HEALTH CARE CRISIS IN AMERICA, 1971

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST SESSION

ON

EXAMINATION OF THE HEALTH CARE CRISIS IN AMERICA

MAY 5, 1971
CHICAGO, ILL.
MAY 13, 1971
DES MOINES, IOWA
MAY 14, 1971
DENVER, COLO.

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HEALTH CARE CRISIS IN AMERICA, 1971

WEDNESDAY, MAY 5, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Chicago, Ill.

The subcommittee met, pursuant to call, at 1:30 p.m. in the auditorium of the Passavant Hospital, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy (presiding), and Packwood.

Committee staff members present: LeRoy G. Goldman, professional staff member; Jay B. Cutler, minority counsel to the subcommittee.

Senator KENNEDY. The subcommittee will come to order.

I first of all want to express the appreciation of the members of the Senate Health Subcommittee for the kindness of this hospital and its staff for making this facility available to the Senate Health Subcommittee. They have been extremely kind and generous in their time and making it possible for us to have this public hearing here this afternoon.

I also want to express my very warm sense of appreciation to the Greater Chicago health and medical community including specifically the three hospitals that we visited last night and the numerous other health facilities that we visited here today.

During the period of the last 9 weeks the Senate Health Subcommittee has been holding extensive hearings on the problems of the health crisis in this Nation.

In Washington we have listened to the experts, the representatives of the different groups who have important interests in the administration of hospitals, the insurance industry, the American Medical Association, Blue Cross-Blue Shield, and various other groups.

Over the period of the last 2 weeks the Senate Health Subcommittee has begun to hear from the people. We feel there is much that can be learned in the hearing rooms of the Congress, but we think that there is an important dimension that can be added by bringing the subcommittee to the people. Thus far the subcommittee has been in New York, West Virginia, Tennessee, Ohio, and now Illinois.

We realize that there are problems affecting the health of millions of people in this Nation.

We think they are expressed in a variety of different ways. They are expressed by the mother who wants to get a doctor in the middle of the night or even in the day and can't find one.

It is represented in the long waiting lines in emergency rooms and outpatient clinics. It is represented in the extraordinary kinds of medi-

cal bills that individuals are forced to pay even though they are covered by a health insurance plan, which turns out to be terribly inadequate.

It is reflected in the faces of young residents and interns who are trying to provide high quality health care and yet do not have sufficient supporting health personnel, facilities, or equipment to provide that kind of health care that they have been trained to provide.

The health crisis affects every American. It is truly a national tragedy.

And so today we are here to listen to the consumers and to listen to their problems and their comments.

Before we hear from them, I would like to ask Senator Packwood, the Senator from Oregon, who has been extremely interested in the problems of health as a member of the Health Subcommittee, and has been one of its most active members and concerned members, if he would like to make a comment.

Senator PACKWOOD. Most Americans, if they are working, if they are making $7,000 or $8,000 a year, if they have an employer paid or individual health plan, and if they don't get too sick too often, they receive very good medical care.

The medically indigent at best receive haphazard care, sometimes good but limited. But what is also clearly apparent is that catastrophic illness is just that—catastrophic—no matter how much money you make or how thorough your care.

Therefore the two things that I am most interested in are:

1. How is the problem of the catastrophic illness solved? How should it be financed?

2. For the medically indigent what is the best way to provide good medical services?

What is the best approach—a major county hospital or a small suburban neighborhood health center, another alternative, or some combination?

Senator KENNEDY. We would like to express our warm welcome to the distinguished mayor of this great city.

Some weeks ago I took the opportunity of calling the mayor and indicated that we would like to come to the city of Chicago to have a view of the both best type of health services delivery and some of the more troublesome features of health delivery. What we found here has been really a microcosm of our Nation in many respects.

There have been so many comments about Cook County Hospital and the comments that are made about that hospital are just as readily made about D.C. General in Washington, about Massachusetts General in my own State of Massachusetts, and about many others.

However, the things that impressed me, of course, in the visits were, once again, views of those that are trying to provide the services.

Commissioner Brown and Mr. King of the health department traveled with us today. We visited some of the maternal child clinics in the city and we are delighted to have you, Mr. Mayor, to lead our witnesses off this afternoon.

Would you be kind enough to proceed. [Applause.]

I am reminded that it is Boston City Hospital, not Mass. General.

I don't want to get in trouble with John Knowles up there. [Laughter.]

STATEMENT OF HON. RICHARD J. DALEY, MAYOR, CITY OF CHICAGO, ILL.

Mr. DALEY. Senator Kennedy, Senator Robert Packwood, I am happy to welcome you and the members of the Senate Subcommittee on Health to Chicago.

Your mission is a most important one and I hope the people of Chicago can help you achieve your goals to assure the best and most comprehensive medical care for all of the citizens of our country.

The fundamental problem that must be addressed by the Congress of the United States is that health care systems as we know them in this country are failing to do the job.

It is not only failing the residents of the inner city and the rural areas, but also failing to meet the needs of health care of all areas in the Nation.

It is far too expensive, too disjointed, and the care it delivers is too unevenly distributed.

It produces too few doctors and technical personnel and too often its priorities seem to ignore the cost. Under Illinois law, the city of Chicago has no responsibility for providing direct medical care services and yet because the need is so great and the city is a governmental agency which is closest to the people, we have had to become indirectly involved in health care.

Our efforts to date have been largely directed towards high impact specialized programs.

For example, we have developed a model program in the Nation for detecting and treating children with lead poisoning. We are the first city in the Nation to promote and provide quality prenatal and infant care for families who cannot afford the high cost of private care.

We are now providing prenatal care for about 25 percent of the mothers delivering in the city.

We lead the major cities in our country in immunization of our children against all major childhood diseases. Last year alone the city provided more than one million shots against all communicable diseases and we successfully stopped a diphtheria epidemic.

Veneral disease is rampaging in other cities, but our program with respect to syphilis has brought it to the lowest point since 1959.

We are now embarked on a major construction program for a network of comprehensive neighborhood health centers which will serve as a cornerstone of the new health care system. Seven are in the neighborhoods already and I think you visited some of them in Uptown, Woodlawn, and North Kenwood. Provident will open on June 1, 1971.

If the private health care system were functioning effectively and equitably, most of these federally funded local programs dealing with direct medical care would not be necessary, but until such time as the system can be made to work, these programs will require increasing Federal support.

Our citizens are paying for the failure of the system. Even with union and employer health benefits, unheard of a few years ago, the working man and his family are too often required to make extreme sacrifices to meet the cost of medical care and hospitalization.

The poor, on the other hand, find the health care available for them often too hard to reach and too snarled in redtape and long waiting periods.

Chicago has many fine hospitals and medical institutions. It is the center for the Midwest and much of the Nation for research and advanced medical training, and yet within our Chicago metropolitan area we find that hospital beds and medical manpower are poorly distributed.

Some neighborhoods have virtually no doctors or hospitals and other neighborhoods have hospitals which are on the verge of financial collapse because of soaring costs.

Extended care facilities, including nursing homes, should be an integral part of the health care system, but as we have seen, they are not.

Our senior citizens deserve the best that our society can provide, so that they might enjoy their golden years with a minimum of discomforts and the highest quality of medical attention to assure adequate medical care and supervision.

Extended care facilities should function as extensions of private hospitals.

We are urging hospitals to assume this new responsibility as one minor step in the development of a better care system, but the hospitals cannot be expected to take on such major new duties without first being provided with commensurate administrative authority, money, and manpower.

In other sectors we are also receiving evidence that our health institutions have a sincere desire to help improve the system.

Our medical schools are now exploring ways in which we can provide licensed practitioners to serve under contract in city-sponsored neighborhood health centers.

One local medical school is developing a program to attract and train students for innercity neighborhoods as physicians.

The hospitals of the city have recently organized a system for improving emergency room services, according to a regionalized plan to cover the entire city.

They have also devised a similar plan to more adequately serve their immediate neighborhoods.

I have not come before you today to place blame on anyone or to suggest that all that is needed is more money for existing programs and services, but rather I have come to support the need for a total comprehensive approach to remaking the health care system that will provide high quality service with dignity to all of the people.

I have confidence that the people of this Nation want such a system and that legislation will bring about an equitable system of health care which is essential to the welfare of all of our people.

Once again, I welcome you to our city and I look forward to your findings and recommendations.

[Applause.]

Senator KENNEDY. Thank you very much, Mr. Mayor.

As you mentioned, both in the maternal clinic we visited earlier today and also the neighborhood health center, we had a chance again to visit with your people, who are very cooperative.

I think in terms of the comprehensive reform which you mentioned here, that is certainly my conviction.

We have had strong statements by other mayors of major cities who have seen or perhaps know firsthand where the health crisis is most severe in many of the urban areas.

In many respects they are more aware of this health crisis than the rest of us, and having support for a comprehensive approach on this is absolutely basic and fundamental. I want to express our appreciation for your interest, sufficient interest in this problem to be with us here this afternoon in order to deliver your comments.

Senator PACKWOOD. Thank you, Mr. Mayor.

Senator KENNEDY. Thank you very much, Mr. Mayor.

The first witness we will hear will be Mr. Lyle Mattox.

Now, while Mr. Mattox is on the way up, the way we are going to conduct this hearing will be as follows:

We have some five consumer witnesses and two professional witnesses, and then we are hopeful of being able to, as we have at other times, to open up this hearing for other kinds of comments.

So if there are people that would like to make a comment, in the limited amount of time we have after our scheduled witnesses we ask you to put your name on the piece of paper at the table on my right. We have to leave at 3:15 so that we have got until then, approximately an hour and a half.

We hope to have 20 or 25 minutes at the end for anyone who is in here and wants to make a comment.

We will ask you to limit your testimony at that time to, perhaps, a minute of comment unless we have more time available, and then for any of those who are unable to make a comment we will ask them to write down their observations and we will include them as part of the record.

I can assure you that I will get a chance to review these expressions, and I am sure Senator Packwood and the other members of the subcommittee will, and it will be made part of the record.

We will do the best we can. We would like to keep this as informal as possible, and try to get as many consumers as possible. I want to express appreciation to the witnesses for their willingness to come here before the subcommittee.

We find it is very difficult for people to tell about their particular health problems, health needs, and the tragedies which have affected them and their families and also the financial plight that they are in. So I want to say that they provide a very special service.

I think this has really been one of the real problems in developing a health program. Americans, for one reason or another, feel that if they are sick or in need, they don't want to bother other people to share this experience. As a result, I think this has contributed to the sort of topsy-turvy way that the whole health system has developed.

If we are really going to come to grips with it, we have to be able to have the facts and I think the most important fact that probably has been excluded from the health system is the active voice and role of the consumer. We hope to hear from them this afternoon.

Mr. Mattox, we are glad to have you here.

STATEMENT OF LYLE MATTOX, HEALTH SERVICES CONSUMER, CHICAGO, ILL.

Mr. MATTOX. Can I be heard all right?

Senator KENNEDY. Yes, if you would just pull the microphone a little closer.

Mr. MATTOX. My name is Lyle Mattox. I am age 52 years and I am self-employed as a skilled craftsman.

I am a Chicago resident. On November 27, 1970, I suffered a coronary occlusion.

Now, previous to that I had had a history of high blood pressure and, on November 24, after a month of increasing illness I saw a local doctor who instantly diagnosed my condition.

On the night of November 27 I went into St. Elizabeth's Hospital where, on the emergency room table, I suffered the actual coronary occlusion. I was there for 15 days and then released for convalescence at home. On the day of my release we received the updated bill to that date for $1,500 for the hospital expenses plus $150 for the doctor bill. My wife withdrew all of our savings out of the First National Bank and paid those two bills.

A few days later we received a $300 bill from the hospital and by that time an agency called MANG, Medical Aid-No Grant, came to our aid. They paid the $300. They have paid for all subsequent medications. They have paid for doctors' calls and hospital visits.

At the time of my illness I had no private insurance because they would not insure me.

Senator KENNEDY. Why not?

Mr. MATTOX. In 1963 the Prudential Insurance Co. approached us about buying hospitalization and they sold it to my family. But they found out, on examination, that I suffered from high blood pressure and that was the first time that I knew it. Then from then on I could not get hospitalization insurance.

Senator KENNEDY. You had health insurance, though, from 1949 to 1963, is that right? You were covered by a group plan?

Mr. MATTOX. I was covered through—well, most of the war and up until 1962. I was covered by a group health insurance.

Senator KENNEDY. You have been covered from at least 1949, prior perhaps in terms of the war, but at least 1949 to 1962 you were covered by a health insurance policy of your employer, which was the Music Department Store?

Mr. MATTOX. Yes.

Senator KENNEDY. When you left that job, you lost your insurance, became a part-time worker at a music department and you worked 2 hours a week short of qualifying for their group health policy? Is that right?

Mr. MATTOX. That is correct. That was at Roosevelt University, the Chicago Music College.

Senator KENNEDY. And then because of high blood pressure you were refused individual health insurance by several firms, is that right?

Mr. MATTOX. By the before-mentioned company and also I was approached in the middle to late sixties by Bankers Life Insurance Co. and they accepted my initial application knowing my blood pressure condition, and the home office refused to ratify it, and I did not receive it.

Senator KENNEDY. Why don't the insurance companies want to insure you when you have got high blood pressure?

Mr. MATTOX. They don't want to insure anybody unless it is a pretty sure bet. [Laughter.]

Senator KENNEDY. Unless what?

Mr. MATTOX. I don't say that facetiously either.

I mean it very sincerely.

Senator KENNEDY. I am sure you mean it very sincerely.

Mr. MATTOX. Also, they think if you are going to live a thousand or hundred years, fine, but otherwise, they don't want to insure you.

Senator KENNEDY. I'm sorry.

Mr. MATTOX. I say unless you are going to live a hundred years, they don't want to insure you.

Also, my blood pressure was immediately brought under control after I discovered it in 1963 and I was under doctor's care, and the pressure, under medication, became normal.

Senator KENNEDY. Why do you think the insurance companies don't want to insure you?

Mr. MATTOX. Why?

Senator KENNEDY. Yes.

Mr. MATTOX. Well, the only thing I can answer would be by saying I guess they want pretty much of a closed sure gamble on their part.

Senator KENNEDY. What do you mean by "a closed sure gamble on their part"?

Mr. MATTOX. Because if somebody looks as though they are not going to live long enough to give them very much money, I imagine they don't want to have anything to do with them.

Senator KENNEDY. Do you think that that applies to sickness as well?

Mr. MATTOX. Yes.

Senator KENNEDY. Do you think the reason for this, in your case, was because of this high blood pressure?

Mr. MATTOX. It is the only reason I was refused; yes.

Now, I have been approached recently by a company who says, "We will underwrite your hospitalization and medical costs despite the fact that you have had a coronary," but they will only underwrite three-fourths of the cost of any conditions relating to the coronary or to cardiovascular conditions and the premiums will cost about $30 a month. I have not yet heard from them as to whether my application was accepted.

Senator KENNEDY. But anyway, you had this sickness and you have been able to save, as I understand it, some $2,000?

Mr. MATTOX. Yes.

Senator KENNEDY. Over a period of years?

Mr. MATTOX. Yes. I actually saved $4,000.

Senator KENNEDY. And how long did it take you to save that $4,000?

Mr. MATTOX. It had taken us 12 to 15 years.

I had raised two children. They are now grown and on their own, and we had spent part of the money the previous summer to move and to buy household appliances.

Then when this illness came, the entire bank account was wiped out.

Senator KENNEDY. And how long a time—in how long a time was your bank account wiped out?

Mr. MATTOX. Well, I haven't been able to add to it. I am just barely getting back to work now.

Senator KENNEDY. And are you covered by any kind of insurance now?

Mr. MATTOX. No, sir.

Senator KENNEDY. So, if you get sick now what would happen?

Mr. MATTOX. I think probably that the medical aid-no grant under—I think that is an Illinois branch of the public aid, they have been paying my expenses and I imagine they would continue to.

Senator KENNEDY. In other words, you had been working, you had been, as I understand it, a hard-working individual all of your life and you had been able to set some resources aside in savings. And then with just a few days in the hospital with a coronary, which you had absolutely no control over, your whole savings were wiped out?

Mr. MATTOX. That is correct.

Senator KENNEDY. And in effect, if you were to get sick now you would be forced to go on medicaid?

Mr. MATTOX. Yes.

Senator KENNEDY. Or to go on welfare to receive it?

Mr. MATTOX. Yes.

Senator KENNEDY. That is what the system has done to you?

Mr. MATTOX. That is what I am on.

They now pay for my visits to the hospital and to the doctor and for my medication.

Senator KENNEDY. And you want to work as I understand it?

Mr. MATTOX. Do I want to work?

Senator KENNEDY. Yes.

Mr. MATTOX. Yes.

I had a fine business built up and I intend to revive it as rapidly as I can.

Senator KENNEDY. What do you think of a medical system that provides not only the kind of personal hardships which are associated with coronary sickness which you have virtually no control over or virtually very little control over and then wipes you out financially, by taking your savings away.

Do you think there is something wrong with that kind of a health system?

Mr. MATTOX. Well, there are so many things wrong in the world that that is one of them, yes. [Laughter.]

I agree with that.

Senator KENNEDY. That doesn't mean that we shouldn't try to change it, does it?

Mr. MATTOX. That is absolutely right.

Up to this point I don't know that the U.S. Government is involved in a sickness situation like mine.

Now, social security gives no relief at all unless I were to be totally incapacitated for a year and yet I have been paying as a self-employed person $400 a year into social security.

Senator KENNEDY. Yes, I believe under social security you have to be totally disabled.

Mr. MATTOX. Yes.

Senator KENNEDY. For a year.

Mr. MATTOX. Yes, you do.

Senator KENNEDY. That is right and that is before you get any kind of help or assistance?

Mr. MATTOX. That is right.

Senator KENNEDY. Now, we hear in the Congress and the Senate about catastrophic kinds of illnesses and we have heard, and perhaps this afternoon we will hear about individuals that run into extraordinary kinds of medical bills.

In Nassau County we had a father who was paying the medical bills of his son who had been playing football last fall because the son severed his spinal column and he will be paralyzed for the rest of his life. Within a short period the father had $40,000 in medical bills in 6 months. This gentleman, the father, was the number one salesman for a major insurance company and he had the best health insurance program that company provided. Still his back, so to speak, was against the wall because his insurance wouldn't cover the costs.

Now, there is a focus in this Nation and we will probably see the Congress move toward catastrophic illness and try to meet these needs but it appears to me that $2,000 to you is just as castastrophic as $50,000 is to a businessman.

Mr. MATTOX. Yes, when it becomes a matter of any figure down to zero, that is catastrophic. [Laughter and applause.]

Senator KENNEDY. Do you have any questions, Senator?

Senator PACKWOOD. Mr. Mattox, would you tell me more about the medical aid-no grant program which you mentioned?

Mr. MATTOX. At first I thought it was a part of the medical program of the Federal Government but now I am not sure because it seems to be connected as far as the paperwork goes, with the Illinois Public Aid Department.

Senator PACKWOOD. Are the bills sent to you or directly to the hospital?

Mr. MATTOX. I never see the bills.

All I do is take the public aid green card to the hospital doctor or to the drugstore where it is processed.

Senator PACKWOOD. You show the green card and all of your medical expenses are then taken care of?

Mr. MATTOX. That is correct.

Senator PACKWOOD. This is very similar to the type of medical coverage that the Kaiser health plans provide.

Mr. MATTOX. But this is exactly the same kind of card that anybody on public assistance carries.

Senator PACKWOOD. I appreciate that. We may have some other witness who will explain how it is funded and, if so, I would appreciate that information.

Thank you very much.

Senator KENNEDY. One thing that seems apparent to me as a lot of things do, is when you lost your job you lost your insurance practically.

Mr. MATTOX. Yes, I did.

Senator KENNEDY. And we find, now I don't know if it is as high in this State, but we have got about 7.2 percent unemployment in my own State of Massachusetts. I know so many of them want to work but are unable to work and they have lost their insurance. The effect of this is that even though you paid in for all of those years from 1949, anyway, through 1962, some 13 years, it didn't do you any good.

Mr. MATTOX. May I say that I feel that I have been very fortunate in a comparative basis because I did have help when I needed it from the medical aid-no grant.

I did have a good doctor and I had a good hospital that would accept me without knowing that I had a dime in the bank.

The night they took me in they didn't know whether I had a dime or not.

Senator KENNEDY. You had to go on welfare to get it, though, didn't you?

Mr. MATTOX. That is right.

By the way, may I comment that your figure for 1970 for Chicago on daily hospital costs is obsolete, that $99.89, because I pair $1,800 hospital charges for 15 days.

Senator KENNEDY. That is the average, but I see what you mean.

Mr. MATTOX. And that did not involve any surgery or anything like that.

Senator KENNEDY. Okay, thank you very much Mr. Mattox.

The next witness will be Mr. Paul Johnson.

STATEMENT OF PAUL JOHNSON, HEALTH SERVICES CONSUMER

Senator KENNEDY. Mr. Johnson, we want to welcome you.

Mr. JOHNSON. Thank you.

Senator KENNEDY. Would you tell us your story? I understand you had a 10-year-old son.

Mr. JOHNSON. Yes, I had a 10-year-old son.

Senator KENNEDY. Tell us about what happened to your son.

Mr. JOHNSON. On December 15, 1969 he had a seizure at home and he passed out. I picked him up, rushed him to the nearest hospital which, by the way, I went by the police station and was led to a hospital by the name of St. George's here in the neighborhood. I asked the police to carry me out to County, and he said he couldn't go out of his district so I carried him there for emergency service.

The doctor didn't even look at him or put his hand on him at St. George's but in the meantime they interviewed me to find out my history of my financial arrangements, my insurance and this and that, I had Traveler's insurance at the time.

Now, that was very good insurance. It paid for everything toward medical, hospitalization and what not.

However, this was through a company and I couldn't afford it privately.

So we left this hospital and drove all the way from 79th over here to County Hospital where my son died in a matter of an hour or so afterward, but they didn't even give him any kind of care or anything pertaining to medication or examine him or let me know that he was as serious as he was.

If they had let me know we would have made some other arrangements about getting oxygen or what not for him but they didn't do anything.

Senator KENNEDY. You mean you went the first time to St. George's Hospital?

Mr. JOHNSON. Yes.

Senator KENNEDY. And you went to the emergency room of St. George's Hospital and you asked for service?

Mr. JOHNSON. Yes.

Senator KENNEDY. That is, you asked for someone to take a look at your boy, is that right?

Mr. JOHNSON. Yes, but in the meantime they interviewed me before.

Senator KENNEDY. When you did this, in effect, your son was actually in the process of dying and they were asking you questions about where you lived?

Mr. JOHNSON. Yes.

Senator KENNEDY. And about the kind of insurance you had?

Mr. JOHNSON. Yes, sir. "Do you own your own home?" and this and that, and "who do you work for?" and "how long?"

Senator KENNEDY. And then after that when you pleaded with them to get some kind of help——

Mr. JOHNSON. Yes, I asked them if they needed further information and what not they could call out to County Hospital, that he had been a patient there and he was due to go in for a checkup which was that Friday, the 19th, and he didn't make it.

They would have given them the information if they needed it but he didn't even try to do anything.

They would voluntarily—they had voluntarily told me also that if anything happens to Carl, even to have a tooth extracted or a tooth filled or anything, to call them and they would give the doctors the information that is necessary so it wouldn't be fatal to him.

Senator KENNEDY. Then you took your son over to the other hospital, to County Hospital, is that right?

Mr. JOHNSON. Yes.

Senator KENNEDY. Going by all of these other hospitals?

Mr. JOHNSON. Yes, because I was afraid to stop. I think the same thing would have happened if I had stopped at one of the other hospitals which were St. Bernard's and there was another hospital up there, and they were associated and they are run by the same staff, and I would say it would be a waste of my time.

I might as well try to make it to the county.

I drove down the expressway with my oldest son, while my other son was in pain.

Senator KENNEDY. Was your other son with you at the time?

Mr. JOHNSON. Yes. I had my oldest son with me, and my son was in pain and he was going into a coma, and he was hysterical and everything, and we were holding him.

Senator KENNEDY. You were?

Mr. JOHNSON. I laid him down in the car.

Senator KENNEDY. As he was hysterical, the doctor said, "If you don't like the service here, take him elsewhere."

Mr. JOHNSON. Yes.

He told me that "he couldn't be sick with a heart condition if he is able to scream and holler like that", that is what he said.

Senator KENNEDY. So then you went to Cook County Hospital?

Mr. JOHNSON. Cook County Hospital and they decided right away to put a pacemaker in and what not, but he went into a coma and passed before they got a chance to insert it.

Senator KENNEDY. Now, did you every hear from St. George's again?

Mr. JOHNSON. Yes, I heard from them. I paid the emergency room bill.

Senator KENNEDY. You what? [Laughter.]
You what?
Mr. JOHNSON. I paid the bill for the emergency room.
Senator KENNEDY. From St. George's Hospital?
Mr. JOHNSON. Yes.
Senator KENNEDY. They sent you a bill after this?
Mr. JOHNSON. Yes, two bills.
Senator KENNEDY. They sent you two bills?
Mr. JOHNSON. Yes, one was a doctor's bill and one was the emergency room bill.
Senator KENNEDY. One was the doctor's bill and the other was the emergency room bill?
Mr. JOHNSON. Yes.
Senator KENNEDY. How much were they?
Mr. JOHNSON. $12.50 for the emergency room and $7 for the doctor's fee.
Senator KENNEDY. That is evidently the value of your son's life to that hospital?
Mr. JOHNSON. No, it is not.
Senator KENNEDY. I say to that hospital?
Mr. JOHNSON. No, it is not—oh, maybe to the hospital, but not to me.
Senator KENNEDY. And what happened afterward?
Did you lose your job afterwards?
Mr. JOHNSON. Yes, I lost my job through a cutback, lack of business. I had been working for a short period of 15 months and I got laid off and I had to go to unemployment.
Senator KENNEDY. Do you think a hospital ought to be able to pick and choose its patients?
Mr. JOHNSON. No, I don't. I think a hospital is in the neighborhood and I think it is supposed to serve the people that are living in the neighborhood, who are supporting it.
Senator KENNEDY. Because there is something wrong with a health system that sees money first and treatment second?
Mr. JOHNSON. Would you repeat that question?
Senator KENNEDY. Do you think there is something wrong with a health system in our country or at St. George's or anywhere that says, "You have got to pay before you are going to get treated?"
Mr. JOHNSON. Yes, I think so because if I didn't have the money and I am sick, and I think I need the medical care give me a chance to pay it later if I am unable to provide it now.
Senator KENNEDY. Senator Packwood?
Senator PACKWOOD. No questions.
Senator KENNEDY. Thanks very much.
Mr. BROWN. Thank you, Senator.
Mr. and Mrs. Louis Lewis will be our next witnesses.

STATEMENT OF MR. AND MRS. LOUIS LEWIS, HEALTH SERVICE CONSUMERS

Mr. LEWIS. My name is Louis J. Lewis and I am retired—I will be retired, I'm not retired as yet.
Senator KENNEDY. Will you pull the microphone, the center one out to the front of your table so that we can hear you.

Mr. LEWIS. Am I talking loud enough?

Senator KENNEDY. Yes; just pull that one right in front of you.

Mr. LEWIS. I had a sister who recently died from cancer. She was operated on the first time in June of—rather July of 1967. She was in the hospital for about 3 weeks. She stayed at my home for 2 weeks because she couldn't take care of herself. She stayed home another 2 weeks from her job.

Mrs. LEWIS. Two months.

Mr. LEWIS. Two months and then she went back to work and she worked off and on and when she got too sick she stayed home.

In 1968 she took the complete cobalt treatments on the advice of her doctor, and in the meantime she had to see her doctor every week. She went and got examinations and a shot of some sort.

In 1969 she had treatment by special therapy and I don't know what they call it, for cancer, but it took—she took a series of those treatments and in February of this year she got pretty darned sick.

She kept going back to her doctor for a long time until finally in June or July the doctor put her in the hospital to find out what was wrong.

Well, they immediately performed a colostomy operation. They had to relieve the pressure of the cancer, or whatever you call it.

She stayed in the hospital 5 weeks, about 5½ weeks. I knew she couldn't take care of herself so I put her in a nursing home.

She stayed in the nursing home for 5¼ months and she passed away. During the time she was in the nursing home she was under a doctor's care. She also had to go to the hospital for an examination for another tumor. The tumor was inoperable and that is all there was to it.

In the meantime I was getting bills from the nursing home which I paid and everything else was fairly well paid, but if she hadn't had a very good health policy I would have been money out.

Senator KENNEDY. But she had a good health policy, is that right?

Mr. LEWIS. She had a very good health policy.

Senator KENNEDY. And how much were the doctor's bills or hospital bills, approximately?

Mr. LEWIS. Oh, I would say the first one was around $1,200 or so.

Senator KENNEDY. What were the total expenses for the illness over the whole time, do you remember that?

Mr. LEWIS. Oh, I would say around, well, I can't say exactly, but I will say it was, the last 5 months, they were over $10,000 and previous to that they must have been about $10,000 also.

Senator KENNEDY. So it was about $20,000?

Mr. LEWIS. That is right, sir.

Senator KENNEDY. And the Insurance company, the insurance paid about how much of the $20,000, do you remember?

Mr. LEWIS. They didn't pay any of the nursing home except the drugs, 80 percent of the drugs, and the hospitalization paid about 80 percent.

Senator KENNEDY. So they paid what, $7,000 or $8,000 of that first $10,000 because they didn't pay any of the last $10,000 which was associated with the nursing home?

Mr. LEWIS. They paid some of the last.

Senator KENNEDY. The hospital—well, of the $20,000, what do you figure was paid approximately? Do you remember what it was?

Was it about half, was it about a quarter, or what, Mr. Lewis?

Mr. LEWIS. I think it was about——

Senator KENNEDY. Did you have to use up any of your savings, do you remember?

Mrs. LEWIS. Yes.

Senator KENNEDY. Why don't we start off from that side.

How much of your savings did you use up?

Mr. LEWIS. About $3,700.

Senator KENNEDY. About $3,700, so that they didn't pay. They didn't pay the $3,700 and you had to pay that out of your savings, is that right?

Mrs. LEWIS. That is right.

Senator KENNEDY. And then you had a brother or a relation that had some savings too, is that right?

Mrs. LEWIS. No.

Mr. LEWIS. No.

Mrs. LEWIS. No. Her insurance, her health insurance was running out in fact.

Senator KENNEDY. Yes.

Mrs. LEWIS. And had that illness been prolonged it would have gone on and we would have used up our pension money that we have saved.

Senator KENNEDY. Are those the only savings then that you used, was the $3,700?

Mrs. LEWIS. Yes.

Senator KENNEDY. I see. Was that all of your savings?

Mrs. LEWIS. No, but had her illness been prolonged it would have been a pretty good chunk out of our savings.

Senator KENNEDY. But the insurance policy that you had didn't cover the $3,700 in any event?

Mrs. LEWIS. No.

Mr. LEWIS. No.

Senator PACKWOOD. I have no questions.

Senator KENNEDY. Thank you very much.

Mrs. Olga Villa and Miss Ninfa Ruiz.

STATEMENTS OF MRS. OLGA VILLA AND MISS NINFA RUIZ, HEALTH SERVICE CONSUMERS

Senator KENNEDY. How do you do.

Mrs. VILLA. Just fine.

Senator KENNEDY. It is nice to see you.

Mrs. VILLA. Shall I start.

Senator KENNEDY. Yes.

Mrs. VILLA. I am Olga Villa and this is what happened to me.

This was about a year and a half ago that I went to pick up my nephew. He was 4 years old at the time. He had been in the hospital for from 10 to 15 days. He had been very sick and they thought that there was a possibility that he was a diabetic and he had to go through a lot of tests. At that time I went to pick him up and usually when you go and pick up a child you have to dress him and make sure that he is not running a temperature before you leave the hospital.

This time he was already dressed and ready to go.

So I just took him home.

Well, when I got home and started, you know, to change his clothes and put him to bed I noticed that he had bruises all over his body.

Senator KENNEDY. He had what all over his body?

Mrs. VILLA. All over his body.

Senator KENNEDY. What did he have?

Mrs. VILLA. Bruises and scratches, you know, like he had been scratched.

Then when I touched him he was pretty hot so I took his temperature and he had a temperature of about 105.

Well, right away I called the doctor. He lives close by.

Senator KENNEDY. This is as soon as you got home?

Mrs. VILLA. Yes, it was about a half hour later because the hospital is not too far away from my place. So I called the doctor and explained that the baby had a temperature of 105 and he seemed like he was very sick and I noticed that he had bruises on his body and then he said, "Well, bring him over."

So it was a block away and I took him right away and he said, "Well, he must have fallen off the bed." Something like that happened to him in the hospital and I didn't think that was possible because he was very sick and wasn't able, you know, to move.

So the doctor sent us back to the hospital, and when we went there to the hospital the Mother Superior did not admit us. They would not admit him back to the hospital.

Senator KENNEDY. They wouldn't take him back in?

Mrs. VILLA. No.

Senator KENNEDY. They discharged him with a temperature but they wouldn't take him back?

Mrs. VILLA. Right.

Senator KENNEDY. Was this the same day?

Mrs. VILLA. About an hour later. It took me a half hour to get him home.

Senator KENNEDY. And they hadn't taken the boy's temperature?

Mrs. VILLA. Not in front of us. He was all dressed and I took it for granted, because they had OK'ed him to go home; but I took him back and I told the Mother Superior that the doctor sent us back because he was sick and then I wanted to find out about those bruises.

I thought maybe it had something to do with his sickness when I noticed the scratches and then I thought—well, the Mother Superior, she said, "I guess you did that at home."

And you could tell that the bruises had been there for days because they were not new. They were about 2 or 3 days old, or something like that, so I explained that we had just taken him out of the hospital and now we cannot get him back and he is sick.

Well, at that time some policemen were there and I talked to the policemen and I explained what had happened. The hospital didn't want to take him back and then we called this doctor that was seeing him and then when the Mother Superior saw that we had talked to the policeman and had signed a complaint and everything right there, why, right away she took him back.

Senator KENNEDY. After you signed the complaint they took him back?

Mrs. VILLA. When we talked to the policemen and explained everything, they called some doctors in to examine him and the doctors said that the bruises were not from a fall.

Senator KENNEDY. The doctor said this?

Mrs. VILLA. The doctor said that, yes.

Senator KENNEDY. Who examined him?

Mrs. VILLA. Yes, and we were on the other side of the door but we heard that and there was three persons besides myself, and, of course, they were my relatives who were very concerned. The doctor said his bruises were not caused by a fall.

Then when we told the police they advised us to go and see a lawyer, so we did that. We went to the Legal Aid and as far as we know, we are still waiting for them to call us. Nothing was ever done.

My nephew had the measles at the time we took him back besides what he had had before.

Senator KENNEDY. How long ago was this?

Mrs. VILLA. A year and a half ago.

Senator KENNEDY. You are active, as I understand it with the Benito Juarez Health Center?

Mrs. VILLA. Yes, sir.

Senator KENNEDY. What do you do?

Mrs. VILLA. I help in about everything like when we register the people and help out in the lab or with translations and things like that, because we have that language problem when we speak to our people.

Senator KENNEDY. So you have been involved in a health center?

Mrs. VILLA. Yes; for a year.

Senator KENNEDY. And you have been trying to work and help?

Mrs. VILLA. This is one of the reasons why I am very interested.

Senator KENNEDY. So you have got other than just the maternal interest in the caring about your nephew. You also had this kind of an interest in health in any event?

Mrs. VILLA. Yes; we have a lot of problems in our community where things happened to me with our own people.

Senator KENNEDY. What do you think happens?

Mrs. VILLA. Well, one of the policemen that talked to us said that we had to do something about it because the way he saw it somebody in the hospital was sick in the head to do something like what happened to my nephew.

Senator KENNEDY. "Somebody was sick in the head"?

Mrs. VILLA. Yes; somebody, because those were scratches and bruises and the doctor had said that it was not from a fall.

Well, I talked to the doctor, you know, because I consider him my friend. I told him if he would back us up in what had happened and he said that he couldn't say anything different because he had not been there and to him it was their fault.

Senator KENNEDY. Why do you think they discharged the boy with the temperature, then?

Mrs. VILLA. I don't know. I mean, as far as that is concerned, I know this never happened before because I know about that.

They never let you go home if you have a fever, so I just don't know what the reason is.

Senator KENNEDY. Do you think they would have discharged him if they knew what his fever or temperature was?

Mrs. VILLA. I really can't say about that, but as I said, he was dressed and ready to go home.

Senator KENNEDY. Senator Packwood.

Senator PACKWOOD. Mrs. Villa, let me pursue this a bit further because you are raising a question that I too have asked but cannot answer.

The question is not money, is it?

Mrs. VILLA. No.

Senator PACKWOOD. How can we change this type of situation?

What can the Federal Government do?

What kind of a law could we pass or what kind of financing could we provide to prevent the kind of treatment you received?

Mrs. VILLA. Well, my goodness, I really wouldn't know what to say. There are so many things.

Well, to start with, we have this problem, you know, with the language and sometimes we are not understood, you know.

Senator PACKWOOD. We had some witnesses yesterday who were black and they had run into the same discriminatory treatment, and again, it wasn't a money problem.

Mrs. VILLA. I have noticed, when I see people that to me I think can afford to really pay, they are treated very different, and this is not only my opinion, it is the opinion of many people that go to our center.

Senator PACKWOOD. From what we have heard, that is very true.

Mrs. VILLA. I felt bad because I have two sons in the seminary and being a Catholic hospital, I was not expecting something like this, and I was very hurt.

Senator PACKWOOD. Thank you very much.

Miss RUIZ. I think that perhaps maybe a provision could be made to employ some Spanish-speaking people in the hospital or, English or American, Anglos, to understand the language because so many times, our people are turned away because they do not understand them.

These people are poor. These people are sick.

Senator PACKWOOD. Unless Mrs. Villa's English has changed in the last year-and-a-half, she speaks very well now.

Miss RUIZ. That is one instance, but Mrs. Villa happens to be only one instance. We have so many people in our community who do not understand the language and who cannot even begin to verbalize it, much less try to communicate with somebody in the hospital who has a certain attitude.

Senator PACKWOOD. I understand that and am intrigued here because communication wasn't a problem at that particular hospital. They understood her and she understood them.

What is the problem? Can you put your finger on it?

Miss RUIZ. There are so many problems.

Senator PACKWOOD. Why does this happen?

Miss RUIZ. Well, I would say it is the staff or the people that are there. They just don't have a genuine interest.

They don't care just because they work in the medical profession and the medical profession is glorified so that once they come into this

profession, they think that they have all power and therefore they can say who is to come and who is to leave.

Senator PACKWOOD. One of the misgivings I have in dealing with the Federal bureaucracy is that they are not always civil.

Miss RUIZ. Right.

Senator PACKWOOD. I'm not sure that I want to turn medical care over to Federal bureaucracy.

Miss RUIZ. I can see that also, but I would think that is one of the reasons why they are indifferent.

I think they just get immune to sickness and to sick people and to attending to their needs because they are there day in and day out. If you do something, for a long period of time, you just get tired of it and you become immune to the people.

Senator PACKWOOD. If you are poor, you are not supposed to hurt so much?

Miss RUIZ. Right; and they are no longer sensitive to the problems.

Senator PACKWOOD. Thank you.

Senator KENNEDY. All right.

I think what Mrs. Villa has pointed out is what happened to her when she was sophisticated enough to use the system.

I think I should point it out that thousands of people who have a language problem, who are experiencing either abuse or maltreatment, are further disadvantaged because they don't know how to wend their way through the system because of the language difficulties. And they are hesitant to go to a hospital because they don't think they will find somebody at the door who they can speak to.

Miss RUIZ. Yes.

Senator KENNEDY. And for me, I don't think that we have to endure the system that treats people the way Mr. Johnson was treated.

I think it reaches the whole question of quality and if we have got people that have perpetrated these kinds of instances on your nephew and those who treated Mr. Johnson so harshly, I think we have to do something about it. I think we can get standards and I think we can enforce them. I don't think we just have to tolerate this kind of abuse that people have received.

I think a lot can be done and I think that we ought to be able to bring the community into a more active role. If that requires legislation, we ought to be able to legislate and if it requires community assistance, if the communities are going to get the Federal funds, we will insist on it and perhaps then we can reach and correct these abuses.

I agree with Senator Packwood that it is awful awfully difficult to come up and say, "Give me an amendment" to correct what happened to your nephew and Mr. Johnson's son. But I think this problem reaches one of the essential elements of the whole crisis with respect to the health care system and it is a question of quality and what we have to endure; and I, for one, don't think that we should endure these abuses.

Senator PACKWOOD. Before we think about imposing a federal medical bureaucracy on our people, we in the Federal Government should examine what we do for our veterans in our veterans hospitals. I have some misgivings about using this standard of care for everybody.

Senator KENNEDY. Well, I think no one is talking solely about the veterans hospital.

I mean, we can all talk about that, but I am the first one to be critical of the kind of education we buy for the Indians in this country.

There are a lot of meaningful reforms, like neighborhood health centers, that resulted from legislation that was passed in the Congress and which is bringing local people into the health care picture. We visited one this afternoon and that one was trying to provide dental care, and we saw a lot of children in this black community getting this dental care this afternoon who wouldn't have unless it was legislated way back in Washington, D.C.

As I say, we have a lot of problems, but I think that we can solve them.

Well, in any event, Senator Packwood and I will be wrestling around and trying to see what we can do later on, but we appreciate your interest and kindness in coming to tell us your stories.

Miss RUIZ. Thank you.

Senator KENNEDY. Mr. Ralph Lipowski and Mr. Joseph Dorich.

(No response.)

Mr. Lipowski and Mr. Dorich, are they here?

(No response.)

We will then go to Dr. Andrew Brislen.

He is the president elect of the Chicago Medical Society.

STATEMENT OF ANDREW BRISLEN, PRESIDENT ELECT, CHICAGO MEDICAL SOCIETY

Senator KENNEDY. We have Dr. Brislen with us and is that the right pronunciation, Dr. Brislen?

Dr. BRISLEN. Brislen, yes.

It used to be O'Brislen, but it is Brislen now.

Senator KENNEDY. And we have Dr. Campbell and then we will open it up to the floor.

I appreciate your coming here, Dr. Brislen.

Dr. BRISLEN. Thank you for letting me come.

When Mr. Lee Goldman asked me to testify before you, he told me that the subject was to be, "Crisis in Health Care. Does it exist or not." He suggested that I might give my views or those of the Chicago Medical Society on the subject.

I am pleased to give mine. I am not privileged to speak for the society yet. I am the president-elect and in 2 months, when I become president I will be more able to speak for the society.

I am delighted that the subject of your hearing is, "The Crisis in Health Care," because it contains the obvious admission that the crisis is not solely attributable to a deficit in medical care nor solely the responsibility of medicine.

