

# HEALTH CARE CRISIS IN AMERICA, 1971

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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

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FEBRUARY 25, 1971

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PART 2

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# HEALTH CARE CRISIS IN AMERICA, 1971

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THURSDAY, FEBRUARY 25, 1971

U.S. SENATE,  
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON  
LABOR AND PUBLIC WELFARE,  
*Washington, D.C.*

The subcommittee met at 9:30 a.m. pursuant to recess, in room 5302, New Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Eagleton, Javits, and Dominick.

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

Senator KENNEDY. The subcommittee will come to order.

Today the Senate Health Subcommittee resumes its hearings into the health care crisis confronting America and the ways in which that crisis can be brought under control.

Earlier this week, the committee heard testimony from Secretary Richardson of Health, Education, and Welfare. The Secretary described the major elements in the President's health message, which had been sent to the Congress late last week.

As I indicated at the time of the Secretary's testimony, there are important aspects of the President's program which are commendable and which should be promptly enacted by the Congress, such as the merger of parts A and B of medicare, reforms in the organization and delivery of health services, and the increase in the supply of health manpower.

With regard specifically to the area of health manpower, I, along with the distinguished chairman of the Senate Labor and Public Welfare Committee, yesterday introduced two important health manpower bills, S. 934 and S. 935. The first of these bills, S. 934, extends and improves title VII of the Public Health Service Act, and is based in part upon the recommendations of the Carnegie Commission on Health Manpower and on the bicentennial report of the Association of American Medical Colleges.

S. 935 is specifically designed to assist medical centers in the establishment and operation of health maintenance organizations.

Subsequent to the testimony of Secretary Richardson, the committee heard from the Health Security Action Council, as well as an eminent health and medical economist, Dr. Rashi Fein. Both the council and Professor Fein were in general agreement that the whole system by which health care in the country is organized, delivered, and financed is shot through with inadequacies and irrationalities.

If that is the case, it is not reasonable to expect a "Patch up" to suffice.

This subcommittee intends to explore that proposition in order that the public can know the validity of it.

Today we will receive testimony from two panels of distinguished individuals. The first consists of three eminent physicians who will give us the benefit of their thoughts regarding this "system" problem in our health care industry.

The second consists of individuals who will describe the activities of the Citizens Board of Inquiry Into Health Services for Americans.

The report of the board was released yesterday. Several of these individuals are also members of the prestigious committee for national health insurance, though it should be noted that they have not been asked to testify in that capacity.

I would like to welcome each of you, and I look forward to your testimony. Would you be kind enough to come forward, please?

**STATEMENT OF A PANEL COMPOSED OF DR. BRUCE W. EVERIST, DEPARTMENT OF PEDIATRICS, GREEN CLINIC, RESTON, LA.; DR. JOHN HOLLOWAN, JR., PRACTICING PHYSICIAN, NEW YORK, N.Y.; AND DR. MICHAEL DEBAKEY, PRESIDENT, BAYLOR COLLEGE OF MEDICINE, HOUSTON, TEX.**

Senator KENNEDY. Dr. DeBakey, would you proceed?

Dr. DEBAKEY. Thank you very much, Senator Kennedy, I want to say first that I do appreciate the opportunity and the privilege and pleasure of testifying before this committee in support of the Health Security Act, S. 3.

I would like to say at the outset that I am deeply grateful for the privilege and pleasure of appearing before his committee to testify in support of the Health Security Act, and to indicate the reasons why I believe that this is the best program that I have seen yet, and one that I think is long overdue in providing a means by which we can improve the health delivery system in this country.

The first thing that I would emphasize about it is—well, before saying that, Senator Kennedy, may I submit for the record a statement that I have prepared, and then I would like to give my remarks, also for the record, but without having to read my testimony.

Senator KENNEDY. Your statement will be included in its entirety at the end of your testimony.

Dr. DEBAKEY. First, I think there are two important purposes to any program that is developed. One is to provide a means of making adequate personal health services available to all residents of the country on an equal basis, and giving each resident and each citizen of this country an equal opportunity to the availability of health care.

I think this is a very important principle, and not one that we should just pay lipservice to, which we often do.

I think everybody would agree that this is a desirable objective; and would agree that it should be done, but when it comes to providing a method by which it is done, that often leaves much to be desired.

I think the Health Security Act does provide a good system. It does make health care available to every citizen in this country on an equal basis. This is an extremely important aspect of the Health Security Act.

Second, I think that by providing universal coverage it will affect the dynamics of the system, achieve improvements in the health delivery care, and produce better quality care for all the citizens.

In this way, health security is really designed to bridge the gap between the promise of good care to all our residents, and our ability to deliver it.

Now that is not to say that it can be achieved tomorrow, but by accepting a system of this kind, that is, a program of this kind, as developed in the Health Security Act, I think we can look forward to achieving that goal.

The third point that I would like to make, and emphasize particularly, is the fact that this system, or mechanism, by which we achieve good health care for all our residents will also allow for emphasis upon improvement in health care by providing important incentives, and will also tend to void the emphasis that is given in the present system to meeting the increasing costs for medical care created by the inefficiencies of the present system which tend to increase the cost. This will provide a better environment for seeking research money.

The need for medical research—in other words, adequate support for medical research—is extremely important. It is unwise to shift the emphasis completely to medical care delivery at the expense of medical research. I think that the Health Security Act will budget sufficient funds for health care delivery without robbing medical research.

The emphasis upon health at the present time and the increase in cost has a tendency to take money away from medical research, and medical research funds have, in general, been decreased over the last several years, and I don't see any evidence that they are going to be increased, particularly as long as funds are needed to support our present medical care delivery system.

I think that in providing the health resources development fund, we have in this particular area of the Health Security Act a means of buffering the funds that will be required to provide a better means of supporting the health personnel educational activities, expansion of these activities, and innovative programs that will provide incentives for improvement and efficiency in health care delivery systems.

This aspect of the act, I think, is unique in that it certainly provides a budgeting mechanism of adequate amounts to meet the needs for educational costs and expansion of health assistance, technologies, improvement in facilities, and improvement and ways and means by which health delivery can be more efficiently provided.

These are especially important aspects of this act, which make me feel quite strongly that it is the best means available to achieve the objectives we ought to seek, and that is good health care for our citizens.

Senator DOMINICK. Mr. Chairman, unfortunately, as is the case with most Senators around here, I have three subcommittees meeting at the same time. I have an executive subcommittee coming in at 10 o'clock. I wonder if you would be kind enough to let me ask Dr. DeBakey a couple of questions first.

Senator KENNEDY. Certainly.

Senator DOMINICK. Thank you very much.

Dr. DeBakey, your reputation is well known throughout the country, and well deserved. I come from Colorado, and we have great admiration for the work you have been doing. We have been doing a great deal of transplant work ourselves in that area, as you probably know.

The thing that concerns me is the question of why you believe that research will necessarily be increased in funding at the Federal level because we put in a national health insurance program as opposed to the Presidential program.

In what way will we get more money for research that way?

Dr. DEBAKEY. Well, I think that the emphasis today at the present time upon the delivery of health care and the increasing costs has tended to shift emphasis away from research and particularly upon the funding for research, because of competition that it creates for the limited amount of money that is available.

Senator DOMINICK. However, unless we have a partnership between the ability to deliver the care and the research, we are not going to get anywhere in really reducing the health problems of the country, are we?

Dr. DEBAKEY. That is exactly the point I am making, that I think it is illusory to believe that by shifting money from one pocket to another we are going to improve the health delivery system, or achieve the ultimate objective of providing good health care for all our people. Research is a much better ultimate solution, for the simple reason that if we can eliminate disease we have a more efficient way of keeping our people healthy, and research is the only means by which we are going to achieve the knowledge required, the new knowledge required, to eliminate disease.

Now, I think all one has to do is look at the record of the past few years to see the evidence that in competing for the limited Federal dollar, research has not completed as well, and there is more talk about shifting Federal funds to health delivery activities.

Senator DOMINICK. Now you are talking about disease, and of course there is \$100 million additional money in the President's program for cancer research, as you well know.

Dr. DEBAKEY. Yes.

Senator DOMINICK. The level of funding is never enough for any group that wants it from the Federal Government.

Dr. DEBAKEY. Quite right.

Senator DOMINICK. I think we have to take into account the fact that the Federal Government is just as "busted" as any other government around here, and maybe more so. So you have a problem trying to spread out what resources there are.

The thing that concerns me, however, is the fact that although research can and undoubtedly will prevent some of the diseases which you are talking about, be they heart diseases or kidney diseases, or

whatever, then it still does not provide the care for the person with a broken leg, or a fellow who has some kind of an attack suddenly, be it a heart attack or a stroke, or something of this kind, or high blood pressure, or whole group of things of this kind which may be tied up with dietary deficiencies, which may be tied up with just genetics and may be related to a whole number of things of this kind.

We have areas in our country that are, as I have said to Senator Kennedy, that are as big as the whole New England States put together—

Senator KENNEDY. Do you have to keep using that as an example? [Laughter.]

Senator DOMINICK (continuing). In which you can find only one or two doctors. There are people living out there who have a need for medical care, and somehow or other we have to provide it and provide the ability for those medical people to get that medical care.

Dr. DEBAKEY. Senator Dominick, I agree with you completely, and I think that to illustrate the point, I also come from a part of the country where there are many large areas that are not supplied by a single doctor. We have in the State of Texas 24 counties where there is not a single doctor. We have 14 additional counties where there is only one doctor. So there is no question about the critical shortage of personnel. It is both an absolute, and I think, a relative shortage. The absolute shortage consists in terms of the numbers of health personnel available to the total population. There is a definite shortage in that regard. Then there is a relevant shortage in terms of distribution.

Now, I think that this act does provide a better mechanism than any I have seen for meeting the problem you are talking about because of the incentives that are built into it to provide opportunities and means, facilities, for practicing doctors in these areas.

Second, I think with the resources development fund there is the additional aspect of budgeted money that will provide more than \$2 billion, ultimately, a year, as a trust fund from which money is drawn to be used to help support activities of the kind you are talking about, to meet the needs you are talking about.

Senator DOMINICK. You are really talking about our putting more money in.

Dr. DEBAKEY. Yes.

Senator DOMINICK. It is my understanding that under Senator Kennedy's bill, you don't really put more money in, you just increase the Federal share.

Dr. DEBAKEY. Well, while I am not an expert in the economy of the program, I would say that there is certainly a large portion of moneys that are now spent that would, in a sense, be transferred into this kind of a program, that are spent in different ways, and which I think are inefficiently spent in terms of achieving the objective we are seeking.

This is because of the structured nature of these moneys. They are pocketed for different purposes, so that they don't reach all the people, and they don't reach the people who need it the most.

Senator DOMINICK. You would therefore feel that it would be advisable to block whatever Federal grants there are through medical services, and to whatever area of need is considered to be most acute by the areas and States. Is that correct?

Dr. DEBAKEY. Let me say that in terms of achieving the objective, it is correct. Whether or not you do this by blocking or how you achieve it, I would not want to say.

Senator DOMINICK. I thought you were against categorization.

Dr. DEBAKEY. I am against categorization of delivery of health care to a person, yes. I think the most important element of this bill, and this is the thing that I think is extremely important, is that then it creates for every citizen the opportunity of having available to him on a financial basis medical care equal to his neighbor, and this, I think, is extremely important, because then it removes in many ways one of the most important structured elements in segmenting health care to the people.

Senator DOMINICK. Well, the interesting thing is that we have before tried to do something about changing the categorization of funding from the Federal level, we have inevitably run into the people who say, "No, we are not going to get as much money that way as we do if we do it under separate categories." We run into tremendous opposition.

Dr. DEBAKEY. I am talking about a different thing, Senator. I think as far as categorical diseases are concerned as an incentive for research, as an incentive for, let's say, people's support, I personally believe this is desirable, because people know what cancer is, they know what heart disease is, and therefore they tend to support activities or research to eliminate this disease. That is a practical, realistic thing. Now, that is a different thing from segmenting and categorizing people for medical services.

Senator DOMINICK. What you are really saying, though, is that what you want and what you feel is needed is the medical area is more money for research.

Dr. DEBAKEY. There is no question about that, Senator. You referred, for example, to your own center. I am very familiar with the medical center in Denver, for example, and they have had a long tradition of good research and contributions and advances in medicine.

I think you can certainly be proud of them. We are, in the medical profession, proud of them.

They have been leaders in many areas. I was on a project site visit several years ago to get a clinical research grant for a research program, and I thought this was one of the finest programs I had seen.

Senator DOMINICK. Thank you. We appreciate that.

Dr. DEBAKEY. And yet, they were unable to get all the money they needed.

Senator DOMINICK. That is undoubtedly true. It is true with every group in the country.

Dr. DEBAKEY. I agree with the general philosophy that you never have enough money for everything you need. I think none of us have. But I think in the order of priority that medical research funding should have a higher priority than it has now.

If we can afford to have a \$4 billion trust fund for highways, then I think research, medical research, ought to have some kind of priority near that.

Personally, I think it ought to be greater than that, because I think that without health, all these other things are not as important, and

certainly a person who is unhealthy can't enjoy a good highway. It is human nature, I think, at least it is in my experience as a physician, to find that health begins to assume the highest priority when you lose it.

Senator DOMINICK. I think both Senator Kennedy and I would agree from past experience that there is a good deal of truth in that, but also that you need medical services and when you need them, you need them badly, and whether it is research or not, you still need them.

The only point that I am making here is that we have a very difficult job on this committee in trying to determine how best to allocate the funds which are going to be available from the Federal Government, then between health care and research and a variety of other things that are all needed, including continuing education in health.

Dr. DEBAKEY. Right.

Senator DOMINICK. I would like to ask you just one more thing. Do you have any figures which would indicate the increase, or decrease, as it may be, between the proportion of support for health research between Federal and private funds over the last 10 or 15 years?

Dr. DEBAKEY. Well, Senator, I can't give you the exact figures right now. I can certainly get them for you, and if you would like I will send them to you to the best of my ability to get them.

Senator DOMINICK. It would be helpful if you could submit them for the record. It would be most helpful.

Dr. DEBAKEY. I will be glad to furnish them, Senator.

(The material referred to had not been supplied at the time this hearing went to press.)

Senator DOMINICK. I have a feeling that the Federal share of health research has gone up while the private funding for this research has gone down.

I don't know that I am right, but I have a feeling that is true.

Dr. DEBAKEY. I would say that over the past 3 years, if you take certain criteria of research activities, for example, the number of research trainees supported by the different national institutes of health, has steadily gone down over the past 3 years.

Now, I point this out because I think this is extremely important, an important aspect of what is going to happen to us 3 or 4 or 5 years from now.

The people we train in research today are the people who are going to make the contributions to the advancement of knowledge that ultimately will eliminate certain diseases tomorrow.

The people that, for example, did their research and produced the knowledge to eliminate poliomyelitis were trained as research workers 10, 12, 15 years previously.

Senator DOMINICK. Unfortunately, I am going to have to leave. I hate to do this, but I have an executive committee meeting. If you could supply those figures as to the relative proportion of support for research in the Federal and private funds, we will say, between 1960 and 1970, or between 1950 and 1960 if you have them, this would be, I think, extremely helpful.

Dr. DEBAKEY. I will try and get those now.

Senator DOMINICK. Thank you very much, and I am sorry I have to leave.

Dr. DEBAKEY. Thank you.

(The material referred to had not been supplied at the time this hearing went to press.)

Senator KENNEDY. Doctor, isn't it true that the uncontrollable increases for medicare and medicaid have had the effect over the period of these last couple of years of really holding back resources which are available in the research field?

Dr. DEBAKEY. It has certainly been my impression that the spiraling cost of health care has tended to siphon off money from research because of the shift in emphasis for the limited availability of Federal dollars, and the tendency to meet the needs for increasing delivery of care first.

I think there is no question about that.

Senator KENNEDY. My understanding is that of the increases this year in health care, \$900 of it goes to uncontrollable costs in the President's program. It would lend itself to supporting your earlier observation, and my rather firm belief as well.

Dr. DEBAKEY. That is correct. What is also important is that this estimated budget, which is a little greater than the 1971 budget, does not compensate for the increased cost of operation which will amount to anywhere from 6 to 8 percent.

In many institutes the amounts of money have actually decreased. In one of the programs, which I think is an extremely important program, particularly as it relates to heart disease and cancer, the funds are decreased by over \$50 million.

I think it is great if the President is recommending this \$100 million for cancer research, and increasing funds by that amount. My only regret is that he does not find it desirable to do this in other areas that are just as important, and certainly cause more deaths than all other diseases combined, and that is heart disease.

Senator KENNEDY. Would I be fair in suggesting that in your earlier testimony, and perhaps your responses to your dialog with Senator Dominick, your feeling is that if we just compound the inefficiency of the present system by adding increased money to those inefficiencies, we just end up with an inefficient system? This will, as you point out, draw away from the opportunity of available resources in research, and do I further understand that you feel that the approach that we have attempted to adopt with S. 3 would provide more efficient delivery of health care and that since it is more efficient there will be greater resources ultimately available in the field of research?

Dr. DEBAKEY. Yes. I think, though, that as long as we maintain the present structure, no matter how you affect that by putting more money into different aspects, different pockets, the tendency will be to continue the relative inefficiency, and it will simply cost more to do it.

I don't think that you will ever achieve the important objective, which is to provide good health care to all of our people, whether or not they are able to afford it.

This, to me, is the important objective, and the only way that I think you can achieve this is by making it equally available. That is, that no person should feel that he can't afford to pay whatever it costs to get him good care.

Now, once you equalize this and equalize the availability then I think you are in a sense reducing some of the factors, important factors, that tend to accentuate the wastefulness that occurs, and thus to increase the costs.

Senator KENNEDY. How would you evaluate the organization of medical research today as compared to the organization of delivery of health care today?

Dr. DEBAKEY. I think it would be difficult to make comparisons of it, except in this sense. I think we have a better system in medical research for, say, controlling the quality of research, because it is on a competitive basis.

There is a built-in mechanism by which the scientific community itself, through your peers, evaluates continuously the program, and we simply don't have anything like this in the delivery of health care.

Senator KENNEDY. I just have one final question—we intended to hear the panel before we got into this, but since we got started let me ask perhaps one final question. Just in your field of specialty of care and concern for those that have had heart problems, what is the magnitude of expenses of someone who has the kind of heart problem that you might be involved in?

I am trying to think and review in my own mind our program versus the administration's program.

Dr. DEBAKEY. Good morning, Senator Javits.

I would say that in my own personal experience may not be an average example because of the type of work that I do, and the type of patients who are referred to me largely because of the serious and complicated nature of their heart disease problem. But it does tend to highlight the problem, because the average hospital costs, I would guess, are in the neighborhood of \$6,000 to \$8,000.

If you add to that the fact that many of these individuals have, because of the illness, been unable to work for long periods of time, and this drains their reserves, and then for a period of time after they recover, if they get well and can go back to work, their reserves, their financial reserves are virtually drained, even if they are in the middle income class, the higher and middle income class.

There is no insurance program available at the present time that will take care of the full costs of these people.

Every single patient that I have, anyway, that requires this kind of work, and this kind of surgery, will have to pay something.

Senator KENNEDY. What does it average, usually, what percent, do you know?

Dr. DEBAKEY. Well, I would say, and I would have to guess at this—I could give you some more specific figures—but I would say that it would run anywhere from 20 to 30 percent that they have to, take care of themselves.

You have got to keep in mind that it is not just hospital costs for these people. It is the lack of income on the part of the individual who is ill, particularly if he is head of a family.

Secondly, there is the cost of the family, particularly the wife, having to be there, the cost of being in a hotel because frequently they have had to come away from home to do this.

So that it does add to the total financial burden, and certainly everyone of these could certainly be considered catastrophic illnesses, from which many of them never fully recover.

I have many patients who have told me that they have had to sell their homes, they have had to go into debt, to get well.

Senator KENNEDY. Even under the suggested program, they would still have to pay approximately 25 percent.

Dr. DEBAKEY. You are referring to the administration program?

Senator KENNEDY. That is correct.

Dr. DEBAKEY. Oh, yes, I personally feel that is a very inadequate way to meet the needs.

Senator KENNEDY. Thank you, Dr. DeBakey.

(The prepared statement of Dr. DeBakey follows:)

## STATEMENT OF

Michael E. DeBakey, M. D.  
President and  
Professor of Surgery and Chairman  
Cora and Webb Mading Department of Surgery  
Baylor College of Medicine  
Houston, Texas

Presented February 25, 1971  
before the  
Senate Health Subcommittee  
Senator Edward Kennedy, Chairman

Mr. Chairman and Members of the Subcommittee:

My name is Michael E. DeBakey. I am President of Baylor College of Medicine. I am also privileged to serve as Vice-Chairman of the Committee for National Health Insurance, and a board member of the Health Security Action Council.

We are grateful that this Committee is holding these long-overdue hearings on the Nation's health care crisis. I believe that this Committee should closely examine two aspects of that crisis that are sometimes overlooked: the effects of reduced funding for medical research and the inefficient use of the fruits of medical research and technology.

During the past few years, the national concern over the rapidly escalating costs of health services and the need to make health care accessible to more people have threatened the maintenance of a high priority for medical research. Reduced Federal support for health research has created a grave emergency situation in medical research and in the development of systems for health care delivery. Unless immediate measures are taken to reverse this retrenchment permanently, the American investment in medical research since World War II, which has resulted in the most productive scientific enterprise in the world and has yielded unprecedented health benefits for our people, stands the risk of crumbling.

Although the reduced support for medical research is purportedly made to emphasize delivery of health services, any dichotomy of these interdependent activities is purely artificial and illusory. Improvements in health services are directly dependent on medical research. It was medical research that led to the suppression of serious infectious diseases, to satisfactory control of such disabling conditions as hypertension, diabetes, and numerous mental and emotional disturbances, to effective surgical correction of most congenital and acquired heart diseases, to the development of such dramatic procedures as organ transplantation and such devices as mechanical heart assistors, and to numerous other startling medical advances.

When the 89th Congress passed Medicare, Medicaid, the Heart Disease, Cancer and Stroke Amendments and a number of other major health programs, it was not the intent that those programs should siphon funds from the nation's commitment to medical research and professional training. On the contrary, the Congress acted in support of the ideal combination of the new programs to finance and deliver services, along with continued and increased support of research and education programs.

The intent of Congress has been frustrated. The totally unforeseen rate of medical inflation and the resulting increases in the cost of Medicare and Medicaid have devoured Federal and state funds. Research is threatened because investigators must compete with these programs for scant Federal funds. Such competition is not in the public interest.

Further, the competition is likely to intensify -- to the continued detriment of research. Millions of Americans are annually priced out of the health care market. Almost daily I am confronted with tragic cases of patients who can benefit greatly -- who have, in fact, been restored to normal life -- by heart surgery. Too often such patients must be turned away from some hospitals because they cannot afford the cost of prolonged hospitalization. And this fate is not restricted to the poor -- although they suffer most cruelly -- but includes middle class citizens as well.

The inaccessibility of basic health services and the pricing of health care beyond the reach of millions of our people are creating a popular demand for government financing of health costs. If the Congress will grasp this opportunity to create a sound program of national health insurance with effective quality and cost controls -- such as the Health Security program -- we can deal with the dynamics of the present medical care system and make health services available to all the American public. If, on the other hand, the expedient of piecemeal approaches to the financing of health care is adopted -- one program for the elderly, another for the poor, and a continuation of often limited private health insurance coverage for the majority of the population -- the amount of money required to finance personal health care will continue to escalate beyond all reasonable limits.

If this financially injudicious course is followed, I am afraid that it will be politically expedient to continue the flow of money away from most fields of research to subsidize an inefficient delivery system. Problems of cost and access are far more personal and apparent to the public than the related crisis in research. Adequate funding for medical research will be assured only when coupled with efficient methods of financing and delivering personal health services. Otherwise, the funds which should be directed toward research activities will continue to serve as hostage against deficits in direct purchasing programs.

The Congress and the nation must recognize that only a national health insurance program will provide the support and leverage necessary to create new, cost-effective methods of delivering health care. This will not be achieved by subsidizing private health insurance companies, as the present Administration has proposed. Under the proposed "partnership" with private health insurance, the inefficiencies and wasteful duplications of the present system will survive virtually unaffected, and the sum total of national health expenditures on personal health services each year will remain a composite of individual inefficiencies. These inefficiencies and wasteful practices include unnecessary duplication of surgical teams and facilities, I might add.

Instead, we must budget for health services just as we must budget for research and education. Only in this way can we reduce the danger of imbalances in the emphasis given to research and to delivery, with the

resulting crippling of vital activities. The only national health insurance plan submitted to the Congress which contains effective provisions for prior budgeting and control of global expenditures is the Health Security program. Although Health Security does not propose direct funding of medical research, it would provide the means for responsible budgeting of national health expenditures for personal health services and would thus prevent depletion of funds intended to support research.

Our present inefficient system for delivering health care also squanders the fruits of medical research. American medicine has the technical competence to reduce prenatal and infant mortality dramatically. Yet thousands of mothers are without means of access to preventive services.

We must invest in building interlocking networks of health delivery systems to bring the fruits of medical research within the reach of all our people. Only the Health Security program contains sufficient incentives and support funds to create efficient systems for health care delivery.

Although improvements in health care delivery are vitally important, as I have indicated, they must be considered in proper perspective. To concentrate health appropriations heavily on improvement of delivery of health care at the expense of medical research and the training of health manpower is self-defeating. Health Security will help this nation and its government to strike a proper balance.

Senator KENNEDY. I would like to ask the other doctors if they would proceed, and then we might come back to Dr. DeBakey.

Dr. Holloman.

Dr. HOLLOMAN. Yes; I would like to thank you, Senator Kennedy, and the committee, for the invitation to appear here today. Certainly the subject is one which is dear to my heart, and I, too, like Dr. DeBakey, have a prepared statement that I would like for you to have put in the record.

Senator KENNEDY. It will appear in its entirety in the record and you can highlight it or summarize it as you like.

Dr. HOLLOMAN. Thank you. The points I would like to make are probably going to be made many times in many ways by other witnesses, but certainly the basic philosophy with which I am concerned is one which causes me uneasy moments.

In America today, health care is said to be right, and yet nowhere is it planned as a right. There are any of a number of fragmented ways in which health care is planned for, and certainly the basic assumption that people are different because of their pocketbooks, the basic means test that enables medical students to be taught that there is a difference between people, the charity people, the charity patients, that they are somehow less valuable than "private patients" is something I am hoping to see eliminated from the American scene because I believe it is a very divisive philosophy.

I think that in this country health care is a commodity that is sold to the highest bidder, and I think that it is wrong for American citizens, promised good health care as a right, to have to compete for scarce health services.

I live in New York City. I live in a community known as Harlem, U.S.A., and in my community there are any of a number of glaring health deficiencies and abuses.

In New York City, it is stated that two-thirds of the population has to expect care from one-third of the physicians manpower, because two-thirds of the physicians have gone to the suburbs and are treating the more affluent one-third of the population.

This situation can be more than duplicated in any of the inner cities of urban America.

Doctors have been lured to the suburbs because of financial reasons. The situation in which a physician receives an M.D. degree and a license to practice is one which seemingly relieves a physician and society of responsibility.

Having received his degree, and license to practice, he is then free to practice his skill—learned substantially at the expense of the taxpayer through tax-supported institutions, through philanthropic grants, practice in tax-supported hospitals—he is free to exploit a health care delivery system. He is free to exploit the patient. He is free to the extent that any other entrepreneur is free.

I think if we should carry the illustration to an extreme, we will find that the most successful physician is one who sees the largest number of patients, charges the highest fees, and keeps them sick the longest.

In other words, we are operating in a system under a philosophy that promotes sickness rather than health, and I think that the system has to be changed.

Otherwise, there is no way in which we can, by pouring more money into a system in which health personnel are in short supply, can be changed.

The administration's proposal, I feel, does a great deal for certain vested interests, and I think it is very careful not to disturb most of the traditional methods of medical practice.

If we are going to improve the health of this Nation, we are going to have to change some of the traditional methods of medical practice that have brought us to this crisis situation which we all recognize.

We all agree that there is indeed a health crisis, but we do not agree on the way in which the health crisis can be eliminated.

Certainly to continue to have any of the number of vested interest groups make profits at the expense of the American patient, I feel, is wrong. To give health insurance companies, for instance, the opportunity to make a handsome profit on every insurance dollar is, indeed, a mistake.

I think it is unnecessary, it is unusually wasteful. We as a nation are paying a high price for our health care, and we are not getting an adequate return for it. We are in fact spending more and certainly at the present getting less and less.

The level of service as indicated most recently by medicare and medicaid, has not risen commensurate with the dollars we are spending.

The reasonable and customary fee, the fee for service performed per se has done nothing but benefit physicians. It has not distributed health care equitably.

The ability to change this is something that is within our reach if we have the commitment to do it.

If we look at the administration's proposal, I think we will be doing more of the same. I favor the Health Security Act, because I feel it more nearly approaches a solution to the problem, it eliminates many of the areas of waste, it affords an overall plan, it is designed to bring better health care to all Americans.

Thank you, Senator.

(The prepared statement of Dr. Holloman follows:)

Testimony of John L.S.Holloman, Jr., MD prepared for delivery to the Senate Subcommittee on Health, Washington, D.C. February 25, 1971

The American people spent more than 70 billion dollars last year for health purposes. Every available Index confirms the fact that we did not get our money's worth. In short, we spent more and got less.

For millions of American citizens high quality medical care is simply not available at any price and under any circumstances. Indeed, this is a health crisis which cuts across all political, social, economic and geographic lines, affecting rich and poor, black and white, old and young, urban and rural, business and labor alike.

The substantiating statistics need no recounting only because they are, by now, familiar to all of us. We are appalled by conditions among the poor in America but we are in disagreement as to the most meaningful corrective actions to be taken. We are aware of the incestuous relationship between poverty and ill health but we are, at least until the present, unwilling to disturb the "traditional" practices that have combined to produce our present dilemma.

To be poor, is to run the risk of a higher incidence of disease, disability and death. The Louis Harris organization following a survey of health care in this country described the poor as the "living sick". Indeed in America today, the sick get poor and the poor get sick. George Kimble has stated: "It is bad enough that a man is ignorant, for this cuts him off from the commerce of

other men's minds. It is worse that a man is poor for this condemns him to a life of stint and scheming in which there is no time for dreams and no respite from weariness. But it is far worse that a man should be sick for this prevents him from doing anything about either his poverty or his ignorance."

The poor suffer four times as many heart conditions as those in the highest income group, six times as much mental and nervous trouble, six times as much arthritis and rheumatism, six times as many cases of high blood pressure, over three times as many orthopedic impairments, and almost eight times as many visual impairments.

The growing alienation of nonwhite disadvantaged Americans in our inner cities is partially related to the fact that maternal deaths (nonwhite) often occur six or seven times as often as in other sections of the same cities. On a national scale, the ratio of nonwhite to white mothers dying in childbirth is almost 3 to 1. The ratio of nonwhite to white babies dying in their first years is more than 2 to 1. The life expectancy of the black male is 7 years less than for the white counterpart. The American Indian male, at birth, may expect to live 42 years. There are young nonwhite Americans who regard this state of affairs as de facto genocide. The racial health gap has apparently widened. In 1930, for example, the ratio of nonwhite mothers to white mothers who lost their lives in childbirth was 2 to 1.

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These conditions will not improve and the gap will continue to widen as long as we perpetuate "the traditional methods of practice" embodied in our dual system of private and charity medicine which often isolates the poor in separate and inferior health systems.

In addition to the immorality of our health system, we can no longer afford the luxury of planning one service for the more affluent and another, obviously inferior, service for the poor whose health needs are usually greater. All of America is involved in the health crisis which grows more serious with every passing day. Middle Americans can no longer afford needed health care when they can find it; and too many can't find it when they can afford it. Health care should not be a commodity for which Americans must compete.

As recent events make clear, the health care crisis has emerged as one of the most important domestic issues in the country. Leaders of our national government and medical and insurance organizations to whom the words, "national health" or "national health insurance" were an anathema, have now enlisted in the cause of better health, or at least have expanded their vocabularies. Humpty Dumpty told Alice, "When I use words, they mean just what I choose them to mean -- neither more nor less." And when the Nixon Administration offers us a "national health program", I would want to examine its elements closely before agreeing on its promise. A careful dissection of the rhetoric re-

veals that professional vested interests are protected, once again, at the expense of making meaningful changes in health financing and in our health care delivery system.

For a man who diagnosed a "massive health care crisis" 18 months ago, President Nixon has now prescribed nostrums and placebos that will not cure the ailments, but only make matters worse. In medical practice to make a correct diagnosis and then fail to prescribe the correct treatment constitutes malpractice.

He has proposed a Family Health Insurance plan as a substitute for Medicaid. But no amount of statistical gymnastics can conceal the fact that his program would impose new burdens on the medically indigent and even the destitute. It appears to be the Administration's position that the poor should now have the "dignity" of paying for some health services they now receive without direct charge. The Federal government will limit its liability, the insurance companies will receive a windfall -- but where will the poor get the money to pay for the care or for that matter the care itself?

In my city, New York, Gordon Chase, administrator of the New York City Health Services Administration has said: "Mr. Nixon's plan would provide less health care for the poor (in New York City) rather than more. The President's message indicated that poor people earning \$3,000 to \$5,000 will have to pay some significant portion of their health care costs which are now covered in New York and some other states by Medicaid. This

will impose a tremendous financial burden upon cities like New York, since we will probably have to pick up the burden formerly carried in part by the Federal government. Our only alternative would be cutting back the already limited health services which many of our poorer citizens receive."

In the Family Health Insurance Plan, the Administration has written a tragedy.

The President's proposal to consolidate Parts A and B of Medicare by increasing the Social Security wage base is a step in the right direction. However, in this instance as we seem to "give" the elderly something with one hand, we deftly "remove" it with the other hand. That is, we eliminate the monthly charge of \$5.60 but we cut back on the number of hospital days covered by Medicare and much of the added cost will not be covered under existing or proposed programs.

No more promising is the proposal to clobber the employers of America by requiring them to subsidize a wasteful, inefficient, ineffective, semi-functional health care system. The premium costs paid by employers and the wages that employees forego in favor of health coverage ought to be expended in the interests of better health care, more economically provided, with quality controls, assuring financial security, with strong incentives for improvement of the entire health system, and with the system operating in the interests of the people who use it.

No amount of Madison Avenue puffery and no gaudy wrappings

can cover the skinny proposal for Health Maintenance Organizations. This is the one element of the President's entire health program which purports to deal with the crisis of calcification in the present methods of organizing and delivery of health care services. But you can't blast a concrete boulder with clackers. One can find little reason for either providers or consumers of health services to march up the Hill in support of the Health Maintenance proposal

The sorry history of administration support for medical education causes us to pause before rejoicing in his recognition of the plight of our medical schools. They are in deep distress. They need our help. We need their help. We need to provide more money, more encouragement, more incentives for production of greater numbers of physicians, more support for family physicians, more support for the education and training of disadvantaged students, more persuasive arguments for curricula changes. Dr. John Cooper, president of the Association of American Medical Colleges has expressed "general agreement with the thrust of the message" but expressed disappointment with the financial aspects of the plan. Dr. Cooper contends that the President's recommendations "will not solve the problems of our medical schools." He also believes that the administration's plans for loan programs for students in health fields and for medical school construction were inadequate.

We were pleased when the President signed the Emergency Health Personnel Act. For sometime we have supported the idea of permitting the assignment of federally employed young health

professionals to inner city areas with critical manpower and health services deficits.

But now we learn that the Administration is limiting the funding of the Act to ten million dollars for support of only 660 people in the program and at the same time, the Administration is reinstating the doctor draft. They plan to draft 2,100 doctors and dentists for military service. The Administration is willing to provide minimal encouragement for only 660 health people of various types- dentists, physician assistants and nurses- to practice in the cities and rural areas, but it is calling up 2,100 doctors and dentists for the military. In few areas is this Administration's sense of priorities more difficult to understand.

In his health program Mr. Nixon is evidently most concerned with economies. In every area of our health activities there is visible inefficiency. There is a proliferation of government health programs, often imposing uncoordinated demands upon an already overburdened health care system. There is tremendous duplication of services and facilities. There is unnecessary hospitalization and excessive surgery. But the President's health program either overlooks entirely or fails to deal meaningfully with any of these problems.

We have to improve efficiency without compromising our greatest assets; the competence of our doctors, dentists and other health professionals, and the personal relationship between the

provider and the receiver of the health service. We must avoid foolish economies that leave us poor as before but neither stronger nor better. It is false economy to compromise our national health security.

President Nixon's program is a program for the 'Fifties. It will not work in the 'Seventies. It is too little and too late.

(Additional information supplied by Dr. Holloman follows:)

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while many other health workers are paid at or below the federal minimal wage scale? On what basis do we rationalize a fragmented, institution-dominated system of care that is unresponsive to the community and that operates seemingly for the convenience and benefit of the M.D. professionals?

Recent legislative attempts to improve our health care delivery system have failed, fundamentally because they have been conceived in the context of the traditional methods of medical practice which many people believe must not be disturbed. The self-delusion, which permits Americans to continue to believe that the "Made in America" label is synonymous with all that is good and pure, gives them leave simultaneously to believe just as strongly that institutions, individuals, or activities that in some ways resemble those of other countries or that deviate from the American tradition are un-American and, consequently, are to be regarded as bad.

The confidence inspired in the health consumer by the medical jargon and the manner of the health professional has been second only to the religious faith inspired by the words and deeds of our spiritual leaders. In point of truth, ignorance and wasteful inefficiency have been rationalized into more comfortable acceptance, and have been defended with medical dogma. Recently, the visible material success of the medical practitioner has eroded this prevailing confidence and all but shattered the very soul of medicine. Moreover, national health indexes suggest that the professional is the principal profiteer from a costly health delivery system which works disadvantageously for many Americans.

Specialization has become a "cop-out" for too many very talented health professionals. It has been invoked as an excuse for inaction, thereby intensifying the problem rather than contributing to its solution. If these specialists do not

### **Toward a National Health Program**

**A**s the nation becomes involved in the emerging debate on national health insurance, many conflicting philosophies are being exposed. It becomes increasingly clear that the upward spiral of health care cost will not be halted by the introduction of more money into the health equation. The realization of this fact causes us to focus directly on the deficiencies of our present methods of health care delivery, which cannot logically be improved unless changed. What are the philosophical concepts which permit physicians to be paid extraordinarily high fees for their services

wish to be health care planners, all well and good. But these specialists should then encourage health planning by others who have the talent and the skills to plan and to promote change, instead of banding together in specialist societies and in some cases actively blocking needed change.

The health industry is big business, as many Americans are beginning to realize. Not many Americans, however, realize that health care is a commodity sold to the highest bidder, with scant regard for need. Yet, with increasing frequency, we hear in generalized rhetoric that health broadly defined—like life—is the right of all people. Although it is the failure to change the system and to fulfill this right that is frustrating to those of us who are in good health, to those who are sick the current situation may be malignant. It is a fact that if this—the most affluent and technologically advanced nation that the world has ever known—is to survive, it must begin to clean the land, the air, and the water; it must begin to make social concepts into social realities. If this nation is going to continue to prosper, it cannot afford to waste the asset of good health for all. Moreover, in the family of nations, we cannot afford to import scarce health professionals at the expense of other nations, whose health needs are at least as great as our own. Beautification of the “ugly American” dictates prompt abandonment of this internationally unhealthy form of piracy.

In order to adequately plan to insure the health of the nation, we must plan for the delivery of quality health care to all people. We can no longer afford to support the philosophy which distinguishes between people on the basis of their pocketbooks. We can no longer afford the luxury of the duality of services for private patients and for charity patients. We can no longer afford the luxury of planning one service for the rich and another, obviously inferior,

service for the poor whose health needs, incidentally, are usually greater than those of the rich. The incestuous relationship between poverty and ill health is well known. But few health practitioners take the broad view of simultaneous attack on all the factors contributing to ill health—substandard housing, substandard jobs, and substandard education—as well as the disease which brings the patient to the attention of the physician.

The savings which could result from the prevention of disease obviously would far outweigh the cost of the treatment of disease. Yet the common sense of this position is obscured by the rhetoric of those with vested interest in the present disease-oriented system and who are opposed to change. These individuals can give many seemingly logical reasons why preventive medicine will not work, why it is too costly or is otherwise undesirable. Seldom do they confess the real reason behind such excuses—that the interests of the individual lie elsewhere.

A national health program which would address itself to achieving and securing a healthy life for all Americans should be designed now. It can be done now if professionals will remember that they are part of society, not above it. Physicians are licensed by and are privileged to serve society, and the health of the nation must be accepted as a nonprofit national endeavor for the ultimate benefit of all mankind.

Any adequate nationwide health care delivery system must be based on the philosophy that the health professions are primarily in the public interest and hence are service professions. Those individuals who are trained health professionals are increasingly being educated at public expense, either through the direct use of tax monies or through the use of philanthropic tax-exempt monies. Furthermore, much of their work, currently performed for profit, is performed

in, or in direct relationship to, tax dollar-financed or tax-exempt institutions.

The development of our health manpower can no longer be left in its traditional forms. It must be adequately planned for and financed so as to assure the nation an ample supply to meet carefully anticipated needs. In every conceivable way, all the factors which relate to health—including jobs, housing, education, environment and health care delivery—must be correlated in a national health program. Anything less is a placebo which lulls into a temporary quietude the voices of the bulk of that group of people euphemistically called the “silent majority.” Anything less short-changes all of us.

National health insurance is a step forward along the road to total health care, provided that along with it we create a national health program firmly based on philosophical concepts that will draw all Americans together. A national health program based on genuine equality, eliminating profit-inspired special privileges for some at the expense of the rest of us, is a goal that is now attainable. Let us make this a national priority for the 1970s.

(The Journal is indebted to John L. S. Holloman, Jr., M.D., for the above editorial. Dr. Holloman is a practicing physician and Past President of the National Medical Association and Chairman of the Physicians Forum, 2160 Madison Avenue, New York, N. Y. 10037.)

## Medical Care and the Black Community

John L. S. Holloman, Jr., MD, New York

*The fields were fruitful, and starving men moved on the roads. The granaries were full and the children of the poor grew up rachitic, and the pustules of pellagra swelled on their side. The great companies did not know that the line between hunger and anger is a thin line.*

JOHN STEINBECK  
The Grapes of Wrath

The concept of equal health and health rights has been gaining a wider exposure and acceptance in this country. However, in practice, millions of Americans are being denied this basic human right. I believe that beyond an incredible lack of medical care organization, poverty and racism, viewed in their broadest contexts and implications, play a major role in the deplorable state of our nation's health.

The special emphasis which is now being directed at the provision of health services for the poor, or ghetto medicine, is certainly long overdue. The poor and the ethnics of color (brown, black, and red) are the most deprived in our affluent and coldly materialistic society. They are deprived not only of health and medical services but of almost every

other societal benefit which the majority group takes for granted. While these high risk groups are in greatest need of new and increased services, we cannot view health care for the poor outside of the mainstream of American medical thought and practice.

The multiplicity of problems which beset the inner cities and rural pockets of poverty are but the magnification of the ills which all of America must face in the next decade—lack of new housing, decaying and inadequate present housing, crowding, poor quality and unavailable public services, overpopulation, breakdown of traditional educational systems, instability of the primary family unit, lack of adequate environmental controls and resultant pollution, inadequate medical personnel and services, underemployment, drug usage and abuses, and so on—America must face *all* of these problems on a larger and larger scale as our population increases. Speed of new technology outstrips our ability to change values and traditions in an evolutionary way; concentration of wealth is increased in a smaller and smaller percentage of the population; and change is resisted by those whose strength and interest is vested in the power elite of the past.

The American experiment may well fail if America is unable to solve or resolve the problems of the poor. There can be no doubt that many of the poor and lower middle class feel quite like the French peasants who were splashed with mud from the

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Dr. Holloman is in private practice in Harlem, New York, and is chairman of the Physicians Forum and past president of the National Medical Association.

Reprint requests to 2160 Madison Ave, New York 10037 (Dr. Holloman).

king's carriage wheels. If the problems of the cities can be faced honestly and if the national will is committed to the resolution of these problems, there is hope for all of us, but I must admit to a large degree of pessimism.

Measured by a realistic standard of results, progress in ending inequity has been disappointing. Even in securing basic rights—by far the easier part of the problem—we have not been entirely successful. In many areas in which civil rights laws afford pervasive legal protection—employment, housing, education—discrimination persists and the goal of equal opportunity is far from achievement. The plain fact is that some of these laws are not working well. The federal civil rights effort has been inadequate to redeem fully the promise of true equal protection of the laws "for all Americans. As a result, many minority group members are losing faith in the federal government's will and capacity to protect their rights. Some also are losing faith that equality can be achieved through law. It is important that their faith be restored and that the promise of the hard fought battle for civil rights laws be redeemed. (*Federal Civil Enforcement Effort*. Commission on Civil Rights, 1970, preface pp 16-17).

The overall dimensions of the problem have been well defined in terms of health and health services. They are the problems of all America but are applicable to the special situation of the ghetto, and to the rural poor, and are deeply heightened by all the other impinging social factors which converge in the ghetto. They consist of (1) manpower distribution and shortages, at all levels and in all disciplines; (2) medical education problems concerning specialization vs primary physician training, costs of a medical education, and philosophy and curriculum changes; and (3) lack of a coordinated system for the organization and delivery of health services.

Before I attempt to outline what may be some of the solutions to

these problems it is necessary to restate a basic theme. The health problems of the poor and the ethnic minorities cannot be dealt with in the traditional manner to which we have been indoctrinated. The message of the past decade has come across loud and clear to those who will listen. One cannot treat on a symptomatic basis alone. Root causes and sources of social reinfection must be investigated and cured. Physicians and, in fact, all those men of science who have claimed scientific immunity from facing the realities outside the classroom have been forced (in the 60s) to reassess their role in society. For many it has been a rude, crude, and altogether unpleasant experience but they have had to look and listen and make hasty preparations for survival. Health is a total thing and while we cannot, as physicians, deal with every social ill, we can be allied with those agencies and groups within our society who are committed to change and progress. We can, and we must, be involved in the total experiences of the patient who is entrusted to our care.

Solutions to problems such as those which face our nation and, in fact, the world, are related to changing current and dominant value systems—the priority of property rights over human rights, the priority of things over people, the all too frequent equation of power and wealth with "rightness" or "goodness," the continuing conflict between classes of people, the continuing weakness of social justice and the question of humanism materialism. If humanism became a way of life, the solution to these problems would be child's play, for we would do that first which served the people best.

The critical health manpower shortage is felt on a nationwide scale. This is especially true in the

urban and rural poverty areas. While it is true that we need "more" of everything in regard to health personnel, it is also true that we must learn to make better use of existing personnel.

It is necessary that we continue to redefine the role of the physician in relation to society as a whole and, specifically, his role within a *health*, rather than illness, oriented setting. It is very necessary that physicians begin to clearly recognize how other health workers and new technologic skills can assist him in caring for his patients. We must become increasingly concerned with *prevention*, rather than the treatment of disease alone.

The physician of today must learn that some of the tasks which he performs can be performed just as well by a health assistant or aide. He (the physician) will be freer then to care for those who are most seriously ill or who require more of his personal attention. This should help to restore many of the individual touches which have been lost in the patient-physician relationship.

The introduction of new health careers should be encouraged with a broad use of local residents as trainees. It has been amply demonstrated that community residents can be trained in a variety of adjunctive health roles. They relate on a more intimate basis with their neighbors and are able to communicate program aims and health education principles more readily than many professionals from outside the area. This is especially true in ghetto and other poverty areas where cultural and class differences between the professionals and the patients may be barriers to providing and accepting services.

Training of new careerists or indigenous personnel must be struc-

tured in such a way as to encourage and permit upward and lateral job mobility. Training must be open-ended and not bogged down in the traditional criteria and credentials trap. Definitions of new careerists must be somehow established, universalized, and recognized. Restrictive licensing must be struck down and the necessary steps taken to make new health careers as "legitimate" as possible. This is necessary not only for the protection of patients, but for the protection of new personnel and to provide them with legal recognition.

Provisions must be made to seek out and to utilize those who have had training but who are not presently engaged in health services provision. This would include retired physicians, physicians engaged in other occupations or avocations, female physicians with families, all nursing personnel not currently engaged in nursing, etc. We also have large numbers of returning corpsmen who can be reeducated for civilian programs. The use of physicians' assistants (and prototypes) must be accomplished on a universal level and not restricted to use in poor neighborhoods. The physician assistant is not to be employed as the physician substitute. We who live and work in exploited and poor communities will not permit this to happen.

We must make more efforts to contact and redirect those individuals who have clearly professed an interest in the health and medical professions, but who have not, for a variety of reasons, been trained as physicians, dentists, etc. Availability of places in medical, dental, and other professional schools limits each year the number of applicants who can enter. Not only must we increase the number of medical and health professional schools, we must also find

ways to hold onto those students who are interested but who cannot be placed.

Students who may lack the ability to achieve the scientific skills necessary to become physicians may instead be channeled into other health service pursuits. The desire to be of service and the wish to work with people should be considered on a coequal footing with intellectual capacity in the selection process. We must aim not only for intellectual and scientifically oriented health personnel, but for compassionate and committed human beings who care about the community in which they work and the society in which we live.

The maldistribution of health personnel in poor and ghetto areas only serves to accentuate the economic basis upon which medical practice in this society is based. It is difficult to attract physicians and their families to depressed areas which have, incidentally, the greatest health needs. It has been amply demonstrated that most ghetto-based doctors are less well trained, are older, see more patients, practice little preventive medicine, and are more authoritarian than their counterparts who practice elsewhere. This should not depreciate the role of the ghetto physician. His triage activities have saved countless lives. As an individual physician he is many times the only alternative to callous clinic care or no care at all. We can all agree, I think, that specific steps must be taken now to improve care in the ghetto. At the same time we must strive to eliminate the ghetto and improve the quality of life for all.

Ways in which physicians can be brought to areas of greatest health need have been difficult to devise because many solutions have a measure of compulsion contained therein—and

we shrink from the idea as it relates to the professional. Yet crisis situations may require drastic solutions. Physicians and students who do not wish to serve in the military should be permitted and encouraged to render alternate service time in the ghettos of our country. This may be a useful recruitment method also, for it will familiarize students (at all levels) with certain realities of medical practice which they will not encounter otherwise. Under no circumstances should this type of alternate be used merely to circumvent military service. Quality controls, peer review, and community controls must be built into such systems to insure the same quality of services which are available to those outside the ghetto.

Incentives must be devised which will attract physicians to practice in ghetto areas. It is unfortunate that the only incentives which seem capable of attracting the numbers of doctors needed at this time are financial or material ones. But they should be utilized, and, once again, quality control, peer review, and community controls must be built into such an incentive system. Incentives could include low interest or noninterest building and equipment loans, group practices with prepayment plans and subsidized payments based on per capita rather than utilization figures, and medical education costs in return for a specified time of service. New hospital and teaching facilities could be located in ghetto areas. They could offer services and facilities which are not available anywhere else in the city or health region. This might help to bring many health professionals to the area. It will also bring patients from different social classes together for treatment in a single facility. For example, the new Har-

lem Hospital has the only nationally listed burn treatment center in New York city. Theoretically, all severely burned patients in need of specialized and intensive burn care should be cared for in such a center.

The educational aspects of the health manpower problem must also be dealt with in any consideration of our current situation. Schools of medicine should plan to develop a variety of physicians to meet the health needs of our nation at the academic level and at the actual delivery of service level. The trend toward specialization in medical practice has increased in recent years and therefore the number of new graduates who desire to engage in general practice has decreased. For example, in 1966 the field of general practice attracted only 672 of 44,987 interns, residents, and fellows. Specialization has afforded an intellectual cop-out for many professionals, and it has tended to reinforce their narrow view of the patient. There is, and should be, increased emphasis placed upon the importance of the primary physician.

James Dennis, MD, dean of the University of Oklahoma Medical School, has stated:

... at least 25,000,000 persons and perhaps as many as 40,000,000 in urban ghettos and rural areas do not have access to a primary physician. It is only by providing treatment within the family unit for these millions that we can begin to solve our social problems.

I agree with Dr. Dennis but feel that the actual figures are probably higher.

Community medicine or family practice should be developed in all the medical (health) education centers, both at the health student, intern, and resident level. (There are presently 23 programs for training family practice specialists, and 57 of the 100 medical schools either have

or are planning programs in this field.)

Training should include, of course, clinical practice with patients who are broadly representative of the community and society, not just its poorer segments. Training should be conducted under the conditions which exist in the community, outside of an inpatient setting, ie, the office setting, house calls, outpatient practice, and emergency room practice. Primary physicians, who have this type of specialized training, are needed in our black communities and everywhere. More and more Americans wistfully refer to the "old family doctor" and want him, or at least his modern prototype, to be available.

For the past 50 years medical schools have been organized to impart biologic and technologic information and to produce "quality" students. The emphasis has been scientific and disease oriented. Somewhere in the shuffle we seem to have lost our concern for man's humanity and we have been concerned with his pathology. It is necessary to redirect our thoughts to concern for man as a fellow traveller on Spaceship Earth and to adjust the emphasis of our training and skills to the prevention of illness. Our system is called a health care system, but, in fact, it is a sickness care system. The area of preventive medicine should be of great concern to all those who seek solutions for the black community. Those areas which contain the urban and rural poor are high risk areas as reflected in almost every mortality and morbidity statistic in the book.

Programs in preventive medicine must be designed and implemented so that the poor, the illiterate, the deprived, and the forgotten *will be* reached. Programs which are planned with the poor and which meet their needs, as *they perceive*

*them*, will be more successful programs. This is not to say that black, Spanish speaking, Indian, and poor whites do not require professional assistance in learning about the technical aspects of why they become ill and how they can be helped. This is simply another aspect of community medicine, helping communities to learn how to articulate their health needs.

Medical school curricula should be enlarged to contain courses relating to medical care organization, principles of public health administration, comparative study of health care systems, health and urban planning, and educational psychology. Changes must be made not only in curriculum content but in the time honored methods of clinical instruction. The use of ward patients, generally those who are poor or minority group members, as teaching patients has served to perpetuate the dual system of medical care—charity medicine and private medicine. All patients, regardless of ability to pay, who represent medical educational cases should be available as teaching cases.

The cost of financing a medical education has proved to be a barrier for many aspiring and promising students. This is especially true of the poor and minority group student. He has been screened out, too often, by racial and class discrimination. Presently efforts are being made at the upper undergraduate level to bring blacks and other ethnic minorities into medicine. Special curricula—compensatory, culturally enriched, tutorial approaches are being employed and all of these efforts must be increased. Racial and class discrimination has prevented equal opportunity. Equal opportunity can best be provided for by attacking the problems of inequality, simulta-

neously, and at every level. This means doing what is necessary to make the opportunities equal from the level of the unborn child to the opportunity for equal burial rights. Anything less than this is, in my estimation, unequal.

Medical education is already paid for largely by government, federal and state, in one form or another. I believe that all medical education should be completely subsidized by the federal government. This would be a more honest statement of the present de facto situation and perhaps would be a reasonable way to increase, or at least to clarify, the obligation which the physician should have toward society. At present, general taxes do finance much of a medical student's education, and yet, the majority of physicians feel that they owe society only what they wish to give.

Subsidization of education, both basic medical education and specialization education, with implicit societal obligations is an answer. I believe that in this way we influence not only the type and quality of doctor which we produce, but this method may also be helpful in correcting the maldistribution of physicians and health workers to areas of greatest health need. In addition, medical schools and medical faculties must be fully supported on a long range basis.

The concept of health care as a right (or the principle that our society should be dedicated to providing a healthful quality of life) is challenged each time health and educational funds are laid upon the budgetary chopping block. It is impossible for educational institutions and health programs to plan ahead or to think creatively and positively if they cannot count on continuing financial support from government.

I believe that those who profess to be concerned with health must raise questions and take issue with a government whose priorities are so disordered as to place military needs before humans needs, a government which plays on the fears of the "silent majority" in order to maintain the status quo, a government which attempts to answer the cries for social justice with the stern application of law and order. Physicians, scientists, and all concerned individuals must find, or make, channels of communication. We must learn how to build coalitions which will make an issue of the improvement of life—our environment, our society, and the state of our personal health—an issue which our government can no longer ignore or deal with superficially.

The growing awareness that an adequate and an appropriate delivery system for health services is lacking has been heightened since the initiation of Medicare and Medicaid. The traditional patterns of medical practice—rugged individualism and solo entrepreneurship—are absolutely incapable of satisfying the present, and future, demand for medical services. Many highly respected critics of current medical practices suggest that we have a nonsystem, and that we need to create a health care delivery system. It is my feeling that we do have a health care delivery system even though it is one which is inefficient and poorly organized. It is a system which is firmly rooted in our historic, religious, and economic beliefs and practices. It is a system based on privilege. It is, all too frequently, a system in which the physician is the central figure and everything is subject to his relatively unrestricted authority.

A national health program must be designed for the American people.

Its special emphasis should be directed toward serving patients primarily and the special interests of the professionals secondarily. The program should stress preventive medicine, continuous care, and health education for all. It should provide an orderly distribution of services in direct response to the health needs of people and groups of people. It should immediately coordinate all existing health facilities and personnel in a national plan of service. In this way existing health resources could be utilized more effectively and efficiently and needless competitive duplications could be eliminated. Provisions should be made for patient transfer throughout the system in order that the patient's health problems can be most efficiently prevented, detected, and treated. The provision of modern health care requires a comprehensive health team which is, to my mind, a broader concept than even a prepaid group practice. It is a team which views the total patient in his total environment. It plans for a lifetime of as much good health as current techniques can provide and it demonstrates its concern for the future by considering the generation of the yet unborn. Hunger and malnutrition, lead poisoning, food additives, environmental pollution by chemicals and industrial wastes, destruction of wildlife and undeveloped land, and overpopulation—because of the known deleterious effects they visit not only on the present population but upon future generations—are but a few of the health considerations and problems which a new national health care program should confront.

The close coordination of physicians and related health workers in groups is at last beginning to gain acceptance although the dichotomy

between theory (the academic world of medicine) and practice (day-to-day delivery of services) remains great.

The city of New York, for example, has seven medical schools and approximately 20,000 physicians, and about 75% of these doctors have no relationship to any medical school. In the interest of good medical care for the patient through the continuing education of his physician, I suggest that every physician should maintain a life-long relationship with some medical school. It would help relationships between physicians immediately if they could arrange to cooperate more, compete less, and stop disparaging each other's roles. Federal licensure of physicians would help to overcome state politics, and to my mind, is a must in helping to rapidly overcome existing distributional barriers. Closed hospital staffs would be eliminated because the economic, religious, political, and racial barriers integrally related to our present system would cease to exist.

The medical history of a person should be as nearly complete as possible and easily available through the use of computers and data storage facilities and retrieval systems. The medical history should not be used to disqualify a person from employment or advancement. It should be used to promote the personal health and well-being of every member of our nation. Periodic, easily available, and accessible multiphasic screening should be a part of the medical history which is stored for each person. It will be a useful part of a preventive approach in medical practice.

Hospitals should be related to each other as well as to the communities in which they are located. Health facilities should be responsive to the specialized needs of varying communities as well as to the overall needs of the national health program. This

can best be accomplished, I think, by building on and expanding, Regional Medical Programs and their service areas. Hospitals should be closely associated with and coordinated with neighborhood health centers. Provision should also be made in this network of health care facilities for the primary health center. That would be a center located at the perimeter of the health network and would provide immediate and basic health services, as contrasted to comprehensive health services, which would be provided at more central locations. Telephone and televisual communications must reach every person in the nation.

Rapid patient transport to centers and rapid dispatch of trained health personnel to all rural and remote areas should be incorporated into any regional health planning. Included also, in this nation-spanning network of facilities, we must have care centers for the acutely ill, extended care centers which must be well operated custodial care facilities where the old and chronically ill can be cared for with modern design and human dignity. Regional hospitals for more highly specialized care of specific problems should be included. Although patient care should be the paramount focus of the system, teaching and research should be incorporated at every level and should involve every patient. The system should be designed with maximum flexibility and within the bounds of societal responsibility and need.

Just as the southward migration of the birds heralds the approach of winter, so the sudden clamor of various and sundry interests heralds the impending advent of a national health insurance. Pragmatists tell me that the change in the financing mechanism is the next step toward a more equitable health program. The

inflationary squeeze of the health consumer, especially the middle American, occasioned by the legislative and administrative flaws in Titles 18 and 19 of the Social Security Amendments (1965) will have been wasted lessons if the Congress passes another financing mechanism without first taking specific steps to create a health program capable of satisfying the growing demands of an enlightened public.

Members of the black community have long known that the ownership of health insurance does not give them equal access to the physician or the hospital of their choice. The traditional exclusion of black physicians from the admitting staffs of most voluntary hospitals in New York and other parts of this country is documented. It has been, and continues to be, an assault on the health of black Americans.

The debate on national health insurance has already begun. The forces which have vested interest in all that is materialistic in our present system, look upon national health insurance as just another way to increase the profits from their investments in the present system. An examination of most present insurance plans show exactly where the principal interest is placed.

There is a danger that those who are primarily concerned with money and continuance of privilege will sing the siren's song so well that our dream ship of health will be smashed on the reefs of financial woe. The nation's health crisis could become a catastrophe. I believe that the health crisis can be met and solved if there is an honest effort made; one which should be as much removed from politics as possible, for despite the myopia of the legislation, the right to health and health care is inseparable from the right to life.

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Senator KENNEDY. We will now hear from Dr. Everist and then we will come back to the questions.

Dr. Everist?

Dr. EVERIST. I am a country pediatrician, Senator, and I appreciate the opportunity to talk to this group.

Despite the other titles, that is my living, and has been for 22 years. However, I hold no brief for a special "health care crisis" in rural America.

I also have a statement, and it is mercifully brief, so I will read it.

The bucolic husbandry of rural populations by kindly old country doctors is a myth in 1971. Our health problems are not dissimilar from those of the inner city, or the university, or the research laboratory; but, they are compounded by a lower income, more chronic disease, a higher infant mortality rate and fewer modern medical amenities.

These are a matter of degree, not of substance. We do differ, however, in that we have a far greater inequity in the delivery of health services.

It is easier to ignore the health needs of a dispersed population, especially the poor, than in the densely populated areas. It is now in rural America where our anachronistic health delivery system is most distressing.

We have led the world in pure science, applied science and technology in medicine; and yet, our delivery system remains essentially unchanged for the past 30 years. Our delivery system is almost totally geared to the treatment of the sick, as Dr. Holloman has said, with the far less costly preventive medicine given lip service and little more. It follows that if rural health problems are greater, then a preventive program would be even more valuable.

A second priority for rural America shared by urban and suburban and university centers is a lack of control of quality standards. There is a shocking disparity between the worst and the best of medical care in this country, including hospitals and nursing homes as well as physician care.

Ideally, these standards should be set and policed by the profession itself, but there must be motivation and encouragement to make it mandatory.

Senator KENNEDY. How do you set these standards without having the Government accused of interfering with the practice of medicine?

