. They provide varying amounts, depending on years of service. I also believe there is some variation in the bills as to who gets it. I think they all contain a section for dentists and then optometrists, podiatrists are contained in the House bill.

And I think veterinarians and optometrists are in the Hart and Thurmond bills.

Senator NUNN. What is the current situation, if you took a physician's pay at a certain level and compared it to a dentist, compared that to an optometrist, compared that to a veterinarian, and compared that to a podiatrist?

Can you furnish that for the record?

Dr. MOXLEY. Yes, sir.

[The information follows:]

MILITARY MEDICAL PROGRAMS AND PROPOSED REVISIONS OF MILITARY MEDICAL PAY

Comparison of health professional pays at the fifth year of service

Physician	$39,193
Dentist	33,486
Optometrist	25,588
Veterinarian	26,131
Podiatrist	24,088

Senator NUNN. Is there, at present, large disparity between those under current law?

Dr. MOXLEY. There is not, as I look at the figures quickly, a great disparity between physicians and dentists. I am certain there is a difference between physicians and optometrists and podiatrists, but I do not know the magnitude of the difference.

Senator NUNN. Does the Department oppose those provisions in the Hart bill, the Thurmond bill, and the House bill?

Dr. MOXLEY. Yes, sir.

Senator NUNN. Do you have a cost estimate of the Department of Defense's bill?

Dr. MOXLEY. No; not one that I am comfortable with, Mr. Chairman. Unless we have got something in the last 24 hours, we do not have a precise figure. I have been trying to get it, and I will be happy as soon as I get it submitted for the record. I do not have it right now.

Senator NUNN. Could you also get a cost estimate on the other bills to the best of your ability?

Dr. MOXLEY. Yes, sir.

The quickest estimate that we could get between the House bill and the administration bill is that there probably would be an expenditure difference of about $10 million per year, although again it is difficult to focus on it because there are some CHAM PUS trade-offs and so forth that have been calculated to the House

bill and it is clear to say that I think the Thurmond and Hart bill would be more expensive than either of the first two.

Again, I will get you the best figures I can as soon as I can for the record.

[The information follows:]

MILITARY MEDICAL PROGRAMS AND PROPOSED REVISIONS OF MILITARY MEDICAL PAY

Pay proposal cost estimates

	Dollars in millions
H.R. 4076	$37.9
H.R. 5235	[1] 50.9
S. 523	79.1
S. 1100	79.1

[1] Cost estimate prepared by the Congressional Budget Office.

Senator NUNN. Dr. Moxley, before you assumed your current position, you were head of a large medical program in the University of California system. Have you made any analysis of how doctors, whose primary responsibility was medical education, compared with military doctors?

Dr. MOXLEY. Yes.

I can say looking at the figures and, again, the figures vary somewhat in these four bills, but not dramatically, that if you are an O–6, a colonel with 22 years service, for the average academician, the salary that is now in the $62,000, $63,000 range would be a midlevel professor on the average medical school faculty. I think that is true also for the Washington area.

However, there are, reflecting part of the conversation this morning, there are great disparities within any individual faculty and the surgical subspecialists who can make a lot more on the outside are usually paying more than that. Pediatricians who cannot may be paid less than that.

If you look at average figures, I think the average figure of $62,000 in salary would be at the midprofessor level someplace.

Senator NUNN. Is it not almost inevitable, no matter what bill we pass, that as soon as the other professions fully absorb the fact that they have had the same or a similar amount of education yet they are not being paid as much as physicians, is it not inevitable that there will be pressures both from those in the service and similar professionals outside the service to provide parity, even independent of the question of shortages?

Dr. MOXLEY. Pressures, yes. There is no question that there are pressures throughout our society in Government and in civilian sectors by the other health professions to improve their position relative to everyone else, particularly physicians. That goes on on an almost daily basis.

Mr. Chairman, I am certain those pressures would be felt within the military, too.

Senator NUNN. Would you also furnish for the record your cost estimate of what it would cost to bring all the other professions with similar training up to the same pay as the physicians under the administration bill?

I have been here long enough to know how Congress operates. When we give one on the floor, you are going to have all the lawyers and the American Bar Association, you are going to have all the podiatrists, you are going to have all the veterinarians, you are going to have all those people saying how can you pay physicians more than you are paying our people? You are denigrating our profession, and so forth.

I have heard it all before, and we will hear it all again. I know what the inevitable is, and I would like that cost estimate also.

Dr. MOXLEY. Yes, sir. I will provide it for the record.

[The information follows:]

MILITARY MEDICAL PROGRAMS AND PROPOSED REVISIONS OF MILITARY MEDICAL PAY

There are no professionals with similar required training. If one were to calculate the costs associated with those health professionals already covered by one or more of the proposed bills (i.e. dentists, veterinarians, podiatrists, and optometrists), it would then cost an additional $31.8M.

Dr. MOXLEY. I think that the most comparable argument obviously would come from dentists who do have a full 4 years of professional training, as physicians do. Then the arguments would scale down from there, and we would do our best to provide you with that information.

Senator NUNN. On page 1 of your statement, Dr. Moxley, you project reduced shortages of military physicians over the next few years based on recruitment of at least 600 active duty volunteers each year.

How does this 600 recruitment projection compare with, let us say, the last 2 or 3 years?

Dr. MOXLEY. We did better than that, looking at all three services this past year, but I think that it is better than we have done except for this past year. I will have that in just a moment. So it is an optimistic figure, but it is not so optimistic to be unrealistic.

Appointed as of September 30, 1979, there is a total DOD wide of 727.

Senator NUNN. This last year was your best recruiting year?

Dr. MOXLEY. I believe that is correct, yes.

Once again, I am looking at these fairly quickly, but it appears now it was not our best year. Our best year goes back to 1976 when there were 842 and this fell off to 672 and for the past 2 years it has been in the 700's.

