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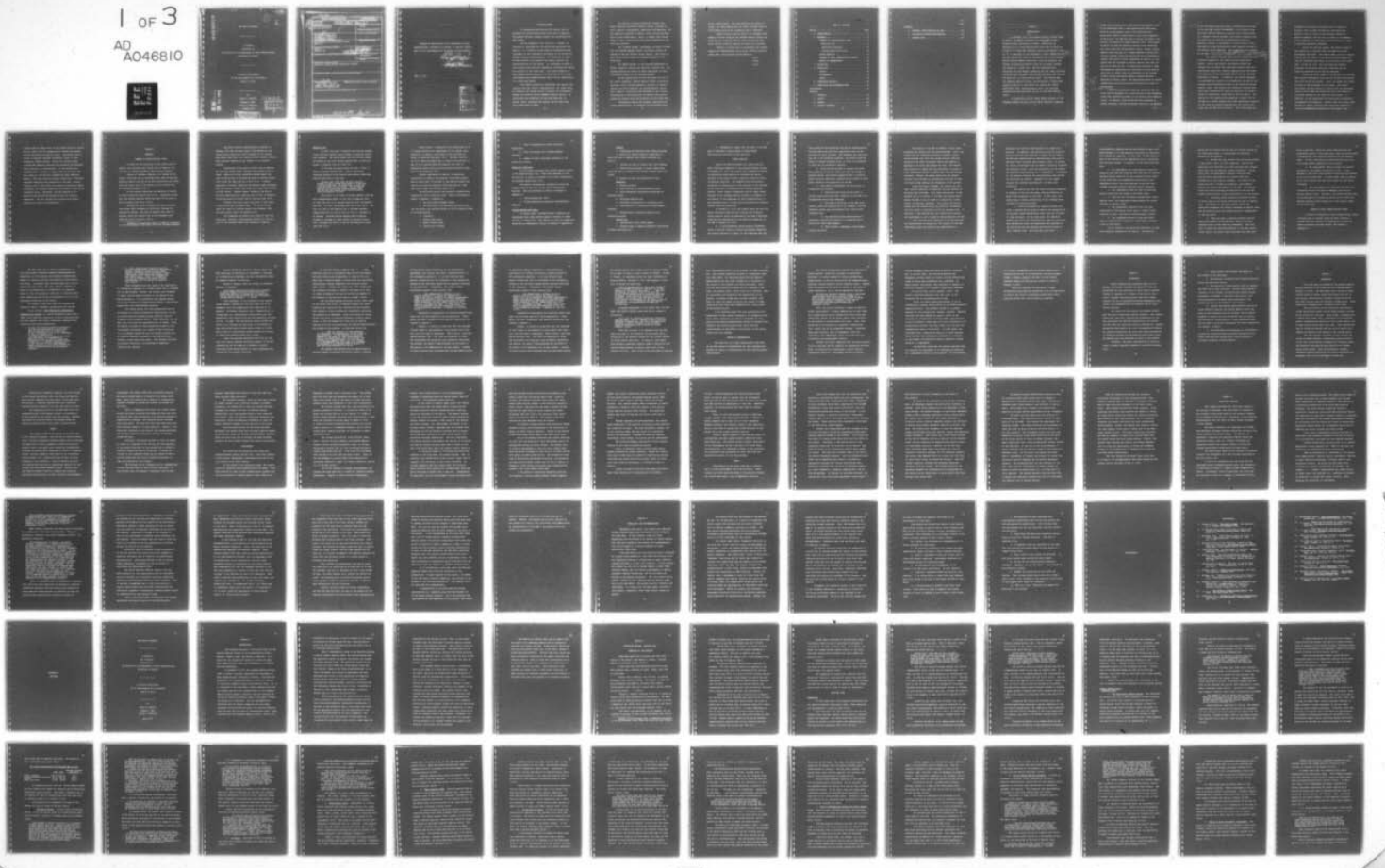

"THE COST OF CARING"

A Project

Presented to

the Faculty of the Department of Mass Communications

University of Denver

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

by

Doran L. Hopkins

Thomas A. Mahr

Philip H. McMillen

August 1977

REPORT DOCUMENTATION PAGE

BEFORE COMPLETING FORM

1. REPORT NUMBER
AFIT-CI-77-82

2. GOVT ACCESSION NO.
(9) Master's Thesis

3. RECIPIENT'S CATALOG NUMBER

4. TITLE (and Subtitle)
The Cost of Caring.

5. TYPE OF REPORT & PERIOD COVERED
Thesis

6. PERFORMING ORG. REPORT NUMBER

7. AUTHOR(s)
(10) Major Doren L. Hopkins,
Major Philip H. McMillen
Captain Thomas A. Mahr

8. CONTRACT OR GRANT NUMBER(s)

9. PERFORMING ORGANIZATION NAME AND ADDRESS
AFIT Students at the University of Denver,
Denver CO

10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS

11. CONTROLLING OFFICE NAME AND ADDRESS
AFIT/CI
WPAFB OH 45433

12. REPORT DATE
(11) August 1977

13. NUMBER OF PAGES
(12) 192 pp.
~~264~~ pages

14. MONITORING AGENCY NAME & ADDRESS(if different from Controlling Office)

15. SECURITY CLASS. (of this report)
Unclassified

15a. DECLASSIFICATION/DOWNGRADING SCHEDULE

16. DISTRIBUTION STATEMENT (of this Report)
Approved for public release; distribution unlimited

17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from Report)

18. SUPPLEMENTARY NOTES

APPROVED FOR PUBLIC RELEASE AFR 190-17.

JERRAL F. GUESS, Captain, USAF
Director of Information, AFIT

19. KEY WORDS (Continue on reverse side if necessary and identify by block number)

20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

012200

Accepted by the faculty of the Department of Mass Communications, University of Denver, in partial fulfillment of the requirements for the Master of Arts degree.

Dr. Harry T. Spetnagel

Dr. Garrett J. O'Keefe Jr.

July 1, 1977

ACKNOWLEDGEMENT

In researching and writing this report, and in producing the sound synchronized slide show it supports, the authors received valuable support and assistance from many people.

We are indebted to Drs. Garrett J. O'Keefe, Jr. and Harry T. Spetnagel for the advice and assistance they gave us. Dr. O'Keefe's strong research background proved invaluable in the formulation and design of our survey and program analysis questionnaires. His attention to detail and keen editor's eye enhanced the overall quality and professionalism of this report. Dr. Spetnagel provided us with guidance and practical suggestions regarding the design and creation of the slide show. Like other students of mass communications before us, we found him to be a vital link between mass communications theory and its application in a slide show format.

The authors gratefully acknowledge the support they received from the client's representative, Mr. Edgar Smith. By acting as the central point of contact and intermediary between the authors and the Arapahoe Medical Society, he facilitated the production of the slide show and, in several cases, prevented the authors and the show from being committeed to death.

The Office of Quality Assurance, serving both Porter Hospital and Swedish Medical Center, provided us with a wealth of photographic experience and expertise. We are especially grateful to Messrs. Peter Strange and Doug Hahn of this organization. Both, it seemed, were always ready to lend a helping hand and extend themselves as the situation required.

Mrs. Barbara Holmes, Coordinator of Public Information for Swedish Medical Center, graciously allowed the authors to use her office's slide library. This saved us many hours of work during the production phase of the slide show.

Mr. Robert Benson, of the Colorado Department of Health, agreed to narrate our show for a nominal fee. His professionalism and wealth of radio experience, we feel, contributed greatly to the finished product.

We are appreciative of the time spent with us by Mr. Lowell Palmquist, Swedish Medical Center's executive director, and Dr. William Robinson, director of medical affairs for Porter Hospital and Swedish Medical Center. Their support, cooperation and knowledge of the factors contributing to the rising cost of medical care greatly helped the authors focus the attention of the slide show.

Secretarial work on the project, especially the survey questionnaire, was speedily and efficiently done

by Mrs. Debra Hubler. She also served as our point of contact for appointments with Mr. Smith, and key hospital staff members such as Mr. Palmquist and Dr. Robinson.

Special mention must be made of the unnamed staff members of Porter Hospital and Swedish Medical Center who permitted us to observe them at work and question them about various technical aspects of health care delivery.

Finally, we would like to acknowledge the constant support and understanding of our wives, Francele Hopkins, LouAnn Mahr, and Elizabeth Brooke McMillen.

D.L.H.

T.A.M.

P.H.M.

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Chapter 1

INTRODUCTION

In November 1976, the Arapahoe Medical Society (AMS) of Denver, Colorado, approached the Department of Mass Communications, University of Denver, concerning the feasibility of a sound synchronized slide show to serve as a vehicle to inform the community about rising medical costs. Dr. H. T. Spetnagel of the Department of Mass Communications and the authors met with two representatives of the Arapahoe Medical Society Women's Auxiliary, which was pursuing the concept of explaining medical costs to the public through the medium of a slide show. The two representatives explained that the medical community had come under increased criticism from the public and elected officials over the past few years due to rising medical costs. They stated that the Arapahoe Medical Society, an association of physicians, wished to explain to the public the reasons for higher physicians' fees, hospitalization costs, and insurance premiums and what the public can do to hold down medical costs.

(cont'd on p. 2)

In discussion with Mr. Edgar Smith, director of the Arapahoe Medical Society and the Public Relations Committee

(comprised of physicians) of the AMS during December 1976, it was determined that a sound synchronized slide show would be an appropriate vehicle for presenting the physicians' views on these topics to the local community. At this point, the AMS felt that it should "go public" and explain the reasons for higher medical costs. They wanted to point out that the physician should not be receiving the total blame for rising medical costs. Rather, rising medical costs are part of a larger problem involving the national economy, political priorities and the developing concept that every citizen, regardless of station in life, should have the ultimate in quality medical care with the cost to be borne by all. At these early meetings a theme developed that physicians are conscious of rising medical costs and its effect upon the pocketbook of the average citizen and are developing medical programs wherever possible to contain costs. The physicians wanted to portray themselves as part of the solution instead of as part of the problem.

(cont fr p 1)

→ The AMS

The Public Relations Committee requested that the slide show be designed for a cross section of the community, since they intended to present it to various civic organizations. In addition, they wanted the show presented to school audiences, elected government officials, and members

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of the electronic and print media. Considering the plans of the AMS, the authors recommended a 12-15 minute slide show that would be general in content and be used as part of a speaker's bureau program. The authors suggested that the slide show be used as an introductory device to generate interest in the subject of rising medical costs followed by an AMS representative with remarks tailored to the members of the audience. This suggestion was accepted by the AMS. (This thesis describes their work ... in producing the slide show entitled: The Cost of Caring. Text of the script is included.)

The authors followed these initial discussions with extensive research of the subject which lasted three months. During this period, the authors studied and analyzed all available data concerning medical costs and interviewed physicians, hospital administrators and staff, and officials of Blue Cross/Blue Shield and the Colorado Department of Health. In addition, the authors designed a non-probability survey to be conducted by the AMS in the southern Denver metropolitan area on attitudes concerning medical costs. The authors also researched existing data about mass communications theory to determine the proper method of presenting a slide show to the lay public. The results of this research were presented in March 1977 to the AMS in a formal proposal which was immediately accepted. At this time the authors proposed that the title of the slide show be "The Cost of Caring." This title would be

developed in the show as connoting cost in terms of dollars; cost in terms of physician time spent with patients; cost in terms of lost prestige facing the medical community; and the cost of effort to the members of the community if they wanted better health as a result of adopting healthier lifestyles.

During the next two months, the authors worked on the production of the show which included the script, photography and sound. The authors made a point of working closely with Mr. Smith of the AMS and faculty members so that all concerned were aware of the content of the slide show. On May 24, 1977, the slide show was formally presented to the Public Relations Committee and the Executive Committee of the AMS and accepted.

During the early stages of the project, the authors made several fundamental decisions which they found served them well during the project. First, one member was chosen to serve as the spokesman for the group. His responsibilities included serving as liaison with the department faculty and the AMS and keeping the other two members of the group informed of all facets of the project. In addition, he was responsible for contractual and monetary arrangements and budgeting. Second, since the authors were exposed to several different AMS committees composed of nearly 50 individuals interested in the project, the

authors used Mr. Edgar Smith as the central point of contact. Within a short time all communication between the authors and the AMS flowed through Mr. Smith. The authors took no action on requests from AMS individuals unless it came through Mr. Smith's office. Third, the authors always attended AMS committee meetings well prepared and presented their positions as professionals. If the authors felt strongly about a concept or issue, they did not back down when faced by "off the wall" suggestions from committee members. The last thing the authors wanted was a "run-away" committee dominating the production of the show. Fourth, although each of the authors had specific production responsibilities, the authors cooperated and worked in each of the production areas. Therefore, each was exposed to all facets of the project and benefited from the learning experience. The full project was carried out by mutual consent and a spirit of cooperation.

Chapter 2

RESEARCH

SUMMARY OF RISING MEDICAL COSTS

A review of the literature on the rising cost of medical care indicates that health care in America, and its cost, is rapidly becoming a major public concern.

Vincent P. Barabba, director, U.S. Bureau of the Census, notes that we are spending seven times as much per person on health care now as we did a generation ago (1950), while the total cost to the nation for this health care has increased tenfold (2:9).*

On the average, Americans are spending 10 percent of their income for health care (4:ii). Expressed another way, the average American works one month of the year to pay his health care bills (24:52).

During 1976, price increases for health services rose faster than increases in the overall economy by a substantial margin. The cost of medical care rose 10.1 percent, while the overall rise in the Consumer Price Index was only 4.8 percent (21:1).

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*Numbers in parentheses refer to numbered references in the bibliography; those after the colon are page numbers.

The Social Security Administration reported in December 1976 that personal health care spending in the nation during fiscal year 1976 increased by $17 billion over fiscal year 1975, to a total of $139.3 billion (16:14). This one-year increase is the largest in our nation's history.

Predictions of the cost of health care in America for the next several years indicate that relief is not in sight. Officials of Blue Cross/Blue Shield expect the cost of health care to increase by about 20 percent during 1977--about the same rate as in 1976 (9:3). A recent Department of Health, Education and Welfare study estimates that the nation's health care costs will reach $224 billion by 1980 (20:28). Another report, issued by the Social Security Administration, predicts that we will be spending $1,159 per person on health care by the year 1981 (2:9).

Pollster Lou Harris says the public is well aware of the rising cost of health care. "It is one of the three top areas of inflation people cite--energy, food, and then health costs," he reports (6:9).

Two components of health care, hospital care and physicians' services, traditionally account for over one half of the personal health care spending in America.

Hospital Care

In 1975, the cost of hospital care was the biggest single and most rapidly rising element in personal health care spending. The nation spent over $46 billion (almost 40 percent of the total health expenditures) or $215 per person on hospital care (4:3 and 2:9).

In the past few years there has been a shift in focus of primary medical care. John M. Danielson, executive director of the Capital Area Health Consortium, explains the shift in this way,

> Doctors can't take care of their patients anymore by going around from house to house with a little black bag. It would take a truck and three busloads of technicians. So the responsibility for organizing primary medical care and the delivery system rests institutionally with the hospital (19:152).

This shift in the focus of primary medical care has had a demonstrable affect on the cost of hospital care. In 1965, the cost of an average hospital stay (nationwide) was $311. In 1975, the average cost was $1,017 (4:1). The cost of a day in the hospital for a Colorado resident jumped from $137 in 1975 to $168 in 1976, an increase of 22 percent. Colorado health experts expect hospital charges to increase at least another 20 percent during 1977, bringing the cost of a day in the hospital to more than $200 (3:1).

Harris notes, "A substantial and significant 70 to 27 percent majority (of respondents in his survey) give hospitals, in general, good marks on the job they are doing in caring for patients" (6:7). He adds, however, "A 2 to 1 majority simply says it would not be willing to pay 10 to 15 percent more for hospital care even if guaranteed better quality service and more personal attention in the hospital" (6:9).

Another observation of Harris' is especially significant in terms of the authors' slide show project. Harris states that "66 percent of the American people say they do not know why hospital costs have gone up, they just have a vague feeling they have" (6:9).

The following factors are generally credited with causing the rise in hospital costs. Each is discussed in detail in Chapter 2, Appendix A.

1. The third party payment system
2. The fact that it is generally the doctor and not the patient who decides whether or not the patient needs to be hospitalized.
3. Inflation
4. Rising labor costs
5. Empty hospital beds
6. Rising cost of drugs

7. Cost of implementing federal and state regulations

8. Cost and greater use of modern medical equipment

9. Impact of heavy government spending in the health care sector.

Physician's Services

In 1975 there were more than 320,000 medical doctors in the United States (7:8). Their fees amounted to over $22 billion, or nearly 19 percent of the total expenditures for personal health care (4:3).

Two factors are generally accepted as being the primary cause of the rise in the cost of physicians' services. Both are discussed in detail in Chapter 2, Appendix A:

1. Rising physicians' fees;

2. Rising malpractice insurance rates/defensive medicine.

Cutting Health Care Costs

In recent years, Colorado doctors, hospitals and legislators have taken various steps to contain or reduce the cost of health care. The efforts by each are summarized below and are explained in detail in Chapter 2, Appendix A:

Doctors

1. Organizing and operating peer review programs

2. Serving on various hospital committees to lower the cost of medical care without reducing its quality

3. Looking for ways to reduce their own overhead

4. Establishing programs to educate physicians about the costs of medical care and the reasons costs are rising

5. Working to ease the malpractice crisis.

Hospitals

1. Sharing services

2. Participating in group purchasing plans

3. Using management engineering techniques to evaluate staffs

4. Reviewing hospital use

5. Providing alternatives to in-patient care

6. Participating in "prospective reimbursement" programs

7. Establishing a statewide reporting and accounting system.

Legislators

1. Considering a rate review system

2. Studying ways to improve Colorado's Certificate of Public Necessity Act

3. Attempting to insure that too many of the same type of hospitals, nursing homes or other health facilities are not built in the same area.

SURVEY ANALYSIS

During the meeting between the authors and the Public Relations Committee of the Arapahoe Medical Society on December 20, 1976, the authors were requested to design an exploratory questionnaire to determine the health concerns of the public within a ten-mile radius of Porter and Swedish hospitals. The committee was particularly interested in ascertaining if the concerns of the citizens of the area were in consonance with national research studies. After further discussions with Mr. Edgar Smith, director of the Arapahoe Medical Society, and members of the faculty of the Department of Mass Communications, it was determined that a survey using non-probability sampling methods would be appropriate.

On January 17, 1977, the authors again met with the Public Relations Committee and outlined the following survey proposal which was approved by the Public Relations Committee and subsequently by the Executive Committee of the AMS on January 18, 1977:

A. A non-probability survey would be conducted within a ten-mile radius of Porter and Swedish hospitals. The authors explained in detail to the committee that the

survey would be non-scientific and that no generalization could be made about the total population; only of the attitudes of those surveyed. The committee was also told that due to the sampling technique, the authors would be unable to compute sampling error, or level of confidence, or vouch for its scientific validity.

B. Since the AMS planned to present the slide show primarily to service clubs and other lay groups in Arapahoe County, the authors suggested that it could be used to solicit individual concerns and attitudes of local people served by the physicians of the AMS.

C. The authors recommended that the survey be accomplished as follows:

1. Questionnaires would be delivered to service clubs within the local community by the AMS to be accomplished during their meetings.

2. The Women's Auxiliary of the AMS would conduct, under the supervision of the authors, a one-day telephone survey using the Mountain Bell "South Area" telephone book.

3. The AMS would place questionnaires in physicians' offices for patients to accomplish while waiting for their appointments.

4. SMC's patient "ombudsman" would sample hospital patients.

The request of the AMS to conduct a local survey presented the authors with two basic problems. First, the authors had not originally planned to conduct a local survey because they felt that enough national data was available from their literature review (see Chapter 2, Appendix A) to write and produce the show. The authors were hesitant to expend the time and effort to conduct a local exploratory survey to gather data that was already available. Second, the survey would cost the authors valuable time and make it increasingly difficult to meet the first of May deadline for completion of the project.

Faced with these dilemmas, the authors met with their faculty committee to determine the best methods of handling these problems. From these discussions, it was decided that as a service to the AMS, the authors would advise the AMS in how to conduct an exploratory survey within a thirty-day timeframe. The authors and faculty agreed that the authors would use pertinent information from the survey in conjunction with the national data. In addition, it was decided that the authors would prepare the questionnaire, but it would be administered by the AMS.

After the Executive Committee of the AMS approved the questionnaire on January 18, the director of the AMS immediately began distributing the questionnaire to

physicians and hospital administrators for sampling of patients. In addition, some physicians took the questionnaires to service club meetings to sample the lay public. The AMS also sampled hospital administrators and staff to determine their attitudes about medical costs. On January 26, twenty interviewers from the Women's Auxiliary conducted the telephone survey, under the supervision of the authors, and completed questionnaires on 72 respondents. On February 18, the authors collected the questionnaires from the AMS and tabulated the results. Appendix E of this paper contains the research questionnaire, raw data, and tabulation.