Dr. EVERIST. I think you will be accused of this, obviously, then.

Senator KENNEDY. This is a difficult question. We will have members of the medical profession saying there is somebody in Washington, D.C., deciding whether we operate or don't operate, and so forth.

Do you think as a practicing physician that we can devise a set of standards that we can police?

Dr. EVERIST. I don't think there is any question about this, and I think it can be administered by physicians. There is little question but that there are standards available that we can follow and can be made mandatory, and physicians know what these are.

Senator KENNEDY. Your position is that we ought to have these kinds of favorable standards, and that it is really essential if we are going to provide quality care on any kind of a massive scale.

Dr. EVERIST. That this kind of thing has to be mandatory?

Senator KENNEDY. And you are suggesting that nothing like this has been instituted in our present program to the present time?

Dr. EVERIST. No; it has not.

Senator KENNEDY. We have now general broad guidelines but nothing with teeth in it, and I gather what you are suggesting is that we ought to be able to devise a system of standards by which quality care could be measured: a yardstick, so to speak.

Dr. EVERIST. Yes; particularly for ambulatory care. We have accreditation for hospitals now, perhaps not as strict as it ought to be, but practically none for ambulatory care.

Senator KENNEDY. Would you proceed?

Dr. EVERIST. A third priority for rural health services is the combined need for orderly referral practices, cooperative arrangements among institutions, and adequate transportation.

As an aside, I think we have to stop thinking in terms of miles, or distances, and start thinking in terms of minutes and quality.

A phrase that had currency in this city a few years ago is apt here. We need medical "communities of solution." We have enough statistics on disease in this country to drown us; yet we have failed to use them in apportioning medical manpower and institutions.

We have the data to know how many transplant centers we need and where they should be. We know how many neurosurgeons are needed for population of 100,000 but we have made no concerted effort to organize them.

The availability of these services for the rural population is a matter of logistics, but impossible if they are allowed to continue at random.

Cost of medical care is currently being counted as a major problem, and maybe it is. But sick people are expensive and unproductive, and so I think maintaining our country in a state of optimum wellness will be worth whatever the cost may be.

In summary, I see three paramount priorities for rural health care, shared more or less by urban and suburban areas. They are the prevention of disease through health education and well-known preventive measures, quality standards with a measurement of competence, for rural practitioners and hospitals, and cooperative arrangements among institutions for orderly referral and "communities" of solution for highly specialized service.

Senator KENNEDY. Very good. It was a short statement, but a very helpful one.

Maybe we could go back to Dr. Holloman for just a minute.

I think you have made a remarkably persuasive case in terms of how those who are existing in the urban city, the inner city, perhaps in the middle-lower income groups, are so severely disadvantaged by the present system, so to speak, not only by the present financing mechanisms for health, but also in the production of medical manpower; and I think you have pointed out quite persuasively that it is the taxes of these individuals who live in the inner city that go to support the medical schools, it is the tolerance of these individuals in permitting the foundations themselves to make the kinds of grants to medical schools. The public pumps in a great deal of public resources in the development of health manpower that is being heavily

supported and, so to speak, subsidized by the people in the inner city; and then when the product comes out, the doctors move into suburban areas and the more lucrative areas, and the poor of the city have once again been denied what, quite appropriately, is their due.

I think you have made this case; at least this is one of the points which is terribly important for all of us to understand, because, as far as the administration's program, they talk about cost consciousness, and it seems that perhaps there is nobody who is more cost conscious than the people who live in the inner city and who are being constantly denied the kind of quality care, or preventive care, which is so essential for those citizens.

I thought this was an interesting, valid, and worthwhile organization.

Senator JAVITS. Mr. Chairman, could we ask Dr. Holloman, whom I know very well, and for whom I have a very high regard, what he suggests we might do about it?

For example, Senator Tower is introducing a bill which would give a special income tax break to doctors who settle and practice in areas such as you think they are abandoning.

The difficulty with this bill, of course, is to deal with the knotty problem of how do you get a doctor into Harlem as against Park Avenue and 96th Street?

In other words, the relationship is really one that is physical. The doctor on 96th Street could just as easily practice at Lenox Avenue and 125th Street, but he does not. I just wonder if you had—or perhaps Dr. DeBakey and his colleagues can help us—with any suggestions to overcome health manpower maldistribution. In my own judgment we are not going to solve the lack of delivery of health services problem with the administration or the Kennedy bill, whatever may be their other merits.

We need really practical ideas as to how to do it.

Dr. HOLLOMAN. Well, certainly the problem is a very acute one. How do you persuade a physician to practice in the inner city?

I think we do have to, first of all, start at a very early point in time. We have to recognize, for instance, that in New York City there are a number of factors other than just plain money that keeps doctors out of the inner city.

Certainly, the seven medical schools in New York City in June of 1969 trained nearly 8 percent of all the physicians being trained in the United States, and, in all seven medical schools in all 4 years, there was a grand total of 11 black physicians.

Much of this problem I have duplicated in a paper which I will give to you and the members of the committee, published in the Archives of Internal Medicine, titled "Medical Care and the Black Community."

I think this paper gives at least some allusion as to how your problem can be solved.

Those individuals who enter the medical profession motivated solely by the desire for monetary reward. I think have no business in the health professions.

I think that the health professions must ultimately become a service profession if health care is to become a right of American citizens.

We must give the opportunity to all classes of American citizens to become physicians, and up to now it has certainly been the prerogative of upper middle class and rich young men to become physicians.

The absence of minority youths in training—there are only about 6,000 black physicians in the country, and a far smaller number of Puerto Rican and Indian. It is far more important to recognize the social consciousness to transform this profession into a service profession in which health care does become a right for all Americans.

Starting at the college level, I think there should be certain financial incentives and financial breaks given to students, and there should be aid in medical school, both in the form of tuition and in living support, so that when a physician is graduated from medical school and completes his medical training, he will have some societal obligations.

He will not have to feel he has to get back from the society what they took from him, because of the struggle some of the physicians have to go through.

The elite-ism could be eliminated.

We want to get physicians to come into Harlem, and so we have to stop teaching them that people in the inner city are different from people in the suburbs, and because they are poor, or less affluent, that they are somehow less valuable. They must learn that medical care rendered in the inner city is at least as important as medical care given in Scarsdale or given on Park Avenue.

Senator JAVITS. Thank you, Dr. Holloman.

If the Chair would allow me, I would like to get the other two witnesses to comment on the same question, but I did not want to interrupt.

Senator KENNEDY. Why don't they respond to that, and then we will get back.

Dr. EVERIST. I agree with Dr. Holloman on this, except that cost is a matter of concern. In a rural parish, where we are really trying to take care of the poor children in our area, we have seven different programs under which we can do this, none of them are alike.

Under one we can get an X-ray, another allows us to see the child twice a month, with another we can see the child once a month, another will provide for hospital care, but no outpatient care, and it is a miserable system.

Inevitably the children are categorized as being in one program or the other, and it is very difficult to do the kind of medicine that we would all like to do, simply because we have to go to so many different ways and means of getting the care.

Dr. DEBAKEY. Senator Javits, I think there are two important elements to your question. One is concern with the availability. The other is the concern with the attractions for it. Now, the medical manpower shortage simply accentuates this problem because the doctors tend to go where they can practice reasonably good medicine, and where the resources and facilities are available for that purpose.

They know that when they are dealing with very poor people they don't have the resources, and will not be able to practice the kind of medicine they would like to practice.

So they are in a sense discouraged from going there. Then, of course, there is the element of financial reward that exists, and they can live better in other areas by doing practice that is gratifying to them.

So what we need to do is, in a sense, to eliminate one of the barriers to this, and that is the availability from an economic point of view, a financial standpoint, of equal medical care to all the people, whether or not they are able to afford it.

The second thing we have got to do is increase our manpower. I happen to be concerned about this problem, too, because I am president of our college of medicine, and I can assure you that we are having difficulty in spite of the fact that we are trying in our own college to double our classes.

We are having great difficulty financially in doing this. Every medical school has. We need to provide more funds for these purposes, and one of the important aspects of the Health Security Act is that it does provide a trust fund to help budget financially, and provides incentives for innovative new ways of delivering care and other aspects of improving the facilities and developing the resources. This is a very important aspect of health security.

Senator JAVITS. Thank you, Doctor.

Thank you, Mr. Chairman.

Senator KENNEDY. Could I ask on that, while we are talking about attempting to double the classes, will you be able to do that with the new capitation grants?

Dr. DEBAKEY. No; we can't.

Senator KENNEDY. Why can't you?

Dr. DEBAKEY. Well, for the simple reason that what it amounts to is about \$1,500 per student per year, and this would come nowhere near meeting the costs, the additional costs.

You see, at the present time we are not meeting the costs, we are under-financed now to meet our present needs, our present operational activities.

Many of the schools are going constantly into their reserves and are in deficit spending simply to maintain a constant operation that is costing more money, with less money available.

Now the addition of \$1,500 per student would not relieve that situation at all. It would not even meet the deficits that are occurring.

So that this would come nowhere near meeting the need to increase the enrollment and increase the output of physicians.

Senator KENNEDY. The legislation which I introduced yesterday would increase that capitation to \$5,000. Would it be of this magnitude? Would that be necessary for you to double your classes?

Dr. DEBAKEY. Yes. It has been estimated that the costs for example in our school, and this has been a pretty good average cost, of about \$14,000 or \$15,000 a year per student, that is, total cost to the institution, with certain resources of funds that are available.

Then this leaves a certain deficit in the total cost. Many of the State schools meet this, of course, from their State appropriations, but the private medical schools generally do not have that available to them with certain exceptions in States like Pennsylvania, New York, and Ohio now, and a few other States are beginning to give out an apportionment of their funds for this purpose.

Certainly I would think that when you get into that amount of capitation, you are getting close to what is required and this would give tremendous help. There is no question about it.

Senator KENNEDY. Getting back to Dr. Holloman, would you think that if we had a greater implementation of the Emergency Health Manpower Act which was passed last year, that this might be one of the answers—not obviously the answer—but could it be a mechanism for getting additional health manpower into the innercity?

Dr. HOLLOMAN. Yes; I think it would help a great deal.

Senator KENNEDY. Initially that was not in the administration's budget. It was funded at a level of \$10 million, which would hardly meet the needs of medical manpower in Harlem alone.

Dr. HOLLOMAN. The problem is so great that this would probably be one-twentieth of the numbers that would be needed to make a significant dent in the problem.

Senator KENNEDY. If we were able to get support for the medical schools in terms of capitation support and additional kinds of construction grants, do you think that it would be useful for the medical schools to reach out into areas of the inner city as Harlem to find talented, creative, and committed individuals who would be desirous of returning to their communities to provide these kinds of services?

Do you think this kind of effort would be useful as well in attempting to help meet the needs?

Dr. HOLLOMAN. Senator Kennedy, I think this would do a great deal to relieve the alienation that the poor and the nonwhite feel so far as the health professions are concerned.

In all fairness, I would say that some of the medical schools, following some of the confrontations on campus 2 or 3 years ago, have instituted programs of recruitment. These programs of recruitment of minority, or nonwhite students or poor students, are hamstrung by insufficient funds.

The medical schools are hurting; the intentions are now, I believe, reasonably good, but with their finances, they are just unable to do what they really want to do.

This, I think, would help a great deal, sir.

Dr. DEBAKEY. I just want to add emphasis to that. We have had experiences of recruiting of minority students and trying to give them summer courses to prepare them to pass the tests and meet the requirements for entrance into medical school, and we have been greatly gratified by the response to this.

But then, the discouragement comes when it is found that there are no finances for these people, and at that point they are simply unable, even if they are accepted, to find adequate scholarships and adequate money.

Senator KENNEDY. You remarked, Dr. Holloman, that the FHIP program is a tragedy. Could you tell us why?

Dr. HOLLOMAN. There are several reasons that I believe this is a tragedy. First of all, we appear to be giving something—this is sort of an illusionary thing. We give it on the one hand and then we definitely take it away with the opposite hand.

Throughout the history, really, of private health insurance, we have found that even though in my community many patients have Blue

Cross and Blue Shield and other private health insurance, they are unable to secure the services that are needed.

They are just not available.

I think even with medicaid in New York, there was a promise that these patients would be treated, as are privately insured patients, and yet throughout the city you will find that they are treated still as charity patients, and treated on indigent wards and this type of thing.

I think that the addition of mere money to an overburdened health care delivery system can only add to the problem.

Senator KENNEDY. I would agree with you on the statement about the FHIP program. I think it is obviously inadequate in terms of its coverage.

You not only have to be married, but you have to have children, so it does not hit the poor single individual. He is not included. This does not include even married people who don't have children, even if they are poor, so there are wide areas where they are not included.

Dr. HOLLOMAN. It could be likened to a grate rather than a floor. There are many cracks.

Dr. DEBAKEY. In addition to that, Senator, people after having a certain type of illness will be canceled, and they simply can't get insurance anymore.

I have seen a number of patients who fall into that category, and these are people who often can no longer work. They are the ones who need medical care the most.

Senator KENNEDY. One of the things that is very much a part of the administration's program that relates, I think, to the problems of the inner city is the development of the HMOs, the health maintenance organizations; and, of course, it is conceived that these programs are going to be able to be financially stable. I mean that has to be implicit in the administration's approach, because they get guaranteed loans on those.

I suppose it is conceivable that they are going to be able to pay back these loans over the period of time, and if they are created in these urban cities where the people are the poorest, it is awfully difficult for me to see how they are going to be able to be financed in such a way as to be financially viable, when we are putting such a burden on those who have such limited incomes at best.

Dr. HOLLOMAN. Yes. Certainly the idea of the health maintenance organization is one that the administration should be commended for.

Certainly this new type of health organization which has had some experience, and, of course, it is not the traditional way in which medical care is given, certainly the members of organized medicine as recently as 20 years ago were condemning physicians who joined organizations which organized in prepaid group practices.

These were challenged with such expressions as "fee splitting," and any other thing "socialized medicine," anything that would raise a red flag to discourage this type of organization.

So those individuals who went into such plans as the Kaiser plan, and the Health Insurance Plan of New York were laboring under handicaps because of the opposition of organized medicine.

Now, the thing has come full swing, and we now begin to talk about health maintenance organization, but we do need to recognize that money, that the complete enrollment, the complete coverage of all of

the population is much more important now than the attempt to selectively place a HMO in one isolated portion of one inner-city area, or one middle-income area. I think that this approach is still in the piecemeal tradition, and unless a sufficient amount of money, a sufficient incentive is made to make it broadly covered, broad enough to cover the larger segment of the population, that it is doomed to some of the difficulties that have been experienced in the past.

Senator KENNEDY. Could you tell us a little bit about the HIP program, and then I would like to ask Dr. Everist to tell us about his program, too.

Dr. HOLLOMAN. Yes. The Health Insurance Plan of Greater New York historically originated during the days of Mayor Fiorello LaGuardia. He said he wanted his workers insured, so he sent out George Baehr and some others to write a health insurance plan, which the city of New York contributed a portion of the payment to, and the employers contributed another portion along with enrollee. This was deducted, and this has worked very well, although it met stiff opposition, and it was condemned first by the county medical society, and then by the American Medical Association.

Despite this opposition, it has persisted, and is now pointed to with pride as a model organization.

Instead of working on a fee-for-service, the physician is paid not to keep people sick, but to keep them well. He is paid a competition fee, he is given a certain amount per patient, and if he sees them a great deal, then he does not get any more money.

So it is to his advantage, then, to make every effort to keep people well, rather than to keep them sick.

My particular role in HIP is as the medical director of an automated multiphasic health center, which I have recently joined. But I think this type of preventive, or baseline examination, can do much to prevent future illness and to reduce the overall cost.

I think it can be an educational experience for those patients who go through the center, and I think that this is the type of thing along with the prepared capitation type of group practice that can do much to improve the health of the Nation.

Senator KENNEDY. How many does your HIP program cover in New York City?

Dr. HOLLOMAN. HIP covers now in excess of 800,000 people in the Greater New York area.

Senator KENNEDY. This concept of financing and its relationship to the doctor has been acceptable and agreeable to physicians.

Dr. HOLLOMAN. It has been acceptable, it has been agreeable. The problem, of course, with all such programs, is that the doctor who is not bound by this particular conviction can move to the more profitable area and charge a fee for service, is a physician to compete with?

But in spite of this problem, the program is working well. I think that some of the doctors are growing perhaps a little bit older now, and we have to keep the needle in them to keep them abreast with the demands of the American public and of the citizens of New York.

Senator KENNEDY. Let me ask you, because this is rather basic in comparison to the two kinds of approaches that are being followed by the administration and in our program, does the competition be-

tween the fee-for-service versus the capitation approach, which the HIP program has, work to the benefit of the sick people in New York?

Dr. HOLLOMAN. I think it would work to the benefit of the sick people in New York without question.

Senator KENNEDY. See if you understand my question. The idea that you have two different financing economic systems, the kind that you have employed in the HIP program and the fee-for-service program, and the competition that fee-for-service is providing for your doctors involved in that program: has that kind of competition helped to meet health needs?

Dr. HOLLOMAN. No. I was thinking of the first part of the question, and I was prepared to sing the praises of capitation fee for service group practice.

I think that competition for scarce resources only elevates the price while reducing the service.

I think the gain, as I indicated in my testimony, is that health should not be a commodity, that patients must not compete for health. It should be arranged in such a way that all patients would have equal access.

Senator KENNEDY. Let me ask Dr. Everist, could you provide the kind of services that you do for the poor in your parish of Louisiana, in Ruston, La., if you were in a solo practice rather than part of a plan?

Dr. EVERIST. No, it would be impossible.

Senator KENNEDY. Why not?

Dr. EVERIST. Because you can't have a 24-hour day coverage for peditrics.

Every third man is on call every third weekend, and every third holiday. That is about all one can tolerate, particularly when the days are 10 to 12 hours long.

Senator KENNEDY. You even had difficulty coming up here to testify.

Dr. EVERIST. Yes. It is a fast trip. I have to be back to work tomorrow.

Senator KENNEDY. Does it have the effect of cutting back on your income?

Dr. EVERIST. No; it has maintained about the same as the man in solo practice, and group practice is by far the easiest way for the doctors to practice, and I think it is much better for the patient, because you don't get as tired, worn out physically every day.

Senator KENNEDY. Finally, Dr. DeBakey, yesterday we put in S. 935, which proposes to assist academic medical centers in establishing and operating HMOs. Could you give us what thoughts you have on that subject?

Dr. DeBAKEY. I have not had a chance to review it thoroughly, but I doubt seriously that this will achieve the objectives we are seeking.

I think the concept of the HMO is desirable; but whether or not it is going to be possible to fund it adequately remains to be determined, certainly in my opinion.

This is going to cost a lot more money than the administration so far has seen fit to put into this program to make it realistic.

In our own experience, we have made an effort in our own medical school to try to find ways and means of providing better medical care

and to upgrade the quality of medical care in certain poor segments of our community; and the chief factor that has obstructed the achievement of this is finance—money.

Senator KENNEDY. Gentlemen, I want to thank you very much for your testimony here. It is enormously valuable and helpful. It adds greatly to the understanding of this subcommittee. You have all had an extraordinary breadth of experience, whether it is in the inner city, or rural America, or one of the great research institutions; so it is a very broad spectrum of background that you have brought to this question and subject, and it is of great value to those of us who are working in this area.

So I want to thank all of you very much.

Dr. DEBAKEY. Senator, we are grateful to you, and for the graciousness with which you received us. We want to thank you for your interest in the problem which we think is of great significance to the country.

Senator KENNEDY. Thank you very much.

Dr. DEBAKEY. Thank you.

Senator KENNEDY. Our next witnesses will be members of the Citizens Board of Inquiry Into Health Services for Americans.

**STATEMENT OF A PANEL COMPOSED OF THE CITIZENS' BOARD OF INQUIRY INTO HEALTH SERVICES: DR. LESTER BRESLOW, CHAIRMAN, DEPARTMENT OF PREVENTIVE AND SOCIAL MEDICINE, THE UNIVERSITY OF CALIFORNIA AT LOS ANGELES; DR. ARDEN MILLER, PROFESSOR OF MATERNAL AND CHILD HEALTH, UNIVERSITY OF NORTH CAROLINA SCHOOL OF PUBLIC HEALTH; MRS. LISBETH BAMBERGER SCHORR, FORMER CHIEF OF PROGRAM PLANNING OF OFFICE OF HEALTH AFFAIRS, OFFICE OF ECONOMIC OPPORTUNITY.**

Lester Breslow, M.D., is chairman of the Department of Preventive and Social Medicine, School of Medicine, of the University of California at Los Angeles. He was formerly the director of the California State Department of Public Health, and a past president of the American Public Health Association.

C. Arden Miller, M.D., is a professor of maternal and child health at the University of North Carolina School of Public Health. He was vice chancellor for health services of the University of North Carolina from 1966 to 1971; and he was formerly dean of the University of Kansas School of Medicine. He is a pediatrician by training.

Mrs. Lisbeth Bamberger Schorr is a housewife and mother. From 1958 to 1965, she was the assistant director of the Department of Social Security, AFL-CIO. She was Acting Chief of Health Services of the Office of Economic Opportunity from 1965 to 1966, and in 1967 she was Chief of Program Planning of the Office of Health Affairs, Office of Economic Opportunity.

We want to welcome all of you here this morning, and we look forward to your comments.

You have an extensive document here. It is 39 pages long, but it is extremely valuable. Do you want to read it, or summarize it?

Dr. BRESLOW. We would like to brief it, Senator Kennedy.

Senator KENNEDY. You have a good deal of time. No one is in a hurry, so do whatever it is you want to.

Dr. BRESLOW. I am Lester Breslow, chairman of the Department of Preventive and Social Medicine, School of Medicine, University of California at Los Angeles. My colleagues are Mrs. Lisbeth Bamberger Schorr, now primarily a consumer of health services, formerly with OEO, Office of Health Affairs; Dr. C. Arden Miller, professor of maternal and child health at the University of North Carolina School of Public Health; and Mr. Harry Huges, lawyer with the Washington firm of Arnold & Porter, formerly codirector of the Washington research project.

As you will see from the list attached to our statement, there are an impressive array of talent in American life.

Senator KENNEDY. Could you tell me a little bit about how this group was set up, and the procedures it follows, and tell us just a bit of a survey of how it was established?

Dr. BRESLOW. Dr. Miller and I took the initiative in organizing the committee. We felt, as directors of new health services research enterprises, that we needed to have, in addition to our professional point of view, the consumer's point of view.

So together we sought private foundations support. All of the money was on a contributed basis, and we organized the board whose membership you have before you.

That board was extremely active in the affairs of the inquiry, making visits to Seattle, St. Louis, Boston, the Rio Grande Valley, rural Arkansas, and many other parts of the country.

We come here today as representatives of the Citizen's Board of Inquiry into Health Services for Americans.

That board includes the four of us in addition to 27 other persons; black and white welfare mothers, prominent medical scientists and educators and practicing physicians, successful businessmen, politicians and labor union representatives. In addition, there were nurses, social workers, several young attorneys, a judge, a prominent author, and a recent medical school graduate.

As you will see from the list of board members attached to the end of the statement, they are an impressive array of talent and effectiveness in American public life.

We come to report that Americans are angry and frustrated about their health services, and to bring some suggestions about how to deal with this matter.

Government officials and health professionals speak of a health care crisis in our country. What they mean is a shortage of health manpower, failing organization of services and poor arrangements for payment. Although this view of the problem is important, it does not get to the heart of the matter.

The heart of the matter is the problem confronting the patient. That was the focus of our boards' inquiry which consisted simply of an effort to listen to as many people of different socio-economic backgrounds in as many settings as possible on the subject of their health care.

We found that the American people do not have to stop and reflect on how they feel about health care. They are angry. A middle class

housewife said, "My doctor has a call hour between 7 and 8 o'clock in the evening. If anything happens to me or the kids after 8 I am afraid to call him. He gets mad because you didn't call during that hour, and if I take the kids to his office I almost pray they're sick."

Patients in every socio-economic class resent systems of care which require payment before services are rendered. The poor suffer most because they may in fact be turned away from services if they cannot pay in advance.

A woman in labor, for example, was left unattended while her husband hurried home, arranged for the sale of his cow and brought money back to pay for delivery.

We are persuaded that a large number of American people are actually denied medical services until they can pay in advance.

Even when they are accepted for care, Spanish speaking Americans cannot even be assured that their complaints are understood, nor can they be confident about understanding instructions as to what to do.

Among people who speak presumably the same language, the same language, is in fact sometimes not spoken. A woman in Boston told us "Those rich doctors at the city hospital treat you like dirt. They don't know anything about the people they are treating."

We were shocked by the frequency with which patients are abused in order to satisfy procedural or professional convenience.

In one State where medicaid recipients are entitled to one visit per month, the patient must first make an appointment with the doctor, then go with proof of the appointment to the county welfare department, get a medical reimbursement form, then back to the doctor, form in hand.

The doctor then submits the form to the State welfare department for his payment. The requirement of preliminary approval was explained to us by the county director of welfare: "There used to be a lot of fraud with doctors claiming payment for patients they had not seen, so now patients are required to get an appointment first to stop the doctors from defrauding the State."

In order to guarantee that a system will work in an honest fashion, it is the sick patient, not the doctor or the welfare department, that is inconvenienced.

Even when they overcome a variety of obstacles to health services people are treated with insensitivity and indignity. A priest told of taking an acutely ill alcoholic to an emergency room and asking that he be given care.

He said: "They took us right to the front of the line when they saw I was a priest. I was assured that he would be admitted and taken care of. Two days later I went back to visit him. No one had heard of his ever having been brought in. I'm sure that when I went out the front door, he was shoved out the back door."

We don't know that these stories are true. For any particular tale of woe there may be a perfectly reasonable explanation, but it is certainly true that the people who relate the stories believe them to be true, and believe they typify medical care in a system which is money grabbing and insensitive to many needs of patients.

Various health insurance plans have provided little security for patients. A New Jersey woman explained that she even pays more under medicare than she paid without it.

My physician used to charge me \$10 for an office consultation. I have a serious heart condition and saw him once a month. This amounted to \$120 a year. A week after Medicare became law his fee was raised from \$10 to \$15.

He now charges \$4 for a blood test which previously was included in his fee. Thus, my monthly bill is now \$19, annually \$228.

In addition my yearly medicare insurance costs \$48. After deducting \$50, medicare will pay 80 percent of reasonable charges: \$142.40. I pay out a total of \$276 including the premium and get reimbursed \$142.40, leaving me \$133.60 to pay out of pocket—\$133.60 more than I paid before medicare.

A high proportion of income in some low-income families goes for medications. We found that a certain tranquilizer was commonly prescribed in Arkansas. At the local drugstore here 30 capsules cost \$6.50. At a middle-class drugstore in Washington, D.C., the cost for the same medication was \$2.50. A drugstore in a Washington ghetto neighborhood, largely with a black clientele, charged \$3.29.

This recitation of anger and grief could go on endlessly. What does it mean?

The consumer, it is clear, knows that something is dreadfully wrong. He knows that he cannot get care when he needs it, in the way that he needs it, at a price that he can pay.

For the consumer individually it is a quantum jump to translate that into the design of new delivery structures and financing mechanisms. But our experience as a board of inquiry has led us to formulate a set of criteria that American consumers seem to be setting for the design of any program of health service. The criteria include:

1. Continual access to basic medical care.
2. Daily access to routine health guidance, by telephone or in person.
3. Immediate access to emergency service.
4. Periodic access to screening procedures.
5. No economic barriers to care.
6. Elimination of barriers involving language, transportation, location, and hours of service.
7. Health service in an atmosphere of respect, friendliness, and dignity.
8. Awareness on the part of providers of the circumstances in which their patients live and work.
9. Prompt provision of care, with time to listen and explain.
10. Opportunity for the consumer to affect the health system, and to choose varying patterns under which to obtain his care.

As part of its work, the Board reviewed past programs which have been designed to improve the quality and availability of health services. In retrospect many of these efforts seem glib and superficial.

For the most part these programs tended to strengthen existing patterns, including their inadequacies, rather than to close gaps and to restore order to random and incomplete services.

We therefore must conclude that the United States is failing to provide adequate health services for its citizens; that our system of health care is in disarray; and that consumers have no significant roles in determining the nature and priorities of health care—all this in spite of the fact that we have the resources and technology for superb care.

Based on its findings, the Board offers these recommendations:

1. New structures should be created for the organization and delivery of care, and certain existing ones should be more widely established. Health care should no longer depend upon the accumulation of isolated decisions, made by individual providers irrespective of the public's needs, on the nature and the distribution of resources and services.

2. Health care delivery systems should be organized and made accountable to the public in the following ways:

(a). Providers should make individual decisions affecting the health of their patients while the public should become the ultimate determiners of how health services are delivered, paid for, and organized.

(b) Consumers must have the dominant decisionmaking role at all levels of the health care delivery system, including control of assets, capital expenditures and arrangement of services. Obviously this does not mean that consumers will usurp the physician's responsibility for meeting his patient's medical needs; a clear line must be drawn between policy (the consumer's business) and the health care of individuals (the physician's business).

(c) The process of selecting consumer representatives in decisionmaking should stress the following principles:

(1) The procedure for selecting consumer representatives must be clear to the community for which services are being provided.

(2) Individual consumers and consumer groups must be able to effect the process of selection.

(3) Consumer representatives must be accountable and responsible to the group which they represent.

3. Persons engaged in providing services in any agency of the health service system should not sit in the policymaking body of that agency.

Otherwise they may be in conflict of interest, decision deciding what services to purchase from themselves. This is not an indictment of health professionals; it is rather an indictment of unreasonable expectations of them.

Acknowledging an adversary relationship and striving to achieve conciliation among parties whose roles and interests are precisely defined may be far more productive than trying to maintain our present conflicted and dominated partnership.

4. Finally, we believe it is the responsibility of government, ultimately the Federal Government, to assure adequate health services for all Americans. To do so it must eliminate economic barriers to health services through some form of universal financing system. Further where care itself is inadequate or unavailable the Federal Government should be the residual guarantor or even provider of health service. Health care has now become an essential and a social right—as fundamental as food, clothing, and shelter.

We are very pleased, Senator Kennedy, to respond to any of your questions.

My colleagues may have additional remarks to make at this time.

Senator KENNEDY. Maybe we should ask Mrs. Schorr if you would like to make any additional comments?

Mrs. SCHORR. I prefer to respond to questions, Senator Kennedy. I am pleased with the way Dr. Breslow responded.

Senator KENNEDY. I noticed you filed a dissenting view on some of the matters.

Dr. MILLER. That is an error. I thoroughly subscribe to all that has been said. There is an asterisk that you may be looking at; it refers to me as a member of the executive council.

There was one dissenting opinion expressed.

Senator KENNEDY. You gave us some worthwhile suggestions, and one of the things that I think we are all trying to think about and work on is the question of quality and cost control. You have talked a little bit about the questions of quality control in your presentation.

I think when we start talking about quality control or the role of the consumer, we are always very quick to be asked, "Aren't you really going to be dictating or interfering with the patient-doctor relationship, and in S-3 we tried to devise some means and ways of bringing about a more active role by the consumer, certainly in the delivery of health services.

The administration has these PRO's, which try to set up some kind of an advisory group. I suppose experience has shown that when an advisory group has been established, for the most part has been taken over the medical community, to date it has not really functioned in ways to best represent the consumer interests.

I would be interested if you could provide at least some additional guidelines to us in terms of how we are really going to be able to establish some national standards for measuring the kinds of health that will be available to people and still preserve the patient-doctor relationship.

What can we really do? How are you going to really legislate that and protect those people that are going to the hospitals and feel that they are waiting for far too long, or receiving inadequate care?

How are you going to be able to reach this?

Dr. MILLER. Senator, I am not able to give a very complete answer to that, from our study, but there are one or two perspectives that I think we can provide.

I think, No. 1, we came away from this effort with the feeling that the doctor-patient relationship is much less cherished by the consumer, at least ones we talked to, than we have been led to believe.

There are consumers who derive great satisfaction from their health services, but they may be consumers who relate to a whole variety of professional or subprofessional people in a comprehensive health care center or in a prepaid group practice. A constant relationship with one practitioner is not a necessary condition for satisfaction from medical care.

A second important perspective involves the consumer's need for assistance from experts who are not actually providing services to him. Outside help is required in setting up quality control standards.

Generally the same physicians who provide the services evaluate their quality. I think it is in the consumer interest to have one mechanism for providing service and another mechanism to undertake the kind of review you have described. A conflict of interest results if one and the same professional mechanism both provides services and evaluates them.

Senator KENNEDY. You think that can be easily set up in such a way—

Dr. MILLER. We believe that it can, and we believe it has been done in isolated instances, which are worthy of careful study and review.

Senator KENNEDY. Could you give us any kinds of examples on this?

Dr. BRESLOW. I think, Senator, that the assurance of quality should be approached in at least two different ways. To give some examples, one is to require that providers who are participating in the health care system meet certain standards that are predetermined.

For example, hospitals should meet standards that I believe ought to be substantially higher than those in the licensure laws and regulations around the country today. We can improve hospital care vastly by insisting upon a higher standard.

Laboratories should be required to participate in performance testing programs, just like industry has quality control through performance testing, many components of the health services system can do the same here; actually check on the quality and correct any deficiencies by performance testing. In the performance of medical procedures, like major surgery, there might well be a requirement in most parts of the country that only physicians who are especially qualified should perform that surgery.

So you can really specify, and I think with agreement, largely, in the medical professions, certain things that are reasonable standards of care, predetermined.

In addition and this is the second approach, I believe that a national system of health care should provide for the observation of physicians care by physicians in the same way that good hospitals have been performing for several decades, to extend this system of peer review from the hospitals throughout health care.

It is not anything new, merely an extension.

Mrs. SCHORR. If I might just add, one of the reasons for our recommendation that more and more out-patient care be delivered through structured organizations rather than by individual physicians practicing alone, is that these arrangements would lend themselves to the kind of peer review that Dr. Breslow is talking about.

When doctors are practicing in offices alone by themselves, it is much more difficult to provide the kind of review of quality by their colleagues than is made possible when they are in some form of group practice.

Senator KENNEDY. What observations could you make in terms of the cost control? Obviously what I am trying to drive at is whether this fee-for-service or budgetary approach is most effective in holding down costs?

Is there anything that you could tell us as a result of your study in this area?

Mr. BRESLOW. Well, we did talk to people who get their care under a variety of arrangements, including some who get their care under

group practice, prepayment arrangements, and others who are in the fee for service system, and while all of them had some criticisms of the systems that are now in existence, I think it is fair to say that those who are enrolled in the group practices prepayment plans had very little to say in the way of objection to the cost of their medical care, whereas those who were subjected to the fee for service system, and particularly the lower income not just very poor, but lower middle class as well who were subjected to demands for payment, cash on the barrelhead, as we used to say, that kind of approach to health care in the fee for service system obviously does make it extremely difficult for people to obtain care. Rather than data from our talking with people, I think the answer to your question more scientifically would come from studies with which I am sure you are familiar, indicating that on a broad basis there are greater opportunities for cost control, where you have a prepayment budget mechanism.

Dr. MILLER. And also greater opportunities for prevention of illness.

Senator KENNEDY. Did you find then in your course of inquiry examples of individuals who were denied services because they actually did not have the financial resources to pay for those services?

Dr. BRESLOW. We cited one instance in the remarks we made. There was the instance of the man who was required to go home from the hospital and literally sell his cow to obtain care for his wife who was in labor. We picked this one out as the most dramatic—but there were others.

Senator KENNEDY. Is that because the doctor refused to move ahead, or the hospital, or what?

Dr. BRESLOW. In this case, it was the hospital.

Senator KENNEDY. Refused to provide the kinds of services for delivery of the woman who was about to give birth to the child until her husband came back to the hospital with the cash in hand to pay for that?

Dr. BRESLOW. That unfortunately is true in far too many instances.

Dr. MILLER. I think there is another aspect to this. We did find a number of clearly documented instances where people were denied services because they could not pay in advance, but what is even more distressing is that so many people at all socioeconomic levels believe they must pay in advance.

Whether that is true or not, as extensively as indicated by our report, I don't know, but people believe it is true.

Senator KENNEDY. That is the cost-consciousness argument?

Dr. BRESLOW. It is not only cost consciousness. I think it is also a matter of security. People just do not feel security in seeking medical care without having money in hand; what we need, obviously, is a system which eliminates economic barriers to care so that people do really feel secure when they go to the physician, hospital, or other provider.

Senator KENNEDY. What is the idea when the husband goes home and tells the neighbor that he has to go sell his cow in order to have his wife delivered?

What does that do in terms of preventive care, in terms of the modern understanding of improving our whole health system?

If all these things are true, and I believe they are, because you have documented them, what would be the implications for preventive care for those of middle income, and even low income?

Mrs. SCHORR. I think that is one of the most important implications of the existing financial barriers to obtaining needed care. The fact that is very frequently commented upon, that when poor people get to the hospital, they are so much more sick than middle-class people, is surely a very direct result of precisely what we are talking about, that when the financial barriers, and also other barriers to seeking care, are as great as they are for so many people, large numbers are going to postpone seeking care until the emergency is acute.

The middle-class mother who can get advice on care for her child by picking up the telephone and calling her pediatrician is going to be much more likely to obtain that advice and be able to give her child the proper care before he gets so acutely ill that he has to be hospitalized, than is the woman who is going to have to find ways of having her other children taken care of while she makes the long trek to the outpatient department of the city hospital, where she is going to have to wait all day in the hopes, which are not always realized, of having some doctor look at her child before the day is over and the lines form again the next day.

So the financial and other barriers that stand between people and the care that they need not only result in unnecessary suffering, but surely also in unnecessary costs to individuals and to the system as a whole.

Senator KENNEDY. Who are these people that need the services and may very well be required to come up with the cash, so to speak, before they receive services? Are these people that are covered by private insurance, but their insurance doesn't cover the whole cost; or are they people who are not covered by any insurance because they can't afford it?

What kind of people are we talking about?

Dr. BRESLOW. In general, the people who fit this category are people who do not have the resources, the cash in hand.

Senator KENNEDY. They get just as sick, and oftentimes sicker, don't they?

Dr. BRESLOW. The statistics indicate, as implied in your question, that they do get sicker. They are sicker as a whole.

There are also people who do not have any insurance, and there are substantial numbers of people in our country without insurance in spite of the advances that have been made in voluntary health insurance and medicare, or they are people who have very inadequate insurance.

There are large numbers of people in this country who purchase and pay out hard money to obtain health insurance which is really of little value.

I am personally shocked oftentimes in reading big advertisements in the newspapers appealing to people to purchase forms of health insurance which are really tragically inadequate and extremely wasteful.

Senator KENNEDY. Why do you think that this has been true? I mean why have the insurance companies really failed to provide effective and comprehensive kinds of programs that are equipped to meet the total health needs of people?

They have been working at it for some 25 years.

As you point out in your comments, and as others have pointed out, they just are not doing the job. I suppose the question comes down to why aren't they doing it, or why can't they do it? What is implicit in this problem that seems to prohibit them from being able to reach this problem?

Dr. BRESLOW. There are a couple of things that are important here. One is that some people simply do not have the cash income to purchase health insurance at all, or to purchase useful health insurance.

They may pay out a few dollars to get totally inadequate care. They are in effect wasting money that might go to health care.

So poverty is part of the answer to your question.

The other part of the answer is that we are dealing with a profit-making industry. There is nothing wrong with profitmaking in our society, but we are dealing here with health care, and in order to guarantee what the insurance companies call retention sufficient to cover their expenses and to assure a profit, especially in insurance policies that are sold to poor people, older people, who are not in groups, there is a very high so-called retention.

The insurance company's claim that they must have a relatively low benefit ratio to the premium income that they get in order to stay in business.

That discrepancy between what they pay out and what they receive is very substantial in the case of many of the health insurance programs.

Dr. MILLER. May I speak to that same point?

We have a long history of providing for the consumer some of the essential ingredients for health care. We have provided him through various insurance mechanisms with more dollars to purchase care; we have tried very hard to provide him with more doctors and more hospital beds.

I think that we have not provided the context within which these essential ingredients for services can be used effectively and efficiently.

I have little confidence that more doctors alone, or more hospital beds alone, or more dollars alone, if not put in a context of systematized care, particularly care with some kind of governance at a local level, will do substantially more to improve services than what we have now.

Senator KENNEDY. What you are suggesting, I suppose, is that those within our society, middle income, the working poor or the poor with families, and so many instances those in greatest need of health care, are less equipped to set aside the kinds of sizable quantities of resources essential to provide the kind of comprehensive care needed for a family. If the poor are working poor, they can only pay out just a small amount of their income because they have so many other kinds of demands in terms of food and in terms of clothing, so they only pay out a little and get very, very little coverage for that.

So I suppose this is why the problem is compounded.

Mrs. SCHORR. There is another problem with using the private insurance mechanism to finance health services and that has to do with the fact that insurance companies base their business on the concept of the insurable risk.

That is why they have been able to insure hospitalization and surgery much more readily than the other components of health services.

We find, then, a distortion of the services that people are actually able to finance because of what the insurance companies feel they are able to insure for.

Now, they are slowly moving away from this, but I don't think there is any evidence that they are able to abandon the concept of the insurable risk sufficiently to be able to underwrite a rational and comprehensive program of health services.

Senator KENNEDY. In terms of the adequacy of the development of health manpower, I was wondering whether there is anything you would like to say about the development of, or the utilization of health manpower to try to meet this crisis, either in reference to the legislation, or just generally?

How are we really going to be able to provide the health manpower resources which are necessary?

Dr. BRESLOW. It is quite clear that we are going to have to do two things. One is to better distribute and rearrange the present health manpower, and also to develop additional and probably new forms of health manpower.

We found that contrary to what many of us had really believed before, people do not demand so much of physician's time.

They are quite happy, we find, in talking with them, to receive care in situations where they know that there is excellent medical supervision, but where there are other types of personnel who may be talking with them, or even providing certain aspects of the care.

So we look forward to the development of physician assistants, nurse practitioners, these new types of health manpower who will work in very carefully regulated and quality controlled situations where the expert medical judgment that they need for supervision is always available.

We think that it is terribly important to extend, to open up, the access to the health care delivery system in ways which are far beyond the ability of the present number and variety and distribution of physicians that we have.

So we look to bills S. 3, or any other proposals among other things, to extend and improve health manpower.

Dr. MILLER. Senator Kennedy, it seems to me in regard to manpower that we clearly need more physicians and more professionals and subprofessionals of all sorts.

But, I am horrified at the thought that we could provide all that manpower and not be much better off, because I think the inefficiencies of our present system of utilization so enormous that we could absorb a lot more manpower and not improve services unless they are provided in systematized systems of care.

Senator KENNEDY. A systematic system of care?

Dr. MILLER. Thank you. That is the best kind.

Senator KENNEDY. Let me ask the panel just some general kinds of reactions that you found from your interviews, such as the attitude of people you talked with toward the commercial insurance programs, toward group practices, toward medicare and medicaid.

What kind of impressions do you gather from the reaction of the citizens in these programs?

Do you find some much more acceptable than others?

Dr. BRESLOW. I think that many individuals are more satisfied with certain forms of care than with others.

Those who must depend in the various States, for example, on Medicaid programs, I think we found them the most dissatisfied, because there was the greatest unevenness and the greatest uncertainty, the greatest lack of security in getting care under Medicaid.

Poor people simply do not know where they stand in regard to the benefits or even whether they are eligible for Medicaid.

That is why many of us believe that there must be a single universal and comprehensive system of financing health care.

Senator KENNEDY. This is because it varies among the States?

Dr. BRESLOW. Not only from State to State, even within States there is variation in the rules, and the rules change from month to month, sometimes from week to week.

Senator KENNEDY. A senior citizen in Massachusetts might be treated one way, and in Iowa another?

Dr. BRESLOW. Not only that. I remember talking to a woman in a rural county in California, a pregnant woman, who had been on Medi-Cal, as it is called in California. She was getting care from a physician of her own choice in her own community and was anticipating admission to a hospital in that community for delivery.

In her 8th month of pregnancy, her husband and a couple of her adolescent sons got jobs picking crops. She reported this to the welfare department, as an honest woman. They therein promptly removed her from eligibility for Medi-Cal benefits in that county, and she had to return to the county hospital, about 20 miles away, for delivery of her child, a county hospital that previous experience, had taught her to hate. This is how Medicaid operates even within a county, and certainly as you point out, there are wide discrepancies among the States with respect to the benefits and arrangements.

Senator KENNEDY. That is cost consciousness. She is cost conscious now.

Dr. BRESLOW. I think she is not the only one who is conscious in this case. It is really tragic the way the benefits can be manipulated for individuals and hundreds of thousands of people in particular States under the present arrangements for Medicaid.

I don't mean by this series of remarks on that one program to imply that the people are thoroughly satisfied with the other programs that have been developed. As we indicated in our remarks, there are certain inequities in Medicare. In some cases, it has literally made things worse for people. Even in the programs that are now getting the most favorable attention in many of the proposals that are being advanced, we found defects, and we would not defend on behalf of consumers, any one of these plans, including the Kaiser plan on the west coast, as being completely adequate.

We found consumers are dissatisfied with some aspects of care. They point out to us that Kaiser must compete with the insurance and other plans that are available to people, and to do this, they have to skimp on services, and on the availability of professional time, too.

So there is dissatisfaction even with the best of the plans, but certainly there is much more with some than others.

Senator KENNEDY. What would the other members of the panel like to say in terms of attitudes, the responsiveness of commercial carriers, and group practices, and medicare and medicaid?

Do you have some general comments?

Dr. MILLER. I think I have none, except to emphasize again that my concern is more with systems of delivery for care than it is with mechanisms for their financing. I think there are a number of methods of financing which show promise of working and which should be applied across the country.

Senator KENNEDY. Do you think S. 3 does that, or are you prepared to comment?

Dr. MILLER. I am encouraged to hope that it does, sir.

Mrs. SCHORR. Senator, I would like to comment on your question regarding the responsiveness of the various systems. I think responsiveness is an absolutely key word.

The systems of insurance that are available to most people today, no one even has any illusions about their being responsive to people's needs. The institutions that have been geared to financing care, as opposed to those that have both financed it and provided it, have not made any pretense of being responsive to what people really need.

It seems to me that if you want a system that is responsive to the needs and wishes of the consumers, of the users of the system, you have to do two things.

You have to provide the financial underpinning whereby everyone has access to services, and then you have to do something to improve the services that are available.

As soon as everybody in this country has financial access to what American medicine can provide, and it is also made possible through the provision of technical assistance, through the availability of start-up funds, through changes in training and utilization of manpower, to improve the services that are available, then there is really nothing wrong with various providers of services competing with one another for the consumer's funds.

If a neighborhood health center wants to compete with a group practice, one under the auspices of a community board and the other under the auspices of a group of physicians, there is nothing wrong with that if the financial base is there for a consumer to be able to make a choice.

We have neither situation today. With rare exceptions, the consumer is not in a position financially to make a choice between the varying patterns of care, and most consumers, even if they had the financial wherewithal, do not have available various patterns of services to choose from.

Senator KENNEDY. I suppose implicit in your response is the fact that you have to have national standards by which those competing systems would be measured, as well; wouldn't you?

I mean if you had a neighborhood health center versus a group practice, you would have to have some kind of quality standards by which they would be evaluated.

Mrs. SCHORR. Absolutely. While we do recommend that consumers be provided with more information and more means of making judg-

ments themselves about various systems of care, it is unlikely that in the foreseeable future we will be at a point where consumers do not need protection through some form of national minimum standards for every program of care that is made available, and supported through a universal financing system.

Senator KENNEDY. Dr. Breslow, let me ask you a question. The administration says that there is twice as much surgery in California as in other parts of the country. Why is this so, who are the people being operated on, and who is paying for it?

Dr. BRESLOW. Senator, I have not seen that statement and don't know on what it was based, but I have seen other data which I think bear on the same question, which is at the root of what you are speaking of here, and that is that the frequency of performance of surgery as a whole, all surgery, and the frequency of performance of certain specific kinds of surgery, such as tonsillectomy and appendicitis, very common operations, is something like twice as great, or more frequent, in a fee-for-services system than it is in a group-practice-prepayment system.

This has been shown in data describing the experience of the Federal employees health benefits programs, under which Federal employees in all parts of the country can select various patterns of care, according to standards that have been established in that program, as long as they meet certain minimum standards. Some employees have elected to get their care in organizations such as Kaiser, HIP, group practice, prepayment, or, as it is now called, health maintenance organizations.

Others have elected to get their care under the fee-for-services systems. The data clearly show that surgery is twice as great in the fee-for-service plans. Now one can ask the question as to which is best. There is, of course, no guarantee that because one is cheaper that it is the best. It may be that people are dying or becoming disabled because of failure to have their appendixes removed when it is appropriate.

So this aspect of the question should, of course, be further investigated, but all the available information suggests that these discrepancies are due to more surgery than is medically justifiable.

That is why I think it is so important in these programs to provide that only those physicians who are especially qualified in making the judgment as to who should have surgery, as well as to perform that surgery, are entitled under the program to be paid for providing it.

I am sorry, I just don't know about the frequency in California.

Senator KENNEDY. That is a very helpful response. Doctor, you would like to say anything about that?

Dr. MILLER. No; but I was reminded of a figure having to do with England. My information was that we have twice as many surgeons as England, and do twice as much surgery.

Senator KENNEDY. Just in winding up here, I am sure your survey included not only the looking into the health problems of the poor, the working poor, but are there any particular observations that you want to make about sort of the middle-income groups, or even higher economic groups in terms of the existing system?

Do you find that the availability of service to them was satisfactory; do you find complaints with them as well?

What do you have to say about that?

Dr. BRESLOW. While most of our attention, as that of others who have looked into the problems, has focused on the most disadvantaged American people, because we do believe in equity in health care for all Americans, we did explore the situation of middle-income and even upper-income people, and we were really surprised, those of us who thought we knew something about health care, to find that dismay and anger about health care extends far beyond the lowest income groups.

It really does enter into the thinking and feeling of people in the middle and higher income groups.

They are angry at what they have to put up with in obtaining care, even though they may have the funds to pay for it. They are very dissatisfied with the arrangements for care, in general.

Now, obviously, there are some people who are very happy with their particular arrangements, those who happen to be sufficiently sophisticated or fortunate to have made good arrangements told us about those.

So we did find that there is some group of people who are satisfied with their care. But we can assure you on the basis of our findings that the dissatisfaction extends throughout all social classes.

I suspect, Senator, that that is the reason why so many in national life today are beginning to give serious attention to the question of health care. It is no longer just a matter of the poor.

It is a matter of health care for the entire American people.

Senator KENNEDY. Is there anything, Mrs. Schorr, that you would like to say, or Mr. Miller?

Dr. MILLER. No. Thank you very much.

Senator KENNEDY. I just have a couple of final questions from Senator Eagleton. In your prepared testimony, you use a woman in St. Louis who was told that when you come to the hospital you have to bring 2 years back rent receipts, and gas and wage slips before they even look at your child.

Senator Eagleton asks, aren't medicare cards issued to those who have qualified, and once an individual has been qualified, isn't the card sufficient to obtain treatment?

Isn't this the case?

Dr. BRESLOW. This particular passage does not indicate whether the woman in St. Louis was in fact eligible for medicaid. There are many poor people and near poor, lower income people who, because of the categorical requirements, having to be in particular kinds of families, or aged or blind or disabled, are not in fact eligible for medicaid, even though they are just as poor as people who are on medicaid.

So hospitals, feeling that they must protect their own financial and fiscal requirements, do insist in many instances as we have reported, and here is another instance, that people demonstrate that they are going to be able to pay the bill.

I don't recall in this particular instance whether the individual was eligible for medicaid.

Even so, there are the most incredible array of requirements imposed on people, even though they are eligible for medicaid, in order to secure care.

Senator KENNEDY. Senator Eagleton pointed out that a team from the American public health association made a tour like yours 2 years ago. They concluded the kind of health care poor people in this country received can only be described as health brutality.

Do you share this conclusion, or do you think this would be exaggerated language and scare talk?

Dr. BRESLOW. No, Senator, as a matter of fact I was a member of that team, and that particular statement was made by my very distinguished colleague and co-worker, Dr. Paul Cornely of this city.

I would like to read just a paragraph here which I think epitomizes what we saw over and over and over again, and which I think justifies Dr. Cornely's statement.

A 59-year-old Mexican American woman in Houston lived with her mother and 2-year-old grandson, left by a daughter who was unable to care for him. They lived in a two-room apartment in a single family house that has been subdivided into eight apartments in which eight people—eight families, 40 people, were living.

She applied for social security benefits but was turned down. She was only 59 years old. She gets no welfare assistance, since her son works. He sends her \$10 a week, since he must support his own family. She told us that it is such a struggle just to keep things where they are without them getting any worse.

Her hand, I remember this very well, was in a very clumsy bandage when we saw her. She had fixed it to protect a burn suffered about a month before. The burn had never been treated by a doctor.

The effects were probably aggravated by diabetes, which she told us she suffered from. The diabetes really should have had continuing medical attention, but as she put it, "sometimes it is just impossible for me to get to the hospital for medicine since I can't even pay for the bus."

We found if she had gotten on to the bus, she would have had to make several changes from where she lived in Houston to get to the public hospital.

Now we found that kind of situation over and over again throughout the country, in urban areas and in rural areas, and I think that Dr. Cornely was absolutely right in calling this a system of health brutality.

Senator KENNEDY. I understand the average taxi fare in Los Angeles County is \$10 to the county hospital, and so the individual asks himself whether he is \$10 sick before he wants to go down there.

Dr. BRESLOW. That is true in the south central part of Los Angeles, popularly known throughout the country because of events in 1965 as Watts.

It is still possible to be \$10 sick in Los Angeles. The county is now building a Martin Luther King hospital in Watts, and that hospital is going to be staffed by an excellent group of physicians, organized in the Drew Post Graduate Medical School. So there is some progress being made.

It is too bad they did not have this in 1964, instead of 1971.

Senator KENNEDY. Finally, Doctor, we have talked, and you have reviewed in some detail in your testimony as to the financing and delivery mechanisms.

In your travels, visits, and interviews with people, did you hear much complaint about the financing of medicare or social security? This is very basic in terms of approach that those of us who believe in instituting a national health insurance program would utilize.

I was wondering in terms of, medicare, for example, whether you ran into complaints about that as a means of assistance in financing aspects of it.

Dr. MILLER. I think our records are full of testimonials from patients who believe their enrollments in medicare has not provided them with the economic security they expected, and they feel it has not removed the economic barrier to the services they seek.

Senator KENNEDY. I was not so much interested in the inadequacies of medicare, which I quite readily agree exist, but as a system in and of itself; I guess it is difficult to differentiate that.

You pointed up and illustrated some rather dramatic examples of the variances in counties and States of the medicaid system, and I was wondering just as a system in and of itself whether you had any observations you wanted to make about it.

Dr. BRESLOW. Senator, we found no objection that I recall in reading all the notes as well as having gone on several of the trips myself, I recall no instances in which any patient objected to the fundamental method of financing medicare; that is, through the social security system.

We found no objection to that as a system.

We did find, as Dr. Miller and Mrs. Schorr and I have pointed out, many objections to the inadequacy of medicare particularly in two respects.

One is the requirement for payment of a certain portion of physicians care prior to the receipt of benefits. You must pay a so-called deductible, and further, you must pay a copayment. People object to this, because it does not make care more difficult to obtain.

Another feature which they call attention to is the fact that since there is really very little, practically nothing in medicare in the way of cost controls, that the costs of physicians care, as well as hospital care has been going up, and that rise has been accelerated by medicare.

So people, I think, it is fair to say, do not object to the fundamental system, but they do object to some of the deficiencies of medicare, particularly the requirements for deductible and copayment.

Senator KENNEDY. You have the deductible under medicare, too.

Dr. BRESLOW. Yes, for the physicians services yes.

Senator KENNEDY. And you ran into the instances where physicians were requiring the payment of that deductible before they were providing care.

Dr. BRESLOW. As a matter of fact, that is provision of medicare, that the patient must—in part B—have a \$50 payment before medicare benefits pick up.

Senator KENNEDY. Would you be kind enough to supply us with your report? We would be very interested if you could supply that and the supporting documents as well.

We will have the staff review the supporting documents. But we would like to have them included either as an appendix or as part of the record or part of the file.

So if you would, make that available to us, and we would appreciate it.

Dr. BRESLOW. We will be pleased to do that. Our report is at the printers now. We are expecting to have it back momentarily.

(The information referred to follows:)

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Report of the  
Citizens Board of Inquiry  
Into Health Services  
for Americans

... and who had suffered much  
under many physicians, and had  
spent all that she had and was no better  
but rather grew worse. mark 5:26

Corita

**Citizens Board of Inquiry  
Into Health Services  
for Americans**

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Special Assistant to the Administrator  
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Health Services and Mental Health  
Administration  
Department of Health, Education  
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Rockville, Maryland

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Stamford, Connecticut

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School of Medicine  
University of Minnesota  
Minneapolis, Minnesota

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Jerry Wurf  
President  
American Federation of State,  
County and Municipal Employees  
Washington, D.C.

\*Member Executive Committee

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and Human Development  
Harvard Medical School  
Harvard University  
Boston, Massachusetts

Cecil Sheps, M.D.  
Director  
Health Services Research Center  
University of North Carolina  
Chapel Hill, North Carolina

Franklin Williams, M.D.  
Medical Director  
Monroe Community Hospital  
Rochester, New York

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*Photography*

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*Cover Artist*

Corita Kent

# Americans are Angry and Frustrated about Health Services

"My doctor has a call hour between 7 and 8 in the evening. If anything happens to me or the kids after 8, I'm afraid to call him. They get mad because you didn't call during the hour. And, if I take the kids to his office, I almost pray they're sick."

"It's gotten so the hospitals will have to be governed or controlled by the government. Doctors are reaping a harvest, and they're really giving us a fleecing."

"The cost of insurance is so high it's ridiculous now. And are hospitals justified in charging what they charge? The ordinary citizen is going into hock for the rest of his life."

"You know, sometimes I think I know more than most of these doctors around here. Shoot, one of my kids had worms. I carried her up to the doctor but he said wasn't no such thing as worms. Well, I told my mother and she fixed me up some molasses and a whole lot of other stuff. We fed it to the child. That night the child was just screaming and hollering and carrying on. Well, I woke up my husband and he pulled out the night pot. We sat her down on it and out came a ball of worms twice as big as my fist. Well, I would've like to take them worms and shove them under that doctor's face, except I couldn't stand the sight of them myself."

"You have no choice but to trust the doctor completely. How would you cope with the situation any other way?"

"Somebody has got to be a voice for the people."

The anger is intense. It springs from frustration with efforts to obtain health services from doctors, hospitals, health departments and a host of programs and agencies that are involved with the delivery of health care. Anger also comes from exasperation that conspicuous deficiencies are met by a succession of studies and, at best, ineffectual efforts at reform.

Let there be no mistake. The anger is well-founded. The deficiencies are real.

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# Foreword

In the summer of 1968 the University of North Carolina and the University of California were presented the opportunity to give renewed emphasis to research and demonstrations on the improvement of health care. Major new federal grants were awarded to both universities for that purpose. As officers in part responsible for fulfillment of these opportunities in our respective institutions we conferred and shared a dilemma. The issues to be investigated, if identified only by experts within academic and professional circles, might derive entirely from professional concerns and expectations. Are these the same concerns that confront the patient or the consumer of professional services? Would our research efforts develop an entirely different and perhaps equally appropriate emphasis if we were guided by knowledge of consumer satisfactions and dissatisfactions, expectations and priorities in health care?

While numerous reports on medical care problems in the United States have appeared in recent years, these have not delineated the problem confronting the patient. Studies have been concerned with health care facilities, health manpower, utilization of services, costs, methods of payment, and the delivery system. All of these aspects of health care have been examined, to a greater or lesser extent, by the increasing body of experts in health care research. But few studies have focused on what consumers want, expect and experience from health services and what they think of present and past efforts to improve health services. And that in itself says much about the need for this study.

From these deliberations there evolved a concept of a Citizens Board to conduct an inquiry into health services for Americans. The Citizens Board of Inquiry into Health Services for Americans was organized in the spring of 1969. Shortly thereafter, a staff was hired and the study of America's health services from the standpoint of the consumer began. That, of course, was the key point—to study America's health services from the viewpoint of the consumer—not from the viewpoint of the health professional.

The inquiry was not intended to be a poll of a random sample of the population. It was an effort to listen

to as many people in as many settings as possible on the problems of obtaining medical care. A point of view expressed only by one person might be as significant a clue for further study as one expressed by many people.

So the Board decided that it and its staff would talk to as many users of health care services in this country as it could during the ensuing months. Board and staff members went to Houston and the Little Rio Grande Valley in Texas; to Stone and Lee County, Arkansas; to San Francisco and Seattle; to Chicago and Portland; to the small town hospitals of Kansas and the halls of the Massachusetts General Hospital in Boston. And Board and staff members went to many other places as well.

The Board spoke to hospital administrators and physicians; to nurses and lab technicians; to health insurance executives and medical educators. But in each and every place, most of the time was spent talking to the people who used the health services.

They spoke to as many consumers as possible—from welfare recipients at Columbia Point, Massachusetts, to crippled coal miners in West Virginia; from business executives to suburban housewives; from blue-collar workers in many industrial sections of America, to Kansas wheat farmers. The Board and staff members talked to the black poor in Oakland; the white poor in Stone County; the Mexican-American migrant worker; and Puerto Rican laborers on the south end of Boston. Board members spoke to the people who comprise the "\$7,000 to \$12,000" income level as well, and persons whose incomes range far higher. We spoke to people who were distressed at the state of America's health system. But we also spoke with some who were satisfied—with some who had developed methods of health care in their own communities which they felt could be models for the rest of the country. The Board listened and listened, and what we heard is set forth in this report.

There are obvious limitations to this kind of inquiry. We may have talked to a skewed sample of people; field representatives may have listened according to their own biases; the Board may have recorded and drawn conclusions colored only by its own experiences and aspirations. And finally, consumers are not necessarily wise

in all matters related to their own health. Even with these disclaimers we believe that the Board developed a story that is worth hearing.

We begin the first chapter by saying Americans are angry about health services. And indeed they are. Unless one has faced a room of angry consumers—whether on the edge of the Oakland ghetto, or in the plush living room of a Lake Shore home in a northern Chicago suburb—one cannot realize the extent or depth of that anger and frustration. Consumers feel that they are locked in a system of health care that exploits them financially and leaves them powerless and at the mercy of the health care providers. But we found that physicians, too, are angry and frustrated and concerned. One senses that they, as well as their patients, are locked in a system they do not fully comprehend, and cannot even begin to control.

The perspectives reported by consumers and the conclusions reached by the Board provide many important and useful clues for those of us engaged in research, education and demonstration on matters of health service. The report may also provide important clues for the entire decision-making American public on matters related to health. For what is in this report is what the Board believes is a most accurate portrayal of the consumers' view of health services in America.