Senator NUNN. The projection you have for next year is below the actual record that you recruited this last year.

Dr. MOXLEY. Yes, sir.

Senator NUNN. General Myers, did you not mention the Air Force recruited 47 percent?

General MYERS. Our historical physician recruiting, Mr. Chairman, in fiscal year 1977, 71 percent; fiscal year 1978, 72 percent; fiscal year 1979, 48 percent. Down, down, down.

Dr. MOXLEY. The same figure. I have 47 percent for last year. However, the Navy was 70 percent, the Army had a particularly good year, and actually it was 110 percent of their goal.

Senator NUNN. General Pixley, how do you explain that successful year, which we are delighted with?

General PIXLEY. Since I assumed the role of Surgeon General of the Army on October 1, 1977, I have personally run that program, literally micromanaged it.

All of the counsellors out in the field report directly to me. I personally get involved, make speeches, and interview physicians. If we have a collection of 10 physicians anywhere, I will go, where possible, to recruit MD's, acquire MD's.

The purpose of the counsellors out there is to identify those who might be interested in coming in.

Over the past year, I have been trying to delegate more of this to some of my more senior physicians and some of the Army hospitals, but I would like to make a comment, Mr. Chairman, on the so-called recruitment off the street.

For the past 2 years, we have recruited each year 325. The previous year, that doubled the recruiting sweep in all the history of our recruiting since World War II.

But I would point out that one-third of that 325 came in because they offered graduate medical education. The other two-thirds were, by and large, older physicians who could provide us only ambulatory care skills. Older physicians, ambulatory care.

We are still not recruiting off the street any orthopedic surgeons, any neurologists, radiologists, or any of the other hard surgical skills.

Senator NUNN. Does Defense propose to reduce the graduate education program, Dr. Moxley?

Dr. MOXLEY. Yes.

There is a proposal. It is now at the level of a Secretary directive that has been developing, Mr. Chairman, over the past 2 or 3 years.

Up until a few years ago the average percent of total effort in graduate medical education for the three services has been in the range of 20 percent, give or take a few percent below 20 percent.

A few years ago, the Army's effort in that regard began to increase. I do not have the specific figures in front of me, but it has gotten up into the range of 30 to 35 percent.

This was studied and a decision was made that 20 percent was a reasonable figure and that the training program should be constrained to that 20-percent level, not restrained quickly, but kept at the 20-percent level.

I have gotten a lot of mail, a lot of phone calls and a lot of conversations about what is going on in graduate medical education to the point, sir, that I am convinced that it is very difficult, if not impossible, to discuss it rationally within the Pentagon or DOD.

I do not have any particular answer. I do not know if 20 percent is correct. I do not know if 25 percent is right. I do not know if 10 percent is right.

What I propose to do, and we are in the process of doing, is asking the Institute on Medicine of the National Academy of Sciences to help us look at this issue and give us their best recommendations on what would be best for the Armed Forces over the next several years.

We hope to have that answer by next summer.

Since the 20-percent cap, as it has been called, which affects the Navy a little bit, the Air Force not at all, and the Army is most affected, does not go into effect until 1985. This will still provide us with some time to make corrections, if corrections are needed.

Senator NUNN. General Pixley, how many of the 600 are projected to be Army under the recruitment plan for the next year?

General PIXLEY. How many what, sir?

Senator NUNN. We are talking about 600 active duty volunteers as what was projected under DOD's plan.

General PIXLEY. Department of Defense?

Senator NUNN. Right.

How much of that 600 was Army?

General PIXLEY. Again, we are projecting trying to recruit off the street 300 to 325.

Senator NUNN. Are you optimistic about being able to do that?

General PIXLEY. I am a little nervous about it. We have not done well since the 1st of October as compared to last year and I think one of the reasons is that we have to live with this 20-percent cap on graduate medical education. We cannot put as many in training now.

While it is true that the 20 percent takes effect in 1985, you see, the Office of Secretary of Defense specifically spelled out figures year by year starting in fiscal year 1981, we will still have to reduce.

Therefore, I would anticipate we will not reach that 325 figure.

About 120 this past year came in because we offered them graduate medical education. For that, they owe us time.

Senator NUNN. Dr. Moxley, what is the reason for decreasing this graduate education program? Aren't the graduates in residency there available for medical care and certainly available for emergencies?

Dr. MOXLEY. As I am certain you are aware, Mr. Chairman, there is a great debate not only within the military but in the civilian sector as to exactly what is a resident and what role do they play?

By and large, the residents view themselves as labor to the point where they are as actively as they possibly can petitioning for the right to form a national labor union and deal with themselves in that regard. This has been supported, in fact, by the American Medical Association and by many of their component medical societies in the States.

The university's position has been that they are receiving an education. They are not complete physicians and therefore they can only practice medicine under supervision.

So I think the question becomes, how much of the service's efforts should be put into supervising graduate medical education people, interns and residents, as opposed to the total mission of the medical departments, which is, as you have heard, to providing peacetime health care to the active duty and dependents and obviously, in wartime, to be ready.

That is the issue in terms of force structure and what you want to accomplish. What is the optimum amount of effort to put in that regard.

Up until 1975 and 1976 all of the services supported the 20-percent level and since then, the Army has been going up. I think the question is, is this the right way to go, and that is what is under review at the present time.

Senator JEPSEN. Are the terms "graduate work" and "specialization", synonymous?

Dr. MOXLEY. Yes, sir. Graduate medical education is a term that came into being about 5 or 6 years ago. It refers to those people who are residents.

What we referred to in the past as interns and residents.

Senator JEPSEN. That program, if you continued it, and increased it, would be a step toward resolving some of the problems you have in filling the things that are difficult to fill.

You have difficulties filling your specialists, your radiologists, neurologists, this type of thing.