Health care includes medical care, but it also includes all the other factors influencing health. Not the least among these is medical care, but medical involvement is only a fraction of the total and certainly does not exceed that of any of the others.

The responsibility of medicine for the existence of a health care crisis is no greater and in many instances is less great than that of the other modalities which contribute to the total health crisis.

Senator KENNEDY. What would you say the elements of the crisis are or are you coming to that? I don't have a copy of your statement.

Dr. BRISLEN. Well, I didn't give you one. [Laughter.]

In many instances it is magnified by deficiencies in other modalities.

Housing, education, nutrition, availability of hospital care, availability of preventive medical care and immunization, social environment, ambition as influenced by opportunity, employment, the various ecological factors, each of these are involved in the delivery of health care.

Certainly as long as there is a gap between the ideal health care and current health care there will be a health care crisis.

It is my personal opinion that the crisis in health care is not at all new. There can be no question that the factors enumerated above have always been deficient. However, the number, not the percentage, the relative number suffering because of the inadequacy of health care was so small that it was considered to be an irreducible minimum until currently when population growth has geometrically progressed to a point where no one can fail to recognize the deficiencies nor isolate himself by turning away nor believe that the solution to the basic problem is the bestowal of largesse.

Medicine, and I as a physician must be involved in the development of systems designed to improve the ability of the physician to deliver, as well as to improve the actual delivery of quality medical care in greater quantity to more people for a predictable and reasonable cost while at the same time avoiding the calamitous results of offering more than it is possible to deliver.

The search for the solution to this problem makes these times most interesting and most stimulating.

Each of you has heard again and again the aphorism that says that, "The Chinese character for crisis includes both that for danger and that for opportunity." We must be wary of seizing at opportunity without full appreciation of the dangers to our national structure of unbridled enthusiasm.

I will answer any questions you may have now.

Senator KENNEDY. Thank you very much, Doctor.

Earlier in the afternoon—well, let's start this off in a different way.

You mentioned that the medical profession is no more responsible for the kind of health crisis that we have than the other modalities, and then you mentioned the questions of "housing, education, socioeconomic, and ambition as influenced by opportunity."

Now, that is what I wrote down here as you were speaking.

Now we listened this afternoon to Mr. Lyle Mattox about how he was a part of an insurance program; got high blood pressure, was dropped by his insurance company and then had to spend all of his savings to pay his bills.

We listened to Mr. Paul Johnson who brought his son to a hospital, and how he was turned aside and later his son died.

Certainly nothing about housing or education or ambition or socioeconomic conditions were mentioned in that. We also listened to Mr. and Mrs. Lewis about the problems that his sister had with cancer and how that cut in heavily into their savings that they had been accumulating for a lifetime. And then Mrs. Olga Villa whose good will is sufficient to involve her heavily even today at the Benito Jaurez Health Center, trying to help her people. I don't know what the questions of housing are, but certainly we listened to those consumer

people who have had some contact with the system, and I don't think that they are untypical.

Where the criteria which you have mentioned here this afternoon really fails to fit in, is with respect to their particular difficulties.

Still they are treated harshly by the system. I repeat—they are treated harshly by the system and they ask, what I think many of us in the Congress ask why the medical societies and the AMA are not leading the spirit of reform rather than being dragged into it?

What kind of reaction do you have to that? [Laughter.]

Dr. BRISLEN. You have raised——[Applause.]

You have raised several points and I made a quick note of at least three, any of which would take a fair length of time to discuss. On the other hand, the things that some of these people who were here testifying mentioned are heinous.

Senator KENNEDY. Are what?

Dr. BRISLEN. Heinous, there is no question about this.

On the other hand, for me to give an opinion on them without knowing all of the facts would be like treating you after making a snap diagnosis without trying to confirm it.

If the facts are such, they are bad and I have no excuse for them.

I presume that there are bad actors in all professions.

Certainly some of this sounds as though there might be some here.

Secondly, you brought up the point of catastrophic illness.

Catastrophic illness, in fact, uninsured illness is dangerous for anyone to have.

Almost anyone is incapable of handling its costs.

I think the services rendered for the costs justify the costs.

The method of paying for them may be a problem.

You mentioned another thing just in passing; hospital costs, which of course influence the cost of medical care.

You suggested that the patient who was taken—the black man's son——

Senator KENNEDY. Mr. Johnson's son?

Dr. BRISLEN. Yes, who had been a patient at the county hospital receiving specialized care. This is an inference which I am making, not because I am familiar with the case, but because I did read something in the newspaper and because of some statements Mr. Johnson made.

The patient had been receiving specialized care in a unit provided to give that specialized care at the county hospital.

The fault in this particular case seems to have been in the delivery of the patient to care. Instead of taking him where be belonged, they took him to a hospital where they were incapable of providing that care.

Senator KENNEDY. Do you think——

Dr. BRISLEN. Now, had the hospital been capable of providing that care, it would have had to have had in existence and in operation, a unit to provide esoteric care, expensive esoteric care which might be called upon only one or two or three times a year.

Now, it seems appropriate to ask "Shall all hospitals be required to have all types of care available or shall certain types of care be located at certain centers with patients being taken where the care can be delivered?"

I think to require all hospitals to have infrequently used expensive equipment will cause daily hospital charges to rise a great deal more.

I am sorry I interrupted on a question of yours, Senator.

Senator KENNEDY. That is all right.

Well, what do you think of Mr. Johnson's situation when they asked him what he was doing for a living or even when they were trying to solicit social information, and no one was examining the child?

Then when he complained about this, Mr. Johnson, and the doctor allegedly said, "If you don't like the service here, take him elsewhere." He did the appropriate thing: He took the child to the hospital where he should have been taken initially—to the county hospital where the appropriate equipment, knowledge, and records of his condition were available.

Dr. BRISLEN. If——

Senator KENNEDY. Do you think that is the kind of treatment he deserved?

Dr. BRISLEN. If, before the child was even looked at, this is improper; yes.

The duty of the hospital and the duty of the physician is to treat the patient.

The fact that the hospital administration may coincidentally and concurrently inquire into financial responsibility is not necessarily reprehensible.

Senator KENNEDY. You see, these witnesses that we heard here this afternoon were consumers and we heard yesterday the same stories in Cleveland.

We heard the same stories in rural West Virginia; we heard the same stories down in Nashville, Tenn.; we heard the same stories in New York.

We are hearing the same stories in every part of our country.

These aren't just poor people that had some kind of a brush with the hospital system in the city of Chicago.

We are getting the same story all over the country.

Dr. BRISLEN. Sir, I recognize this.

Senator KENNEDY. And I think the question that comes to my mind, whether you would agree with me that there is really a crisis in health-care delivery today.

Would you agree with that?

Dr. BRISLEN. Yes, I think there is.

I think there is because there are so many people who need care.

Senator KENNEDY. Well, why wouldn't the AMA then really provide some leadership? Perhaps they will understand you out here, but why wouldn't they really take a leadership role to meet this crisis?

If you recognize the crisis, then you have to recognize the kind of dramatic steps needed to meet the crisis, and that is what crisis means.

Dr. BRISLEN. What would you have the AMA do?

Senator KENNEDY. Well, we could start with having them support S–3. [Applause.]

No, but I say the response should be——

Dr. BRISLEN. Well——

Senator KENNEDY. Let me just finish, please.

AMA's position on medicredit didn't materialize until long after the President said that there was a crisis, and then introduced his own

program. That preceded by some time the formulation and development of the AMA's program.

Theirs deals with financing.

There isn't a part of the medicredit that deals with resource development, manpower development.

There isn't any provision for cost control. I am just hopeful that the leadership of the AMA will propose some cost controls.

We would like their cooperation in getting the kind of resource development we need, to take the lead to get States to relax the laws so that paramedical personnel can actually practice, not just paying lip service to this and saying, "We need paramedical personnel," and then having them do cleaning work in hospitals.

Now, it just seems to me that this is the kind of leadership, and I would think that if you sat down with the AMA, you could think of so many better ways to reform the system then Senator Packwood and I and the other members of the Senate could.

I sincerely hope that we could have that kind of leadership from you and from the association.

Dr. BRISLEN. Well, I think that you will find that we are more than willing to cooperate with you. Maybe we won't buy everything that you have to sell. [Laughter.]

Miss RIPPON. Senator Kennedy, I would like to know how many people in this room feel that Dr. Brislen has spoken representatively for them.

Senator KENNEDY. Well, we will try afterward. [Laughter and applause.]

We will let Dr. Brislen conclude. He has been kind enough to come here and I will let you be first up after we hear from some of the other witnesses, and then you can say what you want but we haven't permitted other interruptions of witnesses.

Senator PACKWOOD. Let me get back to the problem that still concerns me. Our problems do not seem to be money or financing problems, except in the case of catastrophic illness. What we see is a lack of communications between the minority groups in this country and the hospitals. I am not quite sure how to rectify it but do you have any suggestions along that line?

Dr. BRISLEN. I can only speak for the sphere in which I practice. I practice in the Woodlawn Hospital. The Woodlawn Hospital is in the Woodlawn area.

My hospital has a census of approximately 70 percent black. I treat black and white patients in my office and I hope I treat them well.

I treat them better than most of the patients who have been testifying here have been handled.

Now, how should care be delivered? There has to be a total change in the delivery of care. There must be.

I was on a program recently in which someone was kind enough to suggest that maybe I had a Brislen plan. Well, I have a Brislen concept.

I see care being delivered—that is primary health care being delivered in community health centers.

I think community health centers are decidedly advantageous as a way of delivering care. In the first place because community health

centers are established by the community where the community wants them to deliver the services that the community wants, to the community. I think that they should be the source of primary health care and that each health center—each community health center—should be a satellite to a nearby hospital.

One hospital should have two, three—I don't know how many, community health centers. Each hospital backing up and providing the necessary secondary medical care and that each of the hospitals should in turn be satellite backed up by a tertiary care unit and since this is Chicago; and I practice in Chicago, I conceive of this tertiary unit as being one of the medical schools in Chicago, five currently, soon six, and even seven soon.

This system would permit a whole gamut of care starting in a community health center and extending through all echelons as necessary. It would also permit locating specialized equipment throughout the city, that is in the appropriate satellite hospitals so that the patient could be taken to the proper source of treatment.

There are loads of bugs in this. There are loads of problems in this, not the least of which will be to convince some doctors that multiple staff appointments may be desirable and that changes in the ways they do some things may be an improvement.

However, it is a suggestion and although mine it is not the mecca, not a paragon. It is a concept and one you must have to have a concept to begin with. I think this is a good one.

Senator PACKWOOD. Thank you.

Senator KENNEDY. Thank you very much, Doctor. I appreciate your mentioning that you feel that the problem is of crisis proportions because the A.M.A. in Washington wouldn't be nearly as descriptive of this and I think what you have indicated is a good start.

Dr. BRISLEN. I defined it in a little different term.

Senator KENNEDY. Well, we will go with the record on your statement and thank you very much. [Applause.]

Our next witness is Dr. James Campbell.

He is the president of the Rush-Presbyterian-St. Luke's Medical Center.

STATEMENT OF JAMES CAMPBELL, PRESIDENT, RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER

Dr. CAMPBELL. I have no prepared statement.

Senator KENNEDY. We are beginning to get a rundown in terms of time but we want to hear from you, Doctor, so we will let you proceed in your own way.

Dr. CAMPBELL. I have no prepared speech——

Senator KENNEDY. Fine.

Dr. CAMPBELL (continuing). Which will save you some time.

Senator KENNEDY. All right.

Dr. CAMPBELL. I have made some notes.

Senator KENNEDY. Fine, OK.

Dr. CAMPBELL. When I had the good fortune of sitting next to Mr. Mattox, he turned to me and asked: "Are you a victim or an expert?" [Laughter.]

I have the feeling that I am a bit of both.

I think that if we don't have compassion for the stories that you have heard today we are unfeeling and insensitive.

If we were not to try to do something about them, as you, Senator Packwood, and Senator Kennedy are doing, we would be guilty of malfeasance.

It seems to me that there are three issues that stand clear to me. The first of all is cost. It is easy for all of us to understand that dollars are a readily translatable term. The first issue under cost perhaps is: Does cost, does payment for care block the opportunity to get care?

It seems to me that that is clear. I believe this is a crisis. I think all of us, whether we are consumers have had problems—and to paraphrase Pogo: "We have met the consumers and they are us."

I think if costs stands between us and getting care, we have to do something about it.

As purveyors we are victims, Mr. Mattox, as well as experts because our people depend upon us for their bread and butter.

So we are anxious to see that they have a standard of living which is above the poverty level, which until very recently many hospital employees did not enjoy.

So cost has to be scrutinized. First it is a barricade to care and, second, do we get our money's worth?

And this will vary as the technology advances. It will vary as efficiency and system analysis can be brought into play and a help as we become more cost conscious.

I think cost analysis in the health industry is absolutely essential. I think it can be done and must be done and when I say "health industry" I also include not only the purveying of care but also the education portions of the health industry as well.

A second major item which seemed to be discussed was quality control. I think quality control is essential in this industry as in any industry, and I think it is more important when we deal with the ill-measured variables of the spirit and the psyche that are so important in sickness and in health.

Then, finally, it seemed to me, we were hearing the issue of availability discussed. I think many of the things that we heard about, going to an emergency room for care for a sick boy, bothers me because emergency rooms in hospitals don't deliver care any more than Wrigley Field plays ball. It is the Cubs who play ball and it is the people who deliver care. The setting is what we talk about in many instances.

Now, I don't mean to get bogged down in that too much in detail but what we need is manpower.

Now, the statistics which you have are behind you, I would like to emphasize, have particular local meaning with respect to manpower.

The State of Illinois, as you know, it is about fourth in population. It is about third in per capita income, and yet it is 18th among the States in physicians per 100,000 people.

As proud as we are of Chicago, although it is second or third in population in comparison to Los Angeles, New York City, Cleveland, Detroit, and San Francisco and is third in per capita income, it is the

next to the last, and this is the general Chicago area, in the number of physicians per 100,000 people.

Yes; there is a crisis in health care and we share with you the dream of trying to meet that crisis.

I do hope that you will focus on meeting the costs, and I hope that the rest of the Congressmen will focus on meeting the costs in the most appropriate way to keep the consumer in control so that he gets a guaranteed purchase, so to speak, from the purveyors whether they be physicians or osteopaths or hospital service or any other health personnel.

I hope that that will be studied very carefully so the costs won't be a hurdle.

I hope the quality control and the cost control will obviously be our own responsibility for developing the modalities and the methodologies for measurement. But availability, if you do all of those things, even giving a credit card to a store, it is like giving a credt card to a store that has no wares or at least has the shelves only half full.

This is where the real crisis is. Manpower is short. Now, we must meet that and I hope that S. 3 will be given careful scrutiny to see that even more adequate manpower coverage is included and that we keep the timelag in mind.

The way to get people to come back to the ghetto is to start from the ghetto and the way to get people to come to the rural areas is to start from the rural areas and keep the spectrum in mind.

I didn't mean to make a speech when I said I had none prepared.

Senator KENNEDY. Very good.

Dr. CAMPBELL. It is only that I had something to say.

Senator KENNEDY. Well, that is very well said and very precise and, of course, you were kind enough to spend about an hour or so with us earlier today in bringing us through your facility and meeting with some of the other deans of the medical schools and we are very appreciative of your appearance here.

I want to thank you very much for that statement.

Senator PACKWOOD. I have no questions.

Senator KENNEDY. We want to thank you very much, Dr. Campbell.

Now, we have Mrs. Carol Grigna.

Is Carol Grigna here?

Mrs. GRIGNA. Yes.

STATEMENT OF MRS. CAROL GRIGNA, HEALTH SERVICE CONSUMER, AMERICAN INDIAN

Senator KENNEDY. How are you?

Mrs. GRIGNA. Fine.

Senator KENNEDY. I want to welcome you, Mrs. Grigna. I know you have got something to say and we are going to try to hear you through.

We have got about 20 minutes left so we will do the best we can and we want you to be able to feel comfortable and use as much time as necessary to give us your message but we also do have others who want to make some comments.

Mrs. GRIGNA. I am Mrs. Grigna, an American Indian.

Senator KENNEDY. Just pull that microphone, the one with the black end on it, that is the correct one, just pull that a little closer to you so that we can all hear you.

Mrs. GRIGNA. I am an American Indian. I am speaking for about 10,000 or 15,000 American Indians in Chicago.

The American Hospital on Irving Park and Broadway should be investigated. It refuses service to the American Indian.

Senator KENNEDY. Go nice and slow. You are doing very well and everyone should be relaxed and we are very interested in this problem with respect to the American Indians so just take your time now and don't be nervous.

Mrs. GRIGNA. They take our Indian women's babies away, because they said that she was drunk. The nurses signed against the mother and there are hospitals in the city that won't even accept Indians as welfare cases. They are treated like dirt and they have to wait for hours before they are cared for.

Always they are given the worst doctors and I had my son who was beat up by six Puerto Ricans and they gave him an old doctor who could hardly see. I don't recall his name but my son was treated at the American Hospital at that time and the nurses at the American Hospital treat people just like animals.

Now, I am on ADC and I have talked to a lot of Indian people and they have told me a lot of their problems.

I have heard of the poor four Indian children having lead poisoning from old paint in the housing conditions they have to live in and how many more we don't know about.

I have talked to a lot of people and it is terrible the way they get treated by some hospitals; they think we are just a bunch of drunken Indians and our living conditions and welfare are just ignored in the city of Chicago, and not only here but in other urban areas and also on the reservations. It is about time society realized that the Indians should have first priority.

Our territory was taken away from us Indians and we are just treated like animals, and that is something that society can't do, is take away the Indians' pride. They have taken away everything else, on and off the reservation.

Society doesn't know how to handle Indian people because Indians only know about Indians and no one else does.

Other counties benefit from the Indians which are near the reservations and the Indians don't have anything on the reservations.

There should be an Indian hospital here in Chicago specifically for Indians and with all fields of medical care included, including general care.

Let the society not tell the Indians how to take care of Indians because no one else does or ever will.

We have the Society for American Indian Development and Education. This is our organization and before you leave Chicago you should talk to them and you might learn some of the needs and wants of the American Indians.

Thank you.

Senator KENNEDY. I want to thank you very much, Carol, for coming here and sharing these thoughts with us.

I don't think there is any question that the native Americans have been the most forgotten of all our groups in society and this is true in terms of health and it is certainly true in terms of education——

Mrs. GRIGNA. I have taken my children out of school. I do not believe in the public school system.

Senator KENNEDY. I think the comment which you make with such feeling is a forceful reminder to all of us and I think that I know what you have said and you have said it so well and I won't even begin to try and repeat it but it is important in terms of education and it is important in terms of health and it is really under local control. But there is no reason in terms of education that we shouldn't have elected Indian school boards.

There are 225 Indian school boards in this country and there are four elected in spite of the fact that President Nixon said 18 or 19 months ago that we ought to encourage election of local school boards.

They are not active in terms of the determination of education of their young and they are not active in terms of the determination of the kind of quality of health and certainly we ought to recognize this and be much more responsive to it.

Mrs. GRIGNA. Mr. Kennedy, could I say something?

Senator KENNEDY. Certainly.

Mrs. GRIGNA. I forced the board of education to take me to court. My children were behind in school and they were pushing them through school and they didn't have any special programs or classes so they could get caught up in their work.

This is what happens to most Indian children and that is why there are so many dropouts.

The board of education knows of 1,300 Indian children and there are about 15,000 Indians in Chicago with 45 percent of them being of school age.

Where are the other 3,500 Indian children? I asked the judge that and he said, "I don't care about 3,500 Indian children. I care about these six."

Well, I go to court on June 2 and I wonder if they will throw me in jail.

Senator KENNEDY. Sixty percent of all of the Indians live in urban areas, off-reservation areas, and if we are talking about really meeting the kind of needs and realizing our special responsibilities and obligations, we are just going to have to find ways to help and assist them.

Mrs. GRIGNA. My children and I were evicted from our apartment last year and there hasn't been anything done at all for the American Indians in Chicago.

I don't think that because we lived in a living hell for 4 months that this should be something that should go on but rather that there should be something done by now.

Senator KENNEDY. Do you have any questions?

Senator PACKWOOD. No questions.

Senator KENNEDY. Thank you very much. I appreciate very much your coming here.

You have provided a real service to us, really.

Dr. William Towne and Dr. Nick Rango, they are from Cook County Hospital. We are glad to have you here, gentlemen.

STATEMENTS OF WILLIAM TOWNE, RESIDENTS ASSOCIATION OF COOK COUNTY HOSPITAL, AND NICK RANGO, INTERNS ASSOCIATION OF COOK COUNTY HOSPITAL

Dr. TOWNE. I am William Towne and I am a 4-year resident in internal medicine in Cook County Hospital.

We have a document here which represents the feeling of our group which we have presented to you. I would like to read part of this document.

Senator KENNEDY. We want to welcome you, Dr. Towne; Dr. Rango and Dr. Towne were kind enough to bring us through the county hospital last night about 10:30 and it was very helpful having their insight and thank you for coming here.

Dr. TOWNE. Sure. Cook County Hospital——

Senator KENNEDY. We can include this in the record.

I notice that you have a statement some eight pages long and I will be glad to include it if you want.

If you want to speak off-the-cuff and just highlight the particular concerns you have, we will be glad to listen to them but actually we are really running out of time.

We will include this in its entirety in the record and I will take time to read this on the way back this afternoon to the east coast.

But, I would appreciate it if you could really highlight what your particular concerns are.

Dr. TOWNE. Cook County Hospital, is a 2,000-bed charity hospital that, at present, constitutes the only available source of health care for the poor of the Chicago metropolitan area. The population it serves is well over 1 million in number.

The Residents and Interns Association of Cook County Hospital is an organization to which over 95 percent of the house staff of the hospital belong, 400 members. As such, the association is the largest house staff organization in the country.

The house staff consists of those physicians engaged in internship and specialty training at the hospital.

These doctors provide the primary care for all patients at the hospital and are in most cases the only physicians a patient will see during his hospitalization.

Any patient at Cook County Hospital who is asked the name of his doctor will respond with the name of a resident or intern.

Residents and interns at county hospital are not required or expected to participate in medical research. Their interests are in providing quality patient care and in furthering their postgraduate training.

The purpose of this document is to provide the committee with what the residents and interns association's position regarding the existent problems and inadequacies of the health care delivery system.

How this document is to be acted upon is beyond our area of expertise. However, our strong recommendation is that this document be carefully studied and considered by every committee member.

The fact that the health care of the Chicago area poor is inferior has been well documented.

We believe that this is not a reflection of the physicians at Cook County Hospital who are involved in patient care.

For medical conditions requiring the type of intensive care that requires the presence of a physician, severe traumatic injuries, extensive burns, patients from all economic strata are frequently transferred to Cook County Hospital from other institutions, often over great distances.

Almost any physician who has had experience at Cook County Hospital would ask to be brought there were he to suddenly develop a life threatening condition because he could be assured of prompt treatment by a physician who would handle the problem in person and not over the phone.

What, then, are the problems in health care of the population Cook County Hospital serves?

(1) The hospital is inadequate in size for the population it serves. Other Chicago area hospitals refuse to care for the poor of their area.

Patients are frequently transferred to Cook County Hospital in such serious condition that their lives are seriously jeopardized en route—documentation attesting to these unsafe transfers has been accumulated by the residents and interns association.

This practice would be reprehensible enough were it done because the patient had no means to pay.

However, since the advent of third-party payments, we have to our dismay found that having medicare or health insurance does not protect a person living in a ghetto area from receiving such criminal treatment.

The only logical explanation for this phenomenon would seem to be racial or class discrimination.

(2) The distance to Cook County Hospital for many of the population it serves is such an inconvenience that they choose to make the trip only when desperately ill.

Neighborhood health centers have never been provided by local authorities, such as the board of health. Recently some community organizations have started several of these centers.

Their efforts have not only not been aided, but have, in many cases, been actively fought by local government.

The Chicago Board of Health is currently involved in a bitter struggle to close down several community-controlled neighborhood health centers because these centers function independently of the political control of city hall.

(3) Even if the area served by Cook County Hospital were to be limited to a reasonable size, the inefficiency with which the hospital is administered would, in our opinion, still render the health care of the population inadequate.

The remainder of this document will attempt to explain the grounds for that statement.

Maladministration at Cook County Hospital has resulted in the following problems:

1. Impending disaccreditation by the Joint Commission on Accreditation of Hospitals.

The hospital is currently only temporarily accredited by the Commission.

At the time of its next review, the Commission must either fully accredit or discredit the hospital. The lack of meaningful improvements in conditions since their last visit would make an unfavorable judgment seem likely.

2. Increasing difficulty in recruiting attending and house staff physicians. Cook County Hospital matched less than 25 percent of the desired interns for the period of July 1971 to July 1972.

3. Continuation of 19th century "sick-house" conditions of patient care in many areas of Cook County Hospital.

Enclosed is a copy of a current Look magazine article, May 18, 1971, issue, which speaks to many of these conditions publicly.

The fact that patients on most of the other hospital wards have no access to privacy whatsoever does not appear to excite much sympathy with the hospital administration.

The above problems existed before the governing commission was formed. They existed because their solutions would have been politically inexpedient for certain individuals and groups.

The Residents and Interns Association actively supported the formation of a fiscally autonomous governing commission because we felt that improvements in patient care at Cook County would result. Thus far we have not seen those improvements. More importantly, we have detected a sense of priorities that is especially disturbing.

The offices of the governing commission will be air-conditioned before the operating rooms, carpets installed before ward bathrooms are built.

We hoped that we could effect a change in the governing commission by suggesting a person for membership whose goals would be more in keeping with improvement in health care of the population we serve.

The man we chose to endorse was also backed by numerous community groups and to the best of our knowledge, his appointment to the commission was opposed by no one connected with the practice of medicine at Cook County Hospital nor any consumer representative. Nonetheless, this individual was turned down for membership on the commission.

Mr. Stuart Ball, an individual who last year publicly accused a group of concerned doctors, nurses, and paramedical personnel, of a conspiracy, on behalf of the selection committee denied the community's nominee membership.

He stated that Lopez was not eligible by virtue of lacking U.S. citizenship. We consider this statement specious.

In the extreme, enclosed is the legal opinion of the community board's counsel on this point.

We are also forced to conclude on the basis of his past actions as well as his attitude on this question that Mr. Ball is interested in preserving the status quo at County Hospital.

We felt that the acquisition of a governing commission would also lead to reforms in the division of laboratories as well as in the relationship of Hektoen Institute to C.C.H. Both the division of labs and the Hektoen Institute are headed by Dr. Samuel Hoffman.

Dr. Hoffman has been fired by the previous hospital director from the hospital position but he remains on as a result of a civil service technicality.

He has been asked by all of the house staff physicians, by petition, to leave both positions, but has refused to do so.

The laboratories he administers have been under repeated criticism for lack of quality.

The institute he administers doesn't provide laboratory space for the cardiovascular surgery service at Cook County Hospital but does provide space for the same service at the University of Illinois Hospital.

It has somehow come to pass that the laboratory where autopsies are performed in the institute facilities has tables and lighting superior to those in the hospital operating rooms, as well as being air conditioned.

Dr. Hoffman has attacked the Residents and Interns Association as well as the previous hospital director publicly on numerous occasions.

He opposed the appointment of the governing commission.

We conclude that Dr. Hoffman is determined to preserve the status quo at Cook County Hospital.

Dr. James Haughton has been selected by the governing commission to be the chief administrator of Cook County Hospital.

He is the highest paid public official in the State of Illinois, with a higher salary than the Governor and U.S. Senator. He has acquired a staff to match. He has promised sweeping reforms. We are awaiting results with increasing skepticism.

Since his arrival 6 months ago, no substantial improvement in patient care have resulted.

As stated above, we are appalled at the sense of priorities evidenced by Dr. Haughton and the governing commission.

In conclusion, the Residents and Interns Association believes that the health care of the population served by Cook County Hospital is inferior and that as a first step toward improving that care, there must be betterment of facilities and operation and increased efficiency at the hospital itself.

We feel that there is a group of individuals who, while never saying so publicly, opposed that view for their own political reasons.

We reject the idea that Cook County Hospital or any other similar institution should function as an inferior health care system for the poor. We pledge to continue to work as hard as we can and with all means available to bring medical care that is second to none to our patients.

Dr. TOWNE. Cook County Hospital, as I say, is a 2,000-bed charity hospital in Chicago, which is the only available source of health care for the large part of the poor community, a community which numbers well over a million.

We feel that the care for this segment of the population has many inadequacies and some of these inadequacies are the fault of the hospital.

We do not feel that these inadequacies are the fault of the doctors at the hospital nor have they ever been.

We feel that Cook County Hospital always has been and remains today one of the best hospitals for certain types of problems anywhere in the world.

We feel that if one is to become a victim of a severe gunshot wound

in the abdomen or chest, or if one has a heart attack, one could not find better life-saving treatment than at Cook County Hospital, but we feel as far as many things are concerned, that they are also important to the community such as routine tests or workup of illness.

The conditions at Cook County Hospital leave a lot to be desired.

We feel that part of the problem of Cook County Hospital is its size and the size of the area it serves.

We feel that even if the size of the area that it served were diminished to an extent where care were possible, we feel that the care would still not be adequate because of the problems in administration of the hospital.

With this in mind, many groups at the hospital urged the formation of a governing commission at the hospital and in place of the county board, which had previously administered the hospital.

We later on campaigned for fiscal autonomy for this governing commission which was obtained.

The governing commission has now been in operation almost 2 years and we have not been happy with what we have seen there.

This statement documents with facts and figures that situation and we attempted here to say what we think is wrong with respect to the adminisration of Cook County Hospital.

Dr. RANGO. I am Nick Rango, and I am chairman of the intern body at the Cook County Hospital.

I would like to begin by thanking you for coming and it is high time that we begin to talk about, humanistically, the crisis in health care, but what we really mean is the collapse of health care systems.

I think that the emphasis that the hearings have placed on the incredible facts with respect to profiteering which go into the health care system, particularly the insurance companies; Blue Cross, Blue Shield and the way that they handle their patients is a good one. It is not unusual for those of us at county hospital to have patients dumped on us from private hospitals with a little note saying that "His insurance benefits have run out, but he is a good patient, and please do the best you can." These kind of things happen every day. I think I have some things——

Senator KENNEDY. What do you mean, "every day"? Do you mean that it is actually the situation?

Dr. RANGO. Yes, it is. When we are on the wards, and you know we receive our admissions oftentimes as transfers from private hospitals and that is if they don't have the money.

Senator KENNEDY. Why do they transfer them over to Cook County?

Dr. RANGO. Because they don't have money or their insurance has run out. They are transferred from the medical schools if their pathology is uninteresting and they are brought to places like Cook County Hospital.

Senator KENNEDY. You mean just because they can only afford to take so many into their hospitals, given their kind of budgets and therefore, after they reach sort of a ceiling, they turn them over to Cook County Hospital?

Dr. RANGO. I think that is involved, but I think it is something much more important than that and that is the fact that our patients at Cook County, 60 percent of them do have third-party payments and most of these patients are nonwhite.

There is quite a bit of racism that goes into the rejection of the patients at the private hospitals and the responsibility of the medical profession for this racism has never been acknowledged. I think that one of the signs of solution is possibly the recognition, such as depicted by the house staff of the young sector of the medical profession with respect to the admission of this racism and class bias which provides an opening for working with progressive political people such as yourselves.

The thing that I want to just comment briefly on is that I think that we have witnessed here today a very important political phenomenon.

You had three speakers representing different sectors of the health care system who have testified.

One of them represents the political sector, the board of health, Mayor Daley who has told you some of the positive facts about the program, but has not mentioned the fact that in the negative sense these board of health clinics provide second-rate care, and the neighborhood health centers that they are building now are only in response to the community's own efforts in developing neighborhood health centers.

In the last 2 years we have heard from the spokesmen of the traditional medicine, the Chicago Medical Society, which, less than 1 month ago, Senator Kennedy, denounced these neighborhood health centers because they did not have professional people who they thought were qualified to work there.

Well, I have worked at these centers with the women from the Bonito Juarez who represent one of the centers, and I can assure you that they are community-initiated efforts and they were blocked by the medical society.

The last speaker was from the Presbyterian-St. Luke's and he represents the new mode, the new medical mode and they are the liberal corporate kind of approach to medicine that is trying to establish the medical school's interest in these situations.

However, Presbyterian-St. Luke's is still a segregated system who refused to enter into an agreement with the Bonito Juarez Health Center when they came to them last year to provide backup care for the people. These people were turned away and Cook County has been providing that service.

Senator PACKWOOD. Let me ask you something because we toured St. Luke's and then we toured Mile Square. Dr. Campbell indicated that admissions from Mile Square to St. Luke's take place all the time and none are turned down.

Dr. RANGO. Well, 3 months ago they organized Mile Square—let me restate that—3 months ago, we had one of the formal organizers of Mile Square on a general ward at Cook County Hospital.

Senator PACKWOOD. Would you repeat that?

Dr. RANGO. Three months ago, we had one of the community organizers of Mile Square as a patient of Cook County Hospital.

Senator PACKWOOD. I am sure there may be people from Mile Square in a number of hospitals, but Dr. Campbell did indicate to us that if anybody is recommended for admission to St. Luke's from Mile Square, they are admitted.

Dr. RANGO. That is true from Mile Square.

The community that was approaching them last year was the Chicano community in the immediate vicinity of Presbyterian-St. Luke's, and what I am referring to is the institutional lack of responsibility of the medical schools, of the professional medical representatives, the AMA, the Chicago Medical Society, and please, don't turn to these people because they are not the experts.

The solutions will not come from any of those bodies, and only after you have made a radical reappraisement of the structures of medicine and how doctors are paid will you reach a solution.

Senator KENNEDY. Is S-3 radical enough for you?

Dr. RANGO. I think your plan is probably the most progressive of all of them.

Senator PACKWOOD. But not radical enought?

Dr. RANGO. It only begins to solve it.

Senator PACKWOOD. How does it solve the problem when these patients are being discriminated against although they have third-party insurance coverage and the problem isn't money?

Dr. RANGO. I don't think your solution is going to eradicate that. I think that the solution is going to rest with more proper fundamental social changes that will come when you Senators and the politicians start addressing themselves to questions of finance.

Why are the health insurance people allowed to get away with what goes on with respect to Blue Cross and Blue Shield? Why are doctors allowed to make the kind of money that they do?

Until you make a restudy of the structures of health delivery, you can talk all you want about financing, but you won't do any good or it won't do any good.

Senator PACKWOOD. How much should a doctor be allowed to make?

Dr. RANGO. I think that is going to have to be determined in the same way that you determine what other workers are allowed to make.

Senator PACKWOOD. Well, give me a fair idea, say, for a doctor who has practiced 10 years, not what he does make, but what he should make?

Dr. RANGO. I think it depends upon the community, and I think it is reasonably easy for anyone in this country to support——

Senator PACKWOOD. Give me your idea.

Dr. RANGO. $10,000 to $20,000 a year.

Senator PACKWOOD. $10,000 to $20,000 a year?

Dr. RANGO. Sure.

Senator KENNEDY. I want to thank you very much for your appearance here. We have just a few more minutes, and I am delighted that we got a chance to hear from you.

It is good that you came. We have taken the opportunity to meet with the residents and interns in Bellevue in New York City when we were up there. We had about a 2½- or 3-hour rap session up there, which was very informative. We talked about the draft, the effect of this, the young people wanting to work, and the impact of the emergency health manpower bill, and the importance of a lot of different features which we really haven't touched on here. So I know there are so many of these kinds of questions which they are interested in which you can provide information on.

Dr. RANGO. We applaud your efforts, and we are anxious to help in any way we can.

Senator KENNEDY. All right. Now we have Dr. Phil Ricks.

STATEMENT OF PHIL RICKS, PRACTICING PHYSICIAN, CHICAGO, ILL.

Dr. RICKS. I happen to be a physician, obstetrician.

Senator KENNEDY. You can come up here if you care to.

Dr. Ricks, I wish we could give you a lot of time, but at 3:16 we are going to have to walk or leave, I am afraid, but whatever you have to say we would be glad to hear.

Dr. RICKS. I am an obstetrician-gynecologist and a practitioner in the black community.

I think that many of the statements the last gentleman made were quite true.

I want you to know that many of the problems in Chicago, particularly as to why Cook County Hospital is overburdened, is that the majority of the black patients are brought or transferred from the ghetto to a facility such as Cook County and that oftentimes the black physician is not privileged with respect to the facilities of many of the centers, in even the black community or the ghetto.

If you take most hospital staffs, you will find that you have an inordinate number or small proportion of black physicians.

The South Side and the West Side areas where the majority of black patients and physicians reside, if you take them, you will find, as I say, a gross disparity between the number of physicians that have the opportunity of using adequate facilities in many of the larger hospitals.

Many black patients, particularly women in labor, they bypass at least five hospitals on their way to County Hospital.

However, if you take the number of these hospital staffs, you find an inordinate number, I mean, as I say, a small percentage of black physicians, particularly in the surgical specialties and in obstetrics and gynecology.

Now, this gets back to racism, and the story about the patients being rejected is a daily phenomenon in many of these hospitals.

Senator KENNEDY. Thank you very much.

Dr. RICKS. Thank you.

Senator KENNEDY. As I say, thank you very much.

We have Marie Love, Martin Luther King Neighborhood Health Center. Is she here?

Mrs. LOVE. Yes.

Senator KENNEDY. We have just a couple of minutes.

STATEMENT OF MRS. MARIE LOVE, PAST NATIONAL SECRETARY FOR THE NATIONAL CONSUMERS AND CHAIRMAN OF OUR MODEL CITIES HEALTH TASK FORCE

Mrs. LOVE. I wanted to answer some questions of Senator Packwood.

We have a problem with the welfare patient. They have a green card and most of your physicians in the Chicago area do not accept

the green card. They do not accept the people on welfare and the reason it is important to me and to the people whom I represent to have national health insurance program that will include all people so you will not be discriminated against because you have a green card.

You will not be discriminated against because you happen not to belong to the particular religion that developed the hospital in the first place.

Many of the problems come because the hospitals were started either by fraternal organizations or religious institutions and many of those hospitals still remain in neighborhoods where other people now reside in those neighborhoods. And there seems to be a resistance on the boards of many of those hospitals to accepting the new people who now live in the neighborhood.

As you know, when they created or funded the comprehensive neighborhood health centers, they were given a lifespan of 5 years by OEO.

Well, many of those health centers are now reaching that 5-year period. After the 5 years, the health centers were supposed to be self-sustaining.

Many of the neighborhoods where these health centers are located, will not be able to pay the fees that are required unless there is some method of third-party payment.

This is why it is important that some form of insurance that does not have discriminatory clauses built within them, be available to those people.

Then when you go to a medical institution asking for health care, then if your card is green, you will not be given second-rate care because there is some kind of a gentlemen's agreement to where you cannot even get the same medicine. The doctors will not write you a prescription for certain medicine if you show this green card.

You want to know what your committee could do?

Senator KENNEDY. Yes.

Mrs. LOVE. We know most of the medical institutions do receive Federal funds.

I would like to see that built into the legislation because they receive Federal funds. That means that those institutions belong to all of the people, no matter if they belong to that particular fraternal organization or religion or whoever created the institution in the beginning and that being a human being, needing the care, should be important, and that receiving health care should not be based on whether you can afford it.

I would also like to see some kind of different type of program of education indicating that the young men and women who come from the minority groups, who come from the poor communities, that they will be able to go to medical schools. The cost of medical care is phenomenal and many of the youngsters are discouraged before they leave high school to go into college, to take premed because they know they cannot afford the course for the professional schools and I think some legislation is needed in order to provide this kind of vehicle for those people, coming from the poor communities.

Thank you.

Senator KENNEDY. That is an excellent statement and really clarifies some of the points.

I couldn't agree with you more regarding financing neighborhood health centers in terms of the comments you made about the green cards and also the needs. I want to thank you again.

We are going to have to leave. We have a 4 o'clock plane that we are going to try to make. What we are going to do, though, is to ask Dr. Caper, who is a member of the staff of the Health Subcommittee, to stay here until those that have got some comments can give them to him. He will be right up here at this desk and he will be around until the last person has had a chance to comment, and you can come in this afternoon with them or you can mail them in and they will be made a part of the record.

I want to thank you all again for your attentiveness, for your interest, and for your concern that you have shown.

This has been very useful and a very helpful meeting, and it has been for me, and I know the record will reflect that in terms of the other members of the subcommittee.

(Senators Kennedy and Packwood left.)

Miss RIPPON. My name is Martina Rippon.

I am a freshman medical student and I was the one that made that comment about Dr. Brislen because I didn't feel that he spoke for many of us here in this room.

Dr. Campbell—oh, excuse me—well, all right, Dr. Campbell pointed out some of the difficulties involved both in the areas of financing and the areas of availability.

He did not state concerning matters of accessibility, that even if all of these things were paid for, that they would still not be accessible to the people, that they are not accessible now, and that is the poor who still lose out. But mostly I wanted to speak about the problem that Mrs. Villa voiced, that Miss Carol voiced, and the last speaker. These were the matters dealing with people being treated with dignity so that they have a right to health care with dignity and that they are not getting it and that the reason that they are not getting it is that the health care system is not responsive to their needs.

What is needed is a system that is under community control because only under those circumstances will people be able to make their needs known and respected and that is the only guarantee that people will ever get the care with dignity that they deserve.

Dr. CAPER. At this point I order printed, at the direction of the chairman of the subcommittee, all statements of those who could not attend and other pertinent material submitted for the record.

(The material referred to follows:)

STATEMENT REGARDING CHICAGO'S HEALTH CARE CRISIS

Rolf M. Gunnar, M.D.
Director, Division of Medicine
Cook County Hospital

To qualify myself, I have been at Cook County Hospital for 23 years as house officer, voluntary physician during the nine years I was in the private practice of Medicine, Director of the University of Illinois Section of Medicine at Cook County Hospital, Director of the Department of Adult Cardiology, and for the past year, Director of the Division of Medicine. I have been on the faculty of the University of Illinois since 1954 and have been Professor of Medicine since 1967.

I make this statement to supplement the statement made by the Residents and Internes Association of Cook County Hospital since, in most respects, I agree with their statement. I wish to detail some experiences at Cook County Hospital because they seem to exemplify the types of problems that are preventing our health care system from being effective for those patients who need it the most.

I feel that, at the moment, we are facing a dangerous crisis of health care in the Black, Spanish speaking and poor areas of the City of Chicago. There are not enough private hospitals to care for the patient population. The university hospitals are inadequate for this task and there has been a flight of physicians from the inner city so that ambulatory care is almost non-existant. The great hope of a year ago when Cook County Hospital was removed from the control of the Board of Commissioners of Cook County and placed under a non-political Health and Hospitals Governing Commission is now rapidly fading. This new body, instead of facing the real problems of health care delivery, hides behind housekeeping chores to excuse its inaction in major decisions that could improve the quality of health care delivery.