All of the expenses for the Citizens Board of Inquiry were met by private contributions. Grants were awarded from private foundations to Dr. Breslow and to Dr. Miller as principal investigators. The University of North Carolina acted as fiscal agent on behalf of the study. We are most grateful for support and encouragement given

by the Markle Foundation, the Field Foundation, the Z. Smith Reynolds Foundation and the Babcock Foundation. Conclusions and recommendations were developed by the Board independent of any participation by granting foundations.

The Board is most grateful to Mr. Harry Huge for his expert supervision of the staff and for his valuable contribution as a member of the Board; and to Lisbeth Bamberger Schorr for her wise consultations and participation on the Board. We are grateful to all Board members for sharing their wisdom and their time, and collectively, for taking on a difficult assignment in a most responsible fashion.

We are especially grateful to a staff that worked effectively and industriously to execute the Board's intentions.

LESTER BRESLOW, M.D.  
*Chairman, Department of Preventive and Social Medicine  
University of California at  
Los Angeles  
Chairman, Citizens Board of  
Inquiry into Health Services  
for Americans*

C. ARDEN MILLER, M.D.  
*Vice Chancellor, Health Sciences  
University of North Carolina at  
Chapel Hill  
Chairman, Executive Committee  
for the Citizens Board of Inquiry  
into Health Services for  
Americans*

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# Chapter I

## The Voice of the Consumer

**Most Americans do not have adequate health care; they have crisis care. They obtain health services only when sickness or injury forces them to muster the money and risk the obstacles and humiliations.**

There are exceptions. A very few lucky ones participate in systems of true health care that include, for example, routine periodic screening. A Boston mother was thankful for the partnership between her neighborhood health center<sup>1</sup> and the public schools:

"Through the school physical, the clinic discovered that my child had a heart murmur. My doctor said don't worry about it. But the clinic arranged for a heart specialist to see the child. I felt a lot better."

The lack of health screening programs can have inhumane and wasteful consequences. A woman in Oregon told us of her 13-year-old child who cannot read or write:

For years, she was told only that he was going to fail in school, or that he was disturbing the class. Finally, the welfare department referred her to a doctor who discovered the child had "word blindness" (the inability to recognize words as the symbols of ideas). He is now going to a special school and being treated by several doctors.

Even where screening programs do exist, they are often not directly connected to a system of follow-up care. Consumers receive information through impersonal, clumsy, bureaucratic means, so that they are still left with the burdens of initiative and unnecessary anxiety:

The Board met a woman in the rural Southwest who the day before had received a note from school, signed by a doctor, saying that her boy had "phimosis" and should be taken to see a doctor at the county seat, 20 miles away. She had no idea what "phimosis" meant (it is a tightness of the foreskin so that it cannot be drawn back from over the glans) and she was quite worried. She kept the boy out of school hoping that she could get a ride to the doctor from her sister, but her sister never showed up.

Too many Americans view medical encounters as potential tragedies. Financially and organizationally, the health system discourages people from seeking treatment or information except in obvious emergencies:

One mother despaired of getting medical help for her daughter who was suffering severe stomach cramps: "If only I had money to take her to the doctor again, I would. But I can't take her to the doctor unless I can pay cash before he sees her."

A poor Southern white family had severe dental problems. None of them was receiving care because the dentist would not see them unless they were able to pay. The family owed \$125 to the medical center in the state capital and over \$100 to a local pharmacist for previous care.

A VISTA volunteer doctor in eastern Arkansas recounted the following experience: "At one neighborhood action council meeting, I asked all those who in a time of need had not gone to a doctor because they couldn't afford it, to stand up. Fifty out of the 55 at the meeting stood up. . . . People feel an obligation to pay and don't go to a doctor if they know they can't pay, unless their situation is really desperate."

A mother in Boston welcomed the opening of a comprehensive clinic in her neighborhood: "I had to pay the private doctor right after I saw him. I wouldn't go to my doctor unless I had cash. The clinic said, 'Take your time in paying.' But you feel obligated to the clinic. You expect to pay something. With my child's eye operation, I can pay each week on it."

In Chicago, we were told that poor people cannot get a Medicaid card until they attempt to get medical services, and thus many do not seek medical care out of fear that they might not qualify for Medicaid and have to pay the fees out of their own pocket.

A young middle-class housewife in Massachusetts was concerned that although her insurance defrayed some of the hospital and doctor expenses of childbirth, it made no provision for "routine" visits to the pediatrician which she considered necessary to ensure her child's good health.

When we visited a county hospital in Portland, Oregon, there was a six-month wait for appointments at the psychiatric clinic, a four-month wait at the eye clinic, and a three-month wait at the hematology and neurology clinics.

In addition, many people are reluctant to seek care because of cultural, psychological or language barriers. Memories of past rebuffs leave them with shaken confidence:

A Spanish-speaking mother recalled a visit with an injured child to the emergency room of a large city hospital. She was repeatedly put at the end of the line while an interpreter was sought from another section of the hospital. By the end of the day, no interpreter had come, and she was told to take the child home and return the next day if she wished.

Another woman described an equally futile trip to a hospital: "I thought I was expecting a baby once. I went into the hospital, and they had me undress in a little room. The nurse took my pressure and said she'd get a doctor. Then she left me. I was there six hours. Finally, I just got up and left—no one was there—nobody noticed me leaving."

For some of America's forgotten people, exercising the initiative to seek care is impossible or unrealistic

except in the most extreme circumstances:

A 59-year-old Mexican-American woman in Houston lives with her mother and two-year-old grandson, left by a daughter who was unable to care for him. They live in a two-room apartment in a single-family house that has been subdivided into eight apartments in which eight families, 40 people, live. She applied for Social Security benefits, but was turned down. She gets no welfare assistance since her son works, but he can send her only \$10 a week since he must support his own family. She told us, "It's such a struggle to just keep things where they are without them getting any worse."

Her hand was in a clumsy bandage when we saw her. She had fixed it to protect a burn wound suffered over a month before. The burn had never been treated by a doctor, and its effects may have been aggravated by the diabetes from which she suffered. The diabetes requires continuing medical attention, but, as she put it, "Sometimes it is just impossible for me to get to the hospital for medicine since I can't even pay for the bus."<sup>2</sup>

In 1970, millions of Americans sought medical care only when anxiety became overwhelming or life itself was endangered. Preventive care, essential to national health, remained generally unavailable except for a privileged few.

This failure is even more tragic because consumers are enthusiastic about institutions oriented to providing preventive health care.

We met with a group of nine women in Boston who lived close to a new comprehensive neighborhood health center. Of the group only four had had Papanicolaou smears prior to the opening of the center, but since then all nine have been tested. As one put it, "I would never have gone for a pap smear, but I did get one because the clinic was there."

A mother commented on the program of preventive dentistry at the same center: "I have a 17-year-old. I tried to get him to go to the dentist three different times, and then I finally gave up. The clinic had to take out every filling and put in new fillings. Now all my children go up there. We now have fluoride pills for the kids. Everyone I grew up with had bad teeth; now it is important that we get them as kids."

America's health system itself often creates procedural abuses:

In one state, Medicaid recipients are entitled to one free outpatient visit per month. To claim that right, a recipient must first make an appointment with a doctor, then go with proof of the appointment to the county welfare department for a medical reimbursement form, then back to the doctor, form in hand—the doctor submits the form to the state welfare department for reimbursement. The requirement of preliminary visit to

the doctor for an appointment was explained by the county director of welfare: "There used to be a lot of fraud with doctors claiming payments for patients they hadn't seen, so now patients are required to get an appointment first to stop the doctors from defrauding the state."

In Portland, Oregon, many private doctors refuse to treat Medicaid patients. As a result, the city's poor must get their medical care at the county hospital on "Pill Hill," a base for three hospitals, on one of the highest hills in southwest Portland. For some in the city, Pill Hill is as far as 30 miles, several bus rides, and hours away. When asked why the county did not establish decentralized clinics, the dean of the University of Oregon Medical School replied that it would be "inconvenient for medical students" to have to travel away from Pill Hill.

**Once a decision is made to seek care, many Americans have no choice of where or from whom to seek it, and those with a choice usually have available no reasonable basis for decision.**

Rural and small town Americans face a continuing exodus of young physicians. Consequently there is a forced dependence on the skill, judgment, and personality of those doctors who remain in such localities.

"I heard that he done killed two or three girls up that way. Women with babies. He done said many times he don't want to look up any 'nigger.' He would rather look up a dog than up a colored person. When he first come up here he was good, but now he done got rich and he don't want to wait on colored people."

A Kansas town of 2,310 people has two doctors. One is 77 years old. He has been practicing for over 50 years. He has not had a vacation in three years. Until recently, he was the only doctor; now there is another one. The two doctors practice in a modern clinic and are responsible for the running of the 70-bed hospital. They see on the average of 10 patients each in the morning, split the daily hospital load and then see 20 more patients in the afternoon. They "doctor" another small town about four miles away which has 1,000 people and no doctor. In addition, they supervise a local 107-bed nursing home for the old and chronically ill. A farmer told us:

"We need doctors. The old family doctor—he was a man you knew, he came down into the country. If his

horse was stuck we helped him out, he ate with you if it was dinner time. If he passed by your house late at night, and the light was on, he stopped in to see who was sick. The old people in the hills got to travel 17 miles one way to see a doctor, and 20 miles the other. They don't go see a doctor unless they're really bad off . . . some die. There are a lot of farm accidents, mostly youngsters and old people. . . ."

Where attempts have been made to broaden the range of choice and reduce the dependence on doctors, the medical profession has often resisted. Arkansas, for example, has established a midwife training and licensing program. The public health nurse described how this program works:

"A doctor's signature on a card is required by law for midwife deliveries. If the patient has money the doctor won't sign the card even if the delivery would be safe for a midwife. If the patient can't pay, the card gets signed."

The midwives in one Arkansas county reported that their major problem was getting doctors to come when complications occur. One midwife told the following story:

"Last year I had trouble getting a doctor, and the mother died. The baby came and is living. It was at night. I tried to get a doctor, but two of the three doctors was out, and the third wouldn't come. The landlord tried to get him to come, but he still wouldn't. So the landlord and I tried to take her to a local hospital [a 15-to-20 mile trip]. She died on the way—she just bled too much."

Residents of America's inner cities also find fewer and fewer doctors in their neighborhoods. They are forced to rely on hospital emergency rooms as their sole source of medical care:

Chicago has eight hospitals and five medical schools, but poor inner-city residents must seek their care at Cook County Hospital, where the wait may be many hours long. There are only five doctors in the city's Kenwood-Oakland section which has a population of about 50,000. In one medical office building in Chicago's affluent North Side there are more doctors than in the entire West Side poverty ghetto of 300,000 people.

In June 1970, the American Medical Association promised \$50,000 toward the immediate purchase of two mobile units to provide the area with health, education and medical services. The endeavor was to be a cooperative effort between the AMA, the Illinois State Medical Society, the Cook County Physicians Association and the city of Chicago. As of late 1970, the units were still not in operation and no date was set for operation to begin.<sup>3</sup>

Some welfare programs, including Medicaid, have provided poor consumers a degree of choice. This has given them some marginal power to force health care institutions to respond to their needs. In Boston, where the city hospital has inadequately served the inner-city neighborhood, a community leader stated:

"The poor consumers of this city have the power to do a lot more than they're doing. I tell people they can get Medicaid cards that will allow them to choose among the hospitals. Then, I advise them not to go to Boston City but to go to those hospitals I know will accept their cards. Deliveries at Boston City Hospital have dropped off nearly 50 per cent in the last few years, and the hospital could lose its accreditation as a teaching institution for obstetricians. That threat is the only thing that can bring the hospital to improve its services and attractiveness to patients."

More often, state and federal welfare programs have had only a negligible effect on the health options open to poor people:

In Washington, D. C., private hospitals allocate the bulk of their inpatient beds to doctors with staff privileges. Few welfare recipients have such doctors; those who have black doctors often have trouble getting hospitalized since it is often difficult for black doctors to get hospital privileges. Thus, Medicaid notwithstanding, the poor are still left largely dependent on the city's inadequate public facilities.

A welfare director in a rural county described the process for determining eligibility for a program of medical assistance to the non-welfare poor: "First, the county welfare department determines whether an individual meets the income requirements. Then the patient or the welfare department gets a statement of need from the doctor. This statement is sent to the director of medical care services, state welfare department. The director and a team including some physicians review the case and then advise us as to whether the application is approved or disapproved. This usually takes almost one or two weeks. Their decision is based entirely on the medical nature of the case. They usually do not approve diagnostic workups."

In one West Coast city, only 37 per cent of the doctors are willing to take Medicaid patients. A woman told us: "Once I called 20 different doctors asking for an appointment. Each time the receptionist gave me an appointment. Then I would tell them I was on welfare—I think it's only fair to tell them—and suddenly they couldn't take any more patients."

The method of payment can also influence the nature of care sought and thus further limit the range of choice:

A union leader explained: "When you take a child to

the hospital (as opposed to a private doctor's office), the insurance will pay for the emergency room. But unless they cut, sew or set, the insurance won't pay your bill. . . . So, on borderline cases, you tell them to cut in order to have your insurance cover you."

Another union leader: "I was sending some guys to this clinic on an emergency basis, and the doctor was calling it an outpatient visit. So it cost the guy \$8 out of his pocket, because his insurance didn't cover outpatient visits. I told the doctors, 'If you call it an emergency, the insurance pays \$15, so you get more money and the patient doesn't have to pay.'"

A man from Alabama described the impact of his insurance policy on the kind of care he and his wife sought: "I spent \$250 for x-rays and other tests as an outpatient because I could not lay around a hospital for three days. Under the same group plan, our group paid out over \$500 for my wife to take the same tests, except that she occupied a hospital bed for three days to take tests I had as an outpatient for three hours."

With the growth of specialized medical practice, a person who in fact is free to choose among a variety of physicians and visits is often confused and unable to determine which kind of care is appropriate to his needs. The usual way a specialist is chosen is "purely arbitrary" or "by word of mouth." Judgments about doctors are largely based on such things as "bedside manner." A person's only measure of medical skill is whether or not his symptoms are relieved.

A young man suffering from a chronic headache sought relief first from a neurologist recommended by a staff member at a hospital. After an extensive examination, the neurologist concluded there was nothing wrong with him but offered no suggestions for relief of symptoms or alternative treatment. The young man then went to a series of ophthalmologists, each of whom gave him a different prescription for glasses, none of which relieved his symptoms. Then he went to a nose specialist who said that his troubles would be solved by the removal of a deviated septum. After permitting this specialist to act on his diagnosis, the young man discovered that this doctor told almost all his patients they needed to have a deviated septum removed.

He concluded, "I might have done better to have one doctor at least to guide me through the medical maze, but I didn't think of that soon enough."

A few institutions have helped consumers cope with the problems of specialty practice by providing guidance through the maze of expertise. One mother described such an experience with a comprehensive neighborhood center:

"My four-year-old was treated at the clinic and then

taken to the hospital. The doctor at the clinic set up a date for her to go into the hospital. She was treated like a private patient. He alone took care of my child while she was in the hospital. The child liking the doctor I think makes a difference, and my child liked the doctor. The doctor told me, 'I am going to call in some surgeons.' That gave me confidence. They know where they can go for additional help if they need it."

## Having decided where to go for care, the patient must still overcome a variety of obstacles before he receives services.

Even the apparently minor step of trying to receive aid or direction or make an appointment over the telephone may become a major task. In a well-regarded prepaid group insurance plan, for instance, members described the difficulty of getting through to the appointment desk:

"When you call you hear a recording tell you the lines are busy and that your call will be processed as quickly as possible. You have to wait 10 or 15 minutes before they answer when you want to make an appointment."

This was true even in an emergency: "We tried to get an ambulance in a real emergency when our child was severely burned. You must tell the whole story to the person who answers the phone, then repeat it to a doctor who has the authority to call the ambulance. It seems to me they could send the ambulance and ask questions later."

Another lady in another city said: "You have to be desperate to get through to a doctor on the phone at the county hospital. I had to call the hospital and raise Cain. I finally called the county physician's office and the lady there raised Cain with me. This was on a Saturday. . . . Another time I had to threaten to sue when my boy was in the hospital. I called and they said that I should come up during visiting hours. I hadn't given consent for my son's operation and they weren't going to let me talk to a doctor."

The patient discovers that usually the time and place services are available are set for the convenience of the physician, not the patient. Difficulties such as arrangement of transportation, finding a babysitter or losing time from work commonly result:

We heard uniformly from the families we met in one rural county that the doctors there do not make home visits. This was confirmed by the county public health

nurse: "They make no home visits except to closest friends."

A union leader asked: "What about the problem of getting a doctor to come out to the house? What's happened to the doctor who used to come to the house? They don't. They can make more money in their offices. On Wednesday, you cannot get a doctor. After 6 p.m., you can't get one. You have to be sick between 2 and 5 and not on Wednesday."

Another union official recalled: "One time I had to make 25 calls before I could get a doctor for an industrial accident during a Wednesday afternoon."

Even among cooperatives and other health centers that are purportedly consumer-oriented, there are some where the hours are inconvenient:

We spoke with a husband and wife who live with their three children in a suburb of Washington, D. C.: "We belong to Group Health Association, a prepaid group plan. It's hard enough to get care in Washington during the week—the wait is often five hours and up—but on the weekends it's nearly impossible. And whenever something happens to us it's on a weekend. You call up and they try to discourage you from coming—'Can't you wait till Monday?' If you go down there anyway, you have a long wait, and then if you really need something they still say they won't be able to do it. They either tell you to come back Monday, or they send you to another hospital where you have to wait some more."

In poor rural areas throughout this country, the problems are intensified. Typical is Lee County, Arkansas, just across the Mississippi River from the rich Mississippi Delta:

In Lee County, the doctors are clustered in Marianna, the county seat, a trip as long as 27 miles one way for many residents, much of it over dirt roads which are impassable in the rain. Moreover, few of the county's poor have cars. Those who have a friend or relative with a car who will give them a free ride are fortunate, but getting in touch with friends living in isolated areas—often without telephones—is difficult. Without a friend or relative, the going rate for a ride to Marianna is between \$10 and \$15 but can be as high as \$25 depending on the distance traveled, the time of day and the degree of emergency. Those who live in or just outside Marianna may have to pay between \$3 and \$5 for a ride to a doctor's office. The operator of the county's black funeral home will provide ambulance service in emergency situations. He charges \$10 for service within Marianna and \$25 for a ride from the outlying areas of the county. The operator of the white funeral home provides a similar service for the county's white residents.

A small-town doctor reported that she refers patients

who cannot pay to the university medical center 120 miles away. In the case of a "dire emergency," certified as such by a doctor, the state welfare program pays 35¢ per mile plus \$5 for an ambulance ride to the medical center. This comes to just over half of the \$85 charged by the local ambulance operators for such service. In a non-emergency situation, welfare pays only for transportation by bus; no payment is made for the transportation of friends or relatives to accompany or visit a sick person over age 10. It takes close to two hours to get to the medical center by ambulance, close to three hours by car, and as much as half a day by bus since there are no direct routes.

In addition, the outpatient clinic at the university hospital operates on a block appointment system. All patients are given 8 a.m. appointments even though most will not be seen until much later in the day. This forces bus riders to leave the day before their appointment is scheduled.

A few health care institutions have tried to deal with some of these problems. In Portland, Oregon, the Kaiser program agreed to accept 7,000 poor members whose medical fees are paid with OEO funds.<sup>4</sup> Kaiser-OEO members are provided with pick-up and bring-back transportation during the day—a service not available to regular Kaiser Health Plan members. The program also will arrange for a housekeeper and a babysitter if needed. A large number of Kaiser-OEO members found this transportation service the most attractive part of the program.

In Boston, residents were pleased and impressed with a new neighborhood health center's efforts to make medical care less burdensome:

"You can take the kids with you to the clinic. The kids can stay outside on the bench. The medical aides put the children at ease—they're so nice."

"The clinic makes appointments to fit your schedule. For example, they have appointments after school. They also want a follow-up. It only takes a few minutes to get there."

"My old doctor would tell me to come tomorrow or the next day. But the clinic saw me right then and there."

"They fit you in in a half hour or an hour, and you don't have to wait very long."

"Before we had to wait three hours to see a private doctor. Sometimes with all that waiting you just have to break your appointment. Now there is only a short wait at the clinic."

## On arriving at a hospital or other health care facility, the patient may discover that he must "buy a ticket" before receiving any services.

A woman in St. Louis told us: "When you come to the hospital you have to bring two years' back rent receipts, gas, electric and wage slips, before they even look at your child."

A mother in suburban Washington, D. C. recalled: "The last time I was in the hospital was six years ago, when I had my second baby. It's very different now. I couldn't believe it. They stated in a letter that accompanied the form that the sum of \$400 had to be paid two months in advance before I could be taken into the hospital. Well, this was just staggering. . ."

Even in emergencies, the rules hold: "At the hospital usually the first question is, Who is going to pay the bill? Even in emergencies they ask you this."

"Most of my babies was delivered by a midwife, but lately everybody been going up to Marianna to have a doctor do it. Well, the doctor told me he'd do mine. But when the time came, I paid a neighbor to carry me up to his office, but he turned me away, 'cause I didn't have enough money. And I was in labor, mind you."

"I have a nephew who is about 5½ years old. About a month ago out in California, while my brother was at work, the baby required emergency surgery. The doctor wanted to operate, but the hospital authorities would not allow it until my brother could show that he could pay for it. The doctor did not want to move the baby, because it was too dangerous, but he had to have surgery as soon as possible.

"Finally, my brother's employer stepped in and promised to pay the bill if he couldn't. His boss was furious with the hospital.

"The surgery was permitted, but not before the above red tape. An innocent baby would have been allowed to die in an emergency, because his parents could not afford to pay the bill at that time."

Sometimes patients without the price of admission can gain entry into the health system as objects of medical curiosity—teaching cases—but this is an unreliable method of entry and may have undesirable side effects:

A VISTA doctor in eastern Arkansas related the following incident: "I have been working with a patient who had been seen by two doctors. One called the university medical center and told them he was sending her,

and they said OK. She got to the emergency room and they sent her home. Some time later, the county welfare department got a letter saying she needed to be in the hospital for a complete workup, and local doctors should prepare a case history and send it to the department of medicine at the university center. If the department decides she will be a good teaching case, they will admit her."

And a patient said: "You keep getting pawed over by these groups of young doctors—sometimes 15 or 20 at one time." Another felt that "Residents and interns see teaching patients as people who have no right to be treated in a humane way—no right to be frightened about what is being done." Some believed that teaching cases were kept in the hospital longer than necessary.

A few institutions have tried to avoid the "buying a ticket" approach and have instead tried a "treat now—pay later" credit method. The following experiences come from neighborhood health centers:

"In my case, I got a bill three weeks later. The money was not brought up while I was in the clinic. I am living on veterans' aid. The clinic does not press me for money."

"When you enter the clinic, the nurse's aide asks you 'Can I help you?' They treat you, and *then* you get a letter from the clinic a week later which says can you give information on how you are going to pay for this."

## The persistent patient who overcomes the barriers to care may find himself treated with indignity and insensitivity.

A woman described taking a neighbor who apparently was having an epileptic fit or convulsions to the emergency room at city hospital. There, the orderly and physician joked about the difficulty they were having keeping him quiet: "This is one of those who will knock you down if you don't look out. This one will bite your head off."

A priest told of bringing an alcoholic to an emergency room and asking that he be given care: "They took us right to the front of the line when they saw I was a priest. I explained the problem and was assured that he would be admitted and taken care of. Two days later I went back to visit him. No one had heard of him ever having been brought in. I'm sure that when I went out the front door, he was shoved out the back door."

"I went down there—it was an emergency—my child's

head was bleeding and we had to wait two hours. There were old people laying in the corridor—nobody doing anything for them—it was awful."

"After my arm got broken I went into the emergency room about 2 or 3 o'clock in the afternoon. When I left it was about 3 or 4 in the morning. I was in so much pain I don't know what made me sit there so long. I stayed so long in the x-ray room I don't know what them peoples was doing. There weren't too many others there. I was hurt as bad as anyone else as I could see. They say, 'The doctor will see you directly.' I was sitting there on the bench and the doctors would come by and see it right there."

A well-dressed white middle-class woman in Washington, D. C., took two black children she was tutoring on a volunteer basis, to a hospital outpatient clinic for hearing tests at the appointed time, 9 a.m. After waiting four hours, the girls were finally tested. The nurse performing the test was surprised at the woman's presence and asked her who she was. Upon finding out her role, the nurse replied, "If only we'd known [who you were] we would have taken your girls first thing."

One of the doctors in a Southern county has segregated waiting rooms. Black residents feel he does not treat them as well as whites: "He takes white folks who just come ahead of colored folks who been waiting all day, and when he finally sees us he don't examine us as good and he always gives shots. I don't like him 'cause he has a segregated waiting room. We have to wait longer than whites. Whites get to go first, and once in a while the nurse comes for a colored person to keep us calm."

A welfare mother with children, whose sole source of income is the \$75 AFDC (Aid to Families with Dependent Children) check she receives, has had her long-time back trouble diagnosed as a "slipped disc." She went to the doctor to try to get certified as permanently and totally disabled so she could qualify for welfare. "I went to see him on a Tuesday. He asked me if I had \$5. I told him I only had \$3, but I would get the \$2 to him by Friday. He told me to come back when I had \$5. I went to see him the next week, and this time I had \$5. He took the money and asked me if I had a cold. He looked me over and gave me a prescription for the cold and told me that he couldn't examine me to certify me for welfare because I was sick and for me to come back when I felt better."

Rushed, impersonal treatment is common: One woman complained of going "all the way downtown for a five-minute appointment, and I couldn't get an explanation from the doctor." Another woman told us: "I take my children to the hospital on a walk-in basis if something is wrong with them. You get to see the doctor for not more than five minutes. Even when I make an

appointment with my pediatrician, the longest time he has spent for an appointment is 10 minutes."

Small town and rural physicians said they sometimes saw as many as "80 or more patients a day." One told us: "There's no way I could give them all the time they should have."

Some institutions have made an effort to treat their patients with consideration. The following are comments by residents about a new comprehensive health center in their neighborhood:

"For your first visit, the doctor spends about an hour with you."

"Before, at the hospital, they said, 'Take a seat.' Then they said, 'Where do you work?' And then you get mad and scream and yell because you are sitting there very sick. Now [at the center] they take you and then say, 'She's not too bad and someone else is worse so do you mind waiting.' At the hospital they didn't encourage parents to speak. They would say, 'You are a father and sit down.' They put you on the defensive. But the clinic puts you right at ease. The doctor tries to draw the parents out at the clinic."

"It's great to have the same doctor every time."

"They get to know you, and they treat you like an individual at the clinic. The doctors are very thorough. I have the feeling they really care for you."

"I never had the closeness with a doctor that I have up here at the clinic."

"Medical aides [at the center] are people you know."

"It's such a security to know it's there. Poor people get the same treatment as anyone else. They don't turn anyone away. I don't have the same kind of bills I used to. At the clinic you can get a complete physical, and they will find out everything about you all at once. It's more convenient to go to the clinic. It's like pulling teeth to get my husband to go to a doctor, yet he has been to the clinic."

## **Sometimes the line between insensitivity and poor quality care is blurred. A patient's persistent attempts to get more careful attention may have negligible or negative results.**

A woman went from doctor to doctor without ever getting examined:

"I've seen practically every doctor around here trying

to get fixed up. None of them even examined me, but they charge me \$5. They just ask me what's wrong, and I tell them, then one doctor always give me a shot, that's \$3 more, and a prescription, and the other two, why they just gave me a prescription. All this time I was paying all this money for pills and doctors and feeling worse and worse; I swear some of those pills make me sicker."

A woman from Sioux City, Iowa: "My eighth child was born in a big modern hospital. It had everything but care. No doctor [he wasn't called until the baby was being born] no nurse [the baby was born in the labor room]; and I hadn't just rushed in. I was 3½ hours on a floor with a nurse and one aide who left me behind a closed door. Earlier another patient's parents and in-laws ran in and out of every room [looking for help], but no luck, so her father went into the delivery room and got a nurse. My child died, an 8½-pound little girl. If I had had help in my labor I feel she'd have made it. They said it was God's will. I don't believe it was God's—or is it man's will?"

A man who lives on the Blackfoot Indian Reservation with his wife and two young sons related his bitter experiences at the United States Public Health Service Hospital on the reservation. His seven-year-old son had an accident and injured one of his arms. They rushed him to the emergency room at the PHS Hospital for treatment and care. The doctor decided that the arm should be set in a cast. The child was crying, in great pain, as the doctor worked to put the cast on. He finished, gave the parents some instructions for follow-up care, and they left. When they got outside they discovered that the doctor had put the cast on the wrong arm. They went back inside and told the doctor of his error. He apologized for the mistake in a casual manner and then set the right arm in cast.

A community worker in North Dakota told us of one of the people in her area:

"A woman in labor and ready to deliver was admitted as an emergency patient to the Public Health Service Hospital located on the reservation. The admitting nurse informed the patient and her accompanying relatives that the doctor was eating dinner and could not be disturbed, and that furthermore there was nothing to worry about since there was plenty of time before the baby would arrive. When the baby started to come the nurse rushed in and brought the doctor in right away. However, before the doctor could wash his hands and get himself together, the baby came and slipped to the floor. The mother feels the tragedy would not have occurred if the nurse had interrupted the doctor's dinner."

**The patient often discovers that the medical services he has received are more expensive than he had expected, and that the insurance for which he has paid so dearly affords him only minimal coverage.**

A young mother concerned about the rising costs of medical care told us of the costs of her several childbirths: 3½ years ago, she paid \$80 a day for hospitalization; two years ago, she paid \$104 a day; and within the past year, the cost was \$127 a day. The costs for her most recent childbirth were \$508 for the hospital room, \$45 for use of the delivery room, \$325 for the obstetrician, \$50 for the anesthesiologist, \$20 for the pediatrician, and \$30 for a circumcision. Of the total amount, only about \$300 was covered by her insurance.

A working-class mother in a suburb of Washington, D. C., gave the following account of her experience with the costs of childbirth: "When I told the office on the phone that I was a new patient, the receptionist took down the information and quoted me a fee of \$250. I went down there about three weeks later, and the doctor said the fee was \$300. The hospital the doctor uses sent me papers and asked for a payment of \$400 in advance. I called the hospital back and talked to the credit manager, and I told him point blank that I just couldn't pay \$250 to the hospital two months in advance. I said that I just could not understand it, I had insurance and why did I have to pay all this? He left the phone and came back and said, 'Well, because you do have insurance, just send in \$200.' Six years ago, you could send in a \$50 deposit and by the time you were ready to leave the hospital your total bill was \$200 or \$250. Now it is unbelievable that so far it has cost me \$700 to have this baby."

A group of union leaders—particularly concerned with escalating medical costs and inadequate insurance coverage:

"We have Blue Cross-Blue Shield Major Medical. Now that the per diem rate has gone up so high in the hospitals, we wanted to try for Master Medical Plan, which offers more coverage than Major Medical. But it would have taken 21½% out of the wage package to go to Master Medical coverage so we are saddled with the same plan that we had before, for two more years. It is out of our bargaining reach unless we cut some other things."

"Our locals are presently meeting with an actuary to figure out what kind of per diem coverage we can ask for

in our new benefit package. Two years ago, we took the average per diem of 10 hospitals in the area, which was \$38, and now we are really in a hole, because right after we settled this package, the hospitals increased their rates."

"We have full semi-private coverage. But the doctors own half the damn hospitals anyway. Now there are four and six beds in a room, and yet it is still called 'semi-private' . . . I am a member of the Blue Cross-Blue Shield Board of Directors. Blue Cross has got more money than Carter's got liver pills. We started investigating why hospitals don't keep records so that you know whether they are making money or not. Utilization is also an important thing; people shouldn't be put in the hospital as often as they are. Hospital costs are going up to \$100 a day in 1971; it's not wages, it's doctors and the hierarchy and the administrators."

"From July 2nd to July 15th my wife was in the hospital for tests in a semi-private room. The cost for 13 days was \$1,987, but most of it was covered by insurance. When you enter the hospital they scrutinize you and put you in certain categories, then they try to milk the patient for more. The doctors have the best closed shop I know of. Blue Cross and Blue Shield don't pay the same set fee as we would. In this case, the doctor charged me \$200 for the 13 days—he saw my wife once a day."

"Originally, Blue Cross and Blue Shield were a lifesaver because they took care of everything. But then the doctors realized they had a good thing going."

"Somewhere along the line the doctor and hospitals have come up with the idea that you should pay something. Now they feel, no matter how much insurance you have, you still have to pay. We had adequate coverage, yet we still had to pay \$82 on a recent hospital bill. No one could tell me what the \$82 was for. I wouldn't pay it until they told me what it was for. It turned out that it was the first \$40 which was paid already by another insurance company. I had two kinds of insurance, and one was \$40 deductible, but the second one covered the first \$40. The other \$42 was for phone calls. It seems you always have to pay something at the hospital."

"An administrator at the hospital told me, 'No one should leave this hospital without paying something.'"

"Hospitals are always eager to find out how a patient is going to pay his bill. Upon entering a hospital, even with an appointment, the first question is what kind of plan, the number and the type of coverage you have. Most coverage is semi-private. But they always find a reason to put you in a private room. . . . The person with an income of \$5,000 to \$7,500 gets hit the most. They

are being victimized by the new methods used by hospitals and doctors to get more money."

"Everytime you go to the hospital, no matter what you buy, it's always high. For example, one aspirin costs 25¢. In one case I know of, the company thought the hospital bill [for one of the company employees] was exorbitant. We got the bill and looked at how ridiculous it was. We went to the hospital, and they asked how much can this lady afford to pay. The company had said it would pay \$100. The total bill was \$420. We got it settled for \$100. All I can think of is the unfortunate people who don't have anyone to speak for them."

"We have pretty good hospitalization and doctor coverage but the problem is that it costs so much to find out what is wrong with you because we are not covered for that. If we were covered for diagnostic care, it would save on hospitalization later on."

Insurance often covers only part of certain illnesses or conditions; sometimes they are not covered at all:

A West Coast family with three children pays \$31 a month for health insurance. The parents and one son have heart conditions. The three family members with heart disease are not covered by the family insurance because heart disease is one of the diseases exempted by their policy.

Another family paid \$28 a month for health insurance. When one child had an appendectomy, they had to pay \$300 over what the insurance covered, just for hospitalization. They said, "At one point, we owed 13 different doctor and hospital bills, so we just didn't go to the doctor anymore. We let some very serious things go by rather than call a doctor and owe another bill."

Sometimes the fact of insurance coverage actually results in greater costs to the patient. A New Jersey woman explained the effect of the practice under Medicare of reimbursing physicians on the basis of "usual, customary and prevailing charges":

"Often the patient pays much more under Medicare than he paid without it. I am an example. My physician used to charge me \$10 for an office consultation. I have a serious heart condition and saw him once a month. This amounted to \$120 a year. A week after Medicare became law his fee was raised from \$10 to \$15. He now charges \$4 for a blood test which previously was included in his fee. Thus, my monthly bill is now \$19 instead of \$10. My yearly Medicare insurance costs \$48 (\$4 monthly premium for part B). My yearly doctor bill is \$228. After deducting \$50, Medicare will pay 80 per cent of reasonable charges: \$142.40. I pay out a total of \$276, including premium, and get reimbursed \$142.40, leaving me \$133.60 to pay out of pocket—\$13.60 more than I paid before Medicare."

It is not uncommon to find hospitals maximizing their economic gain at the patient's expense:

A staff doctor at the Washington Hospital Center told of the following practice: "We have allocated a few beds for charity patients for whom we get reimbursed \$38 a day by the city. The economics of hospital care are such that the first day is quite expensive, the rest a little less so, and then there is a rapid fall-off and costs stabilize at a rather low level. If we turned over our charity beds very quickly we would take quite a beating. So we tend to keep these patients in the hospital quite a bit longer than other patients, so that we come close to breaking even."

A young secretary in Washington, D. C., with comprehensive insurance coverage, related her experience in a Washington hospital: "When I was admitted, they thought I had a growth and they were going to operate. They decided I should have some tests run on me. That was Saturday. I remained in the hospital but I didn't see a doctor and received no medication or anything until Wednesday night. Then the doctor told me I would start a series of tests the next morning. Well, I had tests on Thursday, then on Friday. When I was supposed to have the rest of the battery of tests they discovered that I hadn't been prepped properly. So they had to hold me over until Monday to complete the tests. The hospital charged me for all those days I was in the hospital. I had to pay for their laziness and their mistakes."

An intern at another Washington, D. C., hospital said: "At least three times in the last several months a mistake has been made and someone has been given the wrong blood type. Each time the mistake was caught in time, but the patient was never told what had happened and he was billed for the extra week in the hospital which resulted from the mistake."

A lawyer in Washington had the following unhappy experience: "I have very comprehensive insurance coverage. When we had our last baby, we wanted to have a semi-private room with rooming-in. This was covered by our policy, but more important, my wife has found that she gets very lonely and depressed in a room by herself after having a baby. The hospital told us that no semi-private rooms were available, and that if we wanted rooming-in, we would have to take a private room. We did so reluctantly. We paid \$75 out of our own pocket for the difference. We later discovered that there were plenty of semi-private rooms with rooming-in available. A girl on the hospital staff told us it was common practice to tell people with an ability to pay that there are no such rooms available so that the higher-priced rooms don't go empty. This whole thing is really incredible."

## Many of the same barriers that deterred the patient from seeking care in the first place interfere with his following through on the medical advice and recommendations he receives.

"In this system it's just impossible to give good health care. Follow-up care is poor because the patients either use up their one Medicaid slip a month or they have no money to begin with and as a result they can't afford the drugs prescribed or the special diets, not to speak of lab tests and x-rays."

A young mother told of trying her best to have a safe pregnancy: "I went for some prenatal care, but not all because I didn't have the money and I couldn't stay on the diet the doctor gave me because I couldn't afford it."

A mother described what she had to do when she discovered her son needed a brace on his leg: "I took him to the city hospital. The doctor there told me to take my son to the health department at the county seat over 100 miles away. Then the doctor from the city hospital came to the county seat and measured him for braces. Then we had to go back to the city to get the braces."

"The pills I'm taking now cost me \$30 every two weeks. I pick them up when I go up to get my [food] stamps, and then I got to get them refilled there so I have to pay someone to just carry me up there for that."

We met a woman whose husband had recently suffered a stroke: "The doctor said my husband should be in the hospital. He insisted on that. But we couldn't get there—we had no money so my husband came home here and just stayed in bed."

The doctor advised her husband, a carpenter by trade, that he should rest and not work for several months. But he was told that his temporary disability did not make him eligible for welfare benefits. The only supplement was \$60 a month in free food stamps, and the wife, five months pregnant, earned \$5 to \$10 a week by baby-sitting.

The high cost of medication is a common deterrent to effective continuing care:

A Portland woman told us that she pays \$28.31 for a month's supply of one of her medications. "We are barely making it. I had to stop taking it because I couldn't afford it."

Patients in Lee County, Arkansas, seemed consistently to complain about the cost of medications. We compared the medication prices at Marianna drug stores with prices charged by two drug stores in Washington, D. C., one in a middle-class white neighborhood, the other in a low-income black neighborhood.

Prescription	Washington, D. C.			Use
	Marianna	Middle-Class, White	Low-Income Black	
Drug A (30 capsules)	\$ 6.50	\$2.50	\$3.29	Tranquilizer used for anxiety, tension, apprehension; also used in treatment of muscle spasms.
Drug B (100 capsules)	5.75	1.90	1.99	Synthetic hormone used in the treatment of thyroid deficiency.
Drug C (100 capsules)	12.00	4.50	4.75	Mild pain reliever, combination of codeine and aspirin used in the treatment of pain, headaches and migraines.

A Lee County doctor gave added dimension to these statistics by telling us that doctors often turn the free drug samples given to them by drug company detail men over to the local pharmacies for credit on their own accounts.

For poor people, medication often consumes a disproportionate share of their already strangling living costs, as the following monthly welfare budgets reveal:

Mr. and Mrs. D. and their nine children:  
\$140 welfare assistance  
\$58 for \$118 worth of food stamps  
\$20 for medication

Mrs. E. and her seven children:  
\$115 AFDC assistance  
\$56 for \$94 worth of food stamps  
\$15 for furniture payments  
\$10 insurance payment  
\$32 for medication

Mrs. F. and two children:  
\$75 AFDC assistance  
\$30 for rent  
\$40 for \$76 worth of food stamps  
\$15 for utilities  
\$14 for medication

Mrs. G. and nine children:  
 \$135 AFDC assistance  
 \$20 for rent  
 \$50 for \$64 worth of food stamps  
 \$10 for insurance  
 \$10 for furniture payment  
 \$20 for telephone and utilities  
 \$30 for medication

Mr. and Mrs. H. and one child:  
 \$165 welfare assistance  
 \$20 for rent  
 \$50 for \$64 worth of food stamps  
 \$10 for insurance  
 \$10 for furniture payment  
 \$20 for telephone and utilities  
 \$30 for medication

In almost all the above cases, we were told by the welfare recipients that the medicines paid for were prescribed without the doctor's examining the patient—each prescription based solely on the patient's description of his own symptoms. Some of the doctors were notorious for prescribing the same medicine regardless of the nature of the disease.

Sometimes, patients engage in work detrimental to their health, or the health of their family, in order to pay bills incurred in getting health services:

A young AFDC mother lives with six of her seven children in a small, flimsy, uninsulated shack. She has been plagued with serious health problems. "I have high blood pressure, bad kidney and a bad heart. For a couple of weeks I went to the doctor each day, and he gave me a heart shot. He said I had a heart attack. It cost me \$15, \$16 or \$17—each time. I pay \$3 for a ride each way. I missed getting food stamps one month so's I could pay the doctor, and now I owe the grocery store \$200.

"Last time I saw the doctor, he told me to go to welfare with a form. Welfare lady said they didn't pay my doctor bills only once a month for the kids. I never went back to the doctor. I haven't seen a doctor in a couple of months. It takes money to go to a doctor."

She had worked 14 hours in the fields picking cotton. "I picked 123 pounds today and got paid \$2.40." She explained why she worked so hard just eight months after her heart attack: "I don't have to pay rent long as I pick cotton, and with all the medicine I paid for I just can't pay the rent. Then too, I ran up that big grocery bill 'cause I was paying the doctor instead and if I don't start paying on that bill, I don't know how we're going to eat in the winter. I know it's bad for me to work, but I just got so far behind. What else can I do?"

A man with a chronic lung disease: "The disease flares up whenever I work in the chicken coop and breathe the dust there, yet I have to do that work in order to pay for my medicine."

**With all the anger and the difficulties, people will still do what they feel they must to get needed health care. While there is great frustration, sometimes even desperation, there is little apathy.**

Most Americans would agree with the mother who said: "To me, the health of my family comes first, and I will pay whatever is necessary to protect their health."

A white farmer in Stone County, Arkansas, described driving his pregnant wife to Mountain View Hospital barely in time for their baby to be delivered. The nurse-supervisor greeted them with a demand for a prepayment of \$100. He told them he would return that afternoon with the money, which he could only raise by selling his cow and two pigs. "I had to run out the door and leave her or they wouldn't have taken her," he said.

He returned with the money, and although he paid what he was told would be the total bill, the hospital sent him an additional bill the next month.

"When word got around what had happened, the town all chipped in and bought the family a milk cow," one of his neighbors said.

The Board witnessed some of the many instances in which personal frustration and desperation are being channeled into group action.

Residents of one community have organized, with the help of VISTA volunteers, a cooperative clinic, which is governed by poor county residents through an elected board of directors. The county health system has placed every imaginable obstacle in the way of the development of this clinic. In the words of the clinic director:

"First, the doctors and the pharmacists got together and tried to prevent us from getting any government grants to help us get started. Then the county medical society prevented our doctor from getting hospital privileges at the county hospital, which means he can't do his lab work there. But we got our money, and we're fighting the hospital privileges thing in court. The people here have put their heart and soul and whatever money they can spare into this thing. We've come too far now to let ourselves get put back to where we were."

A community group on the West Coast met with resistance when they tried to enlist the aid of the county medical society in establishing a community-run clinic. We attended a meeting where society members were asked to participate in any way they thought appropriate. A community organizer suggested, among other

things, that society members might wish to put in some volunteer time at the clinic, help to recruit other doctors to serve there, donate money, or facilitate the establishment of some back-up service for the clinic.

Most society members at the meeting were quite negative about the whole project. They saw it as part of an attack on the fee-for-service system, and even worse, as a beachhead for the establishment of a system of socialized medicine. They made excuses for the present system, and blamed inadequacies on the consumers' lack of knowledge, education and will. The notion of a community-run clinic was utterly foreign: "Physicians who want to treat patients go into private practice. Those who do otherwise are trying to abdicate such responsibilities. A doctor must feel individually responsible for his patients. You should talk about working cooperatively with physicians, not having them as employees." To the suggestion that a community-run clinic is important in areas where there is a pervasive feeling of distrust toward doctors, the answer came: "Why should the poor

distrust us? We know what it means to be poor. Most of us had our beginnings in the Depression era."

In another city some community representatives were given the chance to direct a small neighborhood pediatric clinic under the general auspices of the city hospital.

One of the clinic's board members told us: "We don't want a satellite clinic for what is already inadequate, and our dependence on city hospital for money and back-up services makes us a satellite. I think we're beginning to recognize it is the city hospital, not the clinic, which must be community-controlled if we are ever to get what we need."

**So the question becomes:  
How do Americans get the  
quality medical care they need?**



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## Chapter II

# The Medical Profession, the Hospitals and the Insurance Industry

Each is entitled to what he can get. The public is entitled to expect that good medical care will be available, but it should be available on the marketplace like a Cadillac or anything else.—*Dr. Ralph M. Milliken, President, Los Angeles County Medical Society*<sup>1</sup>

- Approximately 75,000 newborn babies die in the United States each year. In 1969, our infant death rate of 22.4 per 1,000 live births exceeded that of 14 other countries and should be compared with Sweden, the country with the lowest rate—12.9 per 1,000.

- Nonwhite American babies die at a rate nearly double that for white American babies.

- American mothers die in childbirth at a rate exceeding that of 11 other countries.

- Nonwhite American mothers die in childbirth at a rate four times the rate for white American mothers.

- American males have a shorter life expectancy than the males of 19 other industrial countries.

- American females have a shorter life expectancy than the females of 16 other industrial countries.

- Nonwhite Americans have a life expectancy seven years shorter than that for white Americans.

- American males aged 40 are more likely to die before they reach age 50 than males of the same age in 15 other countries.

- The death rate for nonwhite American males between the ages of 40 and 50 is double that for white American males.<sup>2</sup>

This sorry string of statistics cannot, of course, be blamed solely on the providers of health services. There are qualities and conditions in American life and the

American environment that contribute to this dismal record as significantly as inadequate medical care, but the lack of adequate care is certainly an important contributor.

The neglect and despair, the anger and frustration that erupt in the stories in the first chapter are not isolated examples. These same stories and words echo across the country in cities, small towns and rural areas. America is not meeting the health needs of most of its people.

For millions of Americans—the poor and near poor who live in the rural backwaters of this nation or populate its inner cities—the medical care system is not merely inadequate. It is almost nonexistent. In addition, it is often an added source of injustice and oppression. For Americans who are not poor, but earn less than \$20,000 a year, adequate medical care is becoming evermore elusive and evermore expensive.

But good care does exist. Wealthy or privileged Americans have access to the finest medical care in the world, even though it is fragmented. An influential elite can rest assured that financial considerations will not be a barrier to superlative medical care. For example, large corporations often ensure the good health of their leading executives by providing periodic medical examinations. The federal government provides free comprehensive care to members of the armed services and their dependents. Leaders of the federal government—senators, congressmen, Supreme Court justices, and the highest echelons of the administrative branch—have access to quality hospital care for themselves and their families at all military hospitals, including the National

Naval Medical Center at Bethesda, Maryland, one of the nation's finest medical centers.<sup>3</sup> Charges (\$58 a day inpatient and \$12 a day outpatient) are much less than charges that reach as high as \$95-100 a day in some of the country's highly regarded private hospitals.<sup>4</sup>

*Why is our best medical care available for only a select few?*

*In a country that spends more money on health per capita and in absolute terms—\$63,000,000,000, more than 7 per cent of the gross national product—than any other country in the world, why?<sup>5</sup>*

*In a country in which the ratio of physician to population is higher than in most other countries, why?<sup>6</sup>*

*In a country that has one hospital bed for every 240 civilians, why?<sup>7</sup>*

*In a country that has an average of 43.7 dentists per 100,000 population, why?<sup>8</sup>*

The answer, though seemingly complex, can be simply put: Health care providers often act from the narrow bases of institutional or professional interests, unrestrained by consumer influence, by rules of the marketplace or by government regulation. The interests of the providers differ from the interests of health care consumers. Consumers are left powerless to deal with obvious inadequacies and injustices, while conscientious and well-meaning professionals get caught up in a system that does justice neither to their skill nor to their intent.

The scope, complexity and technical sophistication of modern medicine should make it possible for patient-oriented professionals to participate in new modes of care which are both professionally satisfying and suitable to consumer needs. But in practice, such people often face almost insurmountable opposition from complacent representatives of an outmoded, inefficient, doctor-oriented and profit-oriented system.

## **“There is something symbolic in the exchange of cash.”**

*“I run my office like a business, and I am not in medicine as a crusader. There is something very important about making people contribute, even if it is just a small amount. There is something symbolic in the exchange of cash. A person should pay when he walks in the office because otherwise he doesn't always come for necessary things.”—A private practitioner in Stone County, Arkansas*

*“I want to see the private physician who is interested in the patients and who puts the good of the patients before himself. I want to see that continue, and we are not going to see that continue unless we see people paid*

*when they do more work for that extra pay. That is the system and that has made our country great and when we do away with it, God help us.”—Hon. Tim Lee Carter, M.D., Congressman from Kentucky<sup>9</sup>*

The nation lives with a faded tintype image of a family physician. He is a kindly old gentleman riding behind a team of horses, off on a late-night trip to be at a patient's side. But this image is far from the needs of today, if indeed it ever was accurate. Yet in many ways we cling to the paternalism it represented as the comforting operating principle of our medical care system. Dependence on this paternalistic vision has permitted health providers to shape health policy almost by themselves.

The doctor is like other human beings: his own well-being and that of his family are concerns that understandably influence the conduct of his professional life. He is not superhuman, but lacking an organized health system, we too often attempt to solve our medical care problems as if he were. The doctor's inability to sacrifice all of his time—to be always available—has led to consumer frustration with the traditional fee-for-service office visit. This frustration often has diverted attention from an even more basic problem: that even if everybody could afford private office calls, and if the doctor were always there, such visits would still remain crisis care, often inefficient and uncoordinated, and not, broadly speaking, health care at all.

Health professionals function as businessmen who earn their livings from fees paid by sick people.<sup>10</sup> As a result, they may turn away patients who cannot pay, or reject Medicaid patients if the level of reimbursement seems inadequate or the reimbursement mechanism seems cumbersome. The tautness in physician supply leaves them free to determine their own fees according to their own needs rather than their patients'.<sup>11</sup>

A young mother in Quincy, Massachusetts, put it succinctly:

*“Who are you going to argue with over price? If you don't like what the doctor charges, there are 10 people behind you to take your place. The doctor doesn't need you.”*

Dr. John A. Cooper, President of the Association of American Medical Colleges, elaborated on the point:

*“Physicians' fees are not set traditionally by the marketplace. I think a substantial part of the increase in fees is due to the fact that patients receive more sophisticated care in the physician's office than ever before. There is more advanced equipment, more costly service rendered to the patient. But in addition to all of that, it is perfectly obvious that the personal income of the physician has gone up substantially as have the incomes of other professions.”<sup>12</sup>*

Self-Employed Physicians			
Annual Median Income of Physicians Under Age 65 1965 and 1966 <sup>13</sup>			
Category	Median Income		Per Cent Increase
	1965	1966	
<b>Geographical Region:</b>			
United States	\$28,960	\$32,170	11.1
East	25,690	29,750	15.8
South	29,560	33,890	14.6
Midwest	31,410	33,280	6.0
West	28,780	28,770	0
<b>Type of Community:</b>			
Urban	29,950	33,270	11.1
Suburban	27,770	30,340	9.3
Rural	26,900	30,650	13.9
<b>Years in Practice:</b>			
1-5	24,300	28,380	16.8
6-10	31,100	35,230	13.3
11-20	31,180	34,320	10.1
21-30	29,879	30,730	2.9
31 or more	23,650	25,200	6.6
<b>Type of Practice:</b>			
Solo	26,680	29,740	11.5
Group or Partnership	33,430	36,720	9.8

Concerns other than the need and convenience of patients may determine the days and hours and circumstances in which the doctor treats patients. The duration of appointments and the quality of services may be influenced. As Dr. Kerr L. White, Professor and Chairman of the Department of Medical Care and Hospitals at Johns Hopkins University School of Hygiene and Public Health, put it:

"Only about 10 to 20 per cent of the things that physicians and nurses do to patients are based on objective evidence that they are . . . useful. . . . About 20 to 40 per cent of what they do is based on the so-called placebo . . . effects, designed to please and encourage patients, and the other 40 to 70 per cent is a mystery and needs to be examined critically. It is this area where much of the opportunity for reducing current high costs is involved and where the opportunity for measuring efficiency exists."<sup>14</sup>

"Surgical fees in the United States, although perhaps not as large as a generation ago, are still much greater than those in other areas of medicine, and the opportunity for large incomes may attract a disproportionate number of physicians into the practice of surgery. In addition, the 'incentive' of a fee-for-service may tend to increase the number of operations in cases in which the indications are borderline. The converse must, of course,

be considered: that in the absence of such economic incentive, many procedures that are desirable, but not essential, may not be performed."—*John P. Bunker, M.D., Stanford University Medical Center*<sup>15</sup>

"Only 5 per cent of Americans get the full benefit of medical science translated into patient care. Even in the affluent suburbs . . . people are medically deprived. They get the candy-store medicine of a solo practitioner whose current education is carried on by the drug companies."—*Tom Levin, M.D., Director, Health Program, Lincoln Hospital, New York, New York*<sup>16</sup>

"In a study on hospital care received by Teamsters and their families—and I will note for you that the Teamsters are among the elite of the working class, well-paid, and they pay their own way for their hospital and medical care—three-fifths of those hospitalized received optimal medical care; one-fifth fair care and one-fifth received poor care. One-fifth of hospital admissions actually were unnecessary and questions could be raised about the advisability of another 10 per cent."—*Dr. Martin Cherkasky, Director, Montefiore Hospital & Medical Center, New York City*<sup>17</sup>

The lure of financial gain may tempt doctors to neglect the sick in favor of those with cosmetic needs:

"Today more and more persons are seeking plastic [surgery]. Never before have so many elective cosmetic procedures been performed . . . [P]lastic surgery has spawned a new breed of specialist who devote virtually their entire practice to aesthetic procedures. All the nation's 1,200 board-certified plastic surgeons do some purely cosmetic operations, but there are now about 200 plastic surgeons who do little else.

The fees [for cosmetic surgery] range widely and are highest in New York, on the West Coast and in Chicago, and lowest elsewhere. The fee for a rhinoplasty [nose] ranges from \$500 in the Pacific Northwest and certain sections of the Midwest to around \$1,500 in New York and Chicago. A blepharoplasty [eyelids] is \$500 to \$1,200; rhytidectomy [wrinkle removal] \$1,000 to \$2,000. . . ."<sup>18</sup>

**"What could anyone put in the boondocks that could possibly attract me or thousands of other doctors like me?"**

Personal considerations—prestige, intellectual interest, working conditions—influence the decision of what type of doctor to become, whether to specialize, where to

practice. Ordinarily, specialty practice is more lucrative than general practice, with certain specialties particularly rewarding.<sup>19</sup> But these higher incomes do not necessarily reflect social need.

The decision to specialize usually does not correspond to the needs and priorities of the general community. The limited range of medical school experience gives a graduating medical student little opportunity to learn what these priorities are.<sup>20</sup> When pressure is applied to influence the choice of specialties, it is done in response to priorities established by professional institutions or by federal grants.<sup>21</sup> The collective result of such individual decision-making is the composition of the physician manpower available to cure the nation's ills—if the allocation of physicians among the specialties matches social needs, it is only by accident.<sup>22</sup>

Deciding to specialize also affects where a doctor locates his practice. Proximity to large medical centers, with their sophisticated equipment and facilities, permits him to practice the medicine he was taught in medical school. Then too, he may have a family that desires the cultural benefits available only in metropolitan areas.

One middle-class white internist, President of the Fairfax County (Va.) Medical Society, explained why he, and many like him, prefer suburban practice. His suburban community, a 30-minute drive from downtown Washington, with its theaters, concerts, libraries, and other cultural outlets, its modern hospitals and medical schools, is part of a culture and society he has always known and with which he feels comfortable. "I can't see any reason why I should take myself and my family into the middle of nowhere, where I would have to work 80 hours a week, use obsolete medical facilities and inadequate equipment . . ."<sup>23</sup>

Comparatively few young graduates, even those who are not tied to the suburbs, consider rural or inner-city practice. As one Georgetown University medical student put it, "I think doctors of all ages are simply too frightened of the ghettos to set up practices in them."<sup>24</sup>

The collective result of these isolated, random individual choices is an apparent geographic maldistribution of doctors, with physician shortages in rural areas and inner cities. *Higher Education and the Nation's Health*, a report by the Carnegie Commission on Higher Education, found:

The geographic distribution of health manpower is highly uneven, and although there is no clear agreement on what ratio of . . . physicians to population is adequate, there is little question that the supply of health manpower is gravely deficient in some parts of the nation. . . . Merely increasing the supply of physicians will not solve the problem of deficient health care in low income areas.<sup>25</sup>

While Los Angeles had 127 physicians per 100,000 population, in its southeast district of Watts, there were

38. In 1967, 18 states had five or less psychiatrists per 100,000 population; Massachusetts had 22.<sup>26</sup>

Approximately 50,000 persons who live in the impoverished Kenwood-Oakland area of Chicago are served by a total of five physicians in their community. This is a physician-to-population ratio less than one-tenth of the country as a whole. The county hospital and clinics are eight miles away.<sup>27</sup>

In Baltimore, there are only 100 general practitioners for 550,000 slum-dwellers and all but 10 of them are at least 60 years old.<sup>28</sup>

Distribution of Non-Federal Physicians  
by Demographic Area - 1967

Demographic Area	Number of S.M.S.A.'s*	Number of Counties	Population in Millions	Percentage of Physicians
Non-metropolitan counties w/under 10,000 inhabitants		825	4.9	0.8
Non-metropolitan counties w/10,000-25,000 inhabitants		1,021	16.8	3.5
Non-metropolitan counties w/25,000-50,000 inhabitants		485	16.9	4.5
Non-metropolitan counties w/over 50,000 inhabitants		207	14.6	5.2
Central city of 50,000 or more & suburbs	81	97	10.0	4.2
S.M.S.A. w/ 50,000-500,000 inhabitants	152	225	32.9	14.8
S.M.S.A. w/ 500,000-1,000,000 inhabitants	37	90	25.7	14.2
S.M.S.A. w/ 1,000,000-5,000,000 inhabitants	27	118	50.1	32.4
S.M.S.A. w/ 5,000,000 or more inhabitants	3	16	25.3	19.6

\*Standard Metropolitan Statistical Area  
Source: American Medical Association, Department of Survey Research, *Distribution of Physicians, Hospitals and Hospital Beds in the U.S., 1967*.

The problem of distribution becomes even more complex in non-urban areas, for example, where in recent years small towns have experienced a population exodus of young people, leaving the middle-aged and old behind. This is particularly true of the Midwest and the South. The Regional Medical Program in Kansas estimates that 40 per cent of Kansas physicians (including osteopaths) are over 51, and 20 per cent are over 61.<sup>29</sup>

Many medical administrators believe that the small towns of 2,000-3,000 cannot support a full-time physician. As a Kansas regional medical administrator put it:

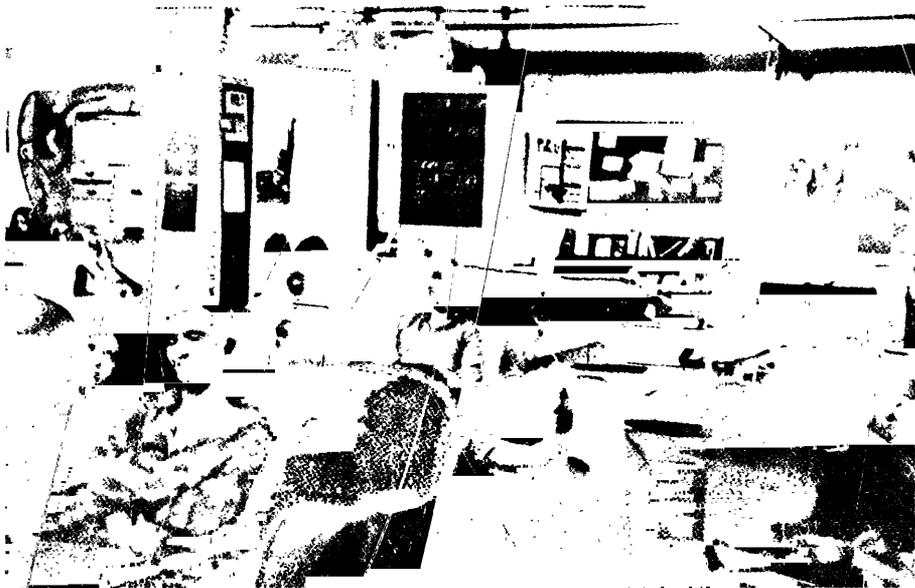
"You often find doctors in trade centers. But in the northwestern part of this state, it's getting difficult to identify trade centers. A few years ago there were farm implement dealers in every town; now people often have to travel to a big town to get a tractor or other implements. The small towns feel that the doctor is their last trademark, that when he goes they've lost their identity."<sup>30</sup>

The real questions then are not only how many physicians are there, but how the services are distributed, what kinds are available and how far one has to travel to get them. Many small towns boast small modern hospitals well-equipped for basic care, but if the town's only doctor is away from the hospital a person traveling to him might do better to travel additional miles to a larger medical center where there are more doctors (and also

more specialists, if he needs them). "It is not unusual," one Kansas physician said, "for a coronary patient to fly 200 miles to Denver, or in an emergency drive 400 miles to Kansas City Medical Center to be treated for an aneurism because that's where the services are."<sup>31</sup>

Distances are relative to many considerations, including psychological ones. In Kansas, the roads are excellent, and as one young neurosurgeon who moved from a small town to a larger medical center told his patient, "It takes less time for you to drive 20 miles to see me at Great Bend, than it would take you if you lived in Great Bend and were just driving across town in normal traffic."<sup>32</sup> But despite this reasoning, having a physician living in one's own community, no matter how old, how busy, or how limited his skills are, is still important for many.

