HEALTH CARE CRISIS IN AMERICA, 1971

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST SESSION

ON

EXAMINATION OF THE HEALTH CARE CRISIS IN AMERICA

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WEDNESDAY, APRIL 14, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE
ON LABOR AND PUBLIC WELFARE,
New York, N.Y.

The subcommittee met at 11:35 a.m., in the Winston conference room, Roosevelt Hospital, New York, N.Y., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy.

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

Senator KENNEDY. The subcommittee will come to order.

First of all, on behalf of the Senate Health Subcommittee I want to express our appreciation to Roosevelt Hospital and the administrators of this great institution for their kindness and hospitality and their generosity in permitting us to meet here this morning.

I also want to extend the regrets of the ranking Republican member of this subcommittee, who had a previous commitment, Senator Javits. He has a statement, and that will be included in the record.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. When we think of America's health care, it calls to mind that famous Charles Dickens quotation, "It was the best of times. It was the worst of times."

For many Americans, the result of our Federal investment in health in 1970—$70 billion or 7 percent of our gross national product—means that killing or crippling diseases of a few years ago—e.g., polio—have been eradicated or largely conquered, and there are impressive new medical techniques, powerful new drugs, and superb new facilities.

For most Americans, unfortunately, the national growth in medical expenditures—from $63 billion to $70 billion in 1 year—has not provided health services but merely gone to meet the skyrocketing costs of inflation. In 1970 physician's fees rose twice as fast as the cost of living, and hospital costs five times as rapidly.

The cost of health care is becoming prohibitive; minor episodes of illness become heavy financial burdens and serious illness is transformed into enormous, lingering debts, and even bankruptcy. Those who can pay for care find themselves being priced out of the market,

and for millions of Americans—particularly those who live in rural areas or in the inner city—care is just not available at any price and under any circumstances.

The issue of adequate and accessible health care is an imperative of social justice. On behalf of the whole Committee on Labor and Public Welfare, of which I am ranking minority member, I commend the chairman of the Health Subcommittee for initiating these health care crisis hearings in New York City. I regret that I am out of the country on official business by order of the U.S. Senate to attend a meeting of the OAS in Costa Rica, but I know Chairman Kennedy and the other members of the subcommittee in attendance and the city team under Mayor Lindsay and the New Yorkers who testify will make New York's case for effective national health care, very clear.

For although New York City has a wealth of medical resources and talent, our citizens mirror the national disparity in health between the rich and the poor and between black and white.

The paradox in New York City health care is seen by a quick overview of pertinent facility and health manpower statistics:

New York City has 632 short-term hospital beds per 100,000 people compared to a national average of 403; and 278 physicians per 100,000 people compared to a national figure of 131.

Yet, with these enormous medical resources, New York City suffers by comparision with the rest of the Nation:

New York City has a death rate of 1,090 per 100,000 population compared to a national rate of 949.

New York City has an infant mortality rate of 24.3 per 100,000 births compared to a national rate of 21.7.

These statistics mask the even more tragic plight of our inner city residents, to them the residency of a physician in their neighborhoods is a rare experience indeed; and the life expectancy of a nonwhite American living in the inner city is 7 years less than his white counterpart, infant mortality rates are twice as great for nonwhites as for whites, and nonwhite maternal mortality is four times as great as the rate for whites.

I believe these hearings into the major dimensions of the health care crisis—cost; manpower shortages and maldistribution; the failure of the delivery system; and the quality of care—will take us, not by steps but by leaps forward for mankind, farther along the road that recognizes a national responsibility for health of all the people.

We will seek—through the legislative process—to close the gap between what we have accomplished and what remains to be accomplished in health care between our achievements and our expectations, between what is—and our impatience for what might be.

Jay Cutler, minority counsel to the Health Subcommittee, is at the hearing and will brief me fully upon my return to Washington.

Senator KENNEDY. During the period of the last 8 weeks the Senate Health Subcommittee has been holding extensive hearings in Washington. We have had the opportunity to listen to the experts in the health area. We have heard from representatives of the various medical schools, we have listened to the representatives of

Blue Cross, Blue Shield, the insurance companies, and we have listened to as many different points of view as we thought was possible during that period of time.

And last evening and today we begin the field hearings of the Senate Health Subcommittee on the general problems of the crisis of health care in our country. We come to New York and the suburbs of New York because we feel that New York in many respects characterizes the health care crisis that we have in our Nation. In many parts of this great city health care is virtually nonexistent, as it is almost nonexistent in some of the suburbs and as it is almost nonexistent in many parts of rural America.

And so during these next few weeks we want to listen to the people, let the people in the system speak. We are convinced that theirs is the voice that really hasn't been heard in the development of our health policy. And so today and through tomorrow and during the period of these next several weeks we are going to be interested in listening to people that have been affected by the health care system, have been paying the bills, or otherwise have been ignored by the health system. We want to let the people in. And so we will be listening to their comments here today and for these next several weeks.

It is entirely appropriate that we have this hearing at the Roosevelt Hospital. The Roosevelt Hospital has had a long association with the members of my family. Senator Robert Kennedy's son, Matthew, was born in this hospital. And so the people here and those that have worked in this hospital have been extremely kind and generous in their interest and services that they provided for the members of our family.

We also wanted to come to New York because of Senator Robert Kennedy's dedication and commitment to the people of this great city and this great State and his very great interest in the problems of health and health care. He realized that individuals can make a difference and that taken together the actions of individual men and women could build mighty waves from tiny ripples and provide the kinds of reform which is so necessary to make health reform in this Nation a reality.

So we are honored and glad to be here for many different reasons.

This is really the purpose of our hearing today, and now we will listen to our witnesses.

The first witness will be Mr. Edward Kaiser.

STATEMENT OF JOHN HOH, UNION COCHAIRMAN, TEAMSTERS JOINT COUNCIL NO. 16 AND MANAGEMENT HOSPITALIZATION TRUST FUND, ACCOMPANIED BY EDWARD KAISER

Mr. HOH. Senator Kennedy, my name is John Hoh. My colleague to my right is Eddie Kaiser, who I brought over here. I, myself, am vice president of Teamsters Joint Council 16 in the city of New York. I am chairman of a committee that has been investigating the health problem of our local welfare funds for the last 12 years. And we have a pile of information that I would like to leave with you after this hearing with the hope that you may find it somewhat

helpful in combating some of the other attempts that are being made in this field, particularly by the insurance companies who would like to get a greater bonanza out of the whole health field than they are already getting.

I brought Mr. Kaiser here, who is a very sad case. I don't think we can be accused that we planned it so. He has been on dialysis, human dialysis for the last few years due to a very acute kidney condition—liver condition, rather.

Senator KENNEDY. Explain dialysis for the purpose of the record.

Mr. HOLL. Well, I will let Eddie make the explanations. But I want to point out that Mr. Kaiser received the benefits of the equipment that he is using due to the help that we were able to get from the city, State and Federal Government, which he has been told last week it is going to be cut short. Mr. Kaiser is going to be confronted by the fact of either coughing up close to $6,000 a year to buy supplies to keep him alive or get the realization of having to die within a period of 2 weeks. This is a dramatic, very sad case, and it must happen by the thousands throughout the United States.

I just want to make one more comment. I have a prepared statement. I don't like to read off a statement, and I leave it with you. We have enough experience whereby it is noted that the figures that I see, your analysis of costs, we are spending three times as much as that already except that it is being diverted into insurance companies, into plans that are inadequate, to a medical society that is very coldhearted in many instances, and we have on top of that the hospitals who have to supply and take care of our people here in the city of New York do have inadequate funds to give that sort of service to our people.

We have all sorts of recommendations. But I can only sum it up in one way. We just cannot permit a continuation of throwing money into this field and at the same time not receive medical care for our members, and I am talking about the Teamsters that I happen to represent here. But I know my members are no better off or worse off than the regular community, and it is a shame. It is a real shame.

Reminds me of a story that I was told when I was a kid. I was told by my father, well, if you save money and you are lucky enough to have a few dollars in the bank by the time you die you can be sure there is nothing left over for your beneficiaries because if the lawyers don't get it the doctors sure as the devil will. And this hasn't changed. If anything, it has become worse. Much worse.

And this medical profession as we have begun to analyze it has to take a different turn for this country here. We have a great country, we have all sorts of resources, we can do tremendous, wonderful things, and it is a crying shame that our members and our people and our public has to suffer the way that man does.

Eddie has been a member of ours for the last 40 years.

Senator KENNEDY. Member of the Teamsters?

Mr. HOLL. Yes, sir; and he had to go into forced retirement due to his physical condition—but I can't blame the doctors for that. He has a physical condition, but he had to go into forced retirement, and now he may have to go forcefully into the cemetery. This is the problem.

Mr. KAISER. Well, John Hoh stated my case pretty thoroughly, and I only have a few things to add to that, and that is the fact that——

Senator KENNEDY. Do you want to take your coat off?

Mr. KAISER. No, I am comfortable. Thanks anyway. This dialysis is a kidney machine.

Senator KENNEDY. Tell me just a little bit about yourself, Mr. Kaiser. You have been a member of this union for 40 years?

Mr. KAISER. Yes, for a long time.

Senator KENNEDY. How old are you?

Mr. KAISER. I am 63 now.

Senator KENNEDY. Can you tell us a little bit about yourself?

Mr. KAISER. Well, in relation to what?

Senator KENNEDY. You have been a member——

Mr. KAISER. I have been a brewer in local 3 for a number of years.

Senator KENNEDY. And then how long ago did you become sick?

Mr. KAISER. When I went for induction in the Army they held me over for 3 days and they rejected me because I assume something was wrong with my kidneys because of the tests they took. So after that I went to a kidney specialist and he told me at that time that I did have a kidney condition, but there was nothing to be done at the present time except keep in touch with the medical doctor.

Over a period of 20 years this condition got worse, and at that time I made connection through the Teamsters with a doctor up in Riverdale, N.Y., and this doctor in Riverdale told me that a doctor over in my burrough of Brooklyn was setting up a dialysis unit and that I should get my family doctor to get in touch with this doctor. And after going to that clinic for about 6 months they told me that further therapy was needed, and when they said further therapy they meant I had to go on a kidney machine.

Now this was about 2 years ago. And I received all my supplies from Elmhurst General Hospital.

Senator KENNEDY. Go ahead, Mr. Kaiser. You were telling us that when you went to be inducted in the Army 20-odd years ago they detected some kind of kidney ailment and later you were sent to a doctor and he diagnosed your——

Mr. KAISER. Referred me to a doctor who had set up a dialysis unit in Elmhurst General Hospital. It took me about 3 months to get an appointment with him. Then he accepted me; after seeing a psychiatrist, a psychologist, and social worker, and several other tests to go through, they accepted me in this program.

Senator KENNEDY. Why did you have to go through all these other tests?

Mr. KAISER. To see if you are mentally able to take the shock that you have this condition, that you may have to go on this machine which requires treatments three times a week, 4 hours each treatment, and you have to have an assistant, which in my case is my wife, to help me out in this program.

Senator KENNEDY. Now I understand. I am sure there are a lot of people that don't quite understand the kind of treatment of dialysis. Do you have to go three times a week——

Mr. KAISER. I have it at home. I have to have the unit at home, and three times a week I have to connect my arterial and venous

vessels up with this machine and have the blood run through this purifier and come back into me, and that is the treatment—4 hours. Four hours each treatment three times a week.

Senator KENNEDY. Now if you didn't have this treatment——

Mr. KAISER. There would be no other way of keeping me alive.

Senator KENNEDY. If this wasn't available to you over what period of time, over, say——

Mr. KAISER. Well, it may vary in different people, you know. This condition came on me so slowly that my body became accustomed to the high amount of poison that was in the blood. In other words, I could tolerate more than somebody else who had an acute case. Mine was chronic.

Senator KENNEDY. Now is this procedure costly?

Mr. KAISER. It costs just for the supplies alone between $5,000 and $6,000 a year, and if I didn't have my wife to act as my nurse for 3 days a week it would cost me about $10,000 a year. And the machine itself I think is around $2,500.

Senator KENNEDY. And you rent that machine?

Mr. KAISER. No, I received the machine from Elmhurst General Hospital. Elmhurst General Hospital gives it to me because of the fact that they are subsidized by the Federal Government insofar as the machine is concerned. But the city of New York is the party who is paying for the supplies, and due to the financial crisis in the city of New York and the State of New York we have been told by the administrator of the program that we will have to find ways and means of financially paying for this program ourselves. Now this may take place in 2 or 3 months. It may not take place at all. They don't know. I think it is according to the city and the State how much money is supplied, how many funds are available for this.

Mr. HOH. May I inject here, Eddie came into my office with a brochure from Bauxter Industries and he asked me what he should do with that. What they were trying to find out is how much credit rating has he got so they can send him the supplies on a weekly or monthly basis, make sure that they get paid for it afterwards.

Senator KENNEDY. Now you pay for these supplies, I understand, and then the city reimburses you?

Mr. KAISER. No; I don't pay for them. I get them gratis from Elmhurst General Hospital. Due to the fact that——

Senator KENNEDY. How long have they been making these——

Mr. KAISER. Well, I have been on this program about 2 years now.

Senator KENNEDY. And now you have had some conversation with them?

Mr. KAISER. With the administrator. We have 150 people there and they are all being told the same story.

Senator KENNEDY. Well, now you have had a conversation with the administrator. Could you tell us a little bit about that conversation?

Mr. KAISER. Well, he said that you know what the situation is in regard to the financial crisis in New York, in the State and city of New York, and it may be that the money that is available now to provide you with this lifesaving equipment is going to be eliminated altogether or cut down to a degree where most patients will have to

find ways and means of paying for it themselves, and in fact the new people that come into the program are not being accepted unless they can prove that they are financially able to pay for it.

Senator KENNEDY. What do they do?

Mr. KAISER. They die. In fact I heard last night on the television news broadcast that there is a vet over in Vietnam who is trying to raise money because his sister and brother need the machine and they are $20,000 in hock already, and he is trying to raise money in Vietnam.

And I heard only a short time ago about a baby who has the same condition and she only has a few months to live because they can't get the money to get her a machine.

Senator KENNEDY. Will you be able to get the money together yourself?

Mr. KAISER. I would be able to get it for a short time and then I would be finished. I have a few dollars naturally.

Senator KENNEDY. But this will take all your savings?

Mr. KAISER. I won't last very long at $10,000 a year.

Senator KENNEDY. And if the city withholds funds from the hospital and they don't make these supplies available to you, you are unable to raise these kinds of funds?

Mr. KAISER. Oh, I can't; $10,000 a year—I can't raise that kind of money for any length of time, that is a sure thing. I am retired. I am living on social security and a brewery worker's pension.

Senator KENNEDY. You are 63, so you wouldn't qualify for medicare.

Mr. KAISER. Not for medicare or medicaid. I don't even know whether medicare would pay for any of these supplies.

Senator KENNEDY. So if there are no funds available, if those funds are cut off what will happen to you?

Mr. KAISER. I suppose I would have to die, that's about all.

Senator KENNEDY. Have you talked to any of the other people that are undergoing this kind of treatment, too?

Mr. KAISER. No—well, there's a number of them that are covered through their major medical insurance. I just don't have major medical insurance. I have group health insurance, which doesn't pay for any of these.

Senator KENNEDY. Your group health insurance doesn't cover——

Mr. KAISER. Doesn't compensate me for any of this.

Mr. HOH. Incidentally, Senator Kennedy, on major medical there is a limitation to the cost that they will cover on that sort of a problem also.

Senator KENNEDY. Well, Mr. Kaiser, we appreciate very much your coming here today. I think your story is very heartrending, and it is just quite clear to us that this health system is apparently unable to respond to the kind of catastrophic illness which is suggested by your case. You are a person of modest means and have been struck down through no cause of your own. You are with this kind of illness completely dependent for the high cost of care on some kind of additional help and support. The insurance policy, I imagine, group policy which you thought would probably cover most of the kinds of illnesses which you would be affected by doesn't

reach this enormously costly program, and the city is cutting back on its budget. And the real dilemma that is presented to you, but really more importantly presented to all Americans, is whether we are going to tolerate a health care system that is not prepared to provide the kind of help and assistance which you need. I think that is really what we have to address ourselves to.

Mr. KAISER. It just doesn't seem right, and where the equipment and the supplies are available——

Senator KENNEDY. It isn't like cancer. They know the answer to this. And it is really just a question of resources and funding.

Mr. KAISER. That is true.

Senator KENNEDY. And without those fundings it is really a matter in this case between life and death.

Mr. KAISER. That's right.

Mr. HOH. Thank you very much.

Senator KENNEDY. Thank you.

Mr. HOH. May I leave my material with your assistant here?

Senator KENNEDY. I wish you would.

Mr. HOH. And I hope we can help in the future to do something about this.

(The prepared statement of Mr. Hoh follows:)

PREPARED STATEMENT OF JOHN HOH, UNION CO-CHAIRMAN, TEAMSTERS JOINT COUNCIL NO. 16 AND MANAGEMENT HOSPITALIZATION TRUST FUND

My name is John Hoh. I am the Union Co-Chairman of Teamsters Joint Council No. 16 and Management Hospitalization Trust Fund.

The Fund was established in 1960 by the labor and management representatives of a dozen Teamster Welfare Funds located in the New York metropolitan area. These Welfare Funds represent approximately 40,000 Teamster members who with their covered dependents constitute a population of approximately 120,000 persons. The inspiration for the establishment of this Fund came from Teamsters Joint Council No. 16 of New York which represents approximately 60 local unions, having about 175,000 members, who, with their families, constitute a population of approximately 500,000.

The purpose of the Fund, which is supported by a penny an hour contributions from the Participating Welfare Funds, was (a) to control the cost and (b) to improve the quality of health care provided for union members.

Labo r and management representatives had learned to their dismay that, despite the expenditure of millions of dollars annually by the various Welfare Trust Funds, the out-of-pocket expenses by their members for health care continued to rise at an exhorbitant rate while the quality of health care deteriorated.

I am sorry that the comparatively short notice received by the Fund did not make it possible for me to arrange for extended oral testimony today. I hope that before this Committee finishes its work there will be an opportunity for the Fund to present witnesses who will be prepared to testify in detail as to the working of our program and the findings we have made. We will be most happy to cooperate fully with this Committee.

Today, I would like simply to offer for your consideration the following reports which show some of the significant findings which have come from the experience and the studies of this Fund:

(1) The Quantity, Quality and Costs of Medical and Hospital Care Secured by a Sample of Teamster Families in the New York Area.

(2) Meeting the Challenge of Health Care Today.

(3) Teamster Comprehensive Care Program.

(4) Recommendations to the Governor's Committee.

(5) The Teamster Centers.

These reports show the gross inadequacy of the existing system, or non-system, of health care to provide a high quality service at a fair and reasonable cost. Our recommendations to the Governor's Committee in 1964 contain some of our principal criticisms and recommendations as of that date. Most of them remain valid today. The situation as to medical manpower has become even more critical. No system can operate effectively while doctors and nurses are in short supply.

We have employed our Teamster Centers principally as a bridge to lead our members from the existing chaos towards the better service and the more reasonable costs that can be obtained for them under expert guidance. Such a procedure obviously will not provide the necessary comprehensive and permanent reform of health care which the entire community cries out for. It is merely a temporary expedient.

As the Teamster Comprehensive Care Program report shows, for a two and one-half year period we explored, on an experimental basis, the problems of providing total health care to a group of about 1,000 Teamster families residing within a reasonable distance of Montefiore Hospital in the Bronx. The results of our pilot program serve to point out the problems which must be faced and resolved in any comprehensive system of health care.

I hope that through the efforts of this Committee and others, a sound, humane and comprehensive health care system can be established for the entire nation.

Senator KENNEDY. The next witnesses are Mrs. Estelle Perlman and Mrs. Lillian Grinker. Mrs. Perlman is the receiver of complaints in the Department of Health and Hospitals in New York City, and Mrs. Grinker is the secretary to the chief of pediatrics, Brookdale Hospital.

STATEMENTS OF MRS. ESTELLE PERLMAN, SECRETARY TO THE NEW YORK CITY HEALTH AND HOSPITAL CORP., AND MRS. LILLIAN GRINKER, EMPLOYEE OF BROOKDALE HOSPITAL

Mrs. PERLMAN. Mr. Senator, as secretary to the New York City Health and Hospital Corp., one of my many duties is to handle all the complaints. It may come through the mayor's office, it may come through city council, it may come through our own president's office. All these complaints are sent out for investigation, and there are many types of complaints, but I selected four of many complaints on hospital costs that involve middle-income people. And we only investigate cases where they are in private proprietary hospitals. Those complaints that come in about voluntary hospitals are sent to the State department of health for investigation, as they are the licensing agencies there.

Now I would like to start off by reading a letter to you that I think is typical of the type of complaints we get daily. This was addressed to the department of hospitals.

> Recently my wife had the misfortune to be confined to a general hospital. I won't go into my feelings regarding Blue Cross or Blue Shield, but will deal specifically with the main complaint.
>
> After undergoing major surgery she was placed in a special nursing unit, and I was called in by the head nurse immediately following the 4-hour operation and told that I must pay $66 every day by 3 p.m. in advance. Raising the money for 18 days that she was there proved a real hardship, but the care was good so I grinned and bore it. But was I ever annoyed when I later found out that I had to pay an additional charge of $10 a day. They gave me the enclosed slip with the insulting words "it is just like any other service charge that you would have to pay for any other form of service."
>
> I never could determine what the hell necessitated such a fee, but I couldn't get my wife out until I paid it. The beating anyone has to take——

Senator KENNEDY. What do they mean they couldn't get the wife out until they paid?

Mrs. PERLMAN. He was told by a clerk in the office, the payment office of the cashier, that unless he paid his bill they would not discharge his wife. Now we could not substantiate this. Everything else was substantiated. But I can tell you this, Senator, that very often I receive phone calls myself with this kind of a complaint, of a family of a patient saying they won't release my wife; I can't pay the bill. Then we put in a call to the hospital and, of course, the patient is released. But this is common practice in some of the hospitals for the cashier to tell this to the family.

He goes on to say:

> The beating anyone has to take when they are ill is somewhat revolting, and doctors and hospitals seems to be governed by an adding machine rather than with sympathy, understanding, and all else that goes with caring for the sick.

Now we substantiated the fact that over and above the $66 per day for this special nursing unit which he paid under hardship he had to pay a fee of $10, and a slip was handed to him which reads as follows:

Service charge. A fee of $10 is made for each day or any part of a day for service charges which include other services such as reservations, transfers, extra bookkeeping, or all other services connected with the functioning of this unit.

Now we investigated it and found it was true, and the hospital agreed to return some of this money to the patient.

Now at $66 a day for 18 days for which he wasn't covered this bill was $1,188, plus the $180 which was refunded to him.

I would like to tell you about another case that I received of a woman who was admitted to a hospital for an incomplete abortion or a miscarriage. The husband was told that this is a service that would be complete at $300 for a 3-day stay. However, if she stayed a lesser period there would be some money returned. Now besides the $300 for the 3 days the husband paid $250 to the doctor and $50 for an anesthesticist. The patient was admitted on May 15 at 4 in the afternoon. The patient was discharged the following morning at 10:05, which is 17 hours, and the $300—that was an all-inclusive rate which the husband complained about, and we in turn complained to the hospital—was broken down to a fee charge, and I would like to read you the fee charge:

One and a half days at $85 a day, $127.50; operating room, $50; drugs, $7.50; blood culture, $7.50; nitrogen, $7.50; cross match of blood, $33; admissions, CBC and urinalysis, $20; culture studies, $20; medical supplies, $13; amounting to $293.50. And the husband was returned a rebate of $6.50.

I have two complaints here on a hospital which demanded, because they were not sure—in one case there was no insurance——

Senator KENNEDY. Why do you have such apparent harassment of sick people by these various hospitals?

Mrs. PERLMAN. They are propriety hospitals and we don't have jurisdiction as to telling them how much can be charged, but this is the plain cold fact.

Senator KENNEDY. In this last instance did that person have insurance that covered all those?

Mrs. PERLMAN. Partial insurance. I should have told you that, Senator. But he still complained that his insurance should have covered the entire amount had he been charged the proper fee.

Now we can't set the fee. I think the insurance company paid something like 200-and-some-odd dollars. It was not the full fee of $293.50. And this is one of the complaints about not being fully covered.

Senator KENNEDY. In terms of your experience how do hospitals justify these numerous costs in terms of lab tests?

Mrs. PERLMAN. Well, they claim that their costs go up due to contracts, whether it is union contracts or the cost of keeping their help on; their nursing services cost more; their general medical services cost more; and this is the usual answer we get. But this is a business and it is for profit, and there are large investments made.

Now I don't say that they are not performing a service. But there must be some stop some place as to how high.

Senator KENNEDY. Well, are they all performing a good service?

Mrs. PERLMAN. Well, I couldn't make that statement that they are all performing a good service, but they are serving beds that are really needed in the community.

These two cases I will just give you briefly. One, a case had no insurance and the father of the patient had to put down a thousand dollar deposit towards the bill to make sure that that bill would be paid. Now this is not unusual.

Senator KENNEDY. Well, how frequently does that happen? You mean this is a father that has a sick child, goes into a hospital, and before that child is going to get treatment that father has to put a deposit on the bill?

Mrs. PERLMAN. Yes. At this point I would like to call on a lady that had an experience with a private propriety nursing home which is part of a large hospital. They have a nursing home unit.

Mrs. GRINKER. Senator Kennedy, the fact that I work at Brookdale has nothing to do with what I am going to say, so I want to make that perfectly clear.

My mother was a patient at Brookdale last year. She is an elderly lady and she was very ill. She nearly died. Now she had been living alone, and for her convalescence, because I go to business, I had to make the decision of putting her into a nursing home, which was painful enough for me to start with.

At the hospital I worked with the social worker and we selected this particular nursing home after I inspected it, and I felt, well, this is pretty much the best of what I could give her under medicare. Now mostly my complaints are about medicare and medicaid. I was told by the social worker at our hospital, and the same thing went for the social worker at this private nursing home, that she could remain 60 days under medicare. And during that period of time I thought I would be able to make some sort of arrangement, depending upon how she felt, as to where she would go at the end of the 90 days.