We must start with the principle that we dedicate ourselves to delivering the finest of health care to the patient population the hospital serves. The quality should be no less than care which would be available in a university hospital or a large private hospital. A prime requisite to excellence in health care is having highly qualified physicians. The patient at Cook County Hospital with skin disease should be able to see a Dermatologist just like the patient from a middle-class community would be able to see a Dermatologist. The same applies to the expertise in many fields including Rheumatology, Allergy, etc., as well as having a general physician qualified to bring all the information together and see the patient as a whole person. This requires a full-time staff at the hospital of academic orientation interested in the delivery of health care. Such a full-time faculty would attract qualified house staff who would render the patient care under the guidance and direction of the senior physician. Cook County Hospital cannot run without qualified house staff, and one must remember that the house staff can change entirely on July 1st of any year. Some of our present difficulties are due to taking on some poorly qualified house staff one year ago at a time of crisis when qualified physicians were impossible to recruit because the full-time faculty was departing. Nine of these house officers have not had their contracts renewed because of poor performance. By rebuilding the faculty, we have recruited an excellent group of house officers in Medicine for July 1, 1971 - but, by July 1, 1972, they could all be gone if they do not see continued growth in the faculty and if present frustrations continue.

The immediate crisis one year ago, when the hospital almost did close, was due to the fact that much of the full-time staff had left, and the chances of keeping the house staff without the senior staff were remote. With the advent of the Governing Commission and the hope that closer ties would be

developed with the surrounding medical schools, full-time staff returned to the hospital and we were able to rebuild the Department of Medicine to cover some of the major disciplines. We developed a Department of Infectious Diseases, which had been non-existent; rebuilt the Department of Hematology, from which all the physicians had left, rebuilt the Department of Adult Cardiology, in which there was only one physician remaining; and increased the staffing in the Department of Renal Diseases.

We now face a similar crisis to the one we faced a year ago. I realize that the historical roles of the universities at Cook County Hospital have been less than satisfactory. In the last few years, this philosophy has finally changed and the local schools have shown that they will accept responsibility for patient care if given the authority to make change. In addition, the creation of a governing board for the hospital gives a mechanism for community participation so that the needs of the consumer can be protected. The Governing Commission and the new Executive Director have not seen fit to develop ties with the surrounding academic community and have decided that the hospital can function independent of support from the medical schools. As I understand it, because of these attitudes, the University of Illinois is proceeding to develop its own University Hospital across the street from Cook County Hospital. They have tried since the Spring of 1970 to obtain an agreement with Cook County Hospital where they could share resources and responsibilities. The University of Illinois needs a community hospital in the inner city; Cook County Hospital needs the academic resources of the University of Illinois or any of the other universities in the City. A planning report developed by the University of Illinois called for a 1,500 bed combined University of Illinois/Cook County Hospital, which could have gone a long way to solve the health care needs of the surrounding community. The University

was willing to build in guarantees for other schools that needed the resources of Cook County Hospital, and the Deans of the area medical schools apparently agreed that with such guarantees this would be a feasible plan. The reason I place these discussions first is that I can foresee the possiblity of a sudden collapse of Cook County Hospital should the full-time staff decide that without the academic opportunities promised a year ago they could not continue to devote their careers to Cook County Hospital. Such an exodus of the qualified physicians would leave our patients without any possibility of quality care. Unsupervised, poorly trained physicians would then be the health care providers for the 2,000 poor patients that come to Cook County Hospital each day.

Another requirement for attracting faculty is the ability to provide laboratory space to allow the physicians of various disciplines to develop sophisticated diagnostic tests needed for patient care as well as pursue some of their own clinical research. For instance, we have had with us for one year a physician trained in some of the sophisticated endocrinological examinations needed for the proper evaluation of patients with high blood pressure. High blood pressure is a common and very serious malady in the Black population of Chicago. This physician, who could have been identifying remediable causes of high blood pressure in our patients, has not been afforded laboratory space or equipment to develop these tests. Our cardio-thoracic surgeon must go to Loyola University, some ten miles away, to do his research because the space and facilities are not available to him at Cook County Hospital. At the same time, we have a modern laboratory building with research laboratory space empty or assigned to physicians working in other institutions. This strange situation comes about due to the fact that there is a private corporation known as the Hektoen Institute which has been able, over the years, to collect the overhead from federal grants for research to be

done at Cook County Hospital, and accumulate the overhead, since the actual overhead costs are paid by Cook County Hospital. In this manner, that Institute has been able to accumulate about $3,000,000 in cash and securities while the young investigator is unable to obtain support to initiate research or purchase equipment. The Director of that Institute is also the Director of Laboratories at Cook County Hospital and, despite the fact that he was charged with a conflict of interest in holding these two positions by the Executive Staff of the Hospital, he has remained in both positions. It may be that having three members of the Board of Commissioners of the County of Cook on the Board of Directors of the Institute has facilitated the development and perpetuation of this strange arrangement. To have accumulated over the years this amount of money while the equipment in the laboratories of Cook County Hospital became archaic has created a good deal of dissatisfaction among the full-time staff at the hospital as well as the house staff. Thus, even though we thought we had escaped from the devastating influence of machine politics, it has remained a severe impediment to appropriate growth of the hospital.

During all this turmoil, the patient population we serve has been unable to have a voice in the direction of the hospital. A community group which attempted to relate to the hospital found that they could only do this through the Division of Medicine. They became a source of great support and information for that Division and had expressed great willingness to relate to the entire hospital. However, the Executive Director of the hospital saw fit to order the disbanding of this group despite the fact that they were made up of highly qualified professionals from the community. Mr. James Wagner, from the Mid-South Health Planning Organization, was the convener. Mr. Obed Lopez from Citizens Health Organization, and Mr. Steven Berry from West Side Health

Planning, were members, as were members from the Uptown Community group, the Benito Juarez Health Center, and Fifth City Health Center. We, as a staff, in the Division of Medicine were very anxious to work with these people since they represented the community we serve. They desparately needed the support of the health centers they were trying to develop. Their small but functioning clinics trying to provide health outposts in the community surrounding Cook County Hospital had been caught in a squeeze between the Health Department of the City of Chicago, which talked a good deal about developing health centers but delivered nothing, and the Model Cities program which, except for the support we were able to give it at Cook County Hospital and an embryonic effort in Uptown, never developed a program. A year ago, I asked the Commission to develop a method to relate the hospital to these community health centers but, to this date, I have not received a reply. The patient in the inner city has a strange and rather disenfranchised lot when it comes to his own health care. Let us compare him to the patient in a suburban community. In the suburban hospitals, the Board of Directors of the hospital comes from the community. The patients, therefore, in the community have input into the governing board of the hospital. At Cook County Hospital, only one member of the Commission has contact with the Community the hospital serves and, had it not been for the demands of the house staff organization of Cook County Hospital, even this person would not have been on the Commission. The patient in the suburban community, through his private physician, can influence hospital policy through the executive staff of the hospital, which is a powerful force in influencing hospital policy. At Cook County Hospital, the patient's physician is frequently the intern or resident and, although they have some representation on the Executive Staff at Cook County Hospital, the Executive Staff of the hospital has very little influence on policy of the hospital. The Joint Conference Committee meets infrequently

and usually without a member of the Governing Commission present. The Executive Director's office has effectively isolated the Executive Staff from influencing policy. In essence, the patient can neither influence policy from above, as he should through the Board of Directors, nor from below, as he should through his physician. With the turning aside of a highly respectable community group that could have been the voice of the community at the hospital, the Commission has isolated itself from the population it serves. Thus, the consumer has no influence on the priorities the commission chooses for expending its resources. When the Commission chooses to afford another public relations executive and cannot afford a Rheumatologist, how does the consumer raise an objection?

I think it is urgent now that we decide whether Cook County Hospital should or should not exist. If the decision is that it should exist, then it should be supported fully by linking it with the neighboring medical schools and building a highly qualified full-time staff orientated to patient care as well as to have laboratory space and support of their own. With such a full-time staff we can attract a house staff to an exciting atmosphere for health care delivery and training. The method of delivering emergency care and outpatient care at the hospital must be entirely restructured to give the patients a feeling of continuity of care and personal concern. We must then link the hospital with a geographic area that it should and does serve and develop health centers in these areas. The health centers that have been initiated by the community groups are the start upon which we could build. We must stop looking at experimental models such as the O.E.O. Mile Square Project as solutions, but instead use their data and our own long experience to be innovative as we expand our services.

If Cook County Hospital is not to continue, then we must be prepared to take the consequences of suddenly closing this institution since a hospital of this type does not phase out but merely collapses. However, there is nothing to indicate that the health care system in Chicago would then provide quality care for the disadvantaged and we would, in my opinion, witness a further disintegration of the present apartheid health delivery system.

Health and Hospitals Governing Commission of Cook County

Cook County Hospital
1825 West Harrison St., Chicago, Illinois 60612 (312) 633-6000

May 7, 1971

James G. Haughton, M.D.
Executive Director
Health and Hospitals
Governing Commission

Dear Dr. Haughton:

As the Director of one of the major Divisions of the hospital, I think it important that I write you and express my concern over some of the recent administrative decisions you have made. Your repeated remarks against an academic orientation for Cook County Hospital, and the decisions to reduce the support for the full-time staff of the Division of Medicine, are stopping the healthy growth of this Division and you must be cognizant of this.

We had the opportunity to create the finest Department of Medicine in the City of Chicago, and had begun a program of staff development toward this end. You have, however, changed the philosophy which could have nurtured such growth and set the goals at a much lower level.

I had understood my charge as Director of the Division of Medicine was to provide the best of patient care. We should provide our patients no less than they could receive either at a large private hospital or a university hospital. I do not agree that there should be a second class of medical care for poor people and will not stand by voiceless if we do not commit ourselves to excellence in patient care. If a person of means deserves a specialist for care of his special problems, then a poor person deserves no less. As a matter of fact, because of the years of neglect shown our patients, the level of expertise needed for their care is probably greater than that needed by the general population.

It is inconceivable to me that this hospital should not have a Dermatology Department with full-time staff members, when we provide the most patient service of any Dermatology group in the city. We provide 17,360 Dermatology outpatient visits per year while the next largest department provides 8,430 outpatient visits per year and has six full-time staff physicians. Does this mean that poor people with skin diseases do not deserve to see a dermatologist?

We have no pulmonary physiologist to evaluate patients with lung problems, no rheumatologist or clinical immunologist to care for the patients with arthritis or asthma. We see innumerable asthmatics in the emergency room of this hospital, but cannot provide the expert workup needed to give them any more than temporary relief.

Under the premise that our patients deserve the best, I have rebuilt the departments of Cardiology, Hematology, and Infectious Diseases, and strengthened the Department of Renal Diseases. I have put attending physicians in the outpatient department, established the Model Cities Clinic, and supported, as best I could, a voluntary relationship with the community clinics.

I have restaffed the Endocrinology Department and, if we can get modern laboratory support, we will have a modern Endocrinology service for our patients.

I should have thought you would have been pleased because, simultaneous with providing consultation services, I have provided full-time attending coverage for almost all the general medical services. We are in sight of your goal of excellence in medical care, and awaiting the supporting services and changes in the physical plant. We wish to attack the outpatient problem and the problem of the community clinics by supporting them, but your change in philosophy may make these goals unobtainable.

Excellent physicians will work at Cook County Hospital because they feel the care they deliver is no less than the best and, in addition, they have a satisfactory intellectual life. This requires laboratories for those whose disciplines require laboratories to diagnose difficult patient problems and pursue patient oriented research. The best clinicians, when recruited for employment, will ask about patient care facilities and availability of laboratory space and support before asking about salary.

The prime requisite for delivery of the finest patient care is a full-time staff of high competence who will then attract junior staff and house staff, and organize and supervise their delivery of care to our patients. Internists of academic orientation can do this and can create the atmosphere of excitement that will attract the best house staff. You have stated that you are not interested in academicians and have followed this by withdrawing laboratory support from the Division.

With the present environment, I am certain we will no longer be able to attract physicians of high excellence. We are in the middle of the City with a fierce physician shortage, and must recognize and act on this or fall into the trap of offering the poor patient worse than mediocre care because we have not tried.

In a recent conversation with Dr. David Earl, Head of the Department of Medicine of Northwestern University, I was hopeful for the return of Northwestern students to our wards. After consideration, he informed me that he could not support such an effort because of the present anti-medical school environment at Cook County Hosptial. This was also the message received by those who heard you speak at the University of Illinois. Without medical students our ability to attract house staff will be tenuous. Without good house staff it will be impossible to deliver patient care of excellence.

You have the ability to reverse this trend. Support the intellectual activities of the full-time staff. Recruit academicians of clinical excellence. Develop close ties with the local medical schools. Measure ourselves not against what we have been, but against what we should be. We can be the best patient care facility in the Midwest, but must have the best of staff to do this. With such a staff, the house staff it would generate, and the input from the community that the Community Board can give, we can be innovative and energetic and be able to make a lasting positive impact on health care delivery to our patients. With a weak Division of Medicine we will only react from weakness and deliver inferior care, even if we have clean floors and a slightly improved physical plant.

Sincerely yours,

Rolf N. Gunnar, M.D.
Director,
Division of Medicine

RMG/mt

cc: Dr. Clyde W. Phillips

Dr. CAPER. The hearing is adjourned.

HEALTH CARE CRISIS IN AMERICA, 1971

THURSDAY, MAY 13, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Des Moines, Iowa.

The subcommittee met in the Iowa Methodist Hospital Nursing School Auditorium, Des Moines, Iowa, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Hughes, and Dominick.

Committee staff members present: LeRoy G. Goldman, professional staff member to the subcommittee; Jay B. Cutler, minority counsel to the subcommittee.

Senator KENNEDY. The subcommittee meeting will come to order.

I first of all want to express the committee's appreciation to Tom Evans and to the staff of the hospital for being kind enough to provide this marvelous setting for our hearing here this morning. They have been cooperative and generous in their time and hospitality and we are in their debt.

I also want to thank Senator Hughes for joining with us in our visit here to Iowa. He has a great insight into health needs and problems as well as into the various health programs in the State of Iowa, having had a very close contact with the whole health issue, as Governor of Iowa, and being a member of committees in the Senate that are concerned with health legislation.

Senator Dominick and I also appreciate the various courtesies which have been extended to us over the last several hours when we were visiting many of the hospitals here in Des Moines, trying to get a better feel for some of the new things going on here in the health area and also some of the problems that the health system faces here in Des Moines.

We come to Iowa in the setting of some 9 weeks of hearings held in Washington. We have listened to the experts, the representatives of the medical associations, the hospital associations, the medical schools, even many of the student organizations.

They have spoken as experts on the health crisis. During the period of the last 3 weeks we have traveled to New York City, a major urban area to Westchester and Nassau Counties, some of the more affluent communities in America, to West Virginia, the second-most rural State in our Nation, to Nashville, Tenn., one of the great medical complexes in the South.

Last week we traveled to several midwestern industrial comunities, Cleveland and Chicago. When we leave Iowa we go on to Colorado.

Finally, the field hearings will conclude in California in the early part of next week.

We take the experiences that we have in our brief visits to hospitals, as part of a total experience of some 4 to 5 months of comprehensive hearings into the health crisis. We try to then draw from this experience recommendations for changes in existing legislation and for new legislation to meet the health needs of our country.

I feel strongly that you can gain a great deal of information in Washington, but until you get out into the field, you really don't see the full picture. There are a number of our colleagues that remain in the Nation's Capitol. But I think the most effective kind of understanding of these problems is to develop a sound basis for understanding the problem in Washington hearings, and then travel around the country and talk to the people who are on the receiving end of the health system.

That's really what we want to do this morning. We have listened to those that have been delivering and financing health care. We are interested this morning in listening to the problems and comments of those that have been receiving these services. We think this is very important, because if there is one lesson that we have learned, it is that the consumer has been left out of the health care system. I firmly believe that in any future legislation at the national level, we have to give the consumer an important role.

We hope later to open the meeting to any of you here this morning that would like to make a comment or observation on the health crisis in the country.

We will hear as many as we can within the time available, and for those that do not have an opportunity to testify, we will hope that you will write down whatever comments you have and submit them to us in the U.S. Senate. We will make those comments a part of the complete record.

We look forward to hearing from you, and reading what ideas and comments you might make.

Before hearing from the consumers, we will hear from our host this morning, Senator Hughes, then I will ask Senator Dominick if he would like to make a comment.

Senator HUGHES. Well, Mr. Chairman, I really don't want to utilize much of the time that we have allotted here to hear the people who have attended the hearing.

I simply wish to offer an official greeting on behalf of the people of Iowa and all of us who are consumers of health services in Iowa, to the entire committee, particularly you as chairman of the committee, and to Senator Dominick of Colorado who has been traveling and making great contributions in the entire field of public health in America. We are pleased that you selected Iowa and Des Moines to hold this particular series of hearings.

Senator KENNEDY. Senator Dominick.

Senator DOMINICK. Mr. Chairman, I just want to acknowledge my thanks to both you and Senator Hughes for the leadership and hard work that we have put into the health field.

I do have just a few things which I think might be of interest to the group, as to the Health Subcommittee jurisdiction and what we have been trying to do.

In the last Congress under the chairmanship of Senator Yarborough, this subcommittee acted on a wide range of health legislation and much of it was enacted into law.

We recommended and Congress enacted legislation which provides grants to schools of public health, assistance to modern agricultural workers' health programs, Federal aid to community mental health centers, Federal assistance to medical libraries, Federal dollars for vaccination programs and extension of the regional medical program which funds projects across the country in health education and delivery, control of heart disease, cancer, strokes, and now kidney diseases.

We also acted on legislation during the last Congress to extend comprehensive health planning, provide additional aid to fight mental retardation and help children with development disability, to extend and improve training programs for allied health professions, to establish a landmark program for the prevention and treatment of alcoholism, to authorize the use of public health service personnel in areas where there are shortages of physicians.

Additionally, we acted on legislation to provide help to persons desiring family planning information. We passed occupational health and safety legislation, the Clean Air Act, the Child Protection and Toy Safety Act, the Federal Coal Mine Health and Safety Act, Lead Base Paint Poison Prevention Act and the Air Pollution Control Standards Act.

In this Congress some 30 bills and resolutions covering a broad range of health matters have already been referred to us. Some of the most important of these deal with problems relating to the shortage and maldistribution of health manpower. For example, the Health Profession's Educational Assistance Act which provides Federal assistance to schools and students of medicine, dentistry, osteopathy, podiatry, pharmacy, optometry and veterinary medicine, will expire July 1 of this year, and bills which would extend and modify that are now pending action before the subcommittee.

It has been said in the analysis of the health care crisis there is an acute and worsening shortage of all kinds of health personnel, especially doctors, but the truth is that we have one of the highest ratios of doctor per capita in the world. The number of physicians is growing at a rate faster than our population.

In 1950 the population of the physician ratio was 711 to 1. Now it is 630 to 1. The number of medical schools and medical students is showing unparalleled growth. In the school year of 1966 to 1967 there were 89 medical schools and just over 33,000 medical students. It is anticipated that by next year, 5 years later, there will be 114 schools and over 43,000 medical students, an increase of 25 schools and 10,000 students.

Now, this is not to say that we don't need more medical schools and more doctors. We do. But as Senator Kennedy has said, the basic problems, or many of them, are maldistribution, too few doctors in the innercity and rural America and maybe a tendency to specialize.

Steps are being taken to correct this and I hope that we will be able to go get some help on it.

What I'm really trying to point out is that the health problems of the country are very complex and it is unrealistic to place too much faith in just simple solutions. We have made progress. More progress must be made.

But there really isn't any simplistic answer, no one scheme or program can do it all. Lincoln once said that for every human problem there is an answer that is simple, neat, and wrong, and I think it is worthwhile keeping that in mind as we go through the various problems that are in the health field.

Let me tell you how delighted I am to be here to listen and to learn.

Senator KENNEDY. Thank you very much, Senator Dominick.

I hope everyone can see these charts, which give a visual representation of the rising costs of health care, both in terms of doctors' fees and hospital fees. We have here also a chart that shows the increase between 1960 and 1970 of an average hospital day in Des Moines. In this other chart, you see the number of patients per doctor in Iowa, which shows a steady increase in the number of patients per doctor. This highlights your increasingly serious doctor shortage.

The AMA suggests one doctor for 750 patients is good, but in rural Iowa it is one doctor to 3,000 people. In 1950 it was one for 1,912. Today it is one to 3,000. So we can see the problem getting worse.

Shortage of health manpower, of course, is a very important feature of the health crisis everywhere in rural America.

We have seen some very interesting programs here in Des Moines attempting to get doctors out into the countryside.

Those who wish to testify should come to this desk. Miss Souliotis, in the green dress, will take your names and we will just call on you in the order in which names are filed.

Mr. Dimery, Porter Dimery.

Mr. Dimery, we are glad to have you. I would just say, sharing one's family sicknesses or hardships is always difficult, and to do it publicly is even more difficult. We are enormously appreciative that many individuals this morning are willing to tell us about their family problems.

American people just don't like to bother other people about it when they are sick. They don't like to bother people about family difficulties. I think that is one of the reasons that we haven't moved more dramatically in the health area, people don't like to speak out.

It is most important if we are to gather some idea of the dimensions of the problems people face, to have this kind of information, so we are very appreciative to all of the witnesses this morning.

STATEMENT OF PORTER DIMERY, DES MOINES, IOWA

Mr. DIMERY. Senators Dominick, Kennedy, and Hughes. Yes, I am going to talk about my personal problem, but I want to go back about 6 years.

I think this is about the time the OEO program came into the city of Des Moines. I was one of the persons that received benefits from this program, and we want to talk about the health problem in the city of Des Moines and the State of Iowa.

Through this program there were people like myself who became involved and brought the awareness of the health problem to the entire State. I don't have any statistics to tell you what has been done in this period of time, but I know there still are people, who like myself, are trying to bring forth these kinds of things to the proper people who are administrators of the health program.

I think we have come a long way in the State of Iowa and the city of Des Moines in terms of health, but there is still a long ways to go. I suppose that you are all aware of that, or you would not be here this morning if there wasn't a problem.

I want to say that I personally, on behalf of my wife and my family, we appreciate this opportunity to bring our information to you because there was a time when we were pretty well up against a wall as far as health problems were concerned.

Unfortunately, there were no particular foundations of any kind that were set aside for the particular problem we had. We went through a series of humiliating experiences before we obtained the kind of help that we needed.

I want to take this time to say to the city of Des Moines and the State of Iowa, I think if we continue to take interest as we have in the last 6 years progress will be made. I say I have been involved in the OEO program, and you will help as a committee, which I think is doing a marvelous job. I think we are going to go a long way in getting some of the problems solved. We don't get the entire health problem solved, but we are going to get most of it done.

I want to say again I appreciate this opportunity.

Senator KENNEDY. Now, you had some problems with your son. Could you share those with us?

Mr. DIMERY. Well, after a period of time there were——

Senator KENNEDY. You were working a number of years and then were caught in the transfer of some jobs. Then your son got sick. Could you tell us a little bit about that?

Mr. DIMERY. Right. This was a very unusual situation. I worked at the Iowa Packing Plant for 20 years and it closed down, and through all the period of time I was deciding what I was going to do, and with the help of Senator Hughes and some other people, why, there was a training course established for meat cutting and retail.

I was just about halfway through this when this happened to my boy, and the diagnosis was that he had tranverse myelitis, which is a very rare kind of disease, I suppose.

There was no foundation, as I said. There were no foundations established for this particular thing.

Senator KENNEDY. This happened when you were between jobs, is that right?

Mr. DIMERY. Right.

Senator KENNEDY. And your boy got sick so he went to the hospital?

Mr. DIMERY. Right. The first initial contact was Broadlawns, which I think you people visited. He was there for a period of time and it was determined that they had done what they could for him, and as a result he was transferred to Iowa City for some work down there, at the end of the crisis period. For purposes of rehabilitation. This is

when the problem, as far as the family responsibility is concerned, when it was time for him to come home.

Senator KENNEDY. How long had he been in the hospital?

Mr. DIMERY. A year and a half.

Senator KENNEDY. And you had gotten another job?

Mr. DIMERY. Yes.

Senator KENNEDY. But when he first went into the hospital you weren't working, is that right?

Mr. DIMERY. Right. I was in school at that time.

Senator KENNEDY. You had been working and then you were in between jobs and found out your son was sick and he went to the hospital and then you got a job. How long was it in between jobs? What was that period of time?

Mr. DIMERY. About 9 months.

Senator KENNEDY. About 9 months. Did you get some bills during this period of time in between jobs?

Mr. DIMERY. Yes.

Senator KENNEDY. Hospital bills?

Mr. DIMERY. Right.

Senator KENNEDY. Were you covered by insurance?

Mr. DIMERY. I had a very small insurance, which is just a kind of thing which just gets you in the door.

Senator KENNEDY. Kind of insurance just to get you in the door?

Mr. DIMERY. Yes. Hospitalization, you know. I think it provided about a 30-percent coverage.

Senator KENNEDY. You need some insurance just to get inside the door?

Mr. DIMERY. Yes, as I went further I found this to be the case. I mean the determination one has to have to overcome these kinds of things, but I think this is one of the problems in the entire health situation.

Senator KENNEDY. What were your total medical bills for your son?

Mr. DIMERY. I would say roughly about $8,000. I know in this particular hospital it was $6,000.

Senator KENNEDY. And how much of that bill did your insurance cover or pay?

Mr. DIMERY. It didn't cover any.

Senator KENNEDY. Didn't cover any?

Mr. DIMERY. No.

Senator KENNEDY. Would it have covered part of that bill if you had been working during that period of time?

Mr. DIMERY. Right. Well, I was just in a probation period with the second job I went into.

Senator KENNEDY. You were in the probation period. But you were in between jobs when you found your son got sick, as I understand it?

Mr. DIMERY. Right.

Senator KENNEDY. And then you were later employed but on the probation period, so the insurance still didn't cover you?

Mr. DIMERY. Right.

Senator KENNEDY. And this is a rare disease which you have absolutely no control over, do you?

Mr. DIMERY. No.

Senator KENNEDY. There was no way you could have taken care of your child or prevented him from having that, as I understand it?

Mr. DIMERY. This is very true.

Senator KENNEDY. Then you got this bill in excess of $6,000. Now, what are you doing about that? What can you do about it?

Mr. DIMERY. Well, fortunately enough of the bill was paid by some very nice people, the entire State of Iowa, including Illinois and some others. They paid for it.

Senator KENNEDY. You had to depend upon the good will of some of your friends, neighbors and other people who were kind enough to make some contribution to pay that bill off?

Mr. DIMERY. Right.

Senator KENNEDY. And so now you don't have any medical bills, or do you?

Mr. DIMERY. Yes, I've had medical bills. I think the first 3 months of this year I've spent about $700.

Senator KENNEDY. How much?

Mr. DIMERY. $700.

Senator KENNEDY. Is this for your son?

Mr. DIMERY. No, not for the son. This is for the entire family.

Senator KENNEDY. How much of those bills are covered by insurance?

Mr. DIMERY. Well, the hospital part.

Senator KENNEDY. About how much would that cover, do you remember, offhand? You are covered now by some hospitalization program?

Mr. DIMERY. Yes.

Senator KENNEDY. And your son, he'll be coming home to enter high school, is that right?

Mr. DIMERY. Right.

Senator KENNEDY. And will there have to be some expenditures for care for him in the future?

Mr. DIMERY. Right.

Senator KENNEDY. And were you able to get a new insurance program that would cover those expenses?

Mr. DIMERY. No. This insurance covers—I mean, the insurance is hospitalization only. It does not cover the same kind of sickness.

Senator KENNEDY. How do you expect to be able to pay for those bills?

Mr. DIMERY. Well, this is up in the air, I suppose, and depends on what I can do. I have no doubt that he is going to be taken care of.

Senator KENNEDY. Well, you'd spend your last dollar, wouldn't you, to take care of him?

Mr. DIMERY. Yes, sir.

Senator KENNEDY. And you have probably spent almost your last dollar for him today, haven't you?

Mr. DIMERY. Very true.

Senator KENNEDY. And still you can only look forward to continuing medical bills for your son for how long in the future?

Mr. DIMERY. Well, until he's able to make himself independent of me, that is, by vocational training and obtaining a job.

Senator KENNEDY. OK. Thank you very much.

Mr. DIMERY. Thank you.

Senator HUGHES. Mr. Dimery, I'd like to ask you just a few questions. I'd rather say Porter than Mr. Dimery. We have been friends for many years.

I'd just like the record to show that Porter Dimery has been a hard-working man all the days of his life that I have had an acquaintanceship with him. He worked in the packinghouse down here for 20 years, as he indicated. He rose to the position of supervisor. He is well respected in his community.

He worked together with me on many of the common problems of this community, the black and white racial problems that existed here, and on job opportunities and public service boards; I had the privilege of appointing him to them when I was Governor of this State.

He is a man who, as he indicated—and I guess I am really stating this as a character witness more than anything else—has worked hard for his family.

I have visited in their home and met their children, and they have experienced what is a rather common tragedy in America. An acute and serious illness struck one of the children, and it literally will take every dime that they have managed to work and save for.

He was in an intermediary training program for meat cutters and butchers at the time his son was stricken, and if it had been possible for this man in any way to cover medical expenses, he would have.

That's the only thing I wanted to make sure that the record shows very clearly. Again I express my appreciation and offer my own encouragement for what you have been doing.

Mr. DIMERY. Thank you, Senator Kennedy and Senator Hughes.

Senator KENNEDY. Thank you, Mr. Dimery. We appreciate very much your appearing here.

Mrs. Allen Hentges.

STATEMENT OF MRS. JUDITH HENTGES, DUBUQUE, IOWA

Mrs. HENTGES. My name is Judith Hentges, and I live at 1137 High Bluff in Dubuque, Iowa. I am employed by National Tea Co. and have been for the last 8 years. I am a member of the Retail Clerks Union, and I underlined this at the very beginning.

Just after the birth of our first baby 11 years ago, my husband came down with cancer. Three operations followed at this time, and a first tumor was treated with 6 weeks of radioactive cobalt. A second tumor was halted with X-ray treatment about a year later. Last November, he went back to work for the first time in 10 years. Three days later he fell, and they found cancer in his hip, and they had to amputate over 25 percent of his body.

During this same 13-year period, the first of our four children, Brad, had undergone six major operations plus measles, meningitis, scarlet fever, and a host of other ailments.

We have a long list of other problems suffered by our family, but I simply won't take time to count these.

My husband had group insurance coverage originally, but it ran out when he was permanently disabled. When I became a member of the Retail Clerks Union 7 years ago, our family was literally saved from

financial disaster. The union has negotiated an excellent program, and I understand clearly that this is a union gain. We have given up wage increases in order to build a better health care program.

In this union, benefits paid for a major portion of our health care bill, but the private insurance system doesn't work. Even when our family had two private insurance programs, it didn't work. We were covered by two different private insurance plans when Brad was ill, and we simply exhausted all private insurance benefits and had to pay everything out of our pocket.

Last summer since July, my husband, Allen, has undergone surgery six different times. Even with the very best union coverage, we face these bills yet: $270 to the doctor, $755 for medicine, $135 for anesthetics, and $210 for the hospital, which totals $1,370, but we got a break as the hospital called and said that our bill was paid in full. Our family has been at Xavier Hospital so often that the Xavier Gift Shop Circle paid the entire $210 of the bill for hospitalization.

Now, I make good money at my job, but I don't make enough to pay $1,160 at any one time. Things have been so tough at our house that my mom and dad have chipped in over $1,600 just to have food, and they have mortgaged their future.

I am 30 years old, and my disabled husband is 34. We are both proud and so are our four children, but we face a bleak future. He didn't want to be ill, and I myself am now waiting surgery on a growth resulting from an ulcer brought on by these stresses.

I think we should figure out a system of help here that keeps us healthy. I think we have a right to this good health care, and I think we should pass a law to make it available to all the people throughout the country.

I am proud, and I don't want benefits staged for myself or my family. I don't like friends passing the hat, and I don't want bowling leagues sending gifts. I am very grateful, but it still hurts. It hurts my husband, and it hurts my children.

As Americans, I think we have a right to good health care; and I want my Government to pass a law that would make this right a reality for all people because there are people that have many, many more problems than we do. [Applause.]

Senator DOMINICK. Mrs. Hentges, we have run into similar situations in other hearings in which there have been circumstances just as difficult as in your case. Would you tell me what problems you encountered with your so-called private insurance? Did your private insurance company just run out of the amount of money that was involved?

Mrs. HENTGES. Yes. When Brad was stricken with the meningitis he was totally deaf for over 6 weeks and he had to have several operations as a result of this, and on meningitis and ear operations they have a maximum and he ran out of the maximum the last two operations that he had. They were well over $3,000.

But, I mean, here again we were very lucky. As I said, I know there are many people who weren't near as lucky because we have been very, very lucky. We have a marvelous doctor and when he found out the insurance companies had paid the maximum, he allowed us $365 off of our total of his bill which was almost half of what we still owed him

and he didn't charge us anywhere near as much as he could have, because he had to rebuild bones. He had a plastic eardrum put in, and several other things.

Senator DOMINICK. What happened in the retail union care program which you now have? Does that program cover a good portion of your bills?

Mrs. HENTGES. Very, very much of it. With Allen's last operation he had to go to Iowa City because it was something that they had never done at the Xavier Hospital. When he was first stricken with cancer he had to go to Iowa City on the State because we had already had over a year with Brad in and out of the hospital. He was born with abnormally large tonsils and extremely small ear canals and he was in the hospital most of the first year he was operated on. When he was 15 months old, in fact, he was operated on on a Thursday and Allen had a chest exploratory operation the following Friday at Iowa City for the cancer, and it was very rare.

We were down there over 3 months and Allen had 6 weeks of cobalt treatment, which at that time was very expensive. It was relatively new, and the State covered all of these costs.

Senator DOMINICK. The State covered all of the expenses?

Mrs. HENTGES. All of these costs for Allen's care down there and they are paying the balance now of his care because he had to have his left leg, entire hip and the entire half of his pelvis removed, plus two other operations along with this, as he had a bone cancer that was running through the bones. He will be going back again in June and we will have to go regularly for 2 or 3 years.

Senator DOMINICK. Is there a maximum amount of coverage in your retail union care program?

Mrs. HENTGES. Well, they pay just so long. I mean I don't know exactly what it is, but I mean they have paid very well because he was in the hospital last summer, the first operations he had. He burst both major arteries in his stomach and he had to have emergency surgery on that. He had several transfusions and was in intensive care in the hospital. The union insurance paid very, very well on that. We were left with somewhere around $600 or $700, and the medical bills were really, you know, what was high, because he was on medication and has been on medication since, and he will be yet for some time to come.

Senator KENNEDY. Your family has suffered enormous pain during the period of these recent years. I suppose the question you are asking is why in our society individuals who have so little control over the kinds of problems you have, should endure not only the enormous pain and suffering and inconvenience and personal hardship but also the financial tragedy as well?

Mrs. HENTGES. Yes.

Senator KENNEDY. I mean it is a thing you have absolutely no control over. As Senator Hughes pointed out about Porter and yourself, you are hardworking people trying to raise a family, making some kind of meaningful contribution to the community, and yet your total savings have been wiped out. This affects the education of your children. It affects your parents' retirement as well. They have been able

to accumulate some savings over a lifetime of service to the community. Why should you and they be confronted with this kind of a bankruptcy?

Mrs. HENTGES. Yes. I feel very strongly that my parents and his parents—his dad is dead now, but he has contributed well over $2,000 for clothing and food and things like this. I mean they are all necessities.

Senator KENNEDY. When we talk about these catastrophic kinds of expenses, I suppose that $1,370 looks as catastrophic to you, as $5,000 or $10,000 would look to a wealthy man. I mean catastrophic expenses are really relative. For somebody who is hard working, such as yourselves, $1,370 is a lot of money, and I for one am not satisfied that even if we provide for catastrophic expenses in terms of some dollar figure, say $15,000 or $20,000, that that would be useful and helpful.

Thank you very much.

Mrs. HENTGES. Thank you.

Senator KENNEDY. Mrs. Williams and Ray Tillery.

Mrs. Williams is a public health nurse. We want to welcome you here.

We have seen the public health nurses performing important services in many different parts of our country. I was most impressed seeing them in some of the most remote, difficult parts of the country in Alaska, and making a terribly important contribution. We are great believers in the public health nursing system, and I want to welcome you here.

STATEMENT OF MRS. JOANNE WILLIAMS, PUBLIC HEALTH NURSE, AND RAY TILLERY, DES MOINES, IOWA

Mrs. WILLIAMS. Thank you. I was asked to come with Mr. Tillery to be able to speak for him, and I will try to do just that, letting him answer questions in writing that you might have, and I will read those to you. I do that since Mr. Tillery had a total laryngectomy last month, and that is the reason that he was referred to the Des Moines Polk County Public Health Nursing Association, and we have been seeing him since that time.

Mr. Tillery was operated on in Iowa City on the 10th of April this year. As opposed to the two people who have been speaking, their problems with medical care have been going on for a very long time. Mr. Tillery's of much less time than that, but probably he is a good example of how these kinds of problems begin, and we would hope that something could be done before the problems that he is now experiencing snowball and become much larger than they are already.

Mr. Tillery, after having the laryngectomy, returned home to Des Moines on the 26th of April and this is where problems begin, particularly in the area of funds.

To have the kind of care that is needed to care for this surgery that he has had requires some special equipment. These things, the main items, would be a humidifier that is crucial for him to have in his home at all times, and a tracheal suction.

He does not know yet how much of his hospital bill is going to be covered. It is a $2,000 bill. He suspects that he will have a portion of that to pay.

He got himself into an emergency situation that we feel that he was not responsible for, soon after returning home, and part of this, we felt, was one of the gaps that have occurred in his care.

He was asked to go to a local agency to obtain the humidifier and the suction that he needed. He followed through with this and did bring home a humidifier, but he did not bring home the suction. He was told that this would have to be rented, and no help was offered in getting that for him.

When we saw him following this, we found that Mr. Tillery had to go to the hospital as an emergency patient. He was taken there by the fire department because he couldn't breathe, and the reason that he couldn't breathe was because—well, two reasons. He hadn't had a suction to do the kind of suctioning that he had been instructed to do and he had a humidifier that he had obtained, but this humidifier worked so poorly he might as well not have had one.

Since that time we have gotten a humidifier for him and we were able to get that without cost to him, but the suction is rented and this is costing him $20 a month until we can find some other means of providing this.

He has not, at this time, been able to have any kind of funds coming in. He, of course, is unable to work yet. He will not be able to return to his old job because of the laryngectomy. He will not be able to speak and his job involved using a telephone.

Social security and other possibilities of funds, these things take time. That means that there is no immediate help for him. That means that there are no funds coming in. Yet, he has costs immediately and bills are coming already. Bills for the suction already.

The fact that he got into this unfortunate emergency situation that just should not have happened means that he had to go to the doctor every other day as a result of that, to be seen, and his insurance doesn't cover doctor bills.

He is still, at this time, having to see the doctor on a weekly basis and this would not have happened had he had the equipment that he needed or had some plan for covering these costs right away, and he doesn't know yet how soon he will have any help with covering these costs and they keep coming.

This is going to be not just for a few weeks but for an indefinite period of time.

That's basically the situation. Maybe you have questions that I could ask him specifically.

Senator KENNEDY. As I understand it, he's worked all his life?

Mrs. WILLIAMS. Yes; he worked as a rate clerk for a truckline.

Senator KENNEDY. About how many years?

Mrs. WILLIAMS. Thirty-one years. And the nature of that job means using the telephone.

Senator KENNEDY. Thirty-one years and he's had this kind of difficulty. As I understand it, after he left the hospital he went home; is that correct?

Mrs. WILLIAMS. Yes.

Senator KENNEDY. And he lives by himself?

Mrs. WILLIAMS. Yes; his wife is dead.

Senator KENNEDY. Lives by himself and he's at home and he is told when he leaves that he has to get a humidifier and also a suction?

Mrs. WILLIAMS. Yes.

Senator KENNEDY. Now, how in the world does somebody know where to go to get a humidifier and suction? Do they know where to go?

Mrs. WILLIAMS. He had some names of places.

Senator KENNEDY. Do they give you a list of places and put you on your own?

Mrs. WILLIAMS. Yes, and he was trying to follow through with this and, of course, when you go to where you are instructed to go and you don't get what you need, then you are blocked, and that's what happened to him. And the fact that he is alone, it was very fortunate that when this happened to him, this emergency arose, it was very early in the morning, about 6 or 7 in the morning, and he was able to arouse someone else in the building.

The gentleman who he did get awake said at first he just didn't want to go to the door, this early in the morning and somebody knocking, and he said, "Who's there", and nobody answered. Of course, Mr. Tillery couldn't answer, and nobody answered and he just almost didn't go to the door. Of course, if he had not, Mr. Tillery undoubtedly would have died.

Senator KENNEDY. Now, what's the cost of renting this kind of equipment?

Mrs. WILLIAMS. $20 a month. That doesn't sound like a lot, but when you don't have any money coming in, you have got that plus bills for doctor's office visits.

Senator KENNEDY. He doesn't have these resources even in terms of social security disability? You have to be disabled for a year before that starts?

Mrs. WILLIAMS. It would be some time.

Senator KENNEDY. And then even the money that you do get is completely inadequate.

Mrs. WILLIAMS. He's made application for it, but it doesn't help now.

Senator KENNEDY. So he's got $20 a month and because he is unable to get that $20 a month cold cash, he is unable to get that piece of equipment.

Mrs. WILLIAMS. And Mr. Tillery, being a very conscientious man about his bills, this bothers him, you know. He showed me he's got one bill already, and they will, of course, be continuing, and this is a concern.

Senator KENNEDY. What did his insurance program in the union cover? It must have covered some of this.

Mrs. WILLIAMS. Probably will cover—again I'm not sure, but hopefully will cover a good portion of the hospital bill.

Senator KENNEDY. His hospital bill?

Mrs. WILLIAMS. Yes; about two-thirds.

Senator KENNEDY. About two-thirds. But he still will have bills. Will they cover the payment for this other equipment?

Mrs. WILLIAMS. No; and not for the doctors.

Senator KENNEDY. That has to be paid for by him?

Mrs. WILLIAMS. By him. Not for the doctor's office visits.

Senator KENNEDY. Has he had some savings over the period of 31 years?

Mrs. WILLIAMS. Some savings. A little.

Senator KENNEDY. How long does he think the savings can last?

Mrs. WILLIAMS. Maybe 2 or 3 months.

Senator KENNEDY. Two or 3 months?

Mrs. WILLIAMS. Without any income coming in. And he, of course, will later begin some training for his speech, but this you cannot begin right away.

Senator KENNEDY. How did you become involved in this case?

Mrs. WILLIAMS. This was through referral from Iowa City and we were pleased that he was referred to us since we are trying to provide some help.

Senator KENNEDY. How much time had elapsed from the time he had been dismissed from the hospital to the time of your referral?

Mrs. WILLIAMS. Just 2 days, but all this happened so quickly.