Dr. MOXLEY. There are two ways that graduate medical education may be provided by the services. One, in DOD facilities, as DOD residency programs. The other is to defer, for instance, the health scholarship student while they obtain their specialty training in a civilian hospital and then they come in and provide and serve their obligation.

In either sense, they enter as board-qualified physicians. The questions that go beyond that are, what is the retention rate of someone who has been trained in a civilian hospital and then has to have an obligation to the service as opposed to someone who has been in the service all the time?

That becomes a very difficult question to deal with, particularly retrospectively, because it is only natural that those who have been in the service all the time, No. 1, know the system and are known by the system and liable to be treated in a different way.

It is very difficult then to really compare populations in a totally unbiased way to get a precise answer. I suspect, therefore, that we are going to have to go on the basis of collective judgment, and what I am trying to do is to bring the best collective judgment I am aware of to bear on the issue.

Senator Jepsen. Thank you.

Senator NUNN. Dr. Moxley, just one other question. For the record, if you could furnish it—I do not expect you to have this with you—what would be the difference between the earnings by a civilian physician compared to his military counterpart?

Let us take the increments of 5 years, 10 years, 15 years, 20 years out of medical school, if the Department of Defense proposal passes? I am speaking of averages here.

Also, if you could furnish that for the record the other three proposals.

Dr. MOXLEY. Yes, I can.

I can give the answer right now. I am certain in the private practice of medicine at almost all levels beyond internship and residency where I think we are in a favorable pay position, the earnings capability on the outside is clearly above that which it is in the service or in any other organization in medical education or in the large group practices in the country.

Two, the question is the degree. It is probably more than the administration's proposal, a little more than in the House and less even for the Hart and Thurmond proposals.

We will do our best to provide you with specific information.

[The information follows:]

MILITARY MEDICAL PROGRAMS AND PROPOSED REVISIONS OF MILITARY MEDICAL PAY

COMPARISON OF CIVILIAN PHYSICIAN

[Earnings with four current physician pay proposals]

Years beyond medical school	Civilian	H.R. 4076	H.R. 5235	S. 523	S. 1100
5	51,120	39,564	46,714	44,514	44,514
10	70,290	48,675	52,723	53,097	53,097
15	72,420	54,628	58,781	59,881	59,881
20	74,550	62,739	64,939	67,139	67,139

Senator NUNN. Thank you.

Let me just say that we are pleased that you are onboard at the Department of Defense. I think this is an extremely important job you have. I do not know of any area in the military that has a more serious deficiency than in the overall medical area.

We have been concerned in this subcommittee for some time about it. We have not had an awful lot of initiative from the administration. Now, the administration, I think, is taking some initiative. In fact, I think your job was vacant for what, 3 years, something like that.

Dr. MOXLEY. Not quite. It was vacant for 18 months.

Senator NUNN. Eighteen months.

Dr. MOXLEY. Yes, sir.

Senator NUNN. Who was your predecessor?

Dr. MOXLEY. Dr. Robert Smith, who is and was before he came to the office, an anesthesiologist from Ohio.

Senator NUNN. I am pleased you are there. I will look forward to working with you.

I want to thank all the Surgeons General for coming today. It would be my intention to have a markup at a very early date, some time in the next 3 or 4 days with the subcommittee and try to get some bill to the full committee level as soon as possible.

At that stage, I will do everything possible to see that the full committee meets on the bill and comes up with some version, hopefully before we adjourn.

Of course, as we already have talked about, it depends on what version we have and how close it is to the House version as to the length of time it will take to get some bill.

What is the last kind of deadline that you have? You said late winter. If we got a bill passed some time in January, early February, would that meet the needs of the decisionmaking process?

Dr. MOXLEY. It is a difficult question to answer, Mr. Chairman. Perhaps it should not be, but it is. I can only underline what everybody else has said, particularly General Myers.

As I have talked to people, to physicians in the field, there is a great sense of urgency that something be done to provide the

stability and to correct the difference between obligated and nonobligated being the most important things that I have heard.

I think that this has gnawed on people, the question of each year what is going to happen, to the point that I cannot give you a specific deadline except to say, as soon as is humanly possible would clearly give us the best leg up.

I suspect decisions are being made on a daily basis because plans have to be made. If somebody is going to leave the service and go into practice, one has to have a practice setting, one has to make arrangements as to how they are going to enter practice, whether they are going to have partnerships so forth and so on.

Certainly it takes many months for those arrangements to be made. It is very important that as soon as you possibly can, with all the other pressures and constraints you have upon you, that you do move forward.

Senator NUNN. I thank all of you for appearing, Dr. Moxley, General Myers, General Pixley, and Admiral Arentzen. We appreciate your being here. We look forward to moving this legislation in some form, as soon as possible.

We would like to get the answers to the questions we have asked for on the record as soon as possible, hopefully no later than the latter part of this week.

We will move as quickly as we possibly can. We will also include in the record statements by the Reserve Officers Association of the United States and the American Optometric Association and a letter from the Fleet Reserve Association.

[Statements and letter follow:]

PREPARED STATEMENT OF RESERVE OFFICERS ASSOCIATION OF THE UNITED STATES PRESENTED BY MAJ. GEN. J. MILNOR ROBERTS, AUS RET., EXECUTIVE DIRECTOR; AND COL. ADOLPH H. HUMPHREYS, AUS RET., DIRECTOR RETIREMENT AFFAIRS

Mr. Chairman and members of the committee, the Reserve Officers Association of the United States appreciates this opportunity to present our views in support of legislation to provide Special Pay to Military Health Care Professionals.

The several bills, S. 1100 (Senator Thurmond), S. 523 (Senator Hart), and H.R. 5235 (Congressman Nichols), contain the elements we believe are necessary to encourage Health Care Professionals to remain in the Active Services and to make military medical careers more inviting. We commend the gentlemen and the cosponsors of the bills for their initiative and originality in drafting these bills in support of an urgent military need.