When she was there about 1 month, no longer, I was at work and I received a phone call from the nursing home, and this is what they said to me: "your mother has been discharged, come and get her." I was stunned. I said "what do you mean?" I see my mother twice a week, once during the middle of the week and once on the weekend. The utilization committee review has decided she no longer is eligible for medicare. And subsequent to this I found out by reading the newspapers, et cetera, that the administration was cutting down on medicare funds and this was affecting the nursing home patients, and my mother was caught in that mess.

Well, she was sick and she didn't know what was going on. So I and my husband are the ones that had to suffer, mostly myself, because I am an only child. They told me you have got to get your mother out immediately, otherwise from this day forward $50 a day is what you have to pay.

I don't have to tell you how distraught I was. I didn't know who to go to, who to turn to, and I kept fighting with them and they were

very insistent. I said "couldn't you accept my mother as a medicaid patient? She has no resources, no financial anything." And they were very adamant. They are a private nursing home and they don't want medicaid patients, and I guess they have a perogative from their point of view. From mine it was another story.

Well, anyway I remember that a friend of mine has a husband who is a lawyer, and I called him and said how is it I could be responsible for the $50 a day. I couldn't remember. The nursing home told me that when I signed, when she was accepted—I naturally didn't read it. I was very upset at her even going in, and I remember saying to the person "what is all this two pages?" He said "that is just to be sure you don't abandon her." Naturally when he said that I got very indignant. I said "what do you mean?" I signed it immediately. In the small print it said should medicare for any reason be changed, or whatever, you are liable at the rate of $50 a day, and that is what they told me.

So when I called my friend who is a lawyer he told me don't you dare take her out. He says "they have no right to do that, and you be insistent that she cannot come home because you go to business, she cannot be alone." And he says "I will make a complaint to the Department of Hospitals." And that's how Mrs. Perlman got the complaint. And I found out when I visited my mother a few weeks later—the nurses were looking at me very peculiarly, and someone said to me "who do you know in the Department of Hospitals?" Of course, I pretended I didn't know what she was talking about.

Then I would say it took a good month before the agony of knowing that she would be accepted was finalized. They said all right, she could stay. But I can't begin to tell you what that month—what it did to me emotionally, and I feel it is grossly unfair because it happened not only to my mother, it happened to all the elderly people at that period.

Now the next thing I want to say is now she is a medicaid patient. And I have no complaints against the nursing home as such. However, each time medicaid is cut—and it has been cut since she is there—the service gets poorer and poorer. One day I came, I thought my mother had gone insane. I didn't know what had happened. She was distraught. So I ran over to the nurse and I said "what's the matter with my mother?" She says "well, between you and me they are cutting down on the medication because of the medicaid cuts." And it was substantiated because I called the doctor immediately, and it was true. They took away this mood elevator they give quite a few—which is not a matter of life and death. In other words, only life and death medications were continued. But anything else was cut out. And that was another horror that I couldn't even begin to describe. They gave it back to her because I made a big stink about it.

I don't think people should have to go through this, patients or the family.

In addition the food is affected. They no longer get the same food now that they did 6 months ago. Again, as I say, I am friendly with the nurses. They know I work at another hospital so they treat me a little different. And they told me because of medicaid cuts they can

no longer continue. They didn't serve the finest food to start with, and now they serve really very poorly. I mean they are not starving, don't get me wrong. But the quality is different.

Frankly, when my friend called me to tell me about the hearing I was petrified. My first thought was "my God, they are going to stop medicaid at the nursing homes." I couldn't imagine why he was calling me. He called to tell me about this meeting and asked me to call Mrs. Perlman so I could come down today, and I am happy to do it because I only hope something can be done because most people are under the impression they are covered when they are covered under medicare, and they are not, and under medicaid, too.

Mrs. PERLMAN. Can I follow that up, Mr. Senator?

Senator KENNEDY. Yes, indeed.

Mrs. PERLMAN. A case exactly like this, the one that was just related—and I was given permission to use his name—a Mr. Amster was admitted to a hospital for 6 weeks. He was sent home, and 2 days later his doctor sent him back into the nursing portion of this hospital because he lives alone and because he needed nursing treatment. He had developed an infection. Well, he was rejected by medicaid. He was there for 6 weeks, and there is a bill pending of $2,201. Originally the bill was over 23, and he from his little savings paid $149.50. He is being swamped by the nursing home constantly with bills which he couldn't possibly pay.

There must be some means for a man like this to be covered. He didn't apply for medicaid because he said he would not go on welfare. I asked him why he hadn't. And he says "I have worked all my life, I have supported myself and I can still support myself." He is home now, and he lives alone. He says "But please tell the Senator this bill must be paid. I don't sleep nights. I received the treatment."

I have many, many more, but I think I will end it up with telling you, Senator, that this morning as I left my office we received a complaint addressed to Mayor Lindsay, one of the complaints that went through to him, and I will just read you the opening sentence. He talks about his father being admitted to a home. Before he was admitted they wanted $3,000 deposit. However, it was settled for $1,000. So he had to pay that down in advance in order to get his father in with the hope that medicare will pick up the bill.

Senator KENNEDY. Prior to getting into the proprietary nursing home they had to put $1,000 in before they could——

Mrs. PERLMAN. Right.

Senator KENNEDY. Are these pretty typical stories?

Mrs. PERLMAN. Yes. I picked these out of many, many hundreds. And I will tell you that the State department of health has many of these complaints where it relates to voluntary hospitals, maybe not the same type complaints, but the costs are very high and where their health insurance does not cover it.

And I could tell you from personal experience, speaking as a consumer, my former husband was sick for 6 years and in that 6 years we went through every bit of our savings and I borrowed $8,000 on my pension fund to take care of his needs. He didn't survive, and I don't regret spending the money. At least I had a

place to go and get it. And I don't take my job as one that I go home with a salary. I feel for every person who sends a complaint across my desk, and I personally look into it, Senator, because I have spent 35 years of my adult life doing voluntary work, which I still do today aside from my paid job, worrying about people that need help constantly. And I am delighted that you are here today to give us an opportunity to tell you what our problems are. [Applause.]

Senator KENNEDY. Well, I appreciate the comments, and I think what these tragic stories reflect is at a time we ought to be expanding health services we are contracting them in terms of care. And it again reflects how devastating it can be when sick individuals in particular are left in the hands of proprietary interests. We believe that quality health care is something that is a matter of right. Certainly I think it is wrong that individuals such as yourself and the thousands of people that have written to you should be exploited for proprietary reasons. I just don't see that it is consistent with what should be standard in our country, and that is that quality health should be a matter of priority, and individuals like yourself shouldn't be disadvantaged or harassed by these private interests with cutoffs and deductibles.

The Administration says that having the deductibles provides cost consciousness for people. They say if you provide a deductible every time they go to the doctor or come to the hospital, it will prohibit unnecessary use of doctors or hospitals, and I don't understand it.

In emergency rooms people wait for hours to try and get some kind of help or assistance to their sick child. I can't see people going down and sitting hours in an emergency room just for the fun of it. There is obviously an important group in our society that believes that this is useful and helpful to promote cost consciousness. I fail to see it.

I want to thank both of you very much. It is very, very helpful.

Mrs. PERLMAN. Thank you.

Senator KENNEDY. The next witness is Mr. Leon Davis, who is the president of local 1199, Drug and Hospital Employees Union.

STATEMENT OF LEON DAVIS, PRESIDENT, LOCAL 1199, DRUG AND HOSPITAL EMPLOYEES UNION

Mr. DAVIS. Senator, I have no prepared statement. I wish to deal with just a few points. There will be others, I am sure, who will have more to say.

I am representing a union whose members are involved in the delivery of medical care, at least the hospital. I am president of local 1199, Drug and Hospital Union in this city, and I am also the president of the National Union of Hospital and Nursing Home Employees, AFL–CIO. We have some appreciation of the problems particularly as far as the hospitals are concerned.

Just to begin with, I am here in enemy territory. I have heard the comments about the management of this hospital. Our experience with the management of this hospital is just contrary. Our experiences have been very bad. Well, it is one of the few hospitals

in this city that has been conducting a campaign against their workers' right to organize. It has spent hundreds of thousands of dollars in litigation against the workers to prevent them to get a union.

This is not irrelevant because the cost that this hospital spends in fighting the union is borne by the patients who come to this hospital.

And I think this is one of the points I would like to deal with—who runs the hospitals, what responsibilities they have, and what accountability they have and to whom. And I will start with Roosevelt Hospital, and with two cases. Eight pharmacists joined the union in 1966. An election was held and our union won the election. In 1970 we got a contract. When we got the contract all the original eight pharmacists left because it was 4 years to wait for a contract. But we had strong litigation because we got an award from an arbitrator for a 3-year contract. They are still in court trying to reduce the contract to 1 year so they can eliminate the union.

I think the point is that these voluntary institutions are a holdover from the past, and frankly there ought to be a change if we are going to have institutions that are going to serve the community. They have boards who do not relate to the community, who do not represent the community.

Now there was a time when medical care was a matter of philanthropy and charity, and at that time the board of trustees made financial contributions to the operation of these institutions.

Senator KENNEDY. I want to interrupt you. We are running into a time problem. We are only going to have 8 or 9 minutes, and I am not interested in this particular problem, but I am interested in the kind of health care that your union members are——

Mr. DAVIS. Let me say this to you. We will deal with that, too, and I would be happy to stop right now, Senator, if it is embarrassing. It is not embarrassing to you, you have nothing to do with it.

Senator KENNEDY. That's right.

Mr. DAVIS. I think the question of who runs hospitals and who delivers it is an important matter for your consideration. The community has no say.

Now the other matter—and I think that this hospital underlines that fact—it is true with every hospital, it is true with union hospitals—where prestige institutions make no real contributions to the community, and consequently that custom ought to be changed. It is a part of your investigation I think that ought to be taken into consideration.

Now our members obviously in addition to being in the service of hospitals and delivery of medical care also are consumers, and most of our people, our members, are black or Puerto Rican. I want to bring your attention to just one point, that in the black and Puerto Rican community in this city there is no adequate medical care. As a matter of fact, in some areas there is none at all.

We have a benefit plan program under which our members are reimbursed for medical care. Since the union was established, all of our workers are covered by hospitalization, with major medical care and life insurance. Our white members get three times as much reimbursement as the black and Puerto Rican members get because

of lack of utilization. The member who works in a hospital gets care in the hospital, but their children and dependents do not get adequate care.

Now the reason for it is there are not enough doctors in the city of New York. Two-thirds of the doctors are located in Manhattan and in the areas where there are private patients. In the Bronx and Brooklyn the number of doctors are few. They are not available, and most of our members have to line up in outpatient departments in the terribly overburdened hospitals in their community. That is the way the medical care is dispersed.

Consequently our members obviously are not the recipients of some of the improved standards that we assumed were responsible for increased hospital costs. And I think when the hospital costs of 1960 were $34.76, they were at the expense of the members of our union. They were not there because of philantropy. Our workers at that time were making $33 a week. Now they are making $130. And we want to assume some of the responsibility and share some of the benefits.

I think the hospitals still could improve their services and still could improve their financial arrangements, but I do not believe that the whole matter here is a question of money. I think what our problem is is we have no system of delivery of medical care. We never did. This is a systemless system for delivery of medical care. We have no commitments——

Senator KENNEDY. We had last week—you might have seen—president of Blue Cross responding to a question about the rising costs of hospitals. He indicated that it is due to the higher wages that employees are receiving. What is your reaction?

Mr. DAVIS. I admit that some of it is due to higher wages, but some of it is also due to the exorbitant salaries paid to administrators, exorbitant salaries to doctors, and lack of utilization of expensive equipment. I think some of it is due to that.

But we have to assume that some of it is due to the fact that for the first time many workers are off welfare. When we started organizing half of our people were on welfare who worked in the hospital, where now they make their own way. And I think our problem is not financial. Our problem is the organization of medical care for every American regardless of cost, and we can afford other expenditures.

I think this is a primary consideration, and we would like to call your attention to it. We will be helpful in any way we can to develop a medical delivery service that will adequately treat all the people in this country.

Senator KENNEDY. Your point is you can't blame these increased costs completely on the increases in the employees of the hospital, as I understand it.

Mr. DAVIS. Some of it I think is due to mismanagement, and some of it is due to other reasons.

Senator KENNEDY. But as you point out, most of the employees that worked in hospitals up until recently were, as you say—half of them on welfare, and perhaps there was no group that was as underpaid as hospital employees in this country.

Mr. DAVIS. Yes, I think that we were buying hospital costs at the expense of workers' philanthropy.

Senator KENNEDY. You represent a union that ought to know its way around the whole health area as well as any particular group. Your employees work in hospitals, they know the system. And yet you testify here this morning that even with their understanding, their associations, their relationship with the hospitals, they can't get quality health care for the members of their family.

Mr. DAVIS. There are none in the communities where they live. There are where they work. They get medical care where they work, but——

Senator KENNEDY. What about their families?

Mr. DAVIS. When they go home there is no medical care in that area. There are no medical clinics, there are no doctors. There are no private doctors.

Senator KENNEDY. An employee who works at a hospital can't get service for his family?

Mr. DAVIS. They could because we pay for it, but they don't always live where they work or near it. Consequently it is a real serious problem.

Senator KENNEDY. OK. Thank you very much.

Our next witness is Mr. Fuchsberg, who is the former president of the American Trial Lawyers Association. He is now chairman of the Inter-Professional Committee of Doctors and Lawyers. He is one of the foremost trial lawyers in the country, and his practice has put him in contact with the health care system at its breaking point—where consumers have become so frustrated and victimized by the system that their problem goes to court.

STATEMENT OF JACOB D. FUCHSBERG, CHAIRMAN, INTER-PROFESSIONAL COMMITTEE OF DOCTORS AND LAWYERS

Mr. FUCHSBERG. Senator Kennedy, I want to thank you for this opportunity to contribute a few facts and ideas to your very intensive and extensive study of this problem. And I know from the chart and I know from the public press that you have newly come to this problem of concern about health care for all Americans. And it is because of that, I am sure, that that sign up on the left isn't completely updated. I was doing a little doodling while I was sitting here updating that 1969 figure. We have $89.76 for hospital cost per day. I checked the figures as of April 1, 1971, and the voluntary hospital figure in New York City as paid by Blue Cross is now $148.28.

In fact, if I was a little nervier I would walk up to that chart and take my doodling and put it right over that $89.76.

Senator KENNEDY. You mean from 1969 to 1971 it has jumped up to that——

VOICE. Put your sign up. Let us see it.

Mr. FUCHSBERG. I will be pleased to do it with the permission of the Senator.

Now I would like you to know this is not a figure taken out of the air. This is actually what Blue Cross pays per day per average hospital care for the voluntary hospitals of New York City.

Senator KENNEDY. Is $148?

Mr. FUCHSBERG. $148.20. And if we were, Senator, to amend that chart right behind you, the one that shows the graph, that 304-percent increase over the period of just this decade would now be in the neighborhood of 500 percent and would probably hit right to the ceiling of this room. And it gives you some idea of something that is at the heart of the problem that I would like to touch on in the few brief moments I have.

Senator KENNEDY. Well, this is interesting because, you see, the construction wage increase—the President has made a recommendation to control construction workers' wages, but hasn't done very much in terms of holding down health costs.

Mr. FUCHSBERG. No, I am afraid that the lobby is a little stronger in one direction rather than another, if I may make nonpolitical comment.

Senator KENNEDY. Everything is nonpolitical.

Mr. FUCHSBERG. Of course.

Now, Senator, I know there are so many aspects to this problem, that I would like to address myself, and do it quite informally, to what I think constitutes a major attack upon our society generally by reason of the inadequacy of health care and its great expense, with astronomical costs in fact—and I probably should say stratospheric costs like that approximate $150 a day. And that excludes the cost of physician services. That is just the hospital end of it.

Now with the cost as tremendous as that it means that, I would say, roughly dealing mainly with three categories of patients, that the financial resources of many Americans—and I am sure it is true throughout this country, and it is certainly true in New York—perhaps to a number as high as 1 million are seriously affected every year, so that many are plunged from being in the so-called middle class into the poverty level as a result of their resources being wiped out.

Now those three classes to which I would like to address the attention of your committee are the following: First of all, the matter of maternity care.

Now it is an illusion to think that Blue Cross covers that. The typical Blue Cross policy provides for a payment of a fixed amount, either $100 or $200 as a contribution towards maternity care.

Now the births of New York State last year were approximately 300,000.

The average time that a newborn child and a mother would stay in the hospital used to be about a week. That would mean a cost of about $1,000.

Now the effect of only getting a $100 contribution to that $1,000 cost at today's prices is to require most young mothers—and most of them are young, and therefore they are in families who have not yet developed great resources—to leave the hospital after 2 or 3 days. Now this may be all right for the women of peasant stock. But there are many women of delicate state who find this produces an injurious health condition that very often permanently plagues them for the rest of their lifetime. So we are dealing not only with the financial question, but with a health consequence and an economic consequence.

Now the second class is in the area of psychiatric care. Now I needn't tell you how, unfortunately, with the pressures of our society, how prevelant psychiatric problems are. Now there have been in New York State about 30,000 cases of the type that I would like to mention to you each year.

Now what happens to those cases? The Blue Cross provision in those cases is only for 30 days of hospital care. If you buy catastrophic insurance beyond that the limit of protection is $10,000. It is nothing. I was dealing with a case yesterday where the patient is spending up to $50,000 a year for the cost of psychiatrists and hospital care at the rates that I have indicated.

And therefore what happens is that sooner or later both the municipal hospitals and the voluntary and proprietary hospitals, the private hospitals, are compelled to turn these people away and they get shunted to State institutions which very often are nothing but mental prisons. And this gives us another area of tremendous consequence.

I had four families whose plight came to my attention within this past week whose lifetime savings, in one case $6,000, in another case $22,000, in another case $125,000, were literally wiped clean, so that in the end they became public charges and in the interim did not receive the type of care that they required.

And the third major case dealing with literally hundreds of thousands of people that are the accident victims of our society, all kinds of accidents, automobile accidents and others. Now Senator, in those cases because of questionable liability and because of inadequate coverage, with limited coverage, there are literally hundreds of thousands of people in this State who have their resources wiped out in order to get care or are relegated—I know one boy who is a paraplegic and who lies in bed without care, day in and day out, with bedsores because there is no bed for him at a public hospital, and he has run out of money, and his mother and father—his father is a minister—have very long ago been wiped clean of any resources. And this you can duplicate in larger or smaller measure over and over again.

And I would say that, therefore, there is at least, taking an approximate figure, 1 million people out of the 18 million or so in New York State who feel this impact every year.

Only a week ago I had a case of a sanitation worker employed by a municipality. He had seven children. He was involved in an automobile accident on his job. But the amount of care that he required was insufficient to support his family and provide medical care, and as a result his family has been permanently plunged into a welfare status.

So what we are doing is plunging people into poverty, giving them inadequate medical care, and ruining their position in society as a result of us failing to give every American the birthright of proper health care without regard to the economic factor that I heard described here by these prior witnesses.

Senator KENNEDY. It is an excellent presentation, and you have had great experience in association with the whole health crisis. Of course, in talking about these mental prisons, in the early part of the

1960's President Kennedy was able to develop that mental health legislation, and under the present administration now there is a freeze in all construction funds in terms of that, a virtual halt in any kind of staffing operation. This is just one other kind of feature of the kind of problem that we are concerned about, that you talked about this morning, and quite appropriately so.

Mr. FUCHSBERG. Thank you, Senator. It has been a long time coming. It is true that the late sainted brother of yours who was our President did speak out on this subject a good 10 and more years ago, and it is certainly time we did something about it. And we hear so much about doing things to prime the pump economically; in this area we can prime the pump economically and we can always deal with the human and personal equation as well.

And I would like very much on behalf, I am sure, of all those assembled here, on behalf of Americans everywhere, to encourage you in your efforts to push forward in this area, and I thank you very much.

Senator KENNEDY. Thank you very much. It has been very helpful.

We have a Mr. Von Luther. And we are running behind, but we are going to hear our other witnesses and we will try and see if we can have a few minutes at the end. We appreciate very much, Senator, your being here.

Mr. VON LUTHER. May I just respond to that in all due respect. It is a point of high personal privilege that I am here, sir, because I represent Harlem, whose health is a disaster. But I also have a responsibility to serve in my community, and I would believe that had you come into a room where I was conducting testimony I would grant you certain courtesy not only as a person, but as an elected official, and I shall not under these circumstances cool my heels when I can go back to my office all afternoon. I think this is precisely the type of treatment which black people get, and I shall not succumb to this.

Senator KENNEDY. Well, it is your choice, Senator. I regret you feel that way, but we have an agenda here.

Mr. VON LUTHER. Of course.

Senator KENNEDY. We are going to try and do the best we can. We appreciate very much——

Mr. VON LUTHER. Senator, you also have an American agenda and my people have been the victims of it.

Senator KENNEDY. Our next witness will be Mr. Livingston.

STATEMENT OF DAVID LIVINGSTON, UNION OFFICIAL

Mr. LIVINGSTON. Thank you, Senator. I would like first to express our appreciation for your providing an opportunity for the consumers of medical care to express themselves as they have already done this morning.

I would like to concentrate this morning on the subject of costs and quality and how we can get medical care to the people who need it.

VOICE. I am going to interrupt here at this point. No matter what health bill is passed by the Congress of the United States, none will be able to guarantee delivery of effective health care to black people of this country unless guidelines for local community control of institutions are built into legislation.

The health crisis in Harlem is critical. The U.S.S. *Hope* is sent abroad to provide medical and training clinic services to the people of developing nations. I suggest that we convert some of these mothball fleets into emergency hospital ships and tie them up in the Harlem River and provide temporary hospital ships to care for the people of the Harlem community.

I also want to say this. Your presumptiousness of bypassing the black community, Senator, is not going to solve the problems of health in the black communities in this Nation. I think it is a little appalling that you bypassed the senator of the Harlem community. Your presumptiousness—this is nothing more than a high-class proposal of your political campaign for the 1972 campaign, and I want you to know that you are going to have to come to the black community if you are going to win our support. And we are talking about health services. You shortchanged us, Mayor Lindsay shortchanged us.

I am going to leave on that note, Senator——

Senator KENNEDY. Well, we know a political speech when we hear one, too. So——

VOICE (continuing). Because you are campaigning for the 1972 election.

Senator KENNEDY. As we point out in our agenda, we will have time this afternoon. We have consumer witnesses here this morning. You are more than invited to remain during the course of our hearings, and then we are going to open it up for floor comments this afternoon at approximately 3 o'clock, and if any of those people ordinary citizens as well as their representatives, want to speak out we will be glad to take their testimony.

We appreciate, Mr. Livingston, your appearance here.

Mr. LIVINGSTON. Thank you, Senator.

I started to say that we are familiar with S. 3 and H.R. 22. And I speak on behalf of about 75,000 consumers of medical care, and we get probably more medical care than most Americans, although we are relatively poor and the great proportion of our people are black and Puerto Rican. Nonetheless, we are organized consumers, as your bill calls for, and we have done certain things that until now have kept our health care reasonably good and reasonably within our cost potential.

We self-insure. We don't buy any insurance or coinsurance from insurance companies and we don't use Blue Cross. We come as close to what would happen if there were national health insurance as it is possible to come without it. And I would like you to know that our experience is we are doing it for a lot less than the insurance companies and Blue Cross and other people in the business of selling health care. We are doing it for a lot less than they do.

Our members get total hospitalization; that is for them and their families, 180 days. They get complete medical care, absent psychiatry and private nursing. And we do it for $279 per member per year.

That is well below the national average, well below what the insurance companies charge, well below what is being done almost everywhere. We are able, have been able so far for ordinary working people, great portions of them black and Puerto Rican, in this high-cost city by staying away from the insurance companies and staying away from the various other people who make money on the health business. We have been able so far to keep our costs within manageable limits.

Now we came today to say that our experience is like that of Mr. Fuchsberg. In the last 2 years hospital costs have risen—and I can give you the figures—by better than 30 percent, at least to us. Our medical costs are rising. We can tell you doctor for doctor what he charged for a given service a year ago and how much more he is charging for the very same service today.

Now we think that national health insurance is possible. We think your estimate, Senator, is a little high. It doesn't have to cost $57 billion. Based on our experience the American people can be provided with comprehensive and high quality medical care for well below what you say. Certainly much less than the $77 billion that the administration says it costs.

But you have got to do three things: let the consumers be organized as participants in the medical care system and help to make decisions, control medical prices, and control medical quality. Now I know the word control is anathema to some people. But we are talking here of something that is essential to the American people. You can't treat this like control of the price of a lady's dress or a man's suit. This is whether he lives or dies, and there has got to be, as your bill provides—and I came this morning really to plead with you. I don't know what political compromises will have to be made. But there is one compromise that you must not make, we think. You must not let them get away with keeping the people out. Health is too important to leave it to the professionals we say. [Applause.]

Second, you must see to it that there is a system for controlling prices and quality. I don't know what the legal capacity of the Senate Committee on Education is, but we think you could do one thing perhaps today that would do a lot of good. While we talk about medical care the prices of it keep rising day by day. By the time we get national health insurance they will have medical prices up to double. The $148.20 which was put up on the board there is outdated by now. And we wonder whether the Senate subcommittee on Health could not declare a medical inflation alert and call for an absolute freeze on medical costs as of now. If you get that done we have got a chance to get a national health insurance system that works.

Thank you.

Senator KENNEDY. Let me ask you, Mr. Livingston—as I understand, your union worked through Blue Cross and Blue Shield for many years, is that right?

Mr. LIVINGSTON. Yes, we did.

Senator KENNEDY. Then you found out there were various gaps in those kinds of programs as well as very significant increases in

cost. So then in effect you went out and insured yourselves, is that right?

Mr. LIVINGSTON. Correct.

Senator KENNEDY. And you have been able to provide more comprehensive benefits to the people of your union than Blue Cross and Blue Shield, been able to do it at a lesser cost than what you would have paid with Blue Cross and Blue Shield. Do I understand you correctly?

Mr. LIVINGSTON. You understand me quite correctly.

Senator KENNEDY. Well, how can you do that?

Mr. LIVINGSTON. Well, the highest paid administrator in our health plan makes less than $14,000 a year. Our legal costs in our health plan—apologies to Mr. Fuchsberg—but they are very, very modest, probably no more than $15,000 a year.