The authors met with the Public Relations Committee on February 28 and the Long Range Planning Committee on March 8 and presented the raw data. At this time, the authors gave a verbal presentation of the findings which included the following points:

1. Since non-probability sampling methods were used, no generalization could be made of the population of the southern Denver metropolitan area; only the attitudes of those surveyed. On the other hand, the committee members were told that non-probability sampling techniques were appropriate since the researchers had knowledge of the population and its elements and knew the nature of their research aims. They were also told that

non-probability sampling was the best method to meet their needs because it is less expensive and easier to administer than probability sampling. In this case, the AMS wanted to know if the concerns of the respondents were in consonance with national studies. In general, it was found that they were.

2. The respondents felt that physician fees and hospital costs were too high and that they were not getting improved medical benefits for the increased dollars spent. It was found that the respondents wanted quality care regardless of cost, but were hesitant to pay this cost through increased taxation (National Health Insurance).

3. The respondents liked the idea of hospitals sharing facilities and staffs to hold down costs.

4. Even with all the media coverage about rising medical costs, the respondents underestimated the actual increase in medical costs.

5. The respondents indicated that they were interested in discovering better ways to achieve health (quality of life), and thereby avoiding costly illness.

6. The respondents wanted to know more about medical costs and were willing to attend public presentations on this topic.

In the long-run, the survey was beneficial in ways not originally foreseen by the authors. Although the

survey did not unearth any new data not already covered by the literature review, it did provide the following benefits to the authors:

1. The AMS was very pleased with the survey because it gave them a "feel" of their community. Some of the physicians were surprised that their patients were unhappy about costs and the American system of medicine. On the other hand, the respondent's answers correlated with national data researched by the authors which gave credibility to the author's findings. One effect of the survey was that it helped to establish a good rapport between the authors and members of the AMS. The authors found that future planning and negotiation with the AMS became easier because of their satisfaction with the survey.

2. Designing survey questions forced the authors to focus early on the issues involving the cost of medical care. The defense of the questionnaire before the committees sharpened the authors' knowledge of medical costs and the means by which the message should be communicated to the lay public.

3. There had been a lingering minority opinion among some members of the AMS that a public relations campaign using a slide show was unnecessary. They felt that if physicians practiced medicine in the best professional manner, the public would recognize that they were

doing a good job. Since the survey indicated that the respondents wanted to know more about costs and would attend a presentation, this minority objection did not surface again. In fact, eventually the physicians who held this view became ardent supporters of the project.

4. The respondents' answers focused the authors' attention to the subject of quality of life. It was decided at this point that preventive medicine would become a part of the slide show. In other words, what can people do to live a better life that will result in less costly illnesses.

5. The respondents also indicated that they were interested in what the medical community was doing to contain medical costs. Therefore, the authors decided that the consolidation of staffs and facilities of Porter and Swedish hospitals would become one of the central themes of the slide show.

SUMMARY OF MASS COMMUNICATIONS THEORY

A review of literature on mass communications theory indicated that no attempt should be made to design a program with the intention or expectation of producing sweeping audience attitude changes (see Chapter 3, Appendix A).

The AMS intent was to obtain a presentation to help them promote favorable community understanding and recognition of local physician and medical-administrator efforts in trying to control the problem of rising health care costs. In essence, what the AMS sought was a way to inform the local public that their medical community is aware of the problem and is attempting to do something about it; but, the problem is such that it requires everyone's cooperation and active participation if it is to be reasonably controlled in the future.

To attempt to meet this need, the authors have designed a public information presentation for the AMS.

In his article, Some Reasons Why Information Campaigns Can Succeed, Dr. Harold Mendelsohn states that, "What little empirical experience we have accumulated from the past suggests that public information campaigns have relatively high success potentials:

1. If they are planned around the assumption that most of the publics to which they will be addressed will be either only mildly interested or not at all interested in what is communicated.
2. If middle-range goals which can be reasonably achieved as a consequence of exposure are set as specific objectives. Frequently it is equally important either to set up or to utilize environmental support systems to help sheer information-giving become effective in influencing behavior.

3. If, after middle-range objectives are set, careful consideration is given to delineating specific targets in terms of their demographic and psychological attributes, their life-styles, value and belief systems, and mass media habits. Here, it is important not only to determine the scope of prior indifference, but to uncover its roots as well (15:52).

These parameters have the capacity for application to information campaigns of a broader scope than is intended for the AMS program. However, the authors have attempted to employ them as much as possible in the design of the AMS presentation. Its construction also employs aspects of two main elements of communications design: motivational appeal and a two-sided message structure.

The target publics for this presentation will be the members of various professional organizations, as well as service-club and community-group audiences located primarily within Arapahoe County. These audiences, for the most part, will have two characteristics in common: First, the people involved will have selectively chosen to view the program; and second, as a result of their selection, it is a probable assumption that the people involved will at least be somewhat interested in the problem being treated--rising health care costs. This audience interest, or personal motivation, is considered an important condition for learning.

Wilbur Schramm and Donald F. Roberts argue that, "The importance of motivation in achievment or learning, or in assimilating knowledge, has been consistently shown in academic studies" (23:452-453).

Robert D. Russell links the concept of selective exposure to interest:

> A principle deriving from behavioral research in public health during the 1950's and 1960's holds that behavior is determined by subjective reality rather than objective--by the individual's own motives and beliefs . . . (22:87)

Otto Lerbinger, in his treatment of the "motivational design," rejects the view that there can be an assumption that the communicator does something to an audience. He further stipulates that, "Communication is instead seen as a transactional process where both the communicator and receiver give and take something of value" (12:78). He adds, "The motivational design assumes that little or no learning can take place in the absence of some unfulfilled need or desire which serves as a drive. Man is seen as a goal-seeking animal constantly striving to reduce the tensions within him" (12:80).

Thus, the personal motivation that will for the most part inspire audience selective exposure to the AMS presentation can be viewed as a seeking to fulfill individual needs and/or desires to better understand the problem and its possible solutions.

W. Phillips Davison comments that, ". . . communications serve as a link between man and his environment, and their effects may be explained in terms of the role they play in enabling people to bring about more satisfying relationships between themselves and the world around them" (12:81). Davison also notes that, "The communicator can influence attitudes or behavior only when he is able to convey information that may be utilized by members of his audience to satisfy their wants or needs" (12:81).

The two-sided message structure, giving "both sides" of the health cost issue, is employed because the target audiences are relatively well educated and have already been exposed to other opinions and information concerning the problem to be addressed. Since the problem of rising health care costs is currently becoming a volatile public issue, it must be assumed that there will be hostile opinions as to the role physicians and medical-administrators are playing in the problem. As Lerbinger points out:

> . . . when an audience is highly educated or intelligent the presentation of both sides is more effective. If the audience is initially opposed to the point of view being presented, even if the educational level is not high, the argument will appear biased. For this reason, it is recommended that two sides of an argument be presented to an audience that is hostile to the view being advocated (12:72-73).

The authors thus believe that by capitalizing on whatever degree of personal motivation brings an audience

to selectively expose themselves to the presentation, individuals will acquire and retain a greater portion of the information presented. It is also believed that greater credibility will be attributed to the information offered by the two-sided communications approach exercised in the production. Furthermore, the authors firmly acknowledge Davison's stern warning that:

> . . . the communicator's audience is not a passive recipient--it cannot be regarded as a lump of clay to be molded by the master propagandist. Rather the audience is made up of individuals who demand something from the communications to which they are exposed, and who select those that are likely to be useful to them. In other words, they must get something from the manipulator if he is to get something from them. A bargain is involved (12:78).

Mendelsohn's prescription for selecting middle-range goals has also been applied to this presentation. These goals, and their formulation into specific objectives, are treated in Chapter 3.

However, it should be noted here that the awareness of each viewer of the problem of rising health care costs will vary with type of employment, family status, individual health profiles, etc. Yet, with the exception of those few individuals and groups who have personally researched the problem, the general understandings and attitudes of the publics to be addressed will be most similar. Studies on public opinion have concluded that the mass media provide

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the general public with a ready source of opinion fodder, be it right or wrong, on daily issues of concern. Joseph T. Klapper, in testimony before the House Committee on Foreign Affairs, February 8, 1967, adds support to this line of thought by explaining,

> There is another area in which mass communication is extremely effective, and that is in the creation of opinion on new issues . . . And once the opinion is created, then it is this new opinion which becomes easy to reinforce and hard to change. This process of opinion creation is strongest, by the way, when the person has no other source of information on the topic to use as a touchstone. He is therefore the more wholly dependent on the communication in question (10:285-286).

A further endorsement of the theory that the mass media mold public opinion comes from Elliot Aronson's observation:

> Let's look at something supposedly objective--like the news. Are the newsmen trying to sell us anything? Probably not. But here, the mass media can exert a subtle influence on our opinions simply by determining which events are given exposure (1:48).

With this in mind, it is apparent that the mass media have been in the forefront of developing public opinion as to the possible causes for the current problem of rising health care costs. In doing so, some media have painted a generally negative image of physicians and medical-administrators as being a major part of the problem (5,17,18). This is not to say that some of them are

not a contributing factor of the problem, for some obviously are. But, without additional sources of information other than these media, the dedicated physicians and medical-administrators who have been attempting to contribute to the control of the problem, are being overlooked. Also, with the ever-increasing barrage of news coverage on the topic, the general public cannot help but be confused. Even our legislators are stymied by the complexities of the problem. As people become more and more confused, they begin to reach for simple solutions and targets to blame, ignoring the fact that they themselves are a major cause of the problem as well.

It is therefore hoped that this presentation will become part of that needed "touchstone" of information from which target audiences will obtain a knowledge of local physician and medical-administrator efforts to provide their community with quality health care, while striving simultaneously to contribute to the control of the rising health care cost problem.

METHOD OF PRESENTATION

The selection of a sound synchronized slide show as the best method of presentation for this informational program was based on considerations of cost and utilization effectiveness.

The initial prerequisite involved the defining of target publics. These were narrowed, as previously mentioned, to include members of various professional organizations, as well as service-club and community-group audiences located primarily within Arapahoe County. However, these designated publics were not chosen on the basis of simple expediency. As Dr. Harold Mendelsohn explains:

> Delineating realistic targets along a continuum ranging from those whose initial interest in a given subject area may be extremely high to those who literally have no interest in what may be communicated becomes an essential step in developing effective public information campaigns (15:51).

Next, the client stipulated a number of specific project requirements. Primary emphasis was on their need for a budget-priced device through which they could most effectively express to the target publics their position on the problem of rising health care costs. Also, this device was to be designed as a speaker's augmentation tool, rather than as an independent message. Therefore, mass media vehicles, such as newspapers, radio and television, were immediately ruled out as per the cost, utilization and target-public factors.

Second, the client requested that the device possess built-in mobility and the capacity for inexpensive revision. Thus, the possibility of developing a motion picture program was ruled out. The weight and bulk of motion

picture equipment would pose definite mobility problems. And, to say the least, the initial production and subsequent revision costs of a motion picture program were viewed as being both prohibitive and infeasible. As Edward Hodnett has stated, "Only assurance of exposure to millions of people or to extremely significant audiences . . . can justify such initial expense" (8:40). The client's projected audiences will only total in the thousands over an extended period of time.

Third, the client questioned whether or not an informational brochure would suffice as the needed speaker's augmentation-tool. The brochure concept as a primary approach for this project was, however, rejected. Research indicates that when people are given a choice in the selection of informational or entertainment opportunities, unless for whatever reason they are truly interested in the problem being treated, they most likely will not pick the informational option (13:142-143). In other words, the likelihood that a majority of people in a given audience would actually read information presented in a brochure, in the absence of stimulation beyond a speaker's lecture material, is improbable.

The decision concerning the brochure approach does not preclude the employment of an informational brochure as a supplemental device in this project. On the contrary,

it is highly recommended that the client develop such a brochure and utilize it in conjunction with the program. Joseph T. Klapper supports the idea of using several different media plus face-to-face contact to convey a message (11:109).

Thus, by a process of elimination, a sound synchronized slide show was determined to be the best device to fulfill the client's stipulated program needs while remaining within cost and utilization parameters.

Chapter 3

OBJECTIVES

Before beginning the production phase of the project, the authors reviewed the objectives they had established for the slide show in their project proposal (Chapter 5, Appendix A) in terms of the aims of their client, insights they had obtained from their formal research and the non-probability survey conducted by the client, and recommendations and comments made by their faculty advisors.

As a result of this review, the authors decided that the show's objectives required revision. The original objectives, they felt, required the presentation of too many statistics and detailed explanations, and ignored the fact that the slide show would be followed by a speaker. Recognizing the benefits of a mix of presentation formats, the authors decided that the slide show should concentrate on conveying concepts and introducing topics which could be expanded upon and discussed in detail by the speaker.

Therefore, the show's objectives were rewritten using a thematic approach intended to convey the concepts that:

1. Rising medical costs affect and should be the concern of all Americans.

2. The practice of medicine has changed drastically during the past half century.

3. The problem of rising medical costs is complex, and there are no easy solutions. Factors such as general inflation in the economy, the third party payment system, government involvement in the health care sector, and rising malpractice insurance rates contribute to the problem and must be considered in its solution.

4. Doctors and hospital administrators working at Porter Memorial Hospital and Swedish Medical Center are aware of and concerned about the problem, and are making attempts to contain the cost of medical care by consolidating services, participating in group purchasing plans, and striving to eliminate unnecessary and costly competition for doctors' services.

5. The individual can contribute to the problem's solution by using his health insurance benefits and the health care delivery system wisely, and by adopting a lifestyle conducive to better health.

Chapter 4

PRODUCTION

The slide show as accepted by the Arapahoe Medical Society consisted of 96 slides and was 13 minutes and 42 seconds in length. The show began with a series of sepia colored slides of Denver scenes from around the turn of the century, establishing a nostalgic reflection of the past when life was slow and basically uncomplicated. These slides were accompanied by a nostalgic music theme.

The next portion of the production used colored slides establishing Denver and the Rocky Mountain environs as the setting for the show. These slides, accompanied by a modern music theme, were a combination of recreational scenes, indicating the quality of life of this region, and of wage earners going about their jobs. This sequence was used to convey the message that the cost of health care affects and should be the concern of the average person.

The next sequence consisted of sepia slides and slides of Norman Rockwell illustrations showing doctors at the turn of the century accompanied by nostalgic music. The narrative indicated how much medicine has changed during this century. This was followed by a modern emergency sequence portraying life saving procedures and equipment that were not available 50 years ago.

Following the emergency sequence, the show focused on the reasons why medical costs are rising and what the local medical community has been doing to hold down costs. The narrator, a hospital administrator and a physician explained various aspects of the cost and quality of care.

The remaining portion of the show dealt with the responsibilities of the average citizen in contributing to the solution of the health care cost problem. Emphasis was placed on using the health care system wisely and adopting lifestyles which will result in better health.

SCRIPT

The authors found the scripting of the slide show to be a difficult process. This was due to several factors. First, the data accumulated through research were voluminous and there was at first a tendency to write the script as though it was a term paper with statistical documentation. Although the authors were attempting to design a conceptual script, the data seemed to lend itself to an illustrated lecture format (i.e., showing pictures of what is being discussed in the narrative). Once the authors realized that statistical data was not appropriate material for the script, the task became somewhat easier. Second, since the issue of medical costs is a complex one involving physicians and hospitals, private insurance and government

involvement, the authors found that the subject material was hard to narrow down to a cohesive 12-15 minute slide show. Third, the authors had a tendency to unnecessarily verbalize instead of letting the visuals and sounds tell the story.

Prior to completing the script, the authors viewed several previously produced slide shows and thus were able to identify what they considered to be effective methods of communicating a message. Two important points surfaced from these shows. The first was that those shows with less wordy dialogue seemed to be more effective. Second, it was found that listening to one narrator soon became monotonous and the more effective shows had a variety of speakers, sounds and music.

Therefore, the authors decided to limit the number of slides to a maximum of 100 and vary the time sequences of the slides from three to ten seconds with a variety of different sounds and musical selections. Dialogue was limited to only necessary words and the authors relied on natural sounds and the voices of hospital personnel to make the presentation more graphic.

The dialogue for Mr. Palmquist and Dr. Robinson was written from the tapes of their initial interviews. It was believed that the speakers' statements would be more

poignant, meaningful and credible if what they said was their original ideas and words.

The emergency sequence, which was less than a minute in length, proved to be a difficult passage to produce. Originally, the concept was to have only sounds and music accompany the visuals, but both the AMS and faculty advisors felt that this sequence would be more effective with voices. Thus, the authors interviewed emergency room physicians, nurses and ambulance attendants to learn the proper technical language for this portion of the script.

Once the rough outline of the script had been developed, the authors found that the most effective method of writing the script was through "brainstorming" sessions. Often one idea would lead to another and these sessions proved to be most valuable during this phase of the project.

PHOTOGRAPHY

The slides for the production were taken and gathered between January and May 1977. Like other aspects of the project, photographic requirements were met by the joint effort of all three authors.

At the outset of the production phase, the authors viewed six different sound synchronized slide shows. (Four were produced by other DU mass communications students and two were produced for Swedish Medical Center (SMC) by an

Englewood, Colorado, public relations firm.) The authors felt that this time was extremely well-spent, as it gave them a much better idea of the types of slides and slide sequences that lend themselves to this type of production.

The authors decided that they required basically six general categories of slides: 1) historical shots of the Denver area around the turn of the century, 2) slides of several Norman Rockwell paintings and illustrations, 3) mood shots and pictures of various types of people at work, 4) shots of doctors interacting with patients and various hospital scenes, 5) an emergency sequence, and 6) miscellaneous shots (mostly close-ups) to illustrate or make a particular point.

The authors contacted Mr. Peter Strange, audio visual director of Porter Hospital and Swedish Medical Center's Office of Quality Assurance (OQA), to arrange photographic support such as slide processing and duplicating, lightstand work, etc. They found the arrangement with the OQA to be both time and money saving. Since the OQA was equipped to process Kodak films requiring E-6 processing (Ektacolor films), the authors generally received one or two-day service.

Two of the authors are amateur photographers, and between them they were able to obtain all required original photographs. Because of their relative inexperience,

however, they relied heavily on the old photographic standbys of bracketing shots and taking several shots of each scene. This approach served them well.

As the result of several phone calls, the authors discovered that both the Denver Public Library and the Colorado Historical Society maintained photo libraries which were available to the public. The authors elected to use the historical society's photo library because the society offered to provide a light stand for the authors use free of charge. Ms. Judy Golden, who worked in the society's photo library, explained that the authors could photograph any of the society's pictures free of charge, since they were working on an audio visual product for a non-profit Colorado organization. The only requirement the society levied on the authors for the use of its photos was that the society be given some form of credit at the end of the slide show, which the authors readily agreed to.

In the early stages of visualizing the historical sequence in the slide show, the authors decided that, if possible, they wanted these slides to have a sepia tone as opposed to the starkness of plain black and white. Mr. Strange suggested that the authors shoot the society's black and white still photos with a medium speed black and white film such as Kodak's Pan X (ASA 125). Subsequently, he explained, his lab would produce a black and white print

and then through another developing and processing step create slides with the desired sepia tones. Quite by accident, the authors discussed their desire for sepia-toned slides with Ms. Golden of the historical society's photo library. She said that she knew of people who had achieved the same effect by using outdoor high speed ektachrome (ASA 160) film on the society's light stand (which was rated at 3200° K). The authors tried this approach and were delighted with the results.

The authors located several books containing Norman Rockwell pictures and illustrations at the University of Denver and Denver Public Libraries. Slides of the desired illustrations were easily made on the OQA's light stand.

One of the greatest obstacles the authors faced was the fact that the majority of their photography had to be accomplished during the winter months. The authors felt it would be unacceptable to have all their outdoor mood shots and shots of people at work taken in a winter setting with people in bulky winter attire. The problem was overcome by duplicating photographs from books, and borrowing and duplicating several slides from the Denver Chamber of Commerce's slide library and another mass communications student's (Ms. Joan Stanko) slide show.

In an effort to familiarize themselves with the two hospitals in which Arapahoe Medical Society members

worked, the authors visited the public relations offices of both Porter Hospital and Swedish Medical Center (SMC). The visit to SMC's public relations office proved most fruitful. Mrs. Barbara Holmes, SMC's Coordinator of Public Information, agreed to allow the authors to use various slides from her office's slide library. This saved the authors many hours of work and the client a good deal of money.