Senator KENNEDY. All this happened in 2 days.

Mrs. WILLIAMS. Yes.

Senator KENNEDY. Did he know that you'd be coming?

Mrs. WILLIAMS. Yes.

Senator KENNEDY. They had told him that there would be somebody?

Mrs. WILLIAMS. Yes. He didn't have really any way of knowing just who we were or anything, but he did know a nurse would come.

Senator KENNEDY. But you don't have anything in your budget that would help?

Mrs. WILLIAMS. No.

Senator KENNEDY. You can recognize the need and see that it is really only a modest sum. You can see $20 a month is significant to somebody who hasn't an income and only a modest savings and has medical bills besides, but you don't have any resources and there is nothing available to you to provide this?

Mrs. WILLIAMS. No. We have no funds through our agency that would cover this. There is, through agency funds, through United Way and so forth, who may be the ones that will be picking up costs for our visits. Of course, our visits, you know, do involve a fee and we would not expect Mr. Tillery to have to pay those. We are not sure just who is going to pay those yet, but it will be picked up some way so that he would not have to pay those.

Senator KENNEDY. I suppose the chances of an emergency would be much less for Mr. Tillery if he had the suction machine and the humidifier, would they not?

Mrs. WILLIAMS. Yes. Because he did receive some instruction before he left the hospital.

Senator KENNEDY. I mean if he had those two devices, the chances for complications are vastly diminished?

Mrs. WILLIAMS. Yes.

Senator KENNEDY. Nonetheless, even as he walks out of this hearing today it is simply financial support that he lacks. He will be going back to his place where he lives, by himself, having that question always in his mind whether that fellow is going to answer the door the next time he knocks.

Mrs. WILLIAMS. Yes, and he will be for a long time going through still a recovery period. Something could happen.

Senator DOMINICK. Mrs. Williams, I gather that Mr. Tillery has worked 31 years for the trucking company. Do they have a retirement program for him?

Mrs. WILLIAMS. Yes. We have talked about that a little bit and there is a possibility that he will go ahead and retire.

Senator KENNEDY. How old is he?

Mrs. WILLIAMS. Is it 62, Mr. Tillery, or 63? 56. That's still, you know, a young man, but he could retire. That would be probably, he's told me, about 4 months before that would begin.

Senator DOMINICK. Now, does the union also have disability payments?

Mrs. WILLIAMS. No.

Senator DOMINICK. How long in your opinion would it take after he applies for social security, to start receiving benefits.

Mrs. WILLIAMS. They will not give us a date. From our experience we would say that it is several months. Probably a minimum of 3 or 4. Possibly considerably longer.

Senator DOMINICK. Is there any way of speeding up that process in this kind of situation?

Mrs. WILLIAMS. Don't know of any. Our agency has contacted——

Senator DOMINICK. The application has been submitted?

Mrs. WILLIAMS. Yes.

Senator KENNEDY. We will follow up. Here's just one example. I'm sure there are thousands of examples like this. We can follow up on this. We will. But I don't know why you should have to have Members of Congress following up on these matters and not having it as a matter of right.

Thank you very much.

Angie Roby, a nurse from Des Moines General Hospital.

STATEMENT OF MISS ANGIE ROBY, NURSE AT DES MOINES GENERAL HOSPITAL, DES MOINES, IOWA

Miss ROBY. I am speaking on behalf of my parents who really didn't feel they could go through this themselves.

They had a 6-year old child who—it will be 3 years this April—had been a fairly normal child. He had a mild cerebral palsy which only really affected him from his elbow down, and he was classified as an epileptic but yet he was a very intelligent child which showed even when he was in kindergarten, so we felt very happy even though he had this limited cerebral palsy.

We thought, well, it could be worse. Well, on a Tuesday in April it struck. He had a seizure which we thought was a regular seizure. We took him to the hospital, but he never came out of the coma One week later on a Sunday Dr. Spevak was called in and he decided the child needed a blood exchange. This didn't help.

He did a craniotomy and tracheotomy. He was still living, but still it didn't help.

My parents, after 2 or 3 months, took him to Rochester in hopes that the tumor they found during the craniotomy could be removed. They spent a week to a week and a half up in Rochester to no avail. They

said that they couldn't prove that there was a tumor by the tests they performed, but yet if he had a tumor they couldn't remove it here they wouldn't be able to remove it there, so they brought him back and he had to travel by airplane both ways because they didn't feel he could travel by ambulance or car.

During this same summer of June, July, and August, both my parents and one of my brothers were admitted to Lutheran. They just couldn't take it any longer because they had all been so close to little Allen, so we had bills pile up from psychiatric care for my mother and my brother.

Then he was readmitted to Mercy up until September. We got a letter from the utilization committee saying they could no longer take care of this child, he didn't need hospital services. He was just taking up a bed.

Senator KENNEDY. What's the utilization committee?

Miss ROBY. As far as I know, they eliminate unnecessary patients to keep the flow of beds open.

Senator KENNEDY. What do you mean by that?

Miss ROBY. Well, I talked——

Senator KENNEDY. What sort of unnecessary patients do they eliminate?

Miss ROBY. Well, they feel, from what I got from one of the doctors, was if they didn't use X-rays and need the facilities that are right there in the hospital, like if they needed custodial care, then they really didn't need a hospital, even though we had insurance that would have covered the child for 2 years. Yet we couldn't bring this child home, we felt, because of the situation with my mother and brother.

Senator KENNEDY. So the utilization committee said the boy had to leave?

Miss ROBY. He had to leave, right.

Senator KENNEDY. In spite of the conditions in your home?

Miss ROBY. Right, and, you know, they weren't going to be out of any money either.

Senator KENNEDY. Well, money doesn't make a difference, does it, to the utilization committee?

Miss ROBY. No. We thought maybe it would, you know, so we explained to them our insurance would pay on this.

Senator KENNEDY. Why did you think it might?

Miss ROBY. Well, as a nurse, I know when insurance runs out a lot of times then they want to transfer them, which would have been fine if our insurance would have run out, to be transferred to Broadlawns.

Senator KENNEDY. They wouldn't want to transfer someone just because his insurance ran out, would they?

Miss ROBY. They will, right, and they will transfer them to Broadlawns. They get very good care and a lot of times the very same doctors.

Senator KENNEDY. Transfer to where?

Miss ROBY. Broadlawns.

Senator KENNEDY. Out of the private into the county hospital?

Miss ROBY. Yes.

Senator KENNEDY. Just because the insurance is running out?

Miss ROBY. Run out; and this a lot of times is to the advantage of the family so they don't have mounting hospital costs.

In November we did bring him home because we had no alternative. My parents had to take out a $5,000 loan to help with the cost to bring him home. We were told that we had to have a bedroom downstairs because they didn't feel this child should be carried upstairs and carried back or left upstairs by himself. So we had to build a bedroom and we had a good $150 or $200 in just supplies that we had to have because he was being tube fed.

He had to have a suction for a while, and all these things added to the cost. Besides, we had to have special diapers made and gowns to fit him.

We had him home until the middle of February. He was readmitted to Methodist Hospital for reevaluation and he had pneumonia and from here he was taken to the convalescent home.

He was there for a month and we were told that he would have to leave because they could only keep him on a rest period basis because they did not take care of total care patients on a long term, but yet there were children there who had been there 2 or 3 years, some of them.

So we contacted Tom Whitney on the Polk County Board of Supervisors.

Senator KENNEDY. They also wanted to move your brother out?

Miss ROBY. Right, and also when he was in Methodist, he was there 20 days for reevaluation and they gave a utilization committee letter saying he no longer needed hospital services. He needed custodial care.

So when they took him to a convalescent home, after about a month or a month and a half my mother got a call saying they would have to remove him, come and get him that day. He was dismissed. It was rainy, it was cold. My mother assumed that the doctor had ordered it, because he had given the order for the child to go to the convalescent home.

We got him home and 2 or 3 days later he was running a temperature. He was developing pneumonia again. She called the doctor. He was very surprised. He didn't even know the child had been dismissed.

Senator KENNEDY. The doctor didn't know?

Miss ROBY. No, he didn't. So then we had him home and he was readmitted. Only after going to welfare, and this was the only way, could we get him readmitted to the convalescent home until we could find a foster home because it was a tremendous burden on my parents. They couldn't afford the cost. It was mounting. They were spending $75 to $100 just on doctor bills, medicine, and supplies that were needed for him, and yet welfare will not pay or help you in your home. My father had a job at Firestone where he made good money, but yet he still had the $5,000 loan and hospital expenses that were partially left over, and doctor bills.

Senator KENNEDY. And eight other children?

Miss ROBY. Right. So eventually we got him back in the convalescent home temporarily until a foster home could be found and welfare told us if we could find one and they approved it, he could go.

Well, we found one. The woman was too old, they were going to retire her. We found another. They had one total care child already and they would not allow them to take another one.

Our sources were beginning to be exhausted and then we got a call, on the birthday of my little brother, that he would be dismissed in a couple of days by the administrator again.

Senator KENNEDY. Didn't they know you were searching, trying to find one?

Miss ROBY. They knew this.

Senator KENNEDY. Were you a nurse at this time?

Miss ROBY. Yes, I was.

Senator KENNEDY. So you know your way around the health system about as well as anyone?

Miss ROBY. And it does just about as much good as a lay person really. Our insurance was paying half of what they paid in the hospital bill. It was $17.50 to the convalescent home, so it was in October that they told my mother that she would have to remove the child in a couple days.

We called Dr. Spevak and he said do not remove the child until he discharged him. We talked to Tom Whitney—that's when the Polk County Board of Supervisors became involved. We had a hearing.

Senator KENNEDY. You had to go to the Polk County Board of Supervisors?

Miss ROBY. And Tom Whitney told us that we wouldn't have to worry. He told my mother that that child would not be removed until there was a place to take him, and they told us that he was to be out of the hospital by December 23, out of the convalescent home.

Well, on December 23 at 4 a.m. we were called to come and get the child and take him to the hospital. December 24 he died.

We still have medical bills left over. Even though they are not mounting like they were during that period, but still you have to alleviate them.

Besides, my mother had polio when she was 3 and we have bills still for her treatment, through the years, for surgery.

Senator KENNEDY. How much are your medical bills, do you think?

Miss ROBY. Well, I know my parents still owe Dr. Spevak $269. They still owe $4,000 on the $5,000. They owe their own family doctor for the care of my mother, close to $300.

Senator KENNEDY. They have that $5,000 loan still to be paid?

Miss ROBY. They have paid most of the interest on it. Now they owe $4,000.

Senator KENNEDY. They still owe the $4,000?

Miss ROBY. Right.

Senator KENNEDY. Plus what, approximately $2,000?

Miss ROBY. Right. Then my mother's shoes, which she needs—should be renewed every 6 months, but she can only buy a pair every year because they are $130.

Senator KENNEDY. Is this because of the polio?

Miss ROBY. Yes. And she's trying to work now at a full-time job to help make ends meet.

Senator KENNEDY. And you are going to try to pay this off?

Miss ROBY. Yes.

Senator KENNEDY. And your insurance didn't cover the——

Miss ROBY. They covered pretty well; most of the hospital bills.

Senator KENNEDY. They paid part of it, but you still have, in spite of that coverage——

Miss ROBY. Right, because they didn't cover anything after the child was placed in the home, and later came back to the home.

Senator KENNEDY. They don't cover that?

Miss ROBY. No, they don't.

Senator KENNEDY. So you and your family, you are going to try and pay that off?

Miss ROBY. Right. My sister works and I work and——

Senator KENNEDY. How old are the other members of the family?

Miss ROBY. Let's see. There's Bob, he was in the service but he's going to school now with the service, but he's 19.

Senator KENNEDY. Where is your home? Are you from Des Moines?

Miss ROBY. Right. On the west side.

Senator KENNEDY. Just as a matter of information, did he volunteer or was he drafted?

Miss ROBY. He volunteered, but he didn't spend the whole time because during the time that the baby got real sick he asked for an emergency leave. He came home. The baby was still sick. He asked for an extension. It was granted by the sergeant. The lieutenant called and told him he could only have 5 days. He was to report back December 19. He reported back. He got there and as soon as he got to the base the lieutenant told him he could take the extra time—if he had the money to go back home, if he wanted to, for Christmas vacation. But my parents could not afford to send him the money to come back home, which if he had been granted the 12 days like he was supposed to have, he wouldn't have had to pay the extra, and then he had to turn around and come back when the baby did die.

Senator DOMINICK. The children's convalescent home then, is designed to take care of those people who they consider to be curable because of that home's specific type of treatment. Is that correct?

Miss ROBY. Well, this is what they claim, but they are also licensed to be a custodial and pediatric nursing home.

Senator DOMINICK. They are licensed for both?

Miss ROBY. They are.

Senator DOMINICK. So they are licensed for a custodial home as well?

Miss ROBY. Right.

Senator DOMINICK. Is it more expensive at one of these children's convalescent homes than it would be in a rest home or some other home?

Miss ROBY. In the laws of Iowa you cannot put a child in a nursing home for elderly people. They feel that this isn't right, and I know my parents wouldn't have, you know, been able to accept this either.

They had taken the child to Woodward for an evaluation that was requested by welfare. They went through the total care area and they couldn't bring themselves to place him there because there are so many in just rows of beds that they didn't feel he'd get the attention he needed, and the care, and also he was so susceptible to infections that he wouldn't have lasted.

Senator DOMINICK. Are the rest of the children in your family younger than you are?

Miss ROBY. Yes.

Senator DOMINICK. And they are all in school?

Miss ROBY. There's three of us out of school now and the others are still in school.

Senator DOMINICK. Now, you said that the insurance coverage would pay the home expenses up to a period of 3 years and yet you say that there were bills left unpaid.

Miss ROBY. They would have paid the hospital for 2 years and full coverage, except for doctors. They wouldn't have paid for the doctors. The convalescent home, they would have paid up to 120 days and we could have gotten an extension and they would have paid $17.50 a day. I think the fee then was $20, and my parents felt that considering the cost that it would have been at home, to bring him home, and the trauma and this, the extra $2.50, they'd manage it somehow.

Senator DOMINICK. Thank you very much.

Senator KENNEDY. Next is Mrs. Charles Banks. Mrs. Banks also is a nurse.

STATEMENT OF MRS. CHARLES BANKS, NURSE, DES MOINES, IOWA

Mrs. BANKS. My husband is the individual I am talking about. He had a very sudden illness and he was taken ill on March 3, 1970. We had absolutely no warning. This is called an intracranial aneurysm. It is something like a stroke, but there's much less chance of any type of guess as to the nature and extent of recovery.

He could have died immediately and practically did, or any number of other things. He was taken to Lutheran Hospital that evening, within a period of about 10 minutes after we knew he was ill, and he stayed there for a little over 2 months. Then he was transferred—not quite. Excuse me. He was transferred on the last of April to Methodist Hospital, to the Younkers rehabilitation part, Younkers Rehabilitation Center, and he was there continuously until August 20, 1970.

We had, in the middle of the summer or thereabouts, some letters from our insurance and they did pay the bill at Lutheran Hospital, but in November of 1970 I got a bill—not a bill, excuse me. I got a letter from our insurance company saying they would only pay for half of his time at the Younkers center, and the reason they gave was that this was rehabilitation care that wasn't covered under our insurance.

Now, we have the maximum coverage that you can have under this insurance. It is Blue Cross-Blue Shield, comprehensive 365 major medical.

I work full time. I was in quite a state. God, I didn't have any idea how I was going to pay a $6,000 bill, and in the meantime anyway I was paying about half of all the doctors' bills and anesthesiology and all these things because my insurance covered roughly half. Occasionally a little more than that.

We had, oh, anywhere from six or more doctors, so we had quite a few doctors to pay.

This is where my doctor here at Younkers really stepped in for me and if he hadn't we just—well, I don't know. I'd still have all unpaid bills.

This is a little bit different. I had a little bid of insight as to where to go, so the first thing I did was to come to the Social Service Department here, and with which I had been in close contact anyway.

All the way along I kept asking if there would be any chance my insurance wouldn't cover care at the rehabilitation center, otherwise I would have transferred my husband to Veterans' hospital in the city. We knew this was going to be a long siege of hospitalization.

The kind of care he needed related to his having some paralysis on one side. He had total memory loss at the time, and no ability to function on his own. They would restrain him in the room or in the wheel chair. He had a lot of bladder problems. Some of these things were directly associated with the acute illness, with bleeding in the head, which is what it was, and then these other problems arose as a result of the surgery. This involvement from the surgery is what gave us some of the other problems.

Primarily the memory and the judgment. The man was what we call mentally incompetent and still is at this point. He is totally disabled and unable to work for that reason.

I had been given no idea that my insurance wouldn't cover the rehabilitation center when I got the letter, and then went back down to social service, and numerous phone calls to my insurance company, to try to find out who I was to talk to. Finally then I found out that if I had my doctor write a letter explaining exactly why the care that he had received essentially the last 2½ to 3 months here at the Younkers Hospital was necessary above and beyond rehabilitation, apparently then they would take this under consideration again.

My doctor did this and the letter pointed out that ever since this part of the hospital had been started, rehabilitation had been a covered service if it was directly in association with an acute illness, which his had been, and then at this point then it was paid.

So we were finally reimbursed for it. By letter we knew it would be covered in February.

Senator KENNEDY. Do I understand that you first went to the Younkers Hospital during April through June, and at that time Blue Cross paid this bill. Then at some point you went down to social services to try to get this——

Mrs. BANKS. No, it paid the first hospital and then he was transferred directly from one hospital to another. He was dismissed in August and in November I got the letter saying they would only pay half of his hospitalization.

Senator KENNEDY. But had you checked before with the Social Service to get their guidance as to whether——

Mrs. BANKS. Right. Several times.

Senator KENNEDY. I mean you had foresight?

Mrs. BANKS. Yes.

Senator KENNEDY. And you believed they would, and then rather than just leave that to chance, you went down to social service and asked them what guidance they might give you because you knew that there was at least the possible alternative of considering the VA Hospital. Then as I understand, they indicated to you that their interpretation was that it would be covered. Then when the time came for the bill, you found out they were only going to pay for half, and then you had to go through all the burdensome procedures to get full compensation for the hospitalization; is that correct?

Mrs. BANKS. Yes; that's right.

Senator KENNEDY. Now, why should Blue Cross be able to make that interpretation themselves?

Mrs. BANKS. I still don't know, Senator Kennedy. I still have a bill I got 2 days ago, that my husband now has been back in the hospital for some minor urinary problems again in January, and just 2 days ago I got another bill, saying a Blue Cross adjustment, and there is $322 they hadn't covered again, so I have to go through this all over again.

Senator KENNEDY. So you have to go through it all over again?

Mrs. BANKS. Right.

Senator KENNEDY. This is arbitrary. They make their judgment and then require you to go through this procedure to get it straightened out?

Mrs. BANKS. The responsibility, as far as their interpretation of it, rests with the consumer. The consumer must go to them and find out if there is some arrangement that can be made, if there is some reason why it should have been a covered charge; and my husband is still in need of 24-hour care. My husband still needs 24-hour care. I have someone with him at all times. I choose to do this so I can work. We had no idea it wouldn't be covered.

Senator KENNEDY. Are you taking steps to get some judgment on this? I would think that most people would have assumed that it would be covered in the first place, but you took an exploratory step to be sure, and then you were still put under the burden of having to get the doctors to sign and write these letters. What are you going to have to do now?

Mrs. BANKS. Well, I have to go through the process of calling and trying to find the right person again, and I suppose pulling out the records that they have and what part of the hospitalization——

Senator KENNEDY. We have Mr. Martin from the Blue Cross with us. He's been kind enough to follow every time we have a hearing. He's been traveling around the country with us. We have a good case for you here. If you can help out Mrs. Banks on this, we'd certainly appreciate that.

You get Mr. Martin, Mrs. Banks, and see what he can do.

Senator DOMINICK. Mrs. Banks, how is your husband now? Is he at home?

Mrs. BANKS. My husband physically would seem fine. Mentally, he is classified as an incompetent, which means he can't be left alone in the house and can't work, and we have no idea whether this is totally permanent or whether some time he might return to some kind of work.

Senator DOMINICK. Do you have any children?

Mrs. BANKS. I don't have any children. My husband had two children, and we had the child-support involvement there. We got social security—he was ill on March 3 and we finally got social security coming through in November. Up until that time, I assumed all the bills.

Senator DOMINICK. This has been part of the problem in the social security disability area. It takes about 6 months to process a disability claim in Baltimore. I am happy to say we have a fellow from Colorado here, who I hope will speed up the system.

Mrs. BANKS. I have a question on that. When I originally went down, I was told there was no such thing as back payment for the

months in between the time he was ill and the time it started, and I am told now that there is and there isn't and there is and there isn't. So apparently this is no set thing either, and whether there would have been some money at that time that would have been available for us, I don't know.

Senator DOMINICK. Was the insurance that you had at that time taken out by you, or was that part of your husband's insurance?

Mrs. BANKS. It was taken out by my husband, and then when his sick leave was exhausted at his place of employment, then I transferred it directly over to my group insurance. This is another concern of mine, because the type of his illness, he would never be able to get another insurance policy that would cover him.

Senator DOMINICK. So at the moment then, you have group insurance under your own name?

Mrs. BANKS. Yes.

Senator DOMINICK. The original bill that you were talking about, which was close to $6,000, has been paid by Blue Cross?

Mrs. BANKS. Yes; this was paid. It was $5,990. Almost $6,000, give or take a couple dollars.

Senator DOMINICK. Well, the best of luck to you.

Senator KENNEDY. We have better than luck. We have Blue Cross right over here. [Laughter.]

The next witness is Clifford Thomas. I understand he couldn't be here; and his daughter, Mrs. Shirley Richards, is here in his place. We are glad to have you.

STATEMENT OF MRS. SHIRLEY RICHARDS, DES MOINES, IOWA

Mrs. RICHARDS. I didn't know about this until 8 o'clock this morning.

Senator KENNEDY. That's all right.

Mrs. RICHARDS. But my mother has multiple sclerosis, and this was diagnosed in the year 1957. She walked up until about 2 years ago when she fell and she broke a vertebra in her back.

She was taken to the hospital, and from there she went here to the Younkers Rehab Center, and she was here, oh, I think a couple of months, 2 or 3 months, and a man from a nursing home nearby said he would be more than happy to have her come over there because they had therapists, and this is what she needed because maybe she could take a few steps, and this would be better than nothing.

So he took her over there, my stepfather. Well, first, he said that he didn't have that type of money to put her into a nursing home. He said, "Well, forget about that. We will help her." So they took her over there and she was there until October and it was something like pretty close to a $4,000 nursing home bill, and I found there were two nursing homes on the south side so I found one that I could get her in so my children could go see her because I figured this would help her too.

So we took her over there, where the charge was $320 a month. I might add, that his income is something like $420. So he kept getting loans in order to do this. Her medication over there was somewhere in the neighborhood of between $50 and $70 a month. It varied. Well, they kept her just drugged. Half the time when we'd go up there she was just sort of half asleep.

Senator KENNEDY. How do you know they drugged her?

Mrs. RICHARDS. Well, this goes on. Because of the type of medication that she was taking. He asked a pharmacist. Well, anyway, it got to the point where—well, there was a member of the family who killed himself and this upset her quite a bit and she went into one of her little rages and started screaming and crying and they put her upstairs in an attic room, and my 10-year-old came home—and this from a 10-year-old—he said, "Mom, there should be such things as mercy killing." He said, "For my grandmother to be up there in that little attic room where you can't even stand up, she'd be better off if she wasn't here."

So the next day I got on the phone—which I might add, we went to the social services. We tried to set some help from the State. We had an appeal. Mr. Gearing turned us down. So we started this all over again last October and we were turned down again.

But anyway I got her into another nursing home which is $310 a month and it is also nearby. She is very happy. Our drug bills were cut in half, anywhere from $30 to $45 a month. They said she didn't need these other medications that had been sent down from the other nursing home. This is why she told me, the nurse there, told me that she had been drugged. They kept her sedated so she wouldn't cause any trouble. This is where I judge my opinion, from what the nurse told me.

I called Multiple Sclerosis and asked them for help, because when we know she'd have to go to a nursing home I was interested in somebody coming into the home and taking care of her this way and there was no way. Finances just wouldn't permit it. We just couldn't get any help any way, any place.

So anyway he has tried and been turned down, and the social service commissioner told us that there's one way that he can get some help and that is if he does not pay his bills. However, he is a very hard working, proud man. If he wouldn't pay his bills, get a court order—which this one nursing home had sued him for the balance of the bill. If he didn't pay his bills, then they wouldn't consider this income. Therefore the State would come in and help him.

She just turned 54 years of age. She cannot get social security because she hasn't worked in the last 15 years, 15 or 20 years they said. She worked for Solar Aircraft. She worked for the ordnance plant. She's worked all of her life, but yet she cannot get social security or any type of help at all.

He has sold his home. He doesn't own anything any more. So that is the story.

I called Multiple Sclerosis, the center, and I asked them for a wheel chair and they said at that time there wasn't any available and so they couldn't help me.

Senator KENNEDY. If you were able to get a wheel chair, what would that mean?

Mrs. RICHARDS. Well, she could have—2 years ago she could have gotten around in this wheel chair. She could have pushed herself because she still has strength in her arms.

Senator KENNEDY. The fact you didn't have the resources for a wheel chair meant she was bedridden?

Mrs. RICHARDS. She is bedridden. She is completely bedridden. About 6 months ago Multiple Sclerosis called me and told me they had a wheel chair available for my mother and I told them it wouldn't do any good now because she can't sit in it. It is the type of disease which just deteriorates the muscles, so this is really sad.

Senator KENNEDY. What do you think the total cost has been to your stepfather?

Mrs. RICHARDS. Well, it's $310 a month plus anywhere from $30 to $45 a month for drugs. This doesn't count the nightgowns I sew.

Senator KENNEDY. You have been paying on this how long?

Mrs. RICHARDS. Two years. Plus he has a back bill of about—I imagine it's about $3,500.

Senator KENNEDY. No insurance?

Mrs. RICHARDS. There was Blue Cross and Blue Shield and they paid about two-thirds; and when she came here, it didn't pay it to the rehabilitation center.

Senator KENNEDY. It ran out?

Mrs. RICHARDS. Yes, it had run out.

Senator KENNEDY. And this wiped out your savings?

Mrs. RICHARDS. Yes. It wiped out his savings. He sold his home, he sold his furniture, and he does have an old automobile, but that's it. He's just been a hard working man all his life.

Senator KENNEDY. How does he think he is going to be able to pay this in the future?

Mrs. RICHARDS. I don't know. There's one person—He just keeps going from day to day. He gets a loan here, a note, and pays this one. This is the way he's been going.

The only people that have paid him, have helped him, was half of his nursing care which was $155, I believe, is the Disabled Veterans. He was a World War II veteran. He faced action, and they are the only ones that could do anything, and I said if they can do something for this man, why can't somebody else? Our taxes pay for this.

Senator KENNEDY. True.

Senator DOMINICK. Did Mr. Thomas have any coverage at his job which would have taken care of his situation?

Mrs. RICHARDS. This is Blue Cross. It is a group plan. I couldn't tell you which one it is because I don't have that information available.

Senator DOMINICK. Is that the insurance program that ran out?

Mrs. RICHARDS. Yes. It ran out because she was in the hospital with this broken vertebra, which I might add the hospital didn't keep very close care or watch on her, and she fell out of bed and was in pretty bad shape then, because when her head hit the floor——

Senator DOMINICK. This is one of the problems that we face in many of the long-term illnesses of this kind. This particular case is really an excellent one to prove the need for some kind of long-term care.

Mrs. RICHARDS. Yes. Well, our doctor is very, very reasonable. I know there are doctors, compared to my doctor, who charge three-fourths more than what they should, and I don't know. When you hear of things like this, you always look to socialized medicine. Would this be an answer?

Senator KENNEDY. You don't really have to go that far. [Laughter.]

Mrs. RICHARDS. Sorry, but why should one doctor be allowed to charge so much more than the other when they usually aren't as good?

I had a case of this in my family a couple weeks ago when I went to a different doctor than our private doctor for my boy.

Senator KENNEDY. We are going to have the medical society testify later.

Mrs. RICHARDS. Well, my doctor I know would be behind me 100 percent because we have discussed this, and this matter of drugs, this is something else. When people are in the nursing home, why should one drug store, one pharmacy, be allowed to charge twice as much as what the pharmacy over here does? They all have the Federal stamp on them, so why should they be allowed to make more money on somebody who is sick and disabled?

Senator KENNEDY. Thank you very much. I appreciate it.

Mrs. RICHARDS. Thank you.

Senator KENNEDY. We now have two professional witnesses.

Kenneth Lister is president-elect of the Iowa Medical Society, and he has some people with him. He will introduce them. Lets see if we can keep to 12 or 13 minutes for this presentation, so we will have time later to open the hearing to others.

Dr. Lister, I appreciate very much your being here.

You have a statement here that is some 12 pages long.

Dr. LISTER. It is our intent to highlight that statement.

Senator KENNEDY. We will put it in the record in its entirety, following your testimony. You have heard a number of tragic situations this morning. We 'd be interested in what insight you would be able to provide this subcommittee into some of these problems and what you think should be done. We are interested in trying to understand both the best and the more difficult aspects of the health system. We have heard about some of the more difficult aspects in this testimony. We have seen some of the best facilities early this morning and last evening. If you could proceed in that way and show us both sides we would appreciate it.

STATEMENT OF KENNETH E. LISTER, M.D., PRESIDENT-ELECT, IOWA MEDICAL SOCIETY, OTTUMWA, IOWA

Dr. LISTER. On my left is Dr. S. P. Leinbach from Belmond, Iowa. He is a past president of our society and a vice chairman of the Rural Health Council in the A.M.A. for many years.

On my right is Dr. Paul Seebohm who is an associate dean of the College of Medicine at the University of Iowa and a professor in the Department of Internal Medicine.

At your suggestion, we will highlight some of the things in this statement which we feel require emphasis and let the remainder go.

Senator KENNEDY. The full statement will appear in the record.

Dr. LISTER. Actually we want to direct our remarks to the delivery of medical care as contrasted to health care. We are not including environment, housing, nutrition, et cetera, so that our remarks will be limited to the delivery system of medical care.

This actually divides itself into four segments, the preventative segment, diagnostic, therapeutic, and rehabilitation.

Preventive care has been totally accepted in our State. We have a very enlightened population and a very active medical population.

We report that 90 percent of our school children have received immunizations including a statewide measles program which has practically eradicated the disease in our locality.

As you are well aware, the poliomyelitis is no longer a problem. We have had eight cases reported in the last 5 years in the State of Iowa, so there are some things of which we can be justly proud.

As far as the manpower picture is concerned, this is a distressing graph which you have over here indicating the doctor shortage in Iowa. I would draw your attention to the fact that in the last two decades, however, it's been relatively stable. Since 1950 the population in the State has remained approximately the same and it is of interest to note that there's been only 23 less doctors in 1970 than there were in 1950.

So, to this group, of course, 2,400 physicians in the State, we have the help of approximately 400 osteopathic physicians who add greatly to the delivery of health services in our State. The cooperation between the physician and the osteopathic physician is increasing almost daily.

In the health manpower picture approximately 50,000 persons are involved in the delivery system in the State, including all the ancilliary people. We are distressed by the rural to urban migration. We have been aware of it for many years. Physicians have tended to leave the small community and congregate in the larger areas. They do this for the same reason that people move out of the rural areas. They want to associate themselves in groups so that they can have time free for study as well as time free for their own pleasures.

We think that this situation is probably beyond remedy. We don't think there is any way that they can be encouraged to stay in the smaller communities as compared to the larger ones.

It is equally true that the mobility of our population has undergone the same improvements and we feel certain there is no citizen of our State who is more than 30 minutes away from either a doctor's office or a hospital.

Senator KENNEDY. You mean there is no one in the State of Iowa that lives farther than a 20- to 30-minute drive away from a doctor or hospital?

Dr. LISTER. That's correct.

In our efforts to remedy the situation so far as numbers are concerned, the State Medical Society has been very active in supporting the College of Medicine to increase enrollment. In the past 5 years the enrollment at the university, as Senator Dominick has mentioned, has increased 40 percent. In 1975 they will have an intern class of 175 students, which will be a big help.

It is of interest that the college now is directing its curriculum into the community health cares anticipating using the larger urban hospitals in their community teaching and we feel that this program in itself will entice younger physicians to stay within our State.

It might be of interest to you to know that the doctors in Iowa have financed a loan program, a foundation program, and we have actually loaned $400,000 to approximately 250 students on a return basis, so there is a continuing loan fund. The students have availed themselves of this money to its maximum.

I won't go into the facilities. I'm sure somebody from the hospital industry will speak to those. There are a few rather unusual ones which are the total responsibility of the medical profession which should be brought to your attention.

As I said, group practice is increasing its popularity and I think it will continue to do so. In addition to this, the State Medical Society has sponsored the development of community health programs. We have some 20 programs in the State now directed not only to the mental health state tself, but abuses of alcoholism and drug abuse. These are actually functioning groups and have been extremely well received.

Most of the people in Iowa, 80 percent, are covered by some form of health insurance. If you include the 16 percent that are covered by governmental programs, medicare and medicaid, 96 percent of the population has some form of health insurance.

We agree that some of this is adequate and some is not adequate, but the figure is quite high in our State.

The medical society has recently developed a foundation for medical care. This foundation will follow some of the tenets of the California foundations. We are not anyways near as sophisticated as they are in the application of peer review, but this is something that we have been doing for many years in our State anyway, so we hope to become more sophisticated and has a continuing on-going peer review program. This will assure quality in medicine at an equitable cost to all of the citizens of our State.

One of our greatest assets is the health of our people. There is no denying that difficult challenges stand before us. No more challenging perhaps than those of the past, but nevertheless demanding our unceasing efforts.

Indispensable in the delivery of modern health care are intelligent, motivated, and responsible people. The Iowa Health Care team is one segment of the total State population known for its industrious nature, and with continuing leadership from this team the health care challenges of today and tomorrow will be met.

Thank you, sir.

(The prepared statement of Dr. Lister follows:)

PREPARED STATEMENT OF KENNETH E. LISTER, M.D., PRESIDENT-ELECT, IOWA MEDICAL SOCIETY, OTTUMWA, IOWA

This statement is for the purpose of providing to the U.S. Senate Subcommittee on Health basic information relative to health care and health care delivery in the State of Iowa. A completely comprehensive discussion of a subject so broad as health care could span many, many pages, even for a moderate-sized state such as Iowa. We have elected to abstract from the massive health care data which is available certain salient facts. In this way we believe it will be possible for the Subcommittee to gain some rather accurate impressions of the health care situation as it exists in Iowa.

The population of the State of Iowa is approximately 2.7 million; its total area is just over 56,000 square miles. In both of these departments Iowa is very near the national mid-point with about as many states larger as smaller.

At its birth in 1946 Iowa was a setting of uncertainties for its scant population. The dreaded cholera took a heavy toll at that time. Life was most precarious during the early years of the State's history.

The frontier Iowan would be amazed at the progress his kin have made in safeguarding and prolonging human life. He would be surprised to learn that nationally people in 1900 lived to an average age of 47.3 years. We think he would be amazed to know that by 1965 the life expectancy figure had increased by 23 years

to 70. We think further he would find satisfaction in knowing Iowa's life expectancy figure of 71.9 years ranks second in the nation. This means the life span of the average Iowan has about doubled in the State's 125 years.

The much-maligned infant mortality statistic has shown great improvement through the years. There were 30.3 deaths per 1,000 live births in 1945; in 1969 this was reduced to 18.9, a figure below the national statistics.

How important is good health to the citizen of Iowa?

Without it, the 220,000 agricultural workers on Iowa's 145,000 farms would be hard pressed to continue providing the nation with 10 per cent of its food supply.

Without it, the productivity of the State's 218,000 industrial workers would be endangered. And the 10 billion dollars worth of Iowa manufactured products would almost certainly dwindle.

Without it, the approximately 40,000 educators in Iowa's public and private elementary and secondary schools would be handicapped mightily in their teaching tasks, and the State's claim on the highest functional literacy rate in the nation would be threatened.

Simply stated, without good health, the state's 1,176,000-member work force—and their families—would be in jeopardy. Our quest for good health should be and is never ending. Our objective is that of making life healthier, happier and more productive for everyone.

What is good health care?

It can be described as that effort expended by the individual Iowan, the parent, the members of the health care team, the community, the state, etc., to provide these elements: Good medical care, adequate nutrition, good dental care, satisfactory working and living conditions, a sensible activity program; rest, relaxation and recreation; and good emotional adjustment.

So defined health care may be divided into several major categories: Preventive or protective care, diagnostic care, therapeutic care and rehabilitative care.

Preventive care receives much attention in Iowa. Some 90 per cent of Iowa's youngsters are immunized against such diseases as whooping cough, smallpox and diphtheria through the combined efforts of private physicians and community clinics. We would call your attention to poliomyletis as a particularly dramatic chapter in preventive medicine in Iowa. In 1952, Iowa had 3,562 cases of polio; in other years cases ran between 500 and 1,500. In 1962, Salk vaccine became available and was administered from border to border; the total number of cases dropped below 10. In the five-year period from 1963 to 1968 Iowa had only eight reported cases of polio. We must, of course, not become complacent; we must maintain our immunization levels.

Fluoridation of water is another important example of protective health activity. Iowa ranks fifth nationally in percentage of population on public water supplies receiving the benefits of optimum fluoridation. This percentage includes all of the state's 10,000-plus communities.

A very recent example of conscientious preventive health care in Iowa is represented by the 1970 state-wide rubella eradication program. The massive effort involved hundreds of volunteers and 750,000 public and private dollars. In excess of 521,000 Iowa youngsters (88.4 percent of the susceptibles) received the vaccine in this concentrated effort. The State Department of Health and the Iowa Medical Society worked closely in the coordination of the program which we understand was a national pacesetter. According to the State Department of Health, over 1,200 hours of time were contributed to the total program by Iowa physicians.

These preventive measures are considered most important by the physicians of Iowa. So, while the State's medical profession is proud of its organ transplant program and other dramatic innovations, it recognizes most assuredly the need for constant attention to those day-to-day efforts to protect the population from sickness and disease.

What about the health manpower picture?

There are approximately 50,000 Iowans working to protect the health of the total population. This means that one of every 22 employed persons in the State is in a health occupation. These individuals have some role in the care of 75,000 patients daily and their efforts comprise a $500,000,000 annual endeavor. There has been a 36 per cent increase in number of health care workers between the early and late 1960's.

Despite this growth there nonetheless exists a real concern among many as to the State's ability to balance the supply of personnel—professionals and supportive workers—with the demand for services. The general shift in Iowa's population from farm to town and city is well known and is part of a state and national phenomenon. The urban population in Iowa increased by about 214,000 (6 per cent) residents from the decade of the '50s to the decade of the '60s. A parallel pattern exists in the health care field. In the late 1940's about 50 per cent of Iowa's medical doctors practiced in the 16 most populous counties; in the late 1950's this increased to 61 per cent, and in the late 1960's two-thirds were in the larger communities. The actual total change in number of physicians (Iowa Medical Society members) during the period studied was only 23, from 2,381 in the late 1940 period to 2,404 in the late 1960 period.

Iowa health professionals have two principal reasons for choosing urban locations: (1) A logical wish to be within close proximity of professional colleagues, of similar and different specialty training, for referral and consultation purposes, and (2) an obvious desire to be near the sophisticated facilities (coronary care, intensive care, rehabilitation units, etc.) which are more economically feasible in the larger clinic or hospital setting.

It is true that a number of small Iowa communities no longer have a physician within their corporate boundaries. And it appears others will likely experience a similar fate when the current practitioner retires. It is equally true that the mobility of Iowans has increased significantly. It is believed that all Iowans are within a 20- to 30-minute drive of a doctor's office or hospital. And rarely does the Iowan have the snarled traffic problem that confronts his metropolitan counterpart.

What specific involvement has the medical profession (Iowa Medical Society) had in the area of health manpower? Here are several examples:

(1) The Iowa Medical Society has advocated a steady growth in the enrollment of The University of Iowa College of Medicine, and in pursuit of this objective the profession has supported an adequate state appropriation for the College. The Society has been gratified at the growth projections which the College has announced, i.e., there were 145 students in the last entering class, there will be 160 in the fall of 1972 and 175 in the fall of 1973. By 1976 there are expected to be 700 medical students at the University, an increase of 40 per cent over 1969. The Society is on record favoring an entering class of 200 if and when adequate resources are available.

(2) Approximately four years ago the Iowa Medical Society created a task force on medical manpower. This body of physicians has sought to examine the future impact of the manpower situation and to recommend means for alleviating problems. This task force has presented two series of statewide seminars to brief both physicians and other community leaders on the manpower situation.

(3) The Iowa Medical Society has supported recent steps which have led to the founding of the Department of Family Practice at the University of Iowa College of Medicine. It is hoped and believed this Department will win many medical students into its fold and will in time produce an increased number of family practitioners for Iowa and elsewhere. This program as well as others are and will bring Iowa's community hospitals much more directly into the medical education mesh.

(4) Cooperative efforts are now going forward to establish a model rural health clinic for use by medical students and others. This program will be in addition to the long-standing preceptorship program which enables and requires medical students to spend brief time with Iowa practitioners in their offices and communities.

(5) The Iowa Medical Society, through its Scanlon Medical Foundation, has loaned $385,000 to over 240 deserving Iowans attending medical school. Approximately half of the loan recipients remain in the State as medical practitioners.

(6) The medical profession has supported sound education programs for much needed paramedical workers. Most recently, the Iowa Medical Society has provided constructive leadership in the 1971 passage of state legislation to formalize the training programs and job descriptions for the rapidly emerging physician's assistant. Nurses, therapists, technicians and other assisting personnel are valued by the medical profession and instructional programs for them are supported. As an indication of growth in this area the number of subbaccalaureate health occupations education programs has jumped from two in the late 1950's to 43 in the late 1960's.

What about health care facilities in Iowa?

More than one-half billion dollars worth of health facility construction has occurred in Iowa since 1947. There has been no less than 170 construction projects during this period. There are 14,000 acute hospital beds in Iowa now, approximately 6,000 more than in 1948.

Hospital length-of-stay in Iowa contrasts sharply with 20 years ago. In 1947, for instance, the average length of stay for an appendectomy was 14 days. Today, the usual hospitalization for this surgery is four days.

The health care facilities in Iowa may be categorized in several groups. There are the private offices, clinics, pharmacies, hospitals and nursing homes. There are municipally and county controlled health care institutions. There are state operated facilities, which include the massive University Hospitals in Iowa City, the four mental health institutes, the two facilities for the mentally retarded, and, incidentally, Iowa has been a leader in the development of a network of community mental health clinics. There are also Federal Veterans Administration Hospitals in Des Moines, Iowa City and Knoxville.