But above and beyond that there is one ingredient we have seen, and that goes to a point somebody made here today when they talked about—I guess it was you who talked about disbelief, the way people conduct themselves toward medical care. You said you couldn't visualize people requiring any incentive to, you know—what do they call it?

Senator KENNEDY. Cost consciousness.

Mr. LIVINGSTON. Yes, to keep people within limits. Now our members get total medical care. We pay all doctors, barring——

Senator KENNEDY. Don't you have deductibles?

Mr. LIVINGSTON. No deductibles.

Senator KENNEDY. Don't you have coinsurance?

Mr. LIVINGSTON. We do not have coinsurance. But we have a disciplined carrying membership.

Senator KENNEDY. Don't they abuse it? You hear so much if these services were available to people generally you would have abuse of it and you would overrun the system in terms of cost. What is your experience?

Mr. LIVINGSTON. We don't think that is true. Now we have occasionally some abuse. Usually a member and a doctor in combination. We suddenly find somebody requiring 100 injections, two a week for a year, for something that probably could be handled with much less. That occurs occasionally. But when a member cheats like that he is cheating his fellow members, and we have a union—he has to answer to his fellow members and within the union. And I would say this, that our members, as we believe the American people themselves would if you had a truly democratic health system—we don't believe that people will abuse. After all, it isn't so hard to convince a person that if he cheats or she cheats, robs, and steals by getting more medical care than they should or getting paid for things that they shouldn't they are just stealing from another member or another American citizen. And we don't believe the charge against national health insurance of abuse will stand up. You can check it for a year or two and you will see.

Senator KENNEDY. Let me ask you how do you assure quality control in your program?

Mr. LIVINGSTON. Well, I would say that our program is weakest in that regard because it is very hard to get a member to come and complain about his doctors. You know how it is, you go to the doctor

and you have to believe in him, he has got his life in his hands, and our members are a little reluctant to make a complaint.

But we do have several dedicated doctors on our staff. We discuss the quality of medical care at membership meetings, and we are trying to develop the concept that the union or the plan is the instrument through which we have to fight for good high quality care.

Now we are going to do one more thing, Senator. We are going to open at our union a health care delivery system of our own where people can come and get everything except a hospital bed, and we will try to prove through that the VA system, if you like, that good medical care is possible and at moderate cost. We think that we can get high quality care through having an informed active membership. And we think if you have an informed and active community organization as part of a national health plan, that that will produce controllable costs and maximum quality.

One of the problems is that the doctors don't know what the patients regard really as maximum quality. There is no system of communication, and where there is communication all too often the patients aren't listened to. And if you have a system where the patients must be listened to, we will learn a lot. The doctors will learn, and we will get good high quality care, we hope.

Senator KENNEDY. Thank you very much. Very, very helpful.

Mr. LIVINGSTON. Thank you.

Senator KENNEDY. I wish you would submit to us a copy for the record of your proposal.

Mr. LIVINGSTON. Yes, sir. We will do that. We will send it to you. Thank you very much.

Senator KENNEDY. We have two more witnesses and then we will recess until 2 o'clock, Mrs. Sue Bronstein and Mr. Gerald Beallor, and then we will hear from Mrs. Lilliam Bloom.

STATEMENT OF GERALD N. BEALLOR, DIRECTOR, DEPARTMENT OF SOCIAL SERVICES, MONTEFIORE HOSPITAL, AND MRS. SUE BRONSTEIN, EMPLOYEE OF MONTEFIORE HOSPITAL

Mr. BEALLOR. Thank you, Senator.

Before I introduce myself I would like to introduce Mrs. Bronstein. We are from Montefiore Hospital. Mrs. Sue Bronstein is a mother and active community member. She is a parents association president. She is quite interested in school health programs, drug programs, and the like.

Mrs. BRONSTEIN. After that, how can I go on?

Well, when I got the phone call from Mr. Beallor requesting if I would appear before you people I said "gee, that's great, but do you want me," because I have been active in the community and I found many shortcomings that have been bothering me, and I would like to present a few of them here.

Montefiore Hospital, which I consider an excellent hospital, has no adult medical clinic. Now in these terms what this means to community people is that if someone isn't feeling well there is no place for them to go except an emergency room. When they go to an emergency room what happens is they sort of specialize, and they go to a specialized clinic time and time again. And I know someone

very well who in the past few months has been going to a specialized clinic—this person has gone to the specialized clinics for a couple of days a week, and the outcome was "well, Mrs. So-and-So, there is nothing wrong with your thyroid, go to your private doctor."

So this is one of the great shortcomings that I see as a community member.

There is also no geriatrics clinic and our neighborhood is made up of many older people in the community, so this also is a very dire emergency.

Our emergency room—if it is a very dire emergency you get excellent care. However, many people use it as a comprehensive medical service, and therefore the waits can be hours, and it is unfortunate. We do need a general adult medical clinic or perhaps a night clinic, because many people use the emergency rooms at night.

As far as preventive programs, they are practically nil, which to my feeling is just incredible. There seem to be no moneys given for preventive programs. And in the drug education program there is no drug education program to the community and to the schools least of all.

I know that the State had a proposed plan for $65 million to be used for drug education, and I know that our school district applied for quite a bit of that money and I know that to date they have not received any of it. So it seems to be a great farce with this money.

Some preventive programs are certainly needed in this area.

Child psychiatry is another impossible kind of situation in our area. I know that Montefiore Hospital evaluates 5 million children a year and only treats 20. That is an unheard of small amount, and it seems this is not the only hospital that treats such a small amount. It doesn't seem to be moneys are forthcoming or perhaps priorities are cut up in different ways. And this I feel is a very important kind of thing because an ounce of prevention can save a pound of I don't know.

And what I had done was in January I had called to try and get an appointment for a child that so-called had to be evaluated, and usually by the time he gets to a guidance counselor and social worker he is 2 years of a problem child, and I was told in June you could have an appointment; that would be just for an evaluation with no promise of treatment. And this is something.

I feel that many hospitals break up their priorities—and perhaps the training of doctors which is very important, and the community must have some services. We have crying needs in our community which just aren't being met, and time and time again I am told the moneys just aren't there for preventive services.

I know that ghetto medicine moneys was supposed to help out in some way, and then recently I have heard that they haven't even been recycled from April to June or July. So I don't know what is happening there.

And it seems with medicaid funds I read in the newspaper that they get lower all the time for different reasons, and in other kinds of areas, the ghetto medicine money, they need matching funds very often and moneys just aren't forthcoming.

Now I know that there was talk of an abortion clinic for Montefiore Hospital, and if they stop the medicaid money will there be an abortion clinic in Montefiore Hospital? Where will they get some of the moneys they were counting on for it?

And the cost—you have a lifetime of savings and you have a month of sickness and it is completely wiped out for the so-called middle-class person that I am beginning to believe is nonexistent any more.

So your plan, which I don't really know that much about, seems like a pretty good one, and thank you.

Senator KENNEDY. As I gather, your point, which I think is an extremely important one, is even where you have a very worthwhile and valuable hospital, its ability to deal with health needs in a given community is extremely limited because of the resources that are made available to it. And I imagine you as a mother and active community resident feel the inadequacies of this kind of experience and the limitations that are evident upon the hospital in providing these services, and I think that is one of the real problems that we are facing.

Mrs. BRONSTEIN. Groups of us have met, the Parents Action Committee—we are trying to work some ways.

Senator KENNEDY. Thank you very much. You have been extremely kind to come down here, and these comments are helpful. That is a serious aspect of the whole health crisis, and we are glad to hear it from somebody who is active in the community and concerned about the community, as you are.

Mr. BEALLOR. Senator, I am Gerald Beallor, director of the Department of Social Services, Montefiore Hospital. I am here as a social worker, one of those professionals in health, but I hope more today not to speak for the profession but to speak as an advocate for those who cannot be here—the aged that are lying in the beds of our hospital; the aged that are in nursing homes; the children that we frequently don't treat in our psychiatric clinics; and so forth, and to take a look at why this is so, and to commend you and your committee for the bill that you are placing before the Congress that we hope the Congress will find the funds for, that can get this war over with and make available the kinds of funding and services that people need.

I think historically we are all aware of the fact that the hospital—Montefiore Hospital, as an example—originally saw itself, as no hospital did, as a community institution. It essentially saw itself as an institution to take care of the health of those that came to it, and doctors locally in the community would take care of health. In reality the doctors of the community, particularly for the aged and the poor, have disappeared. And so the hospital becomes the doctor for the community. But the hospital is a poor doctor for the community.

The priorities and the programs of the hospital are established not by the needs of the aged and the poor and the children that require its services, but by outside groups whose concern, as beneficial as it may be for people, is not related to the community's needs and priorities, but is addressed to other needs. Sometimes it is medical education; sometimes it is the need of a medical group

to do research and develop new programs; sometimes it is an attempt to develop a program that is extremely worthwhile and expensive and costly—heart transplants and things of that kind that benefit a few. But there is no input in terms of priorities as to what the real needs of the community are.

And it is only recently that we and other hospitals have begun to recognize that we have to turn to the community and develop consumer participation, and I hope ultimately control—something that is in your bill, but I think it needs to be strengthened.

I think that we really need to take the consumer and the member of the community into a very real partnership with the professional. I have a skill to render, and so does the physician, and so does the nurse. But that doesn't give me any particular advantage in determining what comes first, and I think that has to come from the person that pays for the service, and if it is done through taxes that means the citizen; and I think that the citizen must come into his own, and it is the only way that we will reform the health system.

Now in addition to that we have other problems. The social worker spends untold unnecessary hours patching together separate services with holes in them, with bureaucratic redtape, with requirement of form upon form upon form. And where a patient is in a private or a propriety hospital or doesn't have a social worker available to help, as you have heard today, what can happen to the family because they are not aware of the ways in which eligibility can be determined can be disastrous to that family.

Now when we begin to straighten out the system we have to raise a question is there a place for any profitmaking corporation in a social utility such as a health care system, do private insurance companies belong. Can we continue to have corporations, whether they are nursing homes or hospitals, making profits from people's health?

In addition to that, our basic service now is a fee-for-service basis, and we want to try to find a way to reward preventive and health maintenance activities.

Finally, what we would like to say is that care for the poor and the aged is going to be more expensive than the kind of care that has been described by some of the previous speakers. The experiences described where health care can be delivered at a considerably lower cost is based on the working population that in general has a less disastrous and chaotic kind of health need. So we have to find a way to provide additional costs and additional moneys to take care of those people who are disadvantaged in our society. If we use the same funding patterns for all members of our society in a single insurance system, then the poor and the aged will be shortchanged again.

Now we prepared a statement, and I am not going to read it now. I would like to have it in the record, Senator. And we would appreciate that consideration be given to all of the kinds of accountability and consumer participation that we think are needed to safeguard the development of a better health care delivery system.

Senator KENNEDY. Well, thank you very much. We appreciate your comments here before the committee. Thank you for your appearance here this morning.

(The prepared statement of Gerald N. Beallor follows:)

Statement Submitted by Gerald N. Beallor, ACSW
Director, Department of Social Services
Montefiore Hospital and Medical Center

For Presentation to the Sub-Committee on Health
of the United States Senate
April 14, 1971

My name is Gerald Beallor. I am Director of the Department of Social Services, Montefiore Hospital and Medical Center. I am currently working on a doctoral dissertation on how altering the delivery system changes an affects the practice of professionals: doctors, nurses, and social workers, etc. I have had extensive clinical and administative experience in health service delivery, especially to the mentally ill and the aged ill.

I appear before the sub-committee today to advocate for those least able to obtain adequate health care: the poor, the working family not covered by any existing programs, and the aged.

Our national capacity to fund the present death dealing war machine demonstrates clearly the potential funds available to sustain and enhance life for all our people if the Congress will so choose.

When we make that necessary choice between death and life, I would respectfully rquest that those that draft the final legislation keep in mind the shape of the services that will develop. Experience has demonstrated unanticipated consequences to well intentiones legislation. The Medicaid ammendments to the Social Security Act are an example. The means test, the gaps in services, the fee for service system, and the bureaucratic administration of the medicaid program all operate to the disadvantage of the patient. Therefore, I propose that a National Health Care Bill do the following:

1. Provide for adequate consumer participation and control.

2. Eliminate intermediaries and health providers that drain off service money via profits. No corporate profits should be permitted in a social utility such as a health care system.

3. Funding should emphasis and reward preventive and health maintenance activities. Funding should be on a program basis rather than fee-for-service, with review for increase as the numbers served in the program increase.

4. The consumer, regardless of ability to pay, should obtain needed care without constant reapplications and involved bureaucratic procedures.

5. The Federal government should set standards and review programs to control quality and costs.

Gentlemen, thank you for this opportunity, a more complete statement by my professional association is attached for your committee's further deliberation.

Roosevelt Hospital, New York City
April 14, 1971

POLICY STATEMENT ON HEALTH CARE IN THE UNITED STATES
A Position Paper
New York City Chapter
National Association of Social Workers

PREAMBLE

The National Association of Social Workers fully accepts the World Health Organications definition of health:

> "Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition....it is a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity."

In endorsing this concept we affirm that any consideration of a health care program-preventive, ameliorative and curative, must be viewed within a context of a public policy that provides for a guaranteed annual income, decent nutrition and housing, and a pollution-free environment.

We affirm, further, that a nation cannot implement, in fact, a program that values the life and health of its people while it expends vast human and material resources in the prosecution of an inhuman and senseless war.

We support the following principles regarding a health care system:

1. A Unified system which does not discriminate, economically, racially, sexually, or geographically.

2. Recognition that the health care system is a social utility and subject to public priorities, public standards and public accountability.

3. Commitment to full consumer participation and control, along with health personnel in the planning, policy, and decision-making processes that go into the organization and delivery of health services.

4. Reorganization of the system and development of resources-physical, financial, and human-to fulfill the mission of providing quality, dignified health care for all people. Existing resources should be incorporated into the new system to preserve the strengths of the old.

In order to implement the intent of the above principles, we make the following recommendations:

PROPOSAL FOR COMPREHENSIVE HEALTH CARE SYSTEM

I. SYSTEM OF ORGANIZATION FOR DELIVERY OF HEALTH SERVICES

A. Patient care must be re-organized so as to provide comprehensive and progressive care for all, regardless of income. The present health care arrangements based primarily on solo practice, fee-for-service for the upper and middle classes and emergency room-crisis care and impersonal clinic care for the low income population, are fragmented, uncoordinated, inefficient, ineffective, and unacceptable.

B. The new system must incorporate certain essential concepts:

1. Preventive health care must be emphasized by means of public education and multiple screening programs to prevent or detect diseases early and assume prompt treatment.

2. Progressive health care must be assured by arrangements which provide, as needed: diagnosis, ambulatory care; hospitalization; adequate social services; treatment by specialists; rehabilitation; care in the home; long-term care.

3. Creation of local and regional community-controlled health boards with responsibility for the provision of all personal and environmental health facilities and services. Each board should have representation of both consumers of the services, and providers of such services in the area.

4. Creation of regional networks of health facilities, so that patient services are based on health needs. The types of facilities and services should include educational and preventive social services, screening programs, neighborhood health centers, acute and chronic hospitals, organized home care, rehabilitation services, nursing homes, half-way houses and all other services required to provide comprehensive care. These networks are to be under the direction of the regional community-controlled health boards.

5. Encouragement of diversity and experimentation with new and different methods of providing care.

II. FINANCING THE HEALTH SERVICES SYSTEM

The delivery of health care in the United States needs to be supported by a public funding mechanism which includes all people in the nation.

1. Establishment of a national health care fund to pay for all personal health care, including preventive, curative, and rehabilitative services. This is to be a mandated trust fund, so constituted as to remove it effectively from annual appropriations by Congress. One way is to have it financed by a progressive income tax.

2. Distribution from the trust fund of all funds for personal health services to be made to the regional and local community-controlled health boards on a per capita basis.

3. Funding through general tax funds for environmental health services, medical research, health education, and construction of health facilities.

4. Establishment of a national Department of Health with Cabinet status, which would be responsible for the administration of all health services, personal and environmental. The Department of Health is to consult regularly on basic policies with a National Health Board composed of representatives from the regional community controlled health boards.

III. HEALTH MANPOWER

Measures must be taken to vastly increase the facilities and programs for training physicians, dentists, nurses, social workers and other allied health manpower categories. Special emphasis should be placed on development of minority group manpower.

Creative re-deployment and utilization of the various professional and allied specializations must be carried out in order to make the most effective use of the potential contribution of each, working as an inter-disciplinary team. This process should be an integral part of comprehensive health planning.

Adequate federal manpower training funds must be provided to finance these training programs.

IV. RESEARCH AND DEVELOPMENT

Basic medical and health care research is essential to continued progress toward prevention, detection and treatment of diseases. The nature of medical and health care research is such that it requires coordination and direction from the national level in order to best utilize facilities and personnel and avoid wasteful duplication of effort.

Collection and dissemination of this advanced knowledge should be part of this process.

Application of this knowledge to health care practice and the development of better methods of delivering health care should be integrated into the activities of regional and local comprehensive health planning agencies.

Research and development programs should be implemented through the regional and local networks, and should be adequately financed by Federal funds.

V. ENVIRONMENTAL HEALTH

The industrialization, mechanization and commercialization of our country have produced hazards of grave concern to our health and well-being. Among the by-products is pollution of our physical and social environments. The federal and local governments have abdicated their responsibility; corporate interest has replaced the public welfare.

(5)

1. Rigid enforcement of existing air pollution codes and establishment of new ones where needed, with penalties of sufficient magnitude to discourage chronic offenders.

2. Crash research programs to produce nonpollutant engines and other technological innovations to reduce pollution.

3. Immediate promulgation and strict enforcement of the highest safety standards for the automobile industry and strict enforcement of laws aimed at the prevention of highway accidents.

4. Establishment of plants capable of treating and converting solid wastes. Strict control of industrial wastes and hazards with the cost borne by industry.

5. Establishment of a national consumer code with strong laws protecting the people by insuring truth in advertising, packaging and labeling of foods and drugs.

6. Renunciation of nuclear, biological, chemical, and all weapons of mass destruction; disavowal of war with its intolerable psychological and physical toll on others as well as ourselves.

Senator KENNEDY. Our final witness will be Mrs. Lillian Bloom. Mrs. Bloom became something of an expert on the health system and will talk about the need for comprehensive health planning. She has had quite a contact with the system through her husband. We are very interested in hearing about it. Would you tell us a little bit about yourself?

STATEMENT OF LILLIAN R. BLOOM, MEMBER OF HEALTH COMMITTEE OF BRONX COMMUNITY BOARD NO. 7

Mrs. BLOOM. Yes. I believe I have been called to tell about a personal bankruptcy in a middle-class family because of the health system, or lack of health system.

My husband became ill in 1962. He had had a hernia operation in 1949; he had his appendix out in 1951. These were ordinary things really. Blue Cross-Blue Shield paid part of it; we paid the rest. And then came the catastrophic sickness, the one that lasted for 2 years, five operations. Blue Cross and Blue Shield paid a very small part.

I sometimes think that our medical system has private eyes who go and figure out exactly how much you are worth, because we were worth exactly $7,001, and what do you know—the bills were $7,001. It was kind of strange.

Mama and papa lived nearby, so they fed us. Therefore we didn't have to go on welfare.

The firm for whom my husband works has a pretty good plan for paying employees who are out sick. Private insurance companies who cover your income discount that insurance when you are ill. You are a lousy risk and that's it, you just don't get any more money.

Then comes the time when you find that he is going to be permanently disabled; there is going to be a gaping wound in the chest. And like Mr. Kaiser told you, the first witness, his wife learned how to do the things that the professionals do, she helps him with the dialysis machine. I was told I could not dress these wounds for my husband. This is now 7 years I have been doing it. It was the job of a registered nurse. It is costly; it is disgusting; it's Christmas every day—thank God for the doctors—it's blue and green and bloody. I know this isn't pleasant, but the thing is you lose your awe of the medical mysticism of the professional who can only do these things, because you find you can do it with your own hands, and so can all of the so-called underprivileged who are really our robbed population. These people who are not supposed to be capable of learning these skills—they can learn these skills. The only thing is your professional will no longer be on that high pedestal.

I came to tell you these things and other things, like my father who went to a veterans hospital to die because the few pennies he saved as a cab driver would have been completely gone down the drain in a voluntary hospital. He didn't want to leave my mother penniless.

I came to tell you these things—for a middle-income family it is true. But I also came to thank all of you to be able to be here at a public open hearing, because March 31 I sat at what was a public

open hearing for an ambulatory advisory committee, community people and Beth Israel Hospital, who could not come into the hospital because they were under court injunctions keeping them from coming to a public meeting. I sat in that room and for the first time in 49 years of my life in New York City I felt threatened and oppressed. There were more hospital guards. New York City policemen, and plainclothesmen in that audience than there were community people. And I sat there quietly because it wasn't my community—but I will be damned, I will not suffer through the sin of silence and not let it be known that community people were kept out of a community meeting because of the fear of the health professionals. This would not be in my nature if I were not to say this.

I live in the same community as Mrs. Sue Bronstein, and I sit on the Ambulatory Advisory Committee of Montefiore Hospital. This committee is mandated by the law under the ghetto medicine program. The ghetto medicine program in itself is a very peculiar program.

I know you are here for a hearing. I think that perhaps I could ask for an investigation rather than a hearing. There was a ghetto medicine program where the moneys were slated for ghetto people, where the moneys were slated for individual freestanding decentralized family health centers, comprehensive family health centers—but instead, the moneys went to bail out temporarily voluntary hospitals with deficits. Well, who set the deficits, and why did my tax money just go to so-called voluntary hospitals? I, myself, do not see them—and I know many people back me on this—do not see them as nonprofit private voluntary hospitals.

I have written some things about this for my own community blackboard. I don't know as how I want to read it here. I do want to leave it with the Senator, though.

I feel it would not be fair if I didn't go back to the middle classes. This is why I was called.

In the Newspaper Mail Deliverers Union bulletin for the month of March the president of the union wrote:

I am sure that the members are quite aware of ever-increasing medical and drug bills which are choking the average working man to a point where the only people who can afford to get sick are the very rich or the very poor.

Unfortunately, Mr. Levy is wrong—the very rich cannot afford it because they don't know what kind of doctor they are going to get. The poor get absolutely nothing.

The outrageous costs of hospital and doctors' fees, etc., and the advantage that is usually taken of those who have medical coverage, by that I mean the fact that when a doctor finds out that you have a group policy as we do, his price mysteriously goes up.

I know—we were victim of that.

This is forcing our Union along with many others to start thinking of self-insurance. Whether this is possible or feasible at this moment, I do not truthfully know, but I do know this, if something is not done either through Federal legislation or through self-help on our part to protect ourselves against these people or groups of people, these so-called professionals, who are putting us in the unfortunate situation of never being able to improve our benefits. On the contrary, it might be possible that we may be forced to curtail benefits.

We are not getting sufficient benefits now and they are talking about curtailing them.

Quite naturally, the Union will do everything conceivable to make sure there is no curtailment of benefits, but I believe that every member should contact his Congressman and ask his friends and relatives to do the same by asking his duly elected representative in Washington to do something about the medical profession's total disregard for the welfare of people who need medical care at reasonable and honest rates.

You know when a middle-class community starts questioning doctors and starts talking about reasonable and honest rates we know we have been had. That is the middle class. I am hoping that the middle class through their constant asking questions like this are going to help the poor people, and I really mean the poor people. Because in going through the city—because I became interested in comprehensive health planning through my interest in the narcotics program—I have gone around the city and I have found things that I had read about, I had been told about, I had empathies with the people who were discussed, but I really had no idea what they were going through until the feeling of oppression at a so-called open meeting. I have seen where there are no services.

Mrs. Bronstein spoke of our area. We have an area that has the highest percentage of senior citizens in the city of New York. There are very, very few facilities for these people. She discussed the fact that Montefiore does not have a general medical clinic. This is true. But I question this after 16 months and two city-state contracts under ghetto medicine—I would say why in 16 months has there not been further movement along this line.

I am sure that there are many other hospitals in the city where the community members would have many things to tell you about the advisory boards. Senator Kennedy, the first way you are going to get a type of true community participation is through the advisory boards of these various voluntary hospitals. The majority of them are made up of well meaning, honest people who receive very little information that they can evaluate.

Senator Von Luther, who left, has a bill now in the New York State Senate asking for fiscal reports to these community people. I am just curious to see whether he is going to get this bill through. This is the first step in really giving some sort of community control, and I don't mean control in the quotes of control, but being able to work on a cooperative basis with the professional, a knowledgeable community.

You have your partnership in health which is made up of three parts supposedly. You have the professional, the government, and the taxpayer, the consumer. But let me tell you, your government and your taxpayer, the consumer, are really one. It is really going to be made up of professional and nonprofessional.

Until the nonprofessional gets the knowledge and expertise that should be available to him and is kept from him, and until the time the professional knows that that person sits down with him, not look down his nose at him, until that time when they cooperate together

all these hearings and everything are going to be useless. They are going to be useless because this is just rhetoric; this is just a concept, consumer participation. There has been no reality to this as yet. Your consumer groups have no power. They have no financial means of gaining any kind of power. Our hospital associations, professional associations, are very powerful. They are very well organized. We don't have the power.

I think the final thing which I feel is the most important, I think most of the health consumers feel is the most important, is no national health insurance program is going to work if you have any private insurance companies, particularly Blue Cross. They are going to do nothing more than gain profits out of this.

I will just give this as an example. I said we went into personal bankruptcy. We came out of personal bankruptcy very, very easily, and I must tell you how. If you are smart enough you know how to invest in health stocks, and we invested in health stocks. As long as we spent so damn much money on American Hospital Supplies and Johnson & Johnson and Pfizer, we invested—we borrowed money, paid the interest, invested, and now we are back on our feet, and we did it on the very health companies that took us. And I can show you the whole dossier of how we did it. It is beautiful. We played the game of the establishment. We came out ahead.

I do want to leave some of this information with you. It might be rather interesting.

Senator KENNEDY. Well, thank you very much. You have been extremely kind in telling us about your particular problem. There are many others who have been wiped out financially, as you have, and people who would be reluctant for one reason or another to mention this particular problem.

Mrs. BLOOM. But, Senator Kennedy, may I just point out one thing. I am middle class and I will survive, but I have met a lot of the poor people who will not survive.