Through ingenuity and resourcefulness, the authors found themselves in the position of having to take relatively few slides for the show. They were determined, however, not to let existing slides rule the script or to sacrifice quality for expediency. Although the show was produced considerably below budget, its quality was not compromised.

The following comments may benefit future students working on this type of production project.

First, if possible, avoid a winter season photography timeframe for outdoor shooting. Though the authors were able to side-step this problem by duplicating pictures from books and slides from other sources, there is little doubt that original photography is inherently higher in quality.

Second, be aware of the fact that Kodak and similar type films requiring E-6 processing can be processed

locally. Though Kodachrome film often provides richer color, it must be sent to another city for processing. This will add to the time between when you shoot your slides and when you have an opportunity to view them. Generally speaking, the authors found that they could not afford this luxury.

Third, if you find yourself having to duplicate slides, remember that duplicated slides have a tendency to darken somewhat and to lose a bit of their sharpness. Whenever possible, use original slides to make duplicates. Doing so will help to ensure that slides obtained in this manner are of the highest possible quality.

Finally, expose yourself to the work and advice of professionals and mass communications students who have gone before you. The authors gained a greater appreciation of the requirements and do's and don't's of slide shows from doing this. Dr. Spetnagel's advice to use close-ups for relatively long narrations, we feel, was sound and enhanced the quality of our final product.

SOUND

Construction of the sound track was an integral part of script development and slide selection. After viewing the slide shows mentioned in the previous section, the authors developed a list of applicable criteria.

First, the authors felt that the narrator's voice should be a contributive factor and not a distraction. The authors believed that stereotyped disk jockey, newscaster or radio announcer voices were inappropriate for the AMS presentation, since such voices would detract from the serious and professional intent of the program. In the authors' opinion, a naturally inflective, "down-home," fatherly type of voice containing solid masculine overtones was needed. These qualities were subsequently discovered in the voice of Mr. Robert Benson.

Second, the authors believed that reliance on just one voice throughout the entire presentation would have a possible hypnotic effect on the audience. This belief was the result of viewing slide shows which had this effect on the authors. Therefore, it was decided early in the production stage that the narration of the authors' show would be broken up by interjecting several other sounds and voices. The first such contrast comes in the form of the medical emergency sequence. Here the background music fades into an ambulance siren which is followed by appropriate dialogue over intense mood-setting music. Subsequent contrasts take the form of statements made by Mr. Lowell Palmquist, a hospital administrator, and Dr. William Robinson. In addition to providing contrast, the authors felt that using these gentlemen's voices would

add credibility to their statements in the minds of the audience.

As noted in the discussion of the script's development, the emergency sequence was particularly difficult to produce. After being checked out on the department's Nagra tape recorder, the authors' attempts to tape actual emergency sounds at SMC's emergency admittance station proved futile. The authors soon learned that the sounds presented on television during a medical emergency sequence are difficult to obtain, since modern emergency rooms are virtually noise free. The authors then attempted to stage the required sounds and dialogue using real doctors, nurses, and ambulance/rescue attendants. This effort also proved futile because of the lack of thespian ability on the part of the hospital staff, and the difficulty of obtaining high quality sound in a non-studio situation. However, not all was lost. After reviewing these tapes, the authors were able to construct a realistic dialogue for the emergency sequence. The authors then employed their own voices, and the voice of one of their wives, to record the dialogue. Good old "Yankee Ingenuity" provided the necessary background emergency situation sounds. The revised version of the emergency sequence was coordinated with and approved by the faculty and Mr. Smith prior to being used in the final mixing of the sound track.

The greatest lesson learned while taping was that the recording sound level should never be changed or adjusted once a recording session has begun. Recording at different sound levels makes it very difficult to splice takes. Having made such a mistake, the authors were required to arrange another appointment with Mr. Palmquist.

The third criterion deals with the selection of background music. The show beings with a series of sepia shots of old Colorado. This created the requirement for nostalgia sounds. The authors selected the arrangement of "Down the Line" by Barry De Vorzon and Perry Botkin, Jr. for this sequence. The arrangement begins with very slow harmonica and guitar sounds which perfectly set the mood. As the slides switch to scenes of modern Colorado, the music transitions into a fully-orchestrated, up-beat version of the same tune. At the end of this slide sequence, a lonely harmonica note is used as a segue to the sound of an ambulance siren. At this point the authors used Dusan Radic's arrangement of "Escape from Slavery" to create the feeling of tension necessary for the medical emergency sequence. The background music for the remainder of the show comes from the arrangements of "Nadia's Theme" by Barry De Vorzon and Perry Botkin, Jr., and "Bellavia" by Chuck Mangione. The authors decided to end the show with a passage from "Bellavia" because they felt it would leave the audience with an up-beat feeling.

When the authors had obtained all necessary recordings and decided on their background music, they created a scratch tape (a rough mix of narration and music made on home recording equipment) of the show's sound track. This endeavor served three major purposes. First, producing the scratch tape required the authors to review all tapes and to select and catalog the desired selections. This process was very time-consuming, but it eliminated confusion and wasted time during the final professional mixing session. Second, the authors were forced to refine the time elements of the show to ensure that it was kept under fifteen minutes. This meant timing each narration and musical sequence to ensure that time and money were not wasted during the final mixing session. Finally, the scratch tape afforded the authors, the faculty advisors, and the client the opportunity to review and recommend changes to the program prior to spending $30 an hour for the final sound track mixing.

The final mixing of the sound track, which took 8-1/2 hours, was accomplished at KOSI radio station by the authors and Mr. Bob Meyer on May 17, 1977.

Chapter 5

EVALUATION ANALYSIS

This chapter discusses the three major phases of the project's evaluation. The first phase of evaluation was actually a continuous review of the authors' progress on all aspects of the project. Therefore, it was conducted simultaneously with the other two major phases discussed in this chapter.

The faculty advisors, Drs. Spetnagel and O'Keefe, both provided invaluable guidance during the writing of the formal proposal and project report. In addition, Dr. Spetnagel's expertise was especially helpful during the production phases, while Dr. O'Keefe's knowledge and experience piloted the authors' efforts in survey and program questionnaire construction and application.

The second major phase of this project's evaluation concerns the development of a short program questionnaire for the client's use.

It should be remembered that the slide show was developed around information-giving logic, not persuasion, as explained in Chapter 2, Summary of Mass Communication Theory. Furthermore, from the beginning, the slide show was designed to serve as a speaker's introductory device,

and not as an isolated program. The authors have sought to provide the client with a simple feedback tool through which indications of audience interest in and reaction to a particular presentation of the slide show might be obtained. The client neither needed nor desired a scientific, evaluative, statistical-data-collection device for measuring the slide show's possible effects on audiences. Data thus collected by the program questionnaire designed by the authors could be used by the client to develop more meaningful subject matter for the speakers bureau and for updating the overall program from time-to-time.

Still, even a questionnaire such as this must be based upon sound research rationale if the data collected is to be meaningful and useful for the purposes intended.

Primary consideration has been given to Dr. Harold Mendelsohn's Active Response Test (MART) as the basis for developing the questionnaire herein constructed.

MART was designed by Dr. Mendelsohn on the concept that communications' effects could be considered a function of three cumulative processes: learning, emotion, and activation (14:413). He points out that these three processes are closely involved with one another. For example, ". . . before a communication can induce action, no simple event like learning (i.e., retention of content) is sufficient to incude that action" (14:413). Thus develops the hypothesis of involvement:

> The involvement hypothesis suggests a totality of psychological experience with a communication in terms of learning, feeling, and preparing oneself to act as a consequence of exposure. The greater the involvement that the communication produces, then the more effective it can be considered (14:413).

MART research indicates that three types of responses to a communication have been distinguished. These are rudimentary, emotional, and active responses (14:414). Dr. Mendelsohn stipulates:

> The determination of whether a recipient responds rudimentarily is based on his ability to recall something about the communication. The determination of whether a recipient responds emotionally is based on recall plus his affirmative answers to the following types of items: (1) the experience of an emotional reaction as opposed to a *feeling of indifference toward* the communication, (2) a feeling of greater friendliness toward the source of the communication, (3) a feeling that the communication was "getting through" to him. The determination of whether a recipient responds actively is based on recall, emotional reaction, plus responses of the following types: (1) an expression that the recipient has learned something about the idea, product, or service that will help him decide in its favor; (2) a declaration that the recipient considers the idea, product, or service worth recommending to others; (3) an expressed desire to follow up or to look into or try the idea, product, or service discussed in the communication (14:414).

Thus, in accordance with Dr. Mendelsohn's prescription, the first three questions are designed to stimulate rudimentary responses from the audience (see Appendix F). These questions should provide an indication of what the audience might possibly have learned as a result of

exposure to the slide presentation. Questions 4 through 9 are designed to try and draw out indications of audience emotional involvement with the content of the presentation. Affirmative answers to these questions will be an indication that there is an emotional involvement on the part of the audience. Questions 10 through 12 are designed to draw out any indications of possible active responses from the audience. Positive answers here will help to alert the client as to whether or not the presentation is "getting through" as desired to the audience.

Additional space is provided following question 12 so that the audience can write-in any other comments or questions they might wish to convey to the presentation representatives. Questions 13 through 15 seek to provide simple demographic information to aid the client in correlating the questionnaire data.

The client has been advised, however, that the data collected via this questionnaire are not considered valid or realiable on a scientific basis for formulating applicable generalizations about any other audiences. Also, it has been recommended that, if the client wishes to compile such reliable and valid data scientifically for statistical purposes, a professional research project should be commissioned for that specific reason.

Prior to the third phase of evaluation, the authors maintained continuous liaison with the AMS Director,

Mr. Edgar Smith. After the slide and script revisions had been implemented and the final sound track mixing accomplished, the finished product was previewed by Mr. Smith in his office. Then, on the morning of May 24, 60 hospital administrators and supervisors viewed the slide show. The overall reactions of the audience were spontaneous applause and highly favorable comments.

On the evening of May 24, the show was officially presented before a joint meeting of the AMS Executive and Public Relations Committees. Again, the reactions of the audience were applause and favorable comments. These audience members were then given the program questionnaire. Of ten questionnaires returned, only one respondent rated the presentation as not being better than most other comparable sources of information on the issues treated. Most respondents felt that the messages contained in the show were presented in a manner so that they were "getting through" to the audience, as well as to themselves. When asked to describe the presentation in their own words, such comments were recorded as: (1) "Great continuity! Comfortable tone! A professional feel!" (2) "Good! Easy to understand, short and to the point!" (3) "Excellent!" (4) "A short, effective explanation of rising health costs!" (5) "Good! Holds interest!"

There were also some criticisms of the presentation. One respondent noted that some of the slides appeared fuzzy. This was in part due to the great distance between the projector and the huge screen suspended from the high ceiling of the auditorium. The screen was continuously in motion due to air currents in the room. This caused the focus to change constantly. Also, the angle at which the projector was situated added to the visual problem. Heretofore, such flaws had not been noticed during the numerous previews. The authors had always viewed the show in smaller rooms with steady screens, and the fuzzy aspects had not shown up. It has been recommended that whenever possible the client move the projector closer to a stable screen to eliminate such distortion.

Next, because the presentation room was so large, the sound had to be turned way up in order for all to hear. The equipment used was not designed for such a high volume setting. The small speaker had a tendency to distort the sound. This problem could be solved by procuring better sound equipment and/or by presenting the show in smaller, more acoustically suitable locations.

Another criticism voiced by several respondents was that the show had dwelt too much on the aspects of the hospital consolidation and not enough on what the physicians

had done aside from the hospital scene. Yet, they were unable to produce any specifics which could have been used to develop the show as they thought it should have been done. This was an issue the authors and the AMS Public Relations Committee had initially examined at the start of the project. It was acknowledged at the start that there were just not enough specific examples of physicians' efforts outside the hospital consolidation that could have served to improve the medical community's image if solely relied upon for building a public relations presentation. In fact, it had been decided by the AMS Public Relations Committee that this project should focus on the rising health care cost problem, and not on physicians alone. The idea of producing a presentation which would deal with the physicians alone was tabled as a possible future project.

It is interesting to note that after the Executive Committee member had voiced his objections to the presentation, a former opponent of the project, and member of the AMS Public Relations Committee, came forward in full defense of the finished presentation. His comments could not have been more complimentary.

A presentation of the slide show and program questionnaire to a community group had been planned for in the formal project proposal. Due to the pressing time requirements for the completion of the project, this fourth

phase of evaluation could not be accomplished by the authors. However, the program questionnaire designed by the authors will fulfill this requirement when administered by representatives of the AMS to lay groups which have viewed the presentation.

Chapter 6

CONCLUSION AND RECOMMENDATIONS

Throughout this report, the authors have mentioned various learning experiences encountered while producing the slide show. In this chapter, these and other experiences will be covered in an attempt to convey lessons that have been learned by the authors and recommendations that can be passed on to future producers of sound synchronized slide shows.

Since the authors will be practicing public relations as a career after graduation, they found this project to be very beneficial because it allowed them to apply scholarly research and data to a real life situation. In this project, the authors not only had to become experts in mass communications theory, but also become knowledgeable in medical economics, medical terminology, and the attitudes and beliefs of the medical profession. Then the authors had to create a vehicle to get a message from the medical community to the lay public. The project was both difficult and challenging. In working with the many people involved in this project, compromise, often under stress, became the byword.

The authors found that the success of the project was due, for the most part, to a spirit of cooperation and mutual respect that existed with the faculty advisors, with the medical community, and with one another. The many shared learning experiences along with meeting outstanding professionals, many now considered as friends, proved to be the highlights of this project

The authors made several fundamental decisions at the onset that served them well during the development of the project. First, the authors decided that they would conduct themselves as professionals when dealing with the medical community. The authors made a point of doing their "homework," thus being able to handle any situation or question that might arise from the members of the several committees within the AMS. The authors extended this professionalism to their dress, manner and deportment when meeting with physicians and administrators. Second, the authors chose a spokesman to serve as liaison with the medical community and used Mr. Smith as the central point of contact. Thus, all communication flowed easily and uniformly among the approximately 50 individuals associated with the project. Third, the authors also selected a spokesman to serve as liaison with the faculty committee, which simplified the communication process. Fourth, the

authors made early decisions concerning the methodology of producing the slide show based on extensive research and analytical thought processes. Thus, few changes had to be made in the general outline of the show during production. Fifth, the authors decided that they wanted their slide show to be a high quality product in all respects; one which they could present with pride and a feeling of accomplishment. Therefore, much time and effort was spent on attention to detail.

The authors initially found that the production of a slide show is learned through the "school of hard knocks." They could find no central source with detailed instructions informing the novice on how to build a slide show. The authors found that the best method of learning the business was to ask questions of everyone and to continue to ask questions until the end. More often, production techniques were discovered after establishing rapport with an individual and probing his knowledge of the business. What may have been second nature to him was a bonanza to the authors.

Throughout the production phases, it was found that it was extremely important to coordinate or inform both the client and faculty members on any problems or new production techniques. The point was that the authors did

not want to produce any material that might not be acceptable at a later date.

This project has allowed the authors a much greater appreciation of what is good or bad in visual presentations. They can now critically analyze a script, photograph or a soundtrack. This knowledge will be extremely helpful in the public relations aspects of their chosen careers.

As a review, the following are recommendations for future producers of slide shows.

1. Do extensive research of your subject and mass communication theory and write a fully developed proposal.

2. Select a spokesman to serve as liaison with the client and faculty committee. Continually coordinate all developments during the production phase.

3. Be professional and knowledgeable in all contacts with the client and faculty. Do your homework.

4. Construct a proposed budget for the worst case possible. It is always better to spend less than budgeted than to be forced to go back to the client and ask for more money.

5. A slide project is difficult and often frustrating. Allow plenty of time to complete the project, normally at least six months if one is taking a full course load.

6. Ask questions and more questions from knowledgeable professionals and use the best sources for film processing and sound mixing. Find out early what the requirements are for the slide show from both faculty and the client.

7. Think ahead and plan your production outline based on analytical thought processes. Know what is expected of you.

8. If possible, have one individual on the team edit the proposal and project report so that there is a common writing style.

9. Keep a diary of all events and decisions. It will prove helpful when writing the final report.

10. Do not let the client dictate production standards. Remember, you are the expert. Keep control of all production aspects.

11. Respect the priorities of the client and faculty. They are busy people and you are only a small part of their lives (although it may seem that your project is the biggest event since the "creation").

12. Work as a team. Cooperate and respect the abilities of one another.

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APPENDIX A

PROPOSAL

"THE COST OF CARING"

A Proposal

For A Project

Presented to

the Faculty of the Department of Mass Communications

University of Denver

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

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by

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April 1977

Chapter 1

INTRODUCTION

This proposal advocates a slide/sound show for the Arapahoe Medical Society to be accomplished by Doran L. Hopkins, Thomas A. Mahr, and Philip H. McMillen. It is hoped that the project will allow the authors to apply mass communications theory and methodology to a creative learning experience.

In November of 1976, the Arapahoe Medical Society (AMS) of Denver, Colorado, approached the Department of Mass Communications, University of Denver, concerning the feasibility of a slide/sound show to serve as a vehicle to inform the community about rising medical costs. Dr. H. T. Spetnagel of the Department of Mass Communications and the authors met with two representatives of the Arapahoe Medical Society Woman's Auxiliary, who were pursuing the concept of explaining medical costs to the public through the medium of a slide show. The two representatives explained that the medical community had come under increased criticism from the public and elected officials over the past few years due to rising medical costs. They explained that the Arapahoe Medical Society, which is an

association of physicians, wished to explain to the public the reasons for higher physician fees, hospitalization costs, and insurance premiums and what the public can do to hold down medical costs.

After a comprehensive study of the manifold problems involving today's medical costs, the authors believe that the physicians should "go public" and explain the reasons for higher medical costs. The physicians should not be receiving the total blame for rising medical costs and the "bad-guy" image of the "high priced physician" is an unfair stereotype for a group of individuals who have dedicated their lives to the eradication of suffering. Rising medical costs are a part of a larger problem involving the national economy, political priorities and the developing concept that every citizen, regardless of station in life, should have the ultimate in quality medical care at a cost to be borne by all.

After discussions by the authors with Mr. Edgar Smith, director of the Arapahoe Medical Society and the Public Relations Committee (comprised of physicians) of the AMS, it was determined that a slide/sound show would be the appropriate vehicle for the presentation of the views of the physicians to the local community. The authors believe that the majority of physicians are con conscious of rising medical costs and its effect upon the

pocketbook of the average citizen. Thus, it has become incumbent upon the physicians to develop medical programs to reduce costs whenever possible. This concept should be the goal of the slide/sound show. The physicians of the Arapahoe Medical Society are seeking and finding solutions to keep down medical costs. In effect, they are part of the solution instead of part of the problem and they want the people to know this.

The Arapahoe Medical Society wants a presentation that can be shown to a cross section of the community. At the onset, they want the presentation shown primarily to service clubs and professional organizations. The authors feel that the presentation will also be an excellent vehicle for presenting the physicians' message to school audiences, elected government officials and members of the electronic and print media. The authors believe that although the show should factually discuss medical costs today, it should neither be dogmatic nor argumentative. The show must appeal to a cross section of the community involving all socio-economic groups with varying educational levels. Although hospital scenes with physicians in white jackets seem inevitable, the show should also entertain to keep the interest level of the audience. Therefore, the authors are planning to design a show that will present a serious message in an informal format with graphic illustrations, caricatures, and photographs.

The subject of medical costs and its effect upon the public is an immediate problem that is constantly receiving full media coverage. Traditionally, physicians have not individually taken part in the public debate of issues affecting medicine. Instead, they have relied upon their professional associations for public relations and lobbying efforts. Thus, a slide show presentation can be an appropriate method for a professional organization to tell their side of the story. This opportunity also provides the authors with a "real world" laboratory to apply theories of research, persuasion and the effects of the media that have been learned in a classroom situation.

Chapter 2

LITERATURE REVIEW: MEDICAL COST

OVERVIEW OF THE PROBLEM

"Americans spend more on health than any other country in the world," says Robert S. Havely, a health adviser to President Carter (16:10).*

A few years ago, most Americans would have read that sentence with a feeling of pride. Today, they read it with alarm.

Health care in America, and its cost, is rapidly becoming a major public concern. The Council on Wage and Price Stability concluded in its April 1976 report: "Rising health care costs are a major public policy problem facing the nation . . ." (25:i).

Vincent P. Barabba, director of the U. S. Bureau of Census, offers this perspective of the problem: "We spend seven times as much per person on health care now as we did a generation ago (1950), while the total cost to the nation for this health care has increased tenfold" (8:9).

This means that Americans, on the average, are now spending 10 percent of their income for health care (25:ii).

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*Numbers in parentheses refer to numbered references in the bibliography; those after the colon are page numbers.

Viewed in another way, the average American works one month of the year to pay for his health care bills (71:52).