The costs of medical training and the educational background required virtually close out many segments of the population, leaving the social and racial composition of the medical profession highly unrepresentative of the general population. A typical 13-year training period includes four years of college, four years of medical school, one year of internship, several years of specialized medical residency and is estimated to cost as high as \$50,000 in tuition fees, books, equipment and living expenses.<sup>33</sup> These costs help explain why current figures show 63 per cent of all medical students come from families with incomes of \$10,000 or more.<sup>34</sup>



Medical School Enrollments (1st Year Class)

	1968-69 (absolute numbers)	% of total	1969-70 (absolute numbers)	% of total
Total Enrollment	35,828		37,756	
Black	783	2.18	1,042	2.75
American Indian	9	0.02	18	0.04
Mexican-American	59	0.16	92	0.24
Puerto Rican	267	0.74	310	0.82
Oriental	421	1.17	452	1.19

Source: Dennis Dove, "Minority Enrollment in U.S. Medical Schools, 1969-70 Compared to 1968-69," *Journal of Medical Education*, March, 1970.

The problem has become more severe in recent years as the cost of medical education continues to rise, and medical schools find it more and more difficult to meet their costs and to find scholarship and loan funds to attract a wide range of students.

Approximately 60 per cent of the medical schools approved by the AMA charge tuition of \$1,500 or more and these costs are combined with the delay in earning power—the average salary of an intern is \$6,355, of a resident \$6,217. Moreover, federal loans for medical students have fallen from 98.3 per cent to 74.8 per cent of the amount requested by the schools to cover their estimated needs during the past three fiscal years and are only about 39 per cent in the fiscal year 1970 budget. In FY'70, it is estimated that only about 20 per cent of the potential borrowers can be aided.<sup>35</sup>

One consequence of this white, upper-income bias in the selection of doctors is that poor patients, and minority-group patients, must often rely for treatment upon physicians who may not be sensitive to the cultural and environmental circumstances of their patients. This ignorance may affect the quality of treatment. At its worst, ignorance may shade into bigotry, and bigotry into discriminatory treatment:

One of the major reasons for admitting black students to medical schools in increasing numbers is that many of them bring new dimensions to medicine. From interviews and a study of their college records, they have an extraordinary degree of expertise, a practical understanding and sensitivity to the various facets of community problems denied to the rest of us who have not had a similar life experience. . . . This does not mean that they should be admitted with the idea that they will solve the health problems of the ghettos; rather they should be free to go into any medical career open to any student. This extra dimension they bring is equally necessary in the revision of medical care in the suburbs and in the rural areas.—*Daniel Funkstein, M.D., Department of Psychiatry, Harvard University Medical School*<sup>36</sup>

White children under the age of 15 in families with income under \$5,000 had an average of 3.3 physician

visits per year. This was well below the 4.2 average of high-income white children, but the equivalent number for lower-income nonwhites was only 1.9. Indeed, for every age and income category, the average number of visits per year for nonwhites was well below the number for whites.<sup>37</sup>

"... the reason [for my leaving medical school] is straightforward: to continue . . . is to continue exploiting poor people, primarily blacks, for narrow, educational ends. The human measure of this exploitation is brutality. . . ."

"Everybody suffers, but the fact remains that the poor, especially blacks, suffer more.

"And I have had my fill of putting it to blacks. I learned to draw blood on old black ladies. I learned to do pelvises on young black women. I learned to do histories and physicals on black bodies and on a few wrinkled rundown white ones. . . . I am forced to participate in a system providing fragmented second-rate care in the present, while loudly proclaiming the best possible care for future patients (mostly white, suburban folk, of course, i.e., if you don't end up having no patients at all, as in research, public health or administration). . . ."—*Chip Smith, 3rd Year Medical Student*<sup>38</sup>

Sometimes, apparent insensitivity stems less from the doctor's socio-economic background than from an orientation learned at medical school and implicit in the fee-for-service system: the primary function of a doctor is to treat the sick, and his time is too precious to waste on patients who may not suffer from disease.

"Many people come in here with pains, aches, colds and flu—things they can take care of themselves. I just shouldn't be bothered except in serious cases."—*Private Practitioner in Stone County, Arkansas*

## "What good is a magnificent new facility if it is inaccessible to the people who need it?"

For the patient, the hospital represents still another component of the health system beyond his control. An entry into the hospital is an entry into an alien environment with the voice of the patient often the last to be heard.

"I have listened to doctors all my career to determine what my hospital needed. . . . That has resulted in paying the highest possible costs . . . a crisis in the delivery of medical care. . . . I have started listening to consumers—to my patients—who were asking simple questions—like why did they have to go to the county or city hospital five miles away when they could have stopped at my 'private' hospital only five blocks away. I couldn't

answer that. And now I am asking myself the same question, Why?"—*Hospital Administrator*

Only very few of America's hospitals can truly be considered "private" establishments.<sup>39</sup> Except for a small percentage, American hospitals are nonprofit, tax-exempt institutions. Be they operated by state or local governments, universities or voluntary associations, they pay no taxes on either their income or their property.<sup>40</sup> In addition, they are the direct beneficiaries of substantial federal subsidies.<sup>41</sup> These privileges have been extended without attendant responsibilities. Hospitals have not been subject to effective government regulation to ensure that they act in the public interest.

What regulation there is of hospitals is, in large part, the responsibility of the Joint Commission on Accreditation of Hospitals, an organization dominated by the providers. In 1918, the American College of Surgeons (ACS) began a program of standardization "to create in the hospital an environment which will assure the best possible care of the patient." In 1952, the college joined with other professional groups to form the Joint Commission, which in 1953, began accrediting hospitals using the old ACS standards. Almost 2,000 hospitals a year are surveyed by the commission. Of the current 22 commissioners, 18 are physicians.<sup>42</sup> Although the program is "purely voluntary" it has had significant effect on hospital standards.

Hospitals are also largely free from the controls of the marketplace. Patients rarely "shop around" for a hospital. The patient's connection with the hospital system is generally through his doctor, and he goes to the hospital where his doctor has staff privileges. Once in a hospital, the patient often is kept uninformed of the course of his treatment and the services he does or does not receive. Moreover, insurance companies have viewed their role as merely payment mechanisms, and have not attempted to exercise the bargaining power of their policyholders.

In the absence of government or marketplace controls, hospital administrators respond to other pressures: hospitals must attract and keep happy a qualified medical staff; teaching hospitals must give major emphasis to their educational function, even if that results in *ad hoc*, episodic care for patients;<sup>43</sup> voluntary hospitals must be constantly aware of sources of financial support.

These forces often coalesce to demand that the hospital outfit itself with the trappings of prestige and status. The latest and fanciest medical equipment must be purchased, despite the charitable purpose for which the institution was established, and the needs of the general community.<sup>44</sup> The institution must be prepared to provide the most prestigious types of services, even though other hospitals in the community can more than meet the need:

"The buyer of the new medical technology does not generally have the specialized knowledge or the time to evaluate the product or to figure out how much it should cost him. With literally hundreds of companies competing for a share of the market for such devices as electrocardiographs, defibrillators and patient monitors, the average hospital administrator or the average physician is in no position to determine whether a particular feature of one model, which adds several thousand dollars to the cost, is really important or whether it is merely the medical electronics equivalent of a chromium tail fin.

"Second, there is no reason to think that the hospitals are particularly concerned about the cost of the devices they buy. In the final analysis, the hospitals don't pay the bill anyhow. The consumer pays, directly or through a third party, Blue Cross, Medicaid, etc. The insurers pay the hospitals whatever the hospital claims was its actual cost of providing service. If the hospital buys and operates a computer, or an intensive care unit, the cost of providing a day's services rises. Automatically, the rate at which Blue Cross, Medicare and Medicaid reimburse the hospitals also rises."<sup>45</sup>

One result of this haphazard way hospitals do business is a tremendous duplication of equipment and facilities, many of which are seldom used:

"We have 15 open-heart programs in the city of New York. Seven of those open-heart programs do 83 per cent of all the heart surgery; eight of them do 17 per cent. Those eight who do 17 per cent do about one case a month. Do you know what it costs to maintain the equipment and the specialized personnel when you do one case a month? Not only is it expensive, but the quality is miserable, since only a cardiac surgical team constantly at work can produce the quality care that is needed."—*Martin Cherkasky, M.D.*<sup>46</sup>

The costs of these extravagances are, of course, ultimately borne by the consumer in the form of high fees, increased insurance premiums, decreased quality of services or costly, excessive and perhaps even unnecessary stays in the hospital.<sup>47</sup> The greatest costs may be to the general community. For the money, manpower and physical resources directed to these prestigious frills might otherwise have provided needed health care. Indeed, even where expensive, sophisticated equipment (or services) is not a frill, its purchase represents a setting of priorities, an establishing of values by which the entire community must live.

"What a hospital considers necessary expenditure may not be the expenditure which would maximally benefit the public health. Hospitals have other priorities—research, education, prestige—which may compete with community health needs. For example, a few years

ago, Mt. Sinai Hospital installed a three-quarter million dollar hyperbaric chamber—the only one in New York. The chamber costs more than \$600,000 a year to operate. In its five years of operation, it has been used for some 450 major operations and some 400 treatments for other medical conditions which benefit from high-pressure oxygenation—i.e., about 190 times a year in all. No doubt the chamber is a lifesaver. But for the same cost, Mt. Sinai could deliver 20,000 outpatient visits a year or set up a vast program to screen children in surrounding East Harlem for lead poisoning and anemia. But it is the hospital that chooses how to allocate its spending, not the community."<sup>48</sup>

The priorities of hospital care are an especially important issue today in urban areas. With private practitioners leaving the inner cities, and those remaining often refusing to treat Medicaid patients, poor residents in those areas increasingly are forced to rely on hospital emergency rooms and outpatient clinics as their only source of care.<sup>49</sup> As a result, many emergency rooms have had imposed upon them a responsibility for delivering primary care. For example, a survey conducted in New York City found that 62 per cent of the visits to emergency departments of hospitals could not be classified as true emergencies.<sup>50</sup> The resident staff of New Haven Hospital classified the medical conditions that brought individuals to the emergency room, 56 per cent were non-urgent and only 6 per cent were classified as emergencies.<sup>51</sup>

But voluntary hospitals have largely refused to recognize this added responsibility. Emergency rooms and outpatient clinics continue to get the short end of hospital resource allocations. They cannot cope with the demand and they often set up financial or other barriers to entry. So the burden falls on the already overworked urban public hospitals, where the waits grow longer and the treatment more cursory.<sup>52</sup>

With respect to inpatient treatment, too, voluntary hospitals have been able to shift to public hospitals the burden of caring for patients on the low end of the socio-economic scale.<sup>53</sup> Medicaid and Medicare often have not remedied this situation. Generally, voluntary hospitals allocate the bulk of their inpatient beds to doctors with staff privileges.<sup>54</sup> This practice has the effect of discriminating against patients without a private doctor—Medicaid and Medicare patients are often in this category—and sometimes against patients with black doctors as a result of racial bias in the awarding of staff privileges.<sup>55</sup> In several instances the denial of hospital staff privileges has been used by local medical establishments as a weapon against doctors who attempt to set up poverty-oriented practices.<sup>56</sup> Poor patients are thus regularly turned away from voluntary hospitals where beds are occupied by patients who need not be hospital-

ized; and the poor are forced to seek admission at public hospitals where bed shortages are harsh reality.<sup>57</sup>

In many ways, public hospitals are the least prepared to respond to these heavy burdens. Ultimately, the management of public hospitals is a governmental responsibility. But the people who must rely on public hospitals for care comprise only a small portion of the general political constituency, and the portion least able to exercise political influence.

The poorest and most deteriorated neighborhoods in Boston are those closest to Boston City Hospital. In 1960, the South End had an infant mortality rate of 38.1 per 1,000 live births; Roxbury had a rate of 37.9; and North Dorchester had a rate of 39.5; while the rate for the city as a whole was 24.2, very close to the national average. Two census tracts not 10 blocks from the hospital had a rate of 79.5, which is among the highest in the country.<sup>58</sup>

For years, a community of poor families in Bexar County, Texas, which includes the city of San Antonio, received medical care at the Robert B. Green, a small hospital on the western side of the area within a relatively short walking distance for most of the people. Recently, however, the county, in partnership with the University of Texas, built a new medical school and hospital facility located approximately 45 minutes to an hour away by bus, requiring a 75¢ fare each way. The old hospital still retains some limited services, but only about 57 of its more than 300 beds are being used. (University and county officials felt they were "too archaic" to be of value.)

While persons to whom we spoke felt that the new hospital was indeed "a gleaming, modern facility," one community person felt that once again the community was the loser: it had not helped determine where the hospital should be nor whether it satisfied community needs. Rather, the needs of the hospital and physician hierarchy once again came first. We were told: "What good is a magnificent new facility if it is all but inaccessible to the people who need it?"<sup>59</sup>

**"For years I have been a union representative on the Blue Shield board and sat at board meetings and watched the doctors bargain with themselves."**

Health insurance has great impact on the practices of doctors and hospitals as well as on the functioning of the health system as a whole. Yet the health insurance industry has been free to shape its involvement in the health

system to suit its own interests, though often these conflict with consumers' needs. As a result, health insurance coverage is limited, despite resultant hardships to consumers; insurance programs have tended to distort priorities in the delivery of health care and health insurance has served as a stimulant to the inflation of health care costs.

Moreover, health insurance organizations have shown themselves to be completely ill-suited for the task, which some have set for them, of representing consumer interest within the health system. The major nonprofit health insurance associations are closely allied with hospital and physician interests, and private profit-making insurance companies are trapped by constraints inherent in the insurance business.

As early as the 1880's sporadic attempts were made by consumers and hospitals to establish nonprofit hospital prepayment plans. Insurance, however, became a significant factor in the American health care system in the 1930's.<sup>60</sup> With the Depression, hospitals found themselves faced with empty beds and unpaid bills. Before the economic crisis of the Depression, hospitals had been financed largely through patient fees, voluntary contributions and endowments and money from federal, state and local taxes.<sup>61</sup> For non-government hospitals, patient fees were the primary source of support.

The Depression, of course, severely challenged these financial bases. Hospital administrators saw some potential for salvation in a program initiated by a group of Houston public school teachers in 1929. Baylor University Hospital had agreed to work with the teachers to provide certain health services in exchange for relatively small periodic payments.<sup>62</sup> Spurred on by the need for a dependable, regular source of income, and using the experience with the teachers as a guide to premiums and benefits, the hospital began to enroll other groups on the same basis. In this way, the first Blue Cross Association was formed.<sup>63</sup> The Baylor Plan attracted national attention, and hospitals throughout the country began to institute similar programs. By 1932, Blue Cross was on its way to becoming a national institution.<sup>64</sup>

Initially, physicians were unenthusiastic about any form of health insurance and as late as 1938 they were still insisting through the AMA that any medical service plans sponsored by physician societies should provide for cash indemnity to the patient who in turn would pay the doctor. This would, they hoped, keep third party intrusion from impairing medical practice.<sup>65</sup> Prompted by the threat of third party entry into the business of insuring against physicians' fees, medical societies began organizing insurance programs over which they could maintain control. Starting with the California Physicians Service, organized in 1939 by the California Medical Society as a defensive move against the governor's

legislative proposal for a state health insurance program, programs of insurance sponsored by local medical societies quickly spread across the country, and Blue Shield, like Blue Cross, began to grow.<sup>66</sup>

In the years between 1948 and 1968, Blue Cross and Blue Shield grew in membership and influence on the health care scene at a rapid rate.<sup>67</sup> By the end of 1969, Blue Cross membership grew to 71.1 million—enrolling 35 per cent of the civilian population while Blue Shield enrolled 63.5 million people. In terms of dollars, Blue Shield paid out \$1.8 billion on behalf of its members, while Blue Cross distributed \$4.39 billion.<sup>68</sup>

Though Blue Cross has always characterized itself as "committed to public service," it was from the outset an organization of, for, and by hospitals, a fact that has become formalized by the relationship of the organization with the American Hospital Association (AHA).<sup>69</sup> In 1933, the AHA began to encourage the development of local Blue Cross plans and "took steps to control and approve arrangements for prepayment. . . . In 1939, the Blue Cross was officially adopted by the American Hospital Association."

In 1952, the American Hospital Association registered "Blue Cross" as a service mark. Today, the national Blue Cross headquarters are located in the same office building in Chicago that serves as national headquarters for the AHA. By charter, the AHA is guaranteed a certain number of positions on the national Blue Cross Board of Directors. Local Blue Cross boards are also invariably controlled by hospital representatives.<sup>70</sup>

At first, the interest of the hospitals in maintaining a stable financial base did not collide with the consumers' interests. The service contract concept of Blue Cross, whereby Blue Cross subscribers are directly entitled to obtain certain specified services (instead of a plan which provides policyholders with reimbursement for expenses), provided fairly comprehensive coverage at relatively low rates.

Although Blue Cross subscribers were pleased in the beginning, over the years their interests and those of the hospital have diverged while the Blue Cross mechanism continues in faithful service to the hospitals. The service contract concept, as applied by Blue Cross, has become the equivalent of a cost-plus contract. Blue Cross negotiates with a hospital to reimburse for certain services provided subscribers at a level based on what the hospital determines are its costs. How these costs are determined or what should be properly included as costs are rarely subjects of negotiation. If costs rise too high, Blue Cross has two choices: 1) raise rates; or 2) give subscribers less coverage. Blue Cross associations around the country have been forced to do both.<sup>71</sup>

As Blue Cross began to open up the market for group health insurance, private insurance companies became

interested in developing their own health insurance programs.<sup>72</sup> They were attracted also by the sales possibilities in being able to offer individuals a complete package of insurance—life, health, accident, and so on. Whatever the reason, when these companies entered the health insurance market, they did so with all the constraints inherent in the business of providing insurance protection for profit. Insurance companies can only afford to insure against known risks. A car, a house, a life are insured for a certain *set value*, and the *likelihood* of the car being in an accident, the house burning, or life ending is determinable by established actuarial principles. Thus, the necessity of having a known risk precludes private companies from providing truly comprehensive health insurance.<sup>73</sup>

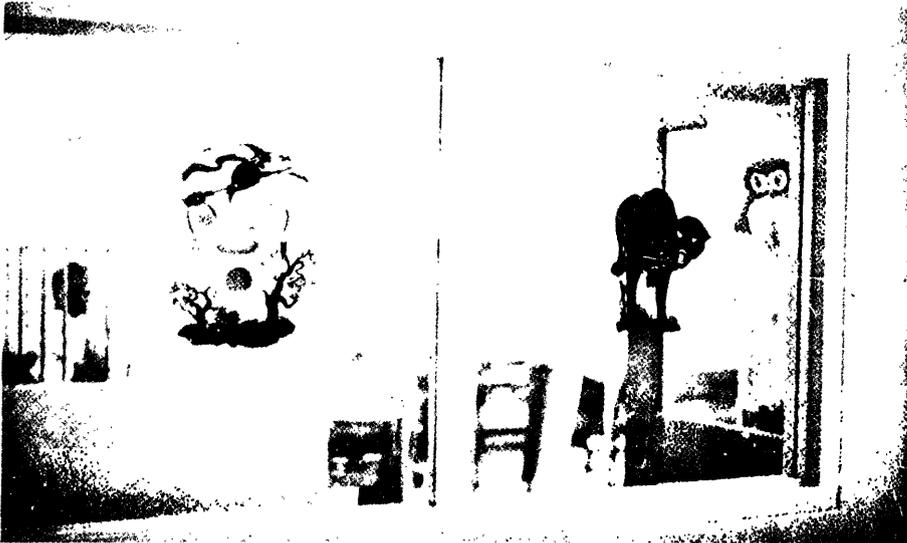
The value of comprehensive coverage to the consumer was that it would be open-ended and thus not susceptible to a fixed setting. The likelihood of health care expenses being incurred was not precisely determinable by statistical means, since whether a policyholder sought health care was, to a large extent, within his control. As a result, to provide health insurance, private companies found it necessary to delimit their coverage far short of the comprehensive ideal and to create devices that would mitigate the patient's control over the amount of expense incurred.

"Today the insurance companies find themselves applying the traditional mechanisms of insurance against specific catastrophies to a completely different problem—that of day-to-day health care, including health

maintenance as well as services for disabling illness. In so doing, they have stretched the basic principles almost beyond recognition. A veritable avalanche of policies has been developed. . . . These have done more to palliate the complaints than to meet the needs of the people; they have been more often designed with the company rather than the consumer in mind and without a basic understanding of the systems through which health services are delivered to patients."<sup>74</sup>—*William A. MacColl, M.D., Group Practice and Prepayment of Medical Care*

The resulting pattern of coverage leaves policyholders un- or under-protected when they most need protection: facing extraordinary medical expenses<sup>75</sup> or seeking preventive care to avoid future expenses. Perhaps more important, in some instances the pattern of coverage interferes with the functioning of the health care delivery system and distorts the priorities of care. Devices are built into insurance plans to discourage policyholders from seeking care when they are uncertain as to whether care is needed.<sup>76</sup> There is little or no coverage of preventive care—a failure that has tended to stifle the development of arrangements to deliver such care.<sup>77</sup>

In addition, care delivered in a hospital receives favored coverage as compared to care given in a doctor's office or clinic, a preference which over time has tended to bias the health care delivery system toward hospital-based care, especially for inpatients.<sup>78</sup> Insurance coverage is sold at differential rates, and those who most need



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medical care—old people, black people, poor people, sick people—must pay the highest rates.

Like Blue Cross, private health insurance programs have served as stimulants to the inflation of medical care costs. The medical art is inexact, and medical practice cannot, and should not, be subjected to rigorous regulation by insurance companies. Yet the resultant opportunity for doctors to abuse the insurance scheme, an opportunity too often exercised, has been a major contributor to the inflation of the cost of care. The inability of the insurer to exercise control over costs has meant that these costs are passed on to the consumer by building an "abuse factor" into the premium rate. The consumer, in turn, is powerless to modify the cost factors unless he does without a physician's services.<sup>80</sup>

Because of the impression created that patients could afford to spend more for care because they were insured, there has been an increased utilization of services, physicians fees have risen and extra charges incurred.<sup>81</sup>

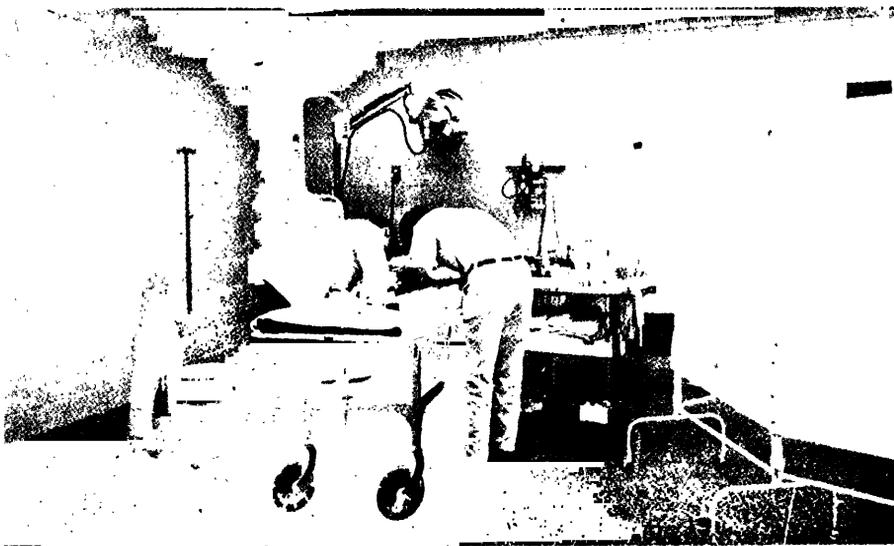
When cost controls are attempted they are aimed at the consumer, at preventing *his* fraud, although he can do little to affect the costs of insuring medical care in a system where "the producers of medical services are also the gatekeepers to who uses the system."<sup>82</sup>

Competition from private companies in the health insurance business has forced Blue Cross to compromise some of its initial operating principles which were particularly beneficial to the general consumer community. Traditionally, Blue Cross offered its coverage on a community-rated basis. Computation of rates and costs was

based on the average experience of the entire community, not certain subgroups within that community.<sup>83</sup> In this way, high- and low-risk individuals could all purchase coverage at the same rates. But the private companies sold insurance on an experience-rated basis: groups with a history of low claim ratios could purchase coverage at favorable rates; groups with a history of poor health had to pay higher rates. This gave private companies a competitive advantage in the market for low-risk groups.<sup>84</sup> As these companies captured ever larger portions of this market, Blue Cross was left with a disproportionate number of high-risk members and experienced increased economic pressure. Some Blue Cross associations responded by turning to such devices as deductibles and co-insurance as a way to control costs. Others considered discarding or modifying the principle of community-rating, and adopting the experience-rating approach.<sup>85</sup> Either way, Blue Cross consumers were the losers. Competition in the health insurance business has served to benefit only those who least need health insurance protection.

Like the doctors and the hospitals, the insurance industry has the consumer literally at its mercy. There is almost no opportunity for the health care consumer to influence the when, where and quality of services he receives or to determine how they should be paid for. Often the bewildered consumer can say only, as a father in Portland, Oregon, said:

"We let some very serious things go by rather than call another doctor and owe another bill."



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## Chapter III

# Consumer Influence on the Federal Role

"For the last 25 years, financing programs for medical care, whether public or private, have served largely to provide financial underpinning for conventional ways of providing services. Wherever the money came from, most of it followed well-worn and sometimes rutted roads into institutional cash drawers and medical pocketbooks. Instead of encouraging change, the programs have been rewarding traditional methods and old inefficiencies. Federal support of vendor payments has made the payments more certain without exerting much influence on the vendors to improve patterns of care."—*HEW Task Force on Medicaid and Related Programs*<sup>1</sup>

"Federal government has increasingly put more money into health, health education and health facilities in this country. Of course, I can recognize that this may be very superficial, but it appears to me that the more money that the federal government or government itself, public money, that goes into health care the greater the cost becomes to the private citizens, which is somewhat of a paradox in a sense."—*Hon. Horace R. Kornegay, U.S. Representative from North Carolina*<sup>2</sup>

Despite the fact that the health care delivery system is settled into patterns of provider dominance and orientation, often at great social expense, federal government programs have done little to break the patterns, to redress the imbalance, or to encourage major innovation in delivery. The programs have, in fact, reinforced the dominance of physicians and hospitals, delegating to them, directly or indirectly, the power to make decisions of broad social importance with little or no public accountability.

In recent years, the federal role in health affairs has increased substantially. Federal health expenditures in fiscal 1970 are expected to total \$18.8 billion—an increase of \$2.2 billion from 1969. In fiscal 1971, this figure is expected to rise to \$20.6 billion. This represents 10.5 per cent of all federal government outlays and can be compared with the total national health expenditures,

a figure currently estimated by the Office of Management and Budget (formerly Bureau of the Budget) at more than \$65 billion.<sup>3</sup> Today health care ranks behind defense and education as the nation's third largest expenditure. Federal health spending for fiscal 1971 is estimated at the following levels:

	1969 Actual	1970 Estimate	1971 Estimate
Development of health resources (total) . . . .	\$3,111	\$3,498	\$3,640
Health Research . . . . .	1,528	1,622	1,660
Training & Education . . . . .	805	951	1,033
Construction of Hospitals & Health Facilities . . . . .	612	705	712
Improving the organization and delivery of health services . . . . .	166	220	235
Provision of hospital & medical services (total) . . . . .	12,794	14,486	16,096
Direct federal hospital & medical services . . . . .	2,860	3,147	3,116
Hospital & medical services (indirect) . . . . .	9,934	11,339	12,980
Prevention & control of health problems (total) . . . . .	651	803	866
Disease prevention & control . . . . .	411	489	504
Environmental control . . . . .	86	134	163
Consumer protection . . . . .	154	181	199
Total outlays from federal & trust funds . . . . .	\$16,556	\$18,787	\$20,602

New emphasis in federal spending has greatly changed the distribution pattern of the government's health dollar. In 1965, only 19 per cent of these funds was directed at financing personal health care for the general population. In 1971, chiefly because of Medicare and Medicaid, two-thirds of all federal health monies are intended for consumers.<sup>5</sup>

The breakdown in federal outlays for medical and health-related activities among government agencies is as follows:<sup>6</sup>

	Fiscal 1969 (in millions)	Fiscal 1970 (in millions)
Department of Health, Education & Welfare . . . .	\$11,820.3	\$13,477.0
Department of Defense . . . .	1,905.1	2,032.6
Veterans Administration . . . .	1,571.6	1,795.2
Department of Housing and Urban Development . . . .	119.2	154.0
Department of Agriculture . . . .	173.4	206.8
Agency for International Development . . . . .	121.2	176.3
Office of Economic Opportunity . . . . .	126.0	148.9
National Aeronautics & Space Administration . . . .	110.6	115.5
Atomic Energy Commission . . . .	95.0	101.7
Civil Service Commission . . . .	40.7	41.2
Department of Labor . . . . .	47.3	51.7
Department of State . . . . .	25.0	28.4
National Science Foundation . . . . .	27.2	29.7
Department of Commerce . . . .	8.4	8.3
Other agencies . . . . .	104.6	153.4
Agency contributions to employee health funds . . . .	246.6	251.7
<b>TOTAL . . . . .</b>	<b>\$16,556.4</b>	<b>\$18,787.6</b>

## Health professionals and health care institutions have shared in these ever increasing federal subsidies without demonstrating either social responsibility or accountability to consumers.

The following brief survey of several major federal health programs illustrates these points:

**HILL-BURTON.** In 1946, after years of Depression and war, the country found itself with an apparent shortage and maldistribution of hospital facilities—half of the nation's counties had no hospital. To remedy this situation, the federal government established the Hill-Burton grant program for the construction and mod-

ernization of hospitals, one of the earliest federal thrusts into the nation's health affairs.<sup>7</sup>

Under the Hill-Burton Act, federal funds are set aside for each state to be used for the construction or modernization of public or nonprofit hospitals. To receive a Hill-Burton grant, public or nonprofit organizations must apply to the agency in their state designated the "state Hill-Burton agency." This agency, in conjunction with a state Hill-Burton advisory council, and under the guidance of a federal formula for determining priorities, decides which applications should be forwarded to the federal Public Health Service (PHS) with a recommendation for approval. An application approved by the state agency and by the PHS will then receive a federal grant (based on the state's population and per capita income) which covers between one-third and two-thirds of the cost of construction of the proposed project. The rest of the funding comes from state and local governments, community resources, and in some areas, conventional lending sources.<sup>8</sup>

Through fiscal 1969, the Hill-Burton program approved construction or modernization of 442,965 hospital inpatient beds and 2,888 other facilities. Of \$11.2 billion, the total cost of the projects, the federal share was \$3.4 billion.<sup>9</sup>

From the beginning, the designers of the program felt the greatest need was for new hospitals in rural areas. Thus for most of its years, the program was rural-oriented. Allotment schedules favored rural states and, within any given state, rural areas.<sup>10</sup> Over the first 20 years of the Hill-Burton program, \$2.75 billion of federal money was allocated among the states for expansion of the nation's medical facilities. Only 4.1 per cent of this money went to the 10 largest cities in the country, cities that had 11.7 per cent of the United States population. Mississippi and Alabama, with one-quarter of the population of these 10 cities, received nearly one-half again as much federal Hill-Burton money.<sup>11</sup>

The rural bias of the Hill-Burton Act became more ironic as accumulated evidence revealed that increasing hospital beds was an inadequate response to the nation's medical care needs. With the aid of federal money, 25-to-50-bed hospitals sprang up in small towns and rural areas across the country, especially the South and Midwest. These hospitals were expensive to build, equip, and maintain. Many have been characterized by low occupancy rates. Many have become little more than glorified nursing homes; some have even had to close their doors. Despite one of the main intentions of the act, the new Hill-Burton hospitals generally did not succeed in attracting more doctors into the areas served. Many communities boasted a hospital, but no doctor to serve in it.

Ellinwood, Kansas, for example, is a town of 2,852 persons. They have a 24-bed hospital, built by Hill-

Burton funds, and one general practitioner, who not only treats the population, but heads the hospital. In recent years, the residents have traveled to the Regional Medical Center at Great Bend, only 10 miles away, where several of Ellinwood's former doctors have gone. As a result, the Ellinwood hospital has had a decrease of regular patients. When a member of the Citizens Board visited the town, there were only two occupants in the hospital—a low but not uncommon figure for the summer months. The doctor, who has practiced in the town for 15 years, is contemplating leaving. If he decides to go and no replacement is found, the hospital will close. A similar story could be told about many other small towns and their Hill-Burton hospitals.

There are many reasons for this changing health profile. Attracting professionals to rural settings has proved largely a futile and frustrating task. Generally, rural areas and small towns have had to depend on the general practitioners in their locales for hospital staff. Few found surgeons to man their surgical suites or other specialists to utilize the sophisticated equipment they had purchased. Even if such skilled manpower had been available, few of these small institutions could use it efficiently. The human and physical resources that must be kept on hand, for instance, to provide a reasonably comprehensive surgical service for accident victims would sit idle an intolerable portion of the time. The

inability to provide specialized services has been compounded by the general failure of these small rural hospitals to establish formal ties with large medical centers. Thus, patients in need of specialized care often cannot link up with the appropriate services through their local Hill-Burton-financed hospital.

So, despite the great expenditures, the health care needs of rural and small town Americans often are not well-served, and meanwhile, urban America languishes in need of the very facilities Hill-Burton has provided to the rest of the country.

Two of the cities with the most critical problems are New York and Chicago. A 1965 study reported that "to make the 130 general-care hospitals in New York City adequate for their current tasks would require an expenditure of \$705 million," excluding the cost of new or expanded hospital services, site acquisition, staff residences, research buildings and parking areas. The study showed that 72 per cent of the surgical suites in the city were inadequate as were 90 per cent of the x-ray facilities, 71 per cent of the emergency departments and 72 per cent of the outpatient facilities.

Two years later, HEW estimated that the cost of modernizing New York City hospitals was \$1.25 billion. Yet, the city's hospitals had received only \$17.5 million in Hill-Burton funds.

In Chicago, the story was similar. The Hospital Plan-



**Total Hill-Burton Projects  
by Type of Construction and Size of Community<sup>1 3</sup>  
July 1, 1964 to June 30, 1968**

Size of Community	Projects		Inpatient* Beds		Outpatient Facilities		Cost (ooo's omitted)		
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Total Cost	Federal Share	Per Cent
TOTAL	2,743	100.0	122,978	100.0	818	100.0	\$3,753,954	\$1,098,993	100.0
Under 2,500	460	16.8	12,509	10.2	122	14.9	288,692	109,991	10.0
2,500-4,999	352	12.8	11,687	9.5	63	7.7	262,068	96,959	8.8
5,000-9,999	373	13.6	16,225	13.2	64	7.8	401,262	144,020	13.1
10,000-24,999	434	15.8	21,927	17.8	110	13.4	638,301	195,157	17.8
25,000-49,999	270	9.8	14,152	11.5	89	10.9	488,187	131,173	11.9
50,000-99,000	222	8.1	11,429	9.3	99	12.1	388,821	101,010	9.2
100,000-249,999	224	8.2	12,586	10.2	89	10.9	408,338	110,994	10.1
250,000 or more	408	14.9	22,463	18.3	182	22.3	878,285	209,689	19.1

\*Includes diagnostic or treatment centers, rehabilitation facilities and public health centers.

ning Council for Metropolitan Chicago reported in November, 1966, that the total cost of hospital modernization in Chicago would be \$255 million. Chicago had received \$14.1 million in Hill-Burton funds. "It is apparent," the council stated, "that there is a financing problem of an extremely serious nature facing hospitals in the Chicago area."<sup>12</sup>

The chart above shows that of the 2,743 Hill-Burton projects completed between 1964 and 1968, 68.8 per cent of them were in communities with less than 50,000 persons while only 14.9 per cent were in cities with 250,000 or more people. In addition, 61.6 per cent of the federal financing share went to communities with less than 50,000 people. In terms of hospital inpatient beds, of the 122,978 built in the period of 1964-68, 86,500 were in communities with less than 50,000 people and of the 818 outpatient facilities, 448 were built in these communities.

With recent amendments to the Hill-Burton Act, Congress has made an effort to re-order the priorities of the program. Increased funds are now provided for modernization, and urban areas have priority in the allocation of grants for modernization.<sup>14</sup> Yet changes like these can only begin to remedy the deficiencies of the program. Many of the program's inequities have a source that runs deeper than the regional biases built into the legislation.

The mechanism for implementing the legislation often has the effect of delegating responsibility for the direction of the program in each state to established hospital or medical interests. Within the rough guidelines

set by federal formulas, state implementing agencies have wide latitude in apportioning the federal money among the various proposed projects. In most states a key role in this apportioning process is played by the state Hill-Burton advisory council, a body that from the beginning of the program has been dominated by representatives of hospitals and organized medicine. As a result, community interests were frequently seen in the narrow light of special interests. For example, until 1970, no Hill-Burton funding had ever gone to a prepaid group practice and, as yet, none has gone to a consumer-controlled medical care facility.<sup>15</sup>

Hospital service areas, the basic units for determining the priorities of intrastate need, have been gerrymandered in some states to keep the federal money in the hands of the politically powerful hospitals and away from those areas and institutions that might be in most need. Watts in Los Angeles is the perfect example. Prior to 1965, Watts was part of four different service areas. Those areas received the money and used it elsewhere, and Watts, with a population of over 100,000, had no hospital.<sup>16</sup>

A 1964 amendment of the Hill-Burton Act provided that in addition to "representatives of non-governmental organizations or groups, and/or public agencies concerned with the operation, construction or utilization of hospital or other facilities for diagnosis, prevention or treatment of illness or disease, or for the provision of rehabilitation services," state advisory councils should include "an equal number of representatives of consumers familiar with the need for the services provided

by such facilities."<sup>17</sup> "[R]epresentatives particularly concerned with education or training of health professions personnel" were added to the group by a 1970 amendment.<sup>18</sup>

If the 1964 addition of representatives of consumers was seen as a mechanism for protecting their interests, the amendment has proved largely ineffectual. Citizens who have been involved in the health care system—some may be hospital trustees or members of voluntary health agency boards—are appointed and labeled "consumer

representatives," though they may have no natural consumer constituency and can in no way be held accountable by the consumer community. Even if these appointees were drawn from a broad cross section of the community, their ability to function in the role of representative would be doubtful. As the chart below indicates, important segments of the citizenry are regularly excluded from even this nominal representation.

A 1970 amendment to Hill-Burton attempts to

**Selected State Hill-Burton  
Advisory Councils<sup>19</sup>**

State	Consumers <sup>20</sup>	Representatives of Non-Governmental Organizations	Representatives of Governmental Organizations
Arkansas	2 real estate brokers, women's club president, housewife, businessman, teacher	2 nursing home owners, nursing home administrator, 2 private physicians, dentist	Hospital & nursing home administrator, school nurse
California	County supervisor, voluntary health agency board member, retired union executive, 2 businessmen, housewife, architect	Medical school department chairman, director of Catholic hospital, mental health & retardation policy representative	Nursing home administrator, state director of mental health
Massachusetts	Engineer, lawyer, architect, pharmacist, banker, retired physician	Director of Catholic hospitals, state medical society representative, hospital administrator, private pediatrician	Commissioner of mental health, commissioner of public health
Nebraska	3 businessmen, lawyer, banker	Hospital administrator, newspaper editor, private physician, hospital trustee, insurance advisory board member	State director of health
Oregon	Professor of physiology, architect, labor leader, banker, farmer, 2 businessmen, druggist, chairman of health section of United Givers Fund	2 hospital administrators, 3 private physicians	State secretary of health, director of veterans affairs
Texas	Banker, mental health coordinator, director of voluntary health agency, rancher, oilman, lawyer	3 hospital administrators, 3 private physicians	State director of health
Michigan	County health department director, community service agency director, state college chancellor, housewife, 2 foundation executives	2 hospital administrators, 2 private physicians, hospital trustee	State university medical school dean
New York	4 labor leaders, Blue Cross president, bacteriology department chairman, 3 representatives of regional hospital review councils, 2 lawyers, Metropolitan Life Insurance vice president, retired businessman, medical care consultant of voluntary agency, businessman, director of school of public health	2 regional hospital review council officials, 2 state medical society officials, director of Catholic hospitals, executive secretary of private hospital association, 4 hospital administrators, clinic director, nursing home administrator, 2 private physicians	County hospital director

<sup>19</sup>In addition to their designation as "consumers" some of these persons may also be hospital trustees or voluntary health agency board members.

provide additional consumer representation in implementing the program. It stipulates that prior to being recommended for approval by a state Hill-Burton agency, a project must be submitted for consideration to the appropriate state or areawide comprehensive health planning organization-bodies that are required by statute to include consumer representatives. But consumer representation on comprehensive health planning bodies is probably as ineffective as that on Hill-Burton advisory councils.<sup>20</sup> Moreover, the legislation calls only for "consideration" of the merits of proposed projects by these organizations and gives them neither power nor authority to enforce their ideas.

More basically, even if the interests of the general community were perfectly represented in the Hill-Burton apportionment process, the ultimate implementation of the program and its goals would still be left in the hands of providers: providers with a set of institutional interests that may be inimical to the aims of the legislation. Once the federal funds reach a given institution, the governmental role essentially ends, and the institution is free to pursue its own goals with little review.

Although Hill-Burton regulations do provide that facilities accepting funds under the program assume a continuing public responsibility, no attempt has been made to implement these assurances and abuse is common.

The regulations state, for example, that:

"Before an application for the construction of a hospital or medical facility is recommended by a state agency for approval, the state agency shall obtain assurances from the applicant that:

(a) The facility will furnish a community service;  
 (b) The facility will furnish below or without charge a reasonable volume of services to persons unable to pay therefore."<sup>21</sup>

But in Marianna, Arkansas, despite regulations, the story is different. The 27-bed Lee County Memorial Hospital, opened in 1958, cost \$337,881, of which \$218,264 came from Hill-Burton funds. Staffed by the four permanent Lee County general practitioners, three registered nurses, and five licensed practical nurses, the hospital generally has had a low occupancy rate of about 50 per cent, according to its administrator. (About 70 per cent of those admitted for treatment are Medicare patients.) But despite the low occupancy rate, patients are consistently turned away.

"There is an entrance fee at Marianna Hospital," the county public health nurse told members of the Citizens Board. "Marianna Hospital couldn't operate without people paying their bills."

The Hospital is governed by a seven-member board of directors, which is chaired by the county judge who also

appoints the six other members. In conversation the judge indicated the belief that there is no significant health problem in Lee County, one of the poorest and most disease-ridden counties in the country. He is proud of the hospital. He told members of the Citizens Board that he had given free rein to the hospital administrator, and the administrator is "running the hospital at a fine profit."

**MEDICARE AND MEDICAID.** Surrounded by controversy, yet filled with promise, Medicare and Medicaid emerged from the legislative process in 1965, promising to bring decent medical care to the old and the poor. In actuality the programs fell short of those expressed hopes. Theoretically, the 20 million people covered by Medicare and 10 million covered under Medicaid, were given access to medical services of their choice, many for the first time. At least a mechanism was provided to pay for services, assuming they were available. They often were not. A great deal more might have been accomplished if programs had been designed to seek more rational and efficient utilization of our limited health care resources—if, indeed, the program had encouraged change rather than "rewarding traditional methods and old inefficiencies."<sup>22</sup>

Unfortunately, the programs have served as stimulants to a general inflation of medical care costs affecting all consumers. The programs have been quite profitable to providers of care. Perhaps most important, Medicare and Medicaid have provided financial reinforcement, subsidy, for a system of health care delivery that does not meet the needs of the American people. The law was designed to pay the bills without changing the system.

**MEDICARE.** Medicare is essentially a health insurance program for the aged, modeled after the plans of private insurance carriers, particularly Blue Cross and Blue Shield. The program has two major parts: Part A, basic hospital insurance, covers virtually everyone over the age of 65; Part B, medical services insurance, which covers physicians', surgeons' and other specified medical care expenses, is available to those over 65 who choose to pay the relatively small monthly premiums. Part A is financed through the Social Security concept of employer-employee contributions to a trust fund. Part B is partly self-supporting, with the balance supplied by federal grants.<sup>23</sup>

The Social Security Administration depends on a number of fiscal intermediaries for the implementation of part A. Groups or associations of hospitals and extended-care facilities have been delegated the authority to nominate the intermediaries that will service their member institutions, although an individual member of one of these groups or associations may choose to select a separate intermediary for itself. Part B is administered through a series of carriers selected by the Secretary of Health, Education and Welfare.<sup>24</sup> The fiscal inter-

mediaries and the carriers are reimbursed only for the costs of carrying out the functions they perform, but they may receive some benefit from their involvement in the program through the achievement of increased economies of scale and the opportunity to broaden their base of operations.<sup>25</sup> And, of course, when Blue Cross is the fiscal intermediary or Blue Shield the carrier, the hospitals and the physicians may benefit from having an intermediary or carrier with which there are close professional ties, instead of a disinterested party.<sup>26</sup>

As of early 1970, an overwhelming proportion of nonprofit and a large number of other types of hospitals (a total of 6,876 out of 7,906 hospitals) nominated, through their membership in the American Hospital Association, the national Blue Cross Association to serve as their fiscal intermediary. In addition, more than half of the extended-care facilities selected Blue Cross as their intermediary. The remaining hospitals and extended-care facilities chose various commercial insurance companies as intermediaries, with a few institutions, primarily government hospitals, electing to deal directly with the government.<sup>27</sup>

The national Blue Cross Association does not function as a direct intermediary but rather as a prime contractor, subcontracting to local Blue Cross plans the actual duties of fiscal intermediaries as conceived by the

legislation. The staff of the Senate Finance Committee, which was holding hearings on Medicare and Medicaid, reported:

"The system which Blue Cross Association established and is expanding as intermediary has been criticized as an additional, artificial, costly, duplicative, and sometimes unnecessary layer of administration. While it may enhance the BCA [Blue Cross Association] position . . . it also seems to have impeded effective and efficient operation of the hospital insurance program. Social Security regional personnel have advised the staff [of the Committee on Finance, United States Senate] that they are often limited to only the most routine of inquiries in dealing with local Blue Cross plans—that everything else must be routed through the Chicago headquarters of the Blue Cross Association.

No local Blue Cross plan has been rejected by the Blue Cross Association for Medicare as being too small or inefficient. The administrative capacity and performance of the subcontractors range widely, yet the Social Security Administration has so far taken the good with the bad under this 'all or none' prime contract arrangement."<sup>28</sup>

Over half of the part B carriers are Blue Shield plans. Given the relationship of Blue Cross to the hospitals and



Blue Shield to organized medicine, the dominant role played by these organizations in the administration of the Medicare program raises serious questions as to the public responsibility and accountability of the program.<sup>29</sup> With regard to the disbursement of huge amounts of federal money, it is not unfair to ask whether these organizations can subordinate the interests of their specific clients to the goals of the program and the general public good.

In a hearing before the Senate Finance Committee in July, 1969, Mr. Robert Ball, Commissioner of Social Security, discussed the serious administrative difficulties that were faced in reviewing the performance of Medicare intermediaries:

Mr. Ball: "I am saying that carrier performance did leave a lot to be desired . . . and can still be improved, but it has come a very long way. In the next fiscal year, we estimate that by their review of this question of medical necessity and the legal coverage of services . . . there will be a saving of about \$120 million in the program. . . . We estimate that program costs will be reduced another \$90 million as a result of their reduction of fees that are billed to them, but that they refuse to recognize as reasonable charges, and then another \$100 million as a result of audit. . . . When the program started out, we let the carriers do it pretty much the way they would run their own business."

Sen. Gore: "I cannot imagine they would run their own business this way."

Mr. Ball: "That is about the size of it. They were doing about that much review in their own business."<sup>30</sup>

**MEDICAID.** If Medicare is little more than Blue Cross-Blue Shield coverage for the aged financed with federal money, Medicaid is largely a new category of welfare benefits tied to established programs that have proved inadequate.

For a state to receive federal Medicaid funds, it *must* provide at least the following basic services: inpatient hospital services, laboratory and x-ray services, skilled nursing home services, physician services, diagnostic screening and treatment for people under age 21 and home health services (beginning July, 1970), to all those eligible to receive welfare under one of the federal assistance categories: the aged, the blind, the disabled, Aid to Families with Dependent Children. In addition, a state may provide specified additional services, and it may broaden the class of eligible recipients to include those who are "medically needy." These are persons with income sufficient to meet daily needs but not medical expenses, and who would qualify for categorical assistance, but for the income requirement.

To provide these services to the required and optional classifications of recipients, federal financial support is available in inverse proportion to the per capita income

of the state. The federal share varies between 50 and 83 per cent of the total cost of providing these services and is determined by the state's per capita income. The highest federal matching funds go to the states with the lowest per capita income. Federal Medicaid money is also available to pay the administrative costs, but not the cost of services of state medical care programs for the medically needy who do not qualify for categorical relief, whether or not they meet the income requirements.<sup>31</sup>

Even this limited effort to transcend the boundaries of welfare assistance categories has in many ways been illusory. No attempt was made in the legislation to restructure the medical care system. Instead, new federal money poured into the system. The costs of medical services began to climb at an unprecedented rate. And the states, already in difficult financial straits, were hard pressed to supply their share of Medicaid funding. The result was great pressure on the states to provide only the minimum mandatory services to the most limited class of recipients. Of the 52 jurisdictions (48 states plus Guam, the Virgin Islands, the District of Columbia, and Puerto Rico) that have a Medicaid program, only 28 have extended coverage to groups other than those in the mandatory categories of recipients. In addition, few states have considered themselves able to provide many of the optional services.<sup>32</sup> Many states even those with programs for mandatory recipients only have met increasing difficulty in financing their share of costs, and have retrenched by cutting services or the eligibility of groups previously eligible for service.<sup>33</sup>

So, the enormous federal investment in Medicaid has provided little medical care that had not been provided previously by state welfare programs. The major difference is that the federal government has now assumed a large part of the burden of paying for those programs.

Moreover, the adoption of the welfare system as a vehicle for delivering medical services to the poor foredoomed a major goal of the Medicaid legislation: to bring the poor into the medical care system on an equal footing with everyone else. For the poor, welfare programs mean hassles with eligibility requirements and demeaning means tests, and the Medicaid program has proved no exception. Often these bureaucratic niceties militate against health care. In Chicago, for instance, eligibility for Medicaid cannot be determined until medical services are actually sought. This policy may serve to deter a would-be recipient from seeking health care if he knows he cannot pay for the care himself and is unsure whether he will be eligible for Medicaid.

In Southern California, where migrant income is erratic at best, the Citizens Board was told of a case where the county welfare department had cancelled a migrant family's Medi-Cal card because the husband was

earning \$120 a week. As in most states, Medi-Cal, the California version of Medicaid, determines eligibility on a monthly rather than on a yearly basis. A single month of earnings higher than the allotted income cancels eligibility until earnings again drop below the cut-off level. Because the family's card had been cancelled, the wife was worried about how she would pay for the delivery of her baby, expected in less than a month. She was told by an official to appeal, but an appeal normally takes 105 days. As one observer put it, "Family planning in Tulare County, California, means getting pregnant during July so that the baby will be due when there are no cherries to pick and thus no income to endanger Medicaid eligibility."

Beyond bureaucratic obstacles the inevitable stigma of welfare medicine affects the dignity of the program's beneficiaries and sometimes the quality of care they receive.

**"As part of the American welfare tradition subject to social stigma, general unpopularity, grudging public support and inadequate financing among competing public services, Medicaid has suffered the worst of the ills that befall our health care system. In addition to falling prey to the same current inflationary forces that plague the rest of American health care, in some instances Medicaid has been forced to pay less-than-adequate prices for frequently less-than-adequate services—to go hat-in-hand on behalf of its beneficiaries."—Report of Task Force on Medicaid and Related Programs<sup>34</sup>**

The Task Force on Medicaid and Related Programs appointed by the Secretary of Health, Education and Welfare to examine the Medicaid program estimated that "only about one-third of the 30 to 40 million indigent and medically indigent who could potentially be covered [by Medicaid] will, in fact, receive services," and that "the cost of covering less than one-third has exceeded earlier estimates of the cost of covering the whole medically deprived population. . . ."<sup>35</sup> This failure relates strongly to governmental deficiencies in the administration of the program: limitation of coverage and benefits, ill-designed enforcement of eligibility requirements, failures in the dissemination of information about the program in the poor communities. The variation in the extent of these deficiencies among the states has produced its own inequity: "State-by-state variations in coverage, benefits and eligibility requirements have produced an inequitable distribution of federal resources among needy people."<sup>36</sup> But again, an overriding factor in the failure of Medicaid has been the delegation of ultimate responsibility to health institutions, doctors and hospitals, without governmental regulation:

In Portland, Oregon, a survey sponsored by the medical society found that only 37 per cent of local doctors would see Medicaid patients. Even among those doctors

willing to participate in the program, some set limits on the number of such patients they would see.

The county welfare director, who has responsibility for the program in the Portland area, commented: "There is a growing problem for welfare [Medicaid] recipients to get doctors' services. It's not discrimination, but doctors don't like to operate under the welfare regulations and fee schedules. If a doctor's office is in a poor community, it is flooded so he likes to limit the number he will see."

In the District of Columbia, Medicaid patients have difficulty gaining inpatient admittance to the city's voluntary hospitals and are forced to rely on the over-worked and inadequate facilities of the city's public hospital, D. C. General.

Willingness to participate in Medicaid may be qualified in other ways. The Task Force on Medicaid and Related Programs made the following finding: "We have concrete evidence that, in most instances, providers not only are reluctant, but also are unwilling to provide services when eligibility is uncertain, or where application for eligibility has not been made; thus early care is often not given."<sup>37</sup>

This ultimate reliance on physicians, hospitals, and on the existing health care delivery system may indeed be the crux of the difficulty of Medicaid and Medicare. If the market for health care services were responsive, one that would accurately reflect social priorities and allocate resources accordingly, then it might make more sense simply to pour government money into the health system. But the market for health services does not operate this way. In the medical market, supply often creates its own demand; unnecessary services often receive priority, while the announced goal of adequate health care for all, goes unfulfilled. Merely to pump additional amounts of money into such a system, either through an insurance mechanism, Medicare or a welfare scheme, Medicaid, is a basic abdication of government's social responsibility. A program that simply reimburses for services allows the providers to determine which services should be rendered and for whom. It delegates the power to providers to allocate federal money.<sup>38</sup>

One implication of programs that merely provide government financing for existing services and institutions, has become quite apparent: intolerable inflation must be borne by all consumers, in or out of the Medicaid and Medicare programs. In the 10 years between 1956 and 1965, physician fees rose at an average annual rate of about 3 per cent. In the three years immediately following the passage of the Medicaid and Medicare programs, the average annual rate more than doubled.<sup>39</sup> The initial actuarial estimates for the Medicare program assumed daily hospital costs would increase at a rate of 5.7 per cent annually until 1970,

### Indexes of Medical Care Prices: 1950 to 1968

(1957-59=100. Prior to 1965, excludes Alaska and Hawaii. These indexes are components of the consumer price index.)

Year	Total Medical Care	Drugs & Prescriptions	Physicians' Fees	PROFESSIONAL SERVICES				
				Obstetrical Case	Tonsillectomy & Adenoidectomy	Dentist Fees	Optometric Examination & Eyeglasses	Hospital Daily Service Charge
1950	73.4	36.6	76.0	67.7	81.5	81.5	89.5	57.8
1955	88.6	92.7	90.0	90.8	92.7	93.1	93.8	83.0
1960	108.1	102.3	106.0	105.0	107.9	104.7	103.7	112.7
1965	112.3	98.1	121.5	117.8	112.2	117.6	113.0	153.3
1966	127.7	98.4	128.5	123.0	127.5	121.4	116.1	168.0
1967	136.7	97.9	137.6	132.3	134.3	127.5	121.8	200.1
1968	145.0	98.1	145.3	139.2	140.9	134.5	125.7	226.6

Source: Department of Labor, Bureau of Labor Statistics: *Price Indexes for Selected Items and Groups, Annual Average.*

with the annual increase declining to a stable level of 3.5 per cent by 1965, but the actual rate of increase was 12.3 per cent in 1967, with estimates in late 1969 predicting a 15 per cent increase in 1969, a 14 per cent increase in 1970, 13 per cent in 1971 and then declining increases until a stable annual increase of 4 per cent is reached in 1977.<sup>40</sup>

The dramatic rise in medical care prices paralleling the implementation of Medicare and Medicaid is well established by the table above.

These figures should be compared with the increase in the Consumer Price Index for the same period:

Consumer Price Index* 1950-1968				
Year	Index (All Items)	Food	Housing	Medical Care
1950	83.8	85.8	79.0	73.4
1955	93.3	94.0	89.7	88.6
1960	103.1	101.4	103.8	108.1
1965	109.9	108.8	108.5	112.3
1966	113.1	114.2	111.1	127.7
1967	116.3	115.2	114.3	136.7
1968	121.2	119.3	119.1	145.0

\*1957-59=100

Source: Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Medicare and Medicaid have been victimized by the inflationary spiral to which they contributed. In the hospital insurance portion (part A) of the Medicare program rising medical prices, more persons served and increased utilization of services will increase the cost of the program to \$5 billion in fiscal 1970—\$473 million more than in 1969. The voluntary supplementary medical insurance portion of the Medicare program (part B) will cost \$1.8 billion in 1970. The chart on page 39 illustrates both the growth pattern of the Medicare program and the increase in cost.<sup>41</sup>

The cost of Medicaid is expected to rise from \$4.6 billion in 1969 to \$5.1 billion in 1970 and an estimated \$5.5 billion in 1971. The federal share of these payments will increase from \$2.4 billion in 1969 to \$2.86 billion in 1971.<sup>42</sup>

The financial pressure on the programs has been exacerbated by specific abuses made possible by the provider-oriented administrative scheme, particularly under the Medicare program. Perhaps the most flagrant abuse can be seen in payments to physicians under part B of Medicare. The statute provides that payments to physicians should be made on the basis of a "reasonable charge." In determining the reasonable charge "there shall be taken into consideration the customary charges for similar services . . . as well as the prevailing charges in the locality for similar services."<sup>43</sup> These criteria leave the physicians in any given area largely in control of the size of the payments they receive from the government for performing services under a government program—a novel kind of arrangement even for a government jaded by the experience of cost-plus defense contracts.<sup>44</sup>

The statute also provides that "such charge will be reasonable and not higher than the charge applicable for a comparable service and under comparable circumstance, to the policy holders and subscribers of the carrier . . ." This added requirement would not seem unduly restrictive in the light of the fact that most carriers are Blue Shield plans, dominated by physicians' organizations, and other carriers, the commercial insurance companies, rarely if ever attempt to interfere with the level of fees set by physicians. Yet there has been abuse of these liberal provisions.<sup>45</sup>

Under Medicare's liberal cost reimbursement formula, a provision for bad debt write-offs and rapid depreciation allowances has led to a number of other abuses, some of which have had serious implications for the nature of health care in many areas of the country. Senator John Williams of Delaware made the following comments in 1969:

"Since Medicare started, there has been a remarkable increase in the number of chains entering the for-profit hospital and nursing home field. These groups, whose stocks have soared to unbelievable price-earnings ratios, are obviously lured by Medicare's generous reimbursement. The 1½ per cent bonus paid on top of reimbursable costs, the prospect of getting accelerated depreciation allowances and then selling a facility at an inflated price, the fact that Medicare will pick up all of the costs of a 100-bed facility even if its total patient load consists of just five Medicare beneficiaries, the fact that there is no effective review of the utilization of beds and services in these facilities, and the fact that the nursing home or hospital can choose the government agent who will determine how much it is to be paid have certainly encouraged the get-rich-quick operations.

"Furthermore, if a chain owns an extended-care facility as well as a hospital, it can see that patients go from its hospital to its nursing home. A chain may also own pharmacies or sell hospital supplies to a ready-made captive market in its hospitals and nursing homes at high non-competitive prices. Chains actively solicit and sell stock to local doctors who thereafter are inescapably subject to conflict of interest any time they place patients in and order services in medical facilities in which they have an ownership interest."<sup>46</sup>

Medicare Costs and Patterns of Utilization					
	1967	1968	1969	1970	1971
<b>a. Hospitals</b>					
Admissions (in thousands)	4,967	5,655	5,918	6,233	6,529
Admissions per 1,000 covered aged	263	291	296	313	323
Benefit payments (in millions of dollars)	\$2,200	\$3,300	\$4,220	\$4,726	\$5,752
<b>b. Extended-Care Facilities</b>					
Admissions (in thousands)	198.6 <sup>1</sup>	448.5	507.6	567.0	622.0
Admissions per 1,000 covered aged	10.5	23.0	25.0	28.5	30.6
Admission as a per cent of hospital admissions	4.0 <sup>1</sup>	7.9	8.6	9.1	9.5
Benefit payment (in millions of dollars)	\$94 <sup>1</sup>	\$330	\$390	\$448	\$512
<b>c. Physicians Services</b>					
Individuals meeting deductible (in thousands)	6,900	8,810	8,990	9,320	9,660
Benefit payments (in millions of dollars)	\$481	\$1,142	\$1,500	\$1,789	\$1,855

<sup>1</sup>Half-year experience only, since benefits began January 1, 1967

When efforts are made to manage the costs of the programs, they are generally at the expense of the consumer, the line of least resistance. The premium for Medicare part B coverage in 1966, was \$3 a month. It was raised to \$4 a month in 1968, and by July 1, 1970, it was up to \$5.30 and probably will increase another 7 to 12 per cent in 1971. Medicare part A employs deductibles and coinsurance (20 per cent is paid by the consumer) features to keep costs down. Since 1966, the amount of the deductible has increased from \$40 to \$44 and most recently to \$52.<sup>47</sup> In addition, many medical services of particular importance to the elderly are excluded from coverage under Medicare: routine physical examination, out-of-hospital drugs, eye examinations for fitting or prescription of eyeglasses, hearing examinations for fitting or prescription of hearing aids, and dentures. As a result of excluding all these devices in the name of controlling costs, "... Medicare in 1969 covered slightly less than half of the health-care expenditures of the aged."<sup>48</sup>

Under Medicaid, controlling costs has meant cutting back on services or tightening eligibility requirements, methods of cost control directly in conflict with the program's objective, which was to assure "the availability and financing of comprehensive health care to all the nation's poor and near poor."<sup>49</sup> In its report, the Task Force on Medicaid and Related Programs concluded: "The promise of Medicaid, that some care at least would be available to all who needed it, has vanished into the obscurity of state determinations of eligibility and the limitations of state resources and priorities."<sup>50</sup>

The promise of Medicare and Medicaid could not be fulfilled because the health care delivery system was not prepared to do so. The response thus far has been to adjust the promise instead of reform the system.

## Comprehensive health planning "without interference with existing patterns of professional practice."

"The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that federal financial assistance must be directed

to support the marshalling of all health resources—national, state and local—to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry and related healing arts.”

So reads the purpose of the much heralded Comprehensive Health Planning and Public Health Services Act passed by Congress in 1966. Though it receives some of the smallest federal outlays in the health field—\$156 million in 1970, as compared to the federal share of Medicaid estimated at \$3 billion in 1970, or the \$323 million spent under Hill-Burton<sup>51</sup> it has been viewed as the crucial way of reorienting the whole health care delivery system. Particularly since it requires the states to plan with respect to the entire health services system to receive funds, and the states and the federal government to work in tandem to determine health priorities.