I just want to say one thing. In my living room there is a little sign, sir, and that little sign has a little saying on it, Senator Kennedy—I think you know what is the right thing to do, I know how political all this is. But a young man once said "I dream of things that never were and say why not," and I say why not, why not now—do we have to wait another 10 years, 15 years, 20 years?

Senator KENNEDY. I think that is perhaps a very good note to end this morning's hearing on. We are running now about 45 minutes behind. We are going to try and get started as close to 2 o'clock as we can.

This afternoon from 2 to 3:30 we have some professional witnesses, then at 3:30 we will listen to some other representatives of the community. If we can move that along quietly, we will open it up to any comments from the floor. So we invite back any of the ones who didn't have a chance to speak this morning.

(The information supplied by Mrs. Bloom follows:)

HEALTH REPORT TO MEMBERS OF BRONX COMMUNITY BOARD NO. 7, APRIL 1971

Last month's explanation of the building of the NEW MORRISANIA Hospital—presently known as the NORTH CENTRAL BRONX HOSPITAL—was

a mechanical report. It does not reveal any of the powerful political forces of the "health power brokers" that resulted in a city hospital—desperately needed in other parts of the borough—being constructed adjacent to and physically joining directly into Montefiore's Hospital and Medical Center. Neither does it explain how Lincoln's plans have remained on the drawing board for fifteen years or how the new Fordham Hospital is probably still ten years away. Why do residents of the lower Bronx travel to Mt. Sinai or Flower Fifth in Manhattan or have to come to the North Bronx for the health services that is their guaranteed right—if we accept the premise that HEALTH IS A RIGHT AND NOT A PRIVILEGE as stated by the WORLD HEALTH ORGANIZATION?

The power of private interests and the availability of public funds through Federal grants and State and City taxes to these "private" health providers should be closely scrutinized and questioned by us when they supersede the fundamental health rights of the American people. This applies to the vast middle class as well as the "underprivileged" as statistics prove that the majority of individual bankruptcies today are caused by a catastrophic illness resulting in monumental bills. The average middle class family knows the difficulty in trying to obtain medical care during an emergency or in locating a new doctor when his MD leaves the area—how much more difficult it is for low income people who have no resources—not even a local hospital or emergency room! ! !

We have the right—and the obligation to those in the community we represent—to question and to demand accountability from those health institutions receiving public funding. How do the so called "private, non-profit, voluntary" hospitals—on your monies—justify fancy new equipment, duplications, luxurious carpeted meeting rooms and offices and VERY high priced "doctors" and administrators and public relations men whose sole duties appear to be that of obtaining *additional public funds* and grants through cries of poverty and deficits.

The once sought solution to the ills of the American Health System have turned out to be the major cause of the runaway costs of the medical system—particularly the cost of hospitalization. The third party payment agencies such as Blue Cross, Medicare and Medicaid virtually guarantees the continuation of higher costs. The hospital boosts its costs—Blue Cross boosts its premiums—You pay. Medicare and Medicaid are tax monies—YOU pay. Therefore how can anyone justify so called "private" hospitals not being accountable to—YOU? ? ! !

For example: From Jan. 1–June 30, 1970, from the Bureau of Fiscal Administration-NYC Dept. of Social Services the voluntary hospitals in the city received 58.6 percent of the monies for outpatient services (clinics and emergency rooms) compared to 41.4 per cent to the municipal hospitals. In total dollar amounts of Medicaid monies (including inpatient as well as outpatient costs) the city hospitals received $110,709,365 and the so called "privates" received $103,201,425 for the 6 month period.

I have been unable to secure the Medicare figures—also tax monies—but suggest you strongly question how "private" are hospital complexes that receive 45 to 80 percent public funds to operate, how non-profit making they are when they can purchase properties not only for hospital related facilities, but income producing tenements and how community oriented they are when they discredit the community who dares ask questions? ? ?

LILLIAN BLOOM.

LILLIAN R. BLOOM,
3288 Reservoir Oval East,
The Bronx, N.Y.

Member of Health Committee of Bronx Community Board No. 7.

Consumer member of Montefiore Hospital & Medical Center Ambulatory Care Services Advisory Committee (mandated under Ghetto Medicine Program contracts).

Chairlady of Neighborhood Council for Better Health.

Co-ordinator of the Bronx Health Action Council—*a consumer* group purpose: to provide *health consumers* with information concerning their health rights and to promote health consumer advocacy.

Chairlady of By-Laws Committee of the New York City Coalition for Comprehensive Health Planning—a coalition of health planning councils recognized

by the MOTF on CHP—purpose to provide *health consumers* with info as above.

Community Medicine Steering Committee—acting recording secty. *Consumers* who have been appointed to Ambulatory Svces. Advis. Com. and who have formed to exchange information and try to obtain information that is withheld from them by the hospitals on whose advisory boards they serve as committed volunteers.

Member of the Subcommittee on Comprehensive Health Planning of the Office of Borough President of the Bronx—chaired by Mr. Henry Becker (NOT an active committee—unfortunately).

Acting Chairlady of the Public Education Committee of the Bronx Unit of the American Cancer Society—concerned with areas of health which are important to individual Bronx communities as well as cancer prevention education.

Recording secretary of the Community Advisory Development Project No. 1 in the Bronx—residential program for 13-17 year male drug abusers & narcotics users—a HEALTH problem.

These are all affiliations with organizations primarily concerned with health and represent our society's demand to show qualifications to speak. How unfortunate! !

The most important qualification should be that of a concerned and involved human being—organizational ties should be of secondary importance—they are meaningless unless they have some policy making powers. *Consumer groups do not have the financing* or the power of the well organized and wealthy associations that have been formed by the hospitals and private health providers to protect their vested interests.

[Reprinted from the 1970 Bronx Board of Trade, Chamber of Commerce Industrial Directory]

MONTEFIORE HOSPITAL AND MEDICAL CENTER

Montefiore Hospital and Medical Center, one of the leading patient-care, teaching and research institutions in the nation, is located at Bainbridge Avenue and East 210th Street. Founded in 1884, in a two-story frame building, having 26 beds for the chronically ill, Montefiore is today a 1200-bed complex with major departments in all branches of modern, scientific medicine.

The hospital has been at its present location since 1912. Its physical facilities, concentrated in a seven-square-block area, include 27 buildings containing 77 departments and 42 clinics. Montefiore's Einstein division, in the northeast Bronx at Eastchester Road and Morris Park Avenue, some four miles away, is a complete hospital in itself. Formerly the Hospital of the Albert Einstein College of Medicine, it was merged with Montefiore in January of 1969, enabling the two institutions to consolidate their medical, scientific and financial resources to better serve the health care needs of the people of the Bronx.

Many of Montefiore's buildings, such as the Klau Pavilion, which houses the departments of Medicine and Psychiatry; the Henry L. Moses Research Institute, a ten-story tower on the southeast corner of Bainbridge Avenue and Gunhill Road, and the Loeb Center for Nursing and Rehabilitation, were built in the 1960's. Construction will soon begin on an apartment building on Wayne Avenue and Gunhill Road to house the hospital's staff members and on a nursing home to be built at the south corner of Bainbridge Avenue and East 210th street.

Keeping pace with Montefiore's physical expansion and program development, the number of interns, residents and fellows comprising the hospital's house staff, has increased year after year over the past decade and in 1969 there were nearly 400 such young doctors at the hospital. In addition to training house staff, Montefiore has also served as the major voluntary teaching hospital for the Albert Einstein College of Medicine since 1963 in a program that provides third and fourth year medical students early contact with patients.

Montefiore's overriding goal is to bring the highest quality of comprehensive medical care to the entire community of the Bronx. At its Dr. Martin Luther King, Jr. and Bathgate Health Centers in the southeast part of the borough, Montefiore brings comprehensive, high quality health care to thousands of people living in one of the most deprived areas. At the Dr. Martin Luther

King, Jr. Health Center, residents of the area are also trained as skilled health workers in a program which provides many people with a way out of poverty while at the same time adding to the pool of health care manpower in the Bronx.

By contract with the City of New York, Montefiore is responsible for the medical program at the 400-bed Morrisania City Hospital at 168th Street and Walton Avenue. Although Morrisania is an old building with endless deficiencies, the medical care provided by Montefiore physicians there is as up to date and scientific as anywhere in the city.

With funds from the Children's Bureau of the United States Department of Health, Education, and Welfare, Montefiore's Comprehensive Child Care Center at 56 East 167th Street, provides continuous, family-orienuted, pediatric care for over 2,000 children living in Health Area 34 of the southeast Bronx. These children, whose only previous experience with a doctor has been in the emergency room of a city hospital, see their own pediatricians on a regular basis, receiving care of a preventive nature as well as treatment for acute illness and have access to specialists in such areas as speech, sight, hearing, diet and behavior.

Now the largest employer in the Bronx, with a staff of over 4,000 employees, Montefiore is firm in its commitment to the delivery of superior medical care to all the people in the Borough of the Bronx.

NOTE: Medical Monopoly of the Bronx? ? Does this serve the health needs of the public or enhance the prestige of the institution? ?

[From the Newspaper and Mail Deliverers' Union Bulletin, March, 1971]

LOOKING AHEAD: HARD TIMES

(By President Carl Levy)

We are approaching the second year of our contracts with the Publishers' and Wholesalers'. The new increase is due the 31st of March, which also means under our percentage arrangement increased contributions into our Pension and Welfare Funds. These contributions are over and above the wages we have contracted for. We were hopeful several months ago in anticipating this increased amount in our Welfare Fund so that we could buy some extra benefits for our membership. We specifically had in mind a Drug Plan—being fully aware of the tremendous cost of prescription drugs to our membership, especially those members who have small children.

I was quite disheartened recently when I received a report from Joseph Baer, the Administrator of our Fund who told me that because of excessive claims against premiums and also because of large increases being asked for by Blue Cross, that the new monies that we will derive from the March 31st increase may have to be used to defray these extra costs. We may not be able to purchase any new Welfare benefits. I am sure that the members are quite aware of ever increasing medical and drug bills which are choking the average working man to a point where the only people who can afford to get sick are the very rich or the very poor.

SELF-INSURANCE

The outrageous costs of hospital and doctors' fees, etc., and the advantage that is usually taken of those who have medical coverage, by that I mean the fact that when a doctor finds out that you have a group policy as we do, his price mysteriously goes up. This is forcing our Union along with many others to start thinking of self-insurance. Whether this is possible or feasible at this moment, I do not truthfuly know, but I do know this if something is not done either through Federal legislation or through self-help on our part to protect ourselves against these people or groups of people, these so-called professionals, who are putting us in the unfortunate situation of never being able to improve our benefits. On the contrary, it might be possible that we may be forced to curtail benefits. Quite naturally, the Union will do everything con-

ceivable to make sure there is no curtailment of benefits, but I believe that every member should contact his congressman and ask his friends and relatives to do the same by asking his duly elected representative in Washington to do something about the medical profession's total disregard for the welfare of people who need medical care at reasonable and honest rates.

There has been discussion in the industry about the fact that the membership has not yet received the new contracts in book form. At the time of this writing, the contracts are at the printers and should in a matter of several weeks be distributed amongst the members. The reason for the delay, has been that quite a bit of new language was placed in the new contracts and many mistakes were found in the original galley proofs, and had to be corrected. I tell you this not only for your information which you are entitled to, but also to dispell rumors.

While I am discussing rumors, and in the process of disspelling them to your satisfaction I hope, I would also like to comment about another story that is becoming quite popular in the industry, which has come to my attention. I am talking about the rumor concerning Michael Alvino, our Day Business Agent, supposedly quitting his job with the Union to take a management job. Just the other day, I called Mike into my office and discussed this with him and am quite happy to say that he assured me that he is definitely not quitting. I also heard people say that I was leaving as your President to take a job somewhere with management. Let me say for everybody to hear, both membership and management that even though I may complain once in a while about this job, as we all do, I love being President of this Union. I can think of no job that management could possibly offer that would satisfy me more than representing the membership of this Union. I have no interest in quitting and come next November I will stand for re-election, God willing.

There are many expert politicians who will criticize me for discussing this type of rumor in my column, by saying "It's only a rumor, let it fade out, why expand on it by discussing it," but I feel that the membership has a right to know the true story of what is going on in their Union and amongst their officials. A rumor like this if not refuted can actually undermine the effectiveness of the administration in their dealing with the membership and with management.

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INTERNATIONAL LADIES' GARMENT WORKERS' UNION

AFL-CIO

1710 BROADWAY • NEW YORK, N. Y. 10019

LOUIS ROLNICK, Director
Welfare & Health Benefits Dept.
1700 Broadway
New York, N.Y. 10019

April 13, 1971

Mr. Max Fine
Roosevelt Hospital
Winston Room
428 W. 59 St.
New York, N. Y. 10019

Dear Mr. Fine:

Enclosed you will find a report of the experience of one of the young people of our organization which is pertinent to the hearings you are holding.

I hope, at the very least, his statement will be included in the record of the hearings.

Very truly yours,

Louis Rolnick
Director

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One does not become aware of the problems that face a family until a major illness occurs in one's own family. It did strike my family and I am writing to share with you the hard learned knowledge that one can not afford to be sick in this country. The hope that your Committee will be able to do something about this problem prompted my writing you.

On October 23, 1970 my father was felled by a stroke. One can imagine the emotional anguish that engulfs a family in the event of grave illness. It is not this anguish about which I want to write. It is the financial aspect of such a tragedy and the availability of appropriate services about which something should be done.

Before becoming ill my father was a carpenter. My mother is a sewing machine operator. Together they were able to support their family on a reasonable budget. Supporting their family of five, while not easy, was a task they faced happily knowing that a better future awaited them. For they have suffered more than enough. Soon after their wedding, World War II erupted. They found themselves in Soviet Concentration Camps, separated from each other by a few thousand miles. They were freed in 1943, reunited and returned to their native Poland at the end of the war. As many Jews they found that their past was entirely annihilated and their future was bleak. They tried to leave the country, but the Polish Government did not let them go. Finally with the liberalization of the Polish regime in 1957 they were able to leave. They went to France, hoping that soon they would be able to begin a new life in the United States. It was not until 1961 that they were admitted to this country. The beginning was hard, but little by little things improved. They sent one son, myself, through college;

their older daughter, now twenty years old, was accepted by the University of Chicago on almost a full scholarship; their younger daughter is an excellent student in junior high school. The future not only looked good but also they were proud of their children. A new life had begun, only to be interrupted by illness. This is where this ordeal begins.

My father was found unconscious in the hallway of his apartment building. It took the ambulance over 45 minutes to arrive. The minutes seemed years. Looking back one shudders how many lives are wasted because help doesn't come soon enough. He was then taken to a local hospital. After the diagnosis of a stroke was made, the resident doctor at the hospital very frankly recommended two things: first, to move him to another hospital because of the shortage of help and physicians, and second, while still at their hospital, to hire a private nurse just to do what the doctor prescribed- to clean his sweat and turn him constantly to prevent complications. Luckily we were able to find someone. The cost was thirty five dollars ($35.00) a night; during the day my mother stayed with my father in order to save money.

With the help of the Medical Department of the Workmen's Circle, of which my parents were members, we were able to find a doctor to sponsor us into a better hospital. There was, however, one catch. We had to wait for a bed. Meantime our worst fears were confirmed. Instead of improving, my father seemed worse. To add to this problem, the conditions in the hospital did not reassure us that he was getting the best of care. The nursing staff was grossly inadequate during the week, and even worse on weekends. We were very anxious to have my father transfered as soon as possible. Finally the word came.

"We have a bed, but it is a private room. If you want it, take it; if not, you will have to wait a little longer." Because of the situation we accepted even though it meant fifty dollars ($50) a day until a bed in a semi-private room was available. We transfered my father by ambulance (cost forty five dollars ($45), cheap because of special arrangements with the Workmen's Circle; otherwise it would be more that one hundred dollars) to a voluntary hospital. Even though the medical care was better than at the other hospital, the doctor told us to hire another private nurse. This time the cost was sixty seven dollars ($67) a night. Slowly, my father began to improve. But the doctor's prognosis was not encouraging. His right side was paralized, he could not talk and he had to be fed intraveneously. The situation was complicated by several infections, including a major infection of the urinary tracts from a catheter which forced the doctor, a neurologist, to consult with two other specialists- an internist and, due to my father's earlier heart condition, a heart specialist.

But slowly my father began to improve. Every advance was greeted by us as a ray of hope. At first he could sit up, then sit on the edge of the bed, then eat solid food, then feed himself with his left hand, finally stand up on one leg and sit down on a wheel-chair. He was by then almost two months in the hospital. Another search was about to begin. The hospital management told us "We don't take care of such cases; he must leave." But go where" The doctor recommended a nursing home. We knew he needed a lot of therapy, and we could not find any nursing home which had a full time therapist or a full time therapy program. The question of how to pay for it arose. At the same time the doctors presented their bills.

Because he was a member of the Carpenter's Union, my father had some coverage. Blue Cross paid for the hospital bill (except for the few days in the private room and the few nights for the private nurse). the union's self-insured program paid the doctor's bills up to $500.00. But the doctors' bills came to another $1000.00. This would wipe out the family's savings. A decision to apply for Medicaid was made. One would imagine that for a person like myself, a college educated, well-informed person, it would be easy. One finds out the requirements, fills out an application and the answer should soon be forthcoming. It is, unfortunately, not that simple. To find out the grounds for eligibility one has to call a number. When one calls the number, nobody answers. It is much easier to get an application. You ask the social worker at the hospital to give you one and she even will help you fill it out. Of course, she has a booklet but you have to be a lawyer in order to understand it. An then there are income requirements. Do you count your past income? your present income? your future income? Do we qualify?

Perhaps here I should stop for a while and reflect. My parents have always fulfilled all their obligations as citizens and they asked very little for themselves. And yet, here they were at a point where a decision whether the income is a few dollars over or not means a decision on whether a disabled person, with some hope of recovery, will have chance to get proper medical attention to be able to improve, or be permenantly condemned to be a vegetable and a burden to himself, his family, and his country. The resolution of the financial question was even more imperative since we had found out about the existence of an institution that specializes in this kind of problem and, moreover, is world-renowned. The

cost at the rehabilitation institute is $125.00 a day plus $80.00 a week for medical attention. Blue Cross does not pay for this kind of an institution. And of course my family would not be able to afford such a staggering cost. Finally Medicaid responded with a positive answer. Somehow my parents' income came within the allowable limits. One could say we were lucky, if one can say such a thing, that this misfortune did not happen six months later. New York State just revised its Medicaid regulations to make it even more difficult to receive this help. I doubt that under these new regulations my family would have been eligible. But at that time the news was greeted with relief because my father would be getting the best care available.

My father went into the rehabilitation institute and, despite some initial medical problems, continued to improove. Little by little he started to walk, with a cane. He can dress and undress himself, eat by himself. He even started to talk, at first "yes" and "no," and then some other words. And even though his right hand is still paralyzed, he is full of hope and the desire to improve. With his three word vocabulary and sign language he would say, "I'll be talking yet, I'll be writing yet with my right hand." We knew the doctor's prognosis; we knew that unfortunately his talking will improve very little over a long time, and that arm will never be well. But we can not stop being amazed by the spirit of my father, by his determination. And the whole family is just thankful that we did not put him into a nursing home where it would have been the end of my father, and instead found this wonderful place that could give not only help but also hope.

But yet another hurdle had to be crossed. Even a rehabilitation hospital has a point at which it has to discharge its patient. This

point has come to us. The doctor prescribed family life, where my father could be cared for by the family, be in a friedly environment and make some more progress. The alternative was a nursing home where my father would most certainly have a setback. There was no question of the choice; we want to take him home. But he needs constant supervision and there lies the problem. My mother had to continue working, for even though my father would receive Social Security disability benefits, it would not be enough to live on. I am now married and live some distance from home so my help is limited. My older sister still attends college, in Chicago, and we would not want to break up her future by cutting her education short. My younger sister is just too young to take care of a disabled person all day long, and besides she spends most of her day in school. The social worker at the hospital suggested that we hire an aide to stay with my father during the day. But this costs money too - one hundred and thirty dollars ($130.00) a week. We applied to Medicaid. Would they help us out? The answer was no. Seeing no other solution we applied to the New York Department of Social Services. They looked at my parents' income, and they said that they have enough to live on. True, if not for the need of an aide, there would be no need for any help. After all, with my father's social security and my mother working, nobody would starve. But with the cost of an aid the annual income would be reduced by more than ninety five per cent (95%), and can a family live on $500 a year? After all, my family spent more than a thousand dollars, exhausting all their savings. There was certainly nothing left to live on. My mother could stop working, and maybe go on welfare. The effect of living on welfare would be demeaning to such proud people as my parents. But worse, what

will be the effect on my father? Wouldn't he feel that his illness had destroyed the family? That he is a burden on everyone" That he is expendable" And my mother? Would not this be a complete break with the outside world" In effect she, too, would be condemned for life at home in a constantly depressing situation? After all she is, at the age of fifty three, a young woman. And my sisters? Will they have to shorten their education? Will my younger sister have to grow up in a home of despair? How will this shape her future?

This is not a rejection of responsibilities. It is an attempt to adjust to the problems of life. Is the hope to try to live some kind of normal life where my father could be surrounded by a happy family life; where everyone would feel that they have contributed their share; where my mother could contribute by bringing her hard earned money for food and other necessities; where my sisters could by continuing to bring their achievements home for everyone to share, wrong? This is the dilemma which we are facing now. And there is no solution in sight.

My father's discharge was postponed two times by now. The amount of money that Medicaid has paid to the hospital since the original date of discharge would have paid for at least twenty (20) weeks of the cost of an aide. But because this service is not covered by Medicaid, we are all losing money. The lack of appropriate facilities to accomodate the people who need medical help is shameful in a country of so many resources. The absolute waste of money because of lack of such facilities is absolutely staggering.

How much money was lost because one hospital did not provide adequate care; how much money was lost because of the wait in the voluntary hospital for Medicaid approval before being able to transfer my father to the rehabilitation hospital; how much money

was wasted by waiting for a solution to a ridiculous question of money. For it appears that money does stand in the way of medical care that should be routine. Money does add to the cost of the already unmeasurable human suffering. Can anybody do something about it?

There is not much that can be done for my father at this point. But this bill presented by Senator Kennedy, if it were in existence, would have prevented the extra suffering. I am hopeful that it will be passed soon, so that in the future no American family, when struck by such tragedy, would have to go through a similar ordeal.

To summerize then:

1. In spite of the fact that my father had some coverage by virtue of his union membership, the family spent $1000, exhausting its savings.
2. Accessibility of necessary service and facilities did not exist at the right time or the right place.
3. To gain access to those services that were accessible required the acceptance of charity and the debasing of the human personality involved.
4. To continue to provide for his needs require again acceptance of public welfare assuming public welfare is convinced that these services should be provided.

Senator KENNEDY. The subcommittee will stand in recess.

(Whereupon, at 1:40 p.m., the subcommittee recessed to reconvene at 2 p.m.)

AFTERNOON SESSION

Senator KENNEDY. The subcommittee will come to order.

We have heard this morning from some of the people of New York who have had bitter encounters with the health care system. We will hear first this afternoon from leading physicians and administrators who operate the health care system.

These men are in positions to rebuild the health services in this country. They are in a position to influence how much we have to pay for health care, and how far we have to travel and how long we have to wait for health care.

Most important, they are in a position to influence how good the care is when we get it. These men represent doctors, hospitals, and others who are the most valuable health resources we have in this country. To be sure, many doctors and hospitals have struggled to change the system, but progress is too slow. The crisis is overtaking us. We have relied on the insurance industry to bail us out—and pay the bills. Some of the industry—the enlightened part—has tried. But they've failed. And you and I have found that in the last analysis, we pay the bills and the insurance agencies are the richer for it.

Last night I visited some of the emergency rooms in New York City that are the first and last resort for hundreds of thousands of people in this city after 5 p.m. In King's County, Elmhurst, and Lincoln Hospitals, I saw people who had waited for hours in pain. I saw children waiting beside men in alcoholic or narcotic stupors. I say busy, harassed physicians and nurses who couldn't possibly be offering the kind of care they were trained to offer, given time and proper facilities.

In my mind, these hospitals are evidence of the trap we are in. They are evidence of how we've shut the people out.

Any system that can be so lacking in compassion must be changed. Whether lack of finances, lack of staff, or lack of concern causes the problem, the system must change. It must change to offer higher quality, lower cost, and more accessible care to all Americans.

We are pleased to have witnesses this afternoon who can testify to the nature and extent of the problem and how it can be solved. Later in the afternoon, because our concern is also with the people in the system, we will hear from more New Yorkers about their experiences with health care in the city.

Our first witness is Mr. Gordon Chase, who is head of Health Services Administration of New York, is also chairman of the Health and Hospital Corp. of New York, chairman of the Conference of Health Planning Agencies, chief medical examiner, New York City Department of Health.

STATEMENT OF GORDON CHASE, HEAD OF HEALTH SERVICES ADMINISTRATION, NEW YORK, N.Y.

Mr. CHASE. Thank you very much, Senator. I am glad you have come to New York City to see and hear at first hand evidence of

the urban health crisis which the mayor recently described to you last week in Washington. There is certainly a crisis at hand in New York City health services.

This crisis can only be intensified by cutbacks in public health programs that may be forced upon us by the State legislature's callous disregard for human needs.

But there are other dimensions to the urban health care crisis which have not surfaced in headlines. They must receive immediate and urgent attention, even though their ultimate solution may be well down the road.

We have in this country and in this city a severe maldistribution of health care resources. You need only travel a couple of miles to find 150 physicians serving a population of 233,000 in central Harlem and contrast this with the more than 4,000 doctors located on Park Avenue and its affluent side streets.

We have a fragmented and inefficient medical care delivery system. You need only count the number of specialty clinics in the outpatient department of a large teaching hospital, and follow a patient with more than one ailment through the maze.

We have, in New York City as elsewhere, too little invested in preventive care—and existing health insurance systems compound our folly.

We treat people in high-cost general hospitals who ought to be in lower cost ambulatory or long-term care facilities. Again, insurance patterns bear much of the blame.

We have galloping inflation in medical care costs and prices. It can be traced to the collision of growing demand with our limited supply of health manpower and services, but races on because of inappropriate utilization of facilities, gaps and duplications in services and inefficiencies that persist in hospitals due to the absence of meaningful cost controls.