During 1976, price increases for health services rose faster than increases in the overall economy by a substantial margin. The cost of medical care rose 10.1 percent, while the overall rise in the Consumer Price Index was only 4.8 percent (58:1).

The Social Security Administration reported in December, 1976 that personal health care spending in the nation during fiscal year 1976 increased by $17 billion over fiscal year 1975, to a total of $139.3 billion (50:14). This one-year increase is the largest the nation has ever experienced. The Social Security Administration explained that the $139.3 billion spent on personal health care represented the costs of hospital care and doctors' services, public health programs, research, and construction.

Predictions of the cost of health care in America for the next few years indicate that relief is not in sight. Officials of Blue Cross- Blue Shield expect the costs of health care to increase about 20 percent during 1977--about the same rate as in 1976 (39:3). A recent Department of Health, Education and Welfare study projects that our nation's health care costs will reach $224 billion by 1980 (57:28). Another report, issued by the Social Security Administration, predicts that we will spend $1,159 per person on health care by the year 1981 (8:9).

Jerome Lynch, president of Colorado Blue Cross-Blue Shield, feels no one in the state of Colorado is untouched by the jump in health costs. As a result, the Blues, the largest private health insurer in the state, have made cutting health expenditures their number one priority (14:3).

Pollster Lou Harris says the public is well aware of the rising cost of health care. "It is one of the three top areas of inflation people cite--energy, food, and then health costs," he reports (30:9).

Two components of health care, hospital care and physicians' services, traditionally account for over half of personal health care spending in America. The following sections will review some of the factors that have caused health costs to rise in terms of these two components.

HOSPITAL CARE

Background

In 1975 there were 7,156 hospitals registered with the American Hospital Association (AHA). These hospitals had approximately 1.5 million beds (73:xi).

That same year, the cost of hospital care was the biggest single and most rapidly rising element in personal health care spending. The nation spent over $46 billion (almost 40 percent of total health care expenditures) or $215 per person on hospital care (25:3 and 8:9).

In the past few years there has been a shift in the focus of primary medical care. John M. Danielson, executive director of the Capital Area Health Consortium, explains the shift this way:

> Doctors can't take care of their patients anymore by going around from house to house with a little black bag. It would take a truck and three busloads of technicians. So the responsibility for organizing primary medical care and the delivery system rests institutionally with the hospital" (55:152).

This shift in focus of primary medical care has had a demonstrable affect on the cost of hospital care. In 1965, the cost of an average hospital stay (nationwide) was $311. In 1975 the average cost was $1,017 (25:1). The cost of a day in the hospital for a Colorado resident jumped from $137 in 1975 to $168 in 1976, an increase of 22 percent. Colorado health experts expect hospital charges to increase at least another 20 percent this year, bringing the cost of a day in the hospital to more than $200 by the end of 1977 (14:1).

Alarmed by the rising cost of health care, the Colorado Legislature appointed a special committee to look into health expenditures. The committee's staff found that more than $415 million was spent in the state during 1975 for hospital care alone, a 48 percent increase since 1972 (14:3).

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Hospitals, noted that: "A substantial and significant 70 to 27 percent majority give hospitals, in general, good marks on the job they are doing in caring for patients" (30:7). At the same time, however, he said: "A 2 to 1 majority simply says it would not be willing to pay 10 to 15 percent more for hospital care even if guaranteed better quality service and more personal attention in the hospital" (30:9). Perhaps the most interesting statistic presented by Harris at the convention was that: "66 percent of the American people say they do not know why hospital costs have gone up, they just have a vague feeling they have" (30:9).

Some of the factors which have contributed to the rise in hospital costs are discussed in the following section.

Factors Behind Rising Hospital Costs

1. The Third-Party Payment System. Most Americans pay directly for only a small proportion of their hospital care. Our health care industry is characterized by a system whereby third parties make payments on behalf of consumers through health insurance, public insurance, or public health programs. In fiscal year 1975, for example, third-party payments accounted for 67.4 percent of the total expenditures for personal health care. These payments took care of 92 percent of the expenditures for

hospital care and nearly 66 percent of physicians' bills (25:14).

Nine out of every ten Americans are estimated to have some form of health insurance (71:53). The Council on Wage and Price Stability estimated that

> approximately 80 percent of health insurance premiums are paid through employment-related group insurance plans. Another 3.0 percent is paid through other group insurance policies; and only 17.5 percent of premiums are for individual policies (25:16).

The Council estimated that under group insurance plans, the employer pays, on the average, 67 percent of the total premium; and in 41 percent of such policies, the employer pays the total premium (25:16). Employer-paid health insurance is costly. Ford Motor Company says the cost of the coverage they provide their employees is rising about 15 percent a year (28:78). "At Ford, for example," says Sidney F. McKenna, Ford's labor relations vice-president,

> the company's cost has grown from 15 cents per hour per worker in 1965 to 90 cents today (1975) because of increased coverage and cost escalation. We pay about $1700 a year per average employee for these insurance premiums (2:49).

General Motors' experience is similar. The company reported that $170 of the cost of each new car represents the cost of health insurance premiums the company pays for its workers. Outside of wages, that is the highest single cost component for a new car. Even the steel costs less (54:20)!

A study conducted by the Social Security Administration noted that between 1965 and 1973, annual contributions to employee health benefit programs (including contributions by both employers and employees) jumped 164 percent, from $7.5 billion to $19.8 billion (25:28).

This vast third-party payment system has had a pronounced affect on the demand for hospital care by both patients and physicians. The Council on Wage and Price Stability explained it this way:

> . . . when a consumer pays out-of-pocket either none or a small fraction of the total cost of providing health services, economic theory and common sense suggest that he will tend to demand more services than if his out-of-pocket cost reflected the full cost of providing that care. Several studies have confirmed this effect, i.e., that the insured patient is willing to buy more care or more expensive care than he would if not insured (25:15).

The tendency is for the individual to think he is getting his health care for free, and he, therefore, ought to make full use of his benefits. The truth of the matter is that the individual ultimately pays for this "free" care in terms of higher taxes, stiffer insurance premiums, or wages foregone to enable management to pay for higher employee health insurance premiums. Ironically, while the proportion of hospital care costs which are paid directly by consumers is decreasing because of the growth of the third-party payment system, the dollar amount paid out-of-pocket by the consumer is increasing because of the huge

jump in the cost of hospital care (8:9). The following chart illustrates this trend (25:2):

Per Capita Expenditures for Personal Health Care

	1965	1975	Percent Increase 1965-1975
Direct Payments	$89.37	$155.10	73.5
Private Insurance Benefits	42.10	126.21	199.8
Federal	14.44	131.92	813.6
State and Local	20.94	56.99	172.2

As suggested earlier, the third-party payment system has also affected the demand for hospital care by physicians. Some health experts assert: "The trend in medicine now is for doctors to treat in hospitals patients who might well be treated at home or in offices" (71:52).

The following is an examination of some of the reasons for this in terms of the next factor.

2. Provider's Choice. In most cases the decision whether or not the patient needs to be hospitalized rests with the doctor. Charles C. Edwards sums up this problem neatly:

> The consumer of health services is in a uniquely disadvantageous position. Except for the decision to seek medical care, he or she has almost no voice in what services will be provided, who will provide them, where and at what cost. And because the physician who makes those choices has no direct concern for what they will cost--since they will be paid for by health insurance or tax dollars, especially if the care is provided in a hospital--the doctor is, in effect, a purchasing agent with almost unlimited access to someone else's money.

> This is not meant to suggest that all doctors are callous spendthrifts. But if a doctor knows that the patient is covered for most or all of the cost of elaborate and expensive diagnostic and treatment procedures, why should the doctor think about saving money where the patient's health is concerned?
>
> Coupled with the mounting practice of defensive medicine to ward off the risk of malpractice suits, the knowledge that some third party will pay the bill acts as a stimulus to hospitalization, to extensive laboratory tests and treatment procedures that are frequently of marginal value, and to other excesses that further inflate the cost of care.
>
> Moreover, this same set of circumstances tends to discourage the use of outpatient facilities, home health care, preventive services and allied health professionals for the simple reason that insurance either does not pay for them at all or sets up economic disincentives in the form of reduced reimbursement (23:22).

Dr. William Roy agrees with Edwards' conclusion about a doctor's concern for the health of his patient:

> We physicians are trained to use every available resource of possible benefit to treat our individual patients--regardless of cost. To my knowledge this has always been so, and it has been my expectation that it must always be so (63:590).

As Edwards noted, the medical care system is unique in the extent to which the provider of the services determines the nature and extent of the services to be provided. The Council on Wage and Price Stability commented on this aspect of the American health care system in its April 1976 report:

> The physician's diagnosis determines the extent to which his or her own services are required as well as the utilization of diagnostic tests, therapeutic drugs, and hospitals. The patient usually lacks sufficient information or expertise, even if so inclined, to question a physician's recommendation or to seek possible alternatives (25:18).

U. E. Reinhardt, an associate professor of Economics and Public Affairs at Princeton University says:

> Can we really be surprised when in virtually every nation with comprehensive health insurance coverage and a generous health-manpower endowment, the number of diagnostic procedures delivered per medical case increases when (a) there is the general adage that more (diagnostic) information is always better, (b) the prescription and delivery of diagnostic procedures triggers such salutary inflows of fiscal nourishment and (c) no supplier of these procedures has to look directly into the eyes of those who are asked to pour forth that fiscal nourishment (62:14)?

Doctors initiate 70 percent of all hospital care, but still, most of them have no idea what the treatment they are prescribing is going to cost," explains Jerome Lynch, president of Colorado Blue Cross-Blue Shield. In his opinion, doctors could help hold down the costs of medical care if they shopped around for the best buy (12:2).

Doctor Roy feels physicians are not prepared for this role of balancing benefits against costs:

> . . . we find the American Medical Association as long ago as 1959, and the American Hospital Association as recently as May (1976) saying that the individual physician must balance benefits with cost for his or her individual patient.
>
> It follows that if every physician knew the cost benefits of his services, and if every physician were equally able to implement the "proper balance between adequate medical care . . . and 'economical use of . . . funds,'" we would need no further rationing system. But I believe we know that this cannot be done (63:593-94).

3. Inflation. From 1965 to 1975, 53 percent of the total cost increase in health care costs was due to inflation (8:9).

Hospital administrators are quick to provide figures illustrating this point. Alex McMahon, president of the American Hospital Association, says:

> "The prices hospitals pay for needed goods and services are rising 50 percent faster than the over-all cost of living."
>
> Some of the increases he noted were sugar packets, up 197 percent in one year; coffee, 24 percent; jelly packets, 114 percent; sliced peaches, 71 percent; and bandages, 43 percent.
>
> The price of wash cloths has increased 72 percent during the past year, while that of patients' gowns is up 39 percent, plastic bags up 110 percent, electricity up 33 percent and heating oil up 160 percent (19:48).

The figures, of course, vary from hospital to hospital. The result, however, is the same--higher costs for the hospital which are passed on to the patient.

4. Rising Labor Costs. Respondents in a Harris survey indicated they thought rising salaries for nurses were one of the five major causes of increasing hospital costs. Oddly, though, rising labor costs in-hospital were singled out as a major factor by only 1 percent of the respondents (30:9). The truth of the matter is that both represent a significant cost to a hospital. Data gathered by the American Hospital Association shows that in 1975, payroll expenditures accounted for over 50 percent of the average hospital's total expenses (73:Table 1).

Wayne C. Allen, vice president of fiscal services for the Colorado Hospital Association, explains: "Hospitals are a labor intensive industry. There is no way of getting

around that. As wages go up, so will the cost of hospital labor" (9:26). Allen and others estimate that labor accounts for 54 to 60 percent of the total budget for a Colorado hospital (9:26).

Hospital administrators point out another cause of rising labor costs for hospitals. It is difficult, they say, to compete for qualified nurses and technicians without raising salaries (19:48).

5. Empty Hospital Beds. Surplus hospital beds are a factor in the rising cost of hospital care. The average occupancy rate of the nation's hospitals, according to the American Hospital Association, is 75.6 percent (13:23). In the Denver area, 70 to 80 percent of the hospital beds are being used, according to Allen (9:26).

A report issued by a National Academy of Sciences committee asserts that these occupancy rates are not high enough. The report suggests that 7 percent of the nation's beds in general hospitals (about 67,000) should be closed. The reason is that empty hospital beds are costly. The committee estimates the cost of maintaining an empty hospital bed to be at least half the cost of an occupied bed (13:23). One estimate places this cost to be $18,250 a year (65:244). Consumer advocate Ralph Nader thinks the cost is greater. He claims Americans are paying $3 billion a year for hospital vacancies (31:9).

Another problem with empty hospital beds is that they create pressure to fill them. The National Academy of Science's committee's report noted: "(surpluses of empty beds) and the availability of hospitalization insurance generate pressures to use high-cost hospital beds in preference to less expensive alternative forms of care" (13:23).

Frank Traylor, a surgeon and Denver-area legislator, says he believes excess hospital beds in the Denver area have contributed to unnecessary hospital admissions. "I have been called by several hospitals--let me emphasize never by private hospitals--with suggestions that I admit more patients," he says. "There would be less pressure to admit patients if there were fewer hospital beds" (9:26).

6. Rising Cost of Drugs. In 1975 the drugs and prescriptions component of the Consumer Price Index rose 7.4 percent. The Council on Wage and Price Stability noted that although this increase was not excessive relative to the rest of the economy, it was highly unusual. In the past, the Council reported, this component rarely increased more than 1 percent annually (25:4).

A controversy surrounds the method by which drugs are prescribed in America. Basically, when a doctor prescribes medicine, he can identify it as the brand-name drug of a specific manufacturer or by its generic (untrademarked) name. In almost all states, if a doctor specifies

a brand name in a prescription, the pharmacist by law must sell you that brand and no other. If the doctor prescribes the drug by generic name, however, the pharmacist is free to substitute, or "upgrade" the prescription and fill it with a brand-name medicine.

A study conducted by the Council on Economic Priorities, a private, non-profit research corporation, shows that the majority of generic prescriptions written by doctors are filled with brand-name compounds. The study noted, however, that:

> Even when brand names were used to fill generic prescriptions, patients paid a bit less than for brand-name prescriptions. In other words, pharmacists, apparently aware of the doctor's intent, either picked one of the less-expensive brands or sold the drugs for less than they would have if the prescription had called for a brand name (83:25-26).

Another facet of the drug controversy is the fact that big firms (15 companies have sales that exceed $100 million a year) pay for the research and development of new drugs and sponsor the promotions which bring them to the attention of the nation's doctors. Critics note that after the patent protection for a particular drug expires, the company still retains its claim to the original trade name. By this point, the critics argue, this trade name is fixed in the doctors' minds to the point where they shut out the products of other manufacturers with identical chemical makeups. The study by the Council on Economic Priorities,

mentioned earlier, turned up evidence to support this contention (83:26).

The Pharmaceutical Manufacturers Association, which represents most big drug firms, contends that all drugs are not created equal. They say that although drugs may be the same chemically, they may not work the same way in the body. The difference they are referring to is known as "bioavailability" which is essentially a yardstick of how the drug is absorbed into the bloodstream. Opponents of the widespread use of generic prescriptions contend that chemical makeup alone does not govern bioavailability:

> Absorption can be influenced by the drug's solubility in digestive juices, by the effect of other ingredients, binders particle size, the age of the preparation, (and) the type of coating (83:27).

Another factor to be considered in the generic prescription controversy is a drug's "therapeutic equivalence." The concern here is that two drugs which are chemically identical and similar in bioavailability, may not provide the same degree of safety and effectiveness.

The Office of Technology Assessment (OTA), a congressional investigative body, says that a majority of the drugs on the market potentially could qualify as being more or less similar in bioavailability and their ability to get the job done therapeutically. The OTA proposes that drugs be separated into two lists. One list would contain drugs which work even though there may be variations in the levels

they reach in the blood. The other list would identify drugs with variations that critically influence their effectiveness or toxicity. The OTA notes, however, that before these lists could be compiled, more research and better record keeping would be needed (83:28).

Doctors find themselves squarely in the middle of the drug prescription controversy. On the one hand, they are concerned about the ability of a drug to help a patient recover his health. On the other, they are coming under increasing pressure to prescribe drugs generically in the hope that it will save patients money. Presently, it seems, most doctors are not convinced that the benefits of generic prescriptions outweigh the risks.

7. Cost of Implementing Federal and State Regulations. Eleven states, including Colorado, are seriously into the business of trying to control health costs either through special commissions or their state health departments (54:20).

Colorado hospital officials note that the increasing number of federal and state regulations are adding to the cost of hospital care by increasing the amount of paperwork necessary to comply with the new rules and standards.

A new Life Safety Code, for example, can cost a large hospital in the Denver area as much as $200,000 a year in added expenditures to keep its building in compliance with ever-changing fire and safety regulations (19:48).

Another example of a program which costs hospitals money is the patients' bill of rights law. This law requires a hospital to hire a person to serve as the patients' representative, a sort of ombudsman on hospital matters. This program, according to one estimate, costs a large hospital about 10 cents per patient per day (19:48).

Utilization review, a program which requires periodic studies to be made of how effectively health facilities are being used, can cost as much as 50 cents per patient per day (19:48).

Two bills are expected to be presented to the Colorado legislature early this year to establish a rate review commission in the state. If the bills are passed, hospitals in the state would have to receive permission from the commission in order to raise their patient fees.

One problem with rate review commissions is that it takes money to run them. The Connecticut Commission on Hospitals and Health Care, for example, estimated its first year cost of operation to be $250,000 (1:70).

Rate review programs also cause hospitals to incur additional operating costs to prepare statistical and financial reports for the regulators. Hans Kleyn, financial administrator of Denver's St. Joseph Hospital, explains: "In the states that have it (a rate review commission), studies indicate that it is costing hospitals 10 cents per

patient per day just to report to the commission." He adds: "Studies do show that rate review could save money in the hotel functions of the hospital, but it doesn't seem to work with the medical functions" (15:22).

8. Cost of Modern Medical Equipment. A review of increases in hospital costs, conducted by the Social Security Administration, showed that the most rapidly rising component of costs has been expenditures for additional equipment and supplies. This component grew approximately 10 percent per year from 1965 through 1973 (25:12).

The Council on Wage and Price Stability noted in its April 1976 report:

> Medical innovations in recent years have been characterized by an emphasis upon complex diagnostic and therapeutic techniques usually requiring hospitalization and complicated, expensive equipment. Examples of this trend include chemotherapy, cancer radiation therapy, renal dialysis, open-heart surgery, organ transplants, intensive care units for heart attacks, burns and trauma, and electronic and whole body scanners (25:20).

The report adds:

> . . . new and sophisticated equipment has been a crucial factor in rising medical care outlays. New technology in medicine, unlike that in other industries, has unfortunately tended, on the whole, to be cost-raising rather than cost-saving (25:20).

The Council cites the use of intensive care units for treating heart attack victims as a good example of the impact of new technology on the cost of medical care:

> In 1960, only 11 percent of private nonprofit hospitals had intensive care units; by 1973 such units were in place in approximately 71 percent.

> These units increased the costs of treating heart attacks dramatically: a recent study found the average cost escalating from $1,449 per case in 1964 to $3,280 per case in 1971, an increase of 126 percent, or 12 percent per year. Although this sharp increase in cost may reflect improved care, some clinical studies reported in several medical journals have questioned the effectiveness of such units compared to less expensive forms of treatment (25:21).

Dr. Anthony Robbins, director of the Colorado Department of Health, is concerned about another medical innovation--the computerized axial tomography (CAT) scanner. The CAT scanner is a remarkable X-ray machine that can create cross-sectional pictures of the human body or head (12:2). A scanner costs about $500,000 to buy and can cost as much as a million dollars a year to operate (77:4).

Dr. Robbins is concerned about the proliferation of these scanners in the state. "There's little disagreement that the 15 CAT scanners approved in the state already are too many," he says (12:2). Officials of Colorado Blue Cross-Blue Shield add: there is an "excessive" number of the scanners (11) in Denver area hospitals (51:43).

As might be expected, doctors and hospital administrators are on the other side of the issue. They say scanners are needed and, in addition, that its impractical to share a scanner with other facilities.

"Any hospital over 250 beds realistically has to have a CAT scanner," says John Rutter, executive assistant administrator at Denver's Mercy Hospital (12:2).

"People just don't understand that hospitals don't have the option of being full service or a half service operation," says John Halfen, assistant director of St. Anthony Hospital. "It's not like operating a bank or gas station. You have to keep up with new technology and be able to staff and maintain a hospital for full service" (9:5).

Dr. William Roy sums up another aspect of the medical equipment problem: "Medical knowledge is said to have a half-life of four to seven years. Likewise, medical technology has a similarly short half-life, and this brief span propels constant and expensive changes (63:590).