The act was designed to overcome serious shortcomings of categorical grants. These were identified as “fragmentation both in health programs and health organizations, gaps in health service coverage, lack of coordination in health planning and services at the state and local levels, undue rigidity in the categorical financing of federally assisted health programs and inability to use efficiently scarce professional health personnel.”<sup>52</sup> As a result, a large number of separate agencies would report

to the governor on a state level, while on the national level, neither the private nor the public sector were doing any effective planning.

Traditionally, federal monies were distributed in states and localities either through project grants (used primarily for experimentation or demonstration) or formula grants (used for on-going programs). The Comprehensive Health Planning Act consolidated the categorical grants, nine of which were distributed to the states on a formula basis, and replaced them under the act with a single block grant, which the states could spend as they thought best, in conformity with their state plan. Originally, there also were seven project grants, used for special problems or in limited geographic areas. These project grants have been retained under the act, but in a more precarious fashion, which will be discussed later.

To understand the significance of the original intent of the legislation, it is important to look at the changing role of public health, not only nationally, where the U.S. Public Health Service was recently totally reorganized, but on the local level. Clemens Gaines, former Assistant Commissioner of Health in Maryland, described the changing emphasis in that state: “Maryland is undergoing major reorganization—there hasn't been one since the 30's. The functions of government at that time weren't the same as today. Health responsibilities were



principally aimed at controlling epidemics and maintaining warehouses for the insane. Government did not attempt to intervene in the normal course of economic and social events."<sup>53</sup>

Nationally, the Social Security Act in 1936 established a federal-state partnership in public health that basically provided some funds to the states for basic programs in environmental services, communicable disease control and limited maternal and child health services. But as the population increased and became more urban, and problems grew and became more complex—the categories increased and overlapped.

The categorical grants paid for a large part of the state's health costs in the particular program categories for which they were available. But even some of the poorer states were hard pressed to match them.<sup>54</sup> Because so many of the programs were new to the states, they were required to draw up state plans to make sure that they used the federal grant for the authorized purpose and allowed for sufficient state expenditures to match the federal money. Because the emphasis was on having a state plan that dealt with categories rather than looking at a state's total needs, the federal grant system actually inhibited comprehensive planning. Furthermore, the federal government constantly required that states try something new. One year they were instructed not to use less than 10 per cent, preferably 20

per cent on something innovative—which forced some to either discontinue services or absorb the cost.<sup>55</sup>

As a result, the categorical approach was increasingly seen by both the states and the federal government as inefficient and unresponsive. The states viewed the rigid restrictions on grant categories as obstacles to their real needs. As one New Jersey health official put it, "We had a heart program, whether we needed it or not, because that's where the federal dollar was."<sup>56</sup> From the federal government's point of view, it was increasingly difficult to determine what a state's individual necessities were, and how best to allocate federal funds. Thus, in response to the new act, PL. 89-749 not only abolished categorical grants and substituted "flexible money" in the form of block grants to the states, but it also included requirements not only for statewide, but also for areawide planning.

The act is divided into five parts: Section 314(a) which added a totally new program of comprehensive statewide health planning by providing formula grants to the states; 314(b) which expanded areawide comprehensive health planning through project grants; 314(c) which was a new program providing project grants for training, studies and demonstrations in health planning; 314(d) which gave formula grants to states, without categorical restriction, for health services; and 314(e) which replaced seven separate project grant programs



with a single project grant program to cover certain health problems in a limited geographic area, such as hookworm in the South, or a special group of people, such as migrants, who are not just a single state's concern; and to stimulate and support innovative programs for a three year period.

Though far-reaching in intent and language, the four-year-old program has been unable to fulfill its designers' broad vision. Criticism ranges from the "act has no teeth to enforce its ideas," to "comprehensive planning has degenerated into planning for planning." Specifically, there are important criticisms which go right to the heart of how to improve the health care delivery system, and what the federal role should be.

Perhaps the most basic problem lies in the preamble of the act which encourages the federal government and states to cooperate with private groups, but expressly does not permit interfering "with existing patterns of private, professional practice of medicine, dentistry, and related healing arts." As we have seen, the private sector controls the bulk of health services, operating 5,820 of the 7,131 hospitals,<sup>57</sup> 1,150 insurance firms, each offering a variety of coverage under 50 different state commissions<sup>58</sup> (excluding 74 separate Blue Shield and 80 Blue Cross programs),<sup>59</sup> and numerous nursing homes and other facilities, with little, if any, external regulation (unless they come under federal Medicare or varying state Medicaid regulations). Thus, unless one can bring about a reorganization and redistribution of resources in the private as well as the public sector, comprehensive health planning becomes a meaningless concept.

Several states reported difficulty getting under way in their comprehensive health planning, and a few explained why. Theodore Ervin, Associate Director of the Michigan Department of Health, put it this way:

The federal government is giving us a mandate to coordinate at the state level, but it isn't doing it at the federal level. Look at Medicaid and OEO and several others—there's not a structured relationship between them and comprehensive health planning. Second, there appears to have been an effort by the federal government to move the planning from the established health agencies to the planners in governors' offices around the country. Third, there was no specificity in the act about how groups should work together. Each program is still a separate categorical program. How likely is Medicaid to go over to the state comprehensive agency and say, 'Here, plan our program.'<sup>60</sup>

It is clear that the era of the categorical programs still persists. Since the bill was passed in 1966, each time it has been amended, another categorical program has been added. There are now six, including alcoholism, drug addiction and migrants. Recently, a seventh passed Congress dealing with communicable diseases. With each

separate proliferation, the block grant is compromised as is any meaningful state plan.

An important part of the design of the state plan is the requirement under 314(a) that a state health planning council be established to advise the official state planning agency. A critical sentence is that a majority of the council members must be consumers of health services. In some areas, such as Maryland, this seems to have worked well since the bulk of its 34-member advisory council really is a cross section of the consuming public—as opposed to industrialists, bankers and others who have little difficulty in obtaining the services they need.<sup>61</sup>

Many states were so delighted with the flexibility of the block grants they did not immediately realize they represented a cut-back in federal funding, particularly in the project grant or "e" money (314e). Because the "e" money was now regarded primarily as experimental and of short duration, there was no on-going support for state programs like tuberculosis that had been absorbed. The design of the legislation meant that tuberculosis should be shifted to "d" or on-going programs but this grant was inadequate and not distributed among the states in the same amounts as the projects they replaced.

With the expansion in the uses federal funds could be put to, the following things occurred according to HEW grant expert Robert Nash:

"The federal grant became a very small percentage of the total expenditure for which it could be used (now about 3 per cent). Second, the plan became a useless and meaningless document to both the states and the federal government, because each state at its option has to select from all its programs a tiny portion to be identified as the 'federally supported and required matching program.' This is all the plan relates to and it is usually selected for accounting convenience.

"When the hodgepodge of pieces of all kinds of programs reflected in all the state plans are compiled at the national level, they add up to no meaningful entity.

"The statutory provision for a federal share between 1/3 and 2/3 becomes a delusion. For example, to get the true picture of the federal grant impact in a state with a federal share of 50 per cent, one must realize that what we are really talking about is 50 per cent of perhaps 6 per cent of the state's eligible program.<sup>62</sup>

What seems to irritate state health planners more than the small amount of federal money they receive, is the host of requirements that accompany it. They often seem unreasonable and expensive to enforce. There is a basic auditing predisposition to be able to "trace exactly where the federal dollar went." In some states this has resulted in the federal government wanting to support the "flashier," high impact programs, rather than mundane, but necessary parts of a health program. As one

official put it, "It's a lot easier to sell a rubella immunization program to an appropriating body than to get money for a big office building which stores health records."

This focus on tracing the federal dollar once again fractionalizes the total health picture of a state, for it means that a state has to artificially pick part of one program (the federal amount is generally so small that it only pays for part) to demonstrate where the money is going, rather than looking at the whole picture, and pooling the funds in a common endeavor and then splitting the whole bill. The absurdity of this perspective was dramatized by a New York State health official, who said, only half ironically, "I suggested to the commissioner of health that he use the federal money to buy paper clips. In New York, it would just about cover that."

There are many federal requirements that a state must meet before it receives any of the "d" or action money. The states object to these requirements on two counts: first they feel that requirements should be part of the initial planning process, and if there are any problems, they should be ironed out in the beginning, not when the programs are getting underway. Second, they feel that since the federal share is so small—Michigan receives \$2.7 million under the act, of which only \$476,000 is distributed to local health departments—the additional cost of meeting the requirements is almost too much to bear.<sup>63</sup>

Third, currently there is a statutory provision that

forbids the states to decrease their efforts where federal money is spent. The result is often that a state undergoing a general budget paring is forced to arbitrarily shift federal funds to some activity that isn't cut back, again only a bookkeeping transaction. This kind of requirement, while useful in intent, so that a state would not simply rely on federal funds (though this is difficult to imagine since they are so small), turns out to be simply another obstacle to meaningful delivery of health care.

One of the most recent federal requirements that does relate to the planning process says that in order for a "b" or regional planning agency to get federal funds it must implement the federal merit system on the local level. In theory, this is a good idea, the kind of standard the federal government might appropriately enforce. But in reality, it means that Michigan, for instance, which meets most requirements nonetheless would have to set up an extensive enforcement system, to conform to federal regulations for its 83 counties and is provided no money to do so. And even more significant, perhaps, is that the other agencies dealing with health, such as OEO, that often receive more funds, do not have to meet the same standards. "We're being asked to spend money to get money on a differential basis," Theodore Ervin commented.<sup>64</sup> Similarly, California has spent \$274,000 to set up the necessary paperwork to meet the federal government merit system requirement and some feel that the end result is to put them at a disadvantage in competing for employees with other federally assisted programs.



In 1968, the law was amended with respect to the 314(d) allotment, requiring that the states spend "at least 70 per centum of such amount reserved for mental health services and at least 70 per centum of the remainder of a state's allotment under this subsection only for the provision of services in communities in the state." This necessity of funneling 70 per cent of the funds into direct community services becomes an unenforceable standard. In Michigan, for example, where the state and local health budgets are \$80 million annually and the federal government contributes \$2.7 million, there's great flexibility in how the state uses that money. If it were a larger amount, Ervin feels, such as \$10 or \$25 million, such a requirement would have greater impact.

The issue of standards is an important one. Though the federal government has imposed priorities and established such standards as the merit system, the 70-percent requirement and the reporting requirement, the whole process is voluntary and vague. The reporting requirement says that a "state agency will make such reports in such form and containing such information as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General finds necessary to assure the correctness and verification of such reports." Though the federal government loosely requires this reporting device, it is not an effective way to justify appropriations. It was the states, in fact, that finally took the initiative in developing a uniform reporting system on the block grants. They decided through the

Association of State and Territorial Health Officials that they needed to know how their money was being spent, for what, and how effective that was. This 50-state study is funded by a federal contract, but the idea came from the states.

The voluntary nature of the whole act is one reason why many feel that there has been so much emphasis on "getting people together to talk." There is no real clout to act. One of the people who feels this way is Andrew Braun, who heads the metropolitan Washington Council of Government's health division. Said Braun:

"Even if a state does an effective plan, there are no teeth under the present legislation. This is not true in New York State, however, where the state is divided into 13 health planning districts. Each has an areawide planning agency responsible to the state, and the state must OK a facility building, expansion and modernization. California has a law somewhat like this, but not as powerful; the same with Minnesota, and Maryland's General Assembly recently passed a law expanding the licensing of new hospitals and new institutions (though they excluded nursing homes) to conform to the comprehensive plan."<sup>6</sup>

There is a major problem in terms of the project grants under section 314(e). Originally, they were seen as short-term, experimental grants which would allow a state to try new things, and eventually blend the successful into on-going programs, or the "d" section. But no mechanism was established to blend the programs



together, and the "e" money, which was supposed to be small, has grown to almost the same amount as "d" money, which is responsible for supporting the major health programs in a state (under comprehensive health planning).

The "e" money has a life span of three years and is then cut off. Consequently, the cost of maintaining services initiated by these grants falls entirely on the states and communities. Because the "d" grant is not correspondingly increased, the states' share of supporting their whole program increases and thus the amount the federal government contributes diminishes. As a result, state legislatures, such as Florida's, have scrutinized "e" money carefully, and many with tight budgets are increasingly unwilling to take on such innovative programs because of the burden in maintaining them. Nationally, \$18 million was shifted from "e" to "d" funds this year, in an effort to shift support of tuberculosis services from project grants to the formula grant. This promises some traumatic results because the \$18 million is distributed among the states without consideration of varying tuberculosis problems among the states.

The assumption is that the states that lose in this shift will pick up the tab. The impact of this may be great. One of the important ideas of the act was to try new programs, and ultimately incorporate them into the comprehensive needs of a state. This increasingly may become a fiscal impossibility. Furthermore, the cutback in "e" funds only exacerbates the general cutback that occurred when comprehensive health planning was substituted for categorical grants.

For many, the whole concept of partnership in the act has become questionable. What kind of partnership is it that exempts the private sector from the impact of comprehensive health planning? What kind of partnership is it when the federal government imposes stiff requirements on a state and does little else in setting goals, watchdogging the standards it sets or providing meaningful amounts of money? How comprehensive is "comprehensive health planning of services" when it neither includes nor is coordinated with bigger money-getters, the Veterans Administration, OEO, regional medical programs, HUD and so on? Even though the states and federal government were supposed to be deciding together the health priorities, they are essentially still set by the federal government. Model Cities, for example, is a high priority for the little "d" money there is. In a bright yellow "Operational Planning Systems Handbook" distributed by HEW last spring, the attitude of the program is partly expressed in the footnote describing how regional priorities should be developed. Regional priorities are developed only by the regional director, though he "should seek inputs from all pertinent regional office personnel as well as state and local officials." However, as the footnote reads:

"No formal mechanism has yet been devised for involving state and local officials in any phase of the operational planning process; yet our ability to achieve many objectives will depend upon them. We hope in the future to be able to provide for more formal state and local involvement."<sup>66</sup>

Though the program has been in operation for only four years, and one can allow for "bugs" in any new system, particularly one that promises as much as this does, it still seems that the flaws may be fundamental. One of the original pioneers in comprehensive health planning said that what was needed was for the federal government

"... to identify services which constituted a minimum below which no one would fall—in terms of every aspect of health. Comprehensive planning would then show you how to reach that goal. The federal government would pay a certain percentage—ranging perhaps from 20 to 50 per cent (maybe more for the poorer states) of whatever the state spent. By removing fear of cutback in federal appropriations, the states would design plans, governed by national standards, but within which they would determine their priorities."<sup>67</sup>

This need for a strong leadership from above, with the powers to enforce the federal requirements both on the state governments as well as the private sector, would seem fundamental.

In addition, many think that a national forum or council of health advisors located in the White House to formulate general health goals, though still allowing states flexibility, would be useful.

In terms of the federal fiscal commitment, advocates for change believe that the federal commitment to a state should be tied to a state's total efforts rather than to a slender slice of its budget. They feel a need for a financial mechanism so that when "e" money is terminated, the cost of continuing the services should be shared in a federal-state partnership, with the sharing of costs based on services rather than on an unpredictable annual allotment of dollars.

Hill-Burton, Medicare and Medicaid, and Comprehensive Health Planning all represent major federal inputs into the health care delivery system—and they are only examples. The Office of Health and Scientific Affairs in the Department of Health, Education and Welfare had a budget of \$2,810,000,000 in fiscal year 1969 and some 45,967 employees involved in its programs.<sup>68</sup>

The extent of this financing would seem to give the federal government some hard leverage. With it federal officials could help create new public policy to redress the imbalance of health resources, promote new forms of health care delivery and lessen the provider domination of our health care system—but instead, the federal government continues to put money into a system with which, to a very large degree, it does not "interfere."



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# Chapter IV

## From Co-ops to Free Clinics: Attempts to Change the System

Though we have seen that providers dominate the health care delivery system, as early as the turn of the century, small groups of consumers banded together to try to shape medical care to their particular needs. Many of these groups succeeded in providing services in limited geographical areas or, like the labor movement, for its own "family." None, however, was directed at or was able to make fundamental changes in the delivery system.

These early groups were particularly active in the 1920's and 1930's and their vision of health care then is still the vision of today. They dreamed of a health care system where the consumer would play a key role in determining needs; where high quality, comprehensive care (which meant coordinating all medical and preventive services, among the family doctor, specialists and hospital) was delivered with a sense of humanity. They wanted no limits either on the amount of care or eligibility to receive it.

In contrast to circumstances where only those who could afford care received it, reformers wanted everyone to be treated by payment of a small premium to cover costs. By the 1930's, the idea of prepayment took hold both because of increasing medical costs and because security-conscious people in those Depression years were painfully aware that a sudden accident or illness could financially destroy them. Prepayment assured hospitals an operating income and encouraged patients to seek preventive care, rather than to think simply in terms of coverage for the expenses of illness.

Finally, these groups regarded the doctor differently, realizing that small-town practitioners who were on call 24 hours a day, seven days a week, with no respite, time for their families, or continuing education, would be-

come "burnt out" over the years. By the same token, by eliminating "fee-for-service," with its emphasis on a business relationship, and guaranteeing a stated income, the plans offered the doctor financial security and an opportunity to concentrate on a medical relationship.

These ideas were first embodied in the medical cooperatives of the Midwest, where farmers' co-ops had thrived for many years. The first medical cooperative began in the small Oklahoma town of Elk City in 1929. Its vigorous and courageous designer, Dr. Michael Shadid, told the farming community of 6,000 people that they could get high-quality, low-cost medical care if they pooled their resources and built a community hospital. Impressed with the idea, farmers bought shares at \$50 each, hired the first specialists for the area and received medical care on a discount basis.<sup>1</sup>

Almost immediately, however, the harassment that cooperatives and other consumer-sponsored efforts always encounter began. In Elk City, it lasted a good 20 years. The county and state medical societies dropped Dr. Shadid from their rosters (thus leaving him to find his own insurance in the event of a malpractice suit), threatened to get his license revoked, spread rumors about the quality of the hospital, and fought to keep out-of-town doctors from coming to work at the hospital. The local doctors not only refused to join the hospital, but they undermined it by establishing competing hospitals, which allegedly promised the same kind of discounted care.

The hospital was in trouble. Increased attacks lowered morale, aroused suspicion, even among loyal supporters, and memberships began to plummet. Dr. Shadid was forced to arrange a loan on his own life insurance to complete the building of the hospital. And as the De-

pression deepened, even discounted care became too expensive. So Shadid designed a prepayment scheme with dues low enough to wipe out the competition, an act that increased the number of members but, at the same time, inflamed the opposition. Individual care under this scheme cost \$12 a year for one person, \$18 for two, \$22 for three and a maximum of \$25 for four. Hospitalization rates were \$1 a day, with small charges for anesthetic and operating room fees. Services included examinations, treatment, operations, x-rays and teeth extractions.<sup>2</sup>

Despite the low charges, the idea was slow to catch on. But in the early 1930's, with adoption by the powerful Farmers Union, the hospital gained great support as well as protection from the continual harassment. Although the community hospital is no longer a cooperative (its administrators say it could not keep up with the costs and the competition from third-party insurance companies) its contribution to the early cooperative movement was great. It raised the standards of care, attracted the first specialists to the community and integrated clinic and hospital treatment. People in the community joined with the doctors in planning the services. Prepayment allowed people to receive many more services, particularly preventive, than they had before. The cooperative's impact was perhaps even greater outside of Elk City. Dr. Shadid personally stumped across the country describing Elk City's experiences and giving advice on how to set up cooperatives.

The cooperative movement spread throughout the country in the middle 30's, extending from the farm belts to the big cities. Largest and best known of the urban cooperatives was the Group Health Association of Washington, D.C. It was established in 1937 by the Home Owners Loan Corporation for its employees and their families, though later extended to all government employees. In its first year, it enrolled 10,000 persons, charging them monthly dues of \$2 for single people, \$3.30 for families, regardless of size. Dues entitled members to three weeks' hospitalization in a semi-private ward, medical and surgical care, eye examinations and outside consultations, when authorized by the medical director.

GHA is operated by a Board of Directors, chosen from its own membership, which provides for financing (both capital and operating income) and contracts with the medical staff (organized as group) for provision of services on a salary rather than on a fee-for-service basis. In recent years, the cooperative has become so large that most members neither attend meetings nor seem interested in policy decisions. Its size has made it necessary to set up clinics in suburban areas. However, the cooperative still lacks its own hospital and must refer patients to neighboring hospitals.<sup>3</sup>

Cooperatives traditionally have been attacked for

many reasons. The most common complaints against GHA in Washington are typical: there will not be enough money; there is no free choice of doctors; advertising and solicitations are unethical; salaried doctors have no incentive to practice good medicine; members profit from the labors of the doctors who serve them.<sup>4</sup>

Over the years both the ethics and legal organization of co-ops were challenged. The key issues were the right of people to organize for their own care and the right of physicians to make agreements other than on a fee-for-service basis. These issues were basically decided favorably for the co-ops in two long, arduous and dramatic lawsuits waged by the GHA in Washington and later by the Group Health Cooperative in Seattle.

In the GHA case, the U. S. Supreme Court upheld the verdicts of two lower courts, found the AMA and the Medical Society of the District of Columbia guilty of "restraint of trade" under the Sherman Antitrust Act, and ordered them to stop impeding GHA's progress. In the Seattle case, the Supreme Court of Washington ordered the King County Medical Society to stop boycotting the co-op.<sup>5</sup>

The Seattle co-op started 10 years after Group Health in Washington. Seattle was a city long dominated by industrial contract medicine, which was sufficient for workers and families of selected industries, but excluded many others. One of the major differences between the two urban cooperatives was that an existing group practice in Seattle, which owned its own hospital and pharmacy, welcomed the idea of the cooperative and ultimately sold its hospital to the cooperative. In addition, many loyal subscribers of this group practice helped the cooperative by joining its ranks.

The co-op idea in Seattle was sparked by Elk City's Dr. Shadid, who had come to the rural areas outside of Seattle where co-op stores were flourishing. Farmers in those suburban communities had for some time been interested in medical co-ops, but the idea caught on in the city. In a short time 400 families signed up pledging \$100 each for the establishment of a prepaid clinic. Aside from Dr. Shadid's initial advice, the community put the clinic together without the benefit of any expert reports or advice. As one of the Seattle pioneers put it, "We just saw what we wanted and then spent hours experimenting on what would work."

The Seattle cooperative now has a 171-bed hospital, with plans for an additional 300 beds, and three neighborhood centers scattered throughout the Puget Sound region. The medical staff consists of over 100 physicians representing all the basic specialties. Currently there are 113,000 people enrolled in the co-op (65,623 of whom are members). The membership cost is \$200 (\$100 capital investment, \$100 capital dues). This averages out to \$30 a month for a family of four. Care is comprehensive and includes most drugs.

The cooperative serves a geographical area divided into eight districts, each of which elects a representative. These eight elect three at-large members and all 11 constitute the board. The current makeup of the board is one architect, two professors, a representative of the League of Women Voters, two engineers, a lawyer, two businessmen, a journalist and a program analyst for the Navy. The board sets policy, studies all problems and runs the cooperative. In one sense, active involvement in this cooperative has lessened over the years. General business meetings are not well attended, though the election meetings still are. One-third of cooperative users are not members.<sup>6</sup>

Though the real impetus behind medical co-ops died after World War II, a few still survive in rural communities. One of the newest of the rural co-ops began last March in impoverished Lee County, Arkansas. It was a moment of great pride for 350 plantation farming families—most of whom are black, and earn in a good season \$500 a year—when the doors of their new Lee County Cooperative Clinic opened. For this area lacks the most basic services. There are large families—12 children is not uncommon—often with little to eat. The population consists predominantly of children under 18 and people over 45. As one clinic organizer put it, “Everyone else leaves as soon as they can.”

Some of the obstacles faced by the Lee County Cooperative were described in Chapter I. In addition, the only doctor serving the clinic, a VISTA volunteer, was told that in order to obtain admitting and laboratory privileges at the county hospital, he had to be elected to membership in the county medical society. He was denied that membership by a vote of three to one. Shortly after, the hospital refused his application for privileges, though it denied that its refusal was determined by the medical society vote. With no hospital privileges the doctor was limited in the services he could provide. For example, he had to send his laboratory work to his father, a pathologist in St. Louis. Also, he had to get his patients admitted to hospitals out of the county and, for many, this meant long trips.

Second, local doctors have continually tried to thwart the cooperative. A letter from the four doctors and the pharmacists in Marianna, the major town in the county, written on the county medical society stationery, to Arkansas Senator John McClellan, indicates the opposition's spirit:

“We have been invaded by a group called ‘Vista’ which is composed of seven workers of which one is a medical doctor . . . .

“[T]his group attended the Negro churches urging them to fight for what is theirs, another group was told of government funds to be had but that they would have to fight to get them . . . .

“As physicians, pharmacists and taxpayers we feel no

need for such a program in our county and find this very appalling to many. . . .”

Although the practitioners have opposed the clinic, the county health department has cooperated, assisting in inoculations and drug distribution. And despite all the opposition the clinic is functioning. In addition to the doctor (another VISTA was hired in July), three VISTA nurses and one VISTA lab technician, there are four newly trained community aides who handle everything from teaching nutrition to making visits to outlying areas. The community originally raised \$2,000 among themselves, which OEO supplemented by an eight-month planning grant of \$39,875. They were promised an additional \$134,000 for September, 1970, which, at this writing, had not yet materialized.<sup>7</sup>

The community makes all the decisions about the clinic through the board of directors, elected by five neighborhood action councils scattered throughout the county. These nine board members—two farmers, one welfare mother, a housekeeper, a cook, a worker in a United Auto Workers plant, a retired woman, a minister who is a part-time carpenter, and a department store clerk—decide who should be hired and fired, and how the funds should be managed. In addition, they decide the chief health needs of the community. In recent months, they have asked for transportation; so a van was bought—which will be fine in good weather—but they hope to get a jeep for the rainy season when the dirt roads are flooded. They have asked for more intensive training of the community aides who, along with the laboratory technicians, receive training from St. Jude Children's Research Hospital in Memphis 60 miles away.

An important part of the clinic is to spread health care into the outlying areas. Moving in this direction, in the fall of 1970 the clinic opened a health station in Haynestown, a town of 100 people that serves a larger community of 1,200, offering screening, inoculations, well-baby care and basic follow-up. As Ollie Neal, the clinic's administrator, put it: “We tell people when you're dealing with hurting Haynestown isn't your place, it's for prevention.” The well-baby care in the health station is delivered by a nurse practitioner who travels 180 miles once a week from the Tufts University-Mount Bayou Neighborhood Health Center in Mount Bayou, Mississippi.

The clinic needs more nurses and there is also a tremendous need for follow-up care, especially so since many of the patients (2,300 have been served between March, 1969, and October, 1970) are elderly, and there is only one 62-year-old public health nurse for the entire county of 20,000 persons.

For many people the clinic has become a rallying point from which to look at their whole community to see what can be done. As Ollie Neal said: “Not just

today, but in the future." As a result, people have asked not only for acute care but also for vitamins for young children, a well-baby clinic and training in health education. Ultimately they hope to develop a prepaid group practice operating on a sliding fee scale.

**LABOR INVOLVEMENT.** During the Second World War, health care became a major focus of the labor unions. At that time, the War Labor Board set rigid wage controls and the search for non-wage remuneration led to the growth of collective bargaining for fringe benefits. The climate also was ripe for union demands because of post-war business prosperity. Excess profit taxes and tax exemptions for health and welfare contributions reduced the cost of insurance and pension programs.<sup>8</sup> Despite extensive collective bargaining, the unions found that they could not go as far as they liked. Their members still could not afford medical care, and the unions could not offer as many services as they wanted to.

As a result, a number of unions tried different approaches to meet their medical care needs. Some developed their own direct service plans. Others, through groups like the California Council for Health Plan Alternatives, tried to make the collective voice of union members heard in all aspects of planning and organizing health care and dealing with the health industry.

Three direct service plans illustrate some of what labor has achieved where it has attempted to organize health services:

*The Labor Health Institute of St. Louis* is a prepaid group practice plan developed almost entirely by the members of Teamsters Union Local 683. Earning on an average of \$1.35 a month in 1945, the unskilled warehousemen were unable to make budgets cover medical and dental needs. Union President Harold Gibbons appointed a committee made up of members who, in turn, sought the advice of local physicians about what constituted good medical care and how they could develop a plan they could afford. They studied existing insurance plans and found them to be incomplete in coverage and lacking preventive care. Like the co-ops, they sought high-quality comprehensive care for the worker and his family with a preventive emphasis.

Funds came through a collectively bargained agreement that originally provided for an employer contribution of 3½ per cent of the gross pay of the employee. This was later renegotiated so that the employers paid 5 per cent and the contract covered families. In addition, the Institute carries its own hospital insurance (originally carried through Blue Cross) and has expanded coverage to include dental and psychiatric care.

It has its own clinic facilities and maintains a 400-unit retirement home open to the whole community. In addition, it operates a Health and Medical Camp, used as a recreation and convalescent center. With the exception of the medical director, all physicians are part-time and

paid on an hourly rate negotiated to represent the median of physicians' incomes in the community. The 27-member Board of Trustees is made up of union representatives, employers and the public. There is an independent Medical Conference Board of four physicians and one dentist who advise on professional matters.

One of the best known of the union health programs was that developed by the *United Mine Workers*. Geographically isolated, living in poor communities with inadequate facilities and with little education, the miners lived almost totally dependent upon the good will of the company. Almost every family experienced death or severe injury, and preventive care was almost unknown. As a result of the bitter mine strikes, which led to federal government take-over of the mines, a collective bargaining program emerged. This program provided for a royalty payment on each ton of coal into a health and welfare fund. Using this money, the Welfare Fund pushed for the development of new kinds of medical and rehabilitative programs for the miner and his family.

The original concept was to work with existing hospitals and doctors in a given area. But this proved to be a bad idea. A staff headed by Dr. Warren Draper soon found drastic differences between the care provided in approved hospitals with highly trained specialists and that provided by poorly trained doctors in the proprietary hospitals in smaller communities. Discrepancies in hospital admissions, bills, number of days in hospital and surgical procedures often were striking. But when Draper's staff revealed its findings, the medical societies questioned the validity of the data. A bitter battle ensued between the miners and the AMA in the coal-mining regions, and ended with the Welfare Fund dropping those physicians thought inadequate from its lists.

Searching for a new approach to health care, the fund took three major steps: it built a chain of 10 top quality hospitals in Kentucky, West Virginia and Virginia (although these hospitals have subsequently all been sold); it limited the approved panel of physicians; and it stimulated the formation of nine group practices in Pennsylvania, Ohio and West Virginia. Historically, the Welfare Fund had an enormous impact on upgrading and integrating health care for Appalachia and for setting standards for neighboring regions.

In Detroit, the United Auto Workers broke sharply with tradition when it established the *Community Health Association*, not only for union members but for the total community. It organized a prepaid comprehensive program with emphasis on high quality care, group practice coordinated by one's doctor, and the association of each medical group with a participating hospital to assure maximum continuity of care. In 1956, the association purchased Metropolitan Hospital and now also owns three centers in outlying areas. Physicians are salaried. Subscribers number well over 70,000.

Though CHA has opposed lay interference in medical matters, it has demanded that the consumer be heard in non-medical affairs. Like most plans of this type, CHA decided that its members should have a free choice between CHA and the alternative plans. CHA's Board of Directors broadly represents the community with members from management, labor, church, university and hospital institutions.

Recently, CHA, like other union plans, has been caught in a financial vise, wanting to deliver a broad range of services and not being able to afford to do so. Originally, CHA looked closely at the Kaiser plan but did not build in as many cost-saving incentives. Today, however, it is once again considering the Kaiser approach. Generally, unions are finding, as they once did with collective bargaining, that they cannot meet their members' expectations for health care with the funds at their disposal. They are now looking to the federal government to assume the burden of financing health care and are strong advocates of a national health insurance program that will provide the financial support for a broad range of health services.

### **“ . . . with efficiency, comes a shift in emphasis from crisis to preventive care.”**

Of all of the attempts to provide consumers with comprehensive health services through organized group practice combined with a prepayment scheme, the program that has probably had the greatest impact is that of the Kaiser Foundation.

The Kaiser program evolved out of an attempt to provide medical care to workers at geographically isolated construction sites during World War II. It was impossible to provide adequate medical care at these sites without actually bringing in the necessary staff and facilities. A prepayment scheme was arranged among several construction contractors and a group of private doctors to guarantee support and services. The arrangement was not for insurance in the traditional sense. The medical group derived its income from the regular payments made on behalf of subscribers and, in return, contracted to provide certain specified medical services. Unlike the private insurance programs of Blue Cross-Blue Shield, this plan discarded fee-for-service as the basic operating principle for health care delivery. It substituted a capitation scheme, giving a medical group an economic stake in keeping people healthy. The plan was a success, and after World War II, the Kaiser organization—one of the sponsoring contractors—decided to form a foundation to continue the arrangement on a permanent basis, with facilities open not only to Kaiser employees but to the general public.<sup>9</sup>

Since then, the so-called “Kaiser Plan” has flourished and there are today more than two million Kaiser subscribers, served by 21 medical centers (hospital and clinic), 28 clinics and 51 medical offices throughout California, Oregon, Washington, Hawaii, and in Cleveland and Denver.<sup>10</sup> More significant, the Kaiser program has been viewed by many health care reformers as a model for the future.<sup>11</sup>

The key to the Kaiser Plan is an attempt to reverse the incentives for wasteful or unnecessary use of medical services that attend other programs of health insurance. Deterrents to the inefficient use of resources are systematized, and with efficiency, proper organization and economic incentives, Kaiser adherents claim, comes a shift in emphasis from crisis to preventive care.<sup>12</sup>

The Kaiser Foundation Medical Care Program comprises three separate operating organizations: the Kaiser Foundation Health Plan, the Permanente Medical Groups and the Kaiser Foundation Hospitals.

1. *The Kaiser Foundation Health Plan* is a nonprofit corporation which contracts with membership groups and individuals to provide certain health care services for fixed monthly payments over a one-year contract period. With this income, the Health Plan contracts with the two other organizations of the Kaiser program for the provision of professional services, hospital facilities and services necessary to fulfill the contractual obligations to the membership.

2. In each region, the Health Plan contracts with an independent partnership of physicians—one of several partnerships constituting the *Permanente Medical Groups*—for the provision of medical services necessary to provide members with the benefits specified in their contracts. In exchange, the medical partnership receives from the Health Plan a per capita payment for each enrolled member. In addition, the partnership can earn a bonus if costs are kept below a specified level.

3. The Health Plan contracts with *Kaiser Foundation Hospitals* (KFH) for the provision of stated hospital facilities and services. KFH is a nonprofit charitable corporation which shares a common board of directors and executive management with the Health Plan. In return, KFH receives payment sufficient to cover the costs of the facilities and services plus a margin for short- and long-range capital needs. KFH also has an arrangement by which it shares in the revenues generated by keeping costs below a certain level set by contractual formula.<sup>13</sup>

With this arrangement, those within the Kaiser program who provide medical services or hospital services have every incentive to avoid giving wasteful, inefficient, or unnecessary care. This, together with the economies inherent in group practice, accounts for the apparent success Kaiser has had in achieving cost savings for its members. For example, whereas non-Kaiser doctors

TRENDS IN PER PERSON HOSPITAL EXPENSES<sup>16</sup>

	Kaiser (Northern California Region)			United States		
	1960	1965	%Change	1960	1965	%Change
Average daily expense	\$42.79	\$56.06	+31	\$32.23	\$44.48	+38
Annual admissions per 1,000	88	80	-9.1	128.9	137.9	+7.0
Average length of stay	6.86	6.65	-3.1	7.6	7.8	+2.6
Annual patient days per 1,000	604	532	-11.9	978	1,061	+8.5
Annual hospital expenses per person	\$25.85	\$29.82	+15.4	\$31.52	\$47.19	+49.7

operating under standard insurance policies have incentives to hospitalize patients even in cases where hospitalization may be unnecessary, Kaiser doctors profit by keeping people out of the hospital, thus putting rigorous controls on admission to and length of stay in Kaiser hospitals.<sup>14</sup> The result has been that Kaiser members average fewer days in the hospital than do people with various other forms of health insurance, and fewer patient days in the hospital mean a great cost saving for the Kaiser system.<sup>15</sup>

The table above indicates that although Kaiser's cost per day of hospital care increased almost as fast as costs in the nation as a whole, its annual hospital expense per person increased only about one-third as fast as the national average. Kaiser could not do much about the rise in cost per unit of service, but it was able to reduce the number of units required per person—in contrast to a national rise in the number of hospital days per person:

The fact that Kaiser has grown and spread as rapidly as it has seems to indicate that it is effectively meeting some basic needs and desires of consumers. Interviews with Kaiser subscribers usually produce a large proportion of raves:

Mrs. C. is 63 years old. She has been covered by the Kaiser Health Plan on a continuous basis for the past 17 years and she is very satisfied with Kaiser. "Aside from the fact that I've had such good attention, even if I had a cold, I can go to the doctor for \$1 and my kids can go for \$2 and you get the same care. If you have to go to a doctor's office, you have to pay \$5 to \$7 for an office visit. . . . Money is important to all of us."

She had great confidence in the Kaiser doctors. "I have never talked to them that they haven't been interested in what my problem is. They are so exacting—they

will find out what my problem is if it is humanly possible . . . ."

Mrs. S. describes herself as "a middle-class square who has always lived with about a \$15,000 or \$20,000 a year income and never wanted for anything." However, when she and her husband and their eight children moved to Portland neither parent could find work, and they had to go on welfare.

Mrs. S. says she "never understood all the problems poor people have until I was faced with a family of 10 to care for and no source of income." She thinks Kaiser "is the best thing that could ever happen to poor people."

Mr. and Mrs. E. are a young couple in their early 20's. Through his employment Mr. E. belongs to the Kaiser Health Plan; his wife is covered by the plan as his dependent.

Mrs. E. recently had minor surgery at Kaiser. The operation was arranged by her own private doctor, and she was able to get into the hospital for the operation within a week of her doctor's call. The Es paid only \$9.40 out of pocket—for the anesthesia and a biopsy—compared to \$400 her private doctor estimated would be the cost if he performed the operation.

While there seems to be great satisfaction with comprehensive services provided by the Kaiser Plan, at no cost beyond the regular premium, there seems to be dissatisfaction with other aspects of the program, including its responsiveness to consumers. Though the basic premises of the Kaiser program represent, in many ways, a break with medical tradition, one unbroken tradition is the provider-domination of the program. The words of Dr. Cecil Cutting, Executive Director of the Permanente Groups, set forth clearly the attitude of the institution:

"I think a program of this sort [Kaiser] to continue and to be successful must realize that the physician must be given responsibility and he must accept this responsibility. . . . Perhaps the greatest danger in group practice prepayment is . . . its appeal to sophisticated lay purchasers and planners of health care. It tends to provide a mechanism by which others than physicians can establish policy, administration and control.

"Responsiveness to the consumer is imperative, and . . . surely it has been given too little attention by the profession. But the maintenance of the physician in the role of judgment and control of economy versus quality in the provision of medical care is vital."<sup>17</sup>

Kaiser officials maintain that accountability to consumers is achieved through what they term the "dual choice approach," a concept developed by Kaiser. Kaiser never forces its program on consumers. Each consumer enrolled in the Kaiser Plan has at least one alternative program available to him. If Kaiser members are dissatisfied they can go elsewhere.<sup>18</sup> But the power to quit the program can have only a marginal impact on the actual functioning of the Kaiser health delivery system. It can do no more than ensure that the system meets the available competition, and, as we have seen, Kaiser competitors are under no compulsion to respond to the needs of the consumer.

With no better mechanism to safeguard consumer interests within the Kaiser system, the incentives for cost savings could have results beyond the achievement of efficiency. Costs may also be saved by diminishing the value of the services rendered—by reducing the quality or the quantity of services actually delivered to members. Thus, some critics contend that Kaiser members are not hospitalized when they should be, that outpatient treatment is rushed and impersonal, and that the appointment system is set up to discourage usage.<sup>19</sup>

These criticisms are difficult to evaluate. The line between efficient organization of services and reduced quality care is anything but clear. Nonetheless, certain other consequences of the Kaiser incentive system can be identified. Despite claims that Kaiser delivers comprehensive care with emphasis on prevention, a significant portion of the Kaiser membership has little or no contact with the system's health facilities, and there are still those who receive fragmented, episodic care.<sup>20</sup>

The Kaiser program has made only minimal effort to change such patterns of usage. The program requires the patient to assume the initiative for his own care, and not only for initial care, but also for follow-up care. Often some sophistication and much persistence is necessary to get the care promised in the Kaiser Plan brochure. In fact, Kaiser administrators place considerable reliance upon the assumption that all members will not take full advantage of the benefits guaranteed them in the Kaiser contract:

"Our experience has shown that patterns of utilization of services are stable, and are only changed gradually from year to year, so that the financial risks undertaken relate more to the efficiency of the management of the provision of medical services rather than to unanticipated swings in volume of services provided."<sup>21</sup>

To examine some of these issues firsthand, several members of the Citizens Board of Inquiry visited the Kaiser program in Portland, Oregon. The following are excerpts from the report they submitted:

We went to Kaiser-Portland, prepared to view it as a model health care delivery system, but we discovered rather quickly that both Kaiser officials and consumers objected to this characterization.

The medical director of Kaiser-Portland told us: "[We] do not consider ourselves utopian. Our aim is to provide the same services that are available in the general community, but to do so in a more efficient and less costly way. Our goal is to demonstrate that a prepaid group practice can compete successfully with the more generally accepted methods of health care delivery now prevalent, and nothing more."

If there are deficiencies in the Kaiser-Portland program from the consumers' point of view, they seem to stem, directly or indirectly, from the devotion of the organization to this goal of efficiency.

We were told that individual doctors have almost no say about the length of patient appointments, the occasions when phone calls from patients should reach a doctor, and the like. Even the major decision to enroll 7,000 OEO subscribers in the program was made by the executive committee without the general participation of partnership members.

While doctors have little say in the running of the program, consumers have virtually none. For non-OEO participants there is no institutionalized representation or participation at any level in the organization. For OEO participants there is a Medical Advisory Committee which had influence on the selection of poor families for the OEO program and on the selection of outreach personnel to work with those families but on almost nothing else.

Kaiser-Portland officials would argue that the "dual choice" system is the mechanism for consumer control, and that consumer views can be made known through the established grievance procedures. The Kaiser-Portland "grievance procedure" is largely a sham. We spoke to no consumer who was even aware of its existence. The woman in charge of the grievance office told us that "We don't notify people about the grievance system because if we did the office would be just a flood of complaints." She could give us no case where a consumer had gotten satisfaction on a complaint processed through the grievance office.

Consumers often told us that they were rushed through appointments with little chance to talk to the doctors.

Kaiser-Portland has 130,000 members and a staff of about 100 physicians. Kaiser administrators described the average patient load as 20 to 25 for their pediatricians and internists during a 6½-hour day. First appointments, we were told, are scheduled for ½ hour and return appointments are scheduled for 15 minutes, with ample time left for walk-ins. This information was directly contradicted by floor nurses and by appointment sheets for pediatrics which we were able to read. Our check revealed that doctors were regularly seeing 40 and sometimes as high as 50 patients per day. All the Kaiser physicians work five days a week, eight hours a day and feel the pressure of work.

The consumers we met told us that they will at times go to doctors outside the Kaiser system. Kaiser administrators claimed that less than 10 per cent of the members see outside doctors.

The people with whom we spoke had varying reasons for going elsewhere. Many thought of Kaiser as hospitalization insurance ("something to fall back on") and preferred to see outside doctors for outpatient care. The preference often resulted from a pleasant prior relationship with a doctor which the consumer decided to continue after joining the program. Some also preferred the

relaxed, more personal atmosphere of a "private doctor's office."

When we asked non-Kaiser subscribers why they did not enroll in the program, they almost always answered that they like to be able to choose their own doctors. They said this even though they understood that within the Kaiser program they could have their choice of Kaiser doctors.

Although the success of the Kaiser program is sometimes claimed to depend on the emphasis on preventive medicine (i.e., "getting people before they need hospitalization") the consumers with whom we talked, with few exceptions, said that they do not use Kaiser any more than they would other doctors. Those who went for check-ups told us that they did the same before they enrolled in the plan. No consumer stated that he joined the plan because it afforded access to preventive medicine.

There is no organized follow-up system. In addition the appointment system seems set up to deter all but those with the strongest resolve. Several consumers told of their difficulty in getting through to Kaiser on the telephone . . . . When a consumer finally gets through to the appointment center, he will speak to a girl who has been instructed, according to the woman in charge of the appointment center, "to let the patients be the judge of their needs. The girls are never to suggest that the



patient come in unless the patient himself brings it up."

The Kaiser administrators told us that there is a four- to six-week wait for nonacute appointments. The girls at the appointment center pegged the wait at six to eight weeks.

Although at least 20,000 Kaiser-Portland enrollees are entitled by contract to psychiatric care, the Kaiser staff included only one psychiatrist, plus a psychologist and a psychiatric social worker. There was no inpatient psychiatric care, though contract provisions expressly call for such coverage. The director of medical care research at Kaiser-Portland explained these limited mental health resources: "Are mental health services really effective means of delivering care? Since they are so expensive should we offer them? . . . [W]e don't know that the modalities of therapy used in mental health make a difference." Another official added: "We will not innovate in mental health because we don't know what would be productive."

Although the program generally includes house calls as a benefit, few are actually provided—about 300 per year, and most of these are made to nursing homes. Local non-Kaiser physicians have reportedly complained that this thrusts an unreasonable burden upon them.

One official noted that Kaiser-Portland's physical facilities seemed inadequate for present enrollment and that the program was deficient in providing geriatric care and long-term care of the chronically ill.

A special note about the Kaiser-OEO consumers: Most of the consumers in this category that we met had not yet been with the Kaiser program long enough to form any settled pattern of usage, though their comments were generally similar in content to what we heard from long-term Kaiser Health Plan members. One interesting point is that a very attractive part of the Kaiser-OEO package to them is the pick-up and bring-back transportation service that is offered them during the day—this service is financed by OEO funds and is not available to regular Health Plan members.

Members of the Citizens Board also visited the Kaiser Plan in Oakland, where the underlying premise is that by addressing itself to the "whole person's health needs, the program can detect problems in their early stages and treat them quickly." To carry out this premise, the multi-phasic screening program puts an average of 2,000 persons a month through a number of stations, which test and record everything from blood pressure to height and weight to psychological attitudes. A computer links together data from all of these tests, and with these records in front of him, a Kaiser physician talks to the patient and rounds out the medical record and advises him of the need for follow-up care.

The Kaiser research staff is halfway through a 10-year evaluation program, which will, on completion, say

much about the value of preventive care. It will also indicate just what kind of screening needs to be done and when. For example, should people in their 20's and 30's receive a checkup every two to three years, people over 30 yearly, and those over 40 every nine months? This program has received wide publicity for its preventive aspect and for its potential impact on health care delivery.<sup>2,2</sup>

## "Peer control—the greatest strength of HIP"

The Health Insurance Plan of Greater New York (HIP), another approach to the delivery and financing of medical care, is a prepaid insurance system that covers physician services and some clinical procedures (such as x-rays). It provides both the insuring mechanism and a supply of subscribers to its 30 medical groups. These medical groups are independent doctor-partnerships which provide doctor-services to HIP subscribers. The medical groups are remunerated on a per capita per year basis. At present, in addition to the medical groups, HIP has 41 medical centers and 1,160 doctors to serve the 763,000 enrollees.<sup>2,3</sup>

HIP, a nonprofit corporation, ostensibly is run by a 28-member Board of Directors which actually exercises a rather elastic control over the member centers. This Board has two physicians representing the medical groups; the mayor of New York City and two of his appointees; an ex-public official; one state health official; four physicians associated with teaching institutions; one hospital administrator (a physician); one social work professor; four businessmen (one retired); one person associated with a philanthropic organization, and two private consultants (one a physician). Unlike Kaiser, which has no union representation on its board of trustees (although unions make up roughly one-half of all group enrollment in the Kaiser-Permanente Health Plan), HIP has seven union officials representing the unions subscribing to HIP. HIP president James Brindle is also a member of the Board. The Board is self-perpetuating; current members and ex-members meet annually to elect a new board. It is responsible for policy decisions, such as programmatic changes in HIP, and the reallocation or appropriation of large sums of money. The non-salaried Board meets 10 times a year, for a few hours.

The Board apparently is dependent on HIP's administrative arm, President James Brindle and his executive staff, for most, if not all, of the information on which to base its decisions. It also is assumed that the nine doctors on the Board, plus the members of the state and city medical bureaucracy, wield considerable power.

HIP supplies the subscribers and funds to its medical

groups, the doctor partnerships. It also is supposed to set the standards and control the operation of the medical groups. For example, the *Directory of Professional Standards for Medical Groups and Standards for Medical Group Centers* promulgated by the HIP Medical Control Board specifies that centers must be open eight hours a day weekdays and on Saturday mornings, and care must be available on a round-the-clock basis.<sup>24</sup> But one of the groups visited, the New York Medical Group center, does not have Saturday hours. It does have a weekday service as early as 8 a.m. for tests requiring fasting and it also provides service on a non-appointment basis until 7 p.m., two nights a week, plus allergy service and physical therapy nightly until 6 p.m.

The center's medical director conceded that having no Saturday hours might pose a hardship for some subscribers. "I think some must be inconvenient, but when one considers that we have both daytime and evening hours, I don't really believe it's a large problem," he said. The matter of evening hours is an important point to some subscribers, and former subscribers. One woman who works days told us that she switched to another insurance plan solely because HIP's new center in East Nassau, Long Island, is not open evenings to administer her allergy treatment.

HIP's administrators, of course, want to hold down such defections. One possible remedy is a new incentive mechanism, known as supplemental capitation, an adjunct to HIP's flat per capita fee. This is a bonus system, which rewards centers which remain open during the evening. It also rewards those open on Saturday morning, thus serving to "enforce" the standards set by the HIP Medical Control Board. A center can also qualify for the bonus, for example, by footing the bill for physical improvement of the center's facilities.

Another control problem, regardless of hours, is the number of doctors on duty. Many HIP doctors are strictly part-time, as far as their HIP hours are concerned (860 of the 1,160 physicians are part-time).<sup>25</sup> "In our last contract agreement with the medical groups, we tried to develop supplemental-capitation criteria that we are just beginning to get a little data on," a HIP official explained. "We call it workload factors. We began to measure the number of services to a given population, the average time the physician spends with the subscriber and how long it takes for a subscriber to get an elective appointment." The "Directory of Standards" requires each medical group to submit a monthly report of services rendered to subscribers, on forms provided by HIP, and to submit to HIP every six months a schedule of the center's office hours and each of its physicians' office hours.

The adoption of a supplemental-capitation system indicates that HIP was unable, with flat per capita payments, to enforce standards on its centers. In fact,

the flat per capita system may have encouraged some centers to skimp on certain services. For example, an x-ray technician could be hired on a part-time basis rather than a full weekly basis, and/or not assigned to evening hours in cases where the center is open evenings. This, of course, would cause serious inconvenience to patients who work days and would have to arrange their x-ray appointments on a severely restricted schedule.

One HIP spokesman suggested that some subscriber demands are unreasonable. "Priorities," he said, "must be determined by the physicians." In some groups there is a wait of two weeks for an elective health examination, for example, while at other centers, the wait is six weeks. "He [the physician] figures that for a preventive health examination he has to have half an hour of his time. And many will do it on the basis . . . 'Well, I'll do two at the beginning of the session, then I won't take on any more because I've got to be here to see sick people.'"

"I really have the feeling," a HIP doctor said, "that we have not had a substantial problem in terms of subscriber dissatisfaction with the period of time they have to wait for appointments. There is an occasional problem."

In the past decade, New York City physicians, as elsewhere, have become increasingly reluctant to make house calls. This development has affected HIP subscribers as well as fee-for-service patients. To remedy the problem, and to allay complaints from subscribers, HIP has established an Emergency Care Service.

After a center is closed, the patient dials his medical group's phone number. The call will be taken by a group physician or transferred to a central emergency number. The attending doctor makes a decision over the phone. If he thinks the case requires a house call, he contacts a physician who will make a house call and "one of those poor fellows goes out and makes a house call."

If the house-call physician decides the patient requires hospitalization, he contacts the internist on call for the group that night. The internist arranges for the patient to be hospitalized.

Complaints about delivery of service are often answered with explanations about the current expansion of HIP services and the improvement in the quality of its medical care. In this respect, the professional personnel we spoke to at HIP emphasized the importance of peer control by the medical profession. Several HIP doctors termed peer-control the "greatest strength of HIP." "I think everyone has to feel accountable to someone, with the exception of the few saints that have come to our world," one doctor said. "I think that a group practice with a medical director which has peers using the same charts . . . the fact that the doctor knows his note is going to be read by his colleagues . . . not isolated in his office never to be seen . . . makes him behave differently—certainly with respect to quality and standards."<sup>26</sup>

HIP has instituted peer-control at two levels: among the medical professionals within the groups themselves, and among the groups. Last year it negotiated with the medical groups to form the Joint Committee for Improvement of Medical Care. Both the groups and HIP are represented. The committee deals, as an executive put it, with "the quality of care as assessed by the patient." But there are no consumer representatives on this committee. "It provides a means for literally calling the groups on the carpet if they are not performing the way their peers feel they ought to perform."

If a member of one of the groups or a group is not performing properly, there are no "formal sanctions which the committee can invoke." HIP's Medical Control Board, a group of doctors representing every specialty associated with teaching hospitals and universities, promulgates the standards for medical centers and their physicians and "actually individually reviews applications for physicians." The implied threat is that if a physician does not satisfy his peers, he may have trouble obtaining hospital privileges.

HIP apparently has depended until now on internal limits—administrative and peer-group controls—to assure improvement of its medical services and care. None of the joint committees, control boards, or other mechanisms is directly responsible to the subscriber. One of the HIP vice presidents was asked what leverage the subscriber has. His response echoes Kaiser's:

"To begin with," he answered, "he has the option of

deciding whether he wants to stay with the program. Virtually all the enrollments are now on what we call a dual-choice basis. In some cases we have triple choice [three rival plans competing for the insurees' dollar]. Re-openers are periodic, usually once a year. It is the most meaningful means of participation in decision-making—because he says if I'm not satisfied, I'm leaving. And we take that very seriously."<sup>27</sup>

In many cases that option has been more illusory than real. Until 1965, all municipal workers subscribing to medical insurance in New York were covered by HIP, with the city paying half the premium. In 1965, 60 per cent of the municipal workers were covered. Since 1965, municipal workers have had an annual opportunity to choose among HIP, Group Health Insurance, or Blue Shield. Today, HIP insures about half of all insured municipal workers—and half of HIP's enrollees are municipal workers.

Although HIP did lose subscribers to its competitors when the triple choice was made available, at the same time the city began to pick up a larger share of the premium, thereby adding to HIP's attractiveness. GHI, for example, exacts fees in addition to the premium. HIP maintains it lost only ten per cent of its municipal-employee subscribers. On the other hand, HIP's major disadvantage is geographic: most of its centers are in the five boroughs of the city. HIP's recent move to the suburbs (Nassau County) has paralleled city employees' purchase of homes there.



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HIP officials think there is an income-level differential between subscribers who stay with HIP and those who change to other plans. Lower-income groups are believed to elect HIP, for in poor neighborhoods—especially black neighborhoods—there are few fee-for-service physicians available. It is also presumed that employees earning more than \$10,000 a year tend to switch to GHI or Blue Shield. But there are no statistics on this point.

Middle-income people in New York with whom we spoke insisted that they prefer to “pay money out of my pocket” in order to avoid either waiting for an appointment, the anonymity of HIP waiting rooms, or the powerlessness of not being able to “just walk out and get another doctor.”

A HIP subscriber has little chance to exercise control over its services and care. Because of the geographic overlay of HIP centers, some subscribers have a choice of three or four groups. But switching groups is not easy. It requires a formal application to HIP headquarters, which in turn requires the initiative to write a letter of application and the tolerance for delay. HIP strongly discourages changes within a given geographical area. In Manhattan, for instance, all of HIP's Manhattan subscribers might register at the same center—the best.

The subscriber also has the right to change doctors, so any subscriber unable to change his group might try to change his doctor. That is not easy either. Application must be made to the group's medical director, and HIP frequently is unable to offer enough of a choice to grant the application. That is especially true in the smaller groups, and nearly always true when the switch involves specialists.

If a subscriber is not able to change either his group or his doctor, what *can* he do besides quit the plan?

For such dilemmas, HIP provides the “subscriber service” so that the patient is able to appeal to the group medical director. The “Directory of Standards” states that HIP medical groups must “receive complaints from subscribers and physicians or other personnel of the group.”

One HIP official told us: “If he doesn't have satisfaction, we invite him to let us have a crack at solving the problem.” HIP centers have posters reading: “Have you any questions about your health insurance?” And on the posters, the complainant can find the phone number for HIP headquarters. Some complaints apparently do reach the Joint Committee for Improvement of Medical Care—but they cannot be brought there in person by any subscriber.

There are subscriber advisory boards attached to several centers, especially the larger ones, but the boards have no real authority or power.

We asked officials what areas might fall within the competence of an advisory board. “I think they could be

a tremendous help in scheduling. . . . I think the impression I have—that we're not working a tremendous hardship on subscribers not being open on Saturday—may be grossly in error. But to poll people about whether we should be open on Saturdays would be a loaded poll. Everyone would want us to be open. But if you're open on Saturday, people will just drop in. You go shopping, drop in and see the doctor.”

We toured the New York Medical Group Center, which, according to outside observers, is one of the best HIP centers. Three years ago it moved to new quarters designed and decorated largely to appeal to patients. Waiting rooms for different doctors and procedures are separate, easing the emergency room atmosphere common at other centers. The brightly painted walls are hung with pictures, and the pediatricians' area has a blackboard on the wall to amuse the children. Much of this decor is in direct response to subscriber requests, and, with the added proximity to the New York University Medical School, one might guess that the center's 15,000 subscribers have less to complain about than their counterparts at other, less favored, centers. Yet chats with waiting patients suggest that all the extra features combined do not necessarily negate long waits for appointments, or the failure of the appointments desk to group all laboratory procedures and other diagnostic tests in one appointment.

Subscribers have not yet demanded participation in running the center, advisory or otherwise. A HIP official feels it is because they consist largely of teachers and social workers—“that they are not anxious to have participation, or not organized to have participation; they are not aggressive about it.”

HIP's public relations man concurred: “This group [the HIP subscribers] is very articulate. If they have something on their mind, they're prone to come in and talk about it. Also, I think that these particular groups understand prepaid group practice more than the traditional blue-collar groups, so that they're better at communications . . . medically and otherwise. These people would rather deal on a one-to-one basis. . . .”

HIP has certain special problems, particularly recruitment of doctors because of the fee limitations and hospital affiliations.

Most of the 30 HIP medical groups were organized a generation ago. In fact, 25 were organized in HIP's first year—1947-48—and four others within the next five years. Hospitals around the city formed groups of doctors associated in training and residency programs, with these groups supplying their own capital investment. This is referred to as HIP's “physician initiative phase.” Until recently, each medical group made improvements out of its per capita fundings. Today, HIP plays a larger role in capital investment and center improvement. Only one group has been added since

1953, the East Nassau (Long Island) Medical Group, and this required much more HIP initiative than "physician initiative."<sup>28</sup>

Doctors now think that the responsibility for building a HIP center rests with HIP. HIP built the East Nassau center (it also plans to build centers in Rockland and Westchester Counties) and sublets to the East Nassau Medical Group at a subsidized rent. The group pays \$1 per square foot of space and \$1 per enrollee. In effect, the group pays only about half the actual rental cost. During East Nassau's first year of existence, HIP also provided one of its experienced medical directors to run the center.

How else does HIP seek to entice doctors to group practice? HIP offers the incentive of \$22,000 a year to a full-time internist to start with the group. HIP contends that to match that figure in private practice, with the overhead of office and equipment, a physician would have to gross \$35,000 a year.<sup>29</sup>

The starting physician is expected to work at the group 25 hours a week. "We expect him to take his turn on call. We expect him to take care of all his patients that are hospitalized. He may not have another private practice, may not work in a health clinic—this may be an unkind description—but it is a hack sort of work. He may work in any program it is felt will enhance his medical knowledge. In other words, he may work teaching in a university hospital, may work in a clinic which has a residency or intern-training program, and he may do research."

At the New York Medical Group Center, one-fifth of the doctors are now full-time, but that figure may rise. Only specialists whom the group cannot support are being hired to work part-time. HIP is encouraging full-time staffs in all groups to avoid conflict with private practice. One group director explained another reason why he is optimistic about finding full-time doctors today: "I think the cynicism of the generation that preceded and the focus on money also is helping us because I think we're swinging back now to where we were in 1948, not because the market isn't there, but because the motive has changed." He mentioned in passing that it is still difficult to recruit surgeons and he is having "trouble" getting a full-time obstetrician. He thinks though, that he'll "manage" to find pediatricians and internists.<sup>30</sup>

Although limited income was an important factor in making doctors shy of prepaid insurance groups, prestige was another deterrent.<sup>31</sup> In addition, HIP doctors have also suffered discrimination in hospitals. Several years ago the Nassau group was barred from the local hospital and a county ordinance was passed to secure them privileges.

In Staten Island, the HIP group suffered the same problem. Only one HIP obstetrician had hospital privi-

leges in either of Staten Island's two hospitals. "He had to catch all the HIP babies and literally died of exhaustion at 39." That obstetrician's death provoked action in the state legislature to bar discrimination against doctors practicing under prepaid plans.<sup>32</sup>

However, HIP personnel insist that the law has not ended discrimination. It is alleged that HIP doctors do not get promotions on hospital staffs because of prejudice against prepaid plans. In one area HIP doctors function entirely under courtesy privileges. The problem of not being able to get all of a medical group's doctors on the staff of a single hospital also adds to HIP's costs. Sometimes, HIP has to call on a non-HIP doctor to assist in a hospital procedure and then pay the doctor his asking fee.

HIP's growth will be stymied until the plan can offer physicians opportunities to advance in hospital hierarchies. In fact, a group director attributes HIP's failure to grow appreciably in the last two decades to the decision in 1947 not to include hospital facilities and services along with physician services in the HIP package. He pointed to the growth of Kaiser to prove his point. At this time, HIP owns only one hospital in Queens and is planning to build another.

### **"Arrangements must be made so that residents served by the project have a substantial voice in the policymaking."**

In recent years, the federal government has recognized the small but burgeoning consumer activity and has incorporated it as a necessary part of certain health programs. This was most clear in the guidelines for the OEO neighborhood health centers which require that the governing board of the centers be structured "so that at least one-third of its members are persons eligible to receive services from the project and at least one-half of its members are either persons eligible to receive services or are representatives of community groups, such as social service organizations and labor or business organizations."<sup>33</sup>

The impact that community residents have in fact been able to make in the 60 or so of these projects varies greatly. Of the several trends, most fundamental has been the continued attempts at increasing the participation of the centers' users or their representatives in making policy.