We are concerned about the state of Military Medicine presented in testimony before your Committee by the Surgeons General, and before the Subcommittee on Compensation of the House Committee on Armed Services by Mr. Vernon McKenzie, Acting Assistant Secretary of Defense (Health Affairs) and the Surgeons General; and also the findings in the Defense Resources Management Study Final Report, by Donald Rice, February 1979, and the GAO Report to Congress entitled, Military Medicine Is in Trouble, Complete Reassessment Needed, HRD 79-107 dated 16 Aug. 1979.

Both the testimony and the reports reinforce our belief that the shortage of Health Professionals is the most important element in the Military Health Care Program and needs immediate attention. Of the several issues involved in retaining physicians, there are two issues which seem to be foremost. They are pay and graduate education. Pay, as we view it, deals with how well the doctors are compensated for their service in comparison to their civilian counterparts. Graduate medical education influences the physicians' professional standing and assures quality modern medical care for our men and women in the Armed Forces. Neither of these two issues can be slighted in consideration of incentives designed to maintain highly professional medical care and retention of physicians.

The most immediate need is to compensate the physicians at a level more comparable to their counterparts in private practice. The bills before you are well struc-

tured to compensate the various levels of scientific competence and professional development.

All of the Uniformed Services are faced with the possibility of losing a significant number of their physicians who become eligible to leave the service next year. The AF anticipates that approximately 994 (or 41%) of their physicians are eligible to leave the service next year. The Army anticipates a similar percentage of physicians eligible for discharge. In a survey of military physicians conducted by the DoD in 1978, two-thirds of the respondents expressed dissatisfaction with military income as compared to civilian income expectation. Another pertinent point made in the report is that only 10 to 13 per cent of the 03-04 physicians indicated that they would stay in the service whereas 30 to 40 per cent of the 05-06 and above indicated they would stay.

H.R. 5235 provides a substantial incentive to the younger physicians spanning the period of greatest potential losses to the Services and at the same time provides respectable increases for Senior officers. Adoption of this bill we believe will help immeasurably in retaining a larger number of the physicians eligible for separation in 1980 and beyond. H.R. 5235 has a distinct advantage over the Senate bills in that it has already passed the House of Representatives under suspension of the rules, thus indicating the strong support of that body.

The Reserve Officers Association in recognition of the military medical problem passed a Resolution 79-19 at our National Convention entitled, Pay and Incentives for Active and Reserve Health Care Professionals, which establishes our position on this issue. We have attached a copy of the Resolution to our statement for your information. S. 523, S. 1100 and H.R. 5235 embody the major elements we seek in the Resolution. It is very important that legislation be passed this year to forestall losses of Health Professionals in the Active Services beginning in 1980. We urge the Committee to take expeditious action on this legislation to meet the pressing needs of our Active Army, Navy and Air Force Medical Services.

The Reserve Officers Association stands ready to assist you in any way we possibly can toward the accomplishment of this objective.

Resolution No. 79-19.

Reserve Officers Association of the United States

PAY AND INCENTIVES FOR ACTIVE AND RESERVE HEALTH CARE PROFESSIONALS

Whereas, the Military Health Services System is currently experiencing a difficult period, and the importance of medical support for military operations cannot be over emphasized, and

Whereas, recently completed exercises have revealed deficiencies in required resources to complete the medical mission and serious shortages in both active and reserve medical personnel, and

Whereas, there is a recognized urgent requirement for the Services to program resources at the basic level to enhance recruitment and retention of both the Active and Reserve Component Health Care Professionals, and many new, meaningful initiatives are being staffed and prepared for implementation, and

Whereas, Congressional and Department of Defense recognition of these needs and shortfalls is evidenced by hearings and testimony given by the Acting Assistant Secretary of Defense (HA) and the Surgeons General of the several Services before the Armed Services Committees of both the House and Senate, and proposed pay and incentives legislation for the Active Forces has been introduced for consideration, and

Whereas, it is an acknowledged fact that pay and other incentives will enhance recruitment and retention of Health Care Professionals, and

Whereas, the Reserve Officers Association of the United States heartily endorses the new pay and incentives proposals for recruiting and retention of the essential professional resources for the Active Forces, and strongly urge the amendment of these proposals to include pro-rata share participation for the Reserve Components Health Care Professionals; Now, therefore, be it

Resolved, That the Reserve Officers Association of the United States support the enactment of special pay and incentive legislation for Health Care Professionals including an appropriate share for Reserve Component Health Care Professionals.

Adopted by the National Convention, June 16, 1979.

Attest:

J. Milnor Roberts,
Major General, AUS (Retired), Executive Director.

Prepared Statement of the American Optometric Association

The American Optometric Association is the national federation of State optometric associations and societies representing over 23,000 practicing optometrists and students of optometry. The AOA is concerned with the practice of optometry wherever doctors of optometry deliver their professional services. This includes the private practice of optometry and those optometrists practicing in Federal, State, and local programs as well as those optometrists practicing in the Armed Services, the U.S. Public Health Service, the Veterans' Administration and many other programs for national health care now in planning or developmental stages.

Optometrists' Education

Presently there are 13 professional schools and colleges of optometry in the continental United States and two in Canada with an aggregate enrollment in excess of 3,800 students.

The student of optometry must have completed a minimum of two years undergraduate instruction in the basic sciences and humanities; however, over 75 percent have a baccalaureate degree while in excess of 85 percent have completed three or more years of undergraduate training. This undergraduate study compares favorably with medical and dental pre-professional educational requirements. Subsequent to this undergraduate study, a four year professional training program designed to study the function, pathology, psychology, physiology, biochemistry and bacteriology of the eye and visual system as well as many other related areas of the human anatomy amply prepares the student of optometry to deal with the identification, management and referral of conditions of the vision system. The requisite undergraduate study in addition to the four years of professional education leads to the degree of Doctor of Optometry (O.D.).