All these problems interact. We are just beginning to realize that only when basic reform in the health care delivery system accompanies some form of universal health insurance can the problems be finally solved.

But no one knows better than this committee the difficulty of translating that understanding into workable legislation. Complex tradeoffs must be considered, each with political as well as economic, social and medical dimensions. All the problems cannot be solved simultaneously.

Thus, for example, the broader the benefit coverage under universal insurance, the better the redistribution of health services: low income groups gain access to the system.

The broader the coverage the better the efficiency that can be expected in the system: fiscal incentives favoring one kind of care over another for reasons unrelated to medical necessity—therapeutic over preventive, inpatient over outpatient, surgical over medical—would be reduced or eliminated. But the initial effect of broadened coverage and benefits is likely to increase inflationary pressures, because growth and redistribution of health care resources will be slower than the growth in demand for them.

The objective of controlling health care costs and prices inevitably conflicts with the objective of quickly redistributing and reorganizing services. Financial incentives to providers cannot be excessive; but universal coverage of consumers may not be enough to induce enough physicians to practice in urban ghettos or in rural poverty areas. New institutions like prepaid group practices will take time to develop.

Once Congress balances the competing demands for cost control, redistribution of resources, reorganization of services, and breadth of coverage, a host of operational questions must be resolved: mechanisms for reimbursement, means of financing, method of administration, types of incentives for providers, and for resources development. The politics of each issue are no less complex than the merits.

Our staff at the New York City Health Services Administration has been and continues analyzing the strategic and operational questions. I am certain of only one conclusion at this time: that President Nixon's proposal is grossly inadequate for the needs of New York City—and it is based upon those unique needs that I must judge the various plans that have been put forth.

As announced, the President's proposal is grossly inadequate because it requires coinsurance for families in the $3,000 to $5,000 income range. This is ridiculous in New York City. It contemplates inadequate cost control. It would appear to leave many workers uncovered at all. Finally, its incentives for health manpower development are designed more to subsidize existing training than to expand existing output.

A national health plan suited to the needs of New York City can certainly be constructed. Your bill, for example, attempts to deal constructively with our most pressing problems. I urge the Congress to hammer out a final bill and fervently hope it will.

But in the meantime we have got to do more.

Congress and the administration must not become so preoccupied with the inevitable debate on broad reforms that the entire health agenda languishes, and the urban health crisis becomes a disaster.

There must be urgent Federal attention to those primarily urban health problems like lead poisoning, rat infestation, narcotics addiction, and alcoholism which find their victims disproportionately among the poor in our congested urban ghettos. With narcotics addiction and alcoholism, the damage extends far beyond the patient himself to his family, to his neighbors, and, ultimately, into the very fabric of city life.

Right now these problems get insufficient attention from the medical profession and too little funding for research and treatment. They are not clinically interesting. Grant money flows in other, more glamorous directions. Even with research budgets tightening, some startling new surgical technique which helps one person in 100,000 attracts funds and attention, while a program that could help hundreds of thousands goes begging.

The United States ratified the definition of health articulated a quarter century ago by the World Health Organization; that health is not merely the absence of disease, but rather comprises the com-

plete physical, mental, and social well-being of people. The Federal Government makes a mockery of that definition with each day that it beggars programs like rat control, where New York City's successful effort now faces a $900,000 Federal cut; like lead poisoning where the city has already pioneered; like alcoholism, where we have designed a promising new program but need outside funding to make a real dent in the problem; like methadone maintenance, where a planned expansion commensurate with obvious need and proven success could be lost in a wave of false economies at the State level.

We need Federal help now for programs like these. That help need not await the longrun solution to the urban health care crisis.

We need Federal help now to increase the supply of health resources. That help need not await a comprehensive plan of national insurance and national reform.

We face a severe shortage of nurses, particularly in our municipal hospitals. Our Health and Hospitals Corp. has made some significant gains through creative recruiting, training, and job restructuring. But how much harder the job is than it needs to be: Federal spending for nurse training increased by only $3 million between 1966 and 1970—from $53 to $56 million.

In addition to chronic shortages of highly trained health manpower, we in New York share another problem with other cities. We have too many obsolete hospitals and too few nonhospital health facilities. About 15,000 of our 38,000 general care hospital beds are obsolete by Federal standards. So are 10,000 of our 25,000 nursing home beds. We have too few ambulatory and extended care facilities.

The major Federal program for construction of health care facilities—the Hill-Burton Act—has brought less than $10 million annually into the city. The cost of a single new hospital is many times that figure, and we are building six new hospitals plus numerous neighborhood family health care centers. Neither the city, nor indeed the State, can hope to generate the kind of funds that are necessary without severe, perhaps impossible strain. The Federal Government must step in with the help that New York and other cities need.

Another thing the Federal Government can do to make real progress pending final formulation of a national health insurance program is in the vital area of cost control.

I have testified before the Senate Subcommittee on Antitrust and Monopoly, suggesting that Congress consider replacing current reimbursement methods under medicaid and medicare with a method that explicitly encourages productivity gains in hospitals. This method I have termed "cost-minus." Hospitals would receive a prospective reimbursement rate based upon anticipated cost less a specific percentage for anticipated increase in productivity. The mechanism contrasts with traditional reimbursement of hospitals by third-party payers, public and private, which can be termed "cost-plus"—cost, plus immunity from any real cost control.

Having introduced such a change into medicaid and medicare, Congress could induce similar, simultaneous change in State-regulated insurance plans. In parallel fashion, Congress could install under medicaid and medicare a provision that per diem reimburse-

ment to hospitals be related to intensity of care furnished the insured patient. In particular, adjustment for length of hospital stay would remove the existing fiscal incentive for hospitals to keep patients too long in order to recoup the high costs that usually occur in the early days of hospitalization.

To sum up, there are steps Congress and the administration should take now in cost control, in health resource development and in support of urban health programs. They can be taken while the inevitable debate on national health insurance goes on. Each step will help solve part of a massive problem while the ultimate solution is shaped. And I can assure you that no one has a larger stake in that solution than the people of New York City.

Thank you.

Senator KENNEDY. Thank you very much, Mr. Chase. Do I understand that you support a form of national health insurance?

Mr. CHASE. Yes; I do.

Senator KENNEDY. And why do you think that that is the best means of meeting health needs?

Mr. CHASE. Well, I think the present system obviously is not working. There are people who need care who aren't getting care. It seems to me——

Senator KENNEDY. Why don't we just reform the insurance companies and let them do it?

Mr. CHASE. I think once we start talking about who should administer the program this is frankly a very, very tough one for me, because I can see some problems in whoever you have actually administering the program. I am not sure the insurance agencies are the correct mechanism right now, and yet at the same time——

Senator KENNEDY. Certainly their record over a period of time has been weak. They have been in this field for 40 years. They are paying only a third of the medical bills.

Mr. CHASE. I would agree with that. I would agree that is weak, but yet at the same time if you look at some of the public sector programs that operate, say, under medicaid and medicare, I am not particularly happy with the way those have been operating either.

Senator KENNEDY. What about social security? Doesn't that operate pretty well?

Mr. CHASE. I would guess, not being terribly acquainted with it—I really can't comment on it. But I think what we have got here is that I am very unhappy with what is going on right now. I am not happy with any of the insurers, either public or private. I think that some sort of national health insurance which insures real coverage for all of our people which would also include some real elements of cost control is something we have just got to have. What we got now just doesn't work.

Senator KENNEDY. With some quality control?

Mr. CHASE. Absolutely.

Senator KENNEDY. Cost and quality control. You have outlined I think really very well what steps can be taken to attempt to achieve that prior to the time of implementation of any kind of insurance programs.

Mr. CHASE. Well, one of the problems that I really have, and I am trying to stress is this debate has got to go on, it is going to take time, and it is terribly important, and the faster we can get to some sort of national insurance scheme as far as I am concerned the better that is going to be. At the same time in New York City I just take one problem which maybe you call it a health problem, you call it a social problem or whatever, like drug addiction, which just isn't going to wait. And in the end while a lot more can be done with the kinds of funds we have, a lot of the answer is simply more resources.

Senator KENNEDY. What about alcoholism as well?

Mr. CHASE. Absolutely.

Senator KENNEDY. I am sure you are as distressed as I am, in spite of the fact that we authorized—I think it was close to a hundred million dollars this year. Yet there wasn't one cent in the administration's budget request for alcoholism.

Mr. CHASE. I am terribly distressed about that.

What we have done in the past month, we have announced the program that we are going to undertake in New York City to set up some subsystems to treat alcoholism in the city, which is an immense problem, and once again we are running smack into the problem of funds both at the State and Federal level. And we are going to have to scratch and scratch, and if we are lucky maybe we will get enough money to run programs that will take care of 10,000 people, and we have got a problem that is in the area of 300,000 people in New York City. And I think it is a disaster that the move that the Congress made has not been implemented by the administration.

Senator KENNEDY. Well, you have covered a wide variety of inadequacies of Hill-Burton. You are very well aware we changed that formula to provide an element of need in the Senate, and the House refused to budge on that. Without this it worked to the disadvantage of many of the urban areas. And the veto of the Hill-Burton Act of last year, and the veto of HEW appropriations last year had a significant impact in terms of health manpower. There are also inadequacies in the number of nurses we turn out of nursing schools—the nursing school authorization expires this year, and I hope we can change it. But these are all elements of this crisis as well, and I think you have commented on them very validly. I want to thank you very much for your statement and appearance here today.

Mr. CHASE. Thank you.

Senator KENNEDY. Our next witness is Dr. Lowell Bellin, first deputy commissioner, New York City Health Department, former health commissioner of Springfield, Mass., and associate medical director of the Health Insurance Plan of Greater New York, a board certified physician specializing in internal medicine. He has been invited here because of his efforts regarding the quality of health care. You are generally recognized as one of the real experts in terms of quality health care, and this is a feature that we are particularly interested in your comments on.

STATEMENT OF LOWELL E. BELLIN, M.D., M.P.H., FIRST DEPUTY COMMISSIONER, NEW YORK CITY HEALTH DEPARTMENT

Dr. BELLIN. I hope that my background of Massachusetts won't terminate this interview.

Senator KENNEDY. No, I think that perhaps gives you some additional standing.

Dr. BELLIN. Rather than read my statement, you have a copy of it—I thought——

Senator KENNEDY. We will put it in its entirety.

Dr. BELLIN. I thought I would deal with it on an extemporaneous basis.

I want to focus on one extremely important item that Mr. Chase brought up. That was the question of quality cost control. You have that in No. 6 on the sign up there. And while the other five are quite important, I think it is appropriate to point out that without quality and cost control the other five are worthless.

I want to share with you some experiences we have had in the medicaid program.

As you may be aware, about 20–25 percent of the national expenditure in medicaid is poured out in New York City, anywhere from $700 to $750 million a year.

About 4 years ago I was plucked from relative obscurity as associate medical director of the Health Insurance Plan of Greater New York and appointed director of the medicaid program for New York City. I had the responsibility to promulgate, monitor, and enforce standards of quality of care. The entire problem of assessing the quality of care, i.e., of assessing an abstraction called health services is an extremely new type of endeavor for any health department, and our department has been very much preoccupied with the problem for the last few years.

As we began taking a look at some of the expenditures we were amazed to find that there were some extraordinary bills being submitted by different practitioners. We found physicians submitting bills anywhere from $8,000 to $15,000 a month. These were esoteric cases, to be sure, but they were coming in. We had a group of 11 dentists who were submitting bills for a million dollars during the first year or so of the program. And I can share similar stories with respect to some of the other professions as well.

Now the fact that the bills were quite high didn't necessarily suggest any wrongdoing, but it meant we ought to take a look at what was going on.

We began reviewing these bills, and we sent in members of our staff, physicians to physicians' offices, dentists to dentists' offices, podiatrists to podiatrists' offices, optometrists to optometrists' offices, and to the pharmacies.

I think it is worth pointing out that one result of this program was that the American Medical Association passed a resolution against the activities we were carrying on where we were making these onsite visitations in an attempt to assess quality of care.

As we looked at some of these things we found some things that were going on that were quite disturbing.

We called in about 1,300 patients who had received dental services in an attempt to assess the quality of dental work that they had received. There I would point out that it is technically feasible to assess quality of dental care. Anyone in this room, for example, if examined by any one of the 42 dentists on my payroll will soon learn, within 10 or 15 minutes, what is the quality of the dentures, what is the quality of the fillings that he has received during the last 4 or 5 years. And we found as we called in these 1,300 people, that 9 percent of the patients had received a quality of care that would have resulted in the immediate flunking out of any dental student who would have tried to perpetuate this quality of work. For another 9 percent we could not ascertain the care at all in the mouth because simple fraud had been carried out. We had been billed for work that in fact had not taken place.

And in dollars and cents values about 25 percent of the dentures that we found in another study we concluded represented overutilization, i.e., services performed without either therapeutical or preventive justification.

So that we had this troika of abuse: We had (1) poor quality; (2) fraud; and (3) overutilization.

Senator KENNEDY. Who causes the overutilization?

Dr. BELLIN. The primary source of overutilization is the professional, not the patient. I know very often the statement is made, and with very slight justification, that there are patients who go from doctor to doctor wasting time—there are patients who go from optometrist to optometrist collecting glasses, patients who go from dentist to dentist collecting false teeth and presumably putting them in a drawer. I would say there are some patients like that, but from the standpoint of actual expenditure of any publicly funded program, these are very small potatoes indeed. The major portion of overutilization I think has to be laid in the offices of the professionals.

And I want to quickly say this: The total number of professionals who are carrying on such abuse is a very small number. The majority of professionals are recent, excellent, prudent men who are trying to do a good job. Our working statistic based upon 4½ years experience in this town is that only about 5 to 10 percent of the practitioners represent abusers.

It is necessary, therefore, in a program of this magnitude, or any programs of even expanded magnitude such as those that you have introduced, and your colleagues have introduced, in the Congress, to inculcate as an indispensable portion of this program, some sort of structure of quality and cost control. To have this you have to have a kind of structure which in no way is vulnerable to pressure either on the part of the institutions or on the part of the professionals.

We have had enough experience now in medicaid and in medicare during the last few years to indicate that current techniques, that have been accepted as appropriate in the last 5 years, are

simply inadequate. I don't think the best friend of Blue Cross, for example, would dare to make the claim today, at least after the recent investigations in the Congress, that Blue Cross has done as good a job as it might have. Blue Cross as fiscal intermediary in medicare has not imposed on the type of constraints necessary to prevent a variety of abuses.

We have hospital utilization review committees who are not carrying on hospital utilization review in the way we would like it to be carried out. If there is any doubt about the veracity of this statement, all you have to do is review the statistics of length of stay of specific diagnoses pre- and post-medicare, and you will find as you go from diagnosis to diagnosis that there has not really been a holding of the line that we would expect there to be.

Senator KENNEDY. What do you mean? Can you expand on that?

Dr. BELLIN. Well, yes. One can put down a statistical bell-shaped curve as to what the normative length of stay is for a specific diagnosis, whether we are talking about a coronary occlusion, a peptic ulcer without complications, or a case of cystitis or kidney stone, etc. These typical diagnoses correspond to a statistically specific number of patient-days of hospital care. Now it would seem reasonable that if hospital utilization review committees, composed of physicians on the staff who are presumably monitoring these cases properly in their hospital, are doing the proper job, you ought to be able to demonstrate this with statistics that the number of hospital days are either being held to what they used to be or are being actually cut down. But actually you don't find this at all. As a matter of fact, when you go from hospital to hospital in New York City, you will find people remaining in the hospital for the same diagnosis for statistically significant different lengths of stay—2 days, 3 days longer. You may see an 8-day total for a particular diagnosis in one hospital, that may go up to 10 or 11 days in another hospital.

Based upon your own statistics, we have right now in 1971 a hospital per diem of over $135 to $140 per day—this adds up to an extraordinary amount of the public treasure.

How can one really expect doctors in hospital "A" to check doctors in Hospital "A," remaining within the same network of consultation and referral of patients as they do? It is just inconceivable that you have that type of situation.

Senator KENNEDY. Some witnesses have said that this amounts to almost a conflict of interest.

Dr. BELLIN. It is a conflict of interest; clearly is a conflict of interest in my view. At the very least, you should have doctors from Hospital "A" check doctors from Hospital "B." That arrangement at least would establish an arm's-length relationship between the evaluators and the ones carrying on the operations.

Senator KENNEDY. Do you think we have too much surgery being done in this country?

Dr. BELLIN. I think we have, yes.

Senator KENNEDY. Why do you think this?

Dr. BELLIN. Well, I think so for two reasons. You have a fee-for-service system which provides a built-in incentive for productivity. I think that's fine as far as it goes. I think that at the same time you need to have somebody watching this productivity to see if this productivity is necessary. We don't have this kind of guard, we don't have this kind of guardian.

I think the grievance committees of the medical societies do a good job, but don't go far enough into case finding. They only review those cases where there are complaints brought to them. If you review the typical work of any grievance committee of a medical society you find that the major portion of their work represents cases referred to them by third-party payers or sometimes patients where there is an interpersonal clash between the patient and the physician.

I don't believe that grievance commitees carry out whitewashes. I think they do an honest job. What I am saying is this: At least four out of five cases at least based upon our statistics in medicaid during the last few years here in New York City, never are brought to the attention of grievance committees.

You have to have somebody at arm's-length relationship to the person carrying on the services. You have to have somebody who is accountable to the Federal Government, to the funding agency. You have to have a public agency do this.

If you don't believe in this, then I would suggest that to maintain intellectual integrity the Government ought to abolish the FCC and turn over regulation of the communications industry to CBS and NBC.

Senator KENNEDY. Do you think the consumers can have any assurance about the quality if we just continue with the present system?

Dr. BELLIN. No, they cannot. I would say this without any qualification. They will get no more quality than they are currently getting. The major increase in quality that has taken place, I would say, in the last 10 or 15 years has been as a result of increased training and board certification that physicians have received throughout the country. I think this has trickled down to the population and there has unquestionably been an increase in quality. But I think that unless we are prepared to face a plateauing out of quality we must introduce administrative enforceable techniques of quality and cost control.

I point out that American industries have had this for a number of years. It would be inconceivable for Anaconda Copper or Union Carbide to turn out one ingot tomorrow without having quality control engineers on their staffs. Why should health services be any different?

Senator KENNEDY. How would you characterize the general kind of health care that Americans are receiving now in terms of quality?

Dr. BELLIN. It depends what socioeconomic class you belong to, Senator.

Senator KENNEDY. Does it? I mean are rich people getting good quality?

Dr. BELLIN. Rich people get better quality than poor people.

Senator KENNEDY. Are they getting good quality?

Dr. BELLIN. I think in general they are getting good quality because they can afford it. I am not saying it is true in all cases. I happen to have a rich aunt; as a matter of fact, she doesn't get good quality.

Senator KENNEDY. Does it mean necessarily because they are paying for it that they get it?

Dr. BELLIN. No, there is no guarantee. But the brief anecdote about my wealthy aunt is she goes for her anemia to a doctor who has a nice big office on Park Avenue. As a matter of fact, I am not happy with the quality of care she is receiving despite the fact she can afford to pay for it. What I am saying, if this particular physician whom she is going to were subject to periodic analysis of the quality of work he was doing to a greater extent than takes place in a hospital—I am aware of the fact we have tissue committees, I am aware of the fact we have chart review committees. I have served on such committees myself when I was in practice as an internist in Massachusetts. But I am saying that this is not enough. You have to have a government-supported type of quality and cost control or you are going to throw money down the rathole.

Senator KENNEDY. Do you think physicians are prepared to reform themselves?

Dr. BELLIN. I think with the help of government they will reform themselves.

Senator KENNEDY. Thank you very much.

(The information supplied by Dr. Bellin follows:)

REAL QUALITY AND COST CONTROLS IN NATIONAL HEALTH INSURANCE ARE NOT EXPENDABLE!- THE PAINFUL INSTRUCTION OF N.Y.C. MEDICAID

by

LOWELL ELIEZER BELLIN, M.D., M.P.H.
FIRST DEPUTY COMMISSIONER
N.Y.C. DEPARTMENT OF HEALTH

Since graduation from medical school in 1951 my career resume has included 4 years of academic medicine in teaching hospitals, 4 years of traditional fee-for-service solo practice in internal medicine and cardiology, 2 years of military medicine in the Air Force, one year of hospital medicine within the context of socialized medicine in Israel, one year of prepaid group practice in The Health Insurance Plan of Greater New York, as well as a total of nine years of public health and health care administration successively as Springfield, Massachusetts Health Commissioner, Executive Medical Director of New York City Medicaid, and First Deputy Commissioner of the New York City Department of Health.

Such an odyssey from system to system to system forces one to jettison tranquilizing notions that any single system is a panacea. Rather, one concludes that every system of delivery of health care services cries out for its own appropriate technology of administrative quality control and cost control, if that system is to operate optimally. The fact is that today every system lacks these controls and, accordingly, no system is operating optimally. But, no longer can we afford naive dependence on the internal workings of our favorite system to deliver care of excellence, frugality and accessibility particularly as the country moves toward a national system of health care delivery.

Fee-for-service as the method of reimbursement to practitioners carries the danger of service overutilization fostered by practitioners, for piece work payment is the traditional incentive par excellence to insure high productivity. Salary as the method of reimbursement to practitioners in prepaid group practice carries its own danger of service underutilization fostered by practitioners, for the physician will receive the identical salary whether he performs many or few services. Whereas in the fee-for-service system the patient faces the danger of unnecessary surgery, in the salaried system, the patient faces the opposite danger of not receiving the necessary surgery at all. Neither system, then, offers a guarantee of high quality care. The patient remains dependent on the individual conscience of the professional. Medicare and Medicaid should have proven even to the most skeptical that professional conscience, as indispensable as it is, must be supplemented by operative accountability of the professional to the public agency that pays the bills.

There is no point in rehashing what all of us here know -:

(1) how, in Medicare, Blue Cross and Blue Shield as fiscal intermediaries had but little effectiveness in constraining institutional and professional abusers;

(2) how, in Medicare, hospital utilization review committees in fact failed to constrain hospital utilization; unjustified length of hospital stay and unjustified use of consultants continue to plague the program;

(3) how, in Medicaid, with but few exceptions - in New York City and in California there has been an outrageous failure of nerve in controlling abuse of this socially indispensable program.

Consider the experience of the New York City Health Department with respect to Medicaid: -

> "Quality Control - a system for verifying and maintaining a desired level of quality in a product or process by careful planning, use of proper equipment, continued inspection, and corrective action where required".
>
> - p. 1175, The Random House Dictionary of the English Language. The Unabridged Edition, 1967, 1966

The New York City Health Department has had one of the few real programs of quality and cost control of Medicaid health services in the country. Such controls are indispensable to protect the patient from biological peril, the taxpayer from piracy, and the typical practitioner from unwarranted smear. Without defensiveness the Department has perpetrated a number of unconventional

things that have disconcerted public health professionals, irritated the leadership of the professional societies, and positively scared the abusers of Medicaid:

1. The New York City Health Department promulgated an administrative regulation compelling health practitioners participating in Medicaid to take a minimal number of hours of continuing education in certified courses with records of attendance - 50 hours per year for MD general practitioners and 25 hours per year for dentists, optometrists, and podiatrists. In other words, the Department insisted that the professionals of the learned professions keep on learning, even after they get their licenses to practice. A glorious renaissance of postgraduate education burst forth in New York City thereafter, culminating only when the local dental societies collaborated to bring injunctive proceedings against officials to scuttle the program.

2. The New York City Health Department with the assistance of technical advisory committees of the professionals stipulated specific standards of care as a prerequisite for Medicaid reimbursement. Among other examples, the Department laid out staffing patterns in outpatient departments, defined the ingredients of an optometric eye examination, rejected certain medications as non-therapeutic and therefore non-reimbursable, and established time norms for certain health services. In short, the Department began to spell out precisely what it would and would not pay for.

3. The New York City Health Department monitored the quality of Medicaid health care. The Department actually examined the dental care that patients had received from private dentists under Medicaid. Similarly the Department referred samples of patients who had received optometric services to the Optometric Center of New York, and patients who had received podiatric services to the M.J. Lewi College of Podiatry. At these academic institutions the quality of health

services was assessed in accordance with Departmental standards. For the first time in history a health department was applying numerical measurements to what goes on in private offices.

4. Maintaining a policy of disclosure, Dr. Mary C. McLaughlin, Commissioner of Health, periodically released to the Senate Finance Committee, to the New York State Joint Legislative Committee on the Problems of Public Health, Medicare, Medicaid and Compulsory Health and Hospital Insurance, and to the mass media, data generated by these evaluative studies. The City Health Department acquired few new fans among the practitioners for this frankness.

5. The New York City Health Department launched an unprecedented program of onsite visits to the offices of private practitioners in order to appraise the quality of ambulatory care rendered in private offices. What cheekiness was this? It was this last outrage that provoked the AMA denunciation.

TRADITIONAL TECHNIQUES

"Quality Control" - a conventional concept in American industry - is now beginning to slide off the tongues of physicians, hospital administrators, legislators, and public health officials alike, who have become less and less self-conscious about applying the term to the abstraction called health service. If a steel mill can dispassionately check samples of batches of alloys for appropriate mixes of ingredients - and subsequently to modify its metallurgic processes in response to these findings - why shouldn't institutions like hospitals, for example, do the same thing, i.e. assess the quality of care they are rendering to their patients?

As a matter of fact to a limited extent, they do - and have done so for decades.

Tissue committees in hospitals review pathological diagnoses of tissue specimens removed by the surgeon during the operation in order to certify that

the original surgery was justified - that the microscopic findings of the tissue confirm the surgeon's preoperative diagnosis in a reasonable percentage of the cases. Clinicopathological conferences routinely held at most good hospitals critically analyze the quality of diagnostic and therapeutic procedures that failed to save the patient. Samples of medical charts are periodically pulled from the files and are subject to the scrutiny of one's staff colleagues at many hospitals today in the United States. Moreover, every County Medical Society has some type of organizational mechanism whereby aggrieved patients or insurance carriers can refer complaints against allegedly errant physicians for investigative review.

Well, what's wrong with these traditional mechanisms to protect the public from the small percentage of unscrupulous or incompetent practitioners? The answer is simple. As recent headlines on Medicare and Medicaid testify, the methods just have not been effective enough.