In the early days of OEO's health center program, advisory councils were formed to meet this requirement of consumer participation, but the councils often were created *after* the project was funded. The grant itself was

made either to the health institution operating the program (medical schools, health departments, hospitals, group practices) or to a community agency which then contracted with the operating agency to conduct the program. In almost all the centers there was considerable friction between consumers and those responsible for providing care, both about substantive issues such as hours of service, and about the power the advisory board could exercise.

While questions of hours and locations of facilities were often successfully resolved, the most difficult problems centered around hiring and firing, not only of physicians and other professionals, but also of the non-professionals, who had been recruited from the neighborhood, trained and employed by the center. According to one of the early designers of the Neighborhood Health Center program, during the first year of the program, "Many frantic phone calls poured into OEO from Los Angeles, New York, Chicago, Boston, and Denver. We were asked:

**"Does our hospital board of trustees, does the dean of our medical school, does the commissioner of health of this city have to consult with a consumer advisory board about the hiring or firing of physicians? At the same time the community would ask, Is this advisory board ours, if we can't even get rid of a guy on the staff who is rude, unconcerned, insulting, a racist to boot?"**

One expert in the field feels that the tension resulting about decision-making grew not merely from the professionals' unwillingness to give up their traditional prerogatives, nor the consumers' "unreasonable demands to have a say over their own destiny," but rather was simply a product of a rough, ill-timed mechanism for consumer involvement.<sup>34</sup> Specifically, bringing consumers into the planning process after a proposal for support had been submitted by a provider group made effective consumer participation very difficult, and the advisory council turned out to be a poor way to resolve the subsequent conflict.

A new pattern has recently emerged, which seems to be much more successful. First, consumers and providers are urged to work together in the development of the program from the first indication of local interest. Secondly, the public corporation has emerged as a more effective method of consumer involvement, since it provides a forum for solving the many conflicts that arise between consumers and providers.

Today, more and more of the neighborhood health center grants are being made directly to a corporation, newly created for this purpose, composed of both consumers and providers. Several of the grants originally made to provider institutions are now going directly to a joint consumer-provider corporation. Of the 23 projects funded in fiscal year 1970, 12 of the grants and 57 per

cent of the funds went to such corporations.<sup>35</sup> Since the corporation has control over all funds that support the program, and since both providers and consumers sit on the corporation's board of directors, a forum for conflict resolution exists, avoiding the earlier pattern of endless arguments concerning the rhetoric of federal guidelines and the interpretation of the nature of the advisory role. On the other hand, of course, new problems arise, including difficult questions of who represents the consumer (a matter which becomes more acute as the stakes become higher), and of the extent to which significant numbers of professionals are willing to work in circumstances where consumers do indeed exercise a substantial measure of control.

A look at two clinics, one the first OEO neighborhood health center, Columbia Point, and the other a relatively new Public Health Service-sponsored clinic, The Yeatman Clinic, will illustrate some of the issues and successes:

*Columbia Point in Boston*, the first of the OEO health centers, was established in 1965 under the auspices of the Tufts University School of Medicine. Columbia Point is isolated from health care facilities by geography (it is located on a peninsula in South Boston) and by poor transportation. The neighborhood is poor, generally young (nearly two-thirds of the residents are under 20) and female, and has many health problems. The health center staff provides care on a team basis. The team includes an internist, a pediatrician, two public health nurses, a home-health aide, two medical assistants, a receptionist and a secretary.

Three of these Family Health Care Groups, serving 400 families, are located on separate floors of the health center. A psychiatrist and an infant and toddler unit under the direction of a child psychiatrist provide support to the primary groups. The center attempts to provide comprehensive services which span the full range of both preventive and curative services.

Perhaps more significant than the center's organization of medical services is its program for community participation. To get OEO support for the project, it was necessary to define broader goals for the center than the provision of medical services, essential though they may be. The founders of the center proposed to meet this need by establishing a Columbia Point Health Association to represent the community's interests in the center's many services.<sup>36</sup> Services are offered free of charge to all Columbia Point residents. Members of the association were to be chosen by residents of the housing project. In addition, project residents would be trained and employed in non-professional positions in the center.

The Columbia Point Health Center has had a history fraught with difficulty and controversy. The program for consumer participation has run a particularly rocky

course, with disputes as often centering on particular personalities as on concepts or operations. Delivering medical services is still the overriding purpose of the project. One observer commented:

"Consumer participation seemed to be thought of as nice as long as it does not get in the way of the administrative and professional staff's efforts to deliver medical care. The health association is looked upon almost as a burden, an obstacle to overcome, though a necessary obstacle if there is to be acceptance of the center in the community. They rationalize it this way: Consumers are anxious to assume control over the community but the people seem unprepared and unwilling to assume the responsibility that goes along with that power."

In general, consumers in many centers, including Columbia Point, are viewed as a "medium of communication to bring the health center and the community into a closer relationship."

For their part health association members are quite ready to accept the responsibility for improving communications, but they will not limit their role to this. They say:

"We have on paper this long list of all the powers we're supposed to have, all of our responsibilities. And we've been told a lot more by the people at Tufts. The fact of the matter is we don't have any of those powers, except when they decide it's convenient. They say we're

irresponsible. Well how can we be responsible with no responsibility?"

"We know we need expertise and technical assistance. But they're not giving it to us. We got it at the very beginning but then it was withdrawn. They think we want to wreck the clinic, but we've got a lot more reason to keep it going than they have."

"Our goal is to have this clinic be completely run by consumers. We know we can't do it now. But we are going to insist that Tufts give us the benefit of their expertise—you know, set up a real training program with classes and everything—so that by 1971 the health association can be the direct grantee from the OEO."

While consumers praised the center's services because of its accessibility, the high quality care children receive, the willingness of doctors to make house calls in emergencies, and the lack of a charge for medical services, there also was criticism:

"All they really care about is the kids. When an adult comes in they say, 'There's nothing physically wrong with you; it's caused by your environment.' Or they'll say it's because we are on public assistance and have nothing better to do with our time but sit and imagine diseases."

"It's only open during the day on week-days. They give you a number to call if you got a problem some other time, but you never get through to a doctor."



The Citizens Board visited the *Yeatman Neighborhood Clinic* located in a poor, mostly black community on St. Louis' South Side. It is totally controlled by the community through a board of 60 members (all of whom are community people) elected annually in community-wide elections. The board makes all the decisions about the clinic: hiring, firing and management of funds.

The board also runs the Yeatman Corporation, which has 15 committees, covering everything from unemployment and housing to health. The health committee, headed by a spry, over 70-year-old lady who had the original dream of the clinic, holds meetings open to the community, twice a month, on issues broadly relating to the clinic and to health. The medical director, a former pharmacist, reports to the health committee, which in turn makes its recommendations to the board. Ultimate power rests with the board. One board member said, "The whole process may sound tortuous, but it is the only way people can keep control of what's happening."

The clinic is housed in a remodeled furniture warehouse and is equipped with 10 examining rooms, complete dental-care facilities and a parent-toddler center next door. Community residents are employed and trained in every part of the clinic, from the reception area to the pathology lab. Most of the technical training is done with the cooperation of neighboring St. Louis University. The staff consists of 96 people including 14 doctors who average a six-hour day (though this is changing now since several of them who had started part-time see the clinic's success and want to serve the clinic full-time).

Although the clinic is financed by a \$1.5-million Public Health Service grant, everyone who visits the center, except welfare recipients, pays something on a sliding scale, ranging from 50¢ a visit to \$10. How much a family pays is determined by its annual income and size. It is a stark contrast to the local city hospital where one mother reported:

**"If you bring a sick child to Homer Phillips [Hospital], you better take your breakfast and your lunch too. To see a doctor, you have to bring them two years' record of rent, gas, electric, W-2 forms—even though I don't see what last year's salary tells them about your ability to pay this year. It takes about a day to be waited on, to fill out all the forms, and show them your records (if you have them). If there is a delay—if you don't have all your rent forms—it may take longer. And then you come back the next day with your sick child, take another number and start all over again."**

When a patient enters the Yeatman Clinic, he is given a complete physical examination (even if he comes to see the dentist or psychiatrist). In addition, not only is the sick person enrolled, but a file is made for his entire

family. In this way, the clinic feels it has a better understanding of the patient's environment and total living problems. Clinic hours are arranged for the community's convenience: 9-9 weekdays, 9-1 Saturday. Appointments are made and kept. A half-hour wait is considered a long time. If the doctor is delayed, a staff person will explain the delay to the patient and how much of a wait he can expect. (This was one of the major complaints against the city hospital, not just the waiting, but never being told why.)

Dental patients are called a day in advance to remind them of their appointment. In addition to seeing some 131 scheduled patients a day, 25-30 walk-ins are squeezed in. The elderly are picked up (as is anyone who needs it) free. The waiting rooms and all the operating rooms are pleasant, colorful and small with two or three community residents always on hand to answer questions and help. "We know our people and can understand their problems and talk to them," one worker said.

When the doors to the clinic opened a year ago, 60 per cent of the first 3,000 patients had not seen a doctor in five years. (The clinic now averages 1,000 patients a month and the total number of first visits for the first year was 28,866.) The pride the people feel is evident. One mother said, "Some of us who've been here from the beginning feel like the paint on the walls belongs to us."

This pride is also reflected in the number of people who come to meetings—they are jammed—and the number of people who want to run for the Board. Sixty people have been nominated in each of four substations throughout the neighborhood, though ultimately only 15 will be elected from each. Campaigning is fierce and lively, with posters in laundromats, local bars and grocery stores. "It seems like everyone who comes to the center knows someone on the Board," one patient said. "And what this means is that anyone who has a complaint gets very quick action." All complaints, no matter how small, are acted upon immediately. Rudeness is not tolerated. "It means a lot to have the receptionist greet you with a smile," another patient said. Community outreach workers who publicize the center say that one of the biggest things they have to overcome is the feeling that people had in going to the city hospital—the rudeness, the lack of friendliness. Outreach workers go door-to-door talking about the clinic. Preachers talk about it in church, store owners in their shops. One board member said:

**"The city said when the clinic got started, 'These are black people. They can't control something like this.' We got ourselves together and *proved* it could be done. We sweated blood to get this center. I cried, I groaned, I talked to the regional people. We need this place. Yeatman has the highest illiteracy, the hardest pressed people in this city. That's what poverty means. No**

person is turned down for services here. And that's what upgrading a community means."

**"Community people ought to be used where decisions are made. But if they are put on the board they lose some of their freedom."**

Another example of citizen participation is the Boston Department of Health and Hospitals experiment with consumers. The Citizens Board studied this experiment in some depth and feels it illustrates one of the common fallacies about consumer involvement: having some people on a board who are labeled "consumers" is sufficient whether or not the board has any powers, how frequently it meets, and whether or not it is listened to.

In the fall of 1968, the Mayor of Boston recommended to the trustees of the Department of Health and Hospitals that consumers be represented on boards that "deal with matters pertaining to the design, delivery and evaluation of health services." In the year since its inception, the experiment has proved a sham.

Much can be learned from the first year's failure. The experiment was the first of its kind to involve consumers in the workings of a big city hospital and took place in Boston City Hospital, the oldest municipal teaching hospital in the country. Those who use the hospital live in Roxbury, South End and North Dorchester. They are desperately poor communities. The neighborhoods are among the most densely populated in the city, teeming with health problems. And the hospital has failed them, despite a prestigious medical staff provided by Harvard, Tufts and Boston University Medical schools, despite the city's atmosphere of medical enlightenment, and despite the medical facilities and highest physician population ratio in the country.

As in too many cities, sick people avoid going to Boston City Hospital at all costs. As was described in earlier chapters of this report, consumers find the hospital a demeaning and unpleasant place and difficult to get to. Once there, waits are standard, and despite the fact that the majority of Boston's Spanish-speaking population lives within a ten-minute walk of the hospital, there were few interpreters—none in the emergency room. The dimly lit corridors are frightening to the patients, but most difficult for them is the frequent insensitivity of the staff.

However, it was not the helplessness of the consumers in the face of the hospital's deficiencies that moved the trustees to recommend consumer participation. The reform process started three years earlier in response to a

threat that the hospital might lose its accreditation. At that time the city council combined the Department of Health and the Department of Hospitals. But this structural change was not enough to cope effectively with the problems that had accumulated during the years of neglect, nor did it advance representation of the poor in Boston's health services, particularly at the city hospital.

According to one community leader: "Every two years or so there's a big flare-up, usually a strike, then things would be alright again and we'd order a study of the problems." But in 1968, the discovery that there was no x-ray technician on the emergency floor touched off weeks of critical newspaper coverage. The mayor asked for a moratorium on bad press and ordered a 90-day "action-oriented study." But pressure from poor consumers had already begun to build. Prior to the advent of Medicaid, they had seen Boston City Hospital as their only source of care, but with Medicaid they began to seek services at other institutions. The sudden decrease in patient load threatened the hospital's accreditation as a teaching institution, and its image in the poor community became a significant issue. In this setting, the trustees recommended community participation in the Department of Health and Hospitals.

The result was the establishment of seven committees, including community health services, patient care, and building. These committees would serve the board in an advisory capacity. Each, except for the Scientific Advisory Committee, would include two "community people"; the rest were hospital or medical staff and members of the Department of Health and Hospitals, and a member of the board of trustees to serve as chairman.

A little over a year after the inception of this program, the Citizens Board talked with the "community members" of the advisory committees. They were dissatisfied and disillusioned with both the concept of the program and its implementation. The experiences and the reactions of a community member of the Patient Care Committee are representative:

"I was appointed to the Patient Care Committee without any prior notice and without my consent. The first I heard of it was when someone pointed out to me that there was an announcement in the paper and my name was mentioned. I received a letter from the Mayor a few days later informing me of the appointment. I'm not sure why I was chosen, but I have some guesses.

"We had our first meeting several months after I got my letter of appointment. The major topic was whether inpatients should be provided with toothpaste. I tried to steer the conversation toward broader issues but the professionals on the committee had command of the situation. Our second meeting was after a substantial lapse of time. The committee toured the accident ward

to see whether or not patients were seen immediately. We have not met since. I contacted some people about the inactivity of the committee but nothing moved.

"My reaction is one of disappointment and a feeling that I'm just being used by the establishment. When I first learned of the committees, I thought this was a beginning, but in my mind that has been erased. They dream up these committees as a means of perpetuating the system. I want to be a trustee because that's the only real way to change things in the hospital—that's where the decisions are made. But when I called to submit my name for the opening on the Board, they said they were looking for another businessman.

"Putting more consumers on the committees won't help anything because they weren't set up so they would have power, but merely for the sake of appeasement and also because the hospital was faced with the possibility of losing its accreditation because of a drastic decrease in the number of patients."

A priest formerly from the Roxbury area related a similar story:

"In about November, I was asked to be one of the community representatives on the Building Committee. I thought it was a ploy—if I was on the committee, I wouldn't be able to say anything. In February or March we had a meeting. The other community person, from South End, didn't show. The experts decided that the first order of priority for building was a parking garage and housing for the resident staff, and that their building plans required some of the community's land. I told them that if they tried to build what they were proposing, I would muster community support against it. I have never been asked to another meeting. At one point I called and told them I wanted more information so I could do my homework and be prepared for these meetings, but nothing happened. I've kind've just copped out of it. Part of the syndrome of banging your head. Why try?—that's probably reflecting the sentiments of the people in the community."

Only one of the consumer participants with whom we spoke remained at all hopeful that the committee system might be of some value. But her hope was limited and qualified:

"I suppose if my only access was through the committees, I would feel very frustrated too. But fortunately, for me, I have very good access to the Commissioner and the Deputy Commissioner. I don't know how much is going to come from the committee. I suppose some people from the community meeting with administrators is doing something to relieve tensions in the community, but until they get more black and Spanish-speaking doctors not too much will be done."

One local mother described a strategy she has been advocating:

"The poor consumers of the city have the power to do a lot more than they're doing. I tell people they can get Medicaid cards that will allow them to choose among the hospitals. Then I advise them not to go to Boston City but to those hospitals I know will accept their cards. Deliveries at Boston Hospital have dropped off nearly 50 per cent in the last few years, and the hospital could lose its accreditation as a teaching institution for obstetricians. The threat is the only thing that can bring the hospital to improve its services and attractiveness to patients."

The alienation of the community committee members seemed not to concern the Commissioner and the Deputy Commissioner of hospitals and the several members of the Board of Trustees with whom we met. Some trustees were defensive when we tried to discuss the dissatisfaction of the consumer participants. "Why must we discuss these problems?" one trustee asked. "All I hear is criticism. Why us? I don't know any other city hospital which has even involved community people."

Some tried to minimize the importance of the consumer complaints. The Commissioner took the long view, suggesting that we had come "two years early." One of the trustees, as if to excuse the first year's performance, emphasized that the board "is committed to this structure on the basis that if it doesn't work, nothing will."

Yet despite these protestations, there would seem to be a significant gap between the desires and expectations of the consumer participants and the committee programs as outlined and implemented by the Board of Trustees and the Department of Health and Hospitals. Basically, the trustees and administrators of the department view the program as a communication and public relations mechanism. The goal is to lure patients, who are beginning to stray, back to Boston City Hospital. The trustees' report to the Mayor repeatedly emphasized the importance of improved communications in bolstering the image of the hospital in poor communities.

In this context, consumer committee members are seen as serving two purposes: first, helping the administration and trustees by acting as a barometer for consumer concerns; and second, functioning as "ambassadors" from the hospital to the neighborhoods. One measure of the failure of the ambassadorial function, perhaps, is that none of the consumers with whom we met, save consumer committee members, was aware of the department's program for consumer participation.

The first year's performance of the committee system brings into question the commitment of the trustees and administration to even these limited goals. With few committee meetings, with no opportunity for advance

preparation by those chosen to represent the consumers, and with control of committee discussion in the hands of a numerically dominant group of providers, little information has moved from the community people to the policymakers. Possibly this will change with time. But a preference for limiting consumer input to what is presented in this type of controlled atmosphere may be indicated by the administration's complete lack of interest in setting up a mechanism in the hospital to receive consumer complaints and grievances. The Deputy Commissioner mentioned that he had discouraged such an idea when it was put forward by the Student Health Organization the previous summer. His explanation: "Signs indicating a place where one may make complaints are neither a very dignified nor effective way of doing things."

A year's experience has taught, too, that community people cannot be made ambassadors of good will in isolation without something tangible to be sold to their communities. Yet in at least one case, the disillusionment might have been avoided had the administration been sensitive to the needs of the community representatives.

The Commissioner corroborated the story of the priest from Roxbury, presented earlier, that the Building Committee had met only once. The Commissioner conceded that there was little the members of that committee could do about the hospital's new building plans except to help generate support in the community. He added, however, that due primarily to the arguments presented by the priest at the only meeting of the committee, a decision had been made not to tear down any neighborhood dwellings in order to build new parking facilities. He said that the building of a new parking facility and of a residence for house staff was postponed so that a new outpatient department could be erected first. If this is true, it is hard to understand why the priest was not informed of his success. He was left to learn of the changes in building plans through a newspaper story some 10 months after the committee meeting—a story that made no mention of the pivotal role ascribed to him by the Commissioner. By then, he had abandoned any positive thoughts about the value of his role on the committee or the value of the committee to the community.

Even if the committee system had satisfactorily performed the tasks designed for it by the trustees and administration, the question would remain whether these tasks, communication and public relations, really meet the needs and expectations of the consumer community. The consumer committee members whom we met clearly indicated that they would not be satisfied with only an advisory role, and with being forced to rely on the "good hearts of those with the real power to make decisions." They spoke of trying for positions on

the Board of Trustees, of expanding the Board to include an equal number of "businessmen and community people," of having the Board elected by the users of the hospital, but always achieving for consumers some control over an institution so important in their lives. The contrast between their position and the position of the trustees and administration is clear. As the Commissioner said: "Community people ought to be used where decisions are made. But, if they are put on the Board, they would lose some of their freedom. They would become part of the establishment and lose their ability to bring pressure to bear."

Ironically, the success of the committee system, as envisioned by the trustees and administration, might indeed result in diminution rather than enhancement of consumer power over the hospital. Thanks to an unusual combination of circumstances—one of the best state Medicaid programs (in terms of level of reimbursement for ambulatory care) in the country, and a city with a uniquely large number of high quality medical institutions which accept Medicaid patients—poor consumers have achieved a marginal degree of control over the operations of Boston City Hospital by way of their market power. A successful public relations campaign could in the end serve to mitigate that power without providing anything meaningful in return.

*THE FREE CLINIC MOVEMENT.* A recent health care phenomenon—colorful, idealistic and often political—is spreading across the country: the free clinic movement. In the early days, it was often drug-oriented, with treatment provided by well-meaning doctors who wanted to control drug abuse.

The patients, however, soon took on a major role. In Los Angeles, they insisted that they did not want to be cared for if they were going to be lectured about their life style. They emphasized that they wanted to learn how to treat each other, since that was, in fact, a major part of their life style. Like the neighborhood health centers that serve the poor, the free clinics try to deal with an increasing number of highly mobile, often alienated youth—"street people." Like the poor, the youth often feel no one speaks their language; that there is no one to whom they can go to for help; that medical care may become punitive; and that even when they seek medical help, their problems often require lawyers, social workers—in a word "people to help, not hassle."

Though many of the clinics began treating predominantly white, middle-class hippies, a growing number of blacks and "bike people," who mingle with street people, have been coming for help.

The clinics share many of the same characteristics. They usually are housed in storefronts or churches, staffed with volunteer physicians, nurses and pharmacists, and receive occasional help from social workers,

lawyers or therapists, most of whom are also young. And there is a similar spirit: to provide help without judgment in a friendly, non-bureaucratic way. It is expected that everyone will help each other. Physicians and nurses are expected to be on the same footing with the rest of the workers. In San Francisco, a doctor who heads a Mexican-American clinic said: "Everyone here has a responsibility to do everything from sweeping up to talking to the patients." This attitude does not necessarily affect the quality of the care, but it does show the free clinic approach that those who want to be thoroughly involved can be, and that care, which many so desperately need, can be had.

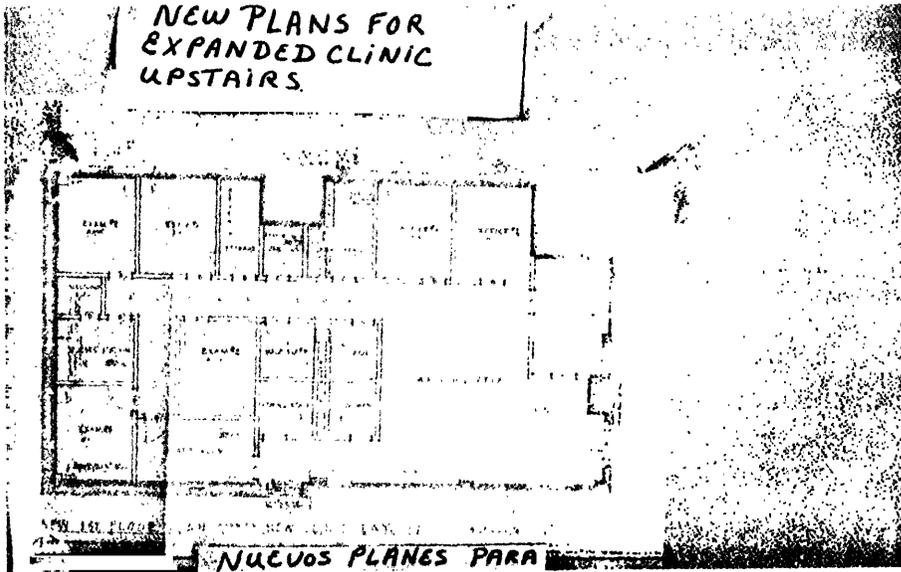
In Cambridge, Massachusetts, where the roving youth street population is estimated at 2,000 to 3,000, the Cambridgeport Medical Clinic has treated 8,000 young people since it opened two years ago. Dr. Joseph Brenner, a psychiatrist and founder-director of the clinic, described some of the common experiences he encountered with young people, which convinced him both that there was no place that street people could go for medical help unless their case was an emergency, and that the clinic was necessary.<sup>37</sup>

A young man using heroin contracted hepatitis and was afraid to seek help since Boston hospitals had been instructed to notify police in such cases. A 19-year-old girl, estranged from her family, went to the hospital when a serious infection developed after a clumsy

abortion, and was lectured on morality. Brenner described it this way:

"The nurse who took the history was openly hostile and made it quite clear to the girl that she disapproved of her dress, her friends, her mores—whatever she perceived them to be—and her illness. She was told bluntly that she deserved everything she got, living the way she did, sleeping around, getting pregnant, having an illegal abortion, and so on. One of the physicians on duty who saw her very briefly, conveyed more or less the same message, and told her that she would have to wait around a while before he would examine her because there were more deserving patients to be seen than she. . . . Humiliated, angry, frightened, exhausted and in pain, she sat in that hospital emergency room with her friends for more than two hours before walking out."

The clinic, which is funded by a grant from a private foundation, is open weekdays from 6:00-10:30 p.m. It has a staff of three doctors, two nurses and a secretary, and sees about 30 patients a night. There are no eligibility requirements but university students are encouraged to use college health services. The clinic treats a whole range of illnesses. There are some drug problems, although Dr. Brenner says that the hard drugs have peaked, and that heroin is as rare as marijuana is common.



People often come to the clinic just to talk, but their deeper problems emerge. By the spring of 1970, the clinic was swamped with medical demands, so it started the Cambridgeport Problem Center, which shares the clinic's rooms, and is open in the afternoon. An informal team (welfare worker, lawyer, social worker, psychiatrist and psychologist working with concerned people who have no particular profession) meets with clients. The atmosphere is loose, and lawyers find themselves doing social workers' "work" and vice versa. The center, which opened last June, has been averaging 30-50 patients a day. Like the other medical clinics, the problem center tries to be nonjudgmental and "to help people make better life choices," as one psychiatrist put it.

Health care for the San Francisco Mexican-American community grew up as the people became politically active. Their activism centered on the trial of Los Siete, a group of seven Chicanos accused of murdering a policeman. As the community mobilized, all kinds of discontent surfaced. Health was one of the issues. In late January, 1970, the Free People's Clinic was opened in the evenings from 6:00-10:30 p.m., above a drug store and near a neighborhood legal service and a youth project.<sup>38</sup>

Once again, the spirit is striking. The tiny waiting rooms are packed with people speaking Spanish and English; children are being read to, and neighborhood "workers" are talking to patients. A young, white, mustachioed doctor wearing a Mexican vest, comes out to greet a tired looking mother holding a child. He talks to her in Spanish; he takes him time. While examining the child, he asks her how her son in Vietnam is, whether her teenage son has found work—and in the middle of the examination he has found out that she is sleeping badly.

Each person who comes to the clinic is assigned a "caseworker," in addition to seeing the doctor. The caseworker speaks Spanish, might be a neighbor, but in any case lives in the community. Some of them are very young—in their late teens—but they go doggedly after problems, helping a patient to find a job, rent money, food for an infant, a place to talk to somebody. In addition to caseworkers, there is a small laboratory on the premises, staffed by a professional, blue-jean-clad lab technician who, in turn, is training a community resident in basic laboratory techniques. Drugs are donated. Spanish is taught, as is English.

An important part of the clinic is the meeting that is held every evening after the clinic closes. Each case handled that night is discussed (in both Spanish and English). Caseworkers give their impressions of the patient, which they glean from careful, though informal talk, before and after the doctor sees the patient. The doctor, in turn, explains what was medically wrong, what caused the problem, and what he prescribes as

treatment. Questions are asked. If the diagnosis is not clear, the patient is referred to a specialist who is willing to examine him with little or no charge.

The staff feels that the clinic is part of a revolutionary way of looking, not only at health care, but at people. Their idea is that everyone who needs health care should get it, and that everyone in a community can learn a great deal about health and help each other. The nightly review of individual case histories draws much self-criticism, which ranges from the medication prescribed to the swiftness with which the case was handled. This criticism, again, is part of the revolution, clinic members say.

In several cities across the country, the Black Panthers are operating free clinics. Among the most active are the Fred Hampton Memorial Health Clinic and its partner, the Malcolm X Memorial Dental Clinic, which occupy former doctor and dental offices in the Black community of Portland, Oregon. Set up jointly by the Panthers and a white radical health group called Health Research and Action Group, the clinic is now run by the Panthers, and treats 100-125 people a week, while the dental clinic averages 85 patients.

Care is delivered without cost by volunteer doctors, specialists as well as general practitioners. They work on a rotating basis (though at least one doctor is on each night, and the clinic tries to get two each night), each weekday night from 7:00-10:00 p.m. Staffed by 25 dentists, the dental clinic is open the same hours four nights a week and Thursday mornings. Though some young doctors are beginning to be attracted to the clinic, the bulk of the 35 doctors are middle-aged.

The rule at the Portland clinic is that medical patients are seen on a first-come, first-served basis, unless one is very ill. Dental patients, as a rule, make appointments in advance, though emergencies for both medical and dental patients take precedence over any appointment or early arrival. The average waiting time to see a doctor is one hour, a maximum of two or three. Again, by contrast to the city hospitals, the waiting rooms are attractive, with magazines to read, toys for the children, and perhaps most important, the patient is always told why there is a delay and given some idea of how long it will be.

The University of Oregon Medical School has been cooperative. At least half of the doctors are from the school. Its dental school also loaned the dental equipment. In addition to the care, many services are provided to the community: pregnancy tests, laboratory tests done by a lab technician on the premises and x-rays.

The Health and Research Action Group dissolved shortly after the clinic opened, but a member of that group has retained an active interest in the clinic and continues to share in the decision-making. Since the clinic opened, fundamental political decisions have been

made by the Panthers. One of the major ones was not to seek or accept any federal funding but to rely on contributions and "money without any strings attached." So far this has meant the doctors supply the necessary equipment, and a black business, the "88¢ Store," has set aside \$50 each month for the clinic. In addition to the businessmen, local ministers and churches have contributed, but it is still a struggle to pay the rent each month.

One of the key problems the Panther free clinic has had is how to reach the really poor in its community, those who need health care most. As one clinic worker put it, "We started out serving the whole city, but we soon found out that it's much easier to attract hippie white kids rather than poor blacks. And if there are too many white kids then the blacks will think it's a hippie thing and that they don't belong." As a result, the clinic is now sending a black member of the community and medical person door-to-door explaining to neighborhood residents what kinds of care are available through the clinic.

The free clinics are certainly no panacea as their promoters will readily say. One Oregon community worker summed it up this way: "When people see the clinic, they tend to say, 'Oh, how nice, a free clinic.' But they forget the scale we're working on. While we see 500 patients a month, a county hospital can see 5,000. We can survive, maybe, on the public relations budgets of drug companies, but that's not the point. Free clinics are not the answer. We need a revolution before medical care is organized for the people, along preventive rather than crisis lines."

**NEW TOWNS.** An area with great potential for involving consumers in health planning is in the new towns—110 of which are planned, with government help, in the coming years. The new communities, some 70 of which exist (though these have been initiated by private developers), were originally conceived of as innovative approaches to urban living. The new communities promised excellence of facilities, schools, recreation, creative land use and employment close to housing to minimize travel. But at this point—with the program one year old—little experimentation in health planning has been tried or is even on the drawing boards in new communities.

Two well developed new communities—Columbia, Maryland, a town of 10,000 between Baltimore and Washington, and Reston, a town of 8,000 run by the Gulf Corporation, located in Virginia, just 17 miles from downtown Washington—are in the process of putting together health programs. At this time, Columbia is much further along in its planning.

Its plan, which began a year ago, provides comprehensive health services to all Columbia residents who want them as well as to the employees of neighboring

industries (through a prepaid group practice of three physicians—two internists and a pediatrician). The cost is \$43.50 per month for a family, regardless of size, and \$14 a month for individuals—with a \$2 co-payment charge on all services and a \$2 charge for all drugs. The monthly charge includes unlimited ambulatory services, full hospitalization and ambulances. In addition, Connecticut General Life Insurance Company covers up to 80 per cent of the cost of special benefits which include referral to a doctor which the Columbia Plan does not have on the staff, convalescent homes and mental health referral up to \$25,000.

Like Kaiser's, the Columbia Plan's emphasis is on prevention. The plan is totally administered by Johns Hopkins University Hospital. Much attention is given to screening of "well patients," and the plan encourages periodic examinations. Using innovations tried in the San Francisco Kaiser pediatric program and the University of Colorado pediatric program, the plan has trained three nurses as health associates to take over much of this screening, though the doctor makes the final assessment on the health of a patient.

The Johns Hopkins administrators are not only eager to provide quality care, but to use Columbia as a testing ground for the development of an integrated health system, delivering all of its care either in the town of Columbia or on referral to Johns Hopkins in Baltimore. The plan is offered on the usual dual choice basis but if a person joins, he must agree to use only doctors in the Columbia Plan. He does have a choice among the three. In this way, they hope to overcome fragmented care, or as one official of the plan put it, "to keep a dermatologist in Washington from prescribing one thing, while the patient's allergist in Columbia is prescribing something totally different—and perhaps in conflict."

In addition to a comprehensive plan, Johns Hopkins hopes to train new paramedics, to use medical students in new ways and to experiment with new forms of health insurance.

As good as the Columbia Plan appears, those who are enrolled in it have had no part in shaping it. In 1964, three years before Columbia became a physical reality, Johns Hopkins began talking with the Rouse Company, the developers of Columbia, about the possibility of delivering medical care to the potential residents. The talks went on for five years, leaving Columbia residents without any internal organized health care when it opened in 1967 and dependent on neighboring Howard County physicians or the old ties they had with doctors in Washington or Baltimore. Though residents felt strongly about this lack of care, they were not able to speed up the negotiations.

Today the organization of the health plan is tripartite. Connecticut General's concern is insurance. There is a Board of Trustees which governs the Columbia

Hospital Corporation composed of nine hospital administrators; it recently decided to include one appointed consumer representative. Thirdly, the partnership of the three doctors makes all the final decisions regarding medical matters. The plan did decide that it was important to have consumer input to the program, so it suggested last July that an advisory committee of plan members be established. But the committee's role is seen simply as advisory, and it has no real power to influence decisions. It receives its information from a health plan official, and no one, as yet, attends the hospital corporation meetings.

Currently, the plan is using an outpatient clinic while a new hospital is being designed. The consumers are not part of the design process. The doctors have decided to limit their partnership to three, and that decision is also out of the purview of consumers. In a word, the consumers' role is seen as educating the community about the plan (45 per cent of the residents now belong), being informed about the functioning of the plan and making grievances known to plan administrators.

In effect, what Columbia offers is not new or innovative but good care for the enrolled 5,200 members. As it increases to its planned size of 120,000 and the quality of care has to be extended, health care may emerge as a major issue, but there is no way for the residents to affect the present structure.

Reston, though an older community established in 1961 by a private developer, has tried to involve residents from the outset. Smaller than Columbia and slower to grow, it used nearby medical facilities and had only two dentists, one full-time internist and several part-time specialists. A new medical building is planned for late 1972 and will accommodate two internists, two pediatricians, a podiatrist, two dentists, one orthodontist and several part-time specialists, all in solo practice.

In 1967, Georgetown University in Washington, D. C., and Reston began a joint health care project to develop ways in which Reston residents and health professionals could plan the community's health program and facilities and define the health characteristics of the population. In contrast to the role of Johns Hopkins in Columbia, however, Georgetown saw itself as

an adviser and educator rather than as ultimately providing the medical services that the project would decide the town needed.

After two years of study, however, conflict arose over just what role the university should have. Many in Reston were impressed by Johns Hopkins' move into Columbia and wanted Georgetown to provide similar services. At the same time, the strong resident Citizens Health Committee wanted to retain a maximum amount of consumer participation in whatever health services were provided. A power struggle ensued and work came to a standstill.

Today, Georgetown is negotiating with an insurance company and is making final arrangements with Reston to provide health services. Their model is Johns Hopkins in Columbia, though they plan to retain a more significant role for consumers—putting substantial numbers on the board that runs the health facility—but not allowing them control over policy or practice.

As one community leader put it: "What we want in Reston is to meet the people's health needs. We don't want one system. We want the private doctors who are here to thrive, and if the people want to use them instead of our system fine. We want competition, and most of all to have people have options so that they can get the best care." Compared to the dreams of urban planners who envisioned new towns not only as centers of innovation in their own environs, but also as catalysts and coordinators for a whole region, this comment is particularly disappointing.

The consumer movements of both past and present described throughout this chapter have highlighted many of the problems of health care delivery in America today and perhaps shed some light on the potential solutions. But these movements were and are fragmented and limited to particular regions and/or special groups of union members, the poor, youth and so on. The Citizens Board of Inquiry respects the value of these movements. In our final chapter, we present a series of recommendations in which we hope to strike at the core of the problem which these movements faced—how to restructure the system of delivering health care to make it responsive to the needs of those who must make use of it.



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# Chapter V

## Conclusions and Recommendations

No matter how ignorant any person is, there is one thing he knows better than anybody else, and that is where the shoes pinch his own feet, and that is because it is the individual that knows his own troubles, even if he is not literate or sophisticated in other respects. The idea of democracy as opposed to any conception of aristocracy is that every individual must be consulted in such a way, actively not passively, that he himself becomes a part of the process of authority, of the process of social control; that his needs and wants have a chance to be registered where they count in determining social policy.—*John Dewey, Problems of Men*

### Conclusions

**I. The United States has failed to provide adequate health services to the vast majority of its citizens.**

There are millions of Americans who now receive virtually no health care. There are millions of other Americans who receive care only sporadically. Most health care is delivered at staggering financial costs and, in many cases, with unnecessary suffering.

There is an urgent need to abolish chaos in the delivery of health care. That need is not based on a sentimental view of powerless consumers nor on a cynical view of providers.

The disarray in our health care delivery system drains the resources of government at all levels, corporations, labor organizations and individual citizens; and even so, the job does not get done.

Consumers using the present system are too often confronted with unavailability of care, delays, neglect and exorbitant costs. Many providers working in the present system are faced with inhuman work loads and intense frustration.

**II. The system is in disarray despite intermittent efforts by some responsible persons to modify it in the consumers' interests.**

There has not been any real, sustained or organized

pressure to create a rational health care delivery system responsive to consumer needs.

Some form of universal financing for comprehensive health care in the United States will be adopted within the near future. But without a drastic alteration of the present delivery system, the adoption of such a program or any other massive infusion of new federal monies will simply compound the failure of the present system.

**III. Consumers have no real or effective role in the planning, organization or delivery of health care.**

Providers and other health care professionals are firmly in control of our health care delivery system. Consumers and providers, because they are pursuing different and usually competing interests, are often at odds in determining what health services are needed and how they should be delivered. This adversary relationship can be constructive. Consumers and providers are not equal partners and it is unreasonable and unjust to expect health care professionals to assume full responsibility for furthering consumer interests.

**IV. Consumers have few meaningful options in health care today.**

There are few effective competing systems to lower costs or guarantee better health care. Most health care, particularly non-hospital care, is offered under arrangements where the consumer has no way to evaluate the system of care or to make the system responsive to him. This must be changed. Individual providers should not continue to have the sole right to determine when, where and under what circumstances health care services should be offered.

**V. America has the technology and the resources to provide adequate health care for each of its citizens.**

It is time to translate the right of this nation's citizens to receive adequate health care from an empty slogan to a meaningful reality. The federal government must promptly assume the final and residual responsibility for assuring each American access to high quality, comprehensive health services, rendered under acceptable circumstances.

## Recommendations

The Citizens Board of Inquiry into Health Services for Americans recommends:

### I. All Americans should receive adequate health care that has the following minimum characteristics:

A. **Access to required health services.** All services necessary to maintain, protect and regain optimum health including:

1. *Continual access to basic medical care.* This includes not only diagnosis, treatment and rehabilitation, but also such preventive and health maintenance services as immunizations and nutritional guidance.

2. *Daily access to routine health guidance.* This requires being able to reach by telephone, at specified convenient times, personnel who can provide guidance in routine health problems (e.g., care of well children, expectant mothers, chronically ill). It also means that the consumer can get advice about the best point of entry into the health care system in a specific situation; and can be informed about available health services and encouraged to use them.

3. *Immediate access to emergency service.* This requires well-staffed hospital emergency rooms operating around the clock, a telephone easily accessible to every home, with 24-hour, seven-day a week, well-publicized emergency numbers that connect to:

- a) ambulance service with trained attendants;
- b) trained personnel to provide for emergencies such as in cases of accidental poisoning and injuries;
- c) trained personnel to make necessary house calls.

4. *Periodic access to diagnostic and screening procedures* (differing with age, sex and other characteristics), with organized follow-up care providing simple ways of identifying, in the absence of gross symptoms, those who need medical care.

5. *Access, when needed, to non-medical services that maintain, protect or regain health*, such as home-makers or legal services to enforce housing and sanitation codes.

B. **Adequate organization for the delivery of health care.** Not only must adequate care be delivered, but the method of delivery and the circumstances surrounding such delivery must also be adequate, including:

1. *Financing of care* There must be no economic barriers to the receipt of adequate health care.

2. *Prompt service* Health services must be organized to assure minimal waiting time for all care, regardless of whether it is an emergency, an appointment or a telephone consultation.

3. *Encounters with health personnel* Personnel should maintain an atmosphere of friendliness, dignity and personal identification with patients or prospective patients. Neither alienation nor depersonalization are necessary parts of any health care system.

4. *Providers of health care* Health care providers should be aware of their patient's life and work, so they can more effectively relate care to his circumstances.

5. *Organization of services* Services must be so organized to assure that someone on the health care team has enough time to listen to the consumer and to explain the care being provided.

6. *Removal of barriers* Barriers of race, ethnicity, language, transportation, eligibility procedures, location and hours of services as well as financial barriers must be eliminated.

7. *Care of dependents* The health care institution should arrange for care of children while adults are being treated.

8. *Coordination of care* An individual's and a family's care must be made continuous and coordinated. The technology exists to assure that the medical information that has been obtained by any person or institution in the medical care system is available to all other providers of care.

9. *Assessing quality* The consumer must be provided with the requisite information to enable him to make judgments about the quality of care he is receiving.

II. **To extend the full range of health services and make them more responsive to consumers, we believe new structures must be created, and certain existing ones be more widely disseminated. Health care systems can no longer depend upon the accumulation of isolated decisions on the nature and distribution of resources and services made by individual providers irrespective of the public's needs.**

A. No person should have a fee-for-service arrangement as his only option in obtaining health care.

B. Care outside the hospital should be locally organized within any of a variety of well-defined structures. Whether the structure is a prepaid group practice, a neighborhood health center, a medical school-sponsored "foundation", it does not necessarily need a defined physical setting, but *does* require a coherent organizational and administrative framework that reflects consumers' wishes.

C. Financing mechanisms, including current government programs and any national health insurance program that may be developed, should encourage and support the development and operation of a wide variety of such structured health service programs.

III. **Health care delivery systems should be organized and made accountable to the public in the following ways:**

A. Health professionals should make individual decisions affecting the health of their patients while the public should become the ultimate determinant of the health care system and of how health care services are

delivered, paid for and organized.

B. Consumers must have the dominant role at all levels in the decision-making process of the health care system.

C. While we do not advocate any one particular process to be used in selecting persons to represent consumers in decision-making, the selection process should stress the following principles:

1. The procedure for selecting consumer representatives must be well-known and clear to the community or to the consumer group to which services are being provided;

2. Individual consumers and consumer groups must be able to affect the process of selection;

3. Consumer representatives must be accountable and responsible to the group that they represent.

**IV. Consumers must be able to establish goals, objectives and priorities of the newly-structured delivery system and make them effective in the organization and delivery of health services.**

A. Adequate resources must be made available to consumer representatives so that they can make appropriate decisions and recommendations. These representatives must become well-informed about the financing, operations and mechanisms of the health care delivery system and their particular part of it. In some cases, consumer representatives will need a professional staff or consultants whose prime responsibility is to consumers and not to the provider mechanism.

B. The power of the consumer to control and influence the delivery system must be exercised at every level of the health care system: facility, service system or program, and neighborhood, city, state, region or nation. This power should include, but not be limited to, making policy, controlling assets (including capital expenditures), facilities, equipment and services. This does not mean that consumers will usurp the doctor's responsibility for meeting his patient's medical needs. On all levels of decision-making, clear lines between policy (the consumer's primary business) and professional judgment regarding the individual patient (the physician's primary business) should be established.

C. Agencies or institutions that render medical services and that spend public funds or enjoy tax advantages should examine whether having providers of their services in positions of authority over the governance of the same agency or institution is in the best interest of that agency or institution or the services that are provided.

D. Where providers now sit on boards such as on Hospital Boards of Trustees, Blue Cross and Blue Shield Boards, Regional Medical Programs, Boards of Health and various planning councils, they often are in "conflict of interest" positions and, in effect, decide what health

services to purchase from themselves. When this occurs, these providers should be replaced by consumers or by professionals who cannot provide services under the authority of the agency they help control.

E. Where providers are not in such "conflict of interest" roles, they may play an essential part in the decision-making process. But those who derive income and profit from a specific system of health care should not be in a position to be advocate-judge-and-jury of those services.

**V. It is the responsibility of government, ultimately the federal government, to assure adequate health care for all Americans. Where care is inadequate, the federal government must become the residual guarantor, and, if necessary, the provider of health care.**

A. The federal government must eliminate all economic barriers to health services. As part of that action, some form of universal health care financing must be enacted. That might be a national health insurance program, but only in conjunction with the realization of other goals set forth in these recommendations.

B. The federal government must develop and provide the information and technology to periodically evaluate and assess the performance of the health services system.

C. In institutions, localities, areas or jurisdictions where health care is inadequate, government and ultimately federal government should (1) have the authority and (2) exercise that authority to remedy existing defects. In those instances, government—and ultimately federal government—should provide funds, personnel, physical facilities or technical assistance, as required, including, where necessary, government-employed physicians; access to existing government health facilities, including Veterans Administration, military and Public Health Service Hospitals and services; and the regulations, control and operation of hospitals that obtain government funds or support, including tax exempt status.

**VI. In order to bring about these recommended changes, consumers and interested consumer and provider groups should take the following actions:**

A. Work for enactment of legislation at all levels of government to shift to consumers the power to make health care policy.

B. Initiate and support legal action to provide stronger consumer representation on provider-dominated health care bodies, such as Boards of Health, and to provide access to health services.

C. Provide technical assistance for consumers to build consumer strength.

D. Support development of new types of health services.

E. Build coalitions of interested groups to further these goals.

# Dissenting Opinion

NOTE: The Board agreed from its beginnings that unanimous endorsement would be sought on its findings and recommendations. But the Board also agreed that major differences of opinion, if irreconcilable, would be respected and reported in the belief that exposure of these differences would be more rewarding than either a weak compromise or the loss of critical views from a submerged minority.

Dr. Gerald Besson is the only Board member who desired to take advantage of the right of public dissent. His statement is printed below. With his consent this introductory statement and some footnotes are appended.

Dr. Besson was a valuable and constructive participant in the discussions of the Board. He was enthusiastic about the Board's mission throughout its work. We are proud and grateful to count him a colleague in this venture. His statement of dissent was submitted too late for it to be reviewed by the entire Board. If we had the privilege of additional time and money for a meeting to undertake such a review, Dr. Besson's minority report would almost certainly have been briefer. Much of what he reports as dissent would in fact have been endorsed by the majority. His dissent in part is addressed to perspectives developed in early drafts of the report; changes were made at the request of many Board members. For example, Dr. Besson rejects the idea of a federally operated single system of health services for all people in all situations. The majority report agrees (see footnotes). The majority reported that there should be many systems of health care for different people in different situations, that the systems should be locally operated and administered, that they should be guaranteed by government, and ultimately, if necessary, by federal government. The majority urged that these local systems be "structured" or "institutionalized," and that a system, dependent only on the random individual participation of individual providers, on a fee-for-service basis was not adequate.

Dr. Besson takes exception to what seems to be a strident and accusatory tone in parts of the report. Many of us agreed with him, especially on early drafts, and succeeded in having the tone in part modulated. In the last analysis the view prevailed that to eliminate this tone altogether would be to ignore an important aspect of the field work: many people are indeed angry,

strident and accusatory toward health services and their providers.

Finally we should acknowledge that a Board as large, varied, and as able as this one represents many shades of opinion and experience. Although nearly all members were willing to endorse the report, each could also, given time and encouragement, have improved on it with his personal touch. We are grateful to Dr. Besson for giving his.—*C. Arden Miller*

**T**his dissenting opinion is submitted because of some fundamental differences with the majority report. The undersigned, as a practicing physician and a concerned citizen, appreciates the opportunity to have served on this Board and the further opportunity to present this minority view.

There is an inherent bias in the rhetoric of the majority report, which serves no constructive purpose, and, in being accusatory rather than informative, does a disservice to a dedicated profession. Such rhetoric serves to undermine the cooperative effort between consumer, provider and government that is necessary if we are to correct the obvious and poignant inequities in the provision of health care.

It is regrettable that the provider is being discounted as a source of solution for the problems that this report documents. The right to health care must be guaranteed by our entire society, not the federal government alone. To suggest the latter would be a cruel hoax in raising expectations, incapable of being fulfilled. The report, therefore, should have addressed our entire society, including the provider. To denigrate the responsible role the provider must share in guaranteeing the appropriateness, relevance and success of solutions is a disservice to our democratic processes and our pluralistic heritage.

There is a further inherent bias in the selection of consumers for interview which was neither cross-sectional nor representative of all our people. Granting the limitations of time, staff and money that precluded an exhaustive and scientifically sound inquiry, the opinion that resulted from the sampling seems to imply that there is nothing worthwhile in the entire health effort in this country. There is evidence to the contrary, and to deny it undercuts the credibility of this report.

There is, finally, a deep concern about the process of writing a report such as this. It was necessarily written by staff, although the Board was given ample opportunity to react to it. The manner of collecting material, interpreting and presenting it, could only reflect the authors' views, as modified by the Board. No amount of suggestion for change, however, could reconcile fundamentally disparate views, hence this minority statement.

This dissenting opinion rejects the contention of the majority report that it has presented evidence of the gross national inadequacy of health services. What it has done is presented the view of those bereft of health care because of their poverty and those who, because of their socio-culturally deprived life style have strong deterrents to an optimal health state.

This dissenting opinion rejects the contention of the majority report that it has presented evidence for a single nationwide federal program as a solution for our health service problems.<sup>1</sup> Such a simplistic conclusion is an interpretation that is neither supported by the interviews that make up the basis for this report, nor is based on hard data or dispassionate planning.

This dissenting opinion rejects the contention of the majority report that the consumers are powerless in relation to the provider. This cynical view completely ignores the existence of a professional ethic, the strength of consumer advocates and the rapidly emerging role of the consumer in all health policy matters.

This dissenting opinion rejects the inflammatory and emotional appeal by the majority report for crisis relief at any cost without concomitant long-range planning. Such an approach does not do justice to the talents represented on this Board which are capable of sound inquiry, equitable judgment, and constructive proposals for change.

The following is a summary for the basis of this dissenting opinion:

#### (1) Adequacy of health services.

There is no denying that many Americans have less than optimal health care. There is also no denying that the system may often be unresponsive to consumer needs. Nor is there any disagreement that we must, as a mature society, guarantee the right to health services for those in need, without the impediments of cost, inaccessibility or lack of responsiveness. The fundamental problem is to decide exactly how to achieve the greatest degree of equity in the provision of health services consistent with what our society establishes as its order of socio-economic priorities.

*Health and Social Problems.* While this entire report is ostensibly devoted to health, it is apparent to all that health is but a small aspect of one's socio-cultural well-being. To correct inequities in health care without simultaneously correcting inequities in housing, nutri-

tion, education and environment is fruitless. One needs no documentation of the impact of poverty and its attendant evils on one's health state.<sup>2</sup> To accuse the provider for these shortcomings, as the majority report implies, is inappropriate, as well as distracting from the basic problem. The problem is not lack of health services alone, but the entire culture of poverty. Culpability for these social problems cannot be laid at the feet of the provider. They are ageless and worldwide. We have an opportunity as a nation for the first time in history to overcome the deprivations of poverty and with it overcome the greatest impediment to adequate health services.

Health services also represent only a small fraction of one's general health state. The larger amount of one's health state revolves about life styles and habits, as well as his social environment. No amount of change in our health delivery systems will overcome the deaths attributable to auto accidents, smoking, or dietary excesses, to name only a few. Mortality statistics cannot be considered in a vacuum. A death from a late diagnosis of tuberculosis is no less than a death due to an overdose of heroin. Studies of smokers clearly reveal a diminution in life expectancy of the heavy smoker by eight years, compared with the non-smoker. More than 600,000 persons in the United States die annually from heart disease. Consideration of parameters such as stress, smoking, lack of exercise and diet, all of which are matters of life styles, lends a somewhat different perspective on the true nature of the problems of health in this country. It may well be that the greatest area for improvement in the health state of the American public lies not in the improvement of health services, but rather with education and the assumption of individual responsibility for healthful life styles.

*Health Services.* There is no dispute that health services should be accessible, immediate, personal, unhurried, continuous, concerned and excellent, with no financial barriers. This is an ideal state and we should work towards it. It is a state of health care that is available to many in this country and it should be available to all. In a study done in our area [California], 1,500 households were involved in a survey of health needs. The sample was one-half of one per cent of all households in the county. It was a statistically sound cross section of income, race, ethnic origin and geography. Our final results are not collated but it was surprising to find that 72 per cent of respondents who were asked a series of questions about their care were satisfied with their health services.<sup>3</sup> They were satisfied specifically with availability, accessibility and acceptability. While this was a small sample in one small corner of this great country, it was interesting enough for us to pause and wonder whether our perceptions of the inadequacy of health services in this country are based

on dispassionately acquired data, or whether they are based on reports of that portion of our population that is devoid of optimal care and does need assistance. Shall we then base our decisions on national health policies on health services research or on political reactions to the selected anecdotes presented in the majority report?

### (2) Disarray of our Health Delivery Systems.

The problem also is stated to be that our health delivery systems are inefficient and uncoordinated and what is needed is a rational nationwide system. Furthermore, the majority report continues, the marketplace is inappropriate for the provision of health care and should be dispensed with.

The concept of disarray, in contrast to orderliness, is a semantic trap. One could hardly argue against rationality, responsiveness, or orderliness, yet what do we hope to achieve in providing personal health care if not, in the ideal, an intensely personal service responsive to the patient's needs. Disarray, in one man's view, may well represent ideal personal encounter in another man's view. Nor can the so-called inefficiency of the personal encounter be faulted. On the contrary, anyone in need of health services needs, if nothing else, personal encounter. All our service industries do not lend themselves readily to the kind of productivity that has characterized our industrial economy. The healing arts, particularly, involve the human touch and the dedicated concern of a selfless and knowledgeable professional. To sacrifice this in the name of efficiency and a coordinated system would run against the tide that is rising in our national consciousness that the primary function of our institutions should be the fulfillment of human needs. This must be our focus and to ignore it would serve to increase the depersonalization and alienation that is so widespread today.

How then, are these needs best to be served, if not to provide for all what is possessed by those who are satisfied with their care. There are impediments and these should be removed. Manpower must be expanded as a vital national resource. Cost efficiencies must be enhanced by a variety of techniques, such as computer assistance, automated laboratories, peer review, ancillary health personnel and cost accounting. Any impediments to the growth of alternate delivery systems must be removed.

But diversity of choice cannot be so cavalierly dismissed by instituting a planned new delivery system for all. It is the marketplace that allows for the greatest sensitivity to individual needs. It is limitless in the options available, allows the one who *wants* to do the choosing as he sees fit, rather than having someone choose for him, is devoid of moralizing and draws no distinction among those who purchase. Against these benefits are the obvious critical shortcomings that needs

are subservient to ability to pay. While it is true that the harsh inequities of the market economy would be corrected by a new delivery system, other inequities will surely take their place. The forcing of our entire health venture into a single monolithic system, as the majority report recommends, would tend to freeze mistakes, stifle personal choice, diminish quality, and junk our pluralistic heritage.<sup>4</sup> The public interest would be far better served to retain those portions of our system that are satisfactory, to restructure those aspects of our system that are unsatisfactory, and to create new ones where they are lacking. Pluralism in the provision of health services should be maintained. A basic minimum can be provided for all in this context.

### (3) Centralized vs. Decentralized Loci of Authority

In some circles there is a conventional wisdom that the majority report promulgates, that if there is a problem that affects us all, the solution must be provided by the federal government. This is often expressed by cliches suggesting that the federal government must assume responsibility if individuals or institutions don't do what needs to be done or solve problems in a piecemeal rather than a national fashion.

Inherent in these arguments is the idea that there is an omniscience and omnipotence in Washington which would provide by a stroke of the pen on just the right document the instant and all-pervading solution. Nothing could be further from the truth, as is painfully evident to all citizens who have recognized the vast gulf between federal promise and performance.<sup>5</sup> Our only protection against this gulf is to keep the locus of decision as peripheral as possible and maintain a regional and local approach to solutions that allow for the greatest degree of responsiveness possible. This is the basis on which the Partnership for Health and Regional Medical Programs are functioning and both are attracting wide attention as successful models for federal, state and local relationships. Within broad guidelines from the center, the locus of decision and authority functions best when kept as close as possible to the source of need.

Implied threats of assumption of authority by Washington are empty because an informed citizenry is well aware of the technical impossibility of the provision of services by the federal establishment or the instant creation of an entire new infrastructure for the provision of health services. The federal role in this context is best described by the report of the Task Force on Medicaid and Related Programs: "The task force sees management of the system as given direction by federal leadership, specifically in the Department of Health, Education and Welfare. As is envisioned and recommended here, the management function for the health care system is to be innovative but not prescriptive; bold, but not authoritarian. It is the intention that the federal leadership, as

far as possible, shall guide, not direct; motivate, not demand; assist, not provide; and evaluate, not ordain."<sup>6</sup>

#### (4) Consumer Control in Health Policy

There is no question that the entire health effort must be focused on consumer needs. Any institution devoted to health services, old or new, must have a structure responsive to the consumer.

In the absence of this responsiveness, no amount of consumer control will bring about a desired end. The critical aspect of the consumer's position must be to have a formal opportunity for molding the institution to his needs. In the relationship between patient and physician, this is done in endless encounters based on mutual trust and the satisfying of patient needs. If the institution is other than a one-to-one patient-physician encounter, the establishment of policy must be based on a dialogue between provider and consumer by bringing both representatives together to see how needs are not being fulfilled. Policy decisions must be joint decisions. What is important is the creation of an established methodology for assuring both the dialogue and response to the decision. In this context, the seat of power is of secondary importance, since both provider and consumer are indispensable to the service.

The early history of consumer-dominated organizations for health care delivery has been extremely variable and not all favorable. Some Comprehensive Health Planning Agencies, Neighborhood Health Centers, and Regional Medical Programs have demonstrated a brilliant coordinated effort between provider and consumer. However, often the consumers' numerical presence is a ruse for the retention of an inadequate but established lack of responsiveness. Where policy decisions must be based on technical competence, the inept organizational structure that allows such decisions to be made by the consumers who don't have such technical competence undercuts the credibility of the organization. Consumer representation is also often only a token by the choice of acceptable but impotent representatives.

This minority report agrees that consumer representation must not be a sham nor should providers be responsible for contribution to policy decision if there is any conflict of interest. The essential ingredients for an effective, responsive institution are clearly articulated needs, shared control and responsiveness of provider to policy-making bodies that function as community trustees. The majority report seems to be a clarion call only for the assumption of power and not a search for equity.<sup>7</sup>

#### (5) Planning—Problem Solving vs. Goal Achievement

The majority report calls for an urgent response to a crisis in health care. Perhaps the greatest difficulty encountered by planning groups, however, is the juxta-

position of planning for the achievement of long-range goals and, at the same time, solving urgent problems. Our national health effort has been characterized by an emphasis on the latter and the almost complete ignoring of the former. Both are simultaneously necessary. Unless we set our goals for some fixed time in the future and plan a series of intermediate objectives along a reasonable time scale, we can never move towards the realization of aspirations, except accidentally in the course of heading off one crisis or another. The current stampede towards a universal Federal Health Insurance Program exemplifies the dilemma. No amount of delivery system restructuring or payment mechanisms restructuring can provide adequate care without expanding our manpower resources simultaneously. As we embark on a new national venture in the absence of long-range plans, we will replace present crises with new ones.

It is in this context that this minority report expresses its greatest concern. There is no denying that the poignant inequities described in the majority report do exist. It is feared, however, that the emotionalism engendered by the presentation will serve as a stimulus for the further headlong rush, without planning and rational study, into a system that may create more problems than it will solve and leave us further from the ideal than previously.<sup>8</sup>

By all means, let us jointly work towards solving our pressing health problems as equitably and expeditiously as possible. But let us also, at the same time, define our long-range ideals and set about systematically for their achievement.

**CONCLUSIONS:** This minority report is presented not to dispute the documentation of need and inequities described by the majority report but rather to have the reader consider the conclusions reached based on the following caveats:

That personal health is part of one's milieu. It cannot be improved alone but in the context of other basic social conditions.

That health services contribute to but a small part of one's health state. Mounting a national effort to enhance health services without affecting life styles and the hazards of our culture and environment will do little to ameliorate our national health state.

That in the absence of a dispassionately acquired body of knowledge about health services, we may grossly misdirect a national health effort based on political reaction to poignant anecdotal wisdom.

That in our zeal and our passion for order, we may uncritically reject the primacy of the unhurried human touch in the rendering of personal health services and sacrifice it to the efficiency of a single monolithic health system.

That the obvious inequities in our health care are

correctable without relegating the provision of care to the federal government or a new health care infrastructure. Manpower shortages are amenable by the expansion of this national resource. Distributive shortages are amenable by periods of obligatory service or financial incentive. Individual poverty or medical indigency may be amenable by the provision of funds for those in need. Delivery systems that are inadequate for the culture of poverty may be restructured to meet those needs.

That dialogue between provider and consumer acting as community trustees rather than power struggles of vested interests will best serve consumer needs.

That the locus of authority for health decisions should be as peripheral as possible. Central function

should be to provide coordination, guidance, and resource assistance.

That solving health crises alone will only replace one set with another. There is urgent need for concomitantly planning our future in health care and achieving it only by incremental achievement of intermediate planned objectives.

That ultimately our problems revolve around our choice of national priorities. Human needs and the quality of our lives must be our focus. Our affluent society cannot tolerate the gross social inequities that this report documents. In the necessities of life, a basic minimum for all is economically feasible, just and timely.—*Gerald Besson, M.D.*

# Footnotes

## Chapter I

1) For a definition of terms used in this report see the Glossary on page 92.

2) American Public Health Association, *Health Crisis in America*, 1970, pp. 1-3. The staff of the Citizens Board of Inquiry participated in the field work and preparation of this report.

3) For a discussion on the background of this project see the *American Medical Association News*, June 29, 1970, p. 17. Subsequent conversations between the Citizens Board staff and AMA personnel in Chicago provided us with the information that the units are not yet in operation.