Optometric education requirements for degree and licensure equal or surpass requirements for most other related health professions and all related scientific fields.

Optometry: The Profession

The profession of optometry serves as a primary entry point into the health care system of this Nation.

A Doctor of Optometry is a health care professional who is specifically educated and licensed in each State to examine, diagnose, and treat conditions of the vision system.

Through advanced technology and clinical training, optometrists may detect diabetes, hypertension, arteriosclerosis and other diseases of the body as well as primary ocular conditions such as glaucoma and cataract, which require referral to other health care practitioners for treatment.

I would now like to turn our attention to optometry in the military.

Military Optometry

As has been stated by the Acting Assistant Secretary of Defense for Health Affairs, the mission of the military health care system is to provide the health care necessary to support and maintain all military forces in fulfilling their missions, and to create and maintain high morale in the military by providing a comprehensive and high quality uniform program of health services for members and other eligible beneficiaries.

The Department of Defense has stated there are approximately nine million eligible beneficiaries in the DOD health care system. Serving these eligible beneficiaries are about 11,000 military physicians, about 5,000 military dentists, 10,000 military nurses and about 7,500 MSC officers of which almost 500 are military optometrists.

This, then, means there are less than 500 military optometrists attempting to provide eye/vision care services to over nine million eligible beneficiaries, or approximately one optometrist to 20,000 beneficiaries which is twice the population number recommended by the AOA.

It is interesting to note that after dental problems, eye/vision disorders comprise the second-most chronic health condition in the U.S. population.

In the case of the armed services, the present situation is that most eligible military beneficiaries must wait months before they may receive eye/vision care examinations. Military optometrists' patient books are usually filled months in advance, and usually the optometry officers must work on weekends just to keep the patient backlog down to a six to eight week waiting period. It is little wonder why the junior military optometrist is frustrated with the program; he is faced with long

hours and little assistance, inappropriate entrance grade and constructive credit and continuing uncertainty regarding special pay. These negative factors are largely responsible for the manpower shortfalls which optometry has historically shown in the military; shortfalls which are second only to those demonstrated by military physicians.

MILITARY OPTOMETRY AND SPECIAL PAY

Mr. Chairman, on different occasions and in different forums, the three Surgeons General have gone on record in support of bonus pay for optometrists; they so testified in 1977 and again more recently. From what I gather, they believe that special pay is a useful and productive management tool to recruit and retain scarce optometric manpower. The Department of Defense, from time to time, has agreed with this concept.

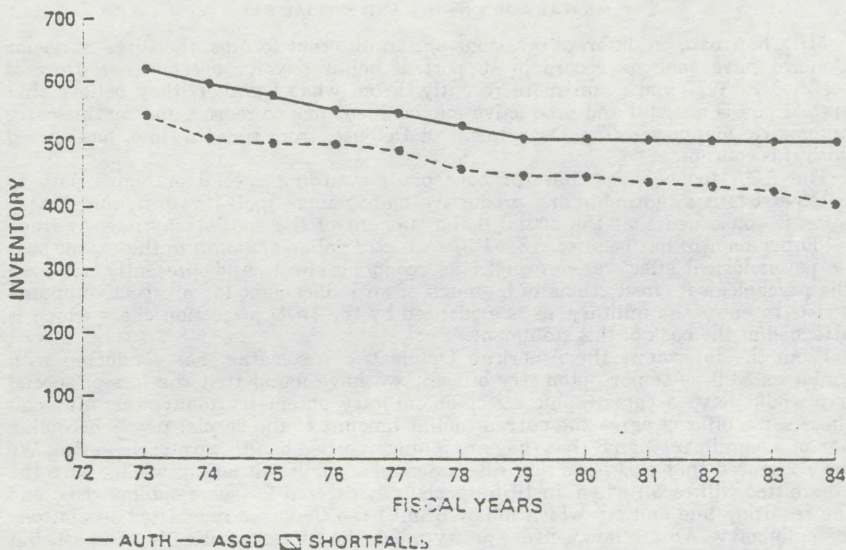
The AOA too believes that the concept of awarding special or bonus pays to optometrists is a ligitimate and productive management tool. However, this Association is concerned that the actual dollar amount of the special pay now awarded ($100 per month) has been so eroded in real 1979 dollar amounts to the extent that its psychological effect far outweighs its economic effect. And, presently not even the psychological effect seems to be much of an inducement for prospective optometrists to enter the military, as is evidenced by the DOD projection chart which is attached at the back of this statement.

From the interviews the American Optometric Association has conducted with junior as well as senior optometry officers, we have found that the loss of special pay would have a catastrophic effect on military optometry manpower, although these same officers agree the current dollar amount of the special pay is becoming less of a significant signal that they are a much needed health care professional. We are convinced that this is an accurate assessment of the situation; we are sure the Committee will recall when, in 1975, special pay expired for some optometrists, and the resulting hue and cry which followed until the Congress re-enacted special pay for optometry. We are now getting pretty much the same signal as in the past, but now the feeling is that the magnitude of the bonus pay should be increased.

The Senate provisions as embodied within S. 523 and S. 1100 would provide increases in special pay for optometrists; increases which would recognize the necessity of retaining highly qualified optometry officers beyond the junior years of service. Howerver, the Senate provisions (S. 523 and S. 1100) do not, in our opinion adequately address the critical recruitment and retention problems faced by the armed services when attempting to commission optometry officers. For example, in the House Report to H.R. 5235, the House Armed Services Committee stated that, "Compared to the current system under which an optometry officer receives $1,200, the special pay system proposed by the committee would provide the greatest increases in the junior years where retention can be affected most significantly."