There are approximately 150 licensed hospitals in Iowa, and 90 per cent of the beds are in hospitals accredited by the Joint Commission on Accreditation of Hospitals. There are approximately 500 licensed nursing homes and more than 300 licesed custodial homes. There has also been a substantial growth in Iowa programs which provide home health care.

What about costs or the economics of health care?

Iowa health care costs are higher than they were five, 10 or 20 years ago, just as they are for food, clothing, housing, etc. Inflation is obviously responsible for part of this. But it is important to bear in mind that Iowa physicians are treating diseases which were incurable 20 to 25 years ago. This treatment requires more highly skilled personnel, more extensive equipment, etc.

As previously mentioned, Iowa's population is about 2.7 million. Of that number, 2.6 million or 96 per cent have some form of health care coverage, be it with a private insurance company, Blue Cross-Blue Shield or the government. Approximately 80 per cent have health insurance with a private insurance company or a Blue Cross-Blue Shield Plan. Medicare covers approximately 350,000 Iowans and Medicaid provides for about 90,000 persons. This means that about 16 per cent of the population is provided coverage by the government.

Many years ago the medical profession, through the Iowa Medical Society, founded Iowa Medical Service, the Blue Shield program which now finances health care for more than one million Iowans. The Medical Society and Blue Shield, while separate corporate entities, work together closely to upgrade and make more comprehensive the programs which are offered through Blue Shield. Significant progress has been made in recent years to bring to Iowans broader health coverage programs.

Blue Shield has functioned as the fiscal intermediary for both Medicare and Medicaid since the inception of both programs in Iowa. While the Iowa medical profession has opposed and continues to oppose the Medicare philosophy of government financed care for all at age 65, it has supported the Medicaid philosophy of medical care for those who need it but cannot afford it. This latter policy has prevailed for many years.

In fact, Iowa can boast of a unique and effective health care program for its indigent, a program which has existed for much of this century. Each of Iowa's 99 counties are privileged to send those low-income persons who need medical care to the University Hospitals in Iowa City. This practice continues in effect even though Medicaid recipients may now elect the point at which they receive care.

While there are undeniably some few Iowans for whom access to health care may not be totally adequate, the State's overall performance is excellent. Those who do not avail themselves of needed care do not, primarily, for lack of motivation or lack of education.

What are specific involvements of the medical profession (Iowa Medical Society) in the socio-economic area?

(1) As has been mentioned, the Society actually established Iowa's state-wide Blue Shield program in Iowa and it also stimulated the formation of Blue Cross.

(2) Through the years the Society has been actively involved in such governmental programs as the Veterans Hometown Care Program, the CHAMPUS Program (the Society was the fiscal intermediary for this program until this year), the Kerr-Mills or MAA Program and its vendor payment forerunners, etc.

(3) The Society has sought to maintain its ethical values through the years and has disciplined those members found to be taking ethical liberties. In the past three years, as a demonstration of the foregoing, the Iowa Medical Society has devised a state-wide peer review program (12 district committees) which is available to all public or private third parties. Questions regarding the manner of treatment or the level of charge rendered by any Iowa physician may be referred to the Society for review and recommendation. The Society's peer review program operates in tandem with the quality assurance program of Blue Shield and safeguards against abuses in both the public (Medicare and Medicaid) and private programs offered through Blue Shield.

(4) As a further and significant indication of the medical profession's belief that it must provide leadership in fostering high quality care in the right quantity and at a reasonable cost, the Iowa Medical Society this year has formed an Iowa Foundation for Medical Care for this primary purpose. From the 11 founding principles of the Foundation four might be set forth here to identify the thrust of the new instrument: (a) To develop, promote and encourage the distribution of quality medical services to those served at an equitable cost and in appropriate quantity; (b) To promote, develop and foster the availability of high quality health care, either alone, or in conjunction with individuals, physicians, medical societies, other professional organizations representing persons engaged in health care, hospitals, nursing homes, schools, the various branches of government, the insurance industry, representatives of management and labor and other interested persons, organizations or institutions; (c) To promote, develop, operate and organize peer review activities providing objectivity in dealing with health costs and utilization of services encompassing the total health needs of patients and by this peer review mechanism to assure the public of optimum use of its health care expenditures, and (d) To promote, foster and coordinate the involvement of the health professions in experimentation and evaluation of programs aimed at relieving acute manpower shortages, in improving the availability of preventive services and in expanding the availability of ambulatory care as an alternative to institutional services and, in connection therewith, to disseminate the results to individuals, physicians, hospitals, schools, foundations, institutions, governmental bodies, corporations and the general public.

(5) Directly related to matters of health care economics are the important health planning programs which have come into being. The Iowa Medical Society was the driving force behind the formation of the now-active Health Planning Council of Iowa (HPCI). This Council has stimulated much activity at the local and regional levels in voluntary planning. Since the inception of HPCI the Iowa Regional Medical Program and the Comprehensive Health Planning Program have come into existence. To each of these bodies the medical profession has given and is giving leadership.

One of Iowa's greatest assets today is the health of its people. This statement has been prepared as testimony to this assertion. There is no denying that difficult challenges stand before us, no more challenging perhaps than those of the past, but nonetheless demanding our unceasing efforts.

Indispensible in the delivery of modern health care are intelligent, motivated and responsible people. The Iowa health care team is one segment of a total state population known for its industrious nature. With continued leadership from this team, the health care challenges of today and tomorrow can be met.

Thank you very much, sir.

Senator KENNEDY. Would the other gentlemen like to make any comments?

STATEMENT OF DR. PAUL M. SEEBOHM, ASSOCIATE DEAN, COLLEGE OF MEDICINE, IOWA CITY, IOWA

Dr. SEEBOHM. Senator, I'd just like to point out the role that the University of Iowa Hospital and College of Medicine Center may play in the health care problem and the educational problem.

The university hospital center is a closely integrated educational and service institution. The hospital administration provides the

service part of the operation and the faculty of the college of medicine provides the professional medical care of the patients in this program and constitutes about 20 percent of at least the hospitalized patient care provided in this State.

We have 300,000 patient days and 250,000 outpatient visits. It is a referral center generally, and a program that was referred to earlier is a fundamental core of the program of health care, and that is the State of Iowa provides for low-income people comprehensive care at the medical center when they are referred to that institution. They are outpatients. They are housed and fed, in addition to being taken care of for their medical needs.

Inpatient care is also comprehensive with no professional charges, so to speak, the service being provided by the faculty.

Senator DOMINICK. I don't quite understand that point. Let me interrupt if I may at this time.

Do I understand correctly that you are saying the medical school provides comprehensive free care coverage for those who can't pay, both inpatient and outpatient?

Dr. SEEBOHM. Yes, sir; for those who are referred to us from the counties, and this is on a county-distributed basis.

Senator DOMINICK. And they are referred to the medical school?

Dr. SEEBOHM. Yes; by other physicians.

Senator DOMINICK. We have had a number of people here already testifying before us on this matter. How does their testimony fit in with that type of situation?

Dr. SEEBOHM. Well, I think several of the patients that testified were referred to the medical center for surgical care. I have forgotten the name of the person who so testified, but she stated that her husband's expenses while in Iowa City were not her immediate problem because she was under this part of the program.

I might say, transportation is also provided to about 30 percent of these patients through a hospital car-ambulance. An assistant goes out through the State and picks up the patient at the farmhouse door if necessary.

Senator DOMINICK. All right. Is this type of coverage not made possible by contributions but by appropriations from the State?

Dr. SEEBOHM. Yes, sir.

Senator DOMINICK. Or is it done from the local medical societies or what?

Dr. SEEBOHM. State appropriations.

Senator DOMINICK. State appropriations.

Dr. SEEBOHM. Now, in addition to the center care at Iowa City we have outreach programs of field clinics for children, obstetrical programs out in the State, the mental health community programs, and there's been a migrant workers' program at Muscatine which has been sponsored by the county medical society, faculty, and students.

The problem of the physician shortage in Iowa we have been trying to attack in the following ways: I might say we have been exporting 50 to 60 percent of the physicians trained in this State to other States who seem to also be in need. We believe that it is going to be necessary to increase the enrollment to help solve this problem, contrary to some of the predictions of others who claim it is all distribution, or maldistribution.

We believe also that we need to work on maldistribution and we have established a family practice department to bolster up the training of the primary care physician.

We have also established community hospital affiliations, one here in Broadlawns, and we have four other communities under negotiation at the present time, so there our students will be able to move out of the hospital center in Iowa City after their core training into the community setting for their additional experience.

Last, we are experimenting with a delivery system program particularly related to a rural health center at Oakdale, which is a community about 5 miles outside of Iowa City.

I'd be pleased to answer any questions.

STATEMENT OF S. P. LEINBACH, M.D., BELMOND, IOWA

Dr. LEINBACH. I am a rural doctor and rather proud of it. I'm at the age where I have seen many of the problems in rural health develop. Many have been resolved, and we still have problems.

I'd like to point out that here in Iowa the 1,200,000 of our population live in rural areas if you include towns of 2,500 and under, so we are pretty much—about 45 percent of the people are rural oriented.

It is my impression, and I spend considerable time in this particular area, that the rural health care, generally speaking, is good. There are some defects and I will mention those later.

I would like to point out that few people in Iowa are further away than a 20-minute drive to a doctor, and within 30 minutes most of them could be in a hospital. Now, there are some very fine hospitals in Iowa. There are 142. Hill-Burton funds were responsible for the development of many of these hospitals, and they are well staffed; 90 percent of them are accredited by the joint commission on accreditation, which causes these hospitals to measure up to certain standards in health care.

Since World War II there's developed in rural areas particularly many small group practices, maybe from two to 10 or 12 doctors join together for the practice of medicine. They join their expertise, their equipment, their personnel, their ancilliary personnel, and thus can do a better job. This is a trend that's occurred and is a rather significant trend as far as health care is concerned in the rural area.

We do have a shortage of physicians. The osteopathic profession is helping very much in this particular area, but we do have a shortage of physicians.

I would like to point out that in the rural area a high percentage of children are immunized against the various infectious diseases, polio, measles, rubella, and the rest of them.

We have had a tremendous reduction in farm accidents as a result of education and, of course, with the development of better, safer equipment. I'd like to state that the Institute of Agricultural Medicine, which is unique in the country located at the University of Iowa City, has done tremendous research into this area.

When I began practice a few years ago, zoonotic diseases, diseases transmitted from animal to men, were very, very common. I saw much of the ravages produced by bovine tuberculosis, tuberculosis of the

spine, tuberculosis of the adrenal gland. We have had a lot of brucellosis, undulant fever, multifever. These have been all eradicated.

Our health care, I think, is very excellent. We are proud of our schools. Ninety percent of the children that graduate from the area in which I practice go on to college or trade training, which is a good indication that these people and their parents are looking forward. They are progressive people, not only in education but in the health care.

I think we have a lot to look forward to in health care in the rural areas. The medical school at the university is expanding its services, increasing its enrollment, and I'm sure that the shortage of physicians that we now have will be in part eradicated.

I'd like to point out though on your chart up there stating that there is one rural physician to each 3,000 people in Iowa, but that really probably isn't a true evaluation for the reason that, for instance anyone who lives within a radius of 20 miles of Des Moines, which would be rural, they would come to Des Moines for their health care, so this group of people is not being neglected, nor are they short of facilities for health care.

I'd like to point out—Senator Hughes is well aware of this—there's been a transition as far as the migration of people out of the rural areas. The small industries are coming into the small towns that relate to either the processing of agricultural products or the development and production of equipment used on the farms. This is significant. We have been concerned about the outmigration from the rural areas, but I think it's been reversed, just as I anticipate that the outmigration of physicians out of Iowa will be reversed. As our schools become more numerous and increase in size and the doctor shortage is eliminated, I'm sure there will be better distribution of doctors.

Dr. LISTER. Could I speak just a minute to the utilization committee? I think there might be some misunderstanding. The utilization committees are required not only by the Joint Commission on Accreditation for hospitals but they are required by Federal law in the handling of any Federal programs.

The utilization committee is a committee of staff physicians who review not only admissions to hospitals, but progression through the hospitals from the acute phase into the extended care facilities into the skilled nursing homes and finally into the custodial home.

The utilization committee's function is actually to determine how long benefits under a contract are obliged. They actually have no authority to remove somebody from the hopsital. The only thing they can do is tell you when payment for these services is no longer obliged by a contracting agent.

Senator KENNEDY. That's about the same, though, isn't it?

Dr. LISTER. It works out about the same, but actually they can't remove anybody from the hospital.

Senator DOMINICK. What would you do, Dr. Lister, in the case of Miss Roby who was talking about her brother being turned out because of the utilization committee?

Dr. LISTER. There should be some other facilities in the community which could properly take care of him outside of an acute hospital bed.

Senator KENNEDY. Who should try and find it?

Dr. LISTER. I think that takes the cooperative efforts of lots of people, physicians, the social service department, hospital facilities.

Senator KENNEDY. It's been shown this morning that the burden is falling completely on these people, these families.

Dr. LISTER. I think this is a matter of education.

Senator KENNEDY. Educating who?

Dr. LISTER. The public and the profession.

Senator KENNEDY. Do they need to be educated? I mean they're out there working day and night trying to get their children, their sisters, their brothers into some kind of facility and we have had two people who have been nurses who probably understand the system as well as anyone else, and if they are having problems of doing it, I just wonder who has to be educated, whether it should be that utilization committee. They should have an additional responsibility to try and find some other facility where the person can get the kind of care that's needed. They are supposed to have the expertise. They are the ones that are studying that patient. They know the needs of that particular patient. They have the doctor's input, the nurses' input. They have seen the records. They know whether a person can go to such a place or not, and they know the various facilities which are available. Probably they know it a good deal better than a sister or mother who just knows she has a sick child.

So I'm not sure that the education shouldn't be within the utilization committee, the medical societies, the hospital administrations. It seems to me that there is a responsibility there as well.

Dr. LEINBACH. Senator, I would say that the cases this morning were very sad, but they are somewhat the exception to the rule. Now, I know physicians do look after the patients after they leave the hospital. They are vitally concerned. That's their primary function.

Senator KENNEDY. Doctor, we have had these stories come up every day, and we have a list of more people here that want to testify. One of the great problems, I think, is that many groups in our society think that these are the exceptions. I don't believe they are. I don't believe they are.

We are finding them all over this country, every community, every city and town. I think you could keep this hearing going for weeks hearing about these kinds of situations. I think we do ourselves a disservice in trying to understand the crisis by saying these are the exceptions.

I don't believe they are. I think that's rather one of the basic and fundamental differences that some of us have with the medical societies. I think that there are a lot more like this, and I think that every individual that spoke up here could give you an example of four or five different families who have had the exact same kind of situation that's happened.

Senator DOMINICK. I would like to ask a couple more questions. I don't know what percent of the population we are talking about, but these still are all individual, tragic cases.

The problem seems to be largely in the question of (*a*) you want to get the patients out of a hospital as soon as you can, both for the better utilization of beds and for the purposes of the utilization committee. In the hospital we have seen here in Des Moines, they have 90 to 95

percent occupancy which is higher than the figure they think it ought to be for proper emergency facilities.

What, if anything, has been done either through the State legislature, the medical association, or anybody else in providing more extensive care and treatment which would be absorbed at some form of public expense?

Dr. LISTER. I think we could safely say that there are very adequate extended care facilities available in the State presently. Their use, however, is hindered by ability to pay for it.

Senator DOMINICK. Yes.

Dr. LISTER. That's the problem. You can't transfer a person to an extended care facility—well, I can't say never, but almost never—unless they require some sort of physical therapy or some actual manipulative assistance. Skilled nursing homes, there is no provision in either Government or private contracts to pay for this kind of care. There has to be some changes made in the financing of health care. We all agree to this. It is just a matter of how best to do it.

Senator DOMINICK. Is it your feeling that this should be done through the regulation of the insurance programs that are being issued, through governmental action, or some other method?

Dr. LISTER. I have the feeling that the insurance industry can upgrade itself quite adequately. I think that the primary problem is in catastrophic illnesses which we have heard described today. These people are entitled to some relief. There is no question about that. I think we are obligated to see that they get it.

Senator DOMINICK. We have provisions in the proposed comprehensive health care program, for some type of Federal regulation of the insurance companies in the event this comprehensive health care program goes through, at the President's suggestion. The program also provides for health education centers in the various States, and a whole variety of things at this time which I think would be helpful. None of these provisions in my opinion hit on one of the real problems in this area, which is the long-term illness or the catastrophic illness problem.

I don't really know what we could do about that. Do you have any thoughts you could give us on that subject?

Dr. LEINBACH. I quite differ with Dr. Lister. I think the Government has to support catastrophic illnesses of a long-term nature. The private insurance industry obviously can't afford to or can't provide these services because they would have to upgrade their premium rates, which would make it rather expensive for all people. I do believe this is one area where the Government has the responsibility, with the type of cases we heard about today; and when private insurance can no longer take over the paying of these bills, then I think there has to be some other source of payment. These people are entitled to good care.

Senator DOMINICK. Do we have any estimate of costs on this? This is one of the things we have been trying to discover, and I don't know whether Senator Kennedy or Senator Hughes has been able to find out. I haven't been able to find any estimate of cost.

Dr. LISTER. Cost of extended care facilities, you mean?

Senator DOMINICK. Catastrophic and long-term illnesses.

Senator KENNEDY. Senator Long's bill provides $21/2 billion. That is what he introduced as an amendment to the social security, $21/2 billion a year.

Dr. LISTER. To set the record straight, Dr. Leinbach may disagree with me, but I don't disagree with him because I thought we said the same thing. [Laughter.]

Senator KENNEDY. I have a fundamental disagreement perhaps because I am not sure that we should have a profit motive in health care. We don't have it in education. I don't know why we should have it in health. But Senator Dominick and I will be debating that for days and weeks to come.

Senator Hughes?

Senator HUGHES. Gentlemen, I really have perhaps a statement, plus a couple of questions. I have had an opportunity, at least, to know and to work with a couple of you. I had the experience of seeing Dr. Leinbach after a tornado swept through his town wiping out half of the town and causing a power failure in his little hospital. He took over over magnificently and provided care under almost impossible circumstances.

The tragedy does hit rural communities, and the availability of these services is absolutely a necessity.

Would it surprise you, however, Dr. Lister, if I were to tell you that when I was Governor of this State, I tried to call a physician for my son-in-law in this city, and that I could not get a physician to go to his home and to see him when he was suffering some severe cramps and intestinal distress. We were afraid to move him, and I called the Polk County Medical Society for help. There was no physician they would give me for help. I was told as Governor of this State to go to the house and get him and bring him to the emergency entrance of this very hospital. No one would see him. Does that surprise you?

Dr. LISTER. I have to admit that I'm not surprised because I have heard it, but I am surprised that it happened.

Senator HUGHES. When that happens to the Governor, you know, I wonder what happens to the rest of the people. I say this even though I know how hard you men work and how dedicated you are and what our medical school is doing. I have supported what they are doing and what they are attempting to do.

So much of the medical care in this State is excellent and magnificent in quality, and yet we have so many that are totally left out. That's what we are talking about.

I might add, just to make the record equal, that last year as a U.S. Senator in the State of Virginia my second daughter was seized one night with severe pain in the abdomen. We called an ambulance. We rushed her to a hospital where we could get no medical help because we couldn't find a doctor who knew us.

The doctor whom we called on, and I called the Senate physician, couldn't make a recommendation to me. Pain was almost impossible to bear, yet they would give her absolutely nothing to relieve the pain. Seven hours later I was calling physicians in Des Moines, Iowa, trying to find out the types of pain relievers and drugs given to her during earlier illness. I finally traced down at Okoboji, the physician who had treated her in Iowa after at least 15 long-distance phone calls. I

called Dr. Bedell at the University Hospitals for help. He had been my own physician for many years. When finally medical care was found and a diagnosis was made, she had suffered from an inversion of the small intestine and gangrene had set in 3 days later.

I threatened a doctor in the hallway of that hospital and told him I'd break his neck if he didn't come in and do something about my daughter. I'm pretty upset when I find conditions like this in America.

I'm sorry these things happen, but in my own personal life they have happened to me and my family.

As far as catastrophic illness, I'd like the record to show that we have suffered that catastrophic illness with one of our daughters. It started with cancer 17 years ago and has proceeded over that long course of 17 years through two major surgical procedures last year, none of which has been covered by insurance.

Now, I am able to pay those bills and I thank God for it, but I don't know what happens to a family who is getting 10 percent of what I am getting every year in the way of a salary. It's obvious, I think, what's happening to many of them from the testimony that has been presented to this subcommittee. I know you share that concern with us and I know that your life is dedicated to trying to alleviate that pain and misery under those sets of circumstances. In conclusion I only want to express my deep appreciation for what you are doing in Iowa. I hope you will help us in any way you can to alleviate these problems in America. We all share those common goals.

Forgive my impassioned plea, but it is pretty upsetting, you know, when you suffer these things yourself, and I know you don't like it and I don't like it.

Thank you very much, Mr. Chairman.

Senator DOMINICK. Could I ask one question? Dr. Lister, I listened to Senator Hughes and I was most interested in what he said. His experience is not unique, if I may say so. It has also happened to us in a variety of different places.

What do we do about this? Is there any system that the medical societies can set up so someone can get a doctor when he needs one or is the idea of a doctor coming to a person's home when they are sick going out of fashion now because there simply isn't enough time for the doctor to make these visits?

Dr. LISTER. I think your last statement is very appropriate. People can be taken care of better in an office setting or hospital setting than they can in their home.

Senator DOMINICK. That's true technically, but the thing that most people are concerned with is their feeling that they need a doctor coming to their home and then maybe the doctor can take them to the hospital, which is fine. It is my feeling that many of the new techniques overlook the concern that the patient and family are experiencing.

I wonder if there are enough qualified people such as paramedicals which could be made available for a program of this kind.

Dr. LEINBACH. Senator Dominick, I think many of the physicians do do something like this. Whenever a person goes out in my community to another area, I tell them to obtain a family physician. He may be a surgeon or he may be a pediatrician. He may be a man in general practice.

But anyhow, if that family gets into difficulty then he can be the person that makes contact for them with their individual physicians that they should see.

Senator HUGHES. What if they can't find them, Dr. Leinbach?

Dr. LEINBACH. Well, I think most physicians would assume that responsibility of being responsible for your well-being with a great amount of concern.

Senator HUGHES. I wish I had found that to be true, you know, but I haven't.

Excuse me, Senator Dominick.

Senator DOMINICK. I was going to reiterate somewhat the same thing. Suppose you have a gal who is just about to have a baby and you go to the obstetrician. Most of the time the obstetrician has an answering service of some type, so that if he is not there someone else can respond.

But you have been dealing with one person all the way through. In this very personal relationship it strikes me that not only are we dealing with the need of a patient to have adequate health care, but we are also dealing with the need of a patient to have a doctor of his choice available. This is what concerns me with any kind of a unilateral approach. I think that with the very evident concern being shown for the multilateral approach we seem to be moving away from the single adequate health care issue.

Not that the concern over the adequate health care issue isn't there, but the fact that some kind of concern is evident.

Dr. LEINBACH. I think that is something medicine fears, because as health care become more sophisticated and more complex, there will be a loss of that physician-patient relationship that has been so important in the history of our people in America, and that is a danger that the medical profession is, I'm sure, aware of.

Senator KENNEDY. Thank you very much.

Mr. GRAHEK. We have your statement and we will put it in the record. If you'd like to make any brief comment, then we could at least get to one or two of the other witnesses.

STATEMENT OF BERNARD M. GRAHEK, PRESIDENT, IOWA HOSPITAL ASSOCIATION

Mr. GRAHEK. My name is Bernard M. Grahek. I serve as president of the Iowa Hospital Association representing 138 hospitals and related institutions and am associate administrator of Mercy Hospital in Cedar Rapids, Iowa, an institution of 305 general acute beds plus 80 extended care and nursing home beds. With me is Donald W. Dunn, executive vice president of the Iowa Hospital Association.

My hospital, similar to those you have visited here in Des Moines, has concern for all the people in our area and our community—those who are able to pay and those who are not. In addition, we are constantly concerned with upgrading the quality of health services we are able to provide. Recent efforts at our hospital have resulted in a carefully planned, developed, and operational trauma center which brings to bear as rapidly as humanly possible the necessary equipment, physicians, nurses, and other health personnel to care for people who are

in need of immediate and emergency care, e.g. accident victims, coronary insufficiencies, burn accidents, and other emergency cases. Documented results are not yet available, but our early experience makes us confident that some patients will be saved and many others will more quickly be returned to good health as a result of this important service.

We in Iowa are appreciative of your efforts, Senator Kennedy, in the areas of nurse manpower and other health professions educational assistance, specifically Senate File 1747 and Senate File 934. Also, we support strongly your work, Senator Hughes, in alcoholism and drug abuse. We commend your preserving efforts to assure funding to administer the Alcoholism Abuse Act of 1970. The member institutions of the Iowa Hospital Association share your concerns on these key issues relating to effective health care.

All of the 138 member institutions of the Iowa Hospital Association are either units of government—city, county, district or State; or are nonprofit corporations under the laws of the State of Iowa, whose only reason for existence is to serve the community need. The persons employed in Iowa hospitals are public servants and we share your concern that all people of this great country receive the benefits of comprehensive health care.

The decade of the 1960's developed the concept that health care, like education, is the right of every person. We in the hospital services enterprise agree that this country should assure access to preventive, curative, and restorative care to all. The passage of medicare, medicaid, mental health, partnership for health, and other health legislation has assisted in implementation of this goal. However, problem areas and key issues have been highlighted, made more visible, by the massive infusion of money, public interest, and public scrutiny attendant to the legislation of the 1960's. I am confident that we will see in the decade of the 1970's, the fulfillment of the promise of health care for all. The health services enterprise, as represented by our community hospitals directed by trustees representing the people being served, stands ready to serve as a partner in meeting the challenge.

Our effectiveness depends on finding the solution to three key issues: First—is health manpower. Of particular concern in Iowa is physician manpower for our rural areas. A ratio of one physician to 1,000 people is regarded as adequate to make medical care available. But when the ratio exceeds 1 to 1,500 people, availability of medical care is less than desirable, and a ratio of one to 2,000 or more makes for inadequate availability of medical care.

Although the physician ratio in Iowa statewide is one to 841 persons which appears to be favorable, it is not so in rural areas which have lost physicians to urban communities. In 1967, Iowa counties of less than 10,000 population averaged one physician to 1,529 people with several counties experiencing a ratio of one to more than 2,000. This poses a dramatic problem in sparsely populated areas with a high percentage of aged persons in need of health care.

Iowa holds a more favorable position regarding nurse manpower, due in large measure to the significant teaching programs in hospital schools of nursing. To assure continuation of adequate nurse manpower, support for Iowa's 18 hospital schools which educate 75 percent

of the registered nurses trained in Iowa, along with support for baccalaureate and associate degree programs—support such as that found in Senate bill 1747—is needed.

The second major issue is finance. The need for financing expensive health care for the aged, the poor, and near poor is apparent. Current Federal programs were built upon a system appropriate for prior decades and a different environment. Administrative pressures have caused curtailment of those programs so that many aged and poor persons, for whom the programs were designed, are now being denied (sometimes months and years after receiving care) of governmental payment for needed health service. Such curtailment, along with arbitrary change in the hospital reimbursement formula, has caused severe strain on hospital capital financing. To establish new services, such as our trauma center, adequate reimbursement to hospitals is essential. A more rational reimbursement method as proposed by the American Hospital Association, which includes prospective rate reimbursement, should be implemented immediately to assure the fiscal integrity and continuation of hospitals, but also to assure incentives for economy in the operation of these community institutions.

The third major issue involves the very system for delivering personal health services. Massive additional infusions of money without modification of the system would be similar to administration of 50 pints of blood to a patient. Veins and arteries would burst and the patient would be lost. In the folder we have provided is a copy of Ameriplan, the report of AHA's high level Perloff committee. This blueprint for a modified health care delievery system integrates a new method of financing with new organizational structure adequately regulated by national and State health commissions. It would foster development of health care corporations to provide comprehensive health services to defined population groups. Incentive to provide preventive and ambulatory care would discourage provision of expensive inpatient care when not essential to the patient's well being. The development of prepaid group practice in regional centers of rural Iowa would alleviate severe physician shortages. A single responsible agency, the Health Care Corporation, would be held responsible for fulfilling an individual's need for care. Decisionmaking and policy formation would be decentralized, assuring programs and activities responsive to the area and community needs. I share the attitude of a fellow native of Minnesota, the Honorable Donald Fraser of Minneapolis, that all problems are not solved by totally centralized administration. Ameriplan allows national standards to be set, regulation at the State level and operational decisions close to the people being served. Ameriplan addresses itself to organizational structure tied to pluralistic, decentralized financing merchanisms and would assure care for all—poor, near-poor, aged and affluent. We commend it to your consideration as solutions are sought to the vexing problems in health care delivery.

Thank you for the opportunity to speak to you on the health care crisis.

I represent the Iowa Hospital Association as the president of the 138 hospitals, Senator, and we share some of the concerns that people in the Senate share as far as health care delivery is concerned.

We feel that it is a right. We wish to cooperate with you and in every way possible to make this right a reality.

We, as members of the Iowa Hospital Association, have and do encourage your continuation of support to our nursing programs, not only the hospital programs, the baccalaureate programs of all the schools in the country.

More attention to the manpower situation is needed. You talked with the doctors a moment ago. They are needed in the rural area. We sense this as far as hospitals are concerned. Hospitals have attempted to participate with their communities in providing health care, in upgrading the health care and I feel that we will continue to create and promote partnerships such as we have been, and just for example in my prepared statement where we have in my hospital, Mercy Hospital, Cedar Rapids, Iowa, we have initiated a trauma center to provide adequate and immediate care for emergencies, and I think that this type of engagement with the Government to the Hill-Harris program is very valuable.

Also I think there is a question of financing insofar as the hospitals are concerned in health care delivery. The need for financing for the care of the aged, the poor, and the near poor is very apparent.

The current Federal programs were built on a system appropriate for prior decades in a different environment, but I think that we have to have a radical change in the health care delivery system.

I feel that this is ultimately important, but I feel there has to be a partnership with the hospitals and physicians and the Government.

I agree with you, Senator, that the consumer has an integral part in this health care delivery system and we should certainly encourage this.

Ameriplan addresses itself to organizational structure tied to pluralistic, decentralized financing mechanisms and would assure care for all—poor, near-poor, aged, and affluent.

We commend this Ameriplan for your consideration, Senators, in the future.

Senator KENNEDY. Thank you very much. We haven't had that plan submitted to us.

Mr. GRAHEK. It is now in the process of being developed.

Senator KENNEDY. But it hasn't been submitted to us yet in the Senate. We will look forward to it.

Mr. GRAHEK. You have a copy of the Ameriplan in the folder I have given you, Senators.

Senator DOMINICK. I just have two questions. I know how pressed for time we are.

One is, we heard from the hospitals last night and this morning about the computerization system which you have and which is, I presume——

Mr. GRAHEK. Shared computer.

Senator DOMINICK. Is it mostly for billing purposes?

Mr. GRAHEK. For accounting purposes.

Senator DOMINICK. Accounting purposes. What type of peer review do you have for billing costs? Such as doctors, hospital, laboratory, or drug costs?

Mr. GRAHEK. With me is Donald Dunn, executive vice president of the Iowa Hospital Association. I will let him talk to that.

STATEMENT OF DONALD W. DUNN, EXECUTIVE VICE PRESIDENT, IOWA HOSPITAL ASSOCIATION

Mr. DUNN. Review is conducted by organized medical staffs within our hospitals of the care delivery. A review of billings and costs are conducted by a third party peer and the most active in this area has been Blue Cross and Blue Shield, both for their own plans and also for their role in medicare and medicaid. That is where the review does occur.

One of the problems that we are now encountering are the cutbacks and denials that are occurring even in the Federal programs as well as in the voluntary programs that we have heard about this morning.

Senator DOMINICK. Say you have a $5,000 hospitalization insurance program under Blue Cross and one hospital charges $100 a day and another charges $40 a day. You are then going to get under comparable care, 2½ times the length of time in the $40 hospital as you do in the $100 before the insurance runs out. Is there anybody monitoring that type of expense program?

Mr. DUNN. Yes; the third party payers are monitoring the differences in charges and costs delivered by hospitals. This is a difficult and a complex review that has to take place, however, because it's comparing apples and oranges when one compares the delivery of a service in an institution like Iowa Methodist Hospital with its complex array of very technical services that a medical center provides, with half, perhaps as little as half, as much as a daily cost and daily charge which would occur in some other areas of the State where services are less complex and where personnel are not compensated as adequately as they are in the metropolitan center.

Mr. GRAHEK. Senator, for example, in my hospital we have had for the past 12 years a free clinic, called a free clinic. We don't receive any county or Federal or State funds for this clinic. It is entirely supported and staffed by our medical staff and our personnel.

The costs of this are borne by those that can afford to pay. In other words, they are put into the overall cost of the hospital.

We also participate in an education program. There's two hospitals in Cedar Rapids, Iowa, and we have a joint internship program which is now going into a family practice program and these costs have to be borne, but we feel that they are necessary.

We talked about the doctor shortage. We feel that the larger hospitals in the State have to attempt to participate in this education program to support the rural areas if we can, and keep the doctors in Iowa.

We also just recently had begun participating in the drug abuse clinic. Our hospital has given the crisis center of Cedar Rapids, with the mental health center sponsorship, some space so these costs have to be a part of it.

Mr. DUNN. I would like to add just one other thing to point out our awareness——

Senator KENNEDY. Quickly if you might.

Mr. DUNN. Yes. Our awareness and our concern and our desire to make things happen at the State level. The Iowa Hospital Associa-

tion is strongly supporting the Senate file 239 which would authorize the creation of nonprofit corporations to deliver comprehensive prepaid group health services, and so we are working in those directions to change that system and assure adequate financing.

Thank you.

Senator KENNEDY. Thank you very much. I appreciate your willingness to summarize. You are kind, and perhaps we will have some additional questions we can file with you later on.

We are running out of time. We will just be able to take a couple witnesses from the list of people here, but I'd like to at least take some.

Mr. Robert Mettler, if he is here. He was here earlier.

Come right up here and just take a couple of minutes. Then I will ask Robert Oberbillig to make just a brief comment.

I know it is difficult, but do the best you can.

STATEMENT OF ROBERT METTLER, DES MOINES, IOWA

Mr. METTLER. I live in Des Moines, Iowa. We were real fortunate. We had what is called a catastrophic illness, I guess you'd call it.

My wife had chronic failure of the kidneys. There was no place in the State of Iowa to take care of this, and to this date yet there is none.

We were real fortunate to get in at Mayo and they performed a kidney transplant a year ago yesterday. She is getting along beautiful and she is waiting for Blue Cross-Blue Shield to pick up with the additional expenses, and it's been rough, but God willing we can make it fine.

Senator KENNEDY. How much of the expenses have you had to pay yourself?

Mr. METTLER. I have no idea. We just pay them as they come.

Senator KENNEDY. How much about? Are you talking about a couple hundred dollars, a thousand dollars?

Mr. METTLER. We are talking about a thousand. Start there.

Senator KENNEDY. That you have to pay of your own money?

Mr. METTLER. Right.

Senator KENNEDY. Do you work now?

Mr. METTLER. Oh, you bet.

Senator KENNEDY. Are you covered by any insurance?

Mr. METTLER. Yes, Blue Cross-Blue Shield, major medical.

Senator KENNEDY. In spite of that you will have to pay a thousand? You tell me approximately.

Mr. METTLER. Well, now, I don't know, Senator.

Senator KENNEDY. How much do you think you have paid out so far?

Mr. METTLER. Oh, a couple, $3,000, $4,000 out of my own pocket and we don't know what the balance is yet because they have still not completely released her. She's getting along beautifully, no problems at all, but she's waiting for Blue Cross and Blue Shield and Mayo to get together to find out how much is left to be decided to be paid for, and I understand that we will have a percentage of that that we will have to come up with at the end.

Senator KENNEDY. Where do you work?

Mr. METTLER. I am service manager at Conway Buick here in Des Moines.

We were real fortunate.

Senator KENNEDY. We hope your wife is well. Thanks very much.

Robert Oberbillig.

STATEMENT OF ROBERT C. OBERBILLIG, DIRECTOR OF THE LEGAL AID SOCIETY, DES MOINES, IOWA

Mr. OBERBILLIG. I am Bob Oberbillig, director of the Legal Aid Society.

Senator KENNEDY. Pardon my mispronunciation. If your name were O'Hara or Shaughnessy, I wouldn't have any trouble. [Laughter.]

Mr. OBERBILLIG. Our office represented the Porter Dimery family. We are continuing to represent them. We have also represented and continue to represent the Clifford Thomas family.

There are legal issues that are involved that are denying these families legal assistance in the State. But contrary to what the doctors have said today, it isn't 96 percent of the people that have available to them medical facilities. The State of Iowa as a result of the *Dimery* case, which incidentally on a technicality was reversed, that would have granted medical assistance to every person in need in the State.

The State in their briefs and in our public statements found there were 350,000 Iowans who had medical needs that did not have the money to provide for them and would be eligible, but for the limited eligibility standards which Iowa follows in providing medicare relief. That's in addition to the 75,000 who are eligible because they relate categorically.

In several of the material areas of our welfare laws which help to determine the eligibility of these programs, we have in Iowa some of the most restrictive eligibility standards such as in the aid to disabled. To qualify you must be helpless, but you must have the assistance of another person in your daily life, not on the basis of employability, but literal helplessness, before you can qualify and there are hundreds of people turned away each year who meet all of the tests of disability on a permanent basis but cannot get medical assistance because they don't qualify on the helplessness theory.

We can go on in the absent parent situation which is what was in existence with the Dimery family. I might say in working with this family for the last 3 years, if it wasn't such a strong family this family would have disintegrated. Porter Dimery would have, under normal circumstances, left the family and their family would have qualified for ADC and then qualified for medical services.

Nobody knows what that family, just one family, went through, to give up, so that the son could get medical services and the parents could relate to him.

The fact is that all the children in that family have sacrificed so that this boy could still be a family member.

The availability of Iowa City may only be a couple hours drive and maybe only an ambulance away, but much of the healing process is having to support a family, and when a child has to be removed

or a parent removed from the family and treated as an inpatient at Iowa City, the process is slowed down and the cost is increased.

What I would like to say though is that I think it is time in the United States and in Iowa—where in Iowa last year we spent $31 million for medical services, we're only one-sixth of the people who are literally eligible. It is time we found different ways of providing this service.

I happen to believe in legal services, and if this can be a similar test, in the city of New York alone legal aid has provided in the crime and civil field to the extent of three-quarters of a million dollars. The city has done some extensive survey work to determine that they have to go to an asisgned council basis. In other words, hiring a lawyer on a per case basis. They found that the probable cost to do that would probably be $29 million. We are still in Iowa providing medical services on that basis. We have not found ways of hiring doctors on a per case basis, but literally hiring them on a salary basis and providing for those that need it and need it on a 24-hour basis.

We have 15 lawyers in the city in legal services on an OEO grant. We served more than 10,000 people last year both by telephone and in the offices and in our courts. We cut costs considerably to provide that type of service. We think that that would be a reasonable way to provide medical services.

We know that the medical students that are coming out of Iowa and other medical schools are no different than the law students. We have a steady stream of young men high in their class coming to our offices willing to work for $10,000 or $12,000 a year to provide services for the poor and the needy.

I'm quite certain that those students are no different coming out of the medical schools as doctors, that they are willing to provide these services if we would provide it.

Now, the Government has found ways of requiring communities such as Des Moines and any other State that has large areas to contract with legal aid societies to provide legal services and to other rural areas on a per diem basis. Why not have the same type of requirement in the medical service?

Senator KENNEDY. Is there a need there though? Is there really a need?

Mr. OBERBILLIG. There is no question there's a need. They may only be 20 minutes from a hospital, but there are people within walking distance from a hospital in the city who cannot qualify for medical services. There are people who live next door to doctors who cannot get it because they don't have the money.

We can also look from another consumer standpoint. The most harassing type of collection practice is those institutions who buy up the medical bills that are unpaid and then go after the debtor who cannot pay them.

In our experience in bankruptcy we find this to be an on-going cause of many bankruptcies.

No, I think medical services and medical expense in proportion to what the State already is paying is well out of proportion. I might also point out that less than 7 percent of our State budget goes for welfare programs in their entirety, and this State has not found the way or ability to meet what they already recognize as a medical need.

Senator KENNEDY. Thank you very much. If you would like to give us an additional note on this area I think it would be helpful. I think we could make it a part of the record if you would like to do that.

Mr. OBERBILLIG. I'd be very happy to.

Senator KENNEDY. We are well over our time. We will take Pat Machio and then we will conclude.

STATEMENT OF PAT MACHIO, LAW STUDENT, DES MOINES, IOWA

Mr. MACHIO. It is my contention that the University of Iowa Medical School is not, in fact, making an effort in good faith to increase enrollment or to do anything to solve the problem of doctor shortage, and in fact, on the contrary, they are intentionally seeking to limit their enrollment.

Senator KENNEDY. Just a minute. They talked about an increase in enrollment of about 40 percent.

Mr. MACHIO. Senator Kennedy, you yourself pointed out in the chart up there, and that has to be mistaken.

Senator KENNEDY. But as I understand, a heavy percentage have been leaving Iowa.

Mr. MACHIO. That's true. They are. But like I said——

Senator KENNEDY. Are you a student up there?

Mr. MACHIO. No; I'm a law student. The figures do not jibe with the chart.

Senator KENNEDY. They could to the extent they have increased their enrollment in the last few years, that a great percentage or the majority that have graduated from the school are going to other States and therefore not going here, so it would be consistent really with the chart.

Mr. MACHIO. It isn't if you calculate the difference offset by the percentage. It doesn't mean they are increasing their enrollment. He gave the figure of 175 students in medical school in 1975, and that certainly isn't staggering.

My basic question is this: Is there Federal medical assistance available to medical schools for education of doctors, and, if so, have they applied for it at various medical schools and what type exists?

Senator KENNEDY. Well, there is, but we don't do nearly enough. We've got several hundred million dollars, about $400 million, of unfunded applications which have been approved at the present time. We have inadequate funding in the budget for health. I think they are also inadequate in terms of direct scholarship grants to students. We are trying to increase the contributions to medical schools. My bill, S. 934, incorporates recommendations of the Carnegie Commission. We've had some hearings, three or four hearings, on this already.

Mr. MACHIO. As chairman haven't you seen some evidence, however meager that it might be, that a lot of medical schools are laying out plans more or less pursuant to the law of supply and demand, that they don't want to get too many doctors into society because then there would be too much of a fuss raised or——

Senator KENNEDY. I think it is a fair criticism to make in terms of the medical societies 20 or 30 years ago. I'm not so sure it is fair at the present time. I think there's been a rather significant increase in enrollment, and quite frankly, the medical schools are in financial crisis. Over half of them, 120-odd medical schools, have applied for emergency grants just to keep their doors open. I think there's a much greater recognition of the need for more doctors by the medical schools today than there was maybe 20 or 25 years ago. I think the schools are under enormous handicaps in trying to provide training.