4) Theodore Colombo, Ernest Saward and Merwyn Greenlick, "IV. The Integration of an GEO Health Program Into a Prepaid Comprehensive Group Practice Plan," *American Journal of Public Health*, Vol. 59, No. 4, April 1969, p. 641.

## Chapter II

1) *Los Angeles Times*, March 4, 1970, Part 1, p. 3.

2) Data from the United States Department of Health, Education and Welfare, Public Health Service, National Center for Health Statistics, *Vital and Health Statistics, Data from the National Health Survey*; United Nations Statistical Papers, *Population and Vital Statistics Report*, Ser. A, Vol. 14, No. 1, and Vol. 22, No. 2. See also: The Carnegie Commission on Higher Education, *Higher Education and the Nation's Health*, October 1970, pp. 13-21. [Hereafter cited as *Carnegie Report*.]

3) Telephone interview with Dr. Henry Milke, Acting Director of Clinical Services, Bethesda Naval Hospital, July 13, 1970. Active duty personnel, as well as retired personnel and their dependents are eligible for hospitalization. Active duty personnel pay nothing while all dependents and retired personnel pay \$1.75 a day.

4) In October 1970, the daily room rate at several randomly-selected hospitals throughout the country was as follows:

Hospital	Private Room	Semi-Private Room
Washington Hospital Center, Washington, D.C.	\$75	\$62
Massachusetts General Hospital, Boston, Mass.	\$95	\$88
Albert Einstein Hospital, New York, N.Y.	\$125	\$100
Cornell Medical Center Hospital, New York, N.Y.	\$120	\$95
Weiss Memorial Hospital, Chicago, Ill.	\$66	\$59
Fairview Hospital, Minneapolis, Minn.	\$52.50-\$80	\$48
Clarkson Memorial Hospital, Omaha, Neb.	\$59-\$80	\$49
Cedars of Lebanon Hospital, Los Angeles, Calif.	\$75-\$80	\$65-\$70

5) "It's Time to Operate: Our Ailing Medical System," *Fortune*, January 1970, pp. 78 et seq. See also: U.S. Department of Health, Education, and Welfare, Office of the Secretary, *Report of the Task Force on Medicaid and Related Programs*, June 1970. This task force estimated that health care accounted for about 7 per cent of the gross national product. "Total estimated national health expenditures for fiscal year 1970 are in the neighborhood of \$64 billion and this health care dollar divides approximately 38 per cent in the public and 62 per cent in the private sector," p. 15.

See also: U.S. Bureau of the Budget, *Special Analyses, Budget of the United States, Fiscal Year 1971*, Special Analysis K, p. 147; U.S. Department of Health, Education and Welfare, Social Security Administration, *Research and Statistics Note*, Note No. 18, 1970, "Projections of National Health Expenditures 1975 and 1980."

6) According to the United Nations *Statistical Yearbook, 1968*, if we estimate the number of active doctors per capita to be about 159 per 100,000 (or one for every 628 persons) then Italy and Denmark with 175 per 100,000 and Australia with 167, have a better ratio, and Austria and West Germany with the same ratio compare favorably. In addition, Czechoslovakia, Hungary, the U.S.S.R. and Israel also had a higher number of physicians per capita than the United States.

The American Medical Association estimates the ratio to be one physician for every 700 people.

Figures obtained from Marguerite Schwartz, Ph.D., American Medical Association Library, Washington, D.C. See also: American Medical Association, Department of Survey Research, Center for Health Services Research and Development, *Distribution of Physicians, Hospitals, and Hospital Beds in the U.S., Regional, State, County, Metropolitan Area, 1967* (Chicago, 1968).

7) According to the United States Department of Commerce, Bureau of the Census, the civilian population of the U.S. as of July 1, 1970, was 202,242,000. *Population Estimates and Projections*, Series p-25, #446. *Hospitals*, the Journal of the American Hospital Association, Volume 43, No. 15, pt. 2 August 1969, states that there were 7,137 hospitals and 1,663,203 hospital beds in the United States. Of this total, 5,820 hospitals with 806,000 of the beds were non-federal, short-term community hospitals, the institutions most Americans use, which provide the greatest proportion of civilian medical services. Psychiatric and tuberculosis hospitals are not included.

8) U.S. Public Health Service, *Dental Visits-Time Interval Since Last Visit-U.S., July 1963 and June 1964*, Washington, D.C., 1966.

According to this study, three-fifths of the population had not seen a dentist in a year's time and one-sixth of the population have never seen a dentist. See also U.S. Public Health Service, *Health Manpower Perspective: 1967*, Washington, D.C., 1967, p. 14.

9) *Hearings on Hospital and Health Facility Construction and Modernization*, before the Subcommittee on Public Health and Welfare, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, 91st Cong. 1st sess., March 25-28, 1969, p. 194.

10) A number of years ago an elderly physician in Scotland complained about practice under the National Health Service. When asked if he would like the service abolished he said, "no I just want it improved. I, for one, never again want to work under a system in which I profit from other peoples' misfortunes."

11) Eli Ginzberg with Miriam Ostrow, *Men, Money and Medicine* (New York: Columbia University Press, 1969). "In most markets, supply and demand are kept in reasonable balance through the movements of prices. But since the nation has declared that people are entitled to quality medical care irrespective of their ability to pay for it, and since affluent consumers are prepared to put their extra income into the purchase of services including medical services... the adjustment mechanism operates differently. The control on expansion is not the price mechanism but is determined primarily by the availability of supply. In short, the supply of medical resources has thus far effectively generated its own demand!" p. 36.

"... The American people have never looked carefully at the large investment in hospital plant and operations they underwrite or the extent of costs that ensue because the hospital is operated for the convenience of the physician. What other explanation is there for the fact that all surgery except emergencies is performed during the first five days of the week and usually only in the morning," p. 92.

For a discussion of the "doctor shortage," see Rashi Fein, *The Doctor Shortage: An Economic Diagnosis*, Brookings Studies in Social Economics (Washington, D.C.; Brookings Institution, 1967).

12) Interview with John A. Cooper, M.D., President, Association of American Medical Colleges, *U.S. News and World Report*, November 3, 1969, p. 73.

13) *Medical Economics*, June 12, 1967, pp. 85-95; June 26, 1967, pp. 114-119, December 11, 1967, pp. 63-75.

According to Internal Revenue Service figures based on business tax returns for 1967, physicians and surgeons netted \$27,000 on the average from their practices; dentists \$20,000, lawyers \$11,000. Among unincorporated retailers, druggists were far ahead with \$11,000 average net. Next came apparel and accessory shops (except for women's) with \$6,700. *Wall Street Journal*, November 11, 1970, p. 1.

14) *Hearings on Health Care in America*, before the Subcommittee on Executive Reorganization, Committee on Government Operations, U.S. Senate, 90th Cong., 2nd sess., April 22-25, 1968, Pt. 1, p. 181-82. [Hereafter cited as *Health Care in America*.]

15) J.P. Bunker, "Surgical Manpower," *New England Journal of Medicine*, Vol. 282, No. 3, January 15, 1970, p. 143.

16) Quoted in David Haggood, "The Health Professional, Cure or Cause of the Health Crisis," *Washington Monthly*, Vol. 1, No. 5, June 1969, p. 62.

17) *Health Care in America*, *op. cit.* Footnote 14, Pt. 1, p. 6. The study to which Dr. Cherkasky's error was done by the Columbia University School of Public Health and Administrative Medicine, *The Quantity, Quality and Costs of Medical and Hospital Care Secured by a Sample of Teamster Families in the New York Area*. Teamsters Joint Council 16 and Management Hospitalization Trust Fund, New York City, 1962.

18) "Cosmetic Surgery," *Medical World News*, Vol. 11 No. 37, September 11, 1970, pp. 41, 50.

19) The Journal, *Medical Economics* is the source of most of the information about physicians' incomes. The following data from a study of physicians in two cities appeared in *Medical Economics*, February 16, 1970, p. 125, and March 16, 1970, p. 115.

Net Income of Physicians in Selected Cities (1968)\*

New York City	General Practitioner	Internist	General Surgeon	
	\$70,000 up	1%	5%	3%
60,000-69,999	1	5	10	
50,000-59,999	1	9	9	
40,000-49,999	10	18	14	
30,000-39,999	15	28	17	
20,000-29,999	31	23	24	
10,000-19,999	34	12	23	
Less	7	0	0	

Chicago	General Practitioner	General Surgeon	OB/Gyn	Pediatrician
	\$70,000 up	3%	11%	7%
60,000-69,999	6	14	11	4
50,000-59,999	7	12	17	9
40,000-49,999	18	24	21	22
30,000-39,999	18	20	22	35
20,000-29,999	28	11	17	17
10,000-19,000	19	5	5	10
Less	1	3	0	1

\*After deduction of operating expenses, but before taxes.

Comparisons of Los Angeles, New York and Chicago, showed the following average incomes:

	Los Angeles	New York	Chicago
General Practitioner	\$37,790	\$23,000	\$30,950
Internist	44,410	35,220	35,770
Surgeon	43,570	31,820	44,440

The following net-income breakdown by fields of practice appeared in *Medical Economics*, February 6, 1967, p. 71.

Self-Employed Physicians: Median Net Income (Before Taxes) By Field of Practice, 1955 and 1965		
	Median Net Income	
	1955	1965
All fields of practice	\$16,017	\$28,960
Orthopedic surgery	24,967	41,850
Radiology	20,850	41,420
Ophthalmology	20,100	35,460
General surgery	18,975	32,510
Obstetrics and gynecology	20,000	30,520
Anesthesiology	19,050	30,240
Psychiatry	17,300	29,340
Internal medicine	14,350	27,730
Pediatrics	14,992	25,240
General practice	14,817	25,090

Other sources: Martin L. Gross, *The Doctors* (New York City: Random House, 1966), pp. 345-49. In attempting to find out how much physicians earn, Gross randomly selected one dozen copies of the *Journal of the American Medical Association* and went through the "Practices for Sale" section, many of which give the gross or net income of the practice. The results of his informal survey show that practices for sale in 1966 averaged a gross income of \$58,000; a net income of approximately \$36,250.

Victor Fuchs, "The Basic Forces Influencing Costs of Medical Care" in U.S. Department of Health, Education and Welfare *Report of the National Conference on Medical Costs* (1967), pp. 24-26.

20) "The medical school diverts many of those it does admit from patient care to research. For the first two years, the student takes a heavily academic curriculum—much of it irrelevant to general practice—but he sees no patients. Dr. Stanley Scheyer, of HEW's Health Services and Mental Health Administration says the students learn that the highest prestige is attached to those internships leading to specialization for academic medicine, the least to general practice. . . . Many students who start out with the desire to make a career in patient care are diverted from that goal by the very institution that is supposed to supply the nation with doctors. This was confirmed with memorable bluntness by a doctor at a teaching hospital: 'We train researchers first, practitioners second. Those who enter practice are usually the second-rate students. . . I feel we shouldn't waste our time on them.'" David Haggood, "The Health Professionals: Cure or Cause of the Health Crisis," *Washington Monthly*, Vol. 1, No. 5, June 1969, p. 69.

*The Task Force on Medicaid and Related Programs, op. cit.* footnote 5, found that medical schools and hospital teaching staffs failed to expose medical students to such alternatives to the fee-for-service pattern of health-care delivery as a prepaid group practice system. p. 33.

Other sources: *Report of the National Advisory Commission on Health Manpower* (1967), Vol. 1, pp. 23-29; Robert J. Haggerty, M.D., "The Role of the University in Education for Family Practice," *The New Physician*, Vol. 18, No. 1, January 1969, pp. 45-49. Daniel Funkstein, "The Learning and Personal Development of Medical Students: Reconsidered," *The New Physician*, Vol. 19, No. 9, September 1970, p. 741.

21) "Present methods of financing medical schools have distorted the schools' purpose. . . . Because research grants are directed toward categorical projects and programs, department

heads plan individually and recruit faculty according to the needs of those programs rather than to the school as a whole. . . . And it is not uncommon for a faculty member to feel that his primary allegiance is to the National Institutes of Health.

"... At the same time, financially hard-pressed clinical departments try to collect as much as possible from third-party payers, each department for its own benefit. . . . The result is a perpetuation of the philosophy of NIH funding, which ignores overall needs in favor of departmental needs." Dr. Robert H. Ebert, Dean, Harvard University Medical School, *Medical World News*, November 21, 1969, p. 17.

For a discussion of the federal role in biomedical research and its impact on medical schools, see Richard M. Magraw, M.D., *Ferment in Medicine* (Philadelphia; W.B. Saunders, Co., 1966) Chapter 10, "The Research Establishment and Expanding Medical Knowledge; Their Effects on Medical Care and Practice" pp. 124-43.

Other sources: U.S. Department of Health, Education and Welfare, *1969 Annual Report*, pp. 175-248, details the purpose and amount of grants made by the National Institutes of Health during fiscal year 1969.

"Sponsored programs are medical school activities that are fostered and supported under special contracts, restricted grants or restricted gifts by agencies or organizations interested in special medical school programs. Funds for sponsored programs must be used according to terms and restrictions specified by the sponsors and agreed to by the school. . . . Sponsored program support increased by 347 per cent from 1958-59 to 1967-68. . . . The institutions heavily dependent on support for sponsored programs find themselves heavily responsive proportionately to the needs and demands of sponsoring agencies." "Medical Education," *Journal of the American Medical Association*, Vol. 210, No. 8, November 24, 1969, pp. 1487-89.

22) According to figures provided by the American Medical Association, there were 324,942 licensed physicians in the United States on file with the AMA as of 1969. The breakdown of specialties follows:

Medical Specialists - 1969	
Allergy	1,706
Cardiovascular diseases	5,970
Dermatology	3,870
Gastroenterology	1,916
Internal medicine	38,258
Pediatrics	17,098
Pediatric allergies	372
Pediatric cardiology	476
Pulmonary diseases	2,240
<b>TOTAL MEDICAL SPECIALISTS</b>	<b>71,886</b>

Surgical Specialists - 1969	
General surgery	28,603
Neurological surgery	2,484
OB/Gyn	18,084
Ophthalmology	9,578
Orthopedic surgery	9,227
Otolaryngology	5,272
Plastic surgery	1,503
Colon and rectal surgery	666
Thoracic surgery	1,857
Urological surgery	5,638
<b>TOTAL SURGICAL SPECIALISTS</b>	<b>82,912</b>

Other Specialists - 1969	
Aviation medicine	1,319
Anesthesiology	10,434
Child psychiatry	1,898
Diagnostic radiology	1,540
Forensic pathology	197
Neurology	2,850
Occupational medicine	2,746
Psychiatry	20,328

Pathology	9,826
Physical medicine and rehabilitation	1,415
General preventive medicine	819
Public health	3,075
Radiology	10,041
Therapeutic radiology	786
Other Specialists	8,753
Unspecified Specialists	13,222
<b>TOTAL</b>	<b>89,249</b>

General practitioners	58,919
Administrators	12,107
Researchers	12,375
Medical school faculty	5,149

(There are also 19,895 physicians listed as inactive with the AMA and 2,081 address unknown.) Figures obtained from Marguerite Schwartz, Ph.D., American Medical Association Library, Washington, D.C.

For the effects of this increase in specialization, see Rashi Fein, *The Doctor Shortage: An Economic Diagnosis*, op. cit. footnote 11. "In three decades, 1931-63, the total physician population ratio rose, but both the number and the ratio of potential family physicians - pediatricians, internists, and general practitioners and part-time specialists in private practice fell." p. 71.

23) *Washington Daily News*, July 7, 1970, p. 7, Col. 2.

24) *Id.* at p. 7, Col. 3.

25) *Carnegie Report*, op. cit. footnote 2, pp. 18-19.

26) S.M. Miller, Pamela Roby and A.A. deVos van Steenwijk, "Creaming the Poor," *Transaction*, Vol. 17, No. 8, June 1970, p. 40.

Other sources: American Medical Association, Department of Survey Research, Special Statistical Studies, *Selected Characteristics of the Physician Population, 1963 and 1967* (Chicago, 1968), p. 13.

"Physicians like the resident population in general have shown increasing concentrations in urban areas. In 1963, 83 per cent of all physicians were located in the 300 Standard Metropolitan Statistical Areas. . . . By 1967, the percentage of physicians in SMSA's had grown to more than 80 per cent."

Walter J. McNerney, "Why Does Medical Care Cost So Much?," *New England Journal of Medicine*, Vol. 282, No. 26, June 25, 1970, pp. 1459-60.

27) American Public Health Association, *Health Crisis in America*, 1970, p. V.

28) David Hapgood, op. cit. footnote 20, p. 62.

29) **Active Health Personnel per 100,000 in Population in the United States by Region**

Profession	Region	Personnel* per 100,000
Physicians (M.D.) 1965*	Middle Atlantic	171
	New England	168
	Pacific	157
	E. North Central	120
	South Atlantic	116
	Mountain	115
	W. North Central	114
	W. South Central	101
	E. South Central	89
Dentists (1965)	Middle Atlantic	58
	New England	53
	Pacific	53
	W. North Central	47
	E. North Central	45
	Mountain	43
	South Atlantic	32
	E. South Central	31

\*Non-federal per 100,000 civilian population

Source: U.S. Public Health Service, *Health Manpower Perspective. 1967*, Washington, D.C., 1967, p. 14.

Information on physician distribution in Kansas provided by telephone interview with Robert W. Brown, M.D., Coordinator Kansas Regional Medical Program, October 5, 1970.

30) *Ibid.*

31) *Ibid.*

32) Interview with James Wiggs, M.D., Great Bend Regional Medical Center, Great Bend, Kansas, July 23, 1970.

33) *Washington Daily News*, July 7, 1970, p. 7, Col. 2.

Other sources: *Carnegie Report*, *op. cit.* footnote 2, pp. 67-69.

34) *Carnegie Report*, *op. cit.* footnote 2, pp. 28-29. Only 48 per cent of all families with heads aged 45-54, the age group in which medical students' parents are likely to be found, reported that much income.

Other sources: "Special Study: Distribution of Black Physicians and Medical Students," *Journal of the American Medical Association*, Vol. 210, No. 8, November 24, 1969, p. 1554; Edwin F. Rosinski, "Social Class of Medical Students," *Journal of the American Medical Association*, Vol. 193, No. 2, July 12, 1965, pp. 95-98.

35) "Medical Education in the United States," *Journal of the American Medical Association*, Vol. 210, No. 8, November 24, 1969, pp. 1462-63, 1484-85, 1496-1505. Stephen Lazar, "Filling the Gaps for Black Students," *The New Physician*, Vol. 18, No. 9, September 1969, pp. 719-22.

To meet some of these difficulties the *Carnegie Report* recommended "a federal program of grants in amounts up to \$4,000 a year for medical and dental students from low-income families. . . ." p. 65.

36) "Medical Education for Social Responsibility," *The New Physician*, Vol. 18, No. 9, September, 1969, p. 114. Other sources: Anselm Strauss, "Medical Organizations and Low Income Groups," *Social Science and Medicine*, Vol. 2, 1969, pp. 143-77. See particularly p. 151 on the middle-class bias of most health workers and the influence of this bias on the quality of care received by poor people.

37) "Poverty, Illness and the Use of Health Services in the United States," *Hospitals*, Journal of the American Hospital Association, Vol. 43, No. 13, July 1, 1969, p. 38.

Number of physician visits per person per year, by sex, color and age, United States, July 1966-June 1967:

Age	Both Sexes		Male		Female	
	White	Non-White	White	Non-White	White	Non-White
	All ages	4.5	3.1	4.0	2.7	5.0
Under 6 years	5.8	3.2	6.0	3.6	5.6	2.7
6-16 years	2.9	1.2	3.0	1.2	2.8	1.3
17-44 years	4.5	3.8	3.3	2.9	5.5	4.7
45-64 years	4.7	3.9	4.3	3.7	5.1	4.1
65 years and over	6.1	4.9	5.5	4.2	6.5	5.5

Age-adjusted number of physician visits per year, by sex, color and family income, United States, July 1966-June 1967:

Family Income	Both Sexes		Male		Female	
	White	Non-White	White	Non-White	White	Non-White
	All Incomes					
Under \$3,000	4.3	3.5	3.9	2.9	4.7	3.9
\$3,000-\$6,999	4.3	3.0	3.9	2.8	4.8	3.3
\$7,000 and over	4.7	3.4	4.2	3.3	5.1	3.5

Source: U.S. Department of Health, Education and Welfare, Public Health Service, Health Services and Mental Health Administration, "Differentials in Health Characteristics by Color: United States—July 1966-June 1967," October 1969, p. 18.

38) Letter dated September, 1969, written by Chip Smith to the executive faculty and deans of the University of Pennsylvania Medical School.

39) Hospitals—By Type—1969

Classification	Hospitals	Beds (in thousands)	Admissions (in thousands)
<b>United States (totals)</b>	7,137	1,663	29,766
<b>All federal</b>	416	175	1,766
All non-federal psychiatric	505	549	538
All non-federal tuberculosis	116	22	36
All non-federal long-term general and other special	280	67	149
<b>All non-federal short-term general and other special</b>	5,820	806	27,276
A. Voluntary nonprofit short-term general and other special	3,430	566	19,659
B. Proprietary for profit	769	48	1,837
C. State and local governmental	1,621	192	5,781

Voluntary, nonprofit, short-term hospitals accounted for 91 per cent of the admissions to hospitals for 1968.

Source: "Guide Issue," *Hospitals*, Journal of the American Hospital Association, Vol. 43, No. 15, August 1, 1969, pt. 2, pp. 474-75.

40) See Section 501-c-3 of the Internal Revenue Code. See also: Revenue Ruling 69-545, Internal Revenue Bulletin 1969-2 at p. 117 for a discussion of hospital exemption qualifications.

41) See Chapter III *infra*, p. 27 et seq.

"The greatest government dollar impact on voluntary hospitals has come from the two billion dollars paid by the federal government to subsidize the construction of hospitals in the Hill-Burton Program and the several billions of federal tax dollars provided to medical schools and teaching hospitals for biomedical research. . . . The exemption from taxation of nonprofit institutions and the tax allowances for charitable donations represent significant indirect forms of support. . . . The federal government pays voluntary hospitals directly for hospital treatment of dependents of the uniformed services, veterans . . . federal employees injured in the line of duty. It also shares . . . in the cost of care of public assistance recipients and the welfare categories of dependent children, blind . . . totally and permanently disabled persons. . . . The Social Security Administration estimated that in 1961, 56 million . . . people were eligible for some medical or hospital care at government expense, regardless of ability to pay. . . ." Jack Masur, M.D., "Government and Hospitals" in *Hospitals, Doctors and the Public Interest*, John Knowles (ed), (Boston: Harvard University Press 1965) pp. 129-30. [Hereafter cited as *Hospitals, Doctors and the Public Interest*.]

42) Joint Commission on Accreditation of Hospitals, *Standards for Accreditation of Hospitals*, October, 1969, pp. IV-VIII for description of how the commission operates.

The founding sponsors of the joint commission were the American College of Surgeons, the American College of Physicians, the American Hospital Association, the American Medical Association and the Canadian Medical Association. The effectiveness of this organization in regulating hospitals has been significant. For example, written into the Medicare Act was the provision that the hospitals participating in the program were to maintain the level of patient care which "had come to be recognized as the norm." The standards of the joint commission were cited in the law as reflecting that norm, and were incorporated in the law by reference. *The Conditions of*

*Participation for Hospitals* which the Social Security Administration promulgated reflected the commission standards.

Other sources: U.S. Department of Health, Education and Welfare, Public Health Service, Health Services and Mental Health Administration, *Health Resources Statistics: 1969*, pp. 245-46; "Hospital Accreditation" *Medical World News*, Vol. 11, No. 20, May 15, 1970, pp. 31-40; Leonard Sloan, *Today's Hospital* (New York; Harper and Row, 1966) p. 189.

A recent report by the Center for the Study of Responsive Law, Washington, D.C. (1970), *One Life-One Physician* has an analysis of the role of the JCAH and its impact on hospitals. The report is an inquiry into the medical professions' performance in self-regulation. See pages 149-59.

43) "The question of what constitutes an 'interesting' teaching case is a matter of considerable debate. The question is 'interesting' to whom? The problems are all interesting to the patients that have them. I think that we have to encourage an organizational framework in the teaching hospital in which reasonable numbers of patients with primary, general problems are cared for at the medical centers. This means taking on complete responsibility for defined populations. These may be geographically defined populations of several thousands, 10,000, 20,000, 50,000 patients or they may be population defined by enrollment, or a combination of both. The medical centers should really give them responsible care, instead of the *ad hoc*, episodic, firefighting type of care that is so costly, inefficient, and inhumane as we do at the present time. This means then that the medical center will not assume responsibility for all of the patient care in all of the area surrounding it, but rather it will assume more responsible care for a segment of the population." -Testimony of Kerr L. White, M.D., *Health Care in America*, *op. cit.* footnote 14, pt. 1, p. 189.

Other sources: Robert Haggerty, M.D., "The Role of the University in Education for Family Practice," *The New Physician*, Vol. 18, No. 1, January 1969, pp. 45-49.

44) See John Knowles, "Teaching Hospital: Historical Perspective and a Contemporary View" in *Hospitals, Doctors and the Public Interest*, *op. cit.* footnote 41, pp. 1-26; Franz Goldmann, *Public Medical Care* (New York; Columbia University Press, 1945); and Richard Shyrock, *The Development of Modern Medicine* (New York; Alfred A. Knopf, 1947).

45) *Pac Bullerin*, January 1970, p. 9. [Hereafter cited as *Health Pac.*]

46) *Health Care in America*, *op. cit.* footnote 14, pt. 1, p. 56.

#### 47) Hospital Expense Per Patient Day:\* 1963-1968

(All Figures in Dollars)

Hospital size	1963	1964	1965	1966	1967	1968	Percentage Change (1963-68)
All Community Hospitals	35.11	37.58	40.56	43.66	49.46	55.80	+59%
6-24 beds	28.73	30.36	33.52	34.91	38.00	41.98	+46%
25-49 beds	29.20	31.58	32.72	35.10	37.19	41.10	+41%
50-99 beds	31.52	34.16	36.11	37.72	42.03	45.24	+44%
100-199 beds	33.82	36.16	38.77	40.97	46.28	51.11	+51%
200-299 beds	36.69	38.58	41.43	44.63	51.63	56.22	+53%
300-399 beds	37.04	39.46	42.75	46.16	51.79	59.24	+60%
400-499 beds	37.46	40.22	43.28	46.53	52.80	60.67	+62%
500 or more beds	37.51	40.21	44.35	48.73	56.47	66.27	+77%

#### Hospital Costs

Year	Average cost per patient day	Average length of stay (days)	Average cost per patient stay
1946	\$ 9.39	9.1	\$ 85.45
1947	11.09	8.0	88.72
1948	13.09	8.7	113.88
1949	14.33	8.3	118.94
1950	15.62	8.1	127.26
1951	16.77	8.3	138.73
1952	18.35	8.1	148.00
1953	19.95	7.9	158.47
1954	21.76	7.8	169.67
1955	23.12	7.8	179.77
1956	24.15	7.7	186.11
1957	26.02	7.6	198.13
1958	28.27	7.6	214.67
1959	30.19	7.8	235.66
1960	32.23	7.6	244.53
1961	34.98	7.6	267.37
1962	36.83	7.6	279.91
1963	38.91	7.7	299.61
1964	41.58	7.7	320.17
1965	44.48	7.8	346.94
1966	48.15	7.9	380.39
1967	54.08	8.3	448.86
1968	61.38	8.4	515.59

\*Patient Day = Expenses per day related to inpatient care as well as outpatient visits to hospitals

Source: *New York Times Almanac, 1970*, p. 497; Health Insurance Institute *1969 Source Book of Health Insurance Data, 1969*, pp. 52-53.

One of the often cited reasons for the increase in hospital costs is the increase in wages paid to hospital workers. Until recently, wages for hospital personnel had been notoriously low. For a discussion of this issue, see Eli Ginzberg, *op. cit.*, footnote 11, pp. 60-72.

48) *Health Pac*, *op. cit.* footnote 45, January 1970, pp. 9-10.

49) There may, of course, be other factors which contribute to the use of the emergency room as a primary care facility. See Harry J. Russel and Mary V. Wells, "Care Beyond Acute General Hospital," *Hospitals*, Journal of the American Hospital Association, Vol. 44, No. 7, April 1, 1970, p. 56; Gabriel Hilkevitz, "The Emergency Room in the Teaching Hospital," *Journal of Medical Education*, Vol. 41, No. 7, July, 1966, p. 724; P. Densen, D. Greene, et al, "Primary Medical Care for an Urban Population, A Survey of Present and Potential Utilization," *Journal of Medical Education*, Vol. 43, No. 12, December 1968, pp. 1244-49.

The studies cited above show that emergency rooms are being used by the poor and working class for treatment of non-emergency conditions. A recent study attempted to assess the effectiveness of the care received. The study found that of 141 patients in an emergency room, 38 patients (27 per cent) received effective medical care and 84 patients (60 per cent), ineffective care and 19 patients (13 per cent) neither effective nor ineffective care. Robert Brook and Robert Stevenson, "Effectiveness of Patient Care in an Emergency Room," *New England Journal of Medicine*, Vol. 283, No. 17, October 22, 1970, p. 904.

50) G. James, "The Emergency Room—Entry to the Health Care System," *Hospital Topics*, Vol. 47, October, 1969, p. 47. James also says that this increase in the tendency of patients to use the emergency unit as their primary source of medical care in most instances "reflects the barriers faced by both urban poor and self-sufficient middle class. Partly these are economic and informational barriers, but also we can note the effect of the inflexible specialty clinic outpatient departments or the unavailability of private physicians in our large metropolitan areas."

51) E. Richard Weinerman, et al, "Yale Studies in Ambulatory Medical Care, V. Determinants of Use of Hospital Emergency Services," *American Journal of Public Health*, July 1, 1966, Vol. 56, No. 7, p. 1037.

52) "Now You Need a Priority to Get Into a Prestige Hospital," *U.S. News and World Report*, March 24, 1969, p. 41. This article points out that if the patient's physician is a staff member, he has a chance of being admitted immediately in an emergency, but the physician's colleagues and utilization board will be watching to make sure the emergency is a real one.

53) Anselm Strauss, "Medical Organization, Medical Care and Lower Income Groups," *Social Science and Medicine*, Vol. 3, 1969, p. 152.

54) H. Somers and A. Somers, *Doctors, Patients and Health Insurance* (Washington, D.C.: The Brookings Institution, 1961), pp. 67-72. [Hereafter cited as *Somers*.] "The distinguishing feature of the Anglo-American voluntary hospital... has been its use by private physicians for private patients with little or no accompanying administrative or financial responsibility."

Other sources: Ray Trussell, "The Problems of Maintaining Quality in Hospitals" in *Hospitals, Doctors and the Public Interest*, *op. cit.* footnote 41, pp. 119-20.

55) "Black M.D.'s Now Welcome-But Some Balk," *Medical World News*, May 15, 1970, p. 22.

56) Chapter IV, *infra* at p. 47. Denial of staff privileges also has worked to the disadvantage of prepaid group practices such as HHP in New York, see Chapter IV at p. 53.

57) *Report of the Mayor's Task Force on Public Health Goals*, District of Columbia, January, 1970, pp. 306-26. Of the 12 general short-term hospitals in the District of Columbia open to the civilian population, 10 are private and two are public. The two public hospitals have been the primary source of medical care for the poor in the District of Columbia. The study found these hospitals, particularly D.C. General, to be overcrowded and decaying facilities, "in which the poor receive poor health care at an inadequately supported public hospital."

A newspaper story said that on one day at least 14 patients were left sleeping in the halls of D.C. General. The story continued.

"Patient care suffered. One woman was admitted to the hospital with a stroke at 3 p.m., Friday. A doctor failed to examine her until 8 a.m., Saturday... [Dr. Martin] Shargel said, 'patients die while waiting for medical care. No doctor would like his wife and child to be treated the way patients at D.C. General Hospital are treated,' said Shargel."

*Washington Post*, Tuesday, September 9, 1969, Section A., p. 1 and p. 11.

58) Citizens Board of Inquiry, Report of the Boston Field Trip, December 10-12, 1969 (on file).

59) Citizens Board of Inquiry. Report of San Antonio Field Trip, March 1970 (on file); additional information provided by Dr. Carter Pannill, Dean, University of Texas Medical School at San Antonio.

60) For a discussion of the early background of health insurance in this country, see I.S. Falk, C.R. Rorem and Martha Ring, *The Costs of Medical Care* (Chicago: University of Chicago Press, 1933), Part VIII, "Recent Developments in Methods of Paying for Medical Care," particularly pp. 450-58 and pp. 473-91. [Hereafter cited as *The Costs of Medical Care*.]

Other sources: *Somers*, *op. cit.* footnote 54, pp. 261-63.

61) Sources of Hospital Income, 1930

Type of Income (in millions)				
Type of Hospital Control	Patient's Fees	Contribution and Endowments	Taxes	Total
Non-government	\$277	50	25	352
Government	\$ 25	4	275	304
Total	\$302	54	300	656

Source: *The Costs of Medical Care*, *op. cit.* footnote 60, p. 331.

62) For an annual fee of \$6 per person, the Baylor Hospital Plan provided for a maximum of 21 days of hospital care in a semi-private room, with a 33 per cent discount for longer stays. "Operating room service, anaesthetics, laboratory fees, routine medicines, surgical dressings and hypodermics" were included.

An extra charge -50 per cent of the regular rates--was made for X-ray services and all maternity care. *The Costs of Medical Care*, *op. cit.* footnote 60, p. 479.

63) The original agreement between Baylor University and the Teachers Association of Dallas was drawn in 1930, and enrolled 2,000 teachers. By March 1932, 36 different contracts had been put into effect, covering approximately 4,000 persons. *The Costs of Medical Care*, *op. cit.* footnote 60, p. 480.

64) The name "Blue Cross" was first used as an identifying symbol by the Hospital Service Association of St. Paul, Minnesota in 1934; other plans later adopted it. Blue Cross Association, *Report to the Nation*, January 1, 1969, p. 7.

At first the Baylor Plan was put forward by individual hospitals, but by 1932 community-wide plans offering subscribers a choice of hospitals in a particular area began to emerge. *Somers*, *op. cit.* footnote 54, pp. 291-93.

The American Hospital Association has played a major role in the development of Blue Cross. See discussion, *infra* p. 23.

65) Richard Magraw, *Ferment in Medicine* (Philadelphia: W.B. Saunders Co., 1966), pp. 188-89. [Hereafter cited as *Magraw*.]

66) *Somers*, *op. cit.* footnote 54, p. 318.

Other sources: *Magraw*, *op. cit.* footnote 65, p. 189. "The effect of doctors' attitudes on the development of medical care insurance as contrasted with hospital care insurance is apparent in the fact that by the end of 1939, Blue Cross had an enrollment of about 4,500,000 whereas Blue Shield (in existence for about a year) had an enrollment of less than 170,000."

67) Enrollment in Blue Cross and Blue Shield Plans, and per cent of civilian population enrolled, December 31, 1940-68 (includes Alaska and Hawaii for all years):

December 31	Enrollment (in thousands)		Per cent of civilian population enrolled	
	Blue Cross-Blue Shield	Blue Cross-Blue Shield	Blue Cross-Blue Shield	Blue Cross-Blue Shield
1940	6,012	260	4.6	0.2
1941	8,399	645	6.4	0.5
1942	10,215	815	7.9	0.6
1943	12,600	1,054	9.9	0.8
1944	15,748	1,518	12.3	1.2
1945	18,881	2,208	14.1	1.7
1946	24,250	3,904	17.2	2.8
1947	27,489	5,732	19.0	4.0
1948	30,448	9,885	20.7	6.7
1949	33,381	11,935	22.3	8.0
1950	37,435	16,102	24.8	10.6
1951	38,424	20,246	25.1	13.2
1952	40,495	23,585	26.1	15.2
1953	42,857	26,902	27.1	17.0
1954	44,243	30,158	27.4	18.7
1955	47,719	34,201	29.0	20.8
1956	50,108	37,040	29.9	22.1
1957	51,869	39,504	30.4	23.1
1958	52,258	40,404	30.1	23.2
1959	53,573	42,257	30.3	23.9
1960	55,938	44,493	31.1	24.7
1961	56,489	46,326	31.0	25.4
1962	58,133	48,062	31.4	25.9
1963	59,141	49,631	31.4	26.4
1964	60,478	51,251	31.7	26.9
1965	61,650	52,669	32.0	27.3
1966	63,408	54,499	32.6	28.0
1967	65,188	57,017	33.1	30.0
1968	67,958	59,815	34.2	30.1

Source: U.S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, Research and Statistics Note, *Enrollment and Finances of Blue Cross and Blue Shield Plans, 1968*, Note 22, December 8, 1969.

68) Blue Cross Association and National Association of Blue Shield Plans, *The Blue Cross and Blue Shield Fact Book, 1970* (Chicago, 1970), pp. 3, 9-11, 17.

69) See Blue Cross Association, *Report to the Nation, June 30, 1967*, pp. 7-8, Blue Cross Association, *Report to the Nation, January 1, 1969*, p. 8.

The American Hospital Association was founded in 1906. Institutional membership includes short- and long-term hospitals in the United States and other countries, also dispensaries and clinics, Blue Cross Plans, hospital auxiliaries, and allied health agencies. These along with individual memberships bring the total enrollment to over 12,000.

According to its bylaws, the association serves the following purposes: to promote the welfare of the people through the development of hospital and outpatient service; to encourage professional education and scientific research; to aid in the health education of the public; to cooperate with other organizations having similar objectives; to distribute factual knowledge with regard to the various specialized services and functions of hospitals; to coordinate such knowledge into an integrated pattern of activity for pursuit by all hospitals; to coordinate the plans, problems, actions and needs of all hospitals for the benefit of individual members.

To provide continuity to the association's affair, each new president, a hospital administrator, serves for three years; first as president-elect, then as president, and finally, as immediate past-president. These three officers with twelve trustees, including two Blue Cross representatives, constitute the board of trustees. Trustees serve three-year terms.

The association's direction is centered in a house of delegates composed of 127 members. One hundred are chosen from each state, the District of Columbia, Puerto Rico, and Canada. Twelve delegates at large are elected at each annual meeting by the house. See Leonard Sloan, *Today's Hospital* (New York; Harper and Row, 1966), Appendix pp. 189-92.

70) Blue Cross Association, *A Report to the Nation, January 1, 1969*, pp. 7-8. In fact, until 1960, the Blue Cross Association was the Blue Cross Commission, a unit of the AHA.

All Blue Cross plans are members of the Blue Cross Association which is governed by a Board of Directors. "Twenty-two of the 26 board members are elected from plans—11 representing districts of the country and 11 at large—and three board members are nominated by the American Hospital Association."

Other sources: Thomas Schwartz, *Medical Plans and Health Care* (Springfield, Illinois; Charles C. Thomas, 1968), p. 15.

"In 1962, [the year on which Dr. Schwartz's analysis is based] 62 per cent of all Blue Cross Board positions—44 per cent hospital representatives and 18 per cent physicians—were occupied by providers; the rest of the positions were held by representatives of labor, subscribers and the general public. Blue Shield plans were controlled by medical societies. . . ."

71) For a detailed description of the operation of Blue Cross, see Somers, *op. cit.* footnote 54, pp. 302-16.

Other sources: Louis Reed, "Private Health Insurance, 1968; Enrollment, Coverage, and Financial Experience," *Social Security Bulletin*, Vol. 32, No. 12, December 1969, pp. 19-35; John Ehrenreich, "The Blue Cross We Bear," *Washington Monthly*, November 1969, Vol. 1, No. 10; pp. 17-26.

Louis Reed, *Financial Experience of Health Insurance Organizations in the United States*, Social Security Administration, Research Report No. 12, 1966, p. 6. "Hospital and medical prepayment as undertaken by Blue Cross and Blue Shield Plans is term insurance and there is no need for the plans to maintain large reserves against future contingencies (although in fact they do). As benefits costs rise, the plans count on increasing subscription charges as necessary. . . . The American Hospital Association's standards for approval of Blue Cross Plans stipulate that a plan's reserves must be sufficient to meet hospital and operating expenses for at least three months."

72) For a discussion of the private insurance company's role in health insurance, see Somers, *op. cit.* footnote 54, pp. 254-90.

The table at bottom will indicate the relative roles of Blue Cross-Blue Shield and the private insurers. Americans paid \$12.9 billion in 1968, to private health insurance organizations in premiums or subscription charges, almost 16 per cent more than in 1967. Benefit expenditures under all private health insurance in 1968 amounted to \$11.3 billion, almost 20 per cent higher than the 1967 total.

73) See Magraw, *op. cit.* footnote 65, pp. 196-201; William A. MacColl, *Group Practice and Prepayment of Medical Care* (Washington, D.C.; Public Affairs Press, 1966), pp. 149-52. [Hereafter cited as MacColl.]

"'Comprehensive coverage' by health insurance . . . is a widely used but quite imprecise term. . . . It . . . signifies an aim for quantitative adequacy an overall benefit-expenditure ratio that will reduce the average consumer's out-of-pocket expenses to more feasible proportions. This means that health insurance benefits in conjunction with manageable out-of-pocket expenditures, should be adequate to promote individual health and family welfare. It involves two related steps:

"1) Extension of coverage to many of the components of care

Private Health Insurance Enrollment as of December 31, 1968: Number of Persons of all Ages Covered by Type of Plan and Specified Type of Care (In Thousands)

Type of Plan	Physician Services									
	Hospital care	Surgical services	In-Hospital visits	X-ray and laboratory examinations	Office and home visits	Dental care	Prescribed drugs (out of hospital)	Private duty nursing	Visiting nurse service	Nursing home care
Total gross Enrollment . . . . .	193,538	177,395	140,426	104,303	89,457	5,821	83,142	87,572	94,936	19,405
Blue Cross/Blue Shield . . . . .	70,510	63,279	58,874	28,389	16,223	35	14,849	18,191	24,253	12,374
Blue Cross . . . . .	67,958	3,464	3,291	1,880	1,079	—	—	—	—	—
Blue Shield . . . . .	2,552	59,815	55,583	26,509	15,144	—	—	—	—	—
Insurance Companies . . . . .	115,768	105,616	73,552	67,534	66,034	3,124	64,523	64,874	64,874	5,581
Group policies . . . . .	76,059	77,415	61,392	60,400	59,400	3,076	59,379	59,349	59,349	3,160
Individual policies . . . . .	39,709	28,201	12,160	7,154	6,634	48	5,144	5,525	5,525	2,421
Independent Plans . . . . .	7,260	8,500	8,000	8,380	7,200	2,662	3,770	4,507	5,809	1,450
Community Employer-employee union . . . . .	2,500	4,100	4,100	4,000	3,900	175	1,350	2,500	4,000	150
Private group clinic . . . . .	4,700	4,200	3,700	4,200	3,100	420	2,400	2,000	1,800	1,300
Dental Society . . . . .	60	200	200	180	200	600	20	7	9	—
						1,467				

Source: Louis Reed, "Private Health Insurance, 1968: Enrollment, Coverage and Financial Experience," *Social Security Bulletin*, Vol. 32, No. 12, December 1969, pp. 19-20.

now generally omitted such as drugs, dental care and psychiatric care. . . 2) A balanced increase in protection among the major components so that the result does not favor excessively one form of service over another and cause an 'unmedical' as well as uneconomical bias in utilization as appears to have been the case in the past." H.R. Somers, "Private Health Insurance," in *Hospitals, Doctors, and the Public Interest*, op. cit. footnote 41, pp. 190-91.

74) MacColl, op. cit. footnote 73, p. 150. See also: Somers, op. cit. footnote 54, pp. 277-85.

Somers has pointed out some of the methods which insurance companies use to control the amount of expense incurred, for example, by either direct or indirect means, private companies always establish an upper limit on the amount that might be paid out under a given policy. This has an ironic result. Ultimately, the purpose of insurance as far as individual policy holders are concerned is to protect themselves against unknown risks. But with respect to health insurance, private companies having controlled and limited their own risk to a known amount, leave consumers to bear the risk of large open-ended expenses. See also: "Exclusions," p. 284. Individual policies frequently impose a waiting period of varying lengths for certain procedures such as appendectomy, tonsillectomy. Dental care is almost always excluded as are eyeglasses and examinations for glasses.

Some policies exclude "pre-existing" conditions—at least for a probationary period and others exclude either specifically or implicitly expenses deemed to be "unreasonable" in price or not "reasonably necessary to treatment of the disability."

75) Private insurance benefits actually met about 36 per cent of all consumer expenditures for health service; the other 64 per cent was mainly an out-of-pocket expense to the consumer. The following chart shows the gaps in private health insurance coverage for persons under 65 (based on the latest complete figures):

**Gaps in Private Health Insurance\* for Individuals Under 65**

13.5% or 24 million people . . .	had no hospital insurance
20% or 35 million people . . .	had no surgical insurance
34.5% or 61 million people . . .	had no in-the-hospital medical expense insurance
50% or 89 million people . . . .	had no insurance to cover X-ray and laboratory examinations when not in the hospital
57.5% or 102 million people . .	had no insurance for visits to doctors offices or doctor visits to their homes
61% or 108 million people . . . .	had no insurance against the cost of prescribed drugs
97.5% or 173 million people . .	had no insurance against dental expenses

\*Based on a 1968 population of over 177 million

**Per Cent of Consumer Expenditures Met by Health Insurance 1958 - 1968**

Year	Per Cent
1958	24.3
1959	25.5
1960	27.7
1961	29.9
1962	30.9
1963	31.7
1964	31.5
1965	32.4
1966	32.0
1967	33.1
1968	36.0

Source: The Committee for National Health Insurance, *Facts of Life and Health Insurance*, November 1969, pp. 21-22.

**Per Cent Distribution of Persons Under 65 Years by Hospital and Surgical Insurance Coverage According to Sex and Age 1968**

Sex and Age	Total Population*	Hospital Insurance		Surgical Insurance	
		Insured	Uninsured	Insured	Uninsured
All ages under 65	100.0	78.2	20.5	76.6	21.9
Under 17	100.0	75.0	23.7	73.5	24.9
17-24	100.0	74.0	23.9	72.3	25.4
25-44	100.0	82.6	16.4	81.1	17.6
45-64	100.0	81.1	17.7	79.0	19.7
<b>Male</b>					
All ages under 65	100.0	78.7	20.0	77.1	21.3
Under 17	100.0	74.7	23.9	73.1	25.2
17-24	100.0	74.5	23.3	72.8	25.0
25-44	100.0	84.4	14.3	83.1	15.5
45-64	100.0	81.6	17.4	79.7	19.0
<b>Female</b>					
All ages under 65	100.0	77.8	20.9	76.1	22.4
Under 17	100.0	75.3	23.4	73.9	24.6
17-24	100.0	73.6	24.4	72.0	25.8
25-44	100.0	80.9	18.2	79.4	19.5
45-64	100.0	80.7	18.0	78.3	20.2

\*Includes persons of unknown insurance status.

Source: U.S. Department of Health, Education and Welfare, Public Health Service, National Center for Health Statistics, *Current Estimates*, Series 10, Number 60, June, 1970, p. 24.

76) See Somers, op. cit. footnote 54, pp. 282-83. Deductibles and co-insurance are commonly used devices which have this effect. The deductible is somewhat similar to that used in automobile collision insurance and provides that the carrier pays only that portion of the total cost of covered expenses for an insured individual that exceeds the specified deductible amount. It may apply to each disability separately or to the calendar—or benefit—year. The co-insurance feature provides that, in addition to the deductible, the insured will pay an agreed portion of the remaining amount usually 20 to 25 per cent.

These devices are used to discourage policy holders from seeking health services in marginal or questionable cases. But the irony is that while they discourage consumers from making the initial contact with the health system, once that contact is made, the physician under present insurance coverage schemes, has every incentive to go ahead if indeed the problem is marginal—despite the extra financial burden on the patient because of co-insurance or deductibles.

Magraw, op. cit. footnote 65, pp. 198-99. Insurance companies and physicians often favor deductibles and co-insurance over completely prepaid coverage because, according to one commentator, it will: 1) "keep the cost of insurance down by having the patients pay part of the bill; 2) motivate patients to minimize rather than maximize their demands; and 3) reassure physicians that demands for medical care (which they personally will be called to fill) can be controlled."

77) Somers, op. cit. footnote 54, pp. 280-81. The decision to seek preventive care depends completely on the judgment of the consumer. Thus, broad preventive coverage is as a practical matter uninsurable. Such coverage would, in effect, discourage the very kind of usage currently being insured. Home and office visits are infrequently covered and are rarely available under individual policies. Most policies will not reimburse until the third or fourth visit and then they impose a limit on the number of visits.

The Committee for National Health Insurance, *Facts of Life, Health and Health Insurance*, November 1969, p. 21. In 1967,

only about half the civilian population under 65 years of age had any coverage for X-ray and laboratory examinations outside the hospital, 57.5 per cent had no coverage of physician office or home visits and 61 per cent had no coverage of prescription drugs outside the hospital.

Other sources: Seymour E. Harris, *The Economics of American Medicine* (New York: MacMillan Company, 1964), pp. 380-81. [Hereafter cited as *Harris*.]

78) *Harris, op. cit.* footnote 77, pp. 360-61.

"The rationale for the prevailing emphasis [of insurance] on surgery and acute hospitalized illness was two-faced: 1) it was assumed to meet the largest and most unpredictable expenses, whereas office calls, medicine and other services involving smaller unit costs and more control over timing could be more easily budgeted. 2) The costs of hospitalized illness were assumed to be more susceptible to sound underwriting and economical administration. It was believed that hospital-related expenses were relatively self-limiting in terms of need and demand—permitting reliable actuarial predictions as to use and cost and hence a reliable premium—whereas the demand for ambulatory care and drugs was infinitely elastic." *Somers, op. cit.* footnote 54, p. 379. *Somers* goes on to show how faulty these assumptions proved to be, pp. 379-80.

Other sources: R. Anderson and O. Anderson, *A Decade of Health Services* (Chicago: University of Chicago Press, 1967), pp. 91-92.

79) With respect to any individual or group of individuals, the likelihood of contact with the medical system can best be predicted by looking at his or their own past experience and present status. As a practical matter, determining insurance rates on this basis serves to discriminate against those people and groups who most need care: old people, black people, poor people and sick people. There is nothing evil about this; experience rating is simply good insurance business. *Somers*, pp. 286-90. See also *MacColl, op. cit.* footnote 73, p. 150, who says "[Experience rating] may be good business, but it is socially obnoxious."

The following chart indicates who is covered by insurance in terms of income:

Per Cent Distribution of Persons Under 65 Years of Age by Hospital and Surgical Insurance Coverage According to Geographic Region and Family Income: United States, 1968

Region & Family Income	Total population under 65 years*	Hospital insurance Surgical insurance			
		Insured	Not Insured	Insured	Not Insured
<b>NORTHEAST</b>					
All Incomes**	100.0	83.9	14.8	82.1	16.5
Less than \$3,000	100.0	39.4	59.0	38.3	60.9
\$3,000-\$4,999	100.0	58.5	40.8	55.6	43.3
\$5,000-\$6,999	100.0	80.4	18.9	78.1	20.9
\$7,000-\$9,999	100.0	93.1	6.4	91.5	7.7
\$10,000 or more	100.0	94.9	4.5	93.4	5.7
<b>NORTH CENTRAL</b>					
All Incomes**	100.0	84.2	14.6	82.2	16.3
Less than \$3,000	100.0	46.0	52.8	44.2	54.6
\$3,000-\$4,999	100.0	65.2	34.0	62.7	36.0
\$5,000-\$6,999	100.0	84.5	14.7	82.8	16.3
\$7,000-\$9,999	100.0	92.3	7.3	90.5	8.9
\$10,000 or more	100.0	94.1	5.4	92.0	6.9

SOUTH					
All Incomes**	100.0	70.3	28.3	68.6	29.7
Less than \$3,000	100.0	33.2	65.6	31.6	67.2
\$3,000-\$4,999	100.0	55.3	43.3	53.1	45.0
\$5,000-\$6,999	100.0	76.0	23.5	74.1	25.1
\$7,000-\$9,999	100.0	85.4	14.1	84.3	15.0
\$10,000 or more	100.0	86.4	9.9	87.8	11.2
WEST					
All Incomes**	100.0	74.7	24.0	73.8	24.8
Less than \$3,000	100.0	29.0	69.1	27.7	70.1
\$3,000-\$4,999	100.0	44.9	54.1	44.1	55.0
\$5,000-\$6,999	100.0	70.0	29.5	69.3	29.9
\$7,000-\$9,999	100.0	84.1	15.2	83.1	16.2
\$10,000 or more	100.0	89.4	9.9	88.4	10.7

\*Includes persons of unknown insurance status.

\*\*Includes persons of unknown income.

Source: U.S. Department of Health, Education and Welfare, Public Health Service, National Center for Health Statistics, *Monthly Vital Statistics Report*, Vol. 18, No. 11, February 2, 1970, p. 3.

See also: *Harris, op. cit.* footnote 77, p. 378.

80) *MacColl, op. cit.* footnote 73, pp. 150, 153-56; *Somers, op. cit.* footnote 54, pp. 413-21, "Carrier Attempts at Cost Controls" and pp. 421-25, "The Medical Profession and Cost Controls."

81) Insurance is an asset in that it reduces the burden of large medical costs by allocating the costs over time and at any one time over large numbers. But against this decisive advantage, we put the additional costs associated with the fact of insurance. When a service is available with no or small additional cost, the patient will tend to use it more than is justified by underlying need. These wastes include costs of administration and additional charges made by hospitals or physicians just because the patient is covered by insurance. *Somers, op. cit.* footnote 54, pp. 354-60, 308-16, 335-40. See also: R. Anderson and O. Anderson, *A Decade of Health Services* (Chicago: University of Chicago Press, 1967), pp. 153-55. The Andersons' study is based on the period 1953-63—but the trends they explored have continued:

"In terms of price the hospital continues to remain the most volatile. . . . During the ten-year period under study, the price of the hospital component increased by 90 per cent, followed by the physician component, 37 per cent and the dentist component, 26 per cent. . . .

"In 1953, general hospitals were receiving 50 per cent of their non-governmental income from insurance agencies and by 1963, 69 per cent. Physicians received 13 per cent of their income from insurance in 1953 and 25 per cent in 1963. . . ."

82) *MacColl, op. cit.* footnote 73, p. 150.

83) *Ibid.* For a discussion of "experience-rating" as opposed to community-rating see *Somers, op. cit.* footnote 54, pp. 309-10.

"Originally, each [Blue Cross] plan had only one policy and its rate was the same for all enrollees in the community regardless of age, sex, or other differences. The result was an averaging between high-cost and low-cost individuals and groups. . . . The insurance companies, however, have always insisted that a complete pooling of costs is 'inequitable' and 'that if the probability of loss differs materially from one insured to another, this process involves undercharging some insureds and overcharging others.' In practice, the pressure of competition may be more important than equity.

" . . . [C]ompetitive necessity causes insurance companies to limit risk-pooling by tailoring premium charges to the costs of particular categories or even particular policyholders. The result is a more advantageous price for

the better risks and a higher—often prohibitive price—for, the poorer risks.”

84) *Harris, op. cit.* footnote 77, pp. 391-92.

85) *Ibid. Somers, op. cit.* footnote 54, pp. 311-16. See John Ehrenreich, “The Blue Cross We Bear,” *Washington Monthly*, Vol. 1, No. 10, November 1969, pp. 19-21; *Health Pac, op. cit.* footnote 45, September 1969, pp. 3-4; “Crisis over the Cost of Health Insurance,” *New York Times*, August 8, 1969.

Chapter III

1) U.S. Department of Health, Education and Welfare, Office of the Secretary, *Report of the Task Force on Medicaid and Related Programs, June, 1970*, p. 26. [Hereafter cited as *Report of the Task Force on Medicaid and Related Programs.*]

2) *Hearings on the Partnership for Health Amendments of 1967* before the Committee on Interstate and Foreign Commerce, 90th Cong., 1st sess., May 2-4, June 20, 22, 1967, p. 55.

3) United States Bureau of the Budget, *Special Analyses, Budget of the United States: Fiscal Year 1971*, Special Analysis K, p. 147.

Total Federal Outlay,  
Federal Outlay for Health and  
Total National Expenditures for Health  
(dollars in billions)

	1960	1965	1967	1968	1969	1970	1971
Total federal outlays	\$92.2	118.4	158.4	178.9	184.6	197.9	200.8
Federal outlays for health	\$ 3.5	5.2	10.8	14.1	16.6	18.8	20.6
Federal health outlays as percentage of total federal outlay	3.8%	4.4%	6.2%	7.9%	8.2%	10%	10.5%
Total national health expenditures	\$26.4	38.9	48.2	53.9	60.3	NA	NA
Federal health outlays as percentage of total national health expenditure	13%	13%	22%	26%	28%	-----	-----

4) *Id.* at p. 148.

5) *Id.* at pp. 147-48.

6) *Id.* at pp. 169-70.

7) For a discussion of the history of the Hill-Burton program, see Jack Masur, M.D., “Government and Hospitals” in *Hospitals, Doctors and the Public Interest*, John Knowles (ed.), (Boston: Harvard University Press, 1965), pp. 137-40. [Hereafter cited as *Hospitals, Doctors and the Public Interest.*] Dr. Masur is a former Assistant Surgeon General and Director, Clinical Center, National Institutes of Health.

Since its initial enactment, the Hill-Burton program (Public Law 79-725, Title VI of the Public Health Service Act) has been amended several times. In 1964 the act was extended through 1969. Recently it was extended for three years over President Nixon’s veto, but as of the final writing of this report, no money had been appropriated.

For a discussion of the legislative background of Hill-Burton, see U.S. Department of Health, Education and Welfare, Public Health Service, Health Facilities Planning and Construction Service, *Facts About the Hill-Burton Program, July 1, 1947-June 30, 1969*, pp. 1-3.

For a discussion of the political fight over the recent Hill-Burton extension, see the American Public Health Association, Inc., *Washington Newsletter*; Newsletter No. 35, July 20, 1970.

8) See 42, U.S.C.A. § 281 et seq. (1969).

9) Department of Health, Education and Welfare, 1969 *Annual Report*, pp. 146-47.

10) Testimony on *Hospital and Health Facility Construction and Modernization* by Hon. John G. Veneman, Under-Secretary, Health, Education and Welfare before the Subcommittee on Public Health and Welfare, Committee on Interstate and Foreign Commerce, House of Representatives, 91st Cong., 1st sess., March 25-28, 1969, pp. 25-26. [Hereafter cited as *Hospital and Health Facility Construction and Modernization Hearings.*]

11) 1967 *Congressional Quarterly Almanac*, pp. 451-53. See also: *Hospitals, Doctors and the Public Interest, op. cit.* footnote 7, p. 139.

“The stress on rural needs in the genesis of the legislation led to the building of many small hospitals—three out of five new general hospitals constructed with Hill-Burton subsidy have less than 50 beds. . . .”

12) Quoted in 1967 *Congressional Quarterly Almanac*, p. 451. See also: *Hospital and Health Facility Construction and Modernization Hearings, op. cit.* footnote 10, pp. 66-68.

“The need for emphasizing modernization and grants for more densely populated areas may . . . be seen from data which compare the gains in existing general hospital beds since 1948. . . . In effect, by emphasis and a system of priority . . . the construction needs of the lower income and more rural states have been substantially met.”

Gains in Existing Hospital Beds  
Eight High and Eight Low Per Capita  
States  
(According to Hill-Burton State Plans)

	Existing Bed per 1,000 population	
	1948	1966
<i>High Income:</i>		
District of Columbia . . . . .	4.61	6.10
Nevada . . . . .	5.91	3.51
Connecticut . . . . .	3.90	3.87
Delaware . . . . .	4.00	3.75
California . . . . .	3.72	3.51
New York . . . . .	4.10	4.14
New Jersey . . . . .	3.95	3.38
Illinois . . . . .	3.70	4.44
Average . . . . .	3.92	3.92
<i>Low Income:</i>		
Mississippi . . . . .	2.13	4.04
South Carolina . . . . .	3.01	3.57
Arkansas . . . . .	2.37	3.69
Alabama . . . . .	2.31	4.02
Tennessee . . . . .	2.43	4.21
West Virginia . . . . .	3.67	4.31
North Carolina . . . . .	2.74	3.80
Kentucky . . . . .	2.47	3.85
Average . . . . .	2.61	3.93

Source: Testimony of H. Phillip Hampton, M.D., American Medical Association, *Hospital and Health Facilities Construction and Modernization Hearings, op. cit.* footnote 10, pp. 97-98, 100.

13) U.S. Department of Health, Education and Welfare, Public Health Service, Health Facilities Planning and Construction Service, *Hill-Burton Progress Report, July 1, 1947-June 30, 1968* (1968), p. 27.

14) The 1964 amendments provided for modernization funds as well as for considerable flexibility in transferring funds between the new construction and modernization categories.

During 1968, only 4 per cent of the projects aided by Hill-Burton grants were for completely new facilities while 96 per cent represented modernization in the form of additions, alterations and replacements.

The amendments also gave the states the option of using their money in modernization or new hospital construction in rural or

urban areas; and they provided an increased federal share for projects located in low-income areas. In addition, independent health centers became eligible for assistance where previously they had to be owned and operated by hospitals or health departments. See 42 U.S.C.A. § 291(a-c).

Department of Health, Education and Welfare, 1969 *Annual Report*, pp. 146-47.

15) Hill-Burton money is going to the Kaiser Foundation Health Plan for a hospital and rehabilitation center started in Vallejo, California in July 1970. Interview with the Director of Public Relations, Kaiser Foundation Hospitals, Oakland, California, November 25, 1970.

16) Information supplied by Dr. Lester Breslow, Chairman, Department of Preventive and Social Medicine, University of California Medical School at Los Angeles; also Chairman, Citizens Board of Inquiry into Health for Americans.

17) 42 U.S.C.A. § 291 (d) (3) (1969).

18) 42 U.S.C.A. § 291 (d) (3) as amended, effective June 30, 1970.

19) Data collected by Citizens Board of Inquiry staff from individual state Hill-Burton agencies.

20) 42 U.S.C.A. § 291 (e).

Prior to approval and recommendation by the state agency, the project should be "considered" by the public or nonprofit private agency or organization which "has developed the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314 (b) . . ." or, if there is no such agency or organization, by the state agency under 314 (a).

The 314 (a) and (b) referred to is Section 314 of the Comprehensive Health Planning and Services Act which provides that "consumers of health services" should be the majority of a state health planning council which will advise the state agency in carrying out its functions. See the section on Comprehensive Health Planning, *infra* p. 37 et seq.

21) 42 CFR 53.111.

22) *Report of the Task Force on Medicaid and Related Programs*, *op. cit.* footnote 1, p. 26.

23) 42 U.S.C.A. § 1395 (1969).

24) 42 U.S.C.A. § 1395 f-h and § 1395 w. See also: Herman Somers and Anne Somers, *Medicare and the Hospitals*, Brookings Studies in Social Economics (Washington, D.C.: Brookings Institution, 1967) pp. 32-35. [Hereafter cited as *Medicare and the Hospitals*.]