OPTIONS OTHER THAN GOVERNMENTAL QUALITY CONTROL

Then why not assign the task of measuring and maintaining quality to commercial health insurance companies? Why call in government? Here the answer is simpler. Despite eloquent pieties at officers' annual banquets, insurance companies really shudder at the thought of entering this technical and political thicket. They have always perceived themselves principally as indemnifying conduits of payment. Historically, they have abided by an aloof policy of hands off the provider of services. In the absence of outright fraud or flagrant overutilization, they have classified all licensed practitioners as acceptable for insurance payment. Certainly the private companies could never be accused of any morbid preoccupation with the subtleties of measuring, much less enforcing, quality standards of the health care that they have been financing with enormous sums of their clients' money.

Over the years Blue Cross has done a somewhat better job in quality and cost control. But, even here Blue Cross is regarded by the cognoscenti as fairly lenient in items such as permissible hospital admissions and length of hospital stay, both of which devour tremendous amounts of treasure. Federal officials confess disillusionment with either the will or the ability of Blue Cross to control abuse or maintain quality in the Medicare program. In Medicare Blue Cross generally acts as fiscal intermediary on behalf of government between patient and practitioner.

Why these attitudes on the part of insurance companies and Blue Cross? Is it because of the technical complexities of quality control? These are formidible but certainly not beyond human intellectual potential. In truth the issue is primarily political. The insurance companies and Blue Cross are simply not at all eager to escalate an adversary relationship with hospitals and practitioners.

Why not consumerism? Shouldn't community participation in hospitals and neighborhood ambulatory care centers be enough to watch over quality?

Right now the New York City Health Department is helping set up ambulatory care enterprises that are intertwined with vigorous community participation. It is important to mention this to identify the ideological credentials of the Department. The recipients of publicly funded services face disillusionment if they choose to place excessive reliance with respect to quality of health services upon community boards. The most aggressive community board in the country can address itself only to the amenities of health care, rather than to its technical excellence. This is not to denigrate amenities, such as accessibility to health care, comfortable waiting rooms, reasonable office hours, courtesy towards patients, etc. These amenities are indispensable ingredients of high quality health care services. But, to achieve technical

excellence such community boards must ultimately depend upon consultative assistance from professionals. It is here that the Health Department is potentially useful.

The only reasonable option is government - not to replace those quality control mechanisms that are in effect - but to buttress them.

PRO AND CON

The ideological position of the New York City Health Department vis-a-vis governmental auditing of publicly funded health care services was proclaimed in the Department's widely publicized paper presented at the annual meeting of the American Public Health Association in Philadelphia in November, 1969: "If it is obligatory for government to assess the quality of the bridges, and the lunar modules that it purchases with public funds from contracting providers, then it is analogously obligatory for government as consumer representative to assess the quality of health services that it purchases from professional and institutional providers of care. Accountability to the taxpayer as purchaser remains the irreducible issue.

"In short, the New York City Health Department remains unpersuaded by the July, 1969 nationally publicized resolution of the American Medical Association at its annual meeting placing the organization on official record as opposed to governmental auditing of quality care."

Actually Health Department auditing of health care antedates Medicaid. For more than a decade the Department has made periodic inspections of the quality of maternal and infant care services in the City's hospitals. Enforcement of standards has depended on the fiscal leverage the Department has been able to exert through withholding of federal funds - or in less elegant terms: "No quality. No money."

However motivated the altruists of Academe and the professional societies may be, the fiscal and political dynamics implicit in an operating social program like Medicaid are more energizing. Medicaid has already been forced to generate administrative techniques to establish, monitor and enforce the standards of health care. Health departments are legislatively designated under Medicaid to stipulate the standards of care. Health departments must also assess the quality of care to verify that the standards are not a dead letter. Health departments in the role of consumer advocate and protector must ascertain whether any of the troika of abuses exist: (1) fraud, (2) poor quality of services, or (3) excessive services, or what we call "overutilization." Fraud is fraud. Fraud alone should be subject to penalty. Poor quality? Excessive services? Does the practitioner know better? or is he incompetent? These latter irregularities need education at least until the practitioner has proven by his obstinacy that gentler techniques simply will not work. Only then should the practitioner be suspended from Medicaid - no light penalty, for Medicaid patients constitute a substantial portion of the practices of 25% - 30% of New York City's physicians, and over 60% of New York City's dentists, pharmacists, optometrists, and podiatrists.

It is axiomatic that operations must be isolated from evaluation. The Pope does not confess to himself. He goes to another priest. A professional society cannot by itself dispassionately audit the activities of its own peer membership. For optimal results the professional society must work in partnership with government. Health professionals working for government bear an obligation as public officials to make certain that taxes are not wasted. The majority of practitioners may be morally above reproach. Yet government has always been obligated to keep the aberrant minority of its population in check lest chaos result.

Would Health Department auditing endanger privacy and the doctor-patient relationship? Keep in mind that confidential information within or derived from hospital records is customarily seen by many people besides the patient's own physician: (1) consultative physicians, (2) nurses, (3) interns, (4) residents, (5) x-ray technicians, (6) medical record librarians, (7) clerks, (8) Blue Cross or commercial health insurance personnel. Even in the private physician's office, the nurse or secretary has access to the charts. Yet with all these eyes scanning intimate data, it is extraordinarily rare for the canons of privacy to be violated. Similarly health departments have always handled delicate information such as the identities of patients afflicted with venereal disease, tuberculosis, or narcotics addiction. To guard the health and the very lives of the patient and the community is the fundamental purpose of the Health Department's review and analysis of confidential information. The dangers of abuse of information in medical records by a health department are peculiarly remote in an agency that throughout its history has routinely processed hypersensitive data with no adverse consequences to privacy, confidentiality and doctor-patient relationships. It is worth recalling that the psychiatrists who deigned to answer the magazine questionnaire on Barry Goldwater's sanity were private practitioners - not health deaprtment staff.

MYTHOS AND FACTS

The question of the quality and cost of health services that the American people receives has always provoked polemic, apologia, defensiveness, and cant. The New York City Health Department has begun to collect hard data. The Department has concluded that fraud which grabs the headlines is actually the least important abuse in dollars and cents. It is also clear that but a small percentage of practitioner abuse ever comes to the attention of professional societies. Patients have referred only 20% of the total cases that the Health Department has investigated for possible practitioner abuse. Remember that professional societies depend almost exclusively on such patient complaints. Patients are notorious innocents. Ten years ago, 23% of the quality of surgical care and associated services for members of the Teamster's Union were judged inadequate by Dr. Raymond E. Trussell and his staff. Yet 80% of the people who had received these inadequate services insisted they were satisfied with the quality of the care. Moreover, professional societies lack the staff or resources to do case findings. At best they can review and recommend after the germane evidence has been gathered by an agency like the City Health Department.

But what about money? If real savings are to be realized, the Health Department must look into hospitals and nursing homes, where $600 million out of the $750 million Medicaid dollars are spent each year in New York City alone. Medicaid physicians in private offices received only $35 million dollars, or just 5% of the total City Medicaid expenditure. But this is not the entire story. Physicians, and only physicians, generally make the decisions (1) when the patient enters the hospital, (2) what services the patient receives, and (3) when the patient is discharged. There are financial consequences to each of these decisions.

Dentists on the staff of the New York City Health Department assessed the

quality of Medicaid dental care received by 1300 patients who came to the Department for examination in response to invitations sent to a total of 6,000. We had selected these 6,000 patients for particular study because their private Medicaid dentists had billed for high volume practices, or had provoked patient complaints, or had submitted questionable invoices. Therefore, these 6,000 cannot be considered a random sample, nor can the 1,300 who submitted themselves to our examination. The statistics derived from this group cannot properly be applied to the total Medicaid dental population, but they are sufficiently disconcerting to clamor for further studies. Of the 1,300 patients examined about 120, or 9%, showed evidence of fraud. In these cases there was no evidence that the dentist had performed the service for which he had billed the City. In another 120 patients, or 9%, the quality of dental work was execrable. The total of fraud plus poor quality was 18%.

Most recently we studied the quality of Medicaid partial and complete dentures, representing the most costly services in the entire dental program. Of the 498 partial dentures our staff checked, only 333, or 66%, represented satisfactory craftsmanship. Of 295 full dentures, a mere 167, or 57%, were found to be satisfactory. These depressing dental Medicaid data render grotesque the legal action of the local dental societies to block the Health Department's program of compulsory continuing education for Medicaid practitioners.

Our studies of quality in Medicaid optometry and Medicaid podiatry are no less provocative. This time the evaluating professionals were on the staffs of the Optometric Center of New York and the M.J. Lewi College of Podiatry, both academic institutions independent of the New York City Health Department. These alma maters of most of New York City's optometrists and podiatrists could hardly be accused of maximizing negligible abuses in order to compile an impressive critique. They followed protocol of audit and evaluation approved by the City Health Department.

Of 500 patients who received Medicaid care from private optometrists, only about 80% could be categorized as receiving completely satisfactory care.

In a similar patient sample the podiatric care received by only 61% could be considered acceptable. We have been particularly distressed by our statistics on the quality of podiatric moulds. In patients over 21 only 71% of the moulds were found to be satisfactory. The statistic was worse in patients under age 21, where it is obviously important for the growing foot of the child or adolescent to receive proper podiatric care. In patients under 21 only 58% received satisfactory moulds.

Statistical buffs will immediately demand control data. Where are the analogous data on comparable non-Medicaid populations? How do we know that the Medicaid statistics are really so bad? Maybe they are no worse than what the non-Medicaid middle class customerily receives in private offices. We don't know for certain. We have always assumed that the middle class gets better care. The pertinent professional literature is curiously sparse on statistics on the quality of ambulatory care. Perhaps the New York City studies will generate such investigations if only in an attempt to refute them.

Dr. Osler Peterson, while on the faculty of the University of North Carolina School of Public Health, found that 55% of patients were not asked to undress or lie down during a physical examination. His studies of North Carolina physicians during the 1950's have their counterpart, at least partially, in the recent onsite Ghetto office visits under the direction of Dr. Florence Kavaler of the New York City Health Department. In general, Dr. Kavaler found inadequacy of office records and episodic and symptom-oriented care, with little attention paid to screening or prevention. She depicted the typical ghetto general practitioner as having limited access to specialists and hospitals but nevertheless compelled to carry an enormous practice. Interestingly she sprang to the defense of the Ghetto practitioner whom she described as "overworked by his patients, abandoned

by his colleagues who prefer delivering health services to the affluent, and patronized, criticized, and misunderstood by Medical Academe, the mass media, and the general public."

The preliminary statistics of Medicaid quality should trouble all but the irredeemably complacent. At the same time there is no need to panic. Upon completion of his formal education today, the average practicing physician, dentist, pharmacist, optometrist, podiatrist, etc. is more conversant in technical knowledge than his counterpart of 40, 30, 20, or even 10 year ago. Likewise the typical patient gets better technical care today than did his parents, or grandparents, albeit often with fewer such amenities as house calls or rapid accessibility to services. But there obviously remains plenty of potential to apply all this superior education of the practitioner. One may argue that rather than the quality of the individual practitioner, it is the delivery system of health services, or the number, kind, or distribution of practitioners that deserves primary attention. But programs of quality control address themselves to these matters as well.

It is the unusual practitioner who relishes a colleague's looking over his shoulder to judge the quality of his professional work. The practitioner is even less enthusiastic about such evaluation when the assessment likely to emerge may at times turn out to be downright unflattering. It is whimsical to expect otherwise. Contrary to the view of simplistic social critics this self protectiveness does not merely reflect the practitioner's covert contempt for the public good, or his pathological concern for the collective professional ego. Opposition to governmental auditions is not purposely malevolent, but rather quite human and quite natural. Recently, there has been evidence in New York City that health professionals are beginning to abandon their traditional touch-me-not elitism. The professional societies recognize that the masses are

no longer in awe and indeed are skeptical about the historic claims and privileges of professionals. On the other hand, professional excellence will never by nurtured by oppressing health professionals. People will not get better care if misled governmental administrators pandering to leveling elements in the population, gleefully give health professionals their comeuppance, and remain content to stop there with no follow up constructive program.

Our evaluative experience in Medicaid has convinced us that most practitioners remain dedicated to their patients' well being. Typical health professionals who care for the medically indigent work extraordinarily long hours often at physical peril to themselves in the Ghetto areas. To characterize as typical those despicable practitioners who mercilessly milk publicly funded programs is terribly unfair. More important perhaps, an exclusive and voyeuristic preoccupation with villainy diverts energies from realistic methods to improve health care programs. It is not mawkish to affirm that to the extent there exists a professional coterie in this country obsessed with considerations of excellence and practical compassion, a major portion of it can be identified in the offices and the institutions of practitioners who minister to the needs of the ill and infirm. Quality control of health services will expand size and distribution of this coterie and hearten those who would be disposed to cast their professional lot with it.

FINAL COMMENT

What generalizations derived from our experiences can we apply to proposals about expanding the scope of publicly funded health care services?

(1) No such program is complete without a public agency to promulgate, monitor, and enforce standards of quality and cost control.

(2) This public agency must be independent of the institutional providers of services.

(3) This public agency must be independent of the professional providers of services.

(4) This public agency must be accountable and responsive to the federal funding agency.

Without such an agency, our country is destined to replay the expensive and profligate health care scenario of the past 5 years.

Senator KENNEDY. Our next witness is J. Douglas Colman, who is president of the Associated Hospital Service of New York. Mr. Colman is also a member of the Federated Hospital Council, member of the New York State Health Planning Committee. Associated Hospital Service is a Blue Cross program of New York, and it is the largest in the country.

STATEMENT OF J. DOUGLAS COLMAN, PRESIDENT, ASSOCIATED HOSPITAL SERVICE OF NEW YORK

Mr. COLMAN. Thank you, Senator. I am glad you are here because we have certainly got some problems that need attention.

I associate myself in large part with the comments that Mr. Chase made. I think that it is good that you are addressing yourself to these problems. I don't envy you, sir, the job of sorting out what you do about them, but many of the things that I think need doing are the kinds of things that Mr. Chase was talking about.

Senator KENNEDY. Do we assume that association in regard to Mr. Chase's comments about embracing national health insurance?

Mr. COLMAN. Yes, we testified in favor of the bill in New York State, and I think the only reason it didn't pass is because large parts of industry and labor were afraid that it would impose an additional burden on employers and they would move to other States.

Senator KENNEDY. Well, if we had a national program——

Mr. COLMAN. That's right. That would even it out.

Senator KENNEDY. That's right. Well, you are prepared then to say that you——

Mr. COLMAN. Sure.

Senator KENNEDY (continuing). Support national health insurance?

Mr. COLMAN. It is a question of how you do it, because there's some very real questions.

Senator KENNEDY. Okay. We have had different testimony from Blue Cross down in Washington.

Mr. COLMAN. I am sure you did. They have a different problem. Let me just skip over the high points rather than read——

Senator KENNEDY. As I understand, of course, that is really because the various Blue Cross associations are virtually autonomous, aren't they?

Mr. COLMAN. Not in an operational sense.

Senator KENNEDY. Policy sense, though.

Mr. COLMAN. We have the right to make independent judgments, yes, sir.

Let me just skip through a couple of points that are different than the ones that Mr. Chase made.

I start off by saying if we are talking about the health of individuals and we only talk about taking care of the sick ones we are trying to bail faster than the boat is leaking. We have got to look

at the individual's responsibility for his own health. We have got to look at the environment.

But that isn't what we are here to talk about today, and I am going to the third one, the health services taking care of the ones that are sick. And there are four parts of that: trained manpower, physical facilities, adequate financing, and management. And I think in terms of those four the one in shortest supply is adequate management, because we don't have anyone really who is responsible for—except in a very few isolated situations—who is responsible for the delivery of a comprehensive set of health care benefits to a defined population. Everybody has a little piece of it, and one of the problems is that people fall down through the chinks. And that is one of our serious problems.

I would emphasize in a different way than Gordon did there are some things that can be done while we are going through the legislative discussion of how you get out a national health care program. One of them is to try to develop some consistency among Federal policies and programs affecting health. Not only at the Federal levels, but as these programs hit the State and local regulatory and administrative and health and welfare agencies and the providers of service, you look at the regulations and the laws themselves in some of these Federal programs and they are not mutually consistent. And the greatest need, particularly in the central city, is for considerate primary care; attempts to deliver such care on a mass basis with dignity and quality have been only rarely successful, and this is a tough job and nobody has any pat answers to it.

I think there are a couple of things that we can do now.

I was very disappointed when medicare was divided into part A and part B. This put some more steel into what I call the iron curtain between inpatient and outpatient care. This is another one of these disparities that take place when we ought to have a coordinated system and we don't. And I think medicare parts A and B split it apart further and kept it apart.

I think providers ought to be required to accept assignments under medicare. If we can't even get them to do that I don't know how we get at the problem of a reasonable delivery of a promised set of benefits in the near future.

The one point that I want to say in my words that I think is the same idea that Gordon was talking about in different words, if you just put a lot of new money into the health care system that probably will do the wrong thing. That's why I say I don't envy your job deciding how to do it. The artful thing is to do it in such a way that the development of manpower, the development of facilities, the development of management, and the development of financing comes in an orderly fashion so that it really improves the care of people. Nobody has learned how to do this on a mass basis that I have ever known of. And it is a tough job. But we sure have to keep trying.

I put in the committee record a little evidence as to what we have been trying to do to get people to pay some attention to the cost

aspect of it. It has built up slowly, kind of a historical record what we were doing in 1960 and what we are doing today.

And when we talk about changing this system we are talking about changes in the professional practice habits of some 200,000 physicians, 2½ million hospital employees, and probably an equal number of workers in other aspects of the health care field. You can't make these changes quickly, but I am not talking about more study. We know more about what should be done than we have ever really done anything about.

I would close by saying that one of the things that we have done here to try to have some impact on this is beginning January 1 we introduced a prospective reimbursement method. We told the hospitals beginning January 1 for 1970 this is what we are going to pay for the year 1970. There are 22 of them that are involved in a class appeal now against that judgment. Where it is going to go I don't know. But we are trying to defend our judgment as to what is a reasonable price for the care that our subscribers get.

I thank you for the opportunity of being here, Senator.

Senator KENNEDY. Well, thank you very much, Mr. Colman. How has Blue Cross increased in New York over, say, the last 5 years?

Mr. COLMAN. Oh, it has gone from about 7.8 million to 8.5 million.

Senator KENNEDY. I mean in terms of the funding of it.

Mr. COLMAN. Oh, the cost of it?

Senator KENNEDY. The cost of it, premiums on it. Have you had many rate increases?

Mr. COLMAN. Oh, sure.

Senator KENNEDY. Well, what?

Mr. COLMAN. There was one in 1964, there was one in 1969, and one is just being implemented now.

Senator KENNEDY. What dimension are we talking about?

Mr. COLMAN. The one in 1969 was a big one. It had to cover the period from 1964 through 1970, and that was 39 and a fraction percent, 39.8 I think.

Senator KENNEDY. And do you have any prospective increase now?

Mr. COLMAN. The one that is going in now is 17.8.

Senator KENNEDY. That is 17.8. When is that going in?

Mr. COLMAN. May 1.

Senator KENNEDY. Now I know over in your neighboring State of Pennsylvania they have had an increase, now they plan another increase next fall, I think.

Mr. COLMAN. I don't know. Well, of course, in Pennsylvania they have five different plans.

Senator KENNEDY. They have had three in the last 2 years, I believe.

Mr. COLMAN. Are we speaking of Philadelphia?

Senator KENNEDY. Yes. But this is going to be it now, your present increase, your May increase?

Mr. COLMAN. That is the best we can project for 1 year. Beyond that we have been unable to make any predictions. One of the things that will govern it will be the collective bargaining that

takes place between the hospitals and 1199 for the renewal of the contract in July 1972.

Senator KENNEDY. Could you tell us a litle bit about the people that are represented on the Blue Cross boards?

Mr. COLMAN. All kinds of people.

Senator KENNEDY. Well, how do you select them?

Mr. COLMAN. Try to find somebody that is knowledgeable in this field and can be considered to be broadly representative of some segment of the community, and try to get them to do some work for nothing.

Senator KENNEDY. Do you have representatives of the hospitals or hospital associations?

Mr. COLMAN. Yes, there are a few.

Senator KENNEDY. Do you have doctors on it?

Mr. COLMAN. A few. By law in New York no more than one-third of our board can be either physicians, hospital employees, or trustees.

Senator KENNEDY. I see. And what is the other two-thirds generally?

Mr. COLMAN. Labor and management generally. A few educators.

Senator KENNEDY. Okay, Mr. Colman. I appreciate your——

Mr. COLMAN. Sir, may I correct one thing? I got curious about that number that was on the board. It was mentioned this morning by the campaign manager for the unsuccessful candidate against Mayor Lindsay, and the implication was it was our average payment to voluntary hospitals. It happens to be our 1971 payment rate for the Mount Sinai Hospital. Our payments to hospitals vary a great deal depending on the scope of services they render.

Senator KENNEDY. Well, what is the cost then per patient day?

Mr. COLMAN. For 1971 I won't know the average until the end of 1971.

Senator KENNEDY. What is it for 1970? What was it the end of 1970, rather than taking the average.

Mr. COLMAN. Our rates are based on annual basis. So it is the same for the year. I have got so many figures I can't pull one right out of the air. But the weighted average of the big teaching hospitals in New York for 1970 was $111.86. For the not so big teaching hospitals it was $102.90. And for the smaller, you might call them community hospitals in New York City, it was $77.54. And for that same group—somewhat smaller, $78.14. And for the suburban hospitals, $73.98. Those are weighted averages for those groups of hospitals for 1970.

Senator KENNEDY. What are weighted averages? What do you mean by weighted average?

Mr. COLMAN. Well, it is a question of if you take the cost of the Cornell Medical Center with 1,100 beds and combine it with the cost of the New York University Hospital of roughly 600 beds you weight it in terms of the size of the two institutions. The cost of the large one times the cost, the cost of the small one times the cost.

Senator KENNEDY. How many Blue Cross plans do you have in New York State?

Mr. COLMAN. Seven.

Senator KENNEDY. Why do you have so many?

Mr. COLMAN. That's the way they started, and nobody has ever been able to get them to change.

Senator KENNEDY. Why can't they reform? Why can't you get them to reform themselves?

Mr. COLMAN. Well, there have been many suggestions that the upstate plans get together.

Senator KENNEDY. Do they have all these administrative costs, overhead costs as well?

Mr. COLMAN. Yes.

Senator KENNEDY. That is paid by the various participants, the subscribers?

Mr. COLMAN. Yes.

Senator KENNEDY. Don't you think they have a right to expect that these groups would get together so you wouldn't have this duplication and overlap?

Mr. COLMAN. Well, I am not so sure how much in that score would be saved, but I think they might be able to develop a greater effectiveness if they did. I have urged the upstate plans to get together. But like many things in New York State, a suggestion coming from New York City isn't very welcome upstate.

Senator KENNEDY. And meanwhile the consumers are paying for that, the fact that they are not prepared to do it.

Mr. COLMAN. There is another side of it. Rochester I think will argue that they have been able to do some things in Rochester because they didn't have to get agreement from all of the rest of upstate New York. And that's the problem.

Thank you, sir, for the opportunity.

Senator KENNEDY. Thank you very much.

(The prepared statement of Mr. Colman follows:)

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Subcommittee on Health

Committee on Labor and Public Welfare

The United States Senate

Statement
by
J. Douglas Colman
President
Associated Hospital Service of New York

April 14, 1971

Mr. Chairman - There is a yawning chasm between what is known about preventing illness and restoring health, and the universal application of this knowledge to the needs of people. This task has commanded the best efforts of many dedicated people over the years. These efforts have been hampered by indifference, self-interest or by underestimating the size and complexity of the problem. Thus, the attention you and your Committee are focusing on this gap is most welcome and timely.

The objective of optimum health for all individuals has three major facets. The first is knowledgeable and disciplined effort on the part of the individual himself. The second is the creation of a living environment conducive to health, adequate food, adequate housing, healthful air and water, etc. The third is reasonable access to high quality health services. It is primarily with this third aspect of the problem that we are concerned today. Anyone who thinks we have come close to achieving this goal for the total population, has his head in the sand.

From one who has spent his working life trying to make good hospital care more widely available, some observations may be useful.

There are four primary ingredients to modern health services. First, trained manpower, beginning with the teacher and laboratory scientist, on to the treating physician, paramedical staff, and to the supporting cadre of service personnel. Some segments of this manpower spectrum are in short supply, but almost all are poorly distributed in relation to the population needing care.

The second essential element of modern health services is physical facilities. Many of these, particularly in the central city, are obsolete from the standpoint of efficient operation. Even more importantly, in some sections of the country, budget stringency and lethargy have prevented an aggressive move away from custodial care.

The third essential element is adequate financing, which again has been inequitably distributed among the total population, and not always rationally directed to the programs of greatest potential for preventing and alleviating suffering.

The fourth essential element in the delivery of health services to people is management - management with sufficient accountability for comprehensive health services to a defined population, and a commensurate authority. This fourth essential element in the delivery of health services is in desperately short supply.

May I now suggest some of the most important next steps that can improve the health services people receive. The first is to achieve some consistency among federal policies and programs affecting health. We have Medicare, Medicaid, Aid to Dependent Children, Maternal and Child Health, Regional Medical Programs, OEO, Model Cities, Comprehensive Health Care Planning, Hill-Burton, the health activities of the Small Business Administration, not only at the federal levels but as these programs impact state and local regulatory and administrative health and welfare agencies and providers of health services. Each one of these programs has wholesome objectives, but their effect upon people as they receive or do not receive health care in a neighborhood is neither consistent nor cumulative. In other words, the whole, instead of being greater than the parts, is less.

Until some coordination among these programs can be achieved that is manifest to the person needing care, their fullest usefulness will not be attained. The great need, particularly in the central city, is for considerate, continuing primary care. Attempts to deliver such care on a mass basis with dignity and quality have been only rarely successful. Therefore, the provider unit which deals with people on a continuing basis, probably should be small, close to where people live and certainly should not be expected to assimilate within its limited management, the conflicting complexities of a morass of disparate public programs. Nor is amalgamation of federal financing any guarantee of consistent policy among federal programs.

Certain steps can be taken now. Real question can be raised about the present attempt to separate hospital, medical and related care in Parts A and B of Medicare. Providers under Medicare should be required at least to accept assignments from patients for the portion of their charges to be covered under Medicare. Unless this can be done under Medicare now, how can we ever expect any reasonable delivery of any promised set of benefits?