Mr. MACHIO. Senator, you can throw out all these handicaps and there are at least 15 reasons why these medical schools can't increase their enrollments, but the one other underlying reason is that they don't want to get too many doctors on the market.

Thank you, sir.

Senator KENNEDY. Thanks very much.

There are other witnesses, but we are going to have to recess this hearing, and we will ask any of the others if they'd like to write down their name and file either a statement up here now or send it in to us later. We will make it a part of the record. If the hospitals or others have been mentioned here or there has been representation made about them which they feel deserves clarification, we will include that as part of the record so that we have as complete a record as possible.

I want to thank all of you for your attentiveness and your interest in this. This hearing has been of enormous value to us. You have been extremely kind and patient. We want to thank all of you for coming this morning. We hope it's been of some interest to you. I want to thank you all.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

(The material referred to follows:)

PREPARED STATEMENT OF RALPH GLENN, DUBUQUE, IOWA

My name is Ralph Glenn. I am from Dubuque, Iowa. I have an interesting case that I would like some advice on if posisble.

This young man is 17 years old. He's not eligible then for social security. He is not a veteran, therefore he cannot go to a Veterans Administration.

His bill was $12,000 for the first three months. He is a quad-paraplegic. His right leg is off at the hip. The left leg and two arms are totally paralyzed.

He is right now in—he went to Iowa State University Hospitals. He's been released from there. He is now in the Younkers Rehabilitation Center.

My problem as executive director of the Tri-State Health Planning Council, a 314(b) Grant organization, comprehensive health planning, is this: Is it possible for me or my organization to request to have this boy put into a Veterans Administration Hospital? He needs it and I'd like to have some advice on that.

Thank you.

PREPARED STATEMENT OF SIDNEY GROSS, PRESIDENT, NATIONAL FARMERS UNION, AN IOWA FARM ORGANIZATION

Senator Kennedy, Senator Hughes, and other distinguished members of the Committee -

Speaking in behalf of the members of Iowa Farmers Union, an Iowa Farm organization, I am pleased to have the opportunity to bring before this Committee what we feel is a case that points up rather well discrimination in the application of health and hospital insurance care in Iowa today.

After being elected president of Iowa Farmers Union in December of 1966, I found car insurance by mail and hail insurance, both through our National organization, was the total insurance services offered by our organization. No health care service was being offered.

Since Blue Cross-Blue Shield does not require licensed agents, in the winter of 1967-68 I contacted, by telephone, Blue Cross-Blue Shield officials in Des Moines as to the availability of a contract with them for health care for our members. Two men from the state Blue Cross-Blue Shield office came out and after visiting for a time asked for the membership list in several counties to take back and check to see how many were already enrolled in an existing Blue Cross-Blue Shield plan.

I was later contacted and informed that, since quite a large number were already enrolled in other groups, Blue Cross-Blue Shield could not see where it would be to the advantage of either of us to proceed further. Being new and naive at this sort of thing I accepted it as a plausible reason. There the matter rested until January of 1970.

Suddenly full page newspaper ads such as these (show) appeared all over the state announcing a statewide "hook up" between Blue Cross-Blue Shield and the Iowa Farm Bureau. Look at those advertisements carefully. Then I would raise the question who paid for them, who is the chief beneficiary and what do they implant in the mind of the average person?

Immediately our state office was bombarded by members asking if we, too, were going to get health care for our members.

Since I could not correlate the fact any more farmers in Iowa Farmers Union would already be signed in existing Blue Cross-Blue Shield contracts than any other cross section of farmers, I immediately called the Des Moines Blue Cross-Blue Shield office protesting the apparent discrimination in providing health care for Farm Bureau members after turning us down two years before.

After several weeks delay, because of other commitments by Blue Cross-Blue Shield officials, a discussion meeting was arranged. At this meeting it was mutually agreed to re-open negotiations regarding a health care plan for Iowa Farmers Union members via Blue Cross-Blue Shield.

In this interim period and while open enrollment was available, we had several inquiries, of which one from a lady in Carlisle, is typical. Her husband, when living, had been a member of Iowa Farmers Union, disagreeing quite strongly with Farm Bureau philosophy. Although she wanted to remain loyal to her husband's memories, she felt she needed health insurance coverage and should take advantage of this open enrollment period unless we, too, would have similar health care available soon. I assured her that we were negotiating and that we hoped to have a like health care plan to offer in the near future but if she wanted to be on the safe side she should take advantage of the opportunity and enroll, which she did. She still laments, to this day, the fact she was forced to join an organization against her will just to get health care.

In May of 1970 a Blue Cross-Blue Shield policy was offered the officials of Iowa Farmers Union for study. The plan (Plan I) was identical

with the Farm Bureau plan except for slightly better provisions regarding prescription drugs and an added $300.00 supplemental accident coverage. However, the family premium rate was upped from $30.00 a month in the Farm Bureau plan, to $39.80 - a difference of almost $120.00 per year.

We protested that the added coverage was not commensurate with the increased costs. Their answer was to bring us Plan II. Plan II contained full coverage Blue Cross-Blue Shield with added Major Medical, exactly like the Farm Bureau policy except that all accident and drug provisions were deleted. Yet the family rate was set at $35.75 per month compared to $30.00 under the Farm Bureau plan, or a difference of $69 per year, even with the lessened coverage.

After due consideration the Executive Board of Iowa Farmers Union decided that this was not really offering a service and that it was stretching loyalty beyond the human breaking point to ask a family in our organization to pay from $70.00 to $120.00 a year more for the same health insurance as their neighbor across the road just to remain loyal to the beliefs of the organization.

We, therefore, termination negotiations with Blue Cross-Blue Shield.

Many of our members still do not have health insurance.

One young family recently experienced a heavy financial drain through an illness of one of the children. They badly need health care insurance at a reasonable rate.

Another result of the Farm Bureau - Blue Cross-Blue Shield hookup is that in many counties of Iowa any contact for Blue Cross-Blue Shield health care insurance must be made through the County Farm Bureau Office. The address and office for both are one and the same.

Senators, this had been a most revealing experience, from the advertising through the rate setting, and where this built-in interlock is leading. We believe this is a vivid demonstration of one of the weaknesses in present health care. That it points up the very real need for a National Health Care Program so that Joe Dokes who lives on one side of the road is not treated differently than John Doe on the other side. So that equality in health care is available to all regardless of organization membership or philosphical direction.

We believe it is time Congress puts a stop to the discrimination and conniving taking place today, at the expense of the health care of the people.

We trust this testimony will be of value in determining legislative direction and we thank you for the opportunity to appear here today.

REPORT ON COST AND PROBLEMS OF HEALTH AND WELFARE

I, William F. Fenton, have been Chairman of Local 254, International Association of Machinists and Aerospace Workers' Health and Welfare Trustees since 1958.

When we started the plan in 1958, the cost was $10.40 per month, which is approximately .06 cents per hour. This was for a basic plan, which at that time was for most of the cost of the health care.

In 1960, the cost of the same plan went to $11.51 per month. In 1961, the cost was $13.57 per month. In 1964 the cost rose to $17.90 per month. In 1967, due to the rise in hospital cost, the program was not adequate and we added Major Medical, which made the cost $30.03 per month.

In 1968, the Insurance Carrier asked for an increase in premium, and we put the program up for bids from Insurance Companies. A new Carrier was selected and the cost remained at $30.03 per month.

In 1969 we were told that there would be an increase of $4.32 per month, unless we would agree to delete the Coordination of Benefits from the policy. This was done and then the cost remained at $30.03 for one year.

We were notified then, by the Carrier, that there would be a premium increase to $39.08 for the same coverage. This now increases the cost for insurance from .06 cents per hour in 1958, to .23 cents per hour in 1971.

We asked the Insurance Companies at this time, to give us a three year guaranteed premium rate which they submitted, showing a $5.23 per month increase, effective 1972, and an additional $6.46 per month increase in 1973, which then made our cost go, for an identical program, from $30.03 in 1970, to $50.76 in 1973, or a 66 2/3 % increase in insurance cost in a three year period.

We were told by the Insurance Companies that the increase would be necessary because Medical Care Costs were rising at the rate of 1½% per month, or 18% per year. This is not a true figure because the 18% each year is compounded on the previous premium rate, which as shown above reflects a 66 2/3% increase rather than a 54% increase.

The insurance program that I have made reference to above, does not pay the full cost of medical care, which leaves the employee then to spend additional monies making his cost for health and welfare insurance in some cases, far in excess of the .23 cents per hour.

Although our plan is better than most plans that I have studied, it still leaves a great loop-hole that should be covered by a Federally supplemented policy. I will refer to one case in particular which resulted in a Kidney Transplant, and although our policy has paid over $30,000., the insured still has a bill in excess of $7,000. Also, in the same case, the Donor was going to be refused, and in most cases would be, any coverage under his Health and Welfare Program because the Insurance Companies were claiming that donating a Kidney is elective surgery and would not be covered.

We have one insurance program which pays the full cost of medical care, however the cost of this program is $61.00 per month which reflects a cost of .35 cents per hour.

We have found that a minimum program that people should be covered by, would at least cost .20 cents per hour and when you reflect this according to the Minimum Wage Law, which provides $1.60 per hour, this then makes an employee pay 12½% of his wages for an insurance program, which most people can not afford; therefore, they do not get Health coverage.

Another problem which adds to the cost of an employee's insurance is that most employers do not pay the full cost of the program and the employee's share is deducted from his pay check, which then makes him pay income tax on this money which then adds another 18% to 30% cost for his insurance.

We have also found that when employees pay part of the premium, if the insurance company pays a retention to the policy holder, very seldom is any of this retention monies distributed back to the employees.

We have also found one large corporation which is doing business in the State of Iowa, that told the employees there would be an increase in their insurance program cost. We then asked this Company for a copy of their D-2 Health and Welfare Disclosure Act Report Form. In checking this form we then found out a $171,000. premium that was paid and then checking the amount of claims paid, there was $33,000. that was not accounted for on the D-2. We asked the Company where this money was and have been refused an answer to this date. Therefore, I think a closer review should be made of all D-2 forms to make sure all information

is submitted as required by law.

I also do not believe that Insurance Companies are interested in keeping the cost of a Health and Welfare Program at a minimum, or do they care about the cost of Medical Care, because they operate on a percentage of the total premium, which I have had Insurance Companies admit to me, is from 13% to 27% of the total premium. This then, taking the situation as mentioned earlier, when we go from a $10.40 per month premium, to a $50.76 monthly premium that the Insurance Company then on the same amount of people, which would reflect approximately the same amount of book work and cases makes this Insurance Company make five times as much money for handling the same group of people.

We have had to supply each hospital in the City of Des Moines with a copy of our Insurance Program. The hospitals claim they need this for billing purposes. I cannot see where the connection should be between a patient's coverage under his insurance program and the amount of his bill. Health care should be based on need rather than money. In the current outmoded organization and distribution of services, delivery and treatment are too often determined by the individual's income--or lack of it--and by the fine print in his health insurance policy. Too often, money determines, both in quality and quantity, the patient's treatment.

Respectfully submitted,

William F. Fenton

WFF:ip
opeiu #37 afl-cio

William F. Fenton
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SCHOOL NURSE -- "CHILD ADVOCATE"

The well and happy family is the basis of a stable and wholesome society as well as a key to individual happiness. Education is concerned not only with familial hygiene but also with the economic, social, cultural, and spiritual phases of family life. Youth should develop consideration for other persons, a realization of the importance of conforming to the mores and ideals of his society, and knowledge of how family life and parental obligation can be met in such a way as to bring satisfaction and achievement to both parents and children. Growth and developmental changes occur continuously. An individual is developing feelings about himself and others and as a member of a group, he must learn to understand, accept, and deal adequately with the changes which are occuring within him. A child receives his education today from many sources and at an early age. Television, radio, motion pictures, magazines, and newspapers bombard the child constantly with ideas not always based on scientific fact. The school, in part, has the responsibility to help children to cope with the world around them. It is necessary, therefore, that a strong, continuous health education program be developed to aid in the assimilation of all that it takes to have a healthy, happy, satisfying life. The program would include all school age children. The combined efforts of the home and school are required in order to provide children and youth with scientific information, sound attitudes, and desirable health practices.

The profession of school nursing is a dynamic discipline which embraces a variety of functions. Because of her medical knowledge, academic preparation, and professional skill, the school nurse has the qualifications to:

1. Assess and evaluate the health and developmental status of the pupil in order to make a nursing diagnosis and establish priority for action.
2. Interpret the health and developmental status of the pupil to him, his parents, and school personnel.
3. Interpret the results of medical findings concerning the pupil to him, his parents, and school personnel.
4. Counsel the pupil, his parents, and school personnel and plan action for eliminating, minimizing, or accepting the health problems that interfere with pupils' effective learning.
5. Motivate and guide the persons responsible for pupils' health to appropriate resources.
6. Recommend to the administrator modifications in the educational program when indicated by the health or developmental status of the pupil.
7. Serve as a health consultant and resource person in the health instruction curriculum by providing current scientific information from related fields.
8. Use direct health services as a vehicle for health counseling.
9. Serve as liaison among the parent, school, and community in health matters.
10. Be a member of the placement committee for special educational programs.

The quality and quantity of learning of each student is in direct proportion to the physical, mental, emotional, and social levels of health. The primary function of the professional school nurse is to strengthen the educational process through improvement of the health status of children, youth, families, and the community. Optimum school nursing services will assure each student the opportunity to realize his maximum health potential. The emphasis, therefore, in school nursing and health education is on prevention of health problems.

Schools reach the whole population. It is recognized that school nurses, due to their direct relationship with individual children, families, and the community, have the opportunity to impart to this blooming society the knowledge of independent health care. Formal and informal health teaching would be utilized to accomplish the goal of independent health care. The reason that health teaching can be successful in this area is that youth is the time of habit formation. By repetition and reinforcement of what constitutes good health care, desirable practices can be established and maintained. Educating the child involves transferring to him the responsibility

for health behavior and equipping him with such attitudes and knowledge as will ensure healthful living now, in later childhood, and in adult life. Children must make adaptations in the transition to the adult life, therefore, reliable, factual information based on scientific knowledge, is essential for a continuation of healthful living. Instruction in health commands the interest of the child, stimulating the enjoyment of positive health rather than concern for disease. A comprehensive program in health education should be designed to provide students with the ability to live a healthy, happy, satisfying life. Modern health education is necessary because to date it is clearly shown that present health practices are poor, our attitudes toward disease have prompted us to act as though the responsibility for our health were our physician's instead of our own, and a lack of basic health information exists among the general population.

Areas for consideration in a health education program could be:

A. Personal hygiene
   1. Privacy
   2. Cleanliness
   3. Nutrition
   4. Grooming
   5. Exercise
   6. Rest and relaxation

B. Anatomy and physiology
   1. Skeletal structure
   2. Body systems
   3. Physical growth and development

C. Heredity and genetics

D. Tobacco, alcohol, and drugs

E. Safety

F. Family unit
   1. Members-needs
   2. Privacy
   3. New members
   4. Death
   5. Grandparents, aunts, uncles, siblings, etc.
   6. Internal pressures-external pressures
      a. divorce
      b. marriage
      c. moving
      d. loss of a member of household
   7. Child roles
   8. Adult roles

G. Community agencies
   1. Social
   2. Voluntary
   3. Church
   4. Public

(9)

H. Interpersonal relationship
   1. Cooperation
   2. Sharing
   3. Decision making
   4. Respect for others
   5. Responsibilities
   6. Understanding handicaps
I. Emotions
   1. Behavior
   2. Decision making
J. Leisure time
   1. Enjoyment of life
   2. Recreation
K. Environment
   1. Ecological problems
   2. Cultural differences
L. Ethical standards
M. Communicable diseases
   1. Disease process
   2. Controls
N. Consumer education

The teaching of health is adapted to the maturity and grade level of the students. His role in society as he grows and develops should be considered.

Society cannot function properly and adequately without good health. The lack of facilities for optimum health care emphasized the need to utilize preventative health measures. The school nurse serves as a liaison between the children, family and available community resources, Knowledge of where to go for health care in time of need is possessed by the school nurse and can be imparted to children and their families with hopeful carry-over for independence in our future.

School nurses propose a method to contain the rising cost of medical care and reduce the present over load on physicians, hospitals, and other health oriented agencies. This method being the utilization of the school nurse practitioner. Special education is now available in three centers in our nation for this purpose; The University of Colorado, Denver, Colorado, St. Louis, Missouri, and the Bunker Hill Program in Massachusetts. More states are moving into this type of program. The emphasis is on delivery of direct services to the child and his family. The preparation of the school nurse practitioner would allow her to perform a physical examination which would include the skills of observation, palpitation, auscultation, and percussion. She would also be able to evaluate simple laboratory prodedures, namely: a complete blood count and urinalysis. School nurses realize the critical shortage of personnel in health professions. One of the objectives of any national health care plan should be to utilize more effectively the existing supply of health manpower. Use of the school nurse practitioner's unique skills will: 1. Greatly reduce the number of children who never receive an assessment of their health status; 2. Increase the number of children who will benefit from adequate management and remediation of their health problems.

In summary we want to stress certain aspects of the preceding. The promotion of healthful living and prevention of disease and injury by the school nurse, educators, and the total school health program, should play a very important role in elimination of escalating medical costs and in development of ambulatory health care services. Health teaching is a privilege and an opportunity as well as a responsibility in the field of education. The school nurse is vital in establishment, maintenance, and reassessment of the health status of children, families, and the community. We can only hope as society looks to the future, that some day every human being will be well, intelligent, physically vigorous, mentally alert, emotionally stable, socially reasonable, and ethically sound.

School nurses

Mrs. Ann Short R.N.
1923 37th
Des Moines, Iowa
50310

Mrs. Susan Amosson R.N.
3433 Hillcrest Dr.
Des Moines, Iowa

Mrs. Lorrine Glazebrock R.N.
8168 Northwest Dr.
Des Moines, Iowa
50322

Mrs. Ruby Wheatly R.N.; B.S.
301 E. Third
Ankeny, Iowa

Senator KENNEDY. The subcommittee will stand in recess.
(At 12:20 the hearing was recessed subject to the call of the Chair.)

HEALTH CARE CRISIS IN AMERICA, 1971

FRIDAY, MAY 14, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Denver, Colo.

The subcommittee met at 1:45 p.m. in lecture room No. 2, Denver Medical Center, Denver, Colo., Senator Edward M. Kennedy (chairman of the subcommittee), presiding.

Present: Senators Kennedy and Dominick.

Committee staff members present: LeRoy G. Goldman, professional staff member to the subcommittee; Jay B. Cutler, minority counsel to the subcommittee.

Senator KENNEDY. I want to express a very warm sense of appreciation to the Colorado Medical School and the deans and the faculty for the cooperation and the hospitality that they have extended in permitting us to have this meeting here this afternoon. They have been extremely kind and generous with their time and cooperation, and I want to acknowledge that at the outset.

Our hearing today is really a continuing part of our effort to learn about the condition of health care in America. We began these hearings some 9 weeks ago in Washington, with a series of meetings where we heard the experts, the representatives of the various interest groups, testify before us.

Then, the subcommittee began a series of field hearings. First, we went into New York City to consider the urban health crisis. After New York City, we traveled to Westchester and Nassau Counties, where a more affluent group of people live, to study the health care issue in the suburbs, especially the quality of care issue.

Then we traveled to West Virginia, which is the second most rural area in the country. From there, we went to Nashville, Tenn., which has one of the great medical centers in the country. Then our subcommittee visited Cleveland and Chicago to see the health problems of urban areas in the midwestern part of the country.

Yesterday we visited Des Moines, Iowa, a city of 250,000 to 300,000 people. We had an interesting opportunity to visit with the heads of many of the private insurance companies, and in the later part of the afternoon we went out into rural Iowa.

Today, we are here in Denver, and we will continue our hearings in the early part of next week in California.

We are particularly delighted to come to Colorado with Senator Dominick, who is the ranking member of the Senate Health Commit-

tee and who, of course, has been greatly interested in the health issue.

Although I have had a chance to visit this great State on many different occasions in the past, I have never had the opportunity to visit as many of its medical centers or the health delivery centers as I have had during the period of the last 18 hours.

In that time, we visited a number of the major hospitals of Denver. We have seen the microeye surgery unit at Mercy Hospital and the computer EKG center at St. Luke's. We have seen the impressive facilities at Denver General Hospital, which is clearly one of the best municipal hospitals in the United States. This morning we visited the Craig Rehabilitation Center, one of the most important rehabilitation centers for spinal injuries, which is enormously impressive.

We also visited the East Side and the West Side Neighborhood Health Centers which are trying to reach out to the community to provide comprehensive health care for lower income families and poor communities. Later this afternoon, we will visit the Park Hill Health Station, which I understand is another important link in the community health network of Denver.

In other portions of our visit, we have heard many of the innovative achievements of medical foundations in Colorado. We have also had an opportunity to talk with some of the deans and students of the medical school at lunch this noontime.

From what we have seen here today in Denver, we can't help but be impressed. We recognize that we do have a health crisis in this country, but it's a good deal less apparent in Denver than it is in many other communities. The crisis is severe in some of the poorer parts of the city of Denver, and I understand that it is also serious in rural Colorado which, unfortunately, we won't be able to visit at this time. But I want to say that we have seen much that is good about the health system in Denver, and that we are indeed appreciative of all of the help and assistance that we have had.

In our hearings this afternoon, we will have testimony from the consumers of health care. We want to listen to their stories, hear how they have been treated by the health establishment, and hear their observations and comments. Then in the time that we have available before concluding the session, we will try to open up the meeting for comments that consumers and others in the audience would like to make. Let me request anyone who would like to make a comment to submit his name now, and we will take them in the order in which the names are presented.

Now, perhaps Senator Dominick would like to make a comment.

Senator DOMINICK. I want to welcome Senator Kennedy to Colorado, to start with. He has instituted a series of hearings which will be of really quite a good deal of value in our determination of what we are eventually going to come up with by way of legislation.

We have, just for the record, all kinds of different pieces of health legislation in Congress. Senator Kennedy's bill, for example, which he's very much in favor of, is not before our committee. It's before the Finance Committee.

The bill that I put in to try and help the Metro Denver Medical Foundation, to be able to provide coverage for civil servants if they

want to, is not before our committee. It's before the Post Office and Civil Service Committee. But we do have before our committee, I think, the responsibility, for building a record, which I think we have done very well, on the problems of the distribution of health care, and the problems of some of the consumers. A radical change both in attitude and in ideas has gone on among health providers throughout this country, and I think this is really a tribute to them. An enormous number of improvements are being made, an enormous number of different types of ideas and methods of distribution of health care are being developed, and all of these will be in the record.

I think whatever bill we eventually come up with will have a good deal of very solid evidence behind it.

Now, one of the things that we have been working on is to try and figure out what we do about bringing medical care to the low-income districts, both rural and intercity. What do we do about making the administration of hospitals more efficient? How do we lower costs to consumers? We have heard testimony on a whole variety of issues of this nature all over the country, and I for one am very happy that we started this series of field hearings. Hopefully, from these we are going to get something of value, not only for Colorado, but for the whole country.

Senator KENNEDY. There has been, as I understand it, a lot of preparation for our visit that I didn't know about. I have a memoranda here prepared by the Colorado Hospital Association to advise the medical societies and other health providers in the area about the subcommittee, and I will just read one paragraph:

> "Representatives from the Colorado Medical Society, Denver Medical Society, surrounding counties' medical societies, dental societies, and myself representing the A.H.A. and C.H.A., were present at the briefing session held on April 30, 1971, at the Colorado Medical Society. In addition, the AMA had three staff people, a gentleman from Chicago who has been traveling throughout the country attending the hearings and taping them, and two AMA field representatives, one from Columbus and one from Denver. The field representatives have been covering the hearings in their own regions and the ones in the region directly to the east. So there is great continuity among AMA staff people."

So, if the doctors are wondering why their AMA dues have been rising, it's because they have a lot of staff going around the country following us.

A rather interesting memorandum. We are glad to read about it.

Now, we shall hear from the consumer witnesses. We are very appreciative of those who come to comment here. It's not a part of our tradition in this country to draw public attention to one's ills or difficulties or pain or suffering or unfortunate family experiences. Usually, people are very reluctant to talk about their problems, and we are very appreciative of the fact that so many individuals have been kind enough to share their experiences with the subcommittee. Only in this way will we really be able to respond with effective health legislation.

Our first witnesses are Mr. and Mrs. Gary Breeze.

STATEMENT OF MR. AND MRS. GARY BREEZE, RESIDENT, DENVER, COLO.

Mrs. GARY BREEZE. Senator Kennedy, Senator Dominick. Gary's accident took place approximately 2 years ago, in July of 1969. He was driving home from work, and there was an automobile accident. He suffered a fractured vertebra, C6–C7, a spinal cord injury, and multitudinous internal injuries.

He was taken immediately to Lutheran Hospital. He was in intensive care 12 days there. We were told initially that he would probably be in intensive care for at least a month, but because of an infection, he was taken out, and put in a private room. He was on a special frame and these things, of course, necessitated a private room.

He was in Lutheran Hospital for 3 months because of the internal injuries, and then he was at Craig Rehabilitation Center for 3 more months. He was a regular outpatient for approximately 2 months and has been an outpatient periodically since then.

Our bill at Lutheran Hospital was something like $12,000.

Now, Gary was in a rather unique position. He had been president of a bank prior to the accident, and he had the job of voting on a particular type of health insurance that he wanted for the bank personnel. The staff was relatively young, and, of course, we looked at it from that viewpoint. So, consequently, he looked at health insurance as maternity insurance for a wife or as insurance for Johnny's broken arm or a skiing accident or something of this sort. We had no precedent as far as something like Gary's accident was concerned.

We voted on what the bank could afford and what we knew. Our insurance covered a 3-month stay in a hospital and then you're out for 3 months before it will cover any more in-hospital costs as such. So it did cover the entire cost at Lutheran and about 2 weeks at Craig.

The costs at Craig Hospital, we were told the day before we entered, would be $3,000 a month. The doctor would be $350 a month; prostheses, which would mean braces, wheelchairs, tilt boards, and things necessitating skin care, would be $5,000, so these things, of course, we have had to pay.

Outpatient care is not considered as a part of the cost. We are still, of course, seeing doctors. We have therapists working with us at all times. These are, of course, you know, on our own. I think that's——

Senator KENNEDY. Now, do I understand that, during the time that Mr. Breeze was at Lutheran Hospital, Blue Cross covered his expenses?

Mrs. BREEZE. Yes; we paid something like $875. The insurance covered all but that.

Senator KENNEDY. For how long a period?

Mrs. BREEZE. Three months.

Senator KENNEDY. And then you went to——

Mrs. BREEZE. Craig Rehabilitation Center.

Senator KENNEDY. And you had to make a deposit there, did you?

Mrs. BREEZE. Yes, $5,000.

Senator KENNEDY. Before he entered Craig?

Mrs. BREEZE. Before he entered Craig.

Senator KENNEDY. And was that money used up?

Mrs. BREEZE. Yes; it was, sir.

Senator KENNEDY. And your husband was a bank president?

Mrs. BREEZE. He was.

Senator KENNEDY. And he was required to put up $5,000 before he could enter Craig?

Mrs. BREEZE. We put up a deposit of $5,000 toward the end of September. Gary was admitted to Craig Rehabilitation Hospital on October 3, Friday, of 1969.

Senator KENNEDY. Then, after leaving Craig, he has also endured some medical expenses?

Mrs. BREEZE. As I said, his prostheses costs over—the total run would probably go about $5,000. His drug bills run about $75 a month; supplies, $50 to $75 a month, and this is the major part of the cost.

Senator KENNEDY. So your expenses now run about $150 a month?

Mrs. BREEZE. Yes.

Senator KENNEDY. How long do you expect these expenses to continue?

Mrs. BREEZE. There's no end in sight, Senator.

Senator KENNEDY. And who pays for that now, the $150 a month you are now charged?

Mrs. BREEZE. Well, we are no longer, of course, on hospitalization insurance. The only thing that the insurance would cover at this point would be if Gary went back in a hospital. So anything at this time we carry ourselves.

Senator KENNEDY. And can you get any insurance now?

Mrs. BREEZE. No, not now.

Senator KENNEDY. Have you tried to?

Mrs. BREEZE. Yes. Of course, we are not insurable now.

Senator KENNEDY. Why do you say "of course"? Won't the insurance companies provide any health insurance to someone in your situation?

Mrs. BREEZE. No, no.

Senator KENNEDY. So you are going to have to pay these bills yourselves?

Mrs. BREEZE. Yes. I haven't found an insurance company that would cover us at this point.

Senator KENNEDY. I haven't either.

What are your prospects now? Are you going to have to go on welfare in order to survive?

Mrs. BREEZE. No. We are fortunate to have parents that have helped us. We would certainly hope that one of these days Gary will be able to go back to work. Hopefully, there will be a day that he will be able to go back to work. This is what we are working toward. We have three little children. It's what he is striving so hard for, but we don't know.

Senator KENNEDY. We have made so much progress, I think, especially in terms of the Vietnam experience in helping and assisting and finding new ways of helping injured individuals. I think there's certainly a hope with you that things will work out well.

Senator DOMINICK. Now, let me just say that Mr. and Mrs. Breeze have been friends of mine for a long time.

Mrs. BREEZE. Yes.

Senator DOMINICK. I frankly hadn't realized that this had happened. Gary. Let me tell you how sorry I am. I wish I had known about it earlier.

Did you find that the Craig Rehabilitation Hospital work was helpful to you?

Mr. BREEZE. Very much so, sir; yes.

Senator DOMINICK. The real question is, how do you finance these kinds of things?

I don't quite understand the financing at Craig. I understand that the Craig Rehabilitation Hospital had been built almost entirely on voluntary contributions.

Mrs. BREEZE. I don't know. I can only speak from our own experience.

Senator DOMINICK. There are people at Craig which we saw this morning, who I'm sure have the same or perhaps even greater problems than you have had and there still is hope that all of these people will be able to go back to work.

Mrs. BREEZE. Of course.

Senator DOMINICK. Now, I wish you the best. I think this is terrible for you, for the county, and for the State. I'm sorry it happened.

Senator KENNEDY. Mr. Breeze, may I ask you this question? You must have felt—as president of the bank—that you were working out an effective insurance program for the employees of the bank, did you not?

Mr. BREEZE. Hopefully; yes, sir.

Senator KENNEDY. And you must have felt, I suppose, when you had your accident, that you were insured for any accidents you might have had, didn't you?

Mr. BREEZE. Well, sir, I can't really recall the accident, of course. I don't recall anything from that time until recently. I can't really say that I did feel that I was insured to take care of this kind of thing, this injury or injuries.

Mrs. BREEZE. I don't think we had ever known anyone that had such insurance. Perhaps that's had a great deal to do with how you feel about this. As I say, it was a particularly young staff at the bank, and you just don't think of something of this nature.

Senator KENNEDY. This really could have happened to anybody, could it not?

Mrs. BREEZE. Yes, of course.

Senator KENNEDY. It was an accident and you happened to be the president of a bank. Yet, as I understand it, the accident has provided a very substantial and significant financial hardship upon your family, and it will affect your children as well. I suppose that a serious question is raised. Why should we have a health system which permits the extraordinary pain and suffering that an individual experiences from a serious accident like this to be coupled with the threat of financial ruin?

That's what happens in our health system. Here you have something that could have happened to anybody. In fact, it happened to a man who is a president of a bank. You would think he would be pretty well able to handle his financial problems. Now, we see the kind of financial tragedy that this accident has caused.

I want to thank you very much.

Mr. BREEZE. Thank you.

Senator KENNEDY. Mrs. Smythe, Mrs. Patrick Smythe. Mrs. Smythe, we want to welcome you.

STATEMENT OF MRS. PATRICK SMYTHE, EMPLOYEE OF COORS PORCELAIN, DENVER, COLO.

Mrs. SMYTHE. Thank you, and as you can tell by looking at me, I'm a specimen of health. It's my husband that is sick.

Two years ago last January he had heart surgery. For 1 year previous to that he had suffered numerous heart attacks.

We did not live in Denver then. However, we were recommended 2 years ago to a doctor in Denver. We came here. He began the surgery. It was a special kind of surgery with a graft. I can't explain it to you because I'm not familiar with—

Senator KENNEDY. Is that open-heart surgery?

Mrs. SMYTHE. Yes. They take arteries and graft them into the heart, or something.

Shortly after the heart surgery, while he was still in the hospital, he had just been taken out of intensive care and he had to have ulcer surgery. As a matter of fact, he almost bled to death before they decided they would have to chance the operation.

Shortly before the latter part of May, he was allowed to go back to our home. He had been in Denver for all that time, most of the time in the hospital.

After we had gone home and had been home about 6 weeks he once again had to come into Denver for more surgery because the incisions would not heal.

He then went home again and it was then that we moved to Denver. Mr. Smythe was told he could not go back to work for 1 year after the surgery, so this means one person earning the living.

Our insurance was exhausted completely. We had a $15,000 major medical policy from Prudential, which had been gone for some time. In the hometown where we lived, everybody knew the history. Everybody is afraid to give this man a job. You know, "What if he has a heart attack while he is working for us? We don't want this man in the place."

We moved to Denver and we found a kind person that gave him a job.

Senator KENNEDY. You think part of the difficulty in finding a job is that it might raise the premiums for health insurance for the employer's group.

Mrs. SMYTHE. Well, this could be. I don't even know if he would have been acceptable. I mean, I don't know. But we did come to Denver. He does have a job.

However, the person he works for does not offer medical insurance.

I also work. I work for Coors Porcelain, and they do have a medical plan. I'm not very familiar with what it is. I have just recently gone to work there, but they will not accept him for 11 months thereafter. Each doctor's call, each hospital call, everything that happens to us is out of our own pocket.

Incidentally, our bills were over $30,000. We lost our home. The year that he had the surgery, our son was a junior in college. I did work, and through the help of my father, we did get him through school. But it has left us at this point with basically nothing.

Mr. Smythe's pay is around $220 a month. This is after taxes. After taxes I bring home around $90 a week.

Of this we are paying St. Luke's a $150 on one hospital bill each month. We are paying $30 on another hospital bill. We are paying two different doctors $50 a month, so after this you see how little we have to live on.

Now, I want you to know that I am not condemning the surgeon. I think he's one of the finest. I'm not condemning the hospital, because he got fine care, by God, he should have had fine care what they charged. I mean, truly. I shouldn't have said that one word, but——

Senator KENNEDY (continuing). No reason why you shouldn't.

Mrs. SMYTHE. It is expensive care, "x" amounts of dollars. There is no such thing as little bills. Everything is not $1 but hundreds of dollars.

In this hospital, he was paying $32 for a room. Yet, this man is in intensive care, and not in a room at all. He is dying. I go and ask, "Why am I paying $32 a day?"

"Well, the doctor might come in this morning and move Mr. Smythe to a room." I said, "Well, put him in the hall for a day."

Senator KENNEDY. You had to pay for a room?

Mrs. SMYTHE. We paid for a room out in the hospital.

Senator KENNEDY. Which he wasn't in?

Mrs. SMYTHE. No, he was in intensive care.

He was in intensive care for almost 5 weeks, but we also paid for a room in the hospital.

Senator KENNEDY. And they were also charging you for intensive care?

Mrs. SMYTHE. Oh, certainly. Not only that, but each and every ounce of blood and each and every little ounce of oxygen, whether he got it or whether it escaped.

Senator KENNEDY. Now, you had medical insurance which paid $15,000 of the approximately $30,000 bill—is that right?

Mrs. SMYTHE. That is everything.

Senator KENNEDY. After you used up your savings, did you still owe anything on the hospital bills?

Mrs. SMYTHE. Yes, about $6,000.

Senator KENNEDY. And your income together is now about $600 a month—is that right?

Mrs. SMYTHE. That's right.

Senator KENNEDY. And out of which you must budget about $300 a month for payment of medical bills?

Mrs. SMYTHE. That's right. Of course, we have our apartment.

Senator KENNEDY. How do you live?

Mrs. SMYTHE. It's pretty slim. As a matter of fact, I was reluctant to use the gas to come over here today. I have that gauged down as to how I can get to work with x number of gallons, and this has to come out each month.

Senator KENNEDY. What about your house?

Mrs. SMYTHE. We lost our house. We sold it. We took what we could out of it to pay off some other bills.

Senator KENNEDY. And you have been paying St. Luke's $150 a month on their bill?

Mrs. SMYTHE. Ever since he got out, yes.

Senator KENNEDY. How long has that been?

Mrs. SMYTHE. Well, a year and a half.

And, of course, St. Luke's knows this man can't go to work so I don't know how they expect it to be paid. They have turned it over to a collection agency because they don't have time to bother with you.

Senator KENNEDY. A collection agency. They are one of the fastest growing health businesses in the country.

[Laughter.]

Senator KENNEDY. What happened when your husband tried to get back into St. Luke's?

Mrs. SMYTHE. When he went in for the surgery on the incision, they immediately put him in a room, and they sent word for me to come right down to the office and pay them before the surgery could be done, because we had no credit.

Senator KENNEDY. Even though you had been paying $150 a month?

Mrs. SMYTHE. This doesn't make any difference.

Senator KENNEDY. And they were aware of your income?

Mrs. SMYTHE. Yes.

Senator KENNEDY. And they still required that you put up a deposit before they would go ahead with surgery?

Mrs. SMYTHE. That's right, and when he went back in last September for the heart catherization—once again, there had to be cash beforehand.

Senator KENNEDY. Could you have gone to another hospital?

Mrs. SMYTHE. No.

Senator KENNEDY. Why not?

Mrs. SMYTHE. Because our surgeon operates only at St. Luke's.

Senator KENNEDY. So you had to go to that hospital?

Mrs. SMYTHE. That's right. My husband could have gone to the veterans hospital. He is a veteran; but here, once again, the doctor couldn't go there to operate.

Senator KENNEDY. Are you happy with the doctor?

Mrs. SMYTHE. Oh, I think he's the most marvelous man I ever saw, and I'm not saying that he's expensive, because the bill was not large for what he did.

Senator KENNEDY. How long do you think you will be paying off medical bills?

Mrs. SMYTHE. For the rest of my life.

Senator KENNEDY. What do you think now of the insurance policy you had?

Mrs. SMYTHE. I think our insurance policy wasn't big enough, as I think most American insurance policies aren't big enough. But can most Americans afford a bigger policy? If you go to a $30,000 major medical, the average person may not be able to afford it.

Senator KENNEDY. We just heard from the president of a bank, and you saw the problems he has had in paying off his health bills.

Mrs. SMYTHE. And your insurance premiums go up. The hospitals raise their room rates another $10 a day. And take all of the doctors—from a psychiatrist to an internal medicine man to a surgeon to a family doctor—there's never been a fairer group of people, and there's only been one doctor who I thought was unreasonable. For one of them it was $125 a call—not one of the surgeons, one of the others. I don't think our problems stem from what the insurance companies pay. They probably pay what they should. I think it stems

from the fact that most of us cannot afford insurance that would cover hospital bills as they are today. I don't know whether hospitals are a moneymaking organization, but they must be.

Senator KENNEDY. Hospitals aren't, but insurance companies are.

Mrs. SMYTHE. Well, I don't know. I mean, of course, my main feeling right now is the hospitals, because they are the ones that have been the orneriest and most inconsiderate.

Senator DOMINICK. Insofar as the hospitals are concerned, I think we can say without exception that there isn't a single one that isn't in a deficit position. I personally went out and raised some money for a new wing at St. Luke's myself.

Mrs. SMYTHE. I paid for that wing. [Applause.]

Senator DOMINICK. This was some years ago.

Mrs. SMYTHE. It was the newest wing.

Senator DOMINICK. Mrs. Smythe, when your husband went into intensive care and the doctor had him admitted into the hospital, was it an emergency?

Mrs. SMYTHE. No. Mr. Smythe was in the hospital about a week before surgery. During this time, there were preparatory steps, such as the heart catherization. I think there was a psychiatrist called in to talk to you before you go into this kind of surgery and make sure you are ready for it. And on and on. He was there for approximately a week before the surgery. The surgery, I think, was performed about the third of February, and he came home about the 26th of May.

Senator DOMINICK. Thank you.

Senator KENNEDY. Now, we saw the marvelous EKG equipment at St. Luke's last night. We saw hundreds of thousands of dollars spent for elaborate equipment, and yet they can't afford to take your husband back.

Mrs. SMYTHE. There is another thing that truly disturbs me about the surgery. Before the surgery, we were told that there was a 90-percent chance that this man will not live. This is surgery which is very new and which has been done very seldom. So you go ahead and you take this chance, and the doctors work like mad. The hospital works like mad to save the man, and then they kill him with the bill.

Another thing that disturbs me is that our Heart Association wouldn't even talk to a person like me. I called them not once but numerous times and begged them, "Is there anything at all you can do for us?"

"No," they said. There's nothing they can do for us, so I am waiting for them to come for a donation.

Senator DOMINICK. For the record, I think it's only fair to say that the electrocardiogram unit in St. Luke's was paid for by a grant and given to the hospital for experimental purposes by the general taxpayer, and not paid for out of patient costs.

Senator KENNEDY. I suppose it's a general question of priorities in health spending.

Senator DOMINICK. But it ought to save money in the end, not increase spending. That's what I understand anyway.

Senator KENNEDY. I understand, Mrs. Smythe, that the Prudential Insurance Co. is constructing a new building in Denver. You will be happy to know about it.

Mrs. SMYTHE. I paid for part of that, too.

Senator KENNEDY. You can watch it rise and go up here in Denver when you are riding to work.

Mrs. SMYTHE. Fine.

Senator KENNEDY. Thanks very much.

Our next witness is Mrs. Catherine Anderson. We want to welcome you.

STATEMENT OF MRS. CATHERINE ANDERSON, RETIRED, DISABLED GOVERNMENT EMPLOYEE, DENVER, COLO.

Mrs. ANDERSON. Thank you, Senator Kennedy and gentlemen of the committee. My problem is similar to the others.

In 1964, I suffered a severe attack of pneumonia, damaging one of my lungs; also, I had acute thrombophlebitis.

It was prior to the building of the new St. Joseph Hospital, and I required 36 tanks of oxygen to save my life. Then I was on crutches and was forced to take total disability from the Government after 17 years of service.

This was quite a drop in salary, which was a shock and upset my family—myself, my husband—but I had no alternative, dropping from a $6,000 a year position to $85 per month at that time.

Before that, my husband was afflicted with anxiety, but it was not very severe. With the worry and the pressure of my illness and health problems, his affliction and health problems became worse, and he became totally disabled.

We panicked. We lost our home, our lovely car, and were forced to move into cheaper living quarters in a less desirable section of the city.

I did not take this as a long-term thing. I felt that it had to be temporary. Each year I pushed myself and pushed myself and would try to return to work.

I will say the Government will give you an opportunity to return to work if you can ever recover, and I do mean reach total recovery. I could not do this.