In concluding this brief discussion of the cost of modern medical equipment, it is interesting to note that no more than 3 percent of the respondents in a Harris survey conducted a year ago cited the rising cost of complex medical equipment as a major cause of rising hospital costs (30:9).

9. Impact of Heavy Government Involvement. The Council on Wage and Price Stability reported in April 1976: "Federal outlays for health now comprise 11.3 percent of the Federal Budget; only national defense, interest on the national debt and income security programs have a larger share" (25:1).

Between 1965 and 1975, government expenditures for personal health care jumped from $7.0 billion to $40.9 billion, an increase of 484 percent (25:14).

In fiscal year 1975, 42.2 percent of all health expenditures came from public funds. Total federal payments that year amounted to $33.8 billion; state and local governments contributed another $16.1 billion (25:16). In addition, the Office of Management and Budget estimates the federal government subsidized the health industry by as much as $8 billion that year by foregoing various forms of income and Social Security tax revenues. Thus, government support to the health industry in 1975 amounted to approximately $58 billion, or almost one half total health expenditures (25:17).

U. S. Senator Herman Talmadge provides a more current illustration of the magnitude of government spending in the health sector:

> Medicare and Medicaid will cost federal and state taxpayers close to $41 billion in fiscal 1977--an increase of $8 billion over fiscal 1976. This means that Medicare and Medicaid will spend almost $200 for every man, woman and child in the United States (77:1).

Many economists believe that expenditures of this size cannot help but affect and alter the dynamics of the health care sector.

One of the major effects government programs and spending have had on the health care sector is to alter

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demand. Vincent P. Barabba, director of the U. S. Bureau of the Census, notes that Medicare and Medicaid "have been dramatically successful in achieving their intended goals: permitting low-income people greater use of health services" (8:9). This success, however, had a price. Dr. S. David Pomrinse explains:

> The nation decided that as a matter of public policy, health care was to be considered a right, and arranged for financial support for the aged and the poor through Medicare and Medicaid since these two groups were least able to pay for their own care. What happened? As the economists say, effective demand increased; the supply of doctors, nurses and beds was fixed, and as could have been predicted, the price went up (56:12).

As the cost of medical care increased, the federal government began to make only partial payments to hospitals for Medicare and Medicaid patient care. The government developed an elaborate system of "reasonable" costs it was willing to pay for. This created problems. For example, Blue Cross officials maintain that, "Last year, the government program paid only 85 to 90 percent of the actual costs of many hospitals' bills for caring for medicaid patients" (39:3).

The result of the government's partial payment practices was that non-Medicare and non-Medicaid patients' hospital bills were increased to make up the difference.

Some health experts and economists argue that the government reimbursement system has an even bigger flaw.

Under the present system, they say, hospital costs are typically paid on a "cost reimbursement" basis. This means that within certain limits, all the costs incurred by a hospital in treating a patient will be reimbursed. The hospitals, therefore, have little incentive to be efficient under this system, since virtually any bill they run up will be paid (25:19). The Council on Wage and Price Stability recognized this fact in its December 1976 report: "One reason for the explosive increases in health care costs may be that no one has a direct incentive to hold the costs down" (52:6). The Council concluded that "doctors, hospitals and the federal government are not going to control costs because there is not enough incentive to do so" (50:14).

Summary

Thus far, the factors discussed have contributed to the rising cost of hospital care. Obviously, many of these factors are interrelated and interdependent.

In the next section, some of the factors affecting the other major component of health care costs--physicians' services--will be examined.

PHYSICIANS' SERVICES

Background

There were more than 322,222 medical doctors in the United States in 1975 (31:8). This means that the country now has more doctors per one thousand people than at any other time in its history (11:7).

In 1975, physicians' fees accounted for nearly 19 percent of the expenditures for personal health care, or over $22 billion (25:3).

Factors Affecting the Cost of Physicians' Services

1. Rise in Physicians' Fees. Probably more people consult doctors than all other professions combined (6:129). Naturally, then, people are concerned about the cost of their services.

The Council on Wage and Price Stability reported that physician fees increased by 11.8 percent in 1975, substantially higher than the 7.7 percent increase in the cost of services in other sectors of the economy. The largest price increases, according to the Council, were for general office visits (12.0 percent) and for obstetrical care (13.9 percent)(25:4).

The American Medical Association reported that the average fee for an initial office visit rose from $12.80 in 1969 to $19.55 in 1974, an increase of 53 percent (25:4).

The authors of Medical Economics asked people to comment on the fees their doctors charged, in a recent Patient Attitude Survey. In response to the question: "Does your regular doctor charge fees you consider . . . (too high, about right, low)?", 70 percent of the respondents chose "about right" (26:65).

While many respondents seemed satisfied with the cost of doctors' services, it is important to note that the percentage of people who think doctors' fees are too high is growing. In 1963, 16 percent of the Patient Attitude Survey's respondents indicated doctors' fees were "too high"; that rose to 22 percent in 1969 and 27 percent in 1976 (26:66).

At the same time, according to pollster Lou Harris, the percentage of the American public that has "a great deal of confidence" in medicine has declined from 73 percent in 1966 to 42 percent in 1976 (6:129). Part of this drop, no doubt, can be attributed to the well-known decline in respect for all institutions which began in the late 1960s. At least some of the drop, however, might be interpreted as the result of "what happens when an increasingly sophisticated public begins to detect fallibility in professionals once thought to border on divine" (6:129).

In this regard, Dr. Theodore Cooper, assistant secretary for health at the Health, Education and Welfare

Department, says: "I don't see a deterioration in the quality of medicine, but a greater awareness of what our deficiencies are. Among these is the rising costs of health care, fueled by rapidly rising doctors' fees" (6:129).

How much money do doctors make? Respondents in Medical Economics' Patient Attitude Survey were asked to estimate the annual income of both their doctor and the "average American doctor." The following table depicts their estimates (26:70):

What Patients Believe Doctors Earn

Salary Range	Their Doctor %	Average Doctor %
$30,000 or less	10	11
$31,000 to $40,000	14	20
$41,000 to $50,000	23	29
$51,000 to $60,000	11	11
$61,000 to $70,000	6	8
$71,000 to $80,000	13	10
$81,000 or more	23	11

How much money do doctors really make? The answer is elusive and difficult to generalize. Medical Economics reported that, according to its Continuing Survey, the median income for doctors in 1975 was $58,440 (26:76). The Office of Management and Budget estimated that in 1976,

> private physicians (excluding interns, residents, teachers and administrators) would receive a median net income (including the value of retirement plans) of $47,000 annually at age 35, rising to $76,000 in the 46-50 age group and then tapering off sharply (29:9).

The OMB noted, though, that its exclusions and extrapolations probably tended to overstate the income of these private physicians (29:9).

U. E. Reinhardt, an associate professor of Economics and Public Affairs at Princeton University, looks at physicians' incomes in terms of their effect on total health expenditures. His concern is not that physicians expect to, or even will, earn $50,000 to $70,000 of net income in 1976, but that "in doing their (professional) thing, they typically obligate society to incur expenditures at least twice and, for some specialities, many more times their annual net income" (62:13).

Reinhardt quickly notes, however, that reducing the incomes of physicians is not the answer to the problem of rising health costs:

> . . . the total gross income earned by physicians in this country amounts to only about 20 percent of national health expenditures. Physicians' net income is probably about 60 percent of that amount--or only about 12 percent of national health expenditures. Other things being equal, a reduction of X percent in physicians' net incomes would therefore reduce national health-care expenditures by only .12X percent. For example, suppose that by some miracle physicians' net incomes in 1975 had been reduced by 25 percent below their actual level (but that the incomes the physicians paid out to others in the form of salaries, or payments for space, equipment and supplies, had been held at the actual 1975 levels). This dramatic policy would have reduced national health expenditures by only about 2.7 percent. The percentage of GNP devoted to health care would have been reduced from the reported 8.3 percent to 8.1 percent (62:22).

If physicians' incomes are not the major factor in rising health expenditures, what is? The Council on Wage and Price Stability noted that increased use of "real inputs"--such as laboratory tests, x-rays, and support personnel--was a prime determinant in increased expenditures (25:13). Many health experts attribute the increase in doctors' use of these real inputs to the skyrocketing cost of malpractice insurance.

2. Rising Malpractice Rates/Defensive Medicine. In the past few years, doctors' malpractice insurance rates have increased dramatically. Physicians paid an average of $610 for malpractice insurance in 1968 and an average of $1,905 in 1973. A government survey of the insurance industry disclosed that premiums went up another 84 percent in 1974 and 125 percent in 1975. Using these percentages, the American Medical Association estimated that the average malpractice payment per doctor for malpractice insurance in 1975 was $7,887 (3:1). The picture for some specialists is even worse. Liability insurance for some of them, for example, has gone from $9,000 to more than $35,000 a year (11:8).

The malpractice issue is a double-edged sword. On one side, doctors are forced to raise their fees to cover the increase in their overhead as a result of rising malpractice insurance rates. The American Medical Association, for example, estimated that patients paid about $1.24

for malpractice insurance each time they visited a doctor in 1975 (3:1). Senator Herman Talmadge, chairman, Subcommittee on Health, Senate Committee on Finance, estimated that malpractice premiums can amount to as much as $15 or even $20 per patient day in some large medical centers (77:4).

On the other hand, the malpractice insurance increases have forced many doctors to practice what is known as "defensive medicine." The American Medical Association conducted a survey of its members and found that more than 70 percent of doctors who were interviewed said they ordered extra tests on patients to protect themselves against malpractice suits (31:9). In a survey of its members, the Texas Medical Association found evidence of the same trend:

- 67% of the Texas doctors said they were ordering more x-rays;
- 66% were ordering more lab tests;
- 65% were making greater use of a second physician's opinion;
- 51% were setting limits on the procedures they were willing to perform;
- 50% were delegating less responsibility for the patient's care to others; and
- 48% were hospitalizing their patients more (3:2).

The consumer, of course, ultimately pays the costs of defensive medicine, as we have noted. The public recognizes the connection between defensive medicine and the rising cost of health care. In a survey conducted last year, Harris found that respondents identified "the escalated cost of malpractice insurance, coupled closely with the rising cost of doctor care" as two of the five major causes of rising hospital costs (30:9).

Dr. Donald S. Fredrickson, director of the National Institutes of Health, says this about the malpractice insurance problem:

> It's clear that we need to examine alternatives to the tort system for adjudicating malpractice claims. This simply cannot be the answer for very long. Those alternatives may be arbitration, mediation or no-fault insurance.
>
> We need some measures that will protect the rights of the patient when true negligence occurs, yet reduce the cost of insurance--and the burden it adds to costs of medical care--to more reasonable levels (35:66).

As an aside, before leaving the malpractice issue, I would like to note that Harris found, in the survey mentioned earlier, that "lawyers are in real hot water over the malpractice issue because the public blames them much more than they do anybody in the health care area" (30:8).

Summary

This section examined some of the factors affecting the price of physicians' fees and the effect price increases have had on national health expenditures.

The following section outlines what is and can be done by concerned individuals to hold down and/or reduce the cost of health care.

CUTTING HEALTH CARE COSTS

Doctors

Colorado doctors are doing the following to help reduce the cost of health care:

1. Organizing and Operating Peer Review Programs. The Colorado Medical Society created the Foundation for Medical Care in 1973. The foundation is a prototype Professional Standards Review Organization (PSRO) involving more than 400 physicians and every general hospital in the state. Dr. Kenneth A. Platt, the foundation's medical director, says the program has helped cut the average stay in the hospital from eight and one half days to just over eight. On first reading, this may not seem to be a significant achievement. Doctor Platt notes, however, that this reduction in the length of stay saved almost $3 million, without lessening the quality of care. In addition, he says, the foundation is tackling the inappropriate use of antibiotics and unwarranted hospitalization for diagnostic work-ups (65:244).

2. Serving on Hospital Committees to Lower Costs Without Reducing Quality. A classic example of the result of this kind of activity is the program at Denver's Porter

Memorial Hospital and Swedish Medical Center. In January 1972, the medical staffs of these hospitals merged in an effort to provide less expensive quality care. That same year, the obstetrical service at Porter was closed and merged with Swedish's. The result--operating costs per delivery were reduced approximately 25 percent (76:3).

3. Looking for Ways to Reduce Their Own Overhead. An increasing number of doctors in the Denver area are forming partnerships or professional corporations, or are sharing office space and employees in an effort to hold down overhead costs (11:9).

4. Establishing Programs to Educate Doctors on the Costs of Medical Care and the Reasons Costs Are Rising. The Denver Medical Society is organizing a program to determine why medical costs are rising and to educate doctors about the cost of the treatment they prescribe. Dr. Frederick A. Lewis, Jr., president of the society, feels physicians have not been trained to care about the cost of the treatment they prescribe. He thinks this is wrong, and the society's program is a result of this conviction.

In addition to the educational program for doctors, the society has formed a committee, composed of non-medical and medically-oriented residents, to mull over the philosophy of medical care, including the question: "How much should be spent to save a life or alleviate pain?"

"These are decisions that no hospital or physician can make," says Lewis. "The public must come to grips with these issues" (9:26).

The Arapahoe Medical Society is developing a slide presentation to educate the public about the rising cost of medical care. Mr. Edgar Smith, the society's director, hopes that those who see the presentation will appreciate the many facets of the problem, as well as recognize what is being and can be done to hold down costs.

5. Working to Ease the Malpractice Crisis. The entire medical profession is working to ease the malpractice crisis by establishing professional liability programs where private insurance is not reasonably available. In addition, doctors throughout the nation are working for legislative reform in this area (11:9).

Hospitals

Hospitals in the Denver area are doing the following to reduce the cost of hospital care:

1. Sharing Services. As we have noted, Denver's Porter Memorial Hospital and Swedish Medical Center made a pioneering effort in this concept, when they agreed to share obstetrics and pediatric departments. The concept is now being tried by other Denver-area hospitals on a more limited basis. Ronald Struxness, executive vice president

of Lutheran Medical Center, notes, for example: "Children's Hospital takes most of the babies born at Lutheran because of its superior facilities for infant care" (69:24).

2. Participating in Group Purchasing Plans. Many Denver-area hospitals are members of a 64-hospital purchasing cooperative, which reduces its members' cost of hospital supplies as a result of savings attained through volume buying (9:26).

3. Using Management Engineering Techniques to Evaluate Staffs. Many hospitals in the Denver area evaluate their staffs in terms of effectiveness and efficiency. Often, as was the case at Lutheran Medical Center and St. Luke's Hospital, these evaluations enable hospitals to redistribute or reduce their manpower to bring about cost savings (69:24 and 9:26).

4. Reviewing Hospital Use. Most Denver-area hospitals have a program to review how long a patient stays in the hospital and to assure that he or she receives only those services which are required for his care.

5. Providing Alternatives to In-patient Care. Out-patient clinics and day surgery units have been established at most hospitals in the Denver area to help reduce the costs of medical care.

6. Participating in Pilot "Prospective Reimbursement" Programs. Eight Colorado hospitals are now concluding

a three-year pilot project in which they were paid on a prospective reimbursement basis. Under the prospective reimbursement system, hospitals are required to set rates for reimbursement from insurance companies on the basis of costs projected before the hospitals' fiscal years begin. "If they can keep their costs within their budget, then they'll be paid in full," says David Sheehan, vice president of Blue Cross-Blue Shield. "If they can't, then they'll start losing money." Many health economists, as well as Blue Cross-Blue Shield officials and the Colorado Hospital Association, support the prospective reimbursement concept (15:22).

7. Establishing a Statewide Reporting and Accounting System. Dr. Anthony Robbins, director of the Colorado Department of Health, feels a data system for monitoring medical procedures in the state is necessary. "We had a similar system in Vermont (where he was commissioner of health), and we believe we achieved some very real savings simply by keeping track of what was going on in different parts of the state," he says (15:21). Arvid Brekke, president of the Colorado Hospital Association, agrees. "One of the problems in controlling costs is that there's little uniformity in reporting and accounting procedures on the part of individual hospitals," he observes. As a result, the hospital association intends to institute a uniform reporting system in the state early this year (15:22).

Legislators

Colorado legislators will be considering the following methods of reducing health care costs this year:

1. Rate Review. As noted in the discussion of federal and state regulations (page), two bills to establish a rate review system in the state are expected to be introduced in the Colorado Legislature early this year. While the rate review system is controversial, many health experts believe it does provide a method for cutting the cost of health care.

2. Tightening Colorado's Certificate of Public Necessity Act. Many health experts believe the state's current law--which requires health facilities to obtain permission to build, expand or make major purchases--is too lax. Frank Traylor, a surgeon and legislator, feels the present law has proven to have more bark than bite. Until recently the Colorado Health Facilities Advisory Council (which regulates the act) has "approved almost everything that came before it," including 15 CAT scanners at a cost of $500,000 each, he says.

"I really don't think a new piece of equipment should be approved until a plan is worked out for who needs it. It shouldn't be dispensed as it has on a first-come, first-service basis" (9:26).

3. Health Planning. The purpose of this type of legislation is to insure that too many of the same type of

hospitals, nursing homes or other health facilities are not built in the same area (15:22).

Individual Citizens

Not all answers to the medical cost crisis will come from hospital administrators or physicians, says Doctor Lewis. Ultimately it will be the public that wrestles with the decisions of where and when to cut costs, he adds (9:26).

Outlined below are some steps individuals can take to cut the cost of health care.

1. Suggestions from Blue Cross-Blue Shield:
   - A. Avoid over-eating and excessive smoking and drinking.
   - B. Get proper rest.
   - C. Get proper exercise.
   - D. Relax from time to time. Vacations are not a luxury, they are essential to good health.
   - E. Avoid medication unless it's necessary and prescribed for you.
   - F. Check your home for accident and fire hazards.
   - G. Don't drive and don't use power tools when you're tired or have been drinking.
   - H. Find a personal physician you like before you get sick or hurt. If a doctor knows

you and your health record, he can take better care of you when something does go wrong.

I. Use your health benefits properly. Don't insist on being admitted to a hospital for tests if they can be done on an outpatient basis. Leave the hospital as soon as you can be released . . . Check your hospital bill to make sure it is accurate (11:12-13).

2. Suggestions from the American Hospital Association:

A. Don't demand that minor surgical procedures be done in the hospital if they can be easily performed in your doctor's office. Emphasize to your employer or insurance company that outpatient care is more economical.

B. When hospitalized, don't demand extra, needless convalescent days.

C. Use a family physician, not your hospital's emergency room, for routine problems.

D. Don't maintain health insurance plans with duplicate coverage.

E. Take care of yourself. Don't wait until you are ill to think about your health.

F. Learn, and help inform others, about how disease and accidents can be prevented.

G. Encourage a sensible approach to malpractice suits.

H. Encourage the sharing of resources by area hospitals so that expensive equipment and services aren't unnecessarily duplicated within a small geographic area (4:4).

Chapter 3

LITERATURE REVIEW: MASS COMMUNICATIONS THEORY

The field of empirical data concerning mass communications theory has a bountiful store of differing interpretations as to possible effects. One effect produced by the mass media, upon which mass communications researchers do agree, is the "reinforcement" effect. For example, when an individual or group already harbors sentiments similar to those expressed via the mass media, the material presented to those persons will generally serve to further structure and strengthen their like beliefs and opinions.

Joseph T. Klapper, a major proponent of the reinforcement theory, formulates his explanation of this concept by stating:

> Within a given audience exposed to particular communications, reinforcement, or at least constancy of opinion, is typically found to be the dominant effect . . . (41:15).

Further support of the reinforcement theory is found in the Marvin Karlins and Herbert I. Abelson operational treatment of persuasion as they observe:

> New information can and does (1) strengthen the desired feelings which some people already have about a specified topic; (2) provide existing supporters of a topic with a way to verbalize their positive sentiments. Thus, for people who already have an opinion that the persuader wants them to have, new information can help to strengthen and solidify that opinion (36:34).

Wilbur Schramm, another noted researcher, also acknowledges the reinforcement theory; but in doing so, he sees it to be something more.

> There are two things we can say with confidence about predicting communications effects. One is that a message is much more likely to succeed if it fits the patterns of understandings, attitudes, values and goals that a receiver has; or at least if it starts with this pattern and tries to reshape it slightly (66:15).

In view of the researchers' consensus on the prominence of the reinforcement effect of mass communications, the authors believe that it is important to note that this consensus is not an endorsement of the "hypodermic" theory of communications in which a communicator can merely place a message in the mind of his audience and receive desired results. Harold Mendelsohn lends support to this belief by stating:

> The new social science approach to mass communications has demonstrated that factors of personality, social-economic position, prior interest and commitment, mass media habits, placement in informal networks of face-to-face communication, and individual motivation serve in varying complex ways to predispose people to mass media messages, and and, at the same time, to intervene between what communicators intended to happen and what actually does happen in the communications situation (49:132).