The attention of society must be focused not only upon the need for cost containment, but also on the sacrifices necessary to achieve it. Our last twenty years have taught us that facilities and services tend to generate where and when financing is available. This does not happen overnight, but one can now see the gradual and cumulative effect of reasonably adequately financed hospital care for much of the employed population, many years of underfinancing of health services for the welfare population, wild swings in the adequacy of Title XIX financing, and relatively generous reimbursement provisions under Title XVIII. Therefore, well before any suddenly adequate financing of care for the entire population, one must first mandate a method for determining the real public need for new facilities and services on some more objective basis than the demonstration of a waiting list for admission. Otherwise new money will generate more gadgets not more health.

In January 1964 we wrote to Senator Metcalf supporting the passage of such legislation in New York. I am told it helped to focus the Legislature's attention on this problem, although we have not yet made a dent on the problem of accumulated obsolescence. Several years ago an estimate was made of the cost of correcting the physical obsolescence of the general hospitals in the New York area. It came to more than $1 billion, today it is probably much higher due to today's construction costs.

Again, any national program to deal with this problem would not achieve its purposes unless the funds were consciously directed to the geographic areas of greatest need, and to the service programs most directly related to primary care. The mechanism to accomplish this result on a national basis does not exist, and probably could not be made to function with continuing effectiveness in less than two years. Without it, any massive infusion of new funds will stand a great chance of being wasted.

By pointing out these problems, I am by no means counselling inaction. I simply plead for action with conscious awareness of the need to time the introduction of changes in the four essential elements of health services - manpower, facilities, money and management - so that the desired result is accomplished and not some unanticipated, ineffective monstrosity.

When we speak of change we are talking about changes in the professional practice habits of some 200,000 physicians, some 2 1/2 million hospital employees, and probably an equal number of workers in other aspects of the health care field. Such changes are not accomplished quickly, but I am not talking about more study. There are more facts available on which to base action than there is willingness to act.

Some idea of the efforts we have made over the past eleven years to alert the public and governmental bodies to these problems is shown by the material I have filed with the Committee for the record.

In 1960 we had simple, sample data from 44 major hospitals in the area. In 1961 we got more detailed data which we were able to use in 1964 to secure the statutory authority already referred to above. By 1965 we could clearly identify the serious underfinancing of all hospital patients except those covered under our service benefit program, and especially for public charge patients. Incidentally, the total amount of underfinancing of public charge patients was about equal to the total of plant obsolesence. By 1967 we were able to identify for the National Conference of Medical Costs the extreme variation in costs among

reasonably comparable institutions.

By 1970 we were able to hold public meetings throughout our area to which consumer groups, legislators, management, labor, hospital trustees and medical staffs, were invited to look at detailed financial and service data of their hospitals and challenged to do something about it. As you can see from the exhibits, this included balance sheets, operating statements, service data, as well as available information on medical manpower in the area.

Effective January 1, 1970, we introduced prospective reimbursement, i.e. a rate determined at the beginning of the year within which the hospitals are expected to live, unless state regulatory authority has previously authorized some major change in the service program of the institution.

This cataloging of unsolved problems and efforts to do something about them, is no counsel of defeat. There is much than can, should, and must be done now.

Firsthand exposure to sick and sometimes bewildered patients, undoubtedly generates in you the same concern it does in me, namely that we not only do all we can to help but also that we hold out no false hopes. Confidence is an essential element both in health and in effective leadership of any public program. It is best generated and sustained by sound plans which are really promises that can be fulfilled.

Senator KENNEDY. Our next witness is Dr. Sidel, who is chief of the Department of Social Medicine and professor of community health of the Albert Einstein College of Medicine. Dr. Sidel has studied the health care systems in other countries, Great Britain, the Soviet Union.

STATEMENT OF VICTOR W. SIDEL, M.D., CHIEF, DEPARTMENT OF SOCIAL MEDICINE, MONTEFIORE HOSPITAL, AND PROFESSOR OF COMMUNITY HEALTH, ALBERT EINSTEIN COLLEGE OF MEDICINE

Dr. SIDEL. Thank you.

I appear before the subcommittee today because of an analysis which Dr. David Kindig—formerly chief resident in social medicine at Montefiore Hospital and now acting medical director of the Dr. Martin Luther King, Jr., Health Center—and I did of the 1970 national health insurance proposals. In this analysis, which we did for the Conference on National Health Insurance convened in Philadelphia by the Leonard Davis Institute of Health Economics of the University of Pennsylvania last November, we developed criteria for the impact of national health insurance programs on the consumers of medical care and described the ways in which the 1970 bills met or failed to meet these criteria. We believe the criteria we developed are important not only because they can help us to choose the legislation which will best meet consumer needs, but also because they will permit us later to judge whether the program adopted has had the desired impact.

Since time for oral presentation today is extremely short, I will present only the criteria.

Senator KENNEDY. We will have your whole statement printed in its entirety, in the record.

Dr. SIDEL. Thank you, Senator.

The reasoning behind these criteria is developed in a quite lengthy document which goes into each of the criteria in some depth, giving the background as well as the specific methods for bringing these criteria to bear on the proposals.

Senator KENNEDY. Will you make that report available for the files of the subcommittee?

Dr. SIDEL. It has been made available.

In brief, the criteria are:

(1) "Consumer participation and control:" (*a*) A national health insurance program should have provision for the consumer's voice to be effectively built into policy-setting; (*b*) The consumer's voice should be present at national, regional, and local levels; (*c*) Provision should be made for recompensating community representatives for their time and effort; (*d*) Provision should be made for professional staff to aid the consumer representatives in their policy recommendations; (*e*) Provision should be made for experimentation with different types of consumer participation and control, with appropriate evaluation of the effectiveness of the various forms tested.

I won't go through all of the specific criteria under (2) "Elgibility." Basically they add up to universal eligibility. In addition we believe that there should be merging of other financing programs into the national health insurance program and that there should be appropriate integration of other service programs into the national health insurance program.

Under (3) "Comprehensiveness and continuity of services," we believe that all personal health services should be covered; we believe there should be no arbitrary time limits on services, limits on number of services, or limits on total cost of services. We believe provision should be made for stronger linkage of the primary practitioner, the specialist, the hospital, and the aftercare facility. We believe emphasis should be placed on health maintenance.

Under (4) "Accessibility and availability of services," we believe there should be explicit protection of the right of all people to access to health facilities. As you know, this has not been true in many parts of the country in the past.

Under (5) "Costs," we believe there should be no out-of-pocket expense to the consumer at the time of need for care.

Under (6) "Quality control," we advocate specification in any bill of quality control procedures and the methods by which they may be made effective. We urge that quality control bodies be established at the national, regional, and local levels. Quality control bodies should include lay members as well as professional members, and there should be explicit methods for enforcement of quality control.

Finally, we advocate (7) "Research and demonstration projects in the health field."

Dr. Kindig and I, in analyzing the 1970 legislative proposals, found that the bills which best met these criteria for the impact of national health insurance on the consumer was the Kennedy bill, S. 4297, and the Griffiths bill, H.R. 15779. Your 1971 bill, S. 3, which includes many of the excellent features of the Griffiths bill, comes even closer toward meeting these criteria. If I may respectfully say so, it is far from a perfect bill and, if you would like, we can suggest some modifications we would like to see. But in our view, the cause of the consumer health care in the United States would be well served by the adoption of this bill or one similar to it which provides for new methods of health care provision for the United States rather than simply for new methods of financing care.

Thank you.

Senator KENNEDY. We would be very interested in your analysis of the legislation and what suggestions you would make in terms of improving it, and if you could make that available to us as a part of the record that would be enormously useful. We would be very grateful.

Dr. SIDEL. We shall try to prepare that analysis for you.

Senator KENNEDY. Thank you very much.

(The prepared statement of Dr. Sidel follows:)

STATEMENT PREPARED BY VICTOR W. SIDEL, M.D.

FOR PRESENTATION TO THE SUB-COMMITTEE ON HEALTH OF THE UNITED STATES SENATE

ROOSEVELT HOSPITAL, NEW YORK CITY

APRIL 14, 1971

My name is Victor Sidel. I am Chief of the Department of Social Medicine at Montefiore Hospital and Medical Center and Professor of Community Health at the Albert Einstein College of Medicine. I have had training in internal medicine, epidemiology and statistics, and in the social sciences; my current professional work is in the area of the analysis, and planning for the improvement, of health care delivery. I have had extensive experience in the study of health care delivery systems in other countries, especially the United Kingdom and the U.S.S.R., and in the study of health manpower.

I appear before the Subcommittee today because of an analysis which Dr. David Kindig, M.D., Ph.D. (formerly Chief Resident in Social Medicine at Montefiore Hospital and now Acting Medical Director of the Dr. Martin Luther King, Jr. Health Center) and I did of the 1970 national health insurance proposals. In this analysis, which we did for the Conference on National Health Insurance convened in Philadelphia by the Leonard Davis Institute of Health Economics of the University of Pennsylvania last November, we developed criteria for the impact of national health insurance programs on the consumers of medical care and described the ways in which the 1970 bills met or failed to meet these criteria. We believe the criteria we developed are important not only because they can help us to choose the legislation which will best meet consumer needs, but also because they will permit us later to judge whether the program adopted has had the desired impact.

Since time for oral presentation today is extremely short, I will present only the criteria. The reasoning behind these criteria, and the analysis of eight proposed pieces of legislation by these criteria, can be found in the material which will be published as a Chapter in National Health Insurance: Proceedings of the Conference on National Health Insurance, edited by Dr. Robert Eilers and Mrs. Sue Moyerman, to be published by Richard D. Irwin, Inc., Homewood, Illinois, copies of which I will submit for the record of these Hearings.

The criteria are:

1. Consumer participation and control

   a) A national health insurance program should have provision for the consumer's voice to be effectively built into policy-setting.

   b) The consumer's voice should be present at national, regional, and local levels.

c) Provision should be made for recompensing community representatives for their time and effort.

d) Provision should be made for professional staff to aid the consumer representatives in their policy recommendations.

e) Provision should be made for experimentation with different types of consumer participation and control, with appropriate evaluation of the effectiveness of the various forms tested.

2. Eligibility

a) There should be no limitation of eligibility by age.

b) There should be no limitation of eligibility by area of residence or length of residence.

c) There should be no limitation of eligibility by social class or income.

d) There should be no limitation of eligibility by race, religion or political belief.

e) There should be no limitation of eligibility by pre-existing medical conditions or risk factors.

f) There should be merging of other financing programs into the national health insurance program.

g) There should be appropriate integration of other service programs into the national health insurance program.

3. Comprehensiveness and continuity of services

a) All personal health services should be covered.

b) There should be no arbitrary time limits on services, limits on number of services, or limits on total cost of services.

c) Provision should be made for stronger linkage of the primary practitioner, the specialist, the hospital, and the after-care facility, but incentives should not be limited to any specific form of practice organization.

d) Emphasis should be placed on health maintenance.

4. Accessibility and availability of services

a) There should be explicit protection of the right of all people to access to health facilities.

b) Provision should be made for the continuing investigation of the need for health facilities in each region and local area, and support should be available for their construction.

c) Provision should be made for the continuing investigation of the need for health manpower in each region and local area.

d) Support should be available for recruitment and training of existing types of health workers.

e) Special provision should be made for the development of new types of health manpower.

f) Provision should be made for encouragement of the redistribution of manpower.

5. Costs

a) There should be no out-of-pocket expense to the consumer at the time of need for care.

b) If there are to be out-of-pocket expenses they should be billed by the national insurance program to the patient; in no case should the patient be forced to pay the provider directly for services rendered.

c) If there are to be out-of-pocket expenses, there should be full protection against catastrophic expenses.

6. Quality control

a) The plan should specify quality control procedures and should indicate the methods by which they will be made effective.

b) Quality control bodies should exist at national, regional, and local levels.

c) Quality control bodies should include lay members as well as professional members.

d) Provision should be made for control over quality of care in non-covered institutions.

e) Methods of enforcement of quality control should include special incentives as well as methods for withholding payment.

f) Provision should be made for the support of development of more effective quality control techniques, including techniques for determining outcome or effectiveness.

7. Research and demonstration

a) Provision should be made for support of appropriate research into and demonstration of new methods for the provision of health services.

b) Provision should be made for review bodies, including both professional and laymen, in setting the priorities for assignment of the research and demonstration funds.

In analyzing the 1970 legislative proposals, Dr. Kindig and I found that the bills which best met these criteria for the impact of national health insurance on the consumer was the Kennedy Bill (S.4297) and the Griffiths Bill (H.R.15779). The 1971 Kennedy Bill (S.3), which includes many of the excellent features of the Griffiths Bill, comes even closer toward meeting these criteria. It is far from a perfect piece of legislation, if I may respectfully say so; but in our view the cause of the consumer of health care in the United States would be well served by the adoption of this Bill or one similar to it which provides for new methods of health care provision for the United States rather than simply for new methods of financing care.

Senator KENNEDY. The next witness will be Dr. George Himmler, president-elect of the Medical Society of the State of New York.

STATEMENT OF GEORGE HIMMLER, M.D., PRESIDENT-ELECT OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

Dr. HIMMLER. I have a prepared statement, Senator, and I will skim through it.

Senator KENNEDY. We will print it in the record.

Dr. HIMMLER. I appreciate this opportunity to express the views of my organization, a federation of 61 county medical societies in New York State.

We believe that a number of situations exist in the health care of the American people that urgently call for correction.

It is quite apparent, for instance, that the inhabitants of the rural areas and dwellers in the so-called inner cities do not have access to the quantity and quality of health services that their conditions require.

There is a substantial overall shortage of health personnel in all categories, and due to maldistribution, this shortage is particularly acute in the inner cities and in rural communities.

Institutional facilities available for care are inadequate, particularly facilities for extended care, custodial care, and home-care programs.

Finally, rapidly rising costs is one of the major causes for concern and is perhaps the most difficult to control.

The Medical Society of the State of New York firmly believes that the health requirements of the public must be met regardless of cost. At the same time, all concerned in meeting those requirements have the responsibility of assuring that all services are of high quality and that the costs are as reasonable as they may be under the circumstances, I emphasize the "all concerned" because, in our opinion, this includes legislators and program administrators as well as physicians and other providers of health services.

A program that is deficient in concept and poorly administered is beyond the power of even the most well-intentioned and devoted provider to implement effectively. I draw your attention to the medicaid program to illustrate and document this statement.

The rural areas and ghetto communities do not attract health professionals in any category, because of the conditions that prevail there. A low capacity for reimbursement is only one of a great number of factors. It seems evident that unless very special incentives are devised for all types of health-care personnel, the problems of these areas will not be solved until there is an oversupply of health professionals which is not likely in the foreseeable future.

At first glance, the most useful expedient to provide health care in these areas is in a clinic setting, but this has not proved to be an adequate solution. OEO clinics have been established and are useful, but they have not begun to fill the need.

The New York State Medical Society, therefore, has sought a way to involve private practitioners in the rendering of health care

in medically deprived areas. This requires that they be organized in some fashion and that there be a mechanism for the distribution of what payment is available for medical services.

The concept of foundations, or health-care delivery organizations, seems to us to be the most promising method of accomplishing this end. Foundations are nonprofit membership corporations of physicians which are authorized to collect either capitation or fee-for-service for care rendered by their members. They distribute these fees in a manner previously agreed on by their participating physicians. They provide a number of other services which I will describe.

One of the important characteristics of foundations is that they can act as intermediaries between Government, insurance carriers, and other funding agencies on the one hand, and groups of practicing physicians on the other, to create contracts for the health care of any specific segment of the population. They have the advantage, in our opinion, that they do not relegate the underprivileged to a special and inferior kind of care.

You are aware that capitation prepayment group practice delivery now enjoys great favor in Government circles as a means of delivering services of high quality, controlling their costs, and diminishing morbidity by periodic health examinations. I would like to make it clear that the Medical Society of the State of New York has no prejudice against such practice and does not oppose it. At the same time, the most ardent proponents of capitation prepayment group practice and health maintenance organizations admit that such organizations require costly facilities and that their claim to economy is based solely on their ability to control utilization.

We call the committee's attention to the fact that the majority of medical services are now rendered by physicians who are in solo or small group practice and who are reimbursed on a fee-for-service basis. In these times of absolute shortage, their skills, offices, and equipment are, in a sense, a public asset which must be preserved. It is unlikely that these physicians can arbitrarily and suddenly be shoehorned into a capitation, multispecialty group practice without disastrous effects on quality, cost, and availability of care, let alone the supply of physicians.

I would caution that capitation prepayment group practice has not yet proved that it can effect substantial economies if employed on a large scale. Under the circumstances, it would seem most prudent to let these two systems prove their relative worth, side by side, before moving abruptly and completely from what we now have to an, as yet untried, system. The foundation mechanism makes this possible, by assisting privately practicing physicians, to render services as comprehensive as those of any health maintenance organization. It also helps to relate private practitioners to capitation group programs, and could prevent the complete chaos that would result if such programs are given the preferential status that some current health insurance bills propose.

Now, Senator, I would like to depart from this text for a moment. I have described other activities of the Medical Society, and I

would like to consider this question of quality for a moment which we have heard a good deal about.

For a peer review or professional service review, or whatever we call it, we agree that peer review as it is currently being conducted is not entirely efficient.

We would also like to point out to you, however, that the medical profession has a well-proven capacity for self-criticism, and for effective self-criticism. This was going on even before Dr. Bellin arrived in New York. We have had tissue committees for many years. We have audit committees. Our utilization review committee does not function particularly well for one simple reason—we have nowhere to put the patients. If they are well enough to be discharged this represents no problem. If they require a transfer and if they still require some element of care and are not ready to return home we are often stuck with them for weeks while we look for a suitable facility in which to put them.

I think the major problem with review has been the fact that we have not automated it to any extent. There is not any data processing involved in it at this moment because nobody has yet developed good systems for doing so. And our Medical Society now is in the process—in the very active process—of developing data processing that will pinpoint where the deficiencies are; and at that time I have no doubt whatever in my mind that the physicians will be perfectly able to judge impartially and dispassionately where the errors lie and to correct it.

I will skip the rest of this presentation. If you have any questions I will be delighted to answer.

Senator KENNEDY. Thank you very much, and we will include it all in its entirety.

Now how is the person that just goes into a doctor's office and gets treated—how are they going to know whether they are receiving quality care or not?

Dr. HIMMLER. Very likely they do not know whether they are receiving quality care or not. But I might point out to you, I don't know how you go to your physician, but generally speaking you just don't drop into a doctor's office, someone with whom you are totally unacquainted. Generally you either find out how well he is liked in the community, what kind of practice he has, and so forth.

Senator KENNEDY. Now where is that? That certainly isn't in the major urban areas of this country and that doesn't exist in the rural parts of this country. What part of suburbia does that exist in?

Dr. HIMMLER. I practice right here in New York City and virtually none of my patients come in off the streets.

Senator KENNEDY. Have you been to Bedford-Stuyvesant; have you been to Harlem? Have you been to Charlton, Mass., or any of these rural areas?

Dr. HIMMLER. I have, indeed.

Senator KENNEDY. And how many of these people can call up a doctor when they need him?

Dr. HIMMLER. Virtually none.

Senator KENNEDY. And where does the error lie?

Dr. HIMMLER. Where does it lie? I think it lies in the situation that makes them what they are.

Senator KENNEDY. Who is pointing out whether it does exist or not? Is it the consumers who are weeping and crying in these emergency rooms at night or is it the medical association?

Dr. HIMMLER. The medical association has done its share pointing it out. I have.

Senator KENNEDY. And what is your view about it? Do you think we have a national health crisis in this country?

Dr. HIMMLER. I think we have some bad situations.

Senator KENNEDY. The President has said it, Secretary Richardson has said it, hundreds of thousands of people that we have seen in a lot of these centers have said it. What does your Society say?

Dr. HIMMLER. My Society says there are a number of bad areas that require correction. If you want to call this an overall crisis for the Nation I do not agree.

Senator KENNEDY. You don't think we have a health crisis?

Dr. HIMMLER. I think we have some health problems.

Senator KENNEDY. Just health problems when you have the increase in the health costs of this country now going up like that; when you have 700 people in the D.C. Hospital that go to the emergency room and never get any kind of treatment at all; when you go into the hospitals that we went into last night in the pediatrics wards and you see communicable diseases among these kids lying next to alcoholics—you don't think that there is a health crisis?

Dr. HIMMLER. I think these are all conditions that urgently require correction, as I previously pointed out. It is a crisis for that group without any——

Senator KENNEDY. That group. Isn't that America?

Dr. HIMMLER. It is America. That is why I am here and spending my time. These are the ones who are suffering. These are the ones who are pointing it out. What I would like to point——

Senator KENNEDY. What about——

Dr. HIMMLER. May I finish what I was saying?

Senator KENNEDY. Sure.

Dr. HIMMLER. What I would like to point out to you, there are large numbers of people who do not have a personal problem in finding good medical care and care of high quality.

Senator KENNEDY. What percentage of the American people?

Dr. HIMMLER. I would say the great majority. Certainly the great middle class and certainly the wealthy.

Senator KENNEDY. Oh, the middle class and wealthy, you think that is the majority of the American people?

Dr. HIMMLER. All right, maybe it is not the majority. Together they may be.

Senator KENNEDY. The middle class and the rich are the majority of people in this country.

Dr. HIMMLER. Where do you define poverty?

Senator KENNEDY. In terms of a person making $8,000, $10,000——

Dr. HIMMLER. Senator, we are off on semantics.

Senator KENNEDY. You think it is semantics.

Dr. HIMMLER. Yes, I think it is, because you particularly want me to say there is a crisis in this country.

Senator KENNEDY. I want you to use whatever characterizations you would like to.

Dr. HIMMLER. If you heard what I said in the beginning, there are grave problems here that require urgent solutions. I do not deny that, nor would I for a minute try to minimize it. I do not agree that we have done nothing about it as a profession. I have had my own disagreements with the AMA on this subject. I agree it is a problem of major proportions. Now whether we argue the word crisis or not I don't think is particularly productive.

Senator KENNEDY. You don't think it is. Don't you think you have to analyze the problem before you have——

Dr. HIMMLER. That is precisely what I finished saying.

Senator KENNEDY. The AMA and medical societies come down in a hum-drum attitude as they testify before our subcommittee, and how do you expect to get a sense of urgency about this question with a hum-drum attitude?

Dr. HIMMLER. What hum-drum attitude?

Senator KENNEDY. Well, the hum-drum attitude that was expressed by the AMA before the subcommittee. They are considering whether medicare is a worthwhile program. What do you think about that? Do you think medicare is a worthwhile program?

Dr. HIMMLER. I think it is a very essential program. I don't say it is a perfect one, but I think it is extremely essential.

Senator KENNEDY. What about medicaid?

Dr. HIMMLER. Medicaid is a tough one because medicaid is essential. Let me put it another way. The care that these individuals are getting under medicaid is essential. I think medicaid is one of the worst possible instruments for delivering that care that I have ever seen.

Senator KENNEDY. We have heard in terms of quality control that having doctors on these review procedures in various hospitals serve on peer review boards amounts to basically a conflict of interest. What is your reaction to that?

Dr. HIMMLER. Well, I happen to know how it operates, and my reaction to that is that this is not true. And let me elaborate for a moment.

I am an attending surgeon at a hospital. An attending surgeon is about as high as you get without being a chief. So that I am not way down in the echelon. Cases of mine are occasionally questioned. I appear before this committee and explain precisely why I behaved as I did and precisely why I conducted the case as I did.

We have other controls. We have chiefs that supervise our work. We have death conferences, which is a little grim to say here, but if you have a particularly bad outcome, fatality, any major complication, that automatically becomes the subject of a conference. And believe me, some of the criticisms that a doctor can get from other doctors can be very unkind indeed, and the disclipline of the medical board lies behind it.

Senator KENNEDY. How many times do they use that?

Dr. HIMMLER. They use it as often as is necessary.

Senator KENNEDY. Well, how many times, for example?

Dr. HIMMLER. Senator, I think some of the information you got is particularly irresponsible to begin with, because to begin with, I would be interested in knowing precisely how many physicians were involved in the fraud, as you call it—and it is called rather—because to my mind, and I was very closely involved with the Medical Society——

Senator KENNEDY. If I can respond to this, I think the general statement was about 5 percent. That is what his general statement was, approximately 5 percent he thought of those who were practicing, 5 to 10.

Dr. HIMMLER. Five percent of providers of services, not of physicians. And the major portion of the problem—and I am not here to separate one profession from another, but the major portion of that problem happened to be in dentistry and some other areas.

Now the medical societies went to the city and asked for the names of the physicians who were abusing this program or rendering poor care. We got virtually no response. And this is a matter of record.

Senator KENNEDY. And so have any doctors been disciplined or lost their license for practice for any of the abuses of any of the systems that you know about?

Dr. HIMMLER. We have no authority over their losing their license to practice. The medical profession has no control over that.

Senator KENNEDY. What kind of enforcement do you have?

Dr. HIMMLER. We have the enforcement of dropping them from our medical society.

Senator KENNEDY. How many times has that been done?

Dr. HIMMLER. It is being done periodically. Not only——

Senator KENNEDY. Well, how many times, for instance, over the period——

Dr. HIMMLER. It is very hard for me to say.

Senator KENNEDY. Well, do you know of any instance?

Dr. HIMMLER. Oh, yes, I know of instances where it has happened. I have sat on a committee.

Senator KENNEDY. What are we talking about, two or three a year or two or three over 5 years?

Dr. HIMMLER. Are you talking about a hospital or medical society?

Senator KENNEDY. Well, I would be interested in both.

Dr. HIMMLER. Well, I would be interested in both, too. I don't know. At French Hospital, where I happen to work, it happens infrequently. But by the same token, we screen the physicians coming in rather carefully.

Senator KENNEDY. Well, you screen them when they come in there. Do you screen them when they are in there?

Dr. HIMMLER. Yes. This is where the audit applies. The screening applies only to whether they are given staff privileges or not. Once they are in they are not home free.

Senator KENNEDY. How many doctors do you have there?

Dr. HIMMLER. At that particular hospital?

Senator KENNEDY. Yes.

Dr. HIMMLER. Roughly 300.