Each year I am hospitalized for pneumonia. I'm hospitalized, put to bed, and require additional medical expense.

I have Blue Cross, and I have never understood why I end up owing so much money—to the medical men, the surgeons, the anesthesiologists. There is problem after problem.

Our child suffered a fall, and we had to take him to Children's Hospital.

We have a 16-year-old boy. This involved surgery, and I ended up with another hospital bill.

I also had to go in to have eye surgery involving special glasses, contact lenses, and we were just lost.

We tried to spread our income across the board. This was impossible. It forced us into bankruptcy.

We felt a deep moral obligation to the people who had trusted us, so we divided our money, split it up, and gave each of them some. We have been able to hold our furniture, but that is all.

It was suggested that we talk to a representative of the welfare department, so that possibly we could get food stamps. I was delighted

at this, but also I felt a depression and letdown. We had struggled so hard. We were taught to push to get ahead, to better ourselves and our condition, and this was quite hard for us.

My dignity was affected, and I'm sure my husband suffered hurts from this. We did start out on welfare, and I felt that when I was able to, I would return to work. I returned to work last May and became quite ill and was hospitalized in August.

I find that I'm playing a game I can't win. We have been given further assistance by Welfare, an additional $27 a month, but we still have an anesthesiologist to pay, a dental bill to pay, internal medical men to pay. We have a psychiatrist for my husband, and sometimes at night I wonder how in the world, how can we win?

I can't figure it out but I manipulate. I juggle the expenses. One month I pay one and the next month I skip the other.

I do appreciate the assistance we have received. I think we probably would have completely crashed without it. It gave us a ray of hope, but I do hope some day we will have a better insurance program. You carry it; you pay it. It will take care of everything.

Thank you.

Senator KENNEDY. You went into bankruptcy.

Mrs. ANDERSON. We went into bankruptcy.

Senator KENNEDY. How many years have you worked?

Mrs. ANDERSON. Seventeen with the Government, and since I have been away from the Government, I attempt to work, but I never make a full year.

Senator KENNEDY. Your husband is not working?

Mrs. ANDERSON. No, sir. He's totally disabled.

Senator KENNEDY. He had been working before?

Mrs. ANDERSON. He had been working. When I was forced into this disability, the worry, the fear caused him to fall and crash completely.

Senator KENNEDY. You have medical bills now that you are paying?

Mrs. ANDERSON. Yes. sir.

Senator KENNEDY. Even after the bankruptcy?

Mrs. ANDERSON. Yes. sir.

Senator KENNEDY. How much in medical bills do you have now?

Mrs. ANDERSON. I have approximately $400.

Senator KENNEDY. $400. That's a lot of money, isn't it?

Mrs. ANDERSON. Yes, it is to a family with an income like ours.

Senator KENNEDY. What has happened to your credit since you have been in bankruptcy? Can you charge anything?

Mrs. ANDERSON. No, sir. We cannot charge one thing.

Senator KENNEDY. Can you get anything? Can you keep a refrigerator or buy some appliances? You have a child?

Mrs. ANDERSON. We have one child.

Senator KENNEDY. You have to pay everything on cash?

Mrs. ANDERSON. Everything has to be on a cash basis.

Senator KENNEDY. How was your credit before this?

Mrs. ANDERSON. It was good.

Senator KENNEDY. You were working for the Government?

Mrs. ANDERSON. Yes. We had accounts at Neusteters. We could purchase the car on credit. And the TV and a home, a lovely home.

Senator KENNEDY. And now you are not able to do that?

Mrs. ANDERSON. That is right.

Senator KENNEDY. Are you going to try and pay those medical bills, the $400?

Mrs. ANDERSON. Yes, sir; we are. We are paying each month. We send a small amount. Sometimes they become quite angry with us. If we have to, we borrow from Peter to pay Paul, but we are getting the job done.

Senator KENNEDY. Now, Mrs. Anderson, there has been a great deal of talk about the proposal that's before the Congress in terms of catastrophic illnesses—people with large medical bills over a long period of time. They say that Congress ought to meet those needs. But I suppose that $400 is pretty catastrophic to you, isn't it?

Mrs. ANDERSON. Yes.

Senator KENNEDY. As catastrophic as a $5,000 bill might be to somebody else?

Mrs. ANDERSON. To me it is. Everyone loves to hold their head high with dignity and know they have paid their bills, made a decent living, and given their child the things they really need and some pleasures.

With our present income we do not have money to go out to dinner, to go bowling. It has to be something without cost. I think we are all entitled to a decent living in America. I think we are.

Senator KENNEDY. How is Blue Cross in paying the bills? Did they cooperate with you?

Mrs. ANDERSON. They have cooperated, but I still do not understand why we end up owing a hospital bill after having coverage.

Senator KENNEDY. You mean that you think when you get Blue Cross hospitalization insurance, you assume they are going to pay the hospital bill?

Mrs. ANDERSON. I evidently have assumed wrong, sir. I feel that something is wrong here. We end up paying an anesthesiologist. I end up being charged for laboratory work, and I do know that something is wrong. I do expect to pay visits to the doctor's office.

Senator KENNEDY. Yes, but you thought the expenses of the hospitalization were covered?

Mrs. ANDERSON. Yes, sir.

Senator KENNEDY. What did they say to you when you asked them about those expenses?

Mrs. ANDERSON. They told me that Children's Hospital operated on a different procedure, that our child was in a private room. Blue Cross could not pay all of the bill.

Senator KENNEDY. You didn't know that when the child went in?

Mrs. ANDERSON. No, I didn't.

Senator KENNEDY. You just thought that your policy covered that?

Mrs. ANDERSON. Right. Now, when my husband entered Mount Airy Hospital, it paid full coverage. We had no balance to worry about.

However, I did lose because I was not able to work. I had to come home and take care of my husband, and at present he has to be cared for. His medications are approximately $36 per month.

Now, I am receiving some assistance from Park Hill Clinic plus some psychiatric consultation, and I am given instructions on how to administer the medication, how to care for him and myself. This has been a very big help.

Senator DOMINICK. Mrs. Anderson, how long did you say you worked for the Government?

Mrs. ANDERSON. Seventeen years.

Senator DOMINICK. You were under their medical coverage?

Mrs. ANDERSON. Yes.

Senator DOMINICK. Did that include Blue Shield as well as Blue Cross?

Mrs. ANDERSON. Right.

Senator DOMINICK. What hospital were you in?

Mrs. ANDERSON. The first hospitalization was at St. Joseph's.

Senator DOMINICK. They took care of the bills there?

Mrs. ANDERSON. I had a balance there.

Senator DOMINICK. For laboratory tests?

Mrs. ANDERSON. I'm not sure what the costs were, but I had a balance.

Senator DOMINICK. Now, did you get retirement pay from the Government because of this occurrence?

Mrs. ANDERSON. Yes. I started receiving $83 per month. It has been boosted due to the rising cost of living, and I now receive $109 per month.

Senator DOMINICK. At that time was your husband working?

Mrs. ANDERSON. My husband was working and worked through 1969, and he collapsed.

Senator DOMINICK. Did the company that he worked for provide any kind of coverage to him?

Mrs. ANDERSON. No, sir; they did not.

Senator DOMINICK. Did he know that?

Mrs. ANDERSON. I doubt if he knew this when he started working for them.

Senator DOMINICK. Did he get any kind of recompense from that company?

Mrs. ANDERSON. No; he did not.

Senator DOMINICK. Did he get any kind of assistance from the company?

Mrs. ANDERSON. No.

Senator DOMINICK. How long had he been working for the company?

Mrs. ANDERSON. He had been working in that position for about 3 years. He would have attacks of anxiety, would become upset and would leave his position. I knew something was wrong, but I could not quite pin it down until we had professional advice from psychiatrists and medical men. He was the former purchasing agent at American Woodmen Insurance Co.

Then he started becoming depressed and would take anything. He wasn't happy with any of his smaller positions, and then he reached total disability.

Senator DOMINICK. What is your son doing?

Mrs. ANDERSON. Our son is attending George Washington High School, and he has a little band put together.

Senator DOMINICK. Is he able to make money to help out?

Mrs. ANDERSON. Occasionally he does, and he's a very fine person about bring it to us. He takes very little of his own pay when he receives it.

Senator DOMINICK. It's your feeling that the medical assistance which you received is agreeable?

Mrs. ANDERSON. Yes. I don't believe I would be here talking to you if I had not had the very best doctors, surgeons, so forth. I had no complaints. My problem was getting them paid.

I have deep respect and admiration for the doctors who cared for me so very well. I know it would not be ethical to mention their names, but they certainly saved my life several times. The surgeons were also very good.

I had been advised not to attempt to work anymore. Of course, I'm forced to stay home now to care for my husband.

Senator DOMINICK. Thank you, Mrs. Anderson.

Mrs. ANDERSON. Thank you.

Senator DOMINICK. Thank you very much.

Senator KENNEDY. Our next witness is Mr. James Quick.

We will try and move along just a little faster. We have a few more consumer witnesses and then two professional witnesses, and then we will open it up to the audience.

Mr. Quick, I thank you very much for coming. Would you like to proceed?

STATEMENT OF JAMES QUICK, PATIENT, NATIONAL JEWISH HOSPITAL, DENVER, COLO.

Mr. QUICK. In 1965, I was exposed to a great deal of limestone dust and came down with pneumonia. After the pneumonia, I was wheezing, and they said it was asthma, and from that day to this I have not been able to work.

I was in the hospital the first go-around about 6 weeks. I was out for 2 weeks, then back in. I've been back in about every 5 weeks ever since, until I came to National Jewish Hospital in Denver. Before I came to National Jewish I was transferred from one State to another, one climate to another, and everything else, and never got any relief until I came to Denver to National Jewish. Since 1965, my total hospital and medical bills have run somewhere in the neighborhood of $80,000.

Senator KENNEDY. How much was that?

Mr. QUICK. About $80,000, including what I have received from National Jewish and Colorado General free, which amounts to about $50,000. I had insurance with two companies, which paid one bill and then canceled.

Senator KENNEDY. What insurance did you have?

Mr. QUICK. New York Life and Travelers.

They had New York Life at the company I worked with. The company changed after I became ill to Travelers under which I was covered for a while. But Travelers never did pay, and they wouldn't pay National Jewish because they said it was a nonprofit organization. The first claim was filed with New York Life by National Jewish, and they wouldn't pay because they said National Jewish was a nonprofit organization.

Senator KENNEDY. They wouldn't pay?

Mr. QUICK. They never paid a dime, never did pay a dime on the bill.

Senator KENNEDY. And do you have a bill?

Mr. QUICK. Well, they have a bill on me but, of course, I'm not required to pay it, because if you can't pay, they don't require you to.

Senator Kennedy. Do you have other medical bills now?

Mr. QUICK. Oh, yes. We paid off the 1965 bills in 1969 in Alabama, and we will be paying other bills here for doctors' office calls while I was discharged from National Jewish.

It will take us the next 2 or 3 years to pay them off.

Senator KENNEDY. About how much are you billed?

Mr. QUICK. Somewhere in the neighborhood of $4,000.

Senator KENNEDY. Are you going to try to pay those off?

Mr. QUICK. We are paying them off. My wife works 5 days in the week and then she works every other weekend 11 to 7, all to make extra to help pay these bills and send our daughter to college.

Senator KENNEDY. Do you work now?

Mr. QUICK. I'm not able to work at anything. I'm back in National Jewish now, have been since January. I was there 22 months the first time, and I have been there since January this time.

Senator KENNEDY. And you and your wife together are trying to pay the bills?

Mr. QUICK. We are paying them off.

Senator KENNEDY. Have you tried to get any insurance?

Mr. QUICK. Yes. As soon as I moved to Denver I had many insurance men contact me. I said, "Yes, I will take some hospital insurance," but when they come down to asthma, they rip up the policy and throw it away.

Senator KENNEDY. When they come to asthma?

Mr. QUICK. When they find out I have asthma.

Senator KENNEDY. So they won't sell it to you.

Senator DOMINICK. Mr. Quick, did New York Life and Travelers pay about $25,000 of your bills?

Mr. QUICK. That's right, about $25,000. That was before I got to Denver. I was in Alabama, Florida, and Texas.

Senator DOMINICK. When you mentioned the $80,000, you were talking about the bill which they keep on you at National Jewish but which they don't require you to pay?

Mr. QUICK. That's right. Actually we have paid right in the neighborhood of $20,000 cash ourselves. All of our savings we have paid in doctors' bills and medical bills and hospital extras.

Senator DOMINICK. But not to National Jewish?

Mr. QUICK. No, the New York Life does not cover while I was in the hospital, and when I was going in the hospital, I always required to have a private room which insurance did not cover, except semiprivate.

Senator DOMINICK. You didn't have any Blue Cross or Blue Shield?

Mr. QUICK. No; because my insurance was through the company.

Senator DOMINICK. Neither your New York nor your Travelers policies covered any hospital expenses?

Mr. QUICK. They did before I came to National Jewish, but they don't cover outpatient expenses when you go to the doctors' office or drug bills, which ran very, very high.

Senator DOMINICK. I sympathize with you. I have been active in this respiratory field for a long, long time. My father-in-law had it severely so I know what problems are involved. It's tough.

As far as National Jewish is concerned, they are——

Mr. QUICK. I wouldn't have lived 30 days longer had I not gone there. It's just unbelievable. They give you the best of everything that's available.

Senator DOMINICK. Thank you, sir.

Senator KENNEDY. You are not going to be able to get any more insurance in the future; are you?

Mr. QUICK. It looks like I won't be.

Senator KENNEDY. And if you didn't have National Jewish, you would be——

Mr. QUICK. I would just have to die, that's all. Nobody would carry you for that amount of a bill.

I didn't realize it until last night. We roughed out how much we had paid out in actual cash since 1965, and it's around $20,000.

Senator KENNEDY. Even though you had some coverage?

Mr. QUICK. I figured I had $25,000 in coverage between the two policies.

Senator KENNEDY. How many years had you worked? You worked in Alabama for a number of years?

Mr. QUICK. Twenty years for the railroad.

Never missed a day of work in 20 years.

Senator KENNEDY. You had good health during that time?

Mr. QUICK. That's right.

Senator KENNEDY. And then through no fault of your own this condition developed?

Mr. QUICK. It developed as a result of paving the street right beside the office where I worked. It was limestone dust in an air-conditioned office. We just ate that limestone dust. I wound up with pneumonia, and I have been sick ever since.

Senator DOMINICK. Mr. Quick, didn't the railroad have any provision to cover you on this?

Mr. QUICK. They just paid disability insurance, which is $170 a month.

Senator DOMINICK. They are paying you that now?

Mr. QUICK. Yes.

Senator DOMINICK. Thank you.

Senator KENNEDY. Thank you very much, Mr. Quick.

Our next witness is Mrs. Dean DeWitt, who is here with her infant child and her physician, Dr. Joseph Butterfield.

Thank you for coming.

Mrs. DEWITT. You are welcome.

Senator KENNEDY. We have never had a baby at one of these hearings. This is our youngest witness. Where do you live?

STATEMENT OF MRS. DEAN DeWITT, SOUTHWEST DENVER, COLO.; ACCOMPANIED BY DR. JOSEPH BUTTERFIELD, ACTING MEDICAL DIRECTOR, CHILDREN'S HOSPITAL, DENVER, COLO.

Mrs. DEWITT. In southwest Denver, in Brentwood.

We have had insurance with our company for 7 years now and thought we were pretty well covered. But when we found out we were having twins, which was 6 weeks before they were born, we discovered that we were not covered for the first 15 days in the hospital. Then one of our babies, unfortunately, was born with a ruptured bowel and has

been in Children's Hospital for the last month and we discovered we had no coverage.

Senator KENNEDY. What do you mean? Your insurance didn't apply?

Mrs. DEWITT. No. We found that newborns are completely uncovered for the first 15 days, on our policy. Well, this was kind of bad because it was a critical time for Debbie. She has had surgery twice, and we wound up with a bill of $5,000. Our hospital insurance has been kind enough to provide something like $700 for the whole thing, so it's been pretty much all but useless.

Senator KENNEDY. How long have you had the insurance policy?

Mrs. DEWITT. Well, before I was married I had it for 3 years, and then we have had it 7 years as a family policy, so I have been with Prudential for 10 years now.

Senator KENNEDY. You have had a policy with Prudential for 10 years?

Mrs. DEWITT. Yes.

Senator KENNEDY. And it excludes the first 15 days of life. I guess this is a pretty common practice, is it?

Mrs. DEWITT. Well, apparently so, because I know I thought that we were the only ones caught by it. But I have run into many parents up there in the last month that have the same difficulty.

Senator KENNEDY. Why do you think the insurance companies do that?

Mrs. DEWITT. Well, I think it's a pretty handy way to get the premiums and get out of the dangerous part of a new baby. This pretty well fixes them up, because if the baby is sick when it's born, this is the bill that's going to be big, and usually it's over by 15 days and the companies get off pretty well.

Senator KENNEDY. How many children do you have?

Mrs. DEWITT. We will have seven children at home, when we get Debbie home.

Senator KENNEDY. And your husband is a furniture repairman?

Mrs. DEWITT. Yes, he subcontracts for May–D&F. He does touchup work.

Senator KENNEDY. How are you paying the bill?

Mrs. DEWITT. We haven't quite figured it out yet. I guess we will have to go on payments.

Senator KENNEDY. What is your husband's take-home pay?

Mrs. DEWITT. It varies with the work that he does. He usually works by the piece. There have been months when we have made $300 or $400, and other months when we have made $800.

Senator KENNEDY. But you are going to have to pay at least some of that. Is that right?

Mrs. DEWITT. Yes.

Senator DOMINICK. Mrs. DeWitt, I don't quite understand your insurance situation. Before you had your twins you had five children, right?

Mrs. DEWITT. Yes.

Senator DOMINICK. Now, on the assumption that nothing happens to them during the first 15 days. I gather the insurance covers the hospitalization during that period?

Mrs. DEWITT. Yes. The maternity benefits will pay $250, which, up until this year, has been sufficient. We had not had any children for 4 years. This wasn't really planned, but when we found out we were going to have some more, we started saving. The insurance didn't cover anything like the full maternity bill. We still had to pay a balance of $214 just on the maternity bill.

Senator DOMINICK. Is that because the maternity benefits didn't cover twins?

Mrs. DEWITT. No, this was just on the $20-a-day deductible.

Senator DOMINICK. I see.

Mrs. DEWITT. And we are paying $38 a month for this policy, and we couldn't afford to have it increased to cover the hospital costs as they went up.

Senator DOMINICK. Mrs. DeWitt, your husband didn't have any policy through his company?

Mrs. DEWITT. No, because he subcontracts. He is not actually an employee, so there is no policy. All we have is our family plan.

Senator DOMINICK. Is this a different situation that you are telling me about because the child is in Children's Hospital, as opposed to being in any other hospital?

Mrs. DEWITT. Oh, I don't believe so. I mean, the policy wouldn't cover any hospital. It wouldn't cover any hospital at all.

Senator KENNEDY. Let me ask Dr. Butterfield: Are you affiliated with Children's Hospital?

Dr. BUTTERFIELD. Yes; I'm the acting medical director.

Senator KENNEDY. Is Mrs. DeWitt's situation unusual? How frequently does this kind of situation occur?

Dr. BUTTERFIELD. I'm also the director of the newborn center into which this child came for help, and we find that the insurance policy exclusion of the newborn during the first 14 or 15 days of life is not uncommon. In fact, we did a study recently and found that about 30 percent of employers' policies had the 14-day exclusion. So the newborn, in fact, is a forgotten American in a sense.

When this does happen, when the parents are unable to meet the total responsibility as in this case, we share the responsibility, and the insurance company here will contribute a small amount. We hope that the National Foundation-March of Dimes may provide some support, and that perhaps the parents themselves will participate to the extent that they can.

In this case, the financial burden will fall largely on Children's Hospital. We anticipate that we will support this case to the extent of possibly 75 percent of the entire bill.

Senator KENNEDY. How often does this happen?

Dr. BUTTERFIELD. The bill itself is a little bit unusual, as Mrs. DeWitt said, because of the complications. This was a very unusual case of intestinal obstruction and other problems. Recognized promptly and dealt with, I think you will admit, very well.

Mrs. DEWITT. Fantastic.

Dr. BUTTERFIELD. Taking all the patients that come to the regional newborn center at Children's, the average bill is about a thousand dollars. Bills of in excess of $2,000 represent about 5 percent.

Senator KENNEDY. How frequently do you find bills of a thousand dollars? These are major bills, and I am trying to find out how fre-

quently it happens that you have complications with infants in the first 15 days.

Dr. BUTTERFIELD. In our experience, of all infants that have problems that need center type of care in the special unit, approximately half would have bills in excess of $1,000.

Senator KENNEDY. How frequently do infants develop complications which bring about medical bills such as this?

Dr. BUTTERFIELD. I think it's a safe statement to say that about 5 percent of all children born require some form of intensive care. That's a guess.

Senator KENNEDY. They wouldn't be covered by the general kind of insurance policy that Mrs. DeWitt has?

Dr. BUTTERFIELD. Correct.

Senator KENNEDY. What should the insurance companies do in this area? Shouldn't they cover this? If cases like this arise 5 percent of the time, shouldn't they be filling that gap?

Dr. BUTTERFIELD. You are asking a question out of my expertise because I'm not an economist. I know that the American Pediatrics Association and the American Medical Association and certain legislators are interested in coverage from the time of birth. For instance, there's a bill, the Brathwaite bill, introduced by Yvonne Brathwaite in California, which would make it a requirement that insurance companies must include the newborn from the moment of birth. This is going through that legislature. Whether that will succeed or not, I don't know.

There should be some sort of inclusion of the newborn. We ought to take care of the high-risk mother and the high-risk newborn.

Senator KENNEDY. I agree. Thank you very much. Thanks so much for coming.

Our next witness, Mr. Jose Villareal, who is accompanied by Mrs. Maria Bealls.

Mrs. BEALLS. I'm a migrant health nurse and I have been working with Mr. Villareal.

STATEMENT OF JOSE VILLAREAL, MIGRANT WORKER; ACCOMPANIED BY MRS. MARIA BEALLS, MIGRANT NURSE, DENVER, COLO.

Mr. VILLAREAL. Back in June I had to have a colostomy operation, so I had to go to intensive care in Greeley. I stayed there for about 3 days, and then I spent about 20 more days down in a room. Then I had to come back within 2 months to have it fixed. Then when I went out, the bill was about $2,000, and we had to pay this. Great Western Insurance paid about a thousand, and we had to pay one-third of the rest of it. We only had about a hundred dollars, and they wanted $350 before we could go out, before they would let me go out.

Senator KENNEDY. What do you mean "before they would let you go out"?

Mr. VILLAREAL. Before I could get out of the hospital.

Senator KENNEDY. Before you could get out of the hospital?

Mr. VILLAREAL. Yes. They wanted $350. We only had $200, so that's what we gave.

Senator KENNEDY. You only had $200.

Mrs. BEALLS. That's right. He was in the hospital for the colostomy, so before he could come out of the hospital to wait until the second operation could be done, the family had to go to the hospital to have him released. But they wouldn't let him out of the hospital unless he could pay $200.

Well, the mother only had a hundred dollars with her at the time. She tried to get in touch with me, and I was nowhere to be found. I was out in the field, and she went back home and talked to some of the family members and some of the other migrants and finally came up with the other hundred dollars so they could release him. Otherwise, he would have had to stay there and continue to pay the hospital bill, which they didn't have the money to pay.

Senator KENNEDY. And they wouldn't let him out?

Mrs. BEALLS. Right, right. We have no hospitalization money for migrants. And this is a problem, because they often go into the hospital. They have emergency problems. They need surgery, and then they have no funds to pay for it. I am holding here all these bills that have been coming to this family, and they don't know what to do with them.

Senator KENNEDY. Those are his hospital bills?

Mrs. BEALLS. Right, just hospital bills from his surgery and the rest of the members of his family.

Senator KENNEDY. Are those bills from collection agencies?

Mrs. BEALLS. Bills from collection agencies, hospital bills, and doctor bills. They don't know what to do with them. The mother is very nervous. She says she doesn't know what to do with these bills, and we don't have any funds in the program to pay for them. We have funds for the doctor for the surgery, but we have no hospital funds at all.

Senator KENNEDY. How much are those hospital bills?

Mrs. BEALLS. It's over a thousand dollars, and this was a problem not only with Jose's family, but with the rest of the migrants. If they have emergency illnesses like appendix, gall bladder, and things that require surgery immediately and the Health Department has no funds allocated for hospitalization, what can you do? You go to the hospital and you tell the hospital, "well, I will try to get money for the hospital bills somehow." But, you just can't find funds for it. And this is a problem, because next time you take a migrant in, they won't accept him because you can't come up with the money.

Senator KENNEDY. The money has to come before the health care comes?

Mrs. BEALLS. Right. Patients have come in, and we haven't been able to pay for them, so they are hesitant.

Senator KENNEDY. Economics before health?

Mrs. BEALLS. Right, and migrants don't have insurance. They don't have money, so what do you do?

Last year we had several organizations that came over and talked to us during orientation. They said, "Well, you know, if you ever need any help for anything, just call on us."

Senator KENNEDY. Who said this?

Mrs. BEALLS. Oh, organizations like Fund and Migrant Administration and various other organizations.

But, whenever you go for help, they just don't come through on anything.

Last year I spent 14 days running around trying to find food for a diabetic who was completely out of food and didn't have money. Finally, one of the doctors at the Health Department said it was a drug requisition, so I could get emergency food for them.

Senator KENNEDY. How typical is this?

Mrs. BEALLS. Very typical, and these people come here without any money. A lot of times they come without relatives, and so it's hard for them to borrow money from other people.

If they had relatives or friends they could turn to, it would be different. The Federal Government is not responsible for them; the State is not responsible for them; and all the health centers here in Denver are fine for the people around here, but they just won't accept migrants, because they are outside the county lines.

Senator DOMINICK. What you are saying is very interesting, because we just finished a second-year grant out at the Fort Lupton area of over $400,000. The Weld County Public Health Organization has now got an application in for the rest of Weld County.

Mrs. BEALLS. Right.

Senator DOMINICK. Now, from what you are saying, this money isn't being spent?

Mrs. BEALLS. Last year it wasn't.

Senator DOMINICK. Who is getting it?

Mrs. BEALLS. I don't know, but I didn't get any of it. My migrants didn't get any of it.

Senator DOMINICK. This is part of the problem we are talking about.

Mrs. BEALLS. I have started work. I have spent several days driving around, calling people, trying to get money for the different services, trying to get migrants settled down, and I talked to the migrants. They are willing to stay, but whenever you come to the organization, there is no money. "We will see what we can do," they say, but nothing comes out of it.

Senator DOMINICK. I just wanted to follow up on that because I have been active in these two particular fields in Weld County.

Mrs. BEALLS. Well, I worked with Weld County part of the time last year.

Senator DOMINICK. The Fund organization is working in Fort Lupton, or at least it's supposed to be?

Mrs. BEALLS. Right. I sent a list of names. It was Mr. Janos I called, who is stationed in Fort Lupton. I went there several times. I talked to him. He said, "That's fine; get all those names for me," and I left in September, and as far as I know, all of the families I sent are still around the area. Jobs were found for them through sources other than Fund. I'm not aware of what's going on now. I have been out of the State.

Senator DOMINICK. In the health care area, though, which is what we are talking about at the moment, you are unable to get any support either out of the Fund or out of the Public Health Service for this problem?

Mrs. BEALLS. What do you mean out of the "Public Health Service"?

Senator DOMINICK. Well, is the Public Health Service able to be of any help to you?

Mrs. BEALLS. No; the Public Health wouldn't have anything to do with the migrants, because they weren't residents. They hadn't been here long enough to apply for welfare or medicaid or anything like that, so we were solely responsible for them. But we didn't have the funds for it, and what could we do? And hospitalization is a real problem, because most of these migrants come here and a lot of them don't want to go to the hospital. They can't afford the time from work to be in the hospital to recuperate from illness.

Senator KENNEDY. What about the Medical Society? Have you ever asked them for help?

Mrs. BEALLS. Well, yes; all these organizations come out at the beginning of the year, and they say, "It's great. If you need any help, come to us."

Last year, as I said, I spent 14 days. I went to the welfare for food stamps.

Senator KENNEDY. How long have you worked in this area?

Mrs. BEALLS. I worked here all last summer, and I am back this year, but I think that, because I was able to communicate with a lot of them, I was able to become aware of their problems. They have been able to tell me the things that were most important to them, the things they were having problems with.

Senator KENNEDY. Let me ask Mr. Villareal, how were you treated in the hospital?

Mr. VILLAREAL. Oh, I was treated pretty good. I had a fine doctor.

Mrs. BEALLS. Our only problem was getting him out.

Senator DOMINICK. I don't think I have anything further. We will try to keep you out.

Senator KENNEDY. Thank you very much.

Mrs. BEALLS. Is there anything you can do about hospitalization? It's really a problem. We just can't do anything without funds for hospitalization. Emergencies come up and people have to go to the hospital, but if you don't have the money and nowhere to get it, what do you do? And pretty soon the hospitals stop accepting them.

Senator KENNEDY. That's what we are here to find out.

Mrs. BEALLS. Good.

Senator KENNEDY. Our next and final consumer witness is Mr. Wally Wirth.

STATEMENT OF WALLY WIRTH, SAFEWAY CHECKER, DENVER, COLO.

Mr. Wirth, we are glad to have you here. You are a checker for Safeway in Denver, is that right?

Mr. WIRTH. That's right; yes.

Senator KENNEDY. Tell us your story.

Mr. WIRTH. My wife has an incurable disease. It's a fungus germ in the bone marrow, and it's called actinomycosis. The medical doctors can probably recognize it, and she has had it over 20 years, and we have been in and out of the hospitals all this time.

In fact, we were able to get into the National Institutes of Health for some research there, but because they weren't doing any research on her particular germ, they wouldn't treat her there. They sent her back here for treatment, and she's been in and out of the hospital quite frequently.

We have to take lab tests approximately once a month, sometimes more often, and these run around $50 a treatment every time we run through this. In the laboratory, they said that certain antibiotics would kill the germ, and so they tried them on her—penicillin and all the rest of the drugs. They would kill the germ in the laboratory, but they wouldn't kill it in her body. She's on full sulfa now. She gets to the point where she becomes too weak and then, of course, we have to hospitalize her.

Our medicine runs around $40 a month. I'm covered by a health insurance plan through the Retail Clerks. It's a really good plan, but it doesn't cover all the bills.

We have spent approximately $75,000 over the last 20 years, and we have paid approximately one-third of this out of our own pocket.

Some years the excess over our insurance will run around $2,000. As you know, a poor grocery clerk makes very little—$7,500 a year. My life, I might say say, has more or less been a financial nightmare. I have lost about half my insurance.

Senator KENNEDY. What do you mean you have lost your insurance?

Mr. WIRTH. Well, I borrowed on it, and it was to the point where it was useless. I borrowed so much that it was useless to pay it back, so I let it go.

Senator KENNEDY. You mean you borrowed on your life insurance to pay your medical bills?

Mr. WIRTH. That's right, and to pay other necessary items. We have been to Mayo's twice, and to Johns Hopkins. We have to fly her there, and these are heavy expenses. These things are terribly expensive, as you know.

I have been on the verge of bankruptcy several times. In fact, about 5 years ago, I had a $4,300 doctor and hospital bill, and I paid about $50 a month on it. I got disgusted, and at the end of the year I went to my attorney, and I said, "Let's file bankruptcy."

He called the hospital, and he gave them an offer of $200 and said, "Well, you either take this or you won't get anything," which they wouldn't have. And so that bill was wiped out. But, as you see, this thing just keeps on and on. They have never found a cure for her illness, and the only thing we can do is try to keep the disease under control.

We have a vial of ACTH in the refrigerator at all times; and when she gets into one of these attacks, which sometimes come frequently, we give it to her. Otherwise, I have to rush her to an emergency room in the hospital and give her treatment there.

I might say that I'm 62 years old, and I will retire in a few years. I have an insurance policy now, and I'm covered fairly well. I'm grateful to the insurance companies and the hospitals and the research clinics—the National Institutes of Health and the Government laboratories, especially the one down in Atlanta, Ga., that has done research on the germ. This laboratory work has been expensive.

The hospitals here in town have done a lot of the work. But after I retire, there will be a time that I will have no coverage for my wife at all. This is the thing that I think you ought to take into consideration.

Senator KENNEDY. You won't be able to buy any insurance?

Mr. WIRTH. I won't be able to buy any, no.

Senator KENNEDY. So after you retire, I guess you can look forward to being forced onto welfare, don't you?

Mr. WIRTH. Well, is this the answer, or what is the answer?

Senator KENNEDY. Well, that's apparently what the system provides now for somebody who has worked all his life and saved. And this is what you have to look forward to, after paying off $20,000 or $25,000 bills yourself. That is what the system has provided for you and your family.

Mr. WIRTH. That's right.

Senator KENNEDY. What do you think of that? Do you think that's pretty rotten?

Mr. WIRTH. I think so; I think so.

Senator KENNEDY. I do, too.

Mr. WIRTH. I'm an ex-serviceman also. I fought for my country, and I would die for it even today.

Another thing Senator Kennedy, have you ever considered people like myself getting some extra tax relief? This would be a big help, and it would have been a big help all the way along. Has anyone ever considered that?

Senator DOMINICK. That's a good point. It hasn't gotten anywhere as yet.

Senator KENNEDY. You had about $25,000 worth of bills that you have paid. If you had been able to subtract your expenses from your taxes, you would have had some relief, but you still would have had to pay out a great deal of money, wouldn't you?

Mr. WIRTH. Yes; that's right.

Senator KENNEDY. As an alternative, would it have helped if you had been covered by a Health Security Act?

Mr. WIRTH. Right. Yes, it would; that's very true.

Senator DOMINICK. Does your company have a retirement program for you?

Mr. WIRTH. Through the union; yes.

Senator DOMINICK. So you will have some income coming in?

Mr. WIRTH. I will have some; yes.

Senator DOMINICK. Why do you say that your insurance lapses at that point? Is that union insurance?

Mr. WIRTH. Union insurance; yes.

Senator DOMINICK. When you retire, the union cuts you off and says you can't have any more insurance?

Mr. WIRTH. Right.

Senator DOMINICK. That's not a very good bargain for you as a union member?

Mr. WIRTH. Well, no. I have two members of the union here.

Senator DOMINICK. I think we ought to bring it out.

Mr. WIRTH. Yes; that's a good point, too. I have tried to buy additional insurance, and they have turned us down.

Senator DOMINICK. Well, I'm sure that you have a problem. I can't even get any for myself, so I'm sure you have a problem in your situation.

Senator KENNEDY. We are pretty well covered under the Federal program.

Senator DOMINICK. I'm not under it. [Laughter.]

Let me ask you something: What you are saying is that you think it might be a good idea to have, in a situation such as the one which you and other people who testified are in, where they have a catastrophic or a longtime condition of illness, where the insurance which they carry due to their own fault or not doesn't cover them, a tax break of some kind? Now, of course, you can deduct a certain percentage of your medical expenses.

Mr. WIRTH. That's right.

Senator DOMINICK. And you do, of course, get an additional deduction at the age of 65.

Mr. WIRTH. Yes.

Senator DOMINICK. But you are talking about something over and beyond that?

Mr. WIRTH. That's right.

Senator DOMINICK. You have some very good input and I'm glad that you have presented it. This has been discussed but it has not come up in the Finance Committee.

Mr. WIRTH. I think it would help in lots of cases.

Senator DOMINICK. Thank you very much.

Mr. WIRTH. You're welcome.

Senator KENNEDY. Thank you very much.

Now, we have two professional witnesses, Dr. Marvin Johnson and Dr. Kenneth Platt. Dr. Johnson is president of the Colorado Medical Society, and Dr. Platt is the president-elect of the medical society.

Dr. PLATT. I'm Dr. Platt, and this is Dr. Johnson [indicating].

STATEMENT OF MARVIN E. JOHNSON, M.D., PRESIDENT, COLORADO MEDICAL SOCIETY, DENVER, COLO.

Dr. JOHNSON. Senator Kennedy, Senator Dominick, I'm glad to have you with us, and we appreciate very much the opportunity to participate in this discussion. The problems that you have pinpointed here today are those, of course, in which we have a great deal of interest too, and I would like, for a few minutes, to tell you about some of the things that the medical society has been doing.

It's always a problem when you see medical successes that end up in economic failures, and we agree that this is a real problem. I think it hasn't been brought out today that many of the hospitals do give quite a bit of free service, and the one I'm associated with makes quite a sizable contribution to the community each year in the form of free service for patients who cannot pay, but I think you very well pinpointed the fact that major illness contributes to big economic problems.

The medical society for a long time has maintained a grievance committee and an insurance committee to ascertain the fairness of fees. I would like to point this out in the public hearing, that the patient always has the opportunity of redress if he feels that a wrong has been done.

Senator KENNEDY. What is the redress that is available?

Dr. JOHNSON. The patient can file a complaint with the medical society stating that he feels he has been treated unfairly either in the treatment itself or in the fee.

Senator KENNEDY. I don't want to interrupt you, but just on this point, I think the opinion I have gathered from the witnesses here is that they have been uniform in their acclaim of the doctors and the hospitals and the treatment. This is a good deal different from what we have heard in other places. The people here have really been uniform in their statements that they think the doctors have done well and the hospitals have done well, but then they get the bill, and what are they going to do? They think the doctors are superb. A mother here this afternoon was just choked with admiration for the doctor who saved her child's life, and for the treatment they received in the hospital. Now, what are they going to do? Against whom should they fill out a claim?

Dr. JOHNSON. Well, we, of course, have no binding control over the insurance companies. This is one of the virtues of a foundation approach, in which standards are set for policies that are realistic. The medical society, in its function of peer review controls which claims are paid and so forth, and I would like to get into that a little bit later in regard to the medicaid program.

I would also say, before I overlook it, that the nurse from the migrant health program has pinpointed an extreme need. The problem there is that all Federal grant funds specifically prohibit any money being paid for hospitalization of the migrant worker, and this is a very bad situation.

Senator DOMINICK. Can I interrupt there? Is that the fault of the operation or of the law?

Dr. JOHNSON. This is the law, Senator?

Senator DOMINICK. Is it the law or just a rule?

Dr. JOHNSON. Well, I can't say as to that. They look the same to me.

Senator DOMINICK. The law or the rule are not always the same as a result of the agencies thinking up their own rules which have little or nothing to do with the laws which we pass.

Dr. JOHNSON. And the migrant worker problem extends beyond health. It gets into the nutrition. It gets into housing. And it's a problem that should probably be handled on a Federal basis because these people go from State to State. There should be some uniform coverage so they could properly be cared for, and I hope the Congress will work on this.

The group at Greeley, the health department, the medical society, and interested citizens cooperated fully in the second request that's in from the Greeley area, and we hope that some money can be forthcoming on that.

Senator DOMINICK. I'm sure there will be money forthcoming.

Dr. JOHNSON. There are some changes necessary. We also feel that there is a need that the migrant worker get better coverage under the workmen's compensation law, but, of course, that's a State matter. But it possibly could be covered in the Federal legislation, too, because this is a high-risk group, and there is no question that they need a lot of help.

Now, just briefly to go over a few things that we have done: In 1961 in this area the medical societies, the four county medical societies in conjunction with the State and county health departments and the voluntary health agencies, had a task force to study the problem of people getting into the health system and finding the resources which are there. Without belaboring of the point, I would like to say that an information and referral service was developed and still exists today. It has functioned for 10 years very successfully. But, again, it's hard to get the information to the people that if they call a certain number, they will get professional information at no charge on where to seek health care. It will help them with other socioeconomic and health-related problems. This has had the full endorsement of a lot of responsible people. It's still working today, and when we needed an emergency publicity campaign for the veneral disease crisis, this has become the center information point. The operations of this group prove that you can utilize Federal funds at the local level with very successful cooperation of every level of government and the private health providers. We think that this is one of the most important things.

Now, we too are deeply interested in the cost of health care. We believe that, of course, prevention and early detection of serious diseases are a key point.

The objective, of course, is disarmingly simple. We agree on that. It is to attain the highest quality of care at the lowest possible cost under an arrangement that preserves the most dignity, safety, well-being, and freedom of the patient and the provider. This is our orientation on these problems, and we are willing to work with anyone that wishes to help them out.

Now, the medicaid program in this State got into sever difficulties, as it has all over the country. This happened because the law was hastily written, without adequate planning for checks and balances, and then there was the inadequate funding that resulted. In actuality, it was probably the inflationary trend, plus the fact that the Supreme Court threw you a curve with the decision throwing out residency requirements, so that the costs were increased by about 25 percent after all the budgets were made.

In any event, we had a medical conference which involved our State Department of Social Services, the Colorado Osteopathic Association, the Colorado Hospital Association, and the Colorado Medical Society, and we devised a plan for utilization review of all inpatient care.

This was carried out using the hospital Utilization Review Committees which already existed and, to borrow a phrase that is often used to damn us a little by innuendo, the fox was indeed given the task of guarding the hen house. We are happy to report that it worked out

all right because we have reduced the average stay from 6.5 days to 4.5 days under this plan. Only 73 percent of the days assigned under the P.A.S. standards are used. Where extensions are requested because of complications or multiple illnesses, we have only a 59-percent utilization of the time granted.

We have a two-appeal mechanism so that no one will be unfairly treated. There's a regional committee that either the hospital, the doctor, or the patient can appeal to, and then we have a State committee in case the regional committee can't come to an agreement. We have saved a tremendous amount of money working closely with our State agency, and we feel we can do the same thing on the outpatient program if given the opportunity to do this.

We are very interested in the manpower crisis. We supported fully the Child Health Associate program. We are supporting the Colorado Health Careers Council, which makes an effort to reach out and recruit people for health careers in all segments of society.

Senator DOMINICK. May I interrupt? Here is the Health Services for Domestics which was passed last year. It does specifically provide for special projects to establish a continuity in health services and to improve the health conditions of domestic agricultural migratory workers and their family, including necessary hospital care.

Right there in the law. If someone is saying that these provisions aren't in the law then they are out of their mind.

Dr. JOHNSON. I'm glad you pointed that out. We will club certain individuals with that information.

Senator DOMINICK. Section 310.

Dr. JOHNSON. It always pays to go to the top. [Applause.]

One or two last points, if I might, Senator. We recognize that obsolescence is the single greatest hazard to the physician, and we are making a great effort to have a successful and available continuing education program for our physicians, which is geared to our peer review results. We feel that everyone can work together, and it is a necessity. The problem far exceeds the capabilities of Government or organized medicine or anyone else. We offer our services individually and those of our Society for any cooperative effort whatsoever because we are just as interested as you are in seeing that we can prevent repetitions of these hardship cases that we have heard about today.

Thank you.