25) *Medicare and Medicaid Problems, Issues and Alternatives*, Report of the Staff to the Committee on Finance, United States Senate, 91st Cong., 1st sess., February 9, 1970, pp. 113-15.

26) *Ibid.* Other sources: *Medicare and the Hospitals*, *op. cit.* footnote 24, pp. 32-35.

27) *Medicare and Medicaid: Problems, Issues and Alternatives*, Report of the Staff to the Committee on Finance, United States Senate, *op. cit.* footnote 25, p. 113. In addition to serving as the major intermediary for hospitals, Blue Cross was also the intermediary for 87 per cent of the home health care agencies and 53 per cent of the extended-care facilities.

"As intermediary in various capacities in Medicare, Medicaid and other public programs in the United States, Blue Cross served . . . 18,413,000 persons in 1969. . . . Blue Shield served 10.9 million (57.3 per cent) of the Part B recipients." Blue Cross Association and National Association of Blue Shield Plans, *Blue Cross and Blue Shield Fact Book, 1970* (Chicago, 1970), pp. 3, 11.

28) *Medicare and Medicaid: Problems, Issues and Alternatives*, Report of the Staff to the Committee on Finance, United States Senate, *op. cit.* footnote 25, p. 115.

29) "The majority of the Part B carriers are Blue Shield plans . . . controlled by physicians. Such organization and control is not inappropriate, but has . . . created questions for Blue Shield as to whom it is accountable and whom it represents when it functions as an agency of the federal government in administering Part B of Medicare.

"When public monies are paid out by a Blue Shield plan—or any other carrier or fiscal agent—the government has the right, in

fact the duty, to be advised by the agent as to how those funds were disbursed. . . .

"In this context, it was distressing and almost inconceivable, that a fair number of Blue Shield plans initially refused to comply with that part of the Social Security instruction in response to a staff request that they identify, by name, physicians who had been paid \$25,000 or more by Medicare in 1968. Most of those plans which declined, at first, to provide the information requested, said that they had not been 'authorized to do so by the physician involved.'

"Clearly the issue raised did not involve 'authorization' by physicians. The staff could find no provisions in law, regulation, or carrier contracts which provided that identification would not be made to the federal government except with express physician 'authorization.'

"The underlying concern of those Blue Shield plans which resisted providing names is understandable. Blue Shield works with and depends upon the goodwill of physicians for much of the success it enjoys in its regular day-to-day business where in most instances it actually contracts with individual doctors. In Medicare, however, the contract is with the United States government. The government's obligation is to undertake such procedures as will assist in assuring its citizens—particularly the millions of elderly who pay premiums—that their money is being properly expended. The government is 'trustee' of the part B trust fund. . . ."

*Id.*, p. 120.

Other sources: Mal Schechter, "Medicare—Alive, But Not Well," *The New Republic*, July 11, 1970, pp. 15-17.

30) Hearings on *Medicare and Medicaid* before the Committee on Finance, United States Senate, 91st Cong., 1st sess., July 1, 2, 1969, pp. 80-81. [Hereafter cited as *Medicare and Medicaid Hearings*.] See pp. 77-80 of the above for discussion of steps which the Social Security Administration took to improve the performance of intermediaries.

The issue of intermediary performance, cost controls and more effective and efficient administration of the Medicare program has, of course, been a subject of continuing debate; and numerous recommendations for improvement have been made by Congress. See Report of the Committee on Ways and Means, "Social Security Amendments of 1970—H.R. 17550," 91st Cong., 2nd sess., May 14, 1970, p. 27 et seq.

The Blue Cross Association feels that "in each year of Medicare, the Blue Cross system's performance as Intermediary has shown steady and impressive improvement." Statement of Bernard R. Tresnowski, Senior Vice President for Government Programs, Blue Cross Association, on H.R. 17550, September 14, 1970.

31) 42 U.S.C.A. § 1396 (1969). One of the most concise and readable explanations of how Medicaid operates is found in the publication of the Advisory Commission on Intergovernmental Relations, *Intergovernmental Problems in Medicaid* (Washington, D.C., 1968), pp. 10-18.

32) See U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, Medical Services Administration, *Medicaid Services—State by State*, MSA-70, January 1970.

33) *Report of the Task Force on Medicaid and Related Programs*, *op. cit.* footnote 1, pp. 11-13.

34) *Id.* at p. 8.

35) *Id.* at p. 2.

36) *Id.* at p. 12.

37) *Id.* at p. 18.

38) As one commentator on Medicare stated:

"The trouble with providing capital to hospitals through services rather than community or government investment is that it puts an unconscionable burden on the sick patient, by-passes or weakens the power of comprehensive health planning bodies and is an incentive to overuse of services. The capacity to generate capital out of services should not be the arbiter of how community or regional needs are met."

**Consumer Price Index and Percentage Change of Medical Care Components,  
Selected Years 1946-69**

Item	Average Annual Price Index							Average Annual Percentage Change					
	1946	1960	1965	1966	1967	1968	1969	1946-60	1960-65	1965-66	1966-67	1967-68	1968-69
CPI, all items	68.0	103.1	109.9	113.1	116.3	121.2	127.7	3.0	1.3	2.9	2.8	4.2	5.4
Less medical care	(1)	102.8	109.1	112.3	115.0	119.7	126.1	---	1.2	2.9	2.4	4.1	5.3
CPI, all services	63.9	105.6	117.8	122.3	127.7	134.3	143.7	3.7	2.2	3.8	4.4	5.2	7.0
Less medical care	(1)	106.2	116.2	120.2	124.7	130.8	139.7	---	1.8	3.4	3.7	4.9	6.8
Medical care total	60.7	108.1	122.3	127.7	136.7	145.0	155.0	4.2	2.5	4.4	7.0	6.1	6.9
Medical care services	58.4	109.1	127.1	133.9	145.6	156.3	168.9	4.6	3.1	5.4	8.7	7.3	8.1
Professional services:													
Physicians fees	66.4	106.0	121.5	128.5	137.6	145.3	155.4	3.4	2.8	5.8	7.1	5.6	7.0
Family doctor, office visits	66.7	105.4	121.2	128.7	138.8	146.8	157.2	3.3	2.8	5.8	5.8	5.8	7.1
Family doctor, house visits	66.4	106.9	124.9	133.4	142.6	151.9	163.3	3.5	3.2	6.8	6.9	6.5	7.5
Pediatric care office visits(2)	---	---	106.1	114.3	123.6	129.6	141.4	---	---	7.7	8.1	4.9	9.1
Psychiatrist, office visits(2)	---	108.2	104.7	109.3	113.7	119.7	129.1	---	.7	4.4	4.0	5.3	7.9

(1) Not available.

(2) Index Base, December 1963

Source: U.S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, *Medical Care Prices Fact Sheet*, Note 2-1970, February 23, 1970

Mal Schechter, "Medicare Alive, But Not Well," *The New Republic*, July 11, 1970, p. 16.

39) *Medicare and Medicaid Hearings*, op. cit. footnote 30, p. 28. Chart at top.

40) *Medicare and Medicaid Hearings*, op. cit. footnote 30, pp. 12-21.

41) U.S. Bureau of the Budget, *Special Analysis, Budget of the United States: Fiscal Year 1971*, Special Analysis K, p. 157.

42) *Id.* at pp. 157-59.

In 1965, the last fiscal year prior to Medicaid, total federal, state and local medical assistance payments under the older provisions of the Social Security Act were \$1.4 billion. In 1966, total medical payments were \$1.9 billion of which 62 per cent were made under the new Medicaid program.

By 1970, when virtually all payments are expected to be made under Medicaid, total medical assistance payments are expected to rise to \$5.8 billion, an increase of about 300 per cent over 1966.

Of the groups covered by Medicaid, the aged poor with their higher-than-average bills account for about \$1.4 billion or 46 per cent of all federal Medicaid payments though they represent only about 32 per cent of the total served under the program. Mothers and children representing about 55 per cent of all persons served under Medicaid account for about \$1 billion or 34 per cent of Federal Medicaid payments.

*Id.* at p. 159.

43) See 42 U.S.C.A. § 1861 (v) and § 1861 (v) (1). See also: 42 U.S.C.A. § 1842 (b) (3).

44) H.R. 17550 which has passed the House of Representatives and is currently being considered in the Senate, proposed to amend this provision to provide for "payment determined on a prospective basis." Prospective reimbursement differs from the present method of reimbursement in that a rate of payment is set in advance of the period over which the rate is to apply. The theory is that once the rate is set the provider will institute cost saving measures which will maximize the difference between its actual costs and the higher prospective rate. Theoretically, this approach to reimbursement introduces incentives not present under the existing reimbursement method which, since it tends to pay whatever the costs turn out to be, provides no incentives for efficiency. Report of the Committee on Ways and Means,

"Social Security Amendments of 1970-H.R. 17550," 91st Cong., 2nd sess., May 14, 1970, p. 29.

45) Report of the Staff to the Committee on Finance, United States Senate, *Medicare and Medicaid: Problems, Issues and Alternatives*, op. cit. footnote 25, pp. 60-65.

46) *Congressional Record*, May 14, 1969, p. S5202. See also: Report of the Staff to the Committee on Finance, United States Senate, *Medicare and Medicaid: Problems, Issues and Alternatives*, op. cit. footnote 25, pp. 135-43.

47) U.S. Bureau of the Budget, *Special Analysis Budget of the United States, Fiscal 1971*, Special Analysis K, p. 157; *Wall Street Journal*, November 4, 1970, p. 40.

48) *Report of the Task Force on Medicaid and Related Programs*, op. cit. footnote 1, p. 10.

"Efforts to contain Medicare costs have been intensified over the past year. Primarily they take the form of more careful review of the level of care provided in hospitals and extended-care facilities, enforcing utilization review requirements, reviewing physicians bills and rejecting unreasonable physician fee increases. In addition, legislation has been proposed which would (1) limit Medicare and Medicaid depreciation payments to medical facilities whose capital improvements have been approved by the state health planning agency; (2) bar from the program hospitals, physicians and other health services providers found guilty of abuses; and (3) expand utilization review authority to include the initial need for hospitalization."

49) *Task Force on Medicaid and Related Programs*, op. cit. footnote 1, p. 12.

50) *Id.* at p. 2.

51) U.S. Bureau of the Budget, *Special Analyses Budget of the United States: Fiscal Year 1970*, Special Analysis L, pp. 152, 158, 164.

52) Testimony of Surgeon General William H. Stewart, *Hearings on Comprehensive Health Planning and Public Health Services Amendments of 1966*, before Committee on Interstate and Foreign Commerce, House of Representatives, 89th Cong., 2nd sess., October 11, 1966, p. 31.

53) Interview with Clemens Gaines, former Assistant Commissioner of Health for Maryland, currently associate for Administrative Affairs, University of Wisconsin Medical School, November 17, 1970.

54) Interview with Robert Nash, Office of the Secretary, Health, Education and Welfare, November 18, 1970. [Hereafter cited as *Nash Interview*.]

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- 55) *Ibid.*
- 56) Interview with William Peebles, Assistant Commissioner for Operations, New Jersey Department of Health, November 17, 1970.
- 57) Committee for National Health Insurance, *Facts of Life, Health and Health Insurance* (Washington, D.C., November 1969), p. 9.
- 58) Stanley W. Olson, M.D., "Society's Responsibility to Medicine: Government as Catalyst in the Planning and Delivery of Total Health Care," *Regional Medical Programs Service-News Information Data*, Vol. 4, No. 11, June 23, 1970, pp. 1-12.
- 59) Blue Cross Association and National Association of Blue Shield Plans, *Blue Cross and Blue Shield Fact Book*, 1970, pp. 3, 11.
- 60) Interview with Theodore Ervin, Associate Director of the Michigan Department of Health, November 20, 1970. [Hereafter cited as *Ervin Interview*.]
- 61) Ed Phoebus, the Project Director of the Maryland Comprehensive Health Planning Agency in an interview with staff members of the Citizens Board described Maryland's organization:
- "We've got half a dozen physicians with us, and a dentist. . . . But for the most part we're very consumer-oriented. When we began looking for council members, we looked at categories, like the unemployed, aged, people on welfare, housewives, some businessmen . . . you know, consumers. And the law—P.L. 89-749—specifically says in excess of half an agency's advisory council members must be consumers. So you try to find out who is interested in getting health care services for their neighbors, and we found lots who were. People like Mrs. Colleen Depkin of Baltimore; she's a housewife. But she's also the mother of a mentally-retarded child, and she began by learning the services that were available for her and her family; what programs, local, federal and state governments could provide. Others, too, like Samuel Lloyd, a young black law student who worked hard to get health care services into Baltimore's ghetto. That kind of talent stands out. We've got George Harrison from down the coast, a seafood packer, and a strong voice for the environment. And then there's a black laundry attendant from Pikesville, sick a lot of the time. And he just became, by God, pretty tired of having to go so many places for health care, and having to shell out so much. So he began working to restructure public health services in his area, and he's a laundry attendant. Ed McGee is from Salisbury and he just retired from our state police. But his military occupational specialty was health-related and he spent a lot of his time working in local community organization to improve his area's health care. . . . [W]e've gone well beyond the half-way requirement about consumer membership. In fact, 21 of our people are consumers. They aren't paid, either, and politics isn't involved here."
- 62) *Nash Interview*, *op. cit.* footnote 54.
- 63) *Ervin Interview*, *op. cit.* footnote 60.
- 64) *Ibid.*
- 65) Interview with Andrew Braun, Metropolitan Washington Council of Governments, November 20, 1970.
- 66) U.S. Department of Health, Education and Welfare, *Operational Planning Systems Handbook*, March, 1970, p. 11.
- 67) *Nash Interview*, *op. cit.* footnote 54.
- 68) U.S. Department of Health, Education and Welfare, *1969 Annual Report*, pp. 30-31.

#### Chapter IV

- 1) William A. MacColl, *Group Practice and Prepayment of Medical Care* (Washington, D.C.; Public Affairs Press, 1966), p. 21. [Hereafter cited as *MacColl*.]
- 2) *Id.* at p. 22.
- 3) Information provided by the Public Relations Department, Group Health Association, Washington, D.C.

- 4) *MacColl*, *op. cit.* footnote 1, p. 26.
- 5) *American Medical Association v. United States*, 317 U.S. 519 (1943); *Group Health Cooperative of Puget Sound v. King County Medical Society*, 39 Wash 2d 586, 237 Pac 2d 737 (1951). Other sources: Horace A. Hansen, "Group Health Plans—A Twenty-Year Legal Review," *Minnesota Law Review*, (March 1958), p. 530.
- 6) Citizens Board of Inquiry field trip to Seattle, Washington. Additional information provided by Group Health Cooperative of Puget Sound.
- 7) Interview with Ollie Neal, Administrator, Lee County Cooperative, September, 1969 and November 23, 1970.
- 8) Raymond Munts, *Bargaining for Health, Labor Unions Health Insurance and Medical Care* (Madison, Wisconsin: University of Wisconsin Press, 1967), p. 9. [Hereafter cited as *Munts*.]
- 9) Kaiser Foundation Health Plan, Inc., *Kaiser Foundation Medical Care Program, 1969 (Annual Report)*, pp. 2-3. Other sources: Sidney Garfield, "The Delivery of Medical Care," *Scientific American*, Vol. 222, No. 4, April, 1970, pp. 16-17. (Dr. Garfield is a member of the Board of Directors of the Kaiser Foundation.) [Hereafter cited as *Garfield*.]
- 10) Kaiser Foundation Health Plan, Inc., *op. cit.* footnote 9, pp. 11, 22. Kaiser has grown from an enrollment of 154,000 in 1950 to the current enrollment of 2,007,000.
- 11) "It's Time to Operate," *Fortune*, January 1970, p. 80 et seq; *Report of the National Advisory Commission on Health Manpower*, Vol. II, November 1967, Appendix IV, "The Kaiser Foundation Medical Care Program," p. 197.
- 12) *Garfield*, *op. cit.* footnote 9, p. 19. Other sources: Ernest W. Saward, "Prepaid Group Practice in the Health Crisis," presented February 23, 1970, at the National Health Forum, *Meeting the Crisis in Health Care Services in Our Communities*, Washington, D.C., 1970, pp. 55-66; Herbert E. Klarman, *The Economics of Health* (New York: Columbia University Press, 1965), pp. 126-31.
- 13) Kaiser Foundation Health Plan, Inc., *op. cit.* footnote 9, pp. 6-9, 30-32.
- 14) Testimony of Dr. Ernest Saward, Medical Director of the Permanent Clinic, *Health Care in America*, Subcommittee on Executive Reorganization, Committee on Government Operations, U.S. Senate, 90th Cong., 2nd sess., April 26, July 9-11, 1968, pt. 2, p. 813 et seq.
- During a panel discussion on prepaid medical care, Walter Palmer, the Regional Controller of Kaiser Foundation Health Plans and Hospitals stated:
- "In our program [Kaiser] prepayment creates an incentive for the efficient management of medical care resources. . . .
- "Utilization of services under the constant and close scrutiny of the physicians in our medical group is maintained at reasonable levels. . . . [W]e have achieved success in our ability to avoid unnecessary surgery and unnecessary hospitalization and our ability to maintain essentially level patterns of utilization. . . .
- "The lack of uncontrolled utilization is attributable to the structure and functioning of our program. In 1968, for all of our regions combined, doctor office visits averaged 3,800 for every 1,000 members (or 3.8 visits per person) hospital discharges were 80 per 1,000 members and hospital days used totalled 510 per thousand with an average stay of 6.4 days." *Group Practice*, Vol. 18, No. 11, November 1969, p. 15.
- For the same year (1968) the national average was 4.2 physician visits per person, 120.2 hospital discharges per 1000 persons and the average length of stay was 9.2 days.
- U.S. Department of Health, Education and Welfare, Public Health Service, National Center for Health Statistics, *Current Estimates from the Health Interview Survey, United States, 1968, Series 10*, No. 6, June 1970, pp. 17-22.
- 15) *Garfield*, *op. cit.* footnote 9, pp. 17-18. Other sources: Testimony of Ernest Saward, M.D., Medical Director of the Permanent Clinic, *op. cit.* footnote 14, pp. 816-17.

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One of the most comprehensive evaluations of prepaid group practice is found in Avedis Donabedian, "An Analysis of Prepaid Group Practice," *Inquiry*, Vol. VI, No. 3, September 1969, p. 3. [Hereafter cited as *Donabedian*.]

Donabedian concludes that:

"Least open to doubt are the capability of prepaid practice to achieve a more rational pattern in the use of medical resources, its ability to control costs and the greater protection it generally offers against the unpredictable financial ravages of illness. Less is known about the levels of quality attained, but there is little to suggest that technical quality suffers and much to suggest that it is maintained and safeguarded. . . .

"[T]here are two problems that have not been fully solved: how to promote the full flowering of the professional spirit and how to nurture the . . . personal relationships between professionals and their clients in complex bureaucracies that are governed by impersonal exigencies of their own. . . ." p. 25.

16) Report of the National Advisory Commission on Health Manpower, Vol. II, November 1967, Appendix IV, "The Kaiser Foundation Medical Care Program," p. 214.

If the admission rates in Kaiser had followed the national trend during 1960-65, Kaiser hospital expenses per person would have increased about 35 per cent or two-thirds of the national percentage increase.

17) "Panel on Prepaid Medical Care (Part 1)," *Group Practice*, Vol. 18, No. 10, October 1969, p. 16. [Hereafter cited as *Panel on Prepaid Medical Care*.]

18) *Id.* at p. 16. Dr. Cutting in enumerating the basic principles important to a successful program stated:

"The fifth basic principle is one of voluntary enrollment. We believe that the concept of a captive patient or a captive doctor is not conducive to the continuing good quality of medical care, so that every member in our program each individual member, has made his selection on a dual choice method between our program and an alternative, usually Blue Cross or an insurance program. This is made not by the majority of a group, but on individual election."

One of Kaiser's criteria for expansion is:

"Competition—existing patterns of health care coverage in the area must be gauged to determine whether the Kaiser Foundation Health Plan can make a significant contribution to the choices available to workers and their families under dual or multiple choice programs." Kaiser Foundation Health Plan, Inc., *op. cit.* footnote 9, p. 11. See also: Avedis Donabedian, *op. cit.* footnote 15, pp. 9-10: ". . . [T]he use of outside services is significant in group practice. It occurs partly because of dissatisfaction with services offered in the plan. Partly it is the expression of previously established relationship with an outside doctor and of the greater convenience under certain circumstances, of obtaining care outside the plan.

" . . . Persons who have a regular physician with whom they are satisfied are less likely to choose prepaid group practice when an alternative plan that permits free choice of physician is offered. . . . To some extent consumer acceptance of prepaid group practice is an expression of the absence of a prior patient-physician relationship or of a breakdown of such relationships."

19) See Chapter I of this Report. The Citizens Board of Inquiry made an extensive visit to Kaiser in Portland, Oregon in November 1969. We interviewed physicians, administrators, other staff personnel and members of the plan. The interviews are on file in the Citizens Board of Inquiry office.

The following letter appeared in the *American Medical Association News*, November 2, 1970, p. 5.

" . . . I average one or two known Kaiser patients in my office per day. . . . It is readily evident that not only are there a lot of dissatisfied members of the plan, but the amount collected in premiums and head tax by the plan is considerably lower than the actual cost of what patients

(and most doctors) consider good care. . . . Since I see a higher percentage of my Kaiser patients on emergencies and night calls than I do my regular patients, this represents other services allegedly paid for by other premiums but not delivered.

" . . . Under delivery of services is probably the greatest source of profit for the Kaiser Permanent Plan."

See also: Health Policy Advisory Center, *Health Pac*, November 1970, pp. 11-14.

20) Citizens Board of Inquiry, Kaiser Portland Field Trip Report. November 1969, on file at the Citizens Board of Inquiry office.

Other sources: J.R.M. Carnoy, "Kaiser, You Pay Your Money and You Take Your Chances," *Ramparts*, Vol. 9, No. 5, November 1970, pp. 28-31. Raymond Munts, *Bargaining for Health, Labor Unions, Health Insurance, and Medical Care* (Madison, Wisconsin; University of Wisconsin Press, 1967), pp. 194-95.

The situation in Kaiser, California has become serious enough to warrant the establishment of the California Council for Health Plan Alternatives, a committee of about one dozen California unions to reappraise all medical care resources available in the state.

21) Walter Palmer, Regional Controller, Kaiser Foundation Health Plans and Hospitals, *Group Practice*, Vol. 18, No. 11, November 1969, p. 15.

22) *Garfield, op. cit.* footnote 9, p. 20.

[Kaiser's] health testing procedure is ideally suited to be a regulator of entry into medical care. Certainly it is more sophisticated than the usual fee-for-service or our present first-come-first-served method. As a new entry regulator, health testing serves to separate the well from the sick and to establish entry priorities. In addition, it detects symptomless and early illness, provides a preliminary survey for doctors, aids in the diagnostic process, provides a basic health profile for future reference, saves the doctor (and patient) time and visits, saves hospital days for diagnostic work and make possible the maximum utilization of paramedical personnel.

Most important of all, it falls into place as the heart of a new and rational medical care delivery system.

See also: Morris F. Collen, Robert Feldman, et al, "Dollar Cost Per Positive Test for Automated Multiphasic Screening," *The New England Journal of Medicine*, Vol. 283, No. 9, August 27, 1970.

To evaluate the cost and effectiveness of a multiphasic screening program 44,663 multiphasic examinations performed between September 1, 1967 and August 31, 1968 were analysed. The patients tested were members of the Kaiser Foundation Health Plan in the San Francisco Bay Area.

Other sources: "Multiphasic Health Screening—a Fad, a Gimmick, or the Significant Innovation," *Group Practice*, Vol. 19, No. 3, March 1970, p. 7 et seq.

23) HIP was organized by New York's Mayor La Guardia to provide medical care to city employees and people in low- and middle-income groups. HIP was registered as a nonprofit corporation in New York State in 1944, and it was in operation by 1947. By the time HIP had been in action for two years, twenty-six groups had been established embracing over 700 physicians and caring for some 200,000 enrollees. By 1967, it had grown to 700,000 subscribers in 32 groups. In 1967, 55 per cent of the total enrollment was composed of municipal employees; 45 per cent are workers in private industry.

A comprehensive study of the early years of HIP was done by Anderson, Odin and Sheatsley, *Comprehensive Medical Insurance*, Health Information Foundation Research Series, No. 9, 1959.

24) Interestingly, the manual also specified that there is to be no lay interference with the physicians' care of the patient.

25) The fact that many doctors are part-time only has always been a problem to HIP. See Munts, *op. cit.* footnote 8, pp. 197-99.

26) HIP has always used peer review as a means for evaluating the performance of the member physicians. A

committee of outside specialists made a three-part study of all doctors in each medical group in six specialties. They studied clinical records to evaluate the competence of each doctor and interviewed each physician. After the study was completed the medical groups terminated the services of several physicians with low scores. E.F. Daily and M.A. Morehead, "A Method of Evaluating and Improving the Quality of Medical Care," *American Journal of Public Health*, Vol. 46, No. 7, July 1956, pp. 848-54.

27) Paul Densen, Ellen Jones, et al, "Prepaid Medical Care and Hospital Utilization in a Dual Choice Situation," *American Journal of Public Health*, Vol. 50, No. 11, November 1960, p. 1710.

Somers states that the principle of "dual choice is a technique for reconciling subscriber free choice" with "closed panel" practice. The procedure usually provides that employees of large scale "health and welfare purchasers" (i.e. unions) may opt individually and usually annually between the panel plan and an indemnity plan of approximately the same price. "This innovation [begun by Kaiser] is one of the most significant recent developments in health insurance not only reconciling considerations of quality and efficiency with 'free choice,' but also serving as a discipline on the service of both competitors." H.M. and A.R. Somers, *Doctors, Patients and Health Insurance* (Washington, D.C.: The Brookings Institution, 1961), p. 351.

Note the section on dual choice and its operation at Kaiser *supra* p. 49 et seq. Other sources: E. Richard Weirnerman, "Patient's Perceptions of Group Medical Care," *American Journal of Public Health*, Vol. 54, No. 6, June 1964, pp. 880-82.

"When groups choosing between HIP and Group Health Insurance of New York were questioned, the factor of free choice of physicians was found to dominate the reasons given by GHI enrollees while the assurance of no out-of-pocket expenses was most commonly cited by those selecting HIP. Significantly, enough a sizeable group in both plans indicated others in the shop joining as the chief inducement.

... [M]uch of the dual choice outcome depends upon which of the competing plans has the initial enrollment advantage and how well-acquainted the group can become with the once-strange group health center method."

28) The early difficulties which HIP encountered with the organized medical profession were very similar to those surrounding the early consumer health movements discussed in Chapter IV. The rapid growth of HIP beginning in 1947, caused the medical societies to charge that HIP engaged in unethical advertising, that HIP's structure did not permit a proper relationship between physician and patient and that HIP was a trial balloon for national health insurance. There were serious charges leveled against participating physicians. The battle was resolved by the Judicial Council of the AMA which absolved the physicians of the charges, feeling probably that the charges against HIP could not stand up in court. There continued to be harassment, however, in the form of attempts to deny HIP doctors admitting privileges to hospitals.

See also: Martin Gross, *The Doctors* (New York: Random House, Inc., 1966), pp. 476-77.

29) A spokesman for the East Nassau Group in 1966 stated: "The new doctor gets a \$14,000 annual wage for his first year [in 1967] after which he enters our profit-sharing plan. A typical senior man nets about \$28,000 a year, plus retirement and disability programs and paid vacations."

Martin Gross, *The Doctors* (New York: Random House, Inc., 1966), pp. 474-75.

Little is known about the kind of physician who chooses prepaid group practice. See *Donabedian, op. cit.* footnote 15, p. 10.

30) It is interesting to note that in 1969, the only HIP group operating in a hospital, Montefiore, a voluntary teaching institution, severed its contract with HIP, claiming that HIP funding was inadequate. This example raised the question of

whether HIP can support a body of highly-trained specialists.

31) A study of the attitudes of HIP doctors toward prepaid group practice showed that a quarter to a third of the physicians interviewed felt that by becoming associated with this type of practice they had lost status in the eyes of medical colleagues as well as of the patients they served.

D.C. McElrath, "Perspectives and Participation of Physicians in Prepaid Group Practice," *American Sociological Review*, Vol. 26, August 1961, p. 596.

32) See Somers, *op. cit.* footnote 27, p. 109; Munts, *op. cit.* footnote 8, p. 195.

33) Office of Economic Opportunity, Division of Health Services, *The Comprehensive Neighborhood Health Services Program Guidelines*, March 1970, p. 6.

34) Interview with Lisbeth Bamberger Schorr, Medical Care Consultant, Washington, D.C., formerly Chief Program Planning and Development, Office for Health Affairs, Office of Economic Opportunity; Member, Citizens Board of Inquiry.

35) Information provided by Office for Health Affairs, Office of Economic Opportunity.

36) These services are emergency, sick and well child, sick adult and adult health screening, home medical care and home nursing, health education, psychiatric services, social work, community organization laboratory, pharmacy, ambulance, specialty consultations and prenatal care.

37) Joseph Brenner, M.D., "A Free Clinic for Street People—Medical Care Without a Hassle," *The New York Times Magazine*, Section 6, October 11, 1970, p. 30.

38) Citizens Board of Inquiry Field Trip to San Francisco, July 29-30, 1970. Interviews on file, Citizens Board of Inquiry office.

#### Dissenting Opinion

1. The Majority Report did not recommend a single nationwide federal program as a solution to our health services problems. The Report explored the existing arrangements for delivering health care, and from the point of view of the consumer, found deficiencies of varying degree in all of them. (See Chapter IV—particularly the sections on Kaiser and HIP, pp. 49-57.) We also scrutinized several federal programs closely and found them wanting (Chapter III). Our recommendation is that all Americans must receive adequate health care and that there should be new forms and structures of health care developed to accomplish this, but that it is the responsibility of government and ultimately the federal government to assure adequate health care for all Americans.

2. In Chapter II of the Report, on p. 15 careful note is taken of the fact that factors in our society other than health care contribute to our well-being—but this should not be used as an excuse for doing nothing about medical care.

3. While our technique for gathering data undoubtedly has its faults, so does a questionnaire survey unless we know who was asked what questions, who responded and who did not.

4. Throughout the Report we have stressed that there probably is no single rational system for delivering health care—rather there may be a plurality of systems all of which would work better than what we now have. The import of our Report is, we hope, that a variety of new approaches can and must be tried—nowhere do we even hint that we should "junk" our pluralistic heritage.

5. We agree with Dr. Besson. Chapter III of the Report is critical of the federal government's attempts to date. Our recommendation is that health care for all is the ultimate responsibility of the federal government, when all else has failed. Perhaps the Regional Medical Programs and the Partnership for Health Program do offer potentially valuable models—but we have no evidence as yet to indicate that this is so.

6. We would concur in this and only hope that it comes to pass.

7. Chapter IV of the Report demonstrates quite vividly what happens to consumers who try to assume power—but do not have the tools to exercise it. This chapter and the Conclusions

and Recommendations (Chapter V) are a call for the consumer to control those aspects of the health care system which should be reshaped to make them more responsive to him and to his

needs—and for the provider to retain the power and control over medical matters—certainly a situation of equity.

8. See Conclusions and Recommendations, Chapter V, p. 69.

## Glossary

**AFDC**—Aid to Families with Dependent Children

**AHA**—American Hospital Association

**AMA**—American Medical Association

**Actuary**—a person trained in the insurance field, who determines policy rates, reserves, and dividends as well as conducts various statistical studies.

**Blue Cross**—an independent, nonprofit membership corporation providing protection against the costs of hospital care.

**Blue Shield**—an independent, nonprofit membership association providing protection against the costs of surgery and other items of medical care.

**Cardiac Disorder**—abnormal condition of, relating to, situated near or acting on the heart.

**Cobalt Machine**—device used with limited, transient effectiveness to treat the anemia of infection, renal disease and cancer.

**Co-insurance**—a policy provision, frequently found in major medical insurance, by which both the insured person and insurance company in a specific ratio share the hospital and medical expenses resulting from illness or injury.

**Deductibles**—found in major medical insurance, is that portion of covered hospital and medical charges which an insured person must pay before his policy's benefits begin.

**Defibrillator**—an apparatus used to counteract irregular contractions of the muscle fibers of the heart by application of electric impulses to the heart.

**Direct Service Plans**—insurance plans, like Kaiser or HIP which furnish services directly through their own hospitals and/or affiliated professional staffs in exchange for a fixed sum. They combine the functions of insurance carrier and provider.

**Fee-for-service**—a charge set by the physician or health professional in exchange for the benefits of a physician or health professionals' knowledge, aid and services.

**EKG**—an electrocardiogram, which is a graphic tracing of the electric current produced by the contraction of the heart muscle.

**CHA**—Group Health Association

**Group Health Insurance Plan**—a policy protecting a specified minimum number of persons usually having the same employer.

**GI**—Gastrointestinal, pertaining to the stomach and intestine.

**GP**—General Practitioner, a physician who does not limit his

practice to a specialty.

**Health Insurance**—a generic term applying to all types of insurance indemnifying or reimbursing for costs of hospital and medical care or lost income arising from an illness or injury. Sometimes it is called Accident and Health Insurance, or Disability Insurance.

**HEW**—United States Department of Health, Education and Welfare

**HIP**—Health Insurance Plan of Greater New York.

**Industrial Contract Medicine**—agreement for the provision of prepaid medical services between industry and labor.

**Insurance**—protection by written contract against the financial hazards (as whole or in part) of the happenings of specified events.

**KFH**—Kaiser Foundation Hospitals

**Major Medical**—insurance policies especially designed to offset heavy medical expenses resulting from catastrophic or prolonged illness or injury. They provide benefit payments for 75-80 per cent of all types of medical treatment by a physician, above an amount first paid by the insured person, and up to the maximum amount provided by the policy—usually \$5,000 or \$10,000 or higher.

**Malpractice**—Dereliction from professional duty or a failure of professional skill or learning that results in injury, loss or damage; injurious, negligent, or improper practice.

**Medical Partnership**—A contractual association between physicians within the same practice.

**OIO**—Office of Insurance Organization

**OB Gyn**—Obstetrics and Gynecology, the branch of medicine that deals with birth, its antecedents and sequels, and that which deals with women, their disease and hygiene.

**PHS**—United States Public Health Service

**Premiums**—The periodic payment required to keep an insurance policy in force.

**Prenatal**—occurring or existing before birth

**Prepaid Medical Services**—An agreed upon payment in advance for medical care which aims for broader coverage than simple insurance coverage. Prepayment is designed to cover early preventive services, ambulatory as well as major illness.

BEST COPY AVAILABLE

Senator KENNEDY. I want to commend you, Dr. Breslow, and your committee for providing this study and the service, because I think the materials which you gathered and assembled by such a distinguished board can't help but to really shake the confidence of the American people in our present health delivery system. You have well documented the situation this morning. At least to those who have had a chance to read your full report, it is most persuasive and compelling, and I know this subcommittee, as well as the members of the Senate and the Congress, will find it extremely valuable material.

I want to commend you and the members of your group who have taken the time and energy to perform this service.

The fact that people such as yourself would be sufficiently concerned about their fellow citizens to develop this kind of a board and seek the support and gather the material and make it available to us is a reflection of the strength of our American system.

It is an enormous service to the country and those people who are not today experiencing the kind of quality health which I am sure you feel they should receive, and I do as well.

I understand Senator Cranston wanted to have an opportunity to introduce you, Dr. Breslow, and he was unable to be here.

I want to thank all of you very much.

(The combined statement of Dr. Breslow, Dr. Miller, Mrs. Schorr and Mr. Huges follows:)

TESTIMONY OF DR. LESTER BRESLOW,  
DR. C. ARDEN MILLER  
MRS. LISBETH BAMBERGER SCHORR AND MR. HARRY HUGE  
REPRESENTING THE CITIZENS BOARD OF INQUIRY  
INTO HEALTH SERVICES FOR AMERICANS  
BEFORE THE SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON LABOR AND PUBLIC WELFARE,  
U.S. SENATE - FEBRUARY 25, 1971

I am Dr. Lester Breslow, Chairman of the Department of Preventive and Social Medicine, School of Medicine, University of California at Los Angeles. My colleagues are Mrs. Lisbeth Bamberger Schorr, now primarily a consumer of health services, but formerly of the Office of Health Affairs of OEO; Dr. C. Arden Miller, who is Professor of Maternal and Child Health at the University of North Carolina School of Public Health, and Mr. Harry Huge, attorney with the firm of Arnold & Porter.

We come here today as representatives of the Citizens Board of Inquiry Into Health Services for Americans.

The Citizens Board evolved out of a concern that while there have been reports issued and Congressional hearings held on medical care problems in recent years,

these have not emphasized the problems confronting the patient. They have emphasized the inadequacy of health care facilities, shortages and limitations of health manpower, utilization of services, costs, methods of payment, and the delivery system and its failings -- but few studies have been done on what consumers want, expect and experience from health services and what they think of present and past efforts to improve them.

The inquiry conducted by the Board was, simply put, an effort to listen to as many people of different socio-economic backgrounds in as many settings as possible on the subject of their medical care.

Perspectives reported by consumers, and the conclusions reached by the Board, provide many important and useful cues for those of us engaged in research, education and demonstration on matters of health service. The report may also provide important cues for the entire decision-making American public on matters related to health.

All expenses for the Citizens Board of Inquiry were met by private contributions.

The Citizens Board, which is composed of the four of us in addition to twenty-seven other persons ranging from prominent medical scientists and educators and practicing physicians, to successful businessmen to politicians, black and white welfare mothers and labor union representatives. In addition, there were nurses, social workers, several young attorneys, a judge, a prominent author, and a recent medical school graduate. As you will see from the list of Board members attached to the end of this statement, they are an impressive array of talent and effectiveness in American public life.

These persons participated actively in the Board's inquiry, particularly in the field trips and visits.

Extensive visits were made to Portland, Oakland, St. Louis, Houston, Seattle, Chicago, and to Boston and its suburbs; and to the Rio Grande Valley in Texas, and to small town and rural Kansas, and to rural counties of the South, one largely poor black and one largely poor white. Field work also was done by board

and staff members in the areas of their own work and residence: suburban Washington, Philadelphia, rural North Carolina, and Los Angeles. Special efforts were made to include sites representative of different socioeconomic levels, different ethnic groups, different life styles, and people with access to different patterns of medical care. In addition to our efforts to gather information, a large amount of it was volunteered in conversations and letters from people who learned about the study from occasional news reports.

Board and staff members spoke with hospital administrators and physicians, with nurses and laboratory technicians, with health and insurance executives, with people involved in a variety of federal programs, and with medical educators. But most of the time was spent talking with people who use health services.

An astonishing number of people with whom we talked are distressed about their experiences with America's health care system. As documentation of negative attitudes accumulated in staff reports, special efforts were made to identify satisfied consumers, and

we found some. There are people who cherish the easy accessibility of health care in comprehensive neighborhood centers; there are people who still enjoy the benefits of a highly regarded family physician; there are people who rejoice in freedom from economic catastrophe when serious illness is cared for under prepaid group practice. There are people who have developed in their own communities methods of health care which they believe can be models for the rest of the country. But many people are distressed. The Board listened to all views and experiences. We would like to share with you what we heard and what we report in our publication, "Heal Thyself."

## II.

A. Anger and frustration are the commonest characteristics of the consumers' attitudes toward health services. American people do not have to stop and reflect on how they feel about these matters. Our efforts to evaluate consumer attitudes were occasionally a source of quick annoyance that still another study was underway. We were asked how we could continue to study

and to survey problems which had already been so well documented and so thoroughly aired and not, instead, take action to improve the consumer's circumstances with relation to the quality and ready availability of the kinds of comprehensive health services he reads about and has been led to expect?

Characteristic remarks were:

From a middle-class housewife: "My doctor has a call hour between 7:00 and 8:00 o'clock in the evening. If anything happens to me or the kids after 8:00 I am afraid to call him. He gets mad because you didn't call during the hour, and if I take the kids to his office I almost pray they are sick."

From a union executive: "It's gotten so the hospitals will have to be governed or controlled by the government. Doctors are reaping a harvest and they are really giving us a fleecing."

From a man in suburban Boston: "The cost of insurance is so high it's ridiculous now. And are hospitals justified in charging what they charge? The ordinary citizen is going into hock for the rest of his life."

B. Patients in every socio-economic class expressed their resentment against systems of care which required either payment or proof of payment before services are rendered. The poor suffer most because they may in fact be turned away from services if they cannot pay in advance.

A woman in St. Louis told us, "When you come to the hospital you have to bring two years back rent receipts, gas, electric and wage slips before they even look at your child."

Even in emergencies the rules hold according to some reports: We were told repeatedly that, "At the hospital usually the first question is who is going to pay the bill." Another woman in Arkansas told us: "Most of my babies were delivered by a midwife, but lately everybody been going up to Marianna to have a doctor do it. The doctor told me he would do mine but when the time came I paid a neighbor to carry me up to his office and he turned me away because I didn't have enough money, and I was in labor, mind you."

In another situation a woman in labor was left unattended while her husband hurried home, arranged for

the sale of his cow and brought money back to pay for the delivery.

Although as physicians, Dr. Miller and I have heard resentment expressed from patients who accused the hospital of requiring payment in advance of services, we thought we knew better. No one was turned away; the hospital was attempting only to fulfill its obligations for fiscal responsibility. I think circumstances have changed or we have been wrong. We are persuaded that a large number of American people are denied medical services until they can pay in advance.

C. Many patients are resentful about the social, cultural and language barriers which separate them from providers of health services. These barriers are most conspicuous in the instance of Spanish-speaking Americans who cannot even be assured that their complaints are understood, nor can they be confident about understanding instructions and interpretations given them. But even among people who speak the same language, the same language is in fact not spoken. A woman in Boston told us: "Those rich doctors at the city hospital treat you

like dirt. They don't know anything about the people they are treating."

The use of indigenous health workers in the comprehensive neighborhood health centers provided welcome relief to many patients who felt that for the first time there was someone who understood their life styles, their problems and who could make realistic recommendations in terms of their resources and interests.

D. Field representatives were shocked by the frequency with which patients are abused in order to satisfy procedural or professional convenience. In one state, for example, Medicaid recipients are entitled to one free out-patient visit per month. To claim that right, a recipient must first make an appointment with a doctor, then he must go with proof of the appointment to the county welfare department for a medical reimbursement form, then back to the doctor, form in hand. The doctor submits the form to the state welfare department for his payment. The requirement of preliminary approval was explained to us by the county director of welfare: "There used to be a lot of fraud with doctors

claiming payment for patients they hadn't seen, so now patients are required to get an appointment first to stop the doctors from defrauding the state." In order to guarantee that a system works in an honest fashion it is not the doctor who is inconvenienced, nor is it the office staff of the welfare department; it is the sick patient.

In Portland, Oregon, many private doctors refuse to treat Medicaid patients. As a result, the city's poor must get medical care at the county hospital located on "Pill Hill," a site for three hospitals on one of the highest hills in southwest Portland. For some people in the city, "Pill Hill" is as far as several bus rides, and hours away. When asked why the county did not establish decentralized clinics, the Dean of the University Medical School replied that it would be "inconvenient for medical students to travel away from Pill Hill."

E. We frequently heard of resistance from the medical profession to efforts at broadening the base for health services. For more than a decade we have

preached about the importance of medical auxiliaries, or physicians assistants, to expand the physician's competence to a larger number of patients. One such effort is represented in Arkansas where a midwife training and licensing program has been established. The public health nurse described how this program works. "A doctor's signature on a card is required by law for midwife deliveries. If the patient has money, the doctor won't sign the card even if the delivery would be safe for a midwife. If the patient can't pay, the card gets signed."

F. A large proportion of the American people believe that even when they overcome a variety of obstacles to health services they are treated with insensitivity and indignity.

A priest told of taking an acutely ill alcoholic to an emergency room and asking that he be given care. "They took us right to the front of the line when they saw I was a priest. I explained the problem and was assured that he would be admitted and taken care of. Two days later I went back to visit him. No one had

heard of his ever having been brought in. I'm sure that when I went out the front door, he was shoved out the back door."

Another woman told of going to a large city hospital: "I went down there -- it was an emergency -- my child's head was bleeding. We had to wait two hours. There were old people lying in the corridor -- nobody doing anything for them -- it was awful."

We don't know that these stories are true. For each tale of woe there may be a perfectly reasonable and defensible explanation, but it is certainly true that the people who related the stories believe them to be true, and believe they typify medical care in a system which is entrepreneurial, money-grabbing, insensitive and abusive to many needs of patients.

Even when we try to be solicitous toward patients we often reveal underlying attitudes of discrimination and insensitivity:

"A well-dressed white, middle class woman in Washington, D. C. took two black children she was tutoring on a volunteer basis to a hospital outpatient clinic

for hearing tests at the appointed time, 9:00 a.m. After waiting four hours, the girls were finally tested. The nurse performing the test was surprised at the woman's presence and asked her who she was. Upon finding her role, the nurse replied, 'If only we'd known we would have taken your girls first thing.'

G. A uniform complaint was that various health insurance schemes for which people have paid dearly have provided little security for patients who are threatened by the economic catastrophe of major illness; and health insurance does not necessarily remove economic obstacles to health services.

A young mother concerned about the rising costs of medical care told about the costs of her several childbirths: "Three and one-half years ago, she paid \$80 a day for hospitalization; two years ago, she paid \$104 a day; and within the past year, the cost was \$127 a day. The total cost for her most recent delivery was \$1,025: \$508 for the hospital room, \$45 for use of the delivery room, \$325 for the obstetrician, \$50 for the anesthesiologist, \$20 for the pediatrician, and \$30 for

a circumcision. Of the total amount only about \$300 was covered by her insurance policy. She had thought her premiums were to cover the cost of her medical needs."

A working class mother in a suburb of Washington, D. C., gave the following account of her experience with the costs of childbirth: "On the phone when I told the office that I was a new patient the receptionist took down the information and quoted me a fee of \$250. I went down there about three weeks later, and the doctor said the fee was \$300. The hospital the doctor uses sent me papers and asked for a payment of \$400 in advance. I called the hospital back and talked to the credit manager, and I told him point blank that I just couldn't have the money in the hospital two months in advance. I said that I could not understand it; I had insurance and why did I have to pay in addition to the insurance. He left the phone and came back and said, 'Well, because you do have insurance just send in \$200.' Six years ago, you could send in \$50 deposit and by the time you were ready to leave the hospital

your total bill was \$200 or \$250. Now it is unbelievable that so far it has cost me \$700 to have this baby."

A group of union leaders were particularly concerned about the escalating costs of medical care and the inadequacy of insurance coverage. They reported to us that they had had Blue Cross-Blue Shield Major Medical, but that because the per diem rate had gone up so high in the hospitals they wanted to try for master medical plan, which offers more coverage than major medical. It would have taken 21-1/2% out of the wage package to go the master medical coverage so they felt saddled with the same plan they had before for two more years. "It is out of our bargaining reach unless we cut some other things."

A New Jersey woman explained that she pays more under Medicare than she paid without it. "My physician used to charge me \$10 for an office consultation. I have a serious heart condition and saw him once a month. This amounted to \$120 a year. A week after Medicare became law his fee was raised from \$10 to \$15. He now charges \$4 for a blood test which previously was

included in his fee. Thus, my monthly bill is now \$19 instead of \$10. My yearly Medicare insurance costs \$48 (\$4 monthly premium for Part B.) My yearly doctor bill is \$228. After deducting \$50, Medicare will pay \$80 of reasonable charges: \$142.40. I pay out a total of \$276, including premium, and get reimbursed \$142.40, leaving me \$133.60 to pay out of pocket -- \$13.60 more than I paid before Medicare."

H. The Board was constantly impressed with the large proportion of the family pay check which goes for medications. This was particularly striking in several poor southern communities. No attempt was made to analyze the appropriateness or the effectiveness of medications. However, a study was done on their costs.

A certain tranquilizer was commonly prescribed in Arkansas. At the local drug store 30 capsules cost \$6.50. At a middle-class drug store in Washington, D. C., with a predominant white clientele, the cost was \$2.50. At a drug store in a ghetto neighborhood of the same city, largely with a black clientele, the cost was \$3.29.

A pain reliever containing a mixture of anodynes was frequently prescribed in Arkansas. The cost of 100 capsules was \$12.00; in Washington, D. C., at the white middle-class drug store it was \$4.50; in the low income black drug store it was \$4.75.

A synthetic hormone cost \$5.75 for 100 capsules in Arkansas; \$1.90 in the white middle-class drug store; and \$1.99 in the low income, black drug store.

A monthly budget for welfare families with nine children which received \$140 per month welfare assistance included \$20 for medication. Another family which was receiving \$165 welfare assistance spend \$30 each month for medication. These stories were repeated again and again.

In a number of instances poor families told of buying medications of dubious worth in preference to food, in the belief that in this way they were serving their families' best health interests.

This recitation of anger and grief could go on endlessly. What does it mean? The stories might mean that our staff were muckrakers. There may have been

some of that, though we worked against it. I am not willing to discount the testimony on that basis. The stories may reflect an American penchant for carping about the establishment, whether it be a medical establishment, an educational establishment, or a baseball establishment. We should, perhaps, diminish the testimony's credibility a bit on that basis.

But our mission was to learn how consumers judge health services. And a disturbing revelation it is. The Board gives credence to a great deal of it; it fits with much objective evidence on the state of health and the adequacy of health services in this country. If we are doing a good job with medical care, against wide misunderstanding, then we have the biggest job of persuasion ahead of us since Moses was found in the bulrushes.

A reassuring aspect of all our observations is that people, although angry, are not apathetic. They work hard to obtain medical care; they are willing to strive to overcome obstacles.

I suspect the poor people of this country have never received adequate medical care in convenient and dignified circumstances. Current widespread testimony to a health crisis may be evidence that the silent majority are now aware that they too receive inadequate care, and even that at a cost of dignity, convenience and money that many are unwilling or unable to pay.

### III.

The Board and its staff reviewed past programs which have been designed to improve the quality and availability of health services. A long succession of national programs has been instituted in the past quarter century in an effort to reinforce faltering mechanisms and patterns for health services. In retrospect many of these efforts appear glib and superficial; possibly they were all that could have been done in the climate of national priorities which then existed. For the most part the programs tended to strengthen existing patterns, including their inadequacies, rather than to close gaps and to restore order to random and incomplete services.

What is the missing ingredient? It may be meaningful involvement of the consumer. We have not included him in our planning and because we have not included him we may have given less than proper emphasis to his needs. When we have tried to include him we have tended to overwhelm him with professionalism. A case can be made that planning done by professionals somehow ends up always to serve professional needs. We have a great deal of evidence that it does not serve consumer needs. Several endeavors such as Regional Medical Program, Hill-Burton Construction and Comprehensive Health Planning have assumed a partnership of interest between providers and consumers and have required that boards be established with consumer representation. Our field representatives searched assiduously to find examples where consumers felt they did in fact serve as equal partners with professionals in the planning and administration of health services. They found very few. Often the consumer representatives are in fact associated closely with established professionals or professional organizations. Ordinarily theirs is a submerged voice. What does that voice say?

One of the Board's field trips included a visit to the first neighborhood comprehensive health center which was established with OEO support by Tufts University at Columbia Point in Boston. A health association was established there to help run the clinic. A member of the association reported as follows: "We have on paper this long list of all the powers we are supposed to have -- all of our responsibilities. And we have been told a lot more by the people at Tufts. The fact of the matter is we don't have any of those powers except when they decide it's convenient for them. They say we are irresponsible, but how can we be responsible with no responsibility?"

Another: "We know we need expertise and technical assistance but they're not giving it to us. We got it at the very beginning but we have a lot more reason to keep it going than they have."

Another: "Our goal is to have this clinic be completely run by consumers. We know we can't do it now but we are going to insist that Tufts give us the benefit of their expertise. You know, set up a real

1971 the Health Association can be the direct grantee from the OEO."

Consumers seem to have a quite different feeling about the Yateman Clinic in St. Louis, a comprehensive health center governed by a 60-man board, all of it elected from among the people who are served by the clinic. The laundromats and store windows of the Yateman area are filled with campaign posters of community leaders electioneering for a term on the prestigious board. One member reported: "The city said when the clinic got started, these are black people, they can't control something like this. We got ourselves together and proved it could be done. We sweated blood to get this center. I cried, groaned, I talked to the regional people; we need this place. Yateman has the highest illiteracy, the hardest pressed people in this city. That's what poverty means. No person is turned down for services here. That's what upgrading a community means."

We don't know what the medical services are like at the Yateman Clinic, but we do know that the people who are served speak about them with glowing enthusiasm.

Consumer representation on governing boards is not always a happy experience. Hospitals in Boston have had problems in their relationships with the community. One hospital established a series of committees with consumer participants. One participant reported as follows:

"In about November I was asked to be one of the community representatives of the building committee. I thought it was a ploy. If I was on the committee I wouldn't be able to say anything. In February or March, we had a meeting. The other community person from south end didn't show. The experts decided that the first order of priority for building was a parking garage and housing for the resident staff and that their building plans required some of the community's land. I told them that if they tried to build what they were proposing I would muster community support against it. I have never been asked to another meeting. At one point, I called and told them I wanted more information so I could do my homework and be prepared for these meetings, but nothing happened. I have kind of just

copped out of it. Part of the syndrome of banging your head. Why try? That's probably reflecting the sentiments of the people of this community."

#### IV.

The consumer, it is clear, knows that something is dreadfully wrong. He knows that he cannot get care when he needs it, in the way that he needs it, at a price that he can pay. For the consumer it is a quantum jump to translate that into the design of new delivery structures and financing mechanisms. But our experiences as a Board of Inquiry have led us to formulate a set of criteria that American consumers seem to be setting for the design of any program of health services, as follows:

##### A. Access to Required Health Services

All Americans must have access to all services necessary to maintain, protect and regain optimum health, whenever and wherever they are needed, including the following:

1. Continual access to basic medical care, including preventive, diagnostic, treatment and

rehabilitation services, meeting reasonable standards of quality, and rendered in whatever setting is most appropriate to the patient's need.

2. Daily access to routine health guidance.

This requires ready telephone or personal access, available at specified convenient times, to personnel who can provide guidance regarding routine health problems (e.g., care of well children, expectant mothers, chronically ill persons); and advice regarding the best point of entry into the health care system in a specified situation.

3. Immediate access to emergency service.

This requires well-staffed hospital emergency rooms operating around the clock, a telephone easily accessible to every home, with 24-hour, 7-day a week, well-publicized emergency numbers which connect to

- (a) ambulance service with trained attendants;
- (b) trained personnel to provide or arrange for appropriate response

- to emergencies resulting from injuries, poisoning, drug abuse, etc.;
- (c) trained personnel to make necessary house calls.

4. Periodic access to diagnostic and screening procedures (differing with age, sex and other characteristics), with organized medical follow-up care providing simple ways of identifying persons who need medical care in the absence of gross symptoms.

5. Access to non-medical services needed to maintain, protect, or regain health, such as legal services to enforce housing and sanitation codes, homemakers, meals-on-wheels, and similar services without which medical care may be ineffective.

B. Circumstances in Which Care Is Provided

Not only must adequate care be delivered, but the method of delivery, and the circumstances surrounding such delivery, also must be acceptable, particularly with regard to the following:

1. There must be no economic barriers to the receipt of adequate health care. This requires that a family's financial circumstances not be a factor in determining the nature of the services available, that eligibility procedures be eliminated as prerequisites to obtaining care, that the receipt of good care becomes no threat to the economic well-being of a family or an individual, and that no one need fear the financial consequences of an illness or accident.

2. Barriers created by language differences, inadequate transportation, inconvenient location of services or hours of operation must be eliminated.

3. All encounters with health personnel should be expected to occur in an atmosphere of respect, friendliness, dignity, and personal identification; alienation and depersonalization are not a necessary part of any health care system.

4. Providers of health care should be expected to have an awareness of the circumstances

in which their patients live and work, so that their care will be appropriately related thereto.

5. Services must be organized to assure prompt provision of all care, be it emergency, by appointment, or by telephone consultation; most waiting for receipt of needed care can and must be eliminated.

6. Services must be so organized, and appropriate personnel so trained and so utilized as to assure that someone on the health care team has enough time to listen and to explain.

7. The health institution must be in a position to arrange for care of dependent members of the family during the time that responsible members of the family are obtaining care.

8. An individual's and a family's care must be made continuous and coordinated; the technology exists to assure that the medical information which has been obtained by any person or institution in the medical care system is available to all other providers of care, as needed.

9. The consumer must be provided with the requisite information to enable him to make judgments about the quality of care that is being rendered under various alternative structures and arrangements.

10. The consumer must be provided the means of affecting the health system and its component parts, as well as with options of varying patterns under which to obtain his care.

Programs designed with these criteria as a foundation, we believe, will not only meet the needs, but also satisfy the wishes and the hopes of American families. Further, we believe that programs based on these criteria can be made fully consistent with economic realities, as well as with the highest standards and aspirations of the medical profession and other providers of health services.

We believe that the failure of past attempts to deal with the health care crisis has been due, at least in part, to a failure to look to the people's needs and their participation as cornerstones for action.

On the basis both of the Board's discoveries and discussions, and our combined experiences over the years, we have some ideas of how the criteria we have suggested can be translated into programs, which we offer to this Committee for its consideration:

A. New structures should be created for the organization and delivery of care, and certain existing ones should be more widely established. Health care can no longer depend upon the accumulation of isolated decisions, made by individual providers irrespective of the public's needs, on the nature and distribution of resources and services.

1. No person should have a fee-for-service arrangement as his only option in obtaining health care.

2. Care outside the hospital should be locally organized within any of a variety of well-defined structures. Whether the structure is a prepaid group practice, a neighborhood health center, a medical school-sponsored "foundation", it does not necessarily need a defined physical setting, but

does require a coherent organizational and administrative framework which is responsive to consumer wishes.

3. Financing mechanisms should encourage and support the development and operation of a wide variety of such structured health service programs.

B. Health care delivery systems should be made accountable to the public. Consumers should have a dominant role in the organization and administration of new local systems of health care. Health services are a public concern; they are not exclusively a professional matter.

1. Providers should make individual decisions affecting the health of their patients while the public should become the ultimate determiners of how health services are delivered, paid for and organized.

2. While we do not advocate any one particular process to be used in selecting persons to represent consumers in decision-making, the

selection process should stress the following principles:

a. The procedure for selecting consumer representatives must be well-known and clear to the community or to the consumer group to which services are being provided;

b. Individual consumers and consumer groups must be able to affect the process of selection;

c. Consumer representatives must be accountable and responsible to the group which they represent.

C. There should be further exploration of possible benefits in recognizing an adversary relationship between providers and consumers of health services. A cooperative relationship, or a partnership, as has been tried in so many systems of care, somehow seems always to end up serving professional rather than consumer needs. This is not an indictment of professionals; it is rather an indictment of unreasonable expectations of them. Physicians are among the most conscientious,

well-intended, hardest working, and altruistic people there are. It does not diminish their stature to emphasize that they are not all-wise in the organization, and economics of essential public services, including medical services. Adversary relationships have a long, noble and fruitful tradition in law. Conceivably they can have an equally beneficial tradition in medicine.

1. Consumers must be able to establish goals, objectives, and priorities and make them effective in the organization and delivery of health services. Adequate resources, including technical assistance and consultation, must be made available to consumer representatives so that they can make appropriate decisions and recommendations.

2. The power of the consumer to control and influence the delivery system must be exercised at every level. This power should include, but not be limited to, making policy, controlling assets (including capital expenditures), facilities, equipment and services. This does not mean

that consumers will usurp the doctor's responsibility for his patient's medical needs. On all levels of decision-making, clear lines between policy (the consumer's primary business) and medical care of individuals (the physician's primary business) should be established.

3. An agency or institution which renders medical services and which spends public funds or enjoys tax advantages should examine whether having providers of its services in positions of authority over the governance of the same agency or institution is in the best interest of that agency or institution or the services which are provided.

4. Where providers now sit on policy making or planning boards, they often are in "conflict of interest" positions and, in effect, decide what health services to purchase from themselves. When this occurs, these providers should be replaced by consumers or by professionals who cannot provide services under the authority of the agency they help control.

5. Where providers are not in such "conflict of interest" roles, they may play an essential part in the decision-making process. But those who derive income and profit from a specific system of health care should not be in a position to be advocate-judge-and-jury of those services.

D. It is the responsibility of government, ultimately the federal government, to assure adequate care for all Americans. Where care is inadequate, the federal government must become the residual guarantor, and, if necessary, the provider of health care.

1. The federal government must eliminate all economic barriers to health services. As part of that action, some form of universal health care financing must be enacted.

2. In institutions, localities, areas or jurisdictions where health care is inadequate, government -- and ultimately federal government -- should remedy existing defects by providing funds, personnel, physical facilities, and technical assistance, as required. It is not difficult to

conceive that for some people in some situations adequate health services cannot be provided except through some unit of government which renders services in a direct fashion to consumers. The federal government has not blanched at assuming this obligation on behalf of its leaders in government, nor on behalf of three million children who are the dependents of active or retired military personnel.

In conclusion, may we say, on behalf of our Citizen's Board, that we may have been reverent to some causes with scant justification, and we may have been irreverent to others that have been sanctified by long tradition. The search for wisdom requires such liberties. New wisdom needs to be found for improving health services to the people of this country. We hope that the findings of the Citizen's Board may define some promising areas for the search to intensify, and that our work will be helpful to the important task of this Committee.

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Gerald Besson, M.D.†  
Physician  
Sunnyvale, California

†Submitted Dissenting Opinion

Harry Huger\*  
 Attorney  
 Arnold & Porter  
 Washington, D.C.

Bertha Johnson  
 Detroit, Michigan

Sanford Kravitz, Ph.D.  
 Dean  
 School of Social Welfare  
 State University of New York  
 Stony Brook, L.I., New York

Harry Lipscomb, M.D.  
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 Health Services and Mental Health  
 Administration  
 Department of Health, Education  
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 Rockville, Maryland

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 Xerox Corporation  
 Stamford, Connecticut

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 International Director  
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 University of Minnesota  
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 Minneapolis, Minnesota

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 National Welfare Rights  
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 Washington, D.C.

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 American Federation of State,  
 County and Municipal Employees  
 Washington, D.C.

Consultants to the Board

Julius B. Richmond, M.D.  
 Professor of Child Psychiatry  
 and Human Development  
 Harvard Medical School  
 Harvard University  
 Boston, Massachusetts

Cecil Sheps, M.D.  
Director  
Health Services Research Center  
University of North Carolina  
Chapel Hill, North Carolina

Franklin Williams, M.D.  
Medical Director  
Monroe Community Hospital  
Rochester, New York

\*Member Executive Committee

Senator KENNEDY. The subcommittee will recess until Monday at 9:30 a.m.

(Whereupon, at 12:07 p.m. the subcommittee adjourned, to reconvene at 9:30 a.m., Monday, Mar. 1, 1971.)