We concur with the House Armed Services Committee that it is necessary to build "front-end" incentives in an effort to retain officers at the junior level where retention has traditionally been the most difficult. Yet we don't feel the House passed bill properly addresses or has given adequate recognition for experience through increased clinical as well as administrative skills and expertise which accrue to the more senior optometry officers. For example, after the 5th year, H.R. 5235 would reduce the amount of special pay by 50 percent over a period of 11 years. We are concerned with the philosophy of awarding reduced pay to those more senior officers who bear increased clinical and administrative responsibilities. We are convinced that such a pay reduction will be perceived by career officers as a disincentive to further their services career. Furthermore, one half of the special pay ($1,000 of $2,000 after 16 years service) is in the form of an annual contractural commitment. We don't believe that this $1,000 contractural commitment is any inducement to a senior optometry officer to remain in the service; such a "bonus" works out to approximately $15 a week after taxes!

Therefore, we urge the committee to adopt a proposal which includes an amalgamation of both the House passed bill, H.R. 5235 which recognizes the necessity to build in "front-end" incentives for the recruitment of junior optometry officers, as well as the concept contained in S. 523 and S. 1100 which awards increased bonus pay in recognition of the specialized training and clinical skills of the senior optometry officers.



FLEET RESERVE ASSOCIATION,
U.S. NAVY, U.S. MARINE CORPS, U.S. COAST GUARD,
Washington, D.C., December 6, 1979.

Hon. SAM NUNN,
Chairman, Subcommittee on Manpower and Personnel, Committee on Armed Services, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: On behalf of the 148,915 members of the Fleet Reserve Association and their families, I express their sincere appreciation for the Subcommittee's prompt action on the pending legislation to provide special pay for military health care professionals, H.R. 5235, S-523, S-1100 et al.

We are aware that the Subcommittee's investigation and public hearing on the critical shortage of military health professionals has placed the deteriorating health care for military health care beneficiaries into proper focus. Therefore, you are familiar with each argument in support of immediate corrective action that we could make. The testimony of the Surgeons General of the Services states our case perfectly. We will not burden you with repetitious statements.

My Shipmates and their families are well aware of the spiraling costs of health care. Each day they pay a greater share of the costs because of the shortage of military doctors. We appreciate that correction of the problem will require larger government expenditures. However, they believe that as productive members of our society, their health care needs should be met by their employer.

We have reviewed the pending legislation and recognize that all measures provide relief for the problem. In our view the measure, H.R. 5235, which the House of Representatives has passed should be the absolute minimum measure of relief enacted.

We respectfully request that our letter be included in the Subcommittee's Report reflecting our concern and support for corrective legislation.

With sincere thanks for this opportunity to state our views we remain sincerely in Loyalty, Protection, and Service,

ROBERT W. NOLAN,
National Executive Secretary.

[Questions submitted for the record by Senator Sam Nunn follow:]

QUESTIONS SUBMITTED BY SENATOR SAM NUNN; ANSWERS SUPPLIED BY JOHN H. MOXLEY

MILITARY MEDICAL PROGRAMS AND PROPOSED REVISIONS OF MILITARY MEDICAL PAY

Senator NUNN. For the record, could you update the shortages in military personnel by specialty areas and by location for each of the Services?

Dr. MOXLEY. Data on physician shortages by specialty are attached for your review. Similar data by geographic location is not readily available. However, listings of overall physician shortages by geographic location are available and are attached. Data on specialty physician shortages by geographic location are being requested from the Services and will be furnished separately.

(The subcommittee received the detailed additional information from Dr. Moxley regarding the shortages in military personnel by specialty areas and by location for each of the Services which may be found in the Committee files.)

Active Duty Physician Shortage by Specialty

Specialty	DoD # Short	DoD % Short	Army # Short	Army % Short	Navy # Short	Navy % Short	Air Force # Short	Air Force % Short
GME-1 Internship	135	17	-	-	70	64	68	21
General Medical Ofcr	288	23	347	65	-	-	-	-
Aviation Medicine	116	13	24	22	51	25	41	7
Research Medicine	23	35	-	-	23	35	-	-
Executive Medicine	98	23	47	22	41	26	10	21
Anesthesiology	51	18	55	43	-	-	3	4
Dermatology	49	26	48	49	-	-	3	6
Emergency Medicine	30	51	27	90	5	62	-	-
Family Practice	120	16	53	22	19	13	48	14
Internal Medicine	468	27	391	42	-	-	103	19
Neurology	38	29	28	39	4	16	6	18
Nuclear Medicine	17	37	8	33	2	29	7	47
Obstetrics/Gynecology	189	28	79	31	-	-	118	38
Ophthalomology	51	25	44	45	1	2	6	10
Pathology	24	7	40	20	-	-	-	-
Preventive Medicine	37	45	33	56	3	18	1	14
Aerospace Medicine	3	7	-	-	3	7	-	-
Occupational Medicine	18	60	7	78	9	47	2	100
Psychiatry	142	25	106	37	9	8	27	16
Radiology	187	38	141	64	24	24	22	13
Submarine Medicine	9	19	-	-	9	19	-	-
Surgery	589	37	502	59	18	7	69	14
Urology	53	26	45	45	4	10	4	6
Other	101	38	81	57	5	9	15	29

Data as of 30 June 1979
Prepared by: Major W.G, Terry, ASD(HA), X44705, 21 July 1979

US Army Hospital 25 OCT 1979

Physician Shortage/Overage By Facility

Medical Centers

Facility	Number Short/Over	Percent Short/Over
Brooke Army Medical Center	+28	+12
Tripler Army Medical Center	+ 9	+ 5
Madigan Army Medical Center	+18	+10
Fitzsimmons Army Medical Center	+18	+ 9
Letterman Army Medical Center	+15	+ 9
William Beaumont Army Medical Center	+18	+12
Walter Reed Army Medical Center	+45	+13
DD Eisenhower Army Medical Center	+ 6	+ 6