(The prepared statement of Dr. Johnson follows:)

COMMENTS ON HEALTH CARE PROBLEMS IN COLORADO
BEFORE SENATE HEALTH SUBCOMMITTEE
Denver, Colorado - May 14, 1971

Marvin E. Johnson, M.D.
President, Colorado Medical Society

The Colorado Medical Society is pleased to have an opportunity to comment on the problems of health care before this important committee. This Society's 100 years of service to the people of this area have given our physicians considerable insight into the needs, the resources and possible solutions to health care problems in this area. Over this past century the members have recognized that the independent, even isolated, role of the physician in rendering medical care to individuals has been altered by technological and sociological changes. Our society has made a sincere effort to define it's new and broader role of contributor to the cooperative effort in providing a better coordinated health care system. I shall endeavor to state some of the problems that we have identified and the actions that have proven helpful.

THE PROBLEM OF PATIENTS and their families having difficulty either entering the system or finding the proper resource to aid in health related problems was identified by a special task force in 1961. This type of situation was found not limited to the indigent nor the aged patient but occurred in all economic and age groups. The four metropolitan county medical societies worked with the State and County Health Departments and the voluntary health agencies under a Public Health Service Grant to establish an Information and Referral Service to assist and advise people without charge and to identify unmet needs. This agency has functioned well for 10 years and performed an additional service to the community by establishing coordinated social service departments in many of the

private community hospitals for the first time. With a relatively small amount of additional funding the system could have been expanded over the entire state.

This agency functions well today and has been designated as the prime informational source for the emergency VD program inaugurated by the State Health Department because of the alarming increase in VD locally and nationally. The experience with this agency proved unequivically the wisdom of careful joint planning and jointly shared authority and responsibility in producing successful and economical programs for health care. This enlightened endeavor is generally credited with having eliminated or prevented many misunderstandings between the many people and institutions involved. Such joint utilization of Federal funds and expertise in cooperation with the regional agencies which are so knowledgeable, well accepted and adaptable can be recommended most highly to those responsible for future planning for health care.

Cost of care is a great problem to everyone who shares in any aspect of the planning or provision of care. In my 28 years as a physician I have concluded that the best possible care is always the most economical ultimately. The prime examples of this premise are prevention of serious illness by simple low cost immunization and early detection of still curable serious illness. The expedience of fruitful research to increase the number of diseases that can be handled this way is espoused by all physicians. The clinician while awaiting further significant breakthroughs in this area and hoping for improved accomplishments by governments in the nutritional, environmental, educational and sociological areas must currently contribute his expertise to cost control. The objective is disarmingly simple to state: Attain the highest possible quality of care at the lowest possible cost under an arrangement that preserves the most

possible dignity, initiative, freedom and safety of both the patient and the physician or other provider of care.

Again the experience in Colorado clearly indicates that cooperation, coordination, mutual planning and trust are perhaps the important but often unused tools in accomplishing this objective. A case in point is the Medicaid Program in the United States. This well intentioned effort to fulfill our national responsibility to provide good care for our needy and unfortunate citizens soon came under great criticism because in every single state it was soon in an extreme deficit position. This happened here and was inevitable. Our analysis of the problem was that the law was hastily written without adequate planning with the providers so that proper checks and safeguards could be incorporated and adequate education on how to use the program could be given. The second error was inadvertent inadequate funding by the federal and state legislatures in the presence of continuing inflation and increasing welfare roles because of an unanticipated Supreme Court decision. The third error was our usual over optimism that the money can never run out so let each of us do what is most convenient for him whether he be provider, patient or administrator. Fortunately our State Department of Social Services, which is responsible for administrating the Medicaid Program, was well organized and informed and detected the coming crisis many months in advance. A conference was arranged with representatives of the Welfare Department, the Colorado Hospital Association, the Colorado Osteopathic Association and the Colorado Medical Society.

A plan was devised for Utilization Review of all Medicaid inpatients by the physicians which constitute the hospital Utilization Review Committee in an effort to minimize length of stay and encourage outpatient workup. The guideline designated was the average stay for patients with each specific diagnosis as published in the national PAS standards. The plan

was for the local hospital Utilization Review Committee to review each case that was still in the hospital on the day prior to the expiration of those assigned days. The patient thus had to be either discharged on the following day or on extension of days granted by the Utilization Review Committee, which was acting as the designated authorized agent of the Department of Social Services. The Department agreed to accept this UR committee decision for any additional days up to the 18 day limit set by law.

To borrow a phrase often used currently to malign the providers of care by inuendo, "The fox was indeed given the task of guarding the chicken-coop." There is great pleasure in reporting that the chickens, the owners of the coop and the fox have all fared beautifully. The hospitals have been saved from that unfair hazard, the decision for retroactive denial which meant no pay or only partial pay long after the patient had been given the service and discharged. The physicians have avoided either the need for prior authorization for admission, further reduction of the already substandard fee or categorical denial of admission for patients with certain specified conditions. Those government departments held responsible for the health care of Medicaid patients have been given tremendous assistance in quality and cost control so that they can concentrate on problem areas rather than routine admissions. Our State Legislators who have the ultimate moral responsibility for sociological decisions and fiscal stability have been aided in their mission by the improved efficiency of all concerned.

The most important result has been that no needed service to patients has had to be reduced. Educational emphasis on outpatient work-up may in fact improve quality of care. The traditional mutually good relationship between patient, provider and third party has not been damaged by any devisive or destructive regulation on anyone.

Objectively this coordinated effort accomplished the following startling results. The average length of stay for Medicaid patients was reduced from 6.5 days to 4.5 days. The length of stay of 6.5 days was 1.2 days below the national average so that the Colorado program was much better than average even before this 2 day reduction in length of stay. Two other statistics that prove the providers can be entrusted with the controls of health programs are these. Only 73% of the days granted under the PAS average standard are used. Only 59% of the days authorized for additional stay in complicated or difficult cases are ever used. Another critical fact is that this program was conceived of, designed, agreed upon and implemented in less than six weeks time and has never faltered. The fact of decreased utilization shows conclusively that the providers can be entrusted with local control under standards mutually agreed upon with the third party payor. Experiences with Foundations for Medical Care such as the one in San Joaquin have demonstrated that these controls can be exerted over outpatient cost and quality. We feel that we shall be able to accomplish this with our Colorado Foundation for Medical Care in the future if given the opportunity to do so by the government.

The efforts to increase manpower have been supported actively by the Colorado Medical Society. The Child Health Associate program of the University of Colorado received our unqualified endorsement. Our society initiated a recommendation that young Public Health physicians be allowed to serve their two years of government service in rural understaffed areas or ghettos. This type of program was introduced at the AMA level by our Delegates and was very much like the Federal Law that was ultimately passed.

For many years the Society and it's Auxiliary have furnished facilities and given operational money to the Colorado Health Careers Council. This Council has carried out a very active educational and recruiting program in the high schools to encourage young people of every group to enter the health field.

Recognizing obsolescence as the single greatest hazard for the physician or other professional, the State Society is working actively in conjunction with the AMA to develop a successful and available continuing education program for it's physicians.

Many other problems exist and some seem to become more difficult with each attempted solution either complicating the old problem or creating a new one. In my experience this type of difficulty can be avoided best by proper coordination of all involved parties in the planning and implementation of a health program. Forthrightness rather than secrecy, cooperation rather than imposition, mutual respect rather than antagonism appear to be the key attitudes to assure progress in new designs for health care. Many things have happened in Colorado which prove the great value in sincere cooperation between Federal Government, Local Government and medical or health organizations. The greatest possible good for the most patients can come only by increasing this coordination and communication. The services of the Colorado Medical Society are available to all, at anytime, in any effort directed toward improving quality and availability of health care while controlling cost and preserving the dignity and rights of our citizens.

Dr. PLATT. Senator Kennedy, Senator Dominick. I have a prepared statement which I will set aside. You have it there for the record.

Senator KENNEDY. It will be entered at the end of your testimony.

STATEMENT OF KENNETH A. PLATT, M.D., PRESIDENT-ELECT, COLORADO MEDICAL SOCIETY, DENVER, COLO.

Dr. PLATT. I would like to speak to you just for a few moments both as a concerned professional and as a compassionate human being. The tragedies you have heard here, both personal and socioeconomic, are in a sense the tragedy of all of us. The very fact that one such instance could occur in a country as rich and powerful as this is a concern, not only to you and me, but to other taxpaying members of this group today.

I am assuming a position now as the president-elect of the medical society. I have been in organized medicine for years, and I can truthfully say that I espouse causes and promote programs that 10 years ago would have been considered heresy in the medical profession.

We have reached that point now where our technology is eating us alive. It's creating a demand for our services and an expense that's far beyond the average capacity of the wage earner to afford.

Now, the medical profession is fortunately becoming more concerned and more enlightened and more knowledgeable about the problems than ever before. It is our hope that through mechanisms like the foundation program, by computerized laboratories and so forth we can cut the cost down, that we can provide the technologically superior care that these people need and demand and keep it within the bounds of their ability to afford and pay for.

There are just a few points that I would like to make, since Dr. Johnson has covered many of the specifics. We feel that the only solution to the costs, whether it's under Government programs or under State programs or under private health insurance, is to orient the public out of the hospital. They have simply got to be trained, and the doctors have to be trained, to seek their care outside the hospital, because it's the cost of the hospital that's taken the cost of medical care beyond the reach of most people.

This is not to indict the hospitals, because they are caught in expanding costs, particularly expanding employee costs. The hospitals are not unaware of this problem, and we have here in Colorado a unique program, which I think you should be aware of, that we believe will be a partial answer to hospital costs.

We have a major urban center with expanding suburbs. Each year the population moves farther and farther away from our core-city hospitals. It becomes a matter of economics, traveling back and forth to seek care or to visit people who are under care in the hospitals.

It makes little sense to build bigger and bigger centrally located monolithic structures. So we are now building a satellite out in the northwest sector of Denver, a full-scale facility, approximately 115 beds, caring for 80 to 90 percent of the needs of the local population. They can remain in their local areas. They can be treated generally

in their local areas. They can be transported when they have major crises by helicopter or by ambulance.

We were able to build that hospital at a cost of $21,000 a bed, which is about a half or a third what it costs in the metropolitan area.

This is one of the ways we are trying to reach out to the public and bring them the care they need at a cost they can afford.

An attempt to set up rigid standards for insurance coverage is being made that will prevent some of the things you have heard today, such as inadequate coverage or exclusions the patient is not aware of.

I'm not going to make a plea for any one great, simple solution to this problem. Many people have varied greatly in their solutions to the problem. It is your prerogative as an elected representative to come up with an answer that makes economic and professional sense.

I hope that when you go back to Washington to debate these problems, you will recognize the contribution that the physicians of Colorado are trying to make their solution. You should also recognize that the health professionals represented in this room and the students represented in this room are just as concerned and just as aware of the problems as you may be.

That's all I have to say.

Senator KENNEDY. Let me ask you, if I could, what has been the reaction of the insurance companies to your efforts to get people out of the hospital beds, or to set up the satellite facilities in the communities? I can remember when I offered an amendment in the Senate to set up a program of neighborhood health centers. It was opposed by the Medical Association, opposed by the Hospital Association, opposed by almost all of the organized health groups. Here was an idea that wasn't developed within the existing health system. We in the Congress like to see initiatives coming from the groups that are working in the field.

I suppose you could say the AMA now has a health insurance bill and so do the hospitals and so does everyone else. There are about four or five different kinds of proposals that represent the different kinds of interests in the health field. I would be interested in what reaction you are getting from the insurance companies to your efforts. I agree with many of the things you have said in trying to achieve the aims you have just outlined here.

Does your group meet with the insurance companies? What kind of reactions are you getting? Do you talk with them?

Dr. PLATT. Yes, in open dialog.

Senator KENNEDY. What's the result? Can you tell us about the dialog?

Dr. PLATT. The dialog is often heated, Senator. The results are mixed, but like the reluctant dragon, I think we will bring them across the threshold.

Senator KENNEDY. Why do they have to be dragged across?

Dr. PLATT. I think that, like most of the physicians 10 years ago, they were concerned with a certain aspect of the socioeconomics of the issue.

Senator KENNEDY. Is it more economics?

Dr. PLATT. I would imagine that, as in any free enterprise system and a profit organization, economics played a great role.

Senator KENNEDY. I suppose that raises the question, whether there ought to be health for profit?

Dr. PLATT. I think it depends on what you call profit.

Senator KENNEDY. I will take the profits insurance companies make on health insurance. Let's use that definition.

Dr. PLATT. I'm not an expert in this field, but I have seen statistics that say that the profit on health insurance in the country as a whole is approximately 1 percent or less.

Senator KENNEDY. Why do private carriers retain almost half of the premiums that are paid in for individual policies, instead of paying them out in the form of health benefits? Why is the overhead so high?

Dr. PLATT. I think this is part of the national debate that has to go on. I would also like to point out that we do not necessarily find that at the Federal level, the economics is of the best.

Senator KENNEDY. That's right. I couldn't agree with you more on that, but often it's been the Federal programs that have tried to meet the need.

Dr. JOHNSON. I think the secret of making the program work is more local or regional responsibility and authority. Many times the local agency is more knowledgeable and more adaptable, because conditions vary from place to place.

Senator KENNEDY. I think it is very worthwhile for you to work with the insurance companies to give them the benefit of your experience.

Senator DOMINICK. I just want to make one closing statement. I think this hearing shows the need we have for an exchange of viewpoints between many people. I don't pretend to defend the insurance companies because just among the witnesses here they have paid out virtually hundreds of thousands of dollars in premiums to fulfill their contract responsibilities, and that ought to be put into the record too. They are not all just trying to rook the public, I don't believe.

Another important area is trying to find some method for covering those situations where people either cannot afford the major type of medical insurance or in the case where during a long-term illness the insurance runs out. I have a feeling that a good deal of this work is going to have to be done with either State or Federal help. I don't think it can be any other way.

The income level or the type of conditions that may be involved which would bring this situation about can be discussed at length somewhere else. I think the input that we have received has been extremely successful insofar as it demonstrated the concern felt here in Colorado which has been complimentary about the medical attention, the hospital attention, and the innovations that have been going on here. I want to congratulate you. I think you have done a great job.

Senator KENNEDY. I want to thank you very much for coming. Your complete statement will be included as a part of the record.

(The prepared statement of Dr. Platt follows:)

KENNETH A. PLATT, M.D.
PRESIDENT-ELECT, COLORADO MEDICAL SOCIETY

TESTIMONY BEFORE THE HEALTH SUB-COMMITTEE OF THE
SENATE LABOR AND PUBLIC WELFARE COMMITTEE
DENVER, COLORADO

Senator Kennedy, Senator Dominick and members of the Senate Subcommittee on Health, I wish to express my thanks for this opportunity to contribute to the current dialogue on the health care system in the United States. It is both fitting and proper that the manner in which health care is delivered and financed should be a matter of National concern. Any nation as rich and as powerful as this cannot afford the "luxury" of neglecting the health needs of its citizenry. That there are problems existing in our present system of health care delivery is an established fact and the only basis for argument is over the methods used to overcome these problems. Well-intentioned and knowledgeable men vary widely in their proferred solutions and it would be presumptuous of me to critique the various plans that are currently before the Congress. Instead, I should like to discuss briefly some of the things currently astir in Colorado as our profession is rising to the challenges before us.

Undoubtedly the most exciting advent in the past two years was the formation of our statewide foundation for medical care. It envisions a network of regional foundation entities tied into geographical and population considerations all under the umbrella of a governing board at the state level. This board would be comprised of representatives from all the major providers of health care such as doctors of medicine and osteopathy; pharmacists; nursing home operators; and hospitals. The foundation's major fields of endeavor

would be in the areas of peer review; utilization control, and quality assurance. It is our sincere belief that through education and peer review both cost controls and quality assurances could be guaranteed. We have already established the effectiveness of such a mechanism in our current cooperative effort with the State Department of Social Services and the Medicaid program. Projected savings to the program for the first year of our joint efforts is in the range of 1.5 millions of dollars. The Foundation is currently exploring ways to expand into other public and private sectors in order to further enhance the already high quality of medical care in our state.

As the committee is well aware, the most troublesome sector in our rapidly escalating health care costs is the hospital sector. In an attempt to bring these troublesome costs under control we have embarked on a program of hospital satellization. Two of the major private hospitals in the Denver area are constructing satellite hospitals in suburban communities. They have found that this meets the local needs but at great savings both in initial construction costs and in management savings. In the suburb of Westminster, St. Anthony's Hospital is just completing a 115-bed satellite built at a cost of only 21 thousand dollars per bed. This compares to an average cost of 35-45 thousand dollars per bed for hospital construction nationwide. In addition, by the joint purchasing, management and staffing of the two hospitals further savings are anticipated.

Another area of progressive innovation in medical care in our state is the increasing use of helicopter evacuation of critical medical and surgical cases from outlying areas to our major metropolitan medical centers. Just in the past month a heliport was dedicated on the roof of

St. Anthony's Hospital in Denver. Already it has been used to receive several accident victims who were evacuated directly there from the scene. It is the intention of most of the major centers in the state to tie in with private, police and military helicopter evacuation teams. Hopefully a state-wide network can be programmed to take care of rapid transit of highway victims to areas of primary care.

These are but a few of the on-going programs of advancing medical delivery in our state. In addition we have pioneered in such areas as neighborhood health centers; migrant worker programs and mass inoculation drives. Nationally recognized as a progressive state in many fields, Colorado has been particularly active in the health care area. It is with pride that I point out to you gentlemen that these accomplishments have been largely created by the private sector of the health care team. In defense of our "cottage industry" and contrary to certain current opinions, I have found the practicing physician both concerned and innovative in his attempts to improve our "non-system". Given governmental support and legislative help I believe that a free profession of concerned individuals can do a great deal to solve these vexing problems. It is my fervent hope that our national goals will be met by building on what we have rather than discarding all we have accomplished for a nebulous, monolithic, bureaucratic program of total federal care.

Senator KENNEDY. We are running into a time problem, but we will hear from some witnesses from the floor. Dr. Sparkano has agreed to file his statement. We had a good visit with him earlier today. It was very informative, and he has agreed to yield his time so that we may hear some of the other witnesses.

Mrs. Espinosa? Is she here?

Mrs. Espinosa, we want to welcome you here.

STATEMENT OF MRS. ESPINOSA, WITNESS FROM THE FLOOR OF THE HEARING

Mrs. ESPINOSA. Senator Kennedy, welcome to you here, and to Senator Dominick. I'm kind of shaky from seeing you this morning at the center.

My problem here is the difficulties that I have had with my children, with myself. I have seven children, and I have gone through a lot of tragedy in the past 2 years with a husband that passed away, a daughter that committed suicide—hung herself 2 years ago on the fifth of April. Another son that had polio—he got polio at 9½ months old. He has had two operations, has braces on his legs—on each leg. The boy is disabled with polio.

He has worked hard trying to get a job, and everywhere he has gone he has been rejected.

He is a good artist—he's an artist, and he has tried hard to get into these jobs with the art program, and Gilbert has gotten nowhere. Funds are not included for purposes of this type of work for Gilbert.

The girl was going to beauty school, too, and there were no funds to help Rosalie finish her school, her college education; Gilbert also.

There is another problem: I have had all this tragedy, the death of the husband, me raising the children alone, and I'm on A.D.C. receiving three twenty-three a month. There are six of us at home now, and we can't make ends meet with this money. One thing that's good is that I have medicaid, which covers my hospital for my children and for myself.

I have been real sick in the past, and I had a wonderful home at 2526 Kearney. It was a nice home.

Duane is another one of my sons. He is a deaf mute and hard of hearing. He is 15 years old, and we had no help from any funds from anyone. We have been trying hard to put Duane through school, and this is one thing that I would really appreciate—if someone would come up with something to help these children with school.

You know that a lot of children need not only money. A lot of mothers are left alone. A lot of children are left alone with just the mother and not a dad, and my kids were left without a dad. Duane is not eligible in any public school because of his hearing and speech therapy.

Another problem that I have had—I always weighed 150 pounds, Senator, and in the past 2 years I don't know what came over me, whether it was my daughter who hung herself in the basement of my home or the other tragedies that came to me.

Gilbert is a problem. Duane is a big problem. I have Debbie and Nora, who are going to Annunciation School today, and I have fees for those girls.

It's a $90 fee for Debbie and $90 for Nora. One is in the eighth

grade. The other one will graduate June the 3d, and it is a problem for us to pay these fees, especially on my welfare.

I have been sick in the past, and I have a nervous condition.

I had a real nice doctor, I thought, but after I had been going to this doctor for a whole year, I found he was treating me for the wrong thing. Every time in his office, he would say, "Take all these pills and take a different kind of pills at a certain hour," and I would take them.

I was always on drugs, heavy drugs. I was always asleep.

OK. I went to him till one time he gave me the wrong medicine and treated me with the wrong medicine. I never did anything about it. I said, "God will help me and he will help me get well." It is in my prayers that I would get well for the sake of my children.

Well, I went and changed doctors. I went to Dr. Richard Hamilton, and he is my doctor now today. I do have a touch of thyroid. At one time I couldn't walk. I couldn't talk. I couldn't help my children. I couldn't see. My vision was blurry. My legs were off—I couldn't do anything for my children.

I wondered what was going on. I called the priest. He called the ambulance, and he said, "Annie, you are going to be rushed to St. Joseph Hospital," and I was rushed there, and I was treated there, and I have been having all these problems for 2 years, and this doctor didn't know what was wrong.

He told me I had a nervous condition and put me on tranquilizers. All the time I was always doped on them, and there was no problem of a nervous condition whatsoever.

The problem with me today, which worried me so much, is that my weight was 150, and today I weigh a hundred and twenty-five. My weight has really gone down since December, and I have a problem of sickness, a nervous condition, and it's not bad. I have thyroid. I have an active thyroid, and I am a diabetic.

And another thing. I tried to get together with the Welfare Department to see if they could help me out with some kind of extra money for my diet because I'm not on insulin. I'm not on pills, but I'm on a strict diet. Sometimes when I don't have the money—when I have to buy for the other children and I don't have enough—I go out. I need this for myself and my children, Senator Kennedy.

Senator KENNEDY. This is certainly a very tragic set of circumstances for you. We don't have any easy answers on this, Mrs. Espinosa, but I want to thank you very much for sharing it with us here today.

WITNESS IN AUDIENCE. I think we have seen from the previous witnesses here what major illness can do even if you have a stable income. But I think it also pretty well illustrates what can happen if you are poor to begin with. The results that can happen are even more distressing, especially as they relate to the family, because the only thing the family had to lose is its relationship. And they have lost a good portion of that because they were economically down to begin with, and now they have had a major illness. It's even more tragic than losing money.

Senator KENNEDY. That's a good point, one that hasn't been made. Thank you very much.

I understand that these hearings are being piped in to Boulder, where Mr. Paul Hagen is standing by. Do you have a comment, Mr. Hagen?

STATEMENT OF PAUL HAGEN, TRANSMITTING BY TELEVISION TO FLOOR OF HEARING FROM BOULDER, COLO.

Mr. HAGEN. Senator Kennedy, Senator Dominick. we have heard several comments concerning the high cost of drugs. These are what my comments are concerned with.

Would you please consider for legislation under your health insurance plan the idea of physicians prescribing drugs by generic name? This would allow poor people to take advantage of the same price structure that others do. There have been several films on this question. The cost varies in the neighborhood of tenfold to twentyfold, depending on the item.

Senator KENNEDY. Senator Nelson in the Senate has had a series of hearings on this issue and has pointed out the problem. I think it's a very worth while suggestion. It's a good comment.

Mr. HAGEN. If they are really interested in cooperating in all of the local areas, they could do it.

Senator KENNEDY. The AMA could do it.

Mr. HAGEN. Yes, they control what the doctors do, and it could be done tomorrow.

Senator KENNEDY. I would like to ask Dr. Platt or Dr. Johnson to make a comment on that.

Dr. PLATT. For those of you who don't know it, I have led the fight in the State for the last 2 years and in the house of delegates of the State society regarding compulsory membership in the AMA, which I think should be abandoned and which we hope will be. This doesn't mean I take necessarily any opposite stand to many of the things the AMA stands for. I merely mean it should be a professional choice.

Interestingly enough, despite the fact that I oppose the AMA on this issue, I still ended up on the board, so I doubt that they control it.

Senator KENNEDY. You are a good politician.

How about the view of the AMA on those pharmaceuticals?

Dr. PLATT. I think there has been some problem here, but I would like to say that many of the physicians in the State, and I, personally, prescribe mostly by generic name.

Dr. JOHNSON. The AMA, God rest their beaten soul, you know, has just sent to all members a new book published by the council on drugs which very accurately reflects those drugs which are good and their generic name in an effort to get rid of useless drugs. So, they are attempting through educational efforts to improve drug prescriptions.

Senator KENNEDY. Do you have the power to do it here in the State without waiting for a national resolution?

Dr. JOHNSON. No.

Senator KENNEDY. Could the medical society here in the State pass that resolution at its next meeting?

Dr. JOHNSON. For one thing, only approximately 2,700 of the 3,200 practicing physicians belong to the Colorado AMA, and this doesn't include the osteopaths.

Senator KENNEDY. That would be a good start, wouldn't it?

STATEMENT OF BOB APTER, MEDICAL STUDENT

Mr. APTER. If I may comment, my name is Bob Apter, a medical student here. The winter clinics passed a resolution recommending generic prescription of drugs and then the Colorado Medical Society will meet on it——

Dr. PLATT. Which, by the way Senator, is an innovation of the State of Colorado to have a student society, and their input is particularly vocal.

Senator KENNEDY. Now what are you going to do with their resolution?

Dr. PLATT. We are going to pass it.

Senator DOMINICK. The Food and Drug Administration also is looking at this, as you know.

Senator KENNEDY. Very good. Well, thank you very much, Mr. Hagen. We hoped to be able to get up to Boulder, but we want to thank you.

Is there another question from Boulder? We would like to have one more. Can you identify yourself, sir?

Mr. HAMPF. Senator Kennedy and Senator Dominick, I am Rudolph Hampf, associate director of the university-industry relations, University of Colorado.

We appreciate receiving and participating in this television interchange with your committee from the Boulder campus, University of Colorado.

Thank you.

Senator KENNEDY. Very good. Are there any other questions?

STATEMENT OF PETER PETERSON, M.D., CHIEF RESIDENT, DENVER MEDICAL CENTER, DENVER, COLO.

Dr. PETERSON. I want to point out something on your map. My name is Peter Peterson. I'm one of the chief residents in medicine here at the Denver Medical Center. This is where we are in Denver County (indicating). This is Adams County (indicating). We have 1,000 doctors in this county; we have 21 in this area (indicating), which is a ratio of 50 to 1. The populations are in a ratio of 4 to 1, and Adams County has one of the highest infant mortality rates in the State. It's twice the national average.

This ratio of doctors to population is about like the Philippines. We have given quite a bit of criticism to the insurance companies and the medical society today, and the university has gotten off scot free.

I would just like to say that the university, to my knowledge, has no Outreach program into this area. Many of our migrants are also in this area and their infant mortality rate is three times the national average.

It's been brought out that the only hospital where migrants can easily be taken care of is Colorado General. However, Colorado General has no responsibility to the migrants, and I would wonder if we shouldn't consider that if we are going to fund Colorado General, we should give them some responsibility also. [Laughter.]

A couple of other points: It's been mentioned that we are concerned with economy; we are concerned with peer review. The doctors from the AMA mentioned that, and ambulatory care, and yet these are not

emphasized in medical school teaching to any great extent. I wonder, if we are going to fund the medical schools, shouldn't we teach them peer review? I don't think that there's any program in the medical school to teach peer review.

There's also a number that has been given that we need 50,000 more doctors in this country, and I don't know where that figure came from. Is anybody able to tabulate that? And when we train these 50,000, are we going to require that they are trained to solve the problems that we are concerned with, which are immunizations, maternal health, child health, and so on?

Thank you.

Senator KENNEDY. Good comment. [Applause.]

Let me ask, since we have some of the medical students, how many of the medical students are going out to practice as general practitioners and going out into rural America or the inner city to practice?

Dr. PETERSON. I asked the dean here if they had any record of how many students go out to practice in rural areas who are trained in this medical center. The information isn't available. And we are going to add 10 students to our medical school class, but likewise, I don't think there will be a record of how many of those people go out and solve the problems that you are concerned with.

Senator KENNEDY. Of the ones that are here today—how many of you intend to practice in rural America?

[There was a showing of hands.]

Senator KENNEDY. How many of you are in the rural health program? I understand you have such a program here. You have only just got started; is that right?

Senator DOMINICK. I would like to ask how many of those which raised their hands are going to practice in rural Colorado?

[There was a showing of hands.]

Senator KENNEDY. Are there further comments? We have about 3 more minutes.

Dr. FRITTS. I will try to limit it to one. We appreciate Senator Kennedy and Senator Dominick coming to Colorado.

Senator KENNEDY. What is your name?

STATEMENT OF C. A. FRITTS, M.D., CHAIRMAN, LEGISLATIVE COMMITTEE OF COMPREHENSIVE PLANNING HEALTH COMMISSION, DENVER, COLO.

Dr. FRITTS. C. A. Fritts, F-r-i-t-t-s, chairman of the Legislative Committee of the Comprehensive Planning Health Commission for Colorado.

Fifty percent of the membership of our group are consumers. We have the State divided into 13 areas, and we have councils in each of those. We are striving to help solve some of the crises you have outlined.

For instance, the quality crisis is certainly one of our main goals. The system crisis is probably the greatest goal. How can the 42 different agencies that are giving health services in our State be correlated so there will be no duplication or less duplication of effort, even in the rural sections?

We are spending a lot of time in working on that. We think we have some legislation that is working satisfactorily. We in the podiatry field are working hard, and I want to go on record that we are getting excellent cooperation from the medical societies. There is no disagreement of any sort, but we are doing our best to see that we keep out of the hospitals, when the hospital average cost is $80.01 a day. If we can keep them walking, keep them out of wheelchairs, we can keep the cost of hospitals down. At least, it won't run up the insurance quite so fast.

Senator KENNEDY. Thanks very much. We have a final student question.

Dr. PFEIFFER. I am Dr. Pfeiffer. I plan to teach in the medical school. I would endorse wholeheartedly points 1 through 4 of the Health Security Act.

I think it's important for the Senators to realize that there are physicians who would support an activity and wholeheartedly work toward some sort of national insurance program, but who would have very grave concerns about the precise structure of the program.

Those of us who have personal concerns with the military or the VA health programs, find that the resources, by and large, are ill-used, because there is no coinsurance, howeever trivial it might be, be it 50 cents a visit or a dollar a visit.

Those of us who have family members or who have worked in a variety of other hospitals would also question very gravely the generally accepted premise that group practice, of which Kaiser is an illustration, is a perfect answer to the problem. I would suggest, and I obviously can't elaborate, that the lower costs are perhaps illusory because of a very markedly different patient population; namely, that the care tends to economize on the single most expensive part over which the doctor has great control—his time in taking a history. This is the most important thing in medical care and it is diminishing, at least today.

There are aspects of efficiency of medical care which are for the moment beyond the reach of this sort of legislation. I would give the single example in cancer detection that there must be patient and physician acceptance and nurse acceptance even in hospitals of such things as undressing, as having retal examinations or transmitting stools for tests for blood. All of these would be appropriate and necessary and inexpensive and nontechnical forms of cancer prevention and detection. But they are just not available to us because of public attitudes.

Thank you.

Senator KENNEDY. Thank you very much. I want to thank all of you very much for your attention this afternoon and for your interest, particularly the witnesses who were kind enough to attend the hearing this afternoon.

We want to express our appreciation, and our thanks again to this fine school for cooperating with us. I think it's been very helpful. I know it has been for me, and I'm sure it has been for the committee.

Senator DOMINICK. I would just second your thought.

Senator KENNEDY. Thank you very much.

At this point I order printed all statements of those who could not attend and other material submitted for the record.

(The material referred to follows:)

HERRICK S. ROTH
PRESIDENT

A. TOFFOLI
SECRETARY-TREASURER

Colorado Labor Council, AFL-CIO

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May 14, 1971

Hon. Edward M. Kennedy, Chairman
Hon. Peter Dominick, Member and U. S. Senator from Colorado
and Other Members
U. S. Senate Committee on Labor and Public Welfare,
Subcommittee on National Health Insurance

Senators Kennedy, Dominick and Members of the Committee:

We are delighted that you are looking at the matter of health care at the grass roots of our Nation's communities. You will find here and in your other visits throughout America the human equations that back up the statistical treatment of "national health," "health care," and "Health insurance" that is already so abundantly clear to you and in the records of your Committee for the ready evidence that makes the case for national health insurance.

We will not burden you, therefore, by repeating these facts. AFL-CIO President George Meany's testimony on September 24, 1970, still reflects the current situation nationally; your own testimony, Sen. Kennedy, on behalf of S 4297, the Health Security Act, on September 23, last, is replete with much of what we in the trade union community believe. We cover a vast cross-sectional income span in organized labor today--from lower to upper middle income--but when the heavy but often absolutely necessary costs of health care fall upon any of us or our families, rest assured, none of us so situated finds it possible to meet the entire cost, even underwritten by private insurance (profit or non-profit based).

So, let us relate for the moment to local area events that will add to the comprehension that each Senator and Representative must have in order to act in the national interest for total health care for every one of our citizens. For instance, this Council and its affiliate local and district labor organizations, in cooperation with the regional administrator of the United Mine Workers Health and Welfare Fund, were among the principal instigators responsible for the Kaiser Health Foundation and Kaiser Permanente Medical Group establishing in

(more)

the last two years a Colorado operation, based for the moment in Denver Metro and growing more rapidly than perhaps even they could comprehend when they elected to open facilities east of the Great Divide in Denver and Cleveland, Ohio.

The experience of this advent in our town and its suburbs has meant (1) a new quality of delivering total health care; (2) a cost operation that is pre-packaged to avoid economic catastrophe for families who otherwise would be or would have become medically indigent; (3) a liberalizing of the viewpoint of both the medical profession and related health care personnel--and we must, indeed, give these highly skilled persons a tip of the hat for the positive manner in which they have received Kaiser and also for their own realistic evaluation of how they best serve in other respects the health care needs of our area; and (4) an outgrowth recommendation to you and your Committee, that any health insurance plan made available under the auspices of Government must permit the operation of pre-packaged, private not-for-profit plans, groups and foundations which meet the requirements of total health care to the families who accept membership in these programs.

Second, if no one else brings this to your attention, we wish to do so. The Craig Rehabilitation Hospital here has received national attention. Its current publication (April, 1971) points out a significant statement by its medical director, Dr. Robert R. Jackson, which in summary points out that the incidence of catastrophic injuries has increased fifty per cent over the past five years involving potential expenditures of up to $500,000 of lifetime care--a cost to society that could approximate $61,500,000 if these cases had not been brought into the Craig program of management for the severely disabled--part of the health care of our society. We hope you will seek from Craig a full report, to study its relationship to national health insurance, and to relate the findings and legislation proposed by your Committee to clinical and hospital rehabilitation programs that are in the national interest so far as both lesser cost and quality of rehabilitation services are concerned.

Lastly, we must caution that you cut no corners. We have had the opportunity to talk personally with HEW Secretary, Elliott Richardson, here in Denver several weeks ago. We especially discussed health care. We urged him not to package less than a full program within the purview of his Administration. We pointed out that health care now assumes the significance of the educational nurture of our society. We don't provide free public education and make it successful by "partial payment," by "partial insurance" and "deductibles." We "insure" for total program for our youth. We must "insure" for total health care of all Americans and hope that you will settle for nothing less. This is our Colorado trade union challenge to you and your Committee. Thank you.

Respectfully submitted,

Herrick S. Roth
President

HEALTH CARE FOR ALL THROUGH THE INCREASED UTILIZATION OF ALLIED HEALTH PROFESSIONALS

by

Henry K. Silver, M.D.*

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It is generally recognized that a crisis exists in providing health care for an enlarging population of children and that the only effective, practical, and acceptable method of meeting the need for additional health manpower is through the proper utilization of various types of well trained "allied" health professionals such as pediatric nurse practitioners, child health associates, and school nurse practitioners. This presentation describes the three programs that I have developed to prepare these new types of health professionals to provide improved and increased health care to children. It also reports on the significance of these programs and on the performance and the acceptance by the public of these health workers.

PEDIATRIC NURSE PRACTITIONER

Our pediatric nurse practitioner program was the first program in the 1960's in the United States to prepare a new category of health worker to carry out functions and activities which physicians traditionally had performed. Nurse practitioners are graduate nurses who receive four months of special training at our medical center which gives them the capability to fill a markedly expanded role in nursing in various public health facilities and in the offices of physicians in private practice. They are the only non-physicians now in practice prepared to provide augmented and improved direct health care for our child population. For the period of the next five to seven years, they will continue to be the only health professionals who could be trained in sufficient numbers to meet the needs for additional health manpower for children; not until 1975 to 1978 will other types of health professionals be graduating in large enough numbers to make an impact on these needs. All other health professionals, including physicians, physician's assistants such as those from the Duke Program, and MEDEX could not be trained rapidly enough (as would be the case with physicians) or do not have the capability to care for children (as is the case with physician's

assistants and MEDEX who, presently, are only equipped to provide health care to adults). Within months, on the other hand, hundreds of pediatric nurse practitioners could be prepared for practice. A number of pediatric nurse practitioner programs have already been established, but the training of 20 nurses a year for the next three years at each of 100 additional pediatric centers -- a goal that is readily attainable -- would result in a doubling of the total quantity of new professional-level health care, including that provided by physicians, that becomes available each year to children.

The pediatric nurse practitioner can take complete histories; perform comprehensive physical examinations; carry out necessary immunization; evaluate hearing, speech and vision; determine developmental status; perform laboratory tests; evaluate and manage common problems of the healthy child and those with minimum illnesses; counsel parents; assist in managing emergencies; care for newborn infants; and handle telephone calls. These functions and activities include most of those that a pediatrician carries out in his office.

We have carried out a number of evaluation surveys of graduates of our program with the following findings:

1) Pediatric nurse practitioners can, by themselves, care for approximately three-fourths of all children coming to an ambulatory office setting for health care.

2) Pediatric nurse practitioners can provide almost total care to all well children, and can evaluate and manage a majority of the problems of sick and injured children seen in the office.

3) Ninety-four percent of parents expressed satisfaction with the combined care provided jointly by a pediatrician and a pediatric nurse practitioner in a private office; fifty-seven percent

found joint care to be better than that which they had received from a physician alone.

4) Ninety percent of parents consider an association of a physician and an allied health professional to be a desirable and inevitable trend in the practice of medicine.

5) There was a high degree of agreement by pediatric nurse practitioners and pediatricians in assessing the health status of children; a significant difference in assessment occurred in only 1% of cases. This is undoubtedly as good as might have been found between different physicians.

6) Pediatricians who have pediatric nurse practitioners as associates in their practices have found that such an association results in the physician seeing from one-third to one-half more patients and in having at least one-third more time than they formerly had.

The concept of the pediatric nurse practitioner has been endorsed by the American Academy of Pediatrics and the American Nursing Association. A nationwide project financed by the Federal Government to train adequate numbers of pediatric nurse practitioners would represent a feasible, inexpensive, and rapid method of meeting a significant portion of the need for health care for children. The cost of such a project would be only a fraction of the cost of training physicians to give the same quantity of child health care.

CHILD HEALTH ASSOCIATE

The second program for allied health professionals that I developed at the University of Colorado is concerned with the training and preparation

of an entirely new category of health worker, the child health associate, who has greater capability and growth potential to provide health care to children than any other allied health professional now serving the public.

Students in this program complete a three-year curriculum at our medical center after two or more years of college preparation for a total course of study of five years after high school. This is in contrast to the eleven years that it takes to prepare a pediatrician and the nine years for a general practitioner. Child health associates have problem-solving and decision-making capabilities similar to physicians. However, they spend even more time in the areas of diagnostic pediatrics, preventive pediatrics, in well-child care and supervision, and in the care of the child with minor illness than is usually spent not only by medical students but also by members of pediatric housestaffs in most pediatric internships and residencies. Child health associates concern themselves with the broad generalized problems of child care which occupy much of the time of pediatricians in private practice -- respiratory ailments, minor injuries, communicable diseases of various types, minor gastrointestinal disturbances, allergy problems, mild disorders of the skin, infections of various types, as well as well-child care and family counseling in many forms. They are qualified and will be certified under a specific law in our State to give almost total diagnostic, preventive, and therapeutic care and services (including the writing of prescriptions for non-narcotic drugs) to approximately 80 percent of all children seen in a typical pediatric practice.

The child health associate program is a new and innovative attempt to cope with our increasing manpower shortage. It is the first program of its kind anywhere in the United States, and represents a major modification

of medical practice since it allows a non-physician to provide total primary care to a patient. The child health associate program could serve as the model for a major revision in medical education and in the system whereby health care is provided; the child health associate and similar health workers in other branches of medicine have the potential of becoming the major purveyors of primary health care.

SCHOOL NURSE PRACTITIONER

The third program we developed, the school nurse practitioner program, prepares the school nurse for an expanded role in providing more and better health care in the school setting. The school nurse practitioner program aims to rectify a major loss in the present health-care system: the failure to utilize fully the skills and services of the 16,000 school nurses in the United States. School nurse practitioners assume basic responsibility for identifying and managing many of the health problems of children. They perform routine health assessments; participate in providing comprehensive well-child care; evaluate and assist in managing children who report with complaints of illness; assess and coordinate the evaluation of perceptual problems and those producing learning disorders, psycho-educational problems, and behavior problems; counsel with parents; visit classrooms, and make home visits. Effective utilization of well trained school nurse practitioners in a school setting ensures greater continuity of care and ushers more children into the general health-care system with the result that the school becomes the place where an increased proportion of the health care of children is given.

At present, school children receive most of their health care either in the offices of physicians in private practice and in various public

health facilities (neighborhood health centers, hospital outpatient departments, well-child conferences, etc.). Unfortunately, many school-aged children fail to be brought to either place for continuing comprehensive care or for the meaningful prevention or correction of physical, emotional, and learning problems. As a result, many children with perceptual difficulties, low-grade chronic health problems, or other conditions affecting their ability to learn may go undetected for long periods of time.

We propose that additional health care be provided in the schools where children between the ages of five and 18 are regularly and readily accessible where meaningful evaluative and preventive services could be provided by well-trained health professionals, where a complete picture of an individual child's problem could be ascertained, and where ongoing care could be provided by well-trained health professionals, where a complete picture of an individual child's problem could be ascertained, and where ongoing care could be provided and therapeutic measures carried out.

Our program is already serving as the model for similar programs elsewhere in the United States.

SUMMARY

The crisis in providing health care for an enlarging population of children can only be met by the effective utilization of "allied" health professionals. The three programs developed by the author to prepare pediatric nurse practitioners, child health associates, and school nurse practitioners have the potential of producing markedly increased and improved health care to children.

Senator KENNEDY. The hearing stands in recess.
(Whereupon at 4:15 p.m., the hearing was closed.)

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