The target publics for this presentation will be the members of various professional organizations, as well as service-club and community-group audiences located primarily within Arapahoe County. These audiences for the most part, will have two characteristics in common: First,

the people involved will have selectively chosen to view the program, and second, as a logical deduction resulting from their selection, it is a probable assumption that the people involved will at least be somewhat interested in the problem being treated--rising health care costs. This audience interest, or personal motivation, is considered a vital aspect of attitude strengthening or reshaping, even to the slightest degree.

Wilbur Schramm and Donald F. Roberts quote researchers as emphasizing that, "The importance of motivation in achievement or learning, or in assimilating knowledge, has been consistently shown in academic studies" (68:452-453).

Joseph T. Klapper's comments on personal motivation point out:

> People tend to expose themselves selectively to communications in accord with their existing views and to avoid exposure to unsympathetic communications . . . People also tend selectively to retain sympathetic material better than unsympathetic material (41:50).

Robert D. Russell adds support to this conception when he presents a behavioralist's view of the element of selective exposure, as found in his study on health education, by stipulating:

> A principle deriving from behavioral research in public health during the 1950's and 1960's holds that behavior is determined by subjective reality rather than objective--by the individual's own motives and beliefs . . . (64:87).

Therefore, it is believed that these factors, personal motivation and selective exposure, are important elements of consideration in the formulation of any program development.

At this point in the literature review, the authors are aware that no attempt should be made to design a presentation with the intention or expectation of producing sweeping audience attitude changes. On the other hand, the AMS did not commission this project to simply reinforce the public's awareness of the rising health care cost problem. Their intent is to procure a vehicle of presentation to help them promote favorable public understanding, if not support, and recognition of local physicians' efforts to help control the problem. In other words, the AMS is striving to identify the doctors of Arapahoe County as a part of the solution to the problem rather than as contributors to its cause. Thus, their objective of enhancing better public understanding is a far more feasible middle-range goal than is any attempt at or expectation of producing sweeping audience attitude changes.

By definition then, the authors are designing a public information presentation. The construction of the presentation will employ aspects of two main elements of communications design: motivational appeal and the two-sided communications approach.

Otto Lerbinger, in his treatment of the "motivational design," expresses a rejection of the view that there can be an assumption that the communicator does something to an audience. He further stipulates that, "Communication is instead seen as a transactional process where both the communicator and receiver give and take something of value" (43:78). Then he explains, "The motivational design assumes that little or no learning can take place in the absence of some unfulfilled need or desire which serves as a drive. Man is seen as a goal-seeking animal constantly striving to reduce the tensions within him" (43:80).

Thus, the personal motivation that will for the most part inspire audience selective exposure to the AMS presentation, can be viewed as a seeking to fulfill individual needs and/or desires to better understand the problem and possible solutions.

W. Phillips Davison comments that ". . . communications serve as a link between man and his environment, and their effects may be explained in terms of the role they play in enabling people to bring about more satisfying relationships between themselves and the world around them" (43:81). Davison extends his comments by pointing out that, "The communicator can influence attitudes or behavior only

when he is able to convey information that may be utilized by members of his audience to satisfy their wants or needs" (43:81).

The two-sided communications approach is favored because the target audiences will be generally well educated; that is most of the individuals exposed to the presentation will have at least a high school education or better. Also, most people who will be exposed to the presentation will have already been exposed to other opinions and information concerning the problem to be addressed. Since the problem of rising health care costs is currently becoming a volatile public issue, it must be assumed that there will be hostile opinions as to the role doctors are playing in the problem. Therefore, as Lerbinger points out:

> . . . when an audience is highly educated or intelligent the presentation of both sides is more effective. If the audience is initially opposed to the point of view being presented, even if the educational level is not high, the argument will appear biased. For this reason, it is recommended that two sides of an argument be presented to an audience that is hostile to the view being advocated (43:72-73).

The authors thus believe that by employing the motivational appeals design, and possibly by capitalizing on whatever degree of personal motivation brings an audience to selectively expose themselves to the presentation, individuals will acquire and retain a greater portion of the information presented. It is also believed that greater

credibility will be attributed to the information offered if the two-sided communications approach is exercised in the presentation. And furthermore, the authors firmly acknowledge Davison's stern warning that:

> . . . the communicator's audience is not a passive recipient--it cannot be regarded as a lump of clay to be molded by the master propagandist. Rather the audience is made up of individuals who demand something from the communications to which they are exposed, and who select those that are likely to be useful to them. In other words, they must get something from the manipulator if he is to get something from them. A bargain is involved (43:78).

In his article, Some Reasons Why Information Campaigns Can Succeed, Harold Mendelsohn reveals that,

> What little empirical experience we have accumulated from the past suggests that public information campaigns have relatively high success potentials:
> 1. If they are planned around the assumption that most of the publics to which they will be addressed will be either only mildly interested or not at all interested in what is communicated.
> 2. If middle-range goals which can be reasonably achieved as a consequence of exposure are set as specific objectives. Frequently it is equally important either to set up or to utilize environmental support systems to help sheer information-giving become effective in influencing behavior.
> 3. If, after middle-range objectives are set, careful consideration is given to delineating specific targets in terms of their demographic and psychological attributes, their life-styles, value and belief systems, and mass media habits. Here, it is important not only to determine the scope of prior indifference, but to uncover its roots as well" (48:52).

Having already considered Dr. Mendelsohn's first two criteria, the third one will now be explored.

The awareness of each viewer to the problem of rising health care costs will, of course, vary with their type of employment, family status and individual health profiles. But, with the exception of those few individuals and groups who have personally researched the problem, the general understandings and attitudes of the publics to be addressed will be most similar. The reasoning behind this view is seen more clearly through the words of Jacques Ellul:

> To the average man who tried to keep informed, a world emerges that is astonishingly incoherent, absurd, and irrational, which changes rapidly and constantly for reasons he cannot understand. And as the most frequent news story is about an accident or a calamity, our reader takes a catastrophic view of the world around him. What he learns from papers is inevitably the event that disturbs the order of things (24:145).

In other words, it can be surmised that the general public, even though it is aware in varying degrees of the currently evolving crisis in rising health care costs, is not generally knowledgeable of the numerous complex facets which comprise the growing problem.

As of late, various media have been attempting to enlighten the public as to these complex facets, including local Denver newspapers. However, Andie L. Knutson, in quoting Percy H. Tannenbaum's research concerning expert communications "gatekeepers," points out:

> In a challenging review of a number of studies of these gatekeepers in the flow of scientific information, Tannenbaum reports evidence that some of the expert communicators who are most eager to help may muddy the waters for lack of valid conceptions regarding the public's interest and views (42:452).

Studies on public opinion have concluded that the mass media provide the general public with a ready source of opinion fodder, be it right or wrong, on daily issues of concern. Joseph T. Klapper, in testimony before the House Committee on Foreign Affairs on February 8, 1967, adds support to this line of thinking by explaining:

> There is another area in which mass communication is extremely effective, and that is in the creation of opinion on new issues . . . And once the opinion is created, then it is this new opinion which becomes easy to reinforce and hard to change. This process of opinion creation is strongest, by the way, when the person has no other source of information on the topic to use as a touchstone. He is therefore the more wholly dependent on the communication in question (40:285-286).

With this thought in mind, it is apparent that the mass media have been in the forefront of developing public opinion as to the possible causes for the current problem of rising health care costs. And, in doing so, some media have painted a generally negative image of doctors as being a part of the problem (26, 52, 54). This is not to say that some doctors are not a contributing factor of the problem, for some obviously are. But, without additional sources of information other than these media, the dedicated

physicians who have been attempting tc contribute to the control of the problem, are being overlooked. Also, with the ever increasing barrage of news coverage on the topic, the general public cannot help but be confused. Even our legislators are stymied by the complexities of the problem. As people become more and more confused, they begin to reach for simple solutions and targets to blame, ignoring the fact that they themselves are a major cause of the problem as well. Daniel Katz comments on this type of situation by explaining:

> Any situation, then, which is ambiguous for the individual is likely to produce attitude change. His need for cognitive structure is such that he will either modify his beliefs to impose structure or accept some new formula presented by others. He seeks a meaningful picture of his universe, and when there is ambiguity he will reach for a ready solution. Rumors abound when information is unavailable (37:31).

A further endorsement of the theory that the mass media mold public opinion comes from Elliot Aronson's observation:

> Let's look at something supposedly objective - like the news. Are the newsmen trying to sell us anything? Probably not. But here, the mass media can exert a subtle influence on our opinions simply by determining which events are given exposure (7:48).

This leads into the next area of review which considers aspects of audience susceptibility to persuasive communications.

The Sherifs and Nebergall explore this element of consideration by stating:

> Susceptibility to change is initially greater on the part of less-involved persons, including the majority of those who endorse moderate points of view on an issue. With their broader latitudes of noncommitment, less-involved persons assimilate communications over a wider range and are more likely to change toward it, since their own stand is less salient as an anchor. Similarly, the effects of variations in the communication situation, such as primacy-recency effects, are greater for less-involved persons than for those strongly committed to a position (70:120).

They further amplify their views by continuing their statement:

> The probability of change toward an advocated position is greater when the number of feasible alternative interpretations of the topic is great, when the individual is somewhat unfamiliar and is not highly involved with the topic, and when the source and communicator have high prestige (70:120).

Thus, the authors will recommend to the AMS that, whenever possible, the presentation be given by a doctor or hospital administrator with public speaking abilities to insure that advantage is fully exercised over this element of receiver susceptibility.

Jacques Ellul presents still another aspect of receiver susceptibility, but from a slightly different vantage point, when he comments that, "An analysis of propaganda therefore shows that it succeeds primarily because it corresponds exactly to a need of the masses" (24:146).

This is not to suggest that simple or false answers are to be provided to the public as a means of satisfying their psychological needs for structured cognitive order. However, such a condition lends itself to promoting, ethically, better public understanding of the issues by taking advantage of the public's need for information.

Having thus reviewed these various aspects of mass communications theory, the authors decided that the presentation should be built around three main concepts:

a. The first concept is to gain audience attention by applying various elements of the reinforcement theory. Here, the program will reaffirm and add supportive information to the general public's realization that there actually is a serious problem concerning rising health care costs, and that something must be done to arrest its escalation.
b. The second concept, the stage having been set via application of the reinforcement theory, will be to emphasize what the doctors of the AMS and the Swedish/Porter Hospitals have been contributing, by their efforts, to arrest the problem in Arapahoe County.
c. The third concept will be to conclude the presentation by emphasizing the need for individual participation in joining their doctors to solve, or at least control, the problem. This will be accompanied with information and suggestions as to how individuals can contribute to the problem solution on a personal basis.

The third concept will be further amplified with a coverage of life-styles and their connection with individual health status. This will be mainly in the format of suggestions whereby individuals can begin to judge themselves and ascertain where they stand in relation to the health cost

problem. These suggestions will be based on material derived from research conducted by economist Victor Fuch, and further studies conducted on Fuch's theories of life-style by Dr. Lester Breslow, Dean of the School of Public Health, University of California at Los Angeles, and Dr. N. B. Belloc of the Human Population Laboratory, California State Department of Public Health (80:8-10).

In his discussion on health education, Robert D. Russell examines the elements of susceptibility, seriousness and means of preventing or controlling ill-health in terms of a model derived from studies conducted by Irwin Rosen-stock and Godfrey Hochbaum:

> An individual's motivation in relation to any particular health issue is determined largely by three kinds of belief:
> 1. The extent to which (people) see it as a health problem with high probability of affecting (them) personally.
> 2. The extent to which (people) believe the problem would have serious consequences for (them) if it did involve (them).
> 3. The extent to which (people) believe some reasonable course of action open to (them) would be effective in reducing the threat (64:93).

Russell continues by stating that, ". . . beliefs about susceptibility, seriousness, and means to prevent or control are determiners of action or inaction: a person lacking one or more becomes less likely to take action" (64:93).

Expectations of effectiveness in changing audience health attitudes are, to say the least, extremely low. The

thrust of intent, however, for including this section is to end the presentation with suggestive means of individual action and involvement in the event that anyone is so moved by the information therein. It will also pose a subliminal question to the audience asking them: "Hey! Now that you've seen what the doctors of the AMS and of the Swedish/Porter Hospitals are contributing to the solution and control of rising health care costs, what are you, the individual, doing to help?"

In summary, the purpose of providing information is to give the audiences the benefit of supportive knowledge concerning the problem of rising health care costs. It is also a means of instigating or initiating some slight degree of attitude alteration on the problem, as a whole, in the direction of greater public understanding thereof. Thus, information giving is a form of persuasive communication. Hovland, Janis and Kelley point out:

> One key element in the persuasion situation is, of course, the "recommended opinion" presented in the communication. This element may be conceptualized as a compound stimulus which raises the critical question, and gives a new answer (34:100).

By applying this concept to the presentation being developed, a critical question raised is whether or not local doctors are a contributing factor to the rising health care cost problem. The slide show will depict that the physician is well aware of the rising cost and has

taken measures to reduce cost. These measures will be seen within a hospital setting. In effect, the physicians are shown as part of the solution instead of part of the problem.

Wilbur Schramm and Donald F. Roberts distinguished between instructional or informational and persuasive communication by pointing out that the essential difference is that the first emphasizes learning and the second yielding (68:43). The authors believe that the implementation of information communication is often regarded as the catalytic force which triggers the activation of persuasion. The goal of this project is to inform the community of the reasons for rising health care cost and what the medical profession is doing to contain cost. Therefore, it is possible that the general publics addressed will not only gain new insight to the central problem, but by doing so they may acquire a more favorable opinion towards their local Arapahoe County doctors.

Chapter 4

METHOD OF PRESENTATION

The selection of a 35 mm slide/sound-synchronized program as the best vehicle of presentation was based on considerations of cost and utilization effectiveness.

The initial prerequisite was to define the target publics. After several discussions with Mr. Edgar Smith, these publics were narrowed to include members of various professional organizations, as well as service-club and community-group audiences located primarily within Arapahoe County. These designated publics were not chosen on the basis of simple expediency. As Harold Mendelsohn explains:

> Delineating realistic targets along a continuum ranging from those whose initial interest in a given subject area may be extremely high to those who literally have no interest in what may be communicated becomes an essential step in developing effective public information campaigns (48:51).

As a result of further discussions, a number of specific project requirements materialized. First of all, the AMS stipulated their need for a budget-priced device through which they could most effectively express to these target publics their position on the problem of rising health care costs. Also, this device was to be designed as a speaker's augmentation-tool, rather than as an independent entity of operation. Therefore, mass media

vehicles, such as newspapers, radio and television, were immediately ruled out as per the cost, utilization and target-public factors.

Next, the AMS requested that the device possess built-in mobility and the capacity for inexpensive revision to facilitate the incorporation and/or deletion of materials as new developments concerning the problem addressed evolve. Here, the authors ruled out the possibility of developing a motion picture program. Since the AMS Woman's Auxiliary will also be utilizing the presentation device, the weight and bulk of motion picture equipment would pose certain mobility problems. And, to say the least, the initial production and subsequent revision costs of a motion picture program were viewed as being both prohibitive and unfeasible. As Edward Hodnett has stated, "Only assurance of exposure to millions of people or to extremely significant audiences . . . can justify such initial expense" (33:40). The AMS program's projected audiences will only total in the thousands over an extended period of time.

Next, the authors investigated the question as to whether or not an informational brochure would suffice as the needed speaker's augmentation-tool. However, research has shown that the brochure concept as a primary approach would not be the most effective device available for this project's development. This research indicates that when

people are given a choice in the selection of informational or entertainment opportunities, and unless for whatever reason they are truly interested in the problem being treated, they most likely will not pick the informational option (47:142-143). In other words, the likelihood that a majority of people in a given audience would actually read and be influenced by the information presented in a brochure, in the absence of stimulation beyond a speaker's lecture material, is highly improbable. Harold Mendelsohn expresses his conclusion on audience option-selection by stating:

> When most people are confronted with a choice between deriving pleasure from "serious" non-entertainment fare or from non-serious entertainment fare, they will choose the latter in much greater proportions than the former (47:142-143).

The conclusion concerning the brochure approach does not preclude the employment of an informational brochure as a supplemental device in this project. On the contrary, it is highly recommended that the AMS develop such a brochure to be used in conjunction with the program herein constructed, and that it be utilized as a further aid to the speaker's overall program presentation.

Joseph T. Klapper gives support to the concept of a multi-media presentation in his following statement.

> The combined use of several media plus face-to-face contact, formal or informal, is believed by both master propagandists and by social scientists to be a peculiarly effective technique of persuasion (41:109).

Thus, by the process of elimination, the 35 mm slide/sound-synchronized vehicle of presentation is considered to be the best device to fulfill the AMS's stipulated program needs, while remaining within their parameters of consideration for effective cost and utilization feasibility.

Chapter 5

OBJECTIVES

The following are the objectives of the slide/sound show project.

1. To show that there is a health cost problem due to a number of interrelated factors and that relief is not in sight. Emphasis will be placed on the amount of family income now being spent on health care and projected amounts by the 1980s.

2. To show why the problem exists in terms of hospital care and physician's services. Hospital care will be shown as the most rapidly rising element in personal care spending.

3. To show the factors causing hospital costs and physician fees to increase. These will include rising labor costs and inflation, cost of government involvement, insurance and medical equipment.

4. To show efforts currently being made by physicians and hospitals to hold down medical cost. Porter and Swedish hospitals will be used as case examples to show successful efforts of peer programs, cost sharing, and innovative out-patient programs.

5. To show what the individual can do to hold down his own medical cost. Examples will be given such as using

insurance benefits and hospital services wisely and ways to stay healthy.

Chapter 6

METHODOLOGY AND PROCEDURES

DESIGN

A twelve to fifteen minute slide show presentation with a synchronized narrative and music sound track will be prepared. The Arapahoe Medical Society will receive one set of original slides, a reel to reel master tape and a synched cassette audio tape.

Although the slide/sound show will factually discuss medical costs today, it will not be dogmatic or argumentative. It will be designed to appeal to a cross section of the community involving all socio-economic groups with varying educational levels. Although hospital scenes with physicians in white jackets seem inevitable, the show will also entertain to keep the interest level of the audience. Therefore, the authors are planning to design a show that will present a serious message in an informal format with graphic illustrations, caricatures and photographs.

Professional narration will be used for this project. The authors also plan to use physician and patient voices along with hospital sounds to dramatize the concern of individuals. The authors will use release forms for both photography and voice recording.

RESEARCH

During a meeting between the authors and the Public Relations Committee (comprised of physicians) of the Arapahoe Medical Society on December 20, 1976, the authors were requested to design an exploratory questionnaire to determine the health concerns of the public within a ten mile radius of Porter and Swedish hospitals. The committee was particularly interested in ascertaining if the concerns of the citizens of Arapahoe County were in consonance with national research studies. After further discussions with Mr. Edgar Smith, director of the Arapahoe Medical Society and members of the faculty of the Department of Mass Communications, it was determined that a survey using non-probability sampling methods would be appropriate.

According to Earl R. Babbie in his book, The Practice of Social Research, purposive or judgmental sampling ". . . may be appropriate for the researcher to select his sample on the basis of his own knowledge of the population, its elements, and the nature of his research aims" (10:167-168). Ferber and Verdoorn in Research Methods in Economics and Business state that

> . . . non-probability samples are useful in certain situations. This is particularly true where representativeness may be of little importance, as in certain taste-testing experiments. Pilot surveys or exploratory situations are other examples, for the primary aim is to probe for possible hypothesis and different situations (27:252).

On January 17, 1977, the authors again met with the Public Relations Committee of the AMS and outlined the following research proposal. The proposal was approved by the Public Relations Committee and subsequently by the Executive Committee of the AMS on January 18, 1977.

A. A non-probability survey would be conducted within a ten mile radius of the Porter and Swedish hospitals. The authors explained in detail to the committee that the survey would be non-scientific and that no generalization could be made about the total population; only of the attitudes of those surveyed. The committee was also told that the authors would be unable to compute sampling error or level of confidence or vouch for its validity. A pretest would be accomplished by the authors using both physician and lay respondents.

B. Since the AMS plans to show the slide show primarily to service clubs and other lay groups in Arapahoe County, the authors told the committee that two objectives could be accomplished from the survey. The first would be to solicit individual concerns and attitudes of local people served by the physicians of the AMS since the physicians were particularly interested in what people in the local community thought of medical costs. The second objective would be of use to the authors in the production of the slide show. Through the use of open-ended questions,

the authors hoped to obtain quotes that could be used in the sound track to show the concerns of the people of Arapahoe County.