Other Hospitals

Facility	Number Short	% Short
Medical Activities		
Community Hospitals		
Alaska	- 5	-20
Ft. Bragg NC	- 3	- 5
Ft. Dix NJ	- 3	- 9
Ft. Hood TX	- 1	- 2
Ft. Lee VA	- 1	- 7
Ft. Leonard Wood MO	- 1	- 3
Ft. McClellan AL	- 1	- 1
Ft. Polk LA	- 4	-11
Ft. Rucker AL	- 1	- 3
Ft. Stewart GA	- 1	- 4
West Point NY	- 1	- 5
Hospitals in Europe		
Bad Kreuzmack GE	- 1	-20
Berlin Germany	- 1	- 8
Vincenza Italy	- 1	- 6
Belgium	- 1	- 7
Korea		
Seoul	- 1	- 4

US Navy Hospitals

Physician Shortage/Overage By Facility

Medical Centers

Facility	Number Short/Over	Percent Short/Over
NTL NAVMED Ctr, Bethesda MD	+44	+13
NAV REG MED Ctr Camp Lejeune NC	- 8	-14
NAV REG MED Ctr Corpus Christi TX	- 6	-26
NAV REG MED Ctr Great Lakes IL	-12	-20
NAV REG MED Ctr Guam, Mariana Is	- 3	- 9
NAV REG MED Ctr Jacksonville FL	+15	+14
NAV REG MED Ctr Memphis TN	- 2	- 6
NAV SUB MED Ctr New London CT	+ 9	+27
NAV REG MED Ctr Newport RI	- 2	- 7
NAV REG MED Ctr Oakland CA	+22	+ 9
NAV REG MED Ctr Okinawa Japan	-10	-24
NAV AEROSPACE MED Ctr Pensacola FL	+23	+34
NAV REG MED Ctr Philadelphia PA	- 5	-10
NAV REG MED Ctr Portsmouth VA	+ 7	+ 2
NAV REG MED Ctr San Diego CA	+47	+10
NAV REG MED Ctr Subic Bay RP	- 1	- 4

Physician Shortage/Overage By Facility - Cont.

NAV REG MED Ctr Yokosuka Japan	- 3	-10

Other Hospitals

Facility	Number Short	Percent Short
NAVHOSP Beaufort, SC	9	31
NAVHOSP Cherry Point NC	1	4
NAVHOSP Guantanamo Bay Cuba	5	45
NAVHOSP Roosevelt Roads PR	4	19
NAVHOSP Rota Spain	1	9
NAVHOSP Whidbey Island WA	1	7

25 OCT 1979

US Air Force Hospitals

Physician Shortage/Overage by Facility

Medical Centers

Facility	Number Short/Over	Percent Short/Over
David Grant USAF Medical Center Travis AFB CA	+17	+21
Malcolm Grow USAF Medical Center Andrews AFB Wash, DC	+15	+19
Wilford Hall USAF Medical Center Lackland AFB TX	+30	+21
USAF Medical Center Keesler AFB MS	-2	-2
USAF Medical Center Scott AFB IL	-1	-6
USAF Medical Center W-P Wright-Patterson AFB OH	+1	+1

Other Hospitals

Physician Shortage By Facility

(As of 30 Sep 79)

Facility	Number Short	% Short
1. Duluth Int'l Aprt MN	1	25
2. Peterson AFB CO	1	12
3. Tyndall AFB FL	3	17
4. Alconbury AB England	1	20
5. Bitburg AB Germany	1	5
6. Camp New Amsterdam, Holland	1	25
7. Hahn AB Germany	2	15
8. Incirlik AB Turkey	2	13
9. Spangdaulem AB Germany	1	10
10. Upper Hayford AB England	1	8
11. Robbins AFB GA	2	13
12. Tinker AFB OK	7	28
13. Brooks AFB TX	1	2
14. Edwards AFB CA	1	5
15. Eglin AFB FL	3	5
16. Hanscom Field NY	1	20

Physician Shortage By Facility - Cont.

25 OCT 1979

	Facility	Number Short	% Short
17.	Patrick AFB FL	1	6
18.	Chanute AFB IL	2	9
19.	Columbus AFB MS	3	20
20.	Goodfellow AFB TX	1	25
21.	Laughlin AFB TX	4	31
22.	Mather AFB CA	6	15
23.	Maxwell AFB AL	6	17
24.	Randolph AFB TX	1	7
25.	Reese AFB TX	3	25
26.	Sheppard AFB TX	5	9
27.	Williams AFB AZ	1	9
28.	Altus AFB UK	3	18
29.	Dover AFB DE	1	6
30.	Dyess AFB TX	1	6
31.	Kirtland AFB NM	4	17
32.	Little Rock AFB AR	1	5
33.	Pentagon WASH DC	1	33
34.	Pope AFB NC	1	10
35.	Clark AB, PI	4	9
36.	Misawa AB Japan	2	20
37.	Yokota AB Japan	5	19
38.	Anderson AFB Guam	1	11
39.	Barksdale AFB LA	5	22
40.	Blytheville AFB AR	2	15
41.	Grissom AFB IN	2	25
42.	Carswell AFB TX	3	6
43.	Castle AFB CA	1	6
44.	Ellsworth AFB SD	1	5
45.	F E Warren AFB WY	3	18
46.	Fairchild AFB WA	4	17
47.	Grand Forks AFB ND	1	6
48.	Griffiss AFB NY	1	7
49.	K I Sawyer AFB MI	3	19
50.	Loring AFB ME	5	33
51.	March AFB CA	4	9
52.	McConnell AFB KS	2	15
53.	Offutt AFB NE	6	16
54.	Pease AFB NH	3	15
55.	Plattsburgh AFB NY	3	21
56.	Vandenberg AFB CA	2	8
57.	Bergstrom AFB TX	2	13
58.	Cannon AFB NM	2	12
59.	England AFB LA	4	29
60.	George AFB CA	1	6
61.	Holloman AFB NM	2	10
62.	Homstead AFB FL	5	16
63.	Luke AFB AZ	2	7
64.	McDill AFB FL	2	7
65.	Moody AFB GA	1	7
66.	Mountain Home AFB ID	3	18
67.	Myrtle Beach AFB SC	3	19
68.	Nellis AFB NV	3	14
69.	Shaw AFB SC	3	15
70.	Hill AFB VT	1	5
71.	Kadena AB Okinawa	1	5
72.	Seymour Johnson AFB NC	1	6
73.	Wurtsmith AFB MI	1	8

Senator NUNN. What would be the difference in earnings for a civilian physician and his military counterpart, 5, 10, 15 years out of medical school if the Department of Defense proposal were enacted?

Dr. MOXLEY. The material to be furnished follows:

COMPARISON OF CIVILIAN AND MILITARY PHYSICIAN COMPENSATION IF H.R. 4076 WERE ENACTED

Years	Civilian	H.R. 4076
5	$51,120	$39,564
10	70,290	48,675
15	72,420	54,628

Senator NUNN. What are some of the advantages and disadvantages for a physician practicing medicine in the armed services?

Dr. MOXLEY. Listed below are some of the inherent advantages/disadvantages of practicing medicine in the armed services.

Advantages

Scheduled duty hours which permits more free time.

Individuals are able to plan a vacation without having to provide for patient coverage.

Malpractice insurance is not necessary.

Individuals do not have to contend with the administrative problems of billing patients.

Need not be concerned with the patients ability to pay, and can provide the best treatment course available.

Disadvantages

Lower compensation.

Required to perform Emergency Room duty regardless of specialty training.

Little control over practice setting and geographic location.

Little control over the numbers and quality of ancillary support personnel.

Long lead time generally required for equipment replacement—thus difficulty in maintaining state-of-the-art patient care techniques.

Senator NUNN. Dr. Moxley, on page 8 of your statement, you indicate that the Armed Forces Health Professions Scholarship Program will provide the Services with sufficient numbers and kinds of specialists?

Dr. MOXLEY. We do not expect the Health Professions Scholarship Program to completely solve all of our specialty shortages, however, by late 1985 we anticipate only minor shortages in a few specialty areas.

Senator NUNN. How do you anticipate retaining these specialists in sufficient numbers after their service obligation is completed?

Dr. MOXLEY. There are a number of initiatives currently underway within the Department of Defense that are designed to retain physician specialists in sufficient numbers after their initial service obligation is completed. Included among these are enhanced pay systems, improved personnel policies, consideration to increase support personnel ratios, modernization of our health care facilities, improved equipment replacement programs, and other similar initiatives designed to make the professional environment more attractive and conducive to improved patient care for these important health care providers.

CHAMPUS

Senator NUNN. What percentage of military medical care would the Department of Defense like to see handled by its in-house physicians and what percentage by CHAMPUS?

Dr. MOXLEY. Our most recent data indicate that approximately 30 percent of all inpatient care and 5 percent of all outpatient care provided by DOD is provided under the CHAMPUS program. We believe that given additional physicians and support personnel the CHAMPUS portion of DOD health care can be reduced to 15 percent of inpatient care and 3 percent of outpatient care. This could be accomplished within the DOD medical facilities currently available. Minor modifications may be necessary in some facilities to meet a specific demand in a particular area. We would be in favor of this approach since it would result in a savings to the government through better utilization of our capital assets.

Senator NUNN. Is the Department today providing more medical care through CHAMPUS than it considers acceptable?

Dr. MOXLEY. Yes. Additional care can be provided in the direct care system for basically the additional labor and other variable costs.

Senator NUNN. How much has CHAMPUS grown in the last decade?

Dr. MOXLEY. The program has grown from $271 million in fiscal year 1970 to an estimated $767 million in fiscal year 1980, or 283 percent. However, over the same period the Consumer Price Index for Semiprivate rooms and physician's fees increased approximately 280 percent and 215 percent, respectively.

Senator NUNN. Has some of this growth been due to the lack of physicians on military installations?

Dr. MOXLEY. Over the past few years we have had to turn beneficiaries away from military facilities because of the physician shortage. In some cases certain specialty services have been closed because specialists were not available in sufficient numbers. We feel certain that many of these beneficiaries have turned to the CHAM PUS program for care but the degree of impact on the program cannot be determined due to a lag in claims data and other program changes that have caused fluctuations in program activity.

Senator NUNN. What do you see as the strengths and weaknesses of CHAMPUS?

Dr. MOXLEY. The strengths and weaknesses follow:

Strengths:

The benefit structure covers more types of services than most other programs.

The "unique-to-CHAMPUS" services and supplies provided under the Program for the Handicapped.

Absence of a premium requirement.

Reasonable administrative costs that allow a greater portion of the appropriated dollars to be devoted to benefit payments.

Weaknesses:

Lack of a central eligibility file.

Beneficiary misunderstanding of the program.

Differences between care authorized under the military direct care system and CHAMPUS.

No protection against catastrophic medical circumstances when beneficiary liabilities for deductibles and cost sharing can be financially devastating.

Senator NUNN. What is being done to overcome some of its (CHAMPUS) shortcomings?

Dr. MOXLEY. The Defense Enrollment/Eligibility Reporting Systems (DEERS) is currently in its initial implementing stages. It should be in place within two years which will provide the central eligibility file necessary to improve beneficiary identification. We are preparing legislation which, if approved, would recognize the "benefits mission" and more closely aline the benefits authorized under the program with those available in the direct care system.

Under new leadership, CHAMPUS during the last year has undertaken an ambitious program of beneficiary education which has gone a long way to reduce the beneficiary misconceptions of the program.

We are currently reviewing a legislative package which would establish a level of catastrophic coverage for CHAMPUS beneficiaries.

Senator NUNN. Thank you, gentlemen. The subcommittee is recessed.

[Thereupon, at 12:35 p.m. the subcommittee recessed, to reconvene at the call of the Chair.]

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