C. The authors recommended that the survey be accomplished as follows:

1. Questionnaires would be delivered to service clubs within the local community by the AMS and accomplished during the meetings.
2. The Woman's Auxiliary of the AMS would conduct, under the supervision of the authors, a one-day telephone survey using the Mountain Bell "South Area" telephone book.
3. The AMS would place questionnaires in physician's offices for patients to accomplish while waiting for their appointments.

EVALUATION

Prior to delivery of the slide/sound show to the Arapahoe Medical Society, it will be reviewed by the Public Relations Committee of the AMS and by lay personnel within the community. They will be requested to fill out a short questionnaire designed to measure their understanding and awareness of the problems of rising health care costs and

what is being, and can be done, about them. In addition, members of the faculty of the Department of Mass Communications will provide a production evaluation. Also, upon delivery of the slide show to the AMS, they will be provided a questionnaire that can be used for continual audience evaluation of the presentation.

TIME SCHEDULE

Since a contract has already been agreed upon for delivery of the slide/sound show to the AMS by 1 May 1977, the following schedule will apply upon approval of this proposal.

February 28, 1977	- Research and survey completed.
March 31, 1977	- Treatment, storyboard, script, photography and film processing completed.
April 30, 1977	- Editing of slides, narrative, and music mix completed. Evaluation accomplished.
May 1, 1977	- Delivery of completed presentation to the Arapahoe Medical Society.

PERSONNEL AND FACILITIES

Both Porter and Swedish hospitals have slide libraries from which duplicate slides may be selected and processed. Porter Hospital has agreed to process all film at a discount. All three authors have 35 mm cameras with a variety of lenses and equipment which may be used for

additional photographs as necessary. In-house photographers are also available through the various medical facilities. The DU Media Services Department will be available for audio tape editing and the mixing of voice and music. In addition, the authors have budgeted for the services of a professional narrator.

BUDGET

A total budget of $1,073.60 has been approved by the Arapahoe Medical Society (see appendix). They have made a down payment of $300 with the remainder due upon completion of the project.

DELINEATION OF RESPONSIBILITY

Liaison with the Arapahoe Medical Society and Department of Mass Communications; Budget and Funding; Contract	Doran L. Hopkins
Research of Medical Costs	Thomas A. Mahr
Research of Mass Communications Theory	Philip H. McMillen
Survey Construction	Thomas A. Mahr Philip H. McMillen
Survey Administration and Tabulation	Doran L. Hopkins
Writing of Proposal	Joint Effort
Soundtrack: Narration, music, mixing; Liaison with Media Services	Philip H. McMillen

Photography:	Photographs, Processing; Liaison with Porter and Swedish Media Service Departments	Thomas A. Mahr
Treatment; Storyboard; Script		Doran L. Hopkins
Editing of Slide Show		Joint Effort
Thesis:	Project History; Treatment; Storyboard; Script Analysis	Doran L. Hopkins
	Soundtrack Analysis	Philip H. McMillen
	Photography Analysis	Thomas A. Mahr
	Research Evaluation	Doran L. Hopkins
	Analysis of Problem Areas and Lessons Learned	Philip H. McMillen
	Evaluation of Project and Conclusion	Thomas A. Mahr
	Editing and Writing of Thesis	Joint Effort

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APPENDIX

BUDGET

Slide Show For Arapahoe Medical Society (AMS)

Film	40 rolls	@ $3.59 per roll	$143.60
Processing	40 rolls	@ $4.25 per roll	170.00
Artwork (Illustration)			200.00
Music			75.00
Professional Narration and Studio			200.00
Audio Tape			30.00
Pre-Production Materials: Storyboard, Visuals, Art Supplies			25.00
Equipment Rental			80.00
Transportation & Miscellaneous Expenses			150.00
			$1073.60

APPENDIX B

SCRIPT

SCRIPT

"The Cost of Caring"

SLIDE	PICTURE	SOUND
1	Opaque Slide	(Nostalgic music from first 54 seconds of "Down the Line")
2	Sepia of mountain scene (LS)	
3	Sepia of downtown Denver (LS)	
4	Sepia of Palace Theater (LS)	
5	Sepia of classroom (MS)	
6	Sepia of two children (MS)	
7	Sepia of two bicycle riders (MS)	
8	Sepia of group picnic in woods (MS)	
9	Sepia of group of skiers (MS)	
10	Sepia of trolley car (MS)	
11	Sepia of old car with family (MS)	
12	Sepia of old gas station (LS)	
13	Sepia of old Denver skyline (LS)	(Nostalgic music fade)
14	Color of modern Denver skyline (LS)	(Modern music theme from latter portion of "Down The Line" with voice over narrative) "For over a century, Denver, Colorado, has been a good place to live and work."
15	Child in field (MS)	
16	Workmen leaving plant (MS)	
17	Fishing in high country (LS)	
18	Woman with computer (CU)	

SLIDE	PICTURE	SOUND
19	Two hikers on mountain (LS)	
20	Workman on scaffolding (CU)	
21	Two horseback riders by river (LS)	
22	Couple camping by lake (LS)	
23	A crowd (LS)	"But Coloradoans, like all Americans, have one thing in common. The average wage earner works one month a year to pay for his health needs. We spend more on health care than any other country in the world. Today, we are spending more than seven times as much as was spent a generation ago on health care." (Modern music fade out)
24	Title Slide--"The Cost of Caring" over Norman Rockwell's painting of doctor and child (MS)	(Nostalgic music from "Down the Line")
25	Norman Rockwell painting of doctor with family (MS)	(Narrator voice over music) "Yesterday's doctor would not recognize his profession today. The tranquil life of the kindly country doctor in the age of the horse and buggy"
26	Sepia of doctor with horse and buggy (MS)	"was medicine in its infancy. The quality of care and treatment has progressed a thousand-fold in just fifty years." (Music fade out)
27	Ambulance on street (LS)	(Ambulance siren)

SLIDE	PICTURE	SOUND
28	Two medics with victim in office (MS)	(Music from "Escape From Slavery" with voice and sound over) (Medic voice) "Patient's ready . . . Stand clear . . . (Sound of machine) . . . Good, looks like he is in sinus rhythm."
29	Medic on radio-telephone (MS)	(Medic voice) Rescue 3 to base station. We're preparing to transport now."
30	Patient being loaded into ambulance (MS)	(Medic voices) "Lift him out easy, guys." "They're ready for us in emergency."
31	Emergency sign (CU)	(Cart noise with nurse voice over) "Take him to room one."
32	Doctors around patient (MS)	(Doctor voice) "OK, we'll want a 12 lead EKG, a cardiac lab workup and a portable chest X-Ray." (Nurse voice) "Right away, doctor."
33	Doctor looking toward equipment (MS)	(Doctor voice) "Monitor his vital signs and cardiac activity. When they're stable, transport him to the cardiac care unit."
34	Heart monitor machine (CU)	(Noise of machine)

SLIDE	PICTURE	SOUND
35	Picture of cells (CU)	(Music from "Nadia's Theme" with narrator voice over) "Medical science and technology make remarkable advances almost daily."
36	Operating room (MS)	"Plastic heart valves,"
37	CAT Scanner (MS)	"brain and body scanners,"
38	Doctor holding baby (MS)	"and modern obstetrics are saving"
39	Nurse with baby (MS)	"and lengthening the lives of hundreds of thousands of persons."
40	Baby in isolette (CU)	"An infant born prematurely with a heart defect twenty years ago usually was doomed to die within a few days. Today, the infant is diagnosed 'high risk' long before its birth and after delivery is sent to an intensive care unit like that at Porter Hospital."
41	Family with newborn baby (MS)	"Such modern techniques are expensive, but how do you measure a life in dollars?"
42	Supplies in warehouse (MS)	"Medicine today is caught up in the same inflationary spiral that has affected the rest of the economy. Where does the inflation hit the medical profession the hardest? In many of the same areas it hits your pocketbook:"
43	Power plant (MS)	"heating and electricity,"
44	Laundry room (MS)	"housekeeping items,"

SLIDE	PICTURE	SOUND
45	Hospital kitchen (MS)	"and food. The prices hospitals and physicians pay for goods and services are rising faster than the overall increase in the cost of living."
46	Patient eating a meal in bed (MS)	"Like you, they make cost comparisons to get the best buy for the money, but they can't cut quality, because quality affects you, the patient."
47	Doctor in surgical mask (CU)	"Doctors find themselves in a difficult position."
48	Four picture montage of doctors in action (CU)	"On the one hand, they are trying to maintain the quality of medical care that you have come to expect."
49	Montage of newspaper headlines (CU)	"On the other hand, they are receiving pressure from the community to hold down the cost of medical care."
50	Meeting of doctors (MS)	"Several years ago, the doctors and hospital administrators of this community foresaw the rising cost of health care and began programs to contain costs, while maintaining the quality of care the community desired."
51	Joint slide of Porter and Swedish hospitals (LS)	"A pioneering effort in cost containment was the combining of the medical staffs and the consolidation of several medical services at Porter and Swedish hospitals. One of the early proponents of this consolidation"
52	Palmquist head and shoulders (CU)	"was Lowell Palmquist, Swedish Medical Center's Executive Director."
		(Music fade out)

SLIDE	PICTURE	SOUND
53	Palmquist at map (MS)	(Narration of Palmquist) "When we first began studying the idea of combining the medical staffs and consolidating overlapping medical services at Porter and Swedish, our main concern was to provide the best quality of medical care at the least cost to the community."
54	Palmquist in meeting (MS)	"As the discussions progressed, it became clear that consolidating some services would actually result in an improvement of the quality of care."
55	Patient in ICU unit (MS)	"For example, a hospital which sees a large number of heart attack cases a year will handle the problem better than a hospital which sees only a few."
56	Pediatrics nursery (MS)	"Consolidating services also reduced costs. We estimate that consolidating pediatrics at Porter and obstetrics at Swedish reduced the cost of delivery by about 25 percent."
57	Warehouse (MS)	"We are working in other areas to reduce costs. We have entered into a group purchasing plan with approximately 60 other Colorado hospitals in an effort to take advantage of the economies associated with volume purchasing. Whenever possible, we buy large quantities directly from the manufacturer."
58	Children on playground equipment (MS)	"Cost savings such as these are important to the community as a whole."

SLIDE	PICTURE	SOUND
59	Dr. Robinson (CU)	(Narrator) "Doctor William Robinson, Director of Medical Affairs for the two hospitals has seen other benefits of the consolidation."
60	Doctor looking at X-Ray (MS)	(Narration of Robinson) "Most people think that competition between hospitals is good. They think it will help to constrain increases in costs. Actually, such competition helps drive up the price of medical care because the hospitals are competing for doctors--not patients."
61	Blood analysis machine (MS)	"This competition usually takes the form of upgrading facilities and acquiring all the latest technology. By combining the medical staffs at Porter and Swedish, we have eliminated this kind of unnecessary and costly competition--through combination of the staffs--both hospitals have all the doctors--and thence there is no need to compete for them."
62	Doctors conferring over patient's X-Rays (MS)	"A second benefit of locating a particular specialty service at one hospital is that all the experts in this specialty can work in one location, thereby concentrating medical knowledge and the required supporting equipment for diagnosis and care."
63	Heart patient (CU)	"I don't think the community can afford two mediocre specialty units--cardiac units for example--it can only afford one good one. I think this is what we have achieved as a result of consolidating this service at Porter."

SLIDE	PICTURE	SOUND
64	Two doctors and nurse (MS)	(Music from "Bellavia" with narrator voice over) "The local medical community has made a start in containing the cost of medical care. However, not all the answers to this problem can come from doctors and hospital administrators."
65	People in waiting room (MS)	"Ironically, a major cause of the increasing cost of health care lies in the payment systems."
66	Patient at admitting desk (MS)	"Because the bill for most of the health care we receive is paid for by someone else, we tend to think we are getting it for free."
67	Form in typewriter (CU)	"This, of course, is only an illusion. We must recognize that we pay for this health care in higher taxes, higher insurance premiums, higher prices for consumer products and in many cases lower wages."
68	Price sticker on car (CU)	"General Motors, for example, reports that $170 of the cost of each new car represents the cost of employee health insurance premiums."
69	Factory furnace showing molten steel (CU)	"That's more than the cost of steel in each car." (Music fade out)
70	Hospital ward (LS)	"You know, fifty years ago, health care wasn't very expensive."
71	Shock treatment (MS)	"It wasn't very good either--half the time you died--but it was inexpensive. Then we got smarter and found ways so that you didn't have to die."

SLIDE	PICTURE	SOUND
72	Bedroom scene (MS)	"As we got smarter and smarter, we found that people wanted the new techniques more and more. They wanted excellence; they wanted perfection and they got it."
73	X-Rays (MS)	"Let's think about cost for a minute. Think about how much cheaper it would have been if we had never invented the X-Ray. How much cheaper it would be without anesthesia. Let me give you an example of what happens today."
74	Doctor Robinson and patient (MS)	"Say, you have had a headache for a few days and you go to your doctor for help. Now, the doctor might want to check for the possibility of a tumor. So he says to you, 'I could recommend a pneumoencephalogram. It is painful. There is a chance of injury and you may have a bad headache for several days. But it is cheap. It will cost only about one hundred dollars.'"
75	Patient in CAT Scanner (MS)	"'On the other hand, I could order a CAT Scan. It is fast, painless, highly accurate and has no after effects. But it will cost a couple hundred bucks. Which one would you choose, especially if the insurance company is paying the bill?'"
76	Law books and regulations (CU)	(Music from "Bellavia" with narrator voice over) "There are no easy answers or quick solutions to the health care cost problem. The private health insurance system, government health programs, and malpractice insurance are all driving up the cost of health care."

SLIDE	PICTURE	SOUND
77	Capitol Building (LS)	"National health insurance is not the answer either. More government intervention will only increase the cost of health care."
78	A crowd scene (MS)	"The habits and attitudes of individuals make it difficult to contain cost."
		(Music fade out)
79	Technician at microscope (CU)	(Narration of Robinson)
		"We can't continue to think that we can spend our way to better health. Modern science has stamped out diseases such as pneumonia, diphtheria, polio and tuberculosis."
80	Patient in bed with equipment in background (MS)	"Our modern equipment can prolong life. But in spite of all this, we have only increased the life expectancy but three years in the United States during the last half century."
81	Mortar and pestle (CU)	"Right now, I can give you a simple, inexpensive prescription that can increase your life expectancy by eleven years. All you have to do is to follow these instructions."
82	Man fishing on dock (MS)	"Eat regularly three times a day, starting with a good breakfast and avoiding snacks . . . exercise regularly . . . get enough sleep . . . don't smoke . . . keep your weight down . . . drink moderately, if at all."
83	Doctor holding X-Ray with patient (MS)	(Music from "Bellavia" with narrator voice over)
		"You can do a lot. Consumers and providers alike, must recognize their past and present responsibilities."

SLIDE	PICTURE	SOUND
84	Child on Father's back in field (LS)	"Many of the leading causes of death in our country--heart disease, lung cancer, obesity, alcoholism, drug abuse, and automobile accidents--are directly related to our life-styles and behavior."
85	Dr. Robinson at nurse's station (MS)	"It is unrealistic to think that the providers of health care can solve the problem by themselves."
86	Two children (CU)	"Good health is not something that can be given by one person to another. It really can't be bought. In the final analysis, good health is our own personal responsibility."
87	Child drinking water from stream (MS)	"We have been blessed with an unusual opportunity to enjoy a rewarding and healthy life."
88	A jogger (MS)	"We can make the most"
89	A skier (MS)	"of what nature has given us."
90	A golfer (LS)	"The choice is ours."
91	Old man and woman in park (MS)	"Perhaps, this is the true cost of caring."
92	Credits (Produced by)	
93	Credits (Special thanks)	
94	Credits (Special thanks)	
95	Title Slide	
96	Opaque Slide	

APPENDIX C

BUDGET

BUDGET

The original budget of $1073.60, contained in Appendix A, was predicted on the most that could possibly be spent within each category. The client was informed that the actual expenses would most likely be less than the budgeted amount. The authors felt that it would be better to over-estimate rather than to under-estimate the expenses.

The actual expenses of $591.96 were much less than the budgeted amount for several reasons. First, both hospitals had slide libraries from which duplicate slides were made which lessened the amount spent for film and film processing. Second, the film processing was accomplished by the audio-visual laboratory, which is part of Porter and Swedish hospitals, and it charged a nominal fee. Third, artwork was accomplished by this laboratory at a nominal cost and was included in the processing fee. Fourth, the authors did not have to rent any equipment.

Actual Expenses

Film	$ 15.09
Film Processing	217.90
Audio Tape	42.64
Script Materials	17.58
Kodak Carousels	18.75

Narrator Services	$ 25.00
Sound Mixing	255.00
TOTAL	$591.96

APPENDIX D

PROJECT TIMETABLE

PROJECT TIMETABLE

Project Action	Date Started	Date Completed
Proposal	1 December 1976	10 February 1977
Survey	20 December 1976	18 February 1977
Script	14 March 1977	15 April 1977
Photography	12 January 1977	15 May 1977
Soundtrack	1 April 1977	17 May 1977

The slide show was accepted by the Arapahoe Medical Society on May 24, 1977.

APPENDIX E

RESEARCH QUESTIONNAIRE AND DATA

RESULTS OF THE MEDICAL CARE SURVEY

FEBRUARY 1977

The Arapahoe Medical Society in conjunction with the University of Denver is conducting a survey to learn how the public views medical costs and the quality of care and service expected from the medical profession. The information will be used for statistical purposes only and is strictly confidential. Do not write your name on this questionnaire.

Most of the questions may be answered by simply placing an "X" on the appropriate line; other questions ask for written-in answers. However, you may write in additional comments whenever you wish to do so.

1. How often did you visit a doctor in 1976?

   7.5 (average)

2. Do you feel doctor's fees in general are:

   a. 41% Too high
   b. 54% About right
   c. .2% Too low
   d. 4% No opinion

3. What do you think is the average yearly income for doctors after expenses and before taxes?

   $55,500 (average)

   *(35 yrs of age--$47,000--medium income)
   (46-50 yrs of age--$76,000--medium income)
   ($58,000--medium for all physicians)

4. Do you feel rising doctors' fees have been accompanied by an increase, decrease, or no change at all in the quality of care received by patients?

   a. 18% Increase
   b. 18% Decrease
   c. 59% No change at all
   d. 5% No opinion

5. Which of the following do you think is a doctor's major source of income?

   a. 29% Direct payments from patients *(34.5%)
   *b. 52% Payments from insurance companies *(39%)
   c. 5% Payments from local, state and federal government programs *(26.5%)
   d. 15% Don't know

*Correct answer based upon national research

6. How many hours a week, on average, do you think a doctor works?

55 hrs (average) *(60 hrs)

7. What do you feel is a doctor's major responsibility to his patient?

See Appendix A

8. Do you or do you not feel that doctors should use all available technology, regardless of cost, to diagnose and treat a patient's illness or accident injuries?

a. 82% Should be used
b. 13% Should not be used
c. 5% No opinion

9. What do you think was the average amount paid by doctors for malpractice insurance in 1975?

a. 2% $1,000 - $2,000
*b. 23% $3,500 - $5,000
c. 26% $7,500 - $9,000 *($7,887--estimated average)
d. 24% $10,000 or more
e. 25% *Don't know*

10. Faced with rising malpractice insurance rates, many doctors have begun practicing "defensive medicine" (i.e., ordering more lab tests, requesting a second physician's opinion more often, hospitalizing their patients more often, etc.). Do you think these reactions are reasonable or unreasonable?

a. 77% Reasonable
b. 16% Unreasonable
c. 7% No opinion

11. What do you estimate the average daily cost of hospitalization in the Denver metropolitan area to be?

$152 (average) *($168--Colorado)
($180--U.S.--1976)
($190--Projected 1977 U.S.)

12. Do you feel the major concern of a hospital should be the cost of, or the quality of, care and services it offers patients?

a. 1% Major concern should be cost
b. 45% Major concern should be quality
c. 53% Both cost and quality are equally important
d. .7% Neither cost or quality should be a major concern
e. .3% No opinion

13. In relation to the quality of care and service to patients, do you feel hospital charges are:

a. 69% Too high
b. 25% About right
c. -0- Too low
d. 6% No opinion

14. Do you feel rising hospital charges have been accompanied by an increase, decrease, or no charge at all in the quality of care provided by hospitals?

a. 26% Increase
b. 18% Decrease
c. 47% No change at all
d. 9% No opinion

15. How much do you think the average hospital stay costs?

$1413 (average) *($1017--1975)

16. What percentage of the charge for a hospital room do you feel represents "room and board" charges?

a. 7% 10%
*b. 28% 20%
c. 38% 50%
d. 12% 75%
e. 15% Don't know

17. Which of the following do you think represents a hospital's major source of income?

a. 4% Direct payments from patients *(8%)
b. 81% Payments from insurance companies *(35.8%)
*c. 6% Payments from local, state and federal government programs *(56.2%)
d. 9% Don't know

18. What do you think of the idea of having several independent hospitals sharing facilities and staffs in an effort to avoid duplicating overhead expenses and to hold down costs?

a. 83% Good idea
b. 3% Bad idea
c. 5% Makes no difference
d. 9% No opinion

19. Approximately how much do you think Americans spent on personal health care in fiscal year 1976?

a. 5% $70 billion
b. 13% $100 billion
*c. 16% $140 billion
d. 17% $200 billion
e. 40% Don't know

20. Approximately how much do you think personal health care spending in America has risen in the past ten years?

a. 11% 50%
b. 29% 100%
c. 31% 200%
*d. 19% 300% (Based on data from 1965-1975)
e. 10% Don't know

21. Listed below are several factors which have contributed to the rising cost of medical care in America. Rank them numerically in order of the impact you feel they had on rising prices.

a. 6 Rising salaries for nurses
b. 2 Escalated cost of malpractice insurance
c. 5 Rising physician fees
d. 7 Rising cost of drugs
e. 4 Increase in office and hospital overhead
f. 3 Rising labor costs (excluding physicians and nurses)
g. 1 Rising cost of modern medical equipment
h. ___ Don't know

22. Do you or do you not feel you know enough about these and other factors which have caused the increase in health care costs

a. 27% I feel I know enough
b. 65% I feel I do not know enough
c. 8% No opinion

23. What percentage of an American family income is spent on health care?

a. 4% 1%
b. 28% 5%
*c. 33% 10%
d. 18% 15%
e. 17% Don't know

24. What type of health insurance do you have? (If you answer "None," then skip question number 25 and go to question number 26)

a. 5% None
b. 18% Individual or family paid policy
c. 33% Employee paid group plan
d. 35% Employer paid group plan
e. 9% Other (please specify)_____
f. -0- Don't know

25. If your insurance plan would pay for either out-patient treatment or hospitalization for a given illness or injury, which would you choose if your physician gave you the choice?

a. 66% Out-patient treatment
b. 28% Hospitalization
c. 6% No opinion

WHY?

See Appendix A

26. In an effort to hold down the cost of health insurance policies, some insurance companies are encouraging out-patient treatment. Do you think this is generally a good or a bad idea?

a. 76% Good idea
b. 12% Bad idea
c. 12% No opinion

WHY?

See Appendix A

27. Some spokesmen for the insurance industry say that people are needlessly hospitalized in order to claim their insurance benefits. Do you agree or disagree?

a. 59% Agree
b. 28% Disagree
c. 13% No opinion

28. How much do you think the average premiums of major health insurance companies increased in 1976?

a. 3% 8%
b. 13% 10%
c. 23% 15%
*d. 40% 20%
e. 20% Don't know

29. Do you feel every American should or should not be provided with quality health care regardless of cost?

a. 74% Should be provided
b. 20% Should not be provided
c. 6% No opinion

30. Are you willing to pay increased taxes to provide quality health care to every American regardless of cost?

a. 40% Yes
b. 50% No
c. 10% No opinion

31. Do you:

See a doctor regularly?	70% Yes	30% No
Avoid over-eating?	81% Yes	19% No
Exercise regularly?	65% Yes	35% No
Avoid excessive smoking and drinking?	86% Yes	14% No
Generally get between 6-1/2 and 8 hours of sleep?	94% Yes	6% No
Eat balanced meals?	89% Yes	11% No
Avoid unnecessary medication?	99% Yes	1% No

32. Do you feel that you are or are not receiving enough information to guide you to better health?

a. 75% I am receiving enough information
b. 20% I am not receiving enough information
c. 4% No opinion

33. Would you or would you not be willing to attend a presentation to learn to achieve and maintain better health?

a. 62% I would be willing to attend a presentation
b. 27% I would not be willing to attend a presentation
c. 11% No opinion

34. What concerns you most about the health care available in America today?

See Appendix A

35. Do you feel health care personnel are or are not aware of this concern?

a. 72% Are aware
b. 15% Are not aware
c. 12% No opinion

36. Would you or would you not be willing to attend a presentation to learn more about health costs?

a. 58% I would be willing to attend a presentation
b. 29% I would not be willing to attend a presentation
c. 13% No opinion

The following questions are for statistical purposes only and the information will be kept strictly confidential.

37. a. 40% Male
b. 60% Female

38. What is your age?

a. 2% Under 20 years
b. 27% 21-30 years
c. 30% 31-40 years
d. 18% 41-50 years
e. 11% 51-60 years
f. 10% 61-70 years
g. 2% 71-80 years
h. .3% over 81 years

39. What is your highest educational level completed?

a. .7% Less than 8th grade
b. 1% Elementary school
c. 37% High school
d. 35% College
e. 26% Graduate school or Professional school

40. What is your marital status?

a. 10% Single
b. 83% Married
c. 2% Separated
d. 4% Divorced

41. What is the number of children in your household under 18 years of age?

2.1 (average)

42. What was your total family income last year before taxes?

a. 7% Under $8,000
b. 10% $8,000 - under $12,000
c. 17% $12,000 - under $16,000
d. 59% $16,000 or over
e. 7% Don't know

43. OTHER COMMENTS:

ATTACHED:

APPENDIX A--Questions 7, 25, 26, 34
APPENDIX B--Survey data

Thank you for your time and patience.

Reference Question 7:

"What do you feel is a doctor's major responsibility to his patient?"

(The respondent's answers were coded as follows)

7(1) 54% Quality of care, health and welfare of patient.
(2) 22% Competence and proper diagnosis.
(3) 5% Availability of physicians (i.e., having a physician available when a patient needs him or time spent waiting to see a physician).
(4) 3% Cost (i.e., keeping costs down).
(5) 16% Being honest and keeping patient informed.

Reference Question 25:

"If your insurance plan would pay for either out-patient treatment or hospitalization for a given illness or injury, which would you choose if your physician gave you the choice?"

(The reasons of those respondents selecting "out-patient treatment" as the answer were coded as follows)

25A(1) 24% Don't like hospitals.
(2) 2% Possibility of secondary infections.
(3) 31% Cost
(4) 30% Rather stay at home, convenience, time saved
(5) 1% It should be the doctor's choice
(6) 12% Don't believe in unnecessary hospitalization.

(The reasons of those respondents selecting "hospitalization" as the answer were coded as follows)

25B(1) 7% Convenience
(2) 18% Less costly because of insurance coverage
(3) 39% Better care
(4) 36% Better insurance coverage

(The reasons of those respondents selecting "no opinion" as the answer were coded as follows)

25C(1) 100% Depends on nature of illness

Reference Question 26:

"In an effort to hold down the cost of health insurance policies, some insurance companies are encouraging out-patient treatment. Do you think this is generally a good or a bad idea?"

(The reasons of those respondents selecting "good idea" as the answer were coded as follows)

26A(1) 30% Keep down unnecessary hospitalization.
(2) 51% Less cost
(3) 19% Rather be at home, convenience

(The reasons of those respondents selecting "bad idea" as the answer were coded as follows)

26B(1) 67% Problem of proper care
(2) 8% Cost not covered by insurance
(3) 25% Should be physician's choice

(The reasons of those respondents selecting "no opinion" as the answer were coded as follows)

26C(1) 83% Depends on illness
(2) 17% Insurance companies have no part in this decision.

Reference Question 34:

"What concerns you most about health care available in America today?"

(The respondent's answers were coded as follows)

34 (1) 39% Cost
(2) 15% Unavailable to all Americans
(3) 2% Unnecessary treatment and medication
(4) 6% Not enough preventive medicine
(5) 2% Lack of research
(6) 18% Lack of time and concern on part of physicians. Physicians are indifferent and impersonal. The competence of physicians.
(7) 5% Government involvement, socialized medicine.
(8) 6% Abuse of insurance programs (government and private programs)
(9) 3% Lack of confidence by citizens in medical profession
(10) 4% Other

APPENDIX B

Question	Telephone (72)	Service Club (54)	Hospital Patients (46)	Hospital Administration (22)	Physician Patients (79)	Totals (273) #	Totals (273) %
1	5.3 (ave)	4.4 (ave)	7.8 (ave)	2.3 (ave)	12.7 (ave)	7.5 (ave)	
2A	26	17	16	10	37	106	41
B	40	30	26	11	35	142	54
C	1	0	1	0	0	2	.2
D	2	0	3	1	5	11	4
3	$56,700 (ave)	$56,600 (ave)	$61,100 (ave)	$51,700 (ave)	$52,100 (ave)	$55,500 (ave)	
4A	9	10	8	10	11	48	18
B	19	7	8	0	13	47	18
C	35	34	27	12	48	156	59
D	6	1	2	0	4	13	5
5A	15	17	7	5	29	73	29
B	34	24	27	16	32	133	52
C	4	3	2	0	3	12	5
D	16	5	4	0	12	37	15
6	52 hrs. (ave)	54 hrs. (ave)	59 hrs. (ave)	58 hrs. (ave)	54 hrs. (ave)	55 hrs. (ave)	
7(1)	48	23	25	10	29	135	54
(2)	9	11	10	5	20	55	22
(3)	3	5	1	2	1	12	5
(4)	1	1	1	3	0	6	3
(5)	8	5	9	2	17	41	16
8A	56	40	33	11	64	204	82
B	7	7	4	8	6	32	13
C	6	1	1	0	4	12	5

Question	Telephone	Service Club	Hospital Patients	Hospital Administration	Physician Patients	Totals #	Totals %
9A	1	2	0	1	1	5	2
B	11	14	12	12	12	61	23
C	14	14	16	6	20	70	26
D	19	16	9	3	19	66	24
E	27	5	9	0	27	68	25
10A	56	36	37	19	57	205	77
B	11	14	5	2	12	44	16
C	3	1	3	1	10	18	7
11	$138 (ave)	$137 (ave)	$163 (ave)	$214 (ave)	$151 (ave)	$152 (ave)	
12A	0	1	0	0	2	3	1
B	42	16	18	7	40	123	45
C	30	37	26	13	36	142	53
D	0	0	1	0	1	2	.7
E	0	0	1	0	0	1	.3
13A	53	41	18	9	67	188	69
B	13	9	23	12	9	66	25
C	0	0	0	0	0	0	0
D	6	2	5	1	3	17	6
14A	13	14	19	16	10	72	26
B	15	13	2	0	18	48	18
C	34	22	22	6	43	127	47
D	10	3	2	0	8	23	9
15	$1307 (ave)	$1266 (ave)	$1704 (ave)	$1314 (ave)	$1459 (ave)	$1413 (ave)	

Question	Telephone	Service Club	Hospital Patients	Hospital Administration	Physician Patients	Totals #	Totals %
16A	8	2	3	0	6	19	7
B	27	19	10	6	14	76	28
C	22	20	18	13	30	103	38
D	6	3	6	2	16	33	12
E	9	10	9	1	13	42	15
17A	3	4	2	0	1	10	4
B	55	40	30	20	62	207	31
C	5	2	3	1	4	15	6
D	4	2	6	0	12	24	9
18A	55	53	37	20	62	227	83
B	3	0	2	2	2	9	3
C	6	1	4	0	2	13	5
D	8	0	3	0	13	24	9
19A	6	3	0	4	0	13	5
B	8	11	7	4	4	34	13
C	4	12	9	7	12	44	16
D	15	2	12	4	14	47	17
E	39	25	18	1	49	132	49
20A	10	0	4	3	14	31	11
B	27	10	15	7	19	78	29
C	21	25	11	5	23	85	31
D	6	14	13	5	13	51	19
E	6	5	3	2	10	26	10

Question	Telephone	Service Club	Hospital Patients	Hospital Administration	Physician Patients	Totals #	Totals %
21A	* *	6	4	4	6	6*	O*
B	* N *	4	1	5	1	2* R	R*
C	* O *	5	5	6	3	5* A	D*
D	* T *	7	7	7	7	7* N	E*
E	* *	3	3	3	4	4* K	R*
F	* A *	2	6	2	5	3*	E*
G	* S *	1	2	1	2	1	D*
22A	* K *	14	18	6	15	53	27
B	* E *	34	24	14	58	130	65
C	* D *	3	4	2	6	15	8
23A	* *	2	1	0	3	9	4
B	3	20	8	9	16	76	28
C	23	16	17	9	25	88	33
D	21	5	10	3	18	48	18
E	12	8	9	1	17	46	17
24A	11	1	4	0	4	11	5
B	2	8	8	5	8	42	18
C	13	9	13	4	26	75	33
D	23	23	12	8	26	81	35
E	12	4	3	2	8	20	9
F	3	0	0	0	0	0	0
25A	0	35	26	18	48	174	66
B	47	14	15	1	24	73	28
C	19	1	1	3	7	16	6
	4						

Question	Telephone	Service Club	Hospital Patients	Hospital Administration	Physician Patients	Totals #	Totals %
25A(1)	10	6	3	0	4	23	24
(2)	0	2	0	0	0	2	2
(3)	9	3	4	8	5	29	31
(4)	8	4	5	3	8	28	30
(5)	0	1	0	0	0	1	1
(6)	2	2	2	0	5	11	12
25B(1)	0	1	1	0	0	2	7
(2)	1	3	1	0	0	5	18
(3)	5	0	3	0	3	11	39
(4)	4	0	1	1	4	10	36
25C(1)	0	0	0	3	2	5	100
26A	47	46	34	22	54	203	76
B	19	3	5	0	6	33	12
C	4	5	4	0	19	32	12
26A(1)	6	6	2	3	8	25	30
(2)	10	13	9	5	6	43	51
(3)	9	3	1	0	3	16	19
26B(1)	4	1	2	0	1	8	67
(2)	0	0	1	0	0	1	8
(3)	0	0	0	0	3	3	25
26C(1)	1	1	2	0	1	5	83
(2)	0	1	0	0	0	1	17
27A	42	37	20	20	37	156	59
B	17	11	22	2	23	75	28
C	12	3	2	0	17	34	13

Question	Telephone	Service Club	Hospital Patients	Hospital Administration	Physician Patients	Totals #	Totals %
28A	2	0	1	0	6	9	3
B	13	4	4	4	9	34	13
C	18	12	10	4	17	61	23
D	14	30	22	13	26	105	40
E	22	4	8	1	18	53	20
29A	56	26	27	13	66	188	74
B	9	23	10	6	4	52	20
C	5	2	3	0	4	14	6
30A	34	18	18	6	27	103	40
B	32	30	26	14	27	129	50
C	5	0	0	1	21	27	10

	Telephone Yes	Telephone No	Service Club Yes	Service Club No	Hospital Patients Yes	Hospital Patients No	Hospital Administration Yes	Hospital Administration No	Physician Patients Yes	Physician Patients No	Totals % Yes	Totals % No
31A	49	22	38	14	30	14	11	11	57	20	70	30
B	58	12	41	9	34	11	19	3	62	14	81	19
C	48	22	35	17	27	18	12	10	51	28	65	35
D	59	11	47	4	42	3	19	4	61	16	86	14
E	68	3	49	2	41	4	19	2	73	4	94	6
F	62	8	49	3	38	7	20	2	69	8	89	11
G	69	2	51	0	45	0	22	0	77	0	99	1

	Telephone	Service Club	Hospital Patients	Hospital Administration	Physician Patients	Totals #	Totals %
32A	55	40	36	17	55	203	75
B	13	11	7	5	18	54	20
C	4	1	2	0	5	12	4

Question	Telephone	Service Club	Hospital Patients	Hospital Administration	Physician Patients	Totals #	Totals %
33A	38	32	29	15	46	160	62
B	28	11	10	5	16	70	27
C	3	7	3	1	15	29	11
34(1)	22	16	12	9	28	87	39
	11	3	8	3	9	34	15
(3)	0	5	0	0	0	5	2
(4)	4	2	3	2	2	13	6
(5)	2	1	1	0	0	4	2
(6)	13	10	1	2	13	39	18
(7)	1	4	4	2	1	12	5
(8)	8	3	2	1	0	14	6
(9)	1	1	0	0	4	6	3
(10)	2	1	3	1	1	8	4
35A	48	32	35	18	50	183	72
B	10	11	4	3	11	39	15
C	10	6	3	1	11	31	12
36A	32	34	29	14	41	150	58
B	33	10	11	5	16	75	29
C	5	5	3	3	19	35	13
37A	13	50	17	18	10	108	40
B	58	4	29	4	66	161	60

Question	Telephone	Service Club	Hospital Patients	Hospital Administration	Physician Patients	Totals #	Totals %
38A	5	0	0	0	0	5	2
B	21	3	9	3	37	73	27
C	25	7	8	9	31	80	30
D	8	14	14	8	5	49	18
E	5	16	8	1	1	31	11
F	6	12	5	1	3	27	10
G	2	2	1	0	0	5	2
H	0	0	0	0	1	1	.3
39A	1	0	0	0	1	2	.7
B	2	0	1	0	1	4	1
C	37	9	22	1	30	99	37
D	21	24	10	5	35	95	35
E	11	21	13	16	10	71	26
40A	14	2	5	1	6	28	10
B	53	48	34	21	65	221	83
C	1	0	2	0	3	6	2
D	3	2	4	0	3	12	4
41	2.3 (ave)	2.0 (ave)	1.8 (ave)	2.1 (ave)	2.1 (ave)	2.1 (ave)	
42A	7	0	5	1	6	19	7
B	4	4	0	1	17	26	10
C	17	4	16	1	8	46	17
D	28	45	22	19	44	158	59
E	12	1	3	0	3	19	7

APPENDIX F

EVALUATION PROGRAM QUESTIONNAIRE

THE COST OF CARING

Program Questionnaire

1. List what you believe to be the main points presented in the slide show.

2. In your judgment, what was the most important point presented?

3. Did the slide show add to your understanding of the issues discussed?

   a. Yes___ b. No___ c. Undecided ___

   Why do you say so?

4. Place a check mark next to each of the following words and phrases that best describe how you felt immediately after seeing this slide show. Check as many as apply.

   a. Angry___
   b. Pleased___
   c. Concerned___
   d. Informed___
   e. Bored___
   f. Not interested___
   g. Relieved___
   h. Interested___
   i. Helpless___
   j. Not informed___
   k. Hopeful___
   l. Frightened___
   m. None of these--Explain:

5. Compared to most other presentations of information about rising health care costs, how would you rate this slide show?

   a. Better than most___
   b. As good as most___
   c. Worse than most___

6. How concerned were you about the rising health care cost problem before you saw this presentation?

   a. Very concerned___
   b. Mildly concerned___
   c. Not at all concerned___

7. Has this presentation increased your concern about the rising health care cost problem and what the local medical community is doing to help control it?

   a. Yes___ b. No ___ c. Undecided ___

   Why do you say so?

8. While you were watching the presentation, did you have the feeling that it was "getting through" to people like yourself or not?

   a. Yes___ b. No ___ c. Undecided ___

9. Did you learn any useful information from this presentation?

   a. Yes___ b. No ___ c. Undecided ___

   If yes, what?

10. Having seen the slide show, do you think that you might consider changing some of your ideas about the rising health care cost problem?

    a. Yes ___ b. No ___ c. Undecided ___

    Please explain:

11. What, if anything, did you learn that you consider important enough to pass on to other people?

12. Did watching the presentation make you feel that you should take steps to improve your own health care habits?

    a. Yes ___ b. No ___ c. Undecided ___

    Why do you say so?

OTHER COMMENTS:

Please fill in the following information which will be used for statistical purposes only.

13. Sex:

a. Male___
b. Female___

14. Approximate age:

a. Under 15___
b. 15-19___
c. 20-24___
d. 25-29___
e. 30-34___
f. 35-39___
g. 40-49___
h. 50-59___
i. 60 & over___

15. What is your occupation?

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APPENDIX G

RELEASE FORM

I HEREBY OF MY OWN FREE WILL GIVE THE ARAPAHOE MEDICAL SOCIETY AND THE UNIVERSITY OF DENVER PERMISSION TO USE MY NAME AND/OR PICTURE AND/OR VOICE FOR PUBLICITY PURPOSES IN ILLUSTRATING MEDICAL COSTS. I UNDERSTAND THAT NO REMUNERATION OR MONETARY GAIN FROM THIS PUBLICITY WILL BE FORTHCOMING AND THAT THE RIGHTS TO ANY PHOTOGRAPH TAKEN OF ME AND/OR ANY REPRODUCTION OF MY VOICE BECOME THE PROPERTY OF THE ARAPAHOE MEDICAL SOCIETY.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE PARAGRAPH AS ATTESTED TO BY MY SIGNATURE BELOW FREELY GIVEN THIS _____DAY OF _____, 1977.

_____
Signature

_____
Witness

_____
Date