Senator KENNEDY. 300. And do you know of any instance where any of them have lost their hospital privilege?

Dr. HIMMLER. Yes. I have been personally—not personally deprived of it, but I have been involved in cases of that nature.

Senator KENNEDY. About how many over say what period of time?

Dr. HIMMLER. Oh, this is a guess—three or four possibly in 2 or 3 years.

Senator KENNEDY. And what were these for?

Dr. HIMMLER. Well, handling patients in what we call a less than optimum way in a number of cases.

Senator KENNEDY. What does that mean?

Dr. HIMMLER. Well, what it means, if we feel that a physician has not handled his patient entirely properly we sometimes subject him to the supervision of another doctor who looks over the cases with him for a period of time, with whom he must discuss his patients and almost join in his care; although the other physician is not paid, he is there in sort of a supervisory capacity. When it seems that the doctor has sharpened up his skill sufficiently then he is permitted to go back——

Senator KENNEDY. In the meantime what happens? Joe Citizen who goes in there when that doctor hasn't gotten sharpened up to scale—does he sharpen up on him?

Dr. HIMMLER. No. In the first place, this does not apply to surgery. Nobody is given major surgical privileges who is not above suspicion.

Senator KENNEDY. Above suspicion. Do you think we have any surgery being practiced in this country which is unnecessary?

Dr. HIMMLER. Do I think so?

Senator KENNEDY. Yes. Or didn't you study this? These are charges, allegations that are being made. I would think the medical society would want to have the record clear on it.

Dr. HIMMLER. The medical society wants to have the record clear on it. I don't know that the record is clear on the allegations to begin with.

Senator KENNEDY. All right. I will just use the President's message, the President of the United States' message. In terms of tonsilectomies, California, for example, has four times the national average, twice the number of surgeons. Now people ask me doesn't that mean you have either too many surgeons or too much surgery out there. You draw your own conclusions. These are charges which are implicit in the President of the United States' message to the Congress. And I would be interested in what your reaction to those is.

Dr. HIMMLER. Well, with all due respect to Mr. Nixon, I don't know how he came to the allegations to begin with. You can take gross data, subject them to a certain amount of analysis and come up with an allegation, and this is easy enough to do. I would like to see the unnecessary cases documented. We have had experience here——

Senator KENNEDY. Who is going to do that? Is that Joe Q. Citizen? Is that somebody who comes on in and goes into an emergency room and suddenly he is on the operating table? I mean what is he going to do, go out and file the various charges or allegations? Who is supposed to do that? Isn't that the medical society?

Dr. HIMMLER. The medical society is doing it.

Senator KENNEDY. What do they come up with?

Dr. HIMMLER. We are coming up with something that is even better now. I told you we had limitations, and we intend to obviate these limitations. I think you were busy chatting when I delivered this portion of it. But we are developing what we hope will be a very sophisticated method of data processing so that we can identify the cases required.

Senator KENNEDY. I heard that. About the data processing. I wasn't chatting during that.

Dr. HIMMLER. I beg your pardon.

Senator KENNEDY. I was chatting other times.

Dr. HIMMLER. Once we have identified these cases is when I said we could very easily exercise the necessary discipline. Where we have fallen down in the past——

Senator KENNEDY. When is that going to be that you will have these techniques and the data processing sort of all worked out?

Dr. HIMMLER. I hope within a year we will be well started on it at least. I am not thinking of it as a 10-year project.

Senator KENNEDY. Not a 10-year project?

Dr. HIMMLER. No. 1 or 2, I hope, at the best.

Senator KENNEDY. 1 or 2 years, and then in the meantime what happens?

Dr. HIMMLER. In the meantime we are doing what we can. I am telling you what we do is not insignificant by any matter of means, and they are not questions of allegations. We are objective in what we do. We don't just run off on an allegation.

Senator KENNEDY. Well, you have an interest in——

Dr. HIMMLER. We have a profound interest in it.

Senator KENNEDY. And you have an economic interest in what is being done.

Dr. HIMMLER. No. What is the economic interest? You mean because I practice my profession for a fee?

Senator KENNEDY. No, the whole review procedure, the peer review procedure which is followed. They have economic interests in the standards which are being applied, do they not?

Dr. HIMMLER. I would not think so.

Senator KENNEDY. As a doctor I would just imagine it enormously difficult to observe if there is going to be a stricter requirement in terms of excess surgery—we have had responsible authorities tell us we have a plethora of surgeons in this country, and if they know

there is going to be a litle stricter kind of requirement on what is going to be tolerated in terms of surgery in a given kind of hospital or given kind of area, I suppose that that engenders an economic reaction from the surgeons in that area, does it not?

Dr. HIMMLER. What I am trying to point out to you, Senator, is that I am not at all sure there will be a stricter kind of requirement. The requirements are quite strict now. I would recommend to you, if you wish, that you go to one of our better voluntary hospitals and see what the requirements are. I think this would be interesting to you, and maybe very revealing.

Senator KENNEDY. We have been trying to do that. We visited a lot of excellent ones, and we have been listening to——

Dr. HIMMLER. Did you find them lax about their criteria for surgery?

Senator KENNEDY. I find that there is too much surgery. I made that conclusion based upon the hearings that we have had. I think there are too many surgeons in the country and I think there is an excess of surgery in this Nation.

Dr. HIMMLER. Based on what you say——

Senator KENNEDY. I base that on the basis of study and the hearings that we have held to date, that's right.

Dr. HIMMLER. I don't think hearings are conducive to that kind of information and conclusion.

Senator KENNEDY. I'm sorry—maybe the hearings aren't but certainly the medical societies aren't doing anything to eliminate any doubt in the American public on this question.

Dr. HIMMLER. That is precisely why I am here, Senator. I have other things to do, and I came here to try to eliminate doubt and to explain our position.

Senator KENNEDY. Well, who are you doing a favor to?

Dr. HIMMLER. Myself and I hope the public and I hope to you by giving you some concrete information.

Senator KENNEDY. I hope so, too, because certainly the public are entitled to it. You should take on that responsibility as the president of the association.

Dr. HIMMLER. I was not complaining of the inconvenience. I was merely making it clear I was doing it from a sense of duty.

Senator KENNEDY. We have a lot of consumers here, people who have given up a day of opportunity of work—perhaps not to make the kind of incomes that you and I make. They are inconvenienced, too, so we appreciate this.

I would like to get back to why you don't think that under the given review board judges some other kind of doctor, and says "I'll scratch your back today, you scratch mine tomorrow."

Dr. HIMMLER. Because ideally they don't even have to know each other.

Senator KENNEDY. Ideally?

Dr. HIMMLER. Ideally, and this is why we want to automate some of this.

Senator KENNEDY. What percentage of the cases do you think they do know each other?

Dr. HIMMLER. Oh, I think right now in a large percentage of the cases, without any question.

Senator KENNEDY. What has been the judgment, what has been the result of these peer reviews? Where have they come out? What kinds of observations would you make where they have been critical of other members in various departments? Do you think of any instances?

Dr. HIMMLER. It happens every day and many times every day where they have been critical.

Senator KENNEDY. Would you elaborate to some extent and give us the results of these?

Dr. HIMMLER. Well, what kind of elaboration would you like?

Senator KENNEDY. Just instances. We are talking about quality.

Dr. HIMMLER. All right, let me give you an instance. It is a clinical instance. I was called into a peer review case with a patient who had extensive cancer of the breast. She had spread to her lungs, and I proceeded to do the breast amputation on her, a simple one, and then proceeded to treat her. Approximately a month later I was called in, and the question was "Dr. Himmler, you operated on this lady, she already had spread from the breast, what was the purpose of removing this breast?" We had a long discussion about it. I pointed out to them that removing the primary was one of the ways of treating it, after which hormone treatment and treatment with chemicals was much more successful.

Now the point is not the outcome of this, because they ultimately agreed with what I had done. But the point is I was called in and questioned and my choice of treatment was questioned, and this I think is an extremely healthy thing. Now this is only one instance.

I am not currently active on a peer review committee because I am too active in other things like the medical society. But this happens day in and day out. This is not an isolated case where they call in one man. This is an ongoing thing in every hospital that is worth its salt.

Senator KENNEDY. I would be interested if you could supply later on for the record in terms of the society the results of these peer reviews, how many instances over the period of last year have they in any way been critical of practicing physicians and what, if any steps have been taken. Could you supply that to us in the future?

Dr. HIMMLER. Yes; if you had asked for one other datum, one other item of information, this might make some sense. And the other item of information is how often would adverse criticism have been justified, because this I think is the important thing, not how often somebody is disciplined.

Senator KENNEDY. I think that is a valid comment, and the request ought to be amended to include that, and what steps where they have found—for one reason or another been critical—what steps have been taken.

Dr. HIMMLER. I would be very glad to supply information of that type.

Senator KENNEDY. Now just finally in terms of the other middle class and upper class that call the doctor, make the appointment, go to the office and are treated in the doctor's office itself, what kind of peer review is there for that sort of practice?

Dr. HIMMLER. There is little or none at the moment.

Senator KENNEDY. Shouldn't there be some?

Dr. HIMMLER. There should.

Senator KENNEDY. Well, what is the society doing about that?

Dr. HIMMLER. This is part of our overall program. Because these——

Senator KENNEDY. Hasn't the problem existed for some time?

Dr. HIMMLER. Has the problem existed for some time?

Senator KENNEDY. Yes.

Dr. HIMMLER. Yes, sir, it has. And why haven't we done it before, why do our problems persist—for lack of time, for lack of financing in some instances, for lack of a good many things.

Senator KENNEDY. Is that part of that program, the computer data program?

Dr. HIMMLER. Yes, sir.

Senator KENNEDY. I think you made some recommendations to the AMA last year.

Dr. HIMMLER. I did.

Senator KENNEDY. You have a reputation of being liberal in the AMA, is that right?

Dr. HIMMLER. Well, I'm not quite sure what I am classified there. I am starting to feel very conservative here.

Senator KENNEDY. I don't know what your position or your recommendations were. As I understand, they were turned down. And as I say, I don't know what these observations or recommendations were. Would you want to just touch on them briefly?

Dr. HIMMLER. Yes, the observations and recommendations I think would have answered some of your very criticisms. I didn't feel that—and please, I am not here to prosecute the AMA—I didn't feel that medicine had taken enough direct interest in the problems. I didn't qualify it as a crisis, but I did recognize the gravity of the problems, pointed them out, and thought we had not taken enough direct interest, not enough responsibility and not enough direct action, which is what my society is trying to do this year.

Senator KENNEDY. And what was the reaction to this I think rather enlightened viewpoint?

Dr. HIMMLER. Shall we call it mixed?

Senator KENNEDY. Well, how successful were you in terms of——

Dr. HIMMLER. This is hard to evaluate. I would not say that more than a third of it was adopted. This is quite obvious. Some of it was referred for further study, which is medical parlance means to be taken out for a decent burial, and some of it I think is being studied further.

Senator KENNEDY. Did this attitude of the society distress you?

Dr. HIMMLER. Does this distress me? Yes, it distresses me. But by the same token, it doesn't discourage me from trying to carry it on a little further. Next year they will adopt a little more of it.

Senator KENNEDY. Should the Government try and help a little bit?

Dr. HIMMLER. Well, I haven't felt the need to call for Government assistance, although for a while I thought I would need the Marines.

Senator KENNEDY. Well, we will try to help anyway.

Dr. HIMMLER. If we are talking about universal health insurance—and let me put this on the record—we are in favor of a form of universal health insurance. No way of being in favor of it entirely as a generic thing.

Senator KENNEDY. Why do you think that that is important?

Dr. HIMMLER. Universal health insurance?

Senator KENNEDY. Yes.

Dr. HIMMLER. The medical society is firmly convinced that nobody should go without care when he needs it, and that means nobody. And the ability to pay is not one of the criteria of who gets care.

Senator KENNEDY. Do you favor deductibles and coinsurance?

Dr. HIMMLER. I don't favor deductibles and coinsurance for a variety of reasons. I don't think they are good for patients. Obviously if they need care and can't scratch up the deductible or the coinsurance this is bad for them. And even if it were considered only—this is considered as an insurance mechanism to cut down on utilization, and I think even as an insurance mechanism it is not valid and it keeps people from getting health care very often when they need it.

Senator KENNEDY. Do you think that people overutilize the facilities today that don't really need them? What has been your experience? I mean do people come on in for the fun of it into these emergency rooms?

Dr. HIMMLER. I think that these are relatively few. In the first place, it is no fun to go to an emergency room if you think about it in those terms. And there is no question that there is some overutilization. We have hypochondriacs. We have people who tend to overutilize. I don't think this is a major element in our problem from that point.

Senator KENNEDY. We are getting along very well here. [Laughter.]

Dr. HIMMLER. Well, once we got over our original difficulties, not too bad.

Senator KENNEDY. You have been very kind. I appreciate your coming. It has been a long day and afternoon.

Dr. HIMMLER. I appreciate being given the opportunity.

Senator KENNEDY. This area of quality is a matter of great concern, and to the extent that you can help us on that question it would be very valuable.

Dr. HIMMLER. Let me just say one final thing. If this were merely a question of providing a reasonable or a believable type of coverup for physicians I don't think any of us in the medical society would be interested in it. If we can't produce a good system of review then we are not interested in doing it because we have no interest in defending physicians in that sense of the word.

Senator KENNEDY. I think the problem is rather basic. I mean I think it is true with regard to a percent in terms of the medical profession as well as the legal profession as well as the political profession. I mean your contemporaries are extremely reluctant to sanction activities of other contemporaries, and I think it is just implicit in the problem. My own feeling is that we have to alter it significantly. I don't think we can expect it to function that way. But I would be interested in what observations you would make on it.

I appreciate very much your appearance here today.

(The prepared statement of Dr. Himmler follows:)

STATEMENT OF GEORGE HIMLER, M.D., PRESIDENT
MEDICAL SOCIETY OF THE STATE OF NEW YORK
April 14, 1971, NEW YORK CITY

TO: U.S. Senate Subcommittee on Health

Gentlemen:

I am Dr. George Himler, President of the Medical Society of the State of New York. I appreciate this opportunity to express the views of my organization, a federation of 61 county medical societies in New York State.

We believe that a number of situations exist in the health care of the American people that urgently call for correction:

It is quite apparent, for instance, that the inhabitants of the rural areas and dwellers in the so-called inner-cities, (less elegantly called the ghettos) do not have access to the quantity and quality of health services that their conditions require.

There is a substantial over-all shortage of health personnel in all categories, and due to maldistribution, this shortage is particularly acute in the inner-cities and in rural communities.

Institutional facilities available for care are inadequate, particularly facilities for extended care, custodial care, and home-care programs.

Finally, rapidly rising costs is one of the major causes for concern and is perhaps the most difficult to control.

The Medical Society of the State of New York firmly believes that the health requirements of the public must be met regardless of cost. At the same time, ALL CONCERNED in meeting those requirements, have the responsibility of assuring that all services are of high quality and that the costs are as reasonable as they may be under the circumstances. I emphasize the "all concerned", because in our opinion, this includes legislators and program administrators as well as physicians and other providers of health services.

A program that is deficient in concept and poorly administered is beyond the power of even the most well-intentioned and devoted provider to implement effectively. I draw your attention to the Medicaid program to illustrate and document this statement.

The rural areas and ghetto communities do not attract health professionals in any category, because of the conditions that prevail there. A low capacity for reimbursement is only one of a great number of factors. It seems evident that unless very special incentives are devised for all types of health care personnel, the problems of these areas will not be solved until there is an over-supply of health professionals which is not likely in the foreseeable future.

At first glance, the most useful expedient to provide health care in these areas is in a clinic setting, but this has not proved to be an adequate solution. OEO clinics have been established and are useful, but they have not begun to fill the need.

The New York State Medical Society, therefore, has sought a way to involve private practitioners in the rendering of health care in medically deprived areas. This requires that they be organized in some fashion and that there be a mechanism for the distribution of what payment is available for medical services.

The concept of foundations, or health care delivery organizations, seems to us to be the most promising method of accomplishing this end. Foundations are non-profit membership corporations of physicians which are authorized to collect either capitation or fee-for-service for care rendered by their members. They distribute these fees in a manner previously agreed on by their participating physicians. They provide a number of other services which I will describe.

One of the most important characteristics of foundations is that they can act as intermediaries between government, insurance carriers and other funding

agencies on the one hand, and groups of practicing physicians on the other, to create contracts for the health care of any specific segment of the population. They have the advantage, in our opinion, that they do not relegate the underprivileged to a special and inferior kind of care.

Our society, aware that a number of foundations had recently been established in New York State, set about stimulating additional interest. There are now at least five county, or regional medical associations, actively investigating and planning such organizations.

The foundation concept has other beneficial features.

One feature is the "built-in" mechanism for the constant supervision of the quality and cost of care, as well as the utilization of services.

Another feature is that the data which a foundation, by its very nature, must accumulate, can be used to detect the weaknesses of the delivery system, and serve as a basis of planning for the elimination of those weaknesses.

Recognizing that these foundations will encounter difficulties in processing data in the volume generated, and realizing that it would be impossible for the foundations to relate to subdivisions of government and other groups that lay partly, or wholly, outside their jurisdiction, the New York State Society is actively engaged in organizing an institute to fill these gaps. This state-wide institute will play the role of intermediary between physicians and government, insurance carriers or consumer groups, in the creation of health care programs at the stat county or multi-county level. It will also support local foundations with technical advice and render other appropriate assistance.

The institute's primary function, however, will be to provide the foundations with a central large-volume electronic data processing center. This processing, which will apply equally to audit utilization and cost review, can be done more economically in a single state center than in each individual foundation.

Centralization will insure uniformity in terminology, procedures and standards, and produce data that are comparable among all areas, which will consequently, be useful in analysis and planning for health care. Such data will be of great value to comprehensive health planning agencies, regional medical programs, local, state and federal agencies, and the medical societies, themselves.

You are aware that the capitation prepayment group practice method of delivery now enjoys great favor in government circles as a means of delivering services of high quality, controlling their costs, and diminishing morbidity by periodic health examinations. I would like to make it clear that the Medical Society of the State of New York has no prejudice against such practice and does not oppose it. At the same time, the most ardent proponents of capitation prepayment group practice and health maintenance organizations admit that such organizations require costly facilities and that their claim to economy is based solely on their ability to control utilization.

We call the committee's attention to the fact that the majority of medical services are now rendered by physicians who are in solo or small group practice and who are reimbursed on a fee-for-service basis. In these times of absolute shortage, their skills, offices, and equipment, are, in a sense, a public asset which must be preserved. It is unlikely that these physicians can arbitrarily and suddenly be shoehorned into a capitation, multi-specialty group practice without disastrous effects on quality, cost and availability of care, let alone the supply of physicians.

I would caution that capitation prepayment group practice has not yet proved that it can effect substantial economies if employed on a large scale. Under the circumstances, it would seem most prudent to let these two systems prove their relative worth, side by side, before moving abruptly and completely from what we now have to an, as yet untried, system. The foundation mechanism makes this

possible, by assisting privately practicing physicians, to render services as comprehensive as those of any health maintenance organization. It also helps to relate private practitioners to capitation group programs, and could prevent the complete chaos that would result if such programs are given the preferential status that some current health insurance bills propose.

The New York Medical Society has made positive contributions to the enhancement of the quality of care:

Post-Graduate Medical Education

We have long recognized the desirability of continuing post-graduate medical education. Believing that this is best accomplished on a voluntary basis, we are now on the verge of implementing a positive, innovative educational program with the cooperation of the New York State medical schools, the New York State Department of Health, the regional medical programs and the medical specialty societies in the state.

A Medical Review Manual

In 1970, the Medical Society of the State of New York developed the Medical Review Manual to facilitate objective evaluation of physician management of hospital patients. The purpose of the manual is to help improve the quality of in-hospital care. More than 800 copies have been distributed, including all acute-care hospitals throughout New York State.

The manual contains standardized review patterns for six medical diagnoses and procedures, including stroke, heart attack, diabetes, hysterectomy, appendectomy, and prostatectomy. The methodology it employs in evaluating physician performance is a practical one for general adaptation by hospitals and by private and public agencies concerned with the quality of medical care.

Although sufficient time has not elapsed to arrive at a definite conclusion, preliminary reports clearly indicate that the manual is meeting the need for a

method of providing quality medical care. HEW has been favorably impressed with the manual and has distributed a copy to each of its public health service districts. As a result of favorable comments received, consideration is being given to expanding the coverage of the manual to include six additional classifications of medical procedures.

Comprehensive Health Planning

Following the enactment of P.L. 89-749 "The Comprehensive Health Care and Public Health Amendments of 1966" and its implementation the following year in New York State, the Medical Society of the State of New York, during the year 1968-69 designated as its No. 1 project, the meaningful involvement of the physicians of New York State in comprehensive planning. A state-wide committee of physicians knowledgeable in health planning was formed and each of the members was appointed a chairman in his respective district of the state to assist the component county medical societies to become knowledgeable in the law and active in the planning movement. Through this committee, the State Medical Society distributed literature and information on the modus operandi of health planning to committees of the local county medical societies. To insure their personal involvement, the presidents of the 61 county medical societies were convened and briefed on the law and its provisions at a special meeting in upstate New York.

To inform further and to involve the general membership, thirteen one-day area conferences were held throughout the state and numerous conferences were held with representatives of both the Federal government and the State government involved with comprehensive health planning. These include meetings with the regional health director, U.S. Department of Health, Education and Welfare, concerning comprehensive health planning; the New York State Commissioner of Health; the director, New York State Health Planning Commission; the secretary of New York State Health Planning Commission and the director, New York State Office of Planning

Coordination. In order to assist county medical societies in their understanding of the law, guidelines were drawn up and distributed to them.

As a result of these activities, most of the county medical societies throughout the State became involved in some degree in comprehensive health planning. Regional plans have been developed and at least seven agencies have been recognized as regional representatives by the State Health Planning Commission and have been funded by Federal organization grants.

Peer Review Mechanism

For the year 1969-70, a major program of the Medical Society of the State of New York was the promotion of peer review concepts. A committee on Peer Review was appointed to establish guidelines for setting up peer review committees at the county or regional levels and to assist with the organization of such groups.

The committee's first task was the education of the county medical societies regarding the need for peer review. A brochure "The Need for Peer Review" was produced for state-wide distribution.

Eight area-wide conferences were scheduled during the months of September and October, 1969. The response to these conferences and distribution of materials indicates that there is overwhelming support of the principle that peer review is not only desirable, but necessary.

We have cooperated closely with the regional medical programs and have supported the expansion of medical schools in the tightening-up of their curricula to increase the annual output of physicians. Our society has actively supported legislation for the training of physician's assistants and has made recommendations for their utilization and supervision.

We will continue to be at this committee's disposal if we can be of any assistance at any time. Thank you again for this opportunity to express our views to the subcommittee.

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Senator KENNEDY. We will now resume with the consumer witnesses. Mrs. Kronberg has four associates with her.

Now we have seven or eight different consumers here that are going to talk and we want to try and reserve just a few minutes at the end for any of the people that have been here during the course of the hearings to make whatever comments they would like to, and we are beginning to run into a time problem. We have to be out a little after 5:15. So we have about an hour and a half, and as I say, we have eight series of witnesses. So we are going to ask if we can move this along as rapidly as we can, as you feel that you can express yourselves and your viewpoints, and then go along.

Mrs. Kronberg has been extremely kind. She has testified before the health subcommittee earlier this year. That was on the day of Mr. Whitney Young's funeral, as a matter of fact, and we had to recess the hearings and commence them in the late afternoon. I think you testified at about 7 o'clock at night before us, and we have improved it by about 3 hours this afternoon. But we want to tell you how much we appreciate the interest you have taken in this problem and the work you have done on it. I think you are extremely well equipped to talk about the impact of the health crisis on consumers, and we are delighted to welcome you today.

STATEMENT OF MRS. SHIRLEY KRONBERG, DIRECTOR OF THE NEIGHBORHOOD SERVICE COUNCILS OF THE NEW YORK HOTEL TRADES COUNCIL, ACCOMPANIED BY MRS. BETTY ROCHE, DISABLED HOTEL MAID, MRS. EDNA DEAN, ALBERTO LAGERRE, ELEVATOR OPERATOR, AND LUCIAN VELEZ, SPANISH-SPEAKING RESIDENT

Mrs. KRONBERG. It is a pleasure to be before your committee again, Senator. Because we testified so late last time and got no press coverage we are going to quickly try to run through some of the things we said in Washington and say them over again hopefully so that the consumer point of view does get some attention.

The hotel workers of New York, by contract between their union, the Hotel and Motel Trades Council, and the Hotel Association, have complete doctor care and Blue Cross coverage for themselves and their dependents.

Our family medical care program is administered through six family medical care centers.

Even though thousands benefit greatly from this program, we find each year that we are operating at a deficit and must renegotiate for additional employer contributions to keep going. With other unions, we are torn between asking more money for the health fund or for urgently needed improvements to meet the rising cost of living of our membership.

It is important for your committee to know that there are a variety of situations in which we are virtually helpless. The worker who loses his job is covered by Blue Cross for 28 days. To continue coverage after that he must pay his own way. But how can he without a job?

Again, a worker going to a hospital emergency room is not covered by Blue Cross except for $7.25 if it is a result of an accident. We will show you that his bill can run into hundreds of dollars, even though there is no overnight stay in the hospital.

Blue Cross paid $80 for maternity confinement and now is increasing this to $100, but the average bill is over $600.

Medicaid eligibility levels for small families are totally unrealistic. A couple having its first child must show an income under $4,000—and this has now been cut by the State legislature by 10 percent, so it will be even less than $4,000 a year—or it will have to pay $500 for the hospital. Childless couples and single persons are virtually excluded from medicaid. Even with a large hospital bill, one must either be totally disabled or have spent one-quarter of his annual income for medical care.

Of course, this applies to people who are working, not those on either social security or disability or welfare.

I would like to show you typical hospital bills received by some workers. Bear in mind that they have received these bills even though they have free doctor care and Blue Cross coverage.

Telephone operator in her late 50's, married, no children. Husband is an elevator operator. She was hospitalized July 8, 1969; discharged July 29, 1969; 21 days; treatment for a nervous breakdown. Blue Cross covered only 2 full days. Balance of bill paid by husband—$2,342.90. Insurance does not cover hospitalization for mental illness.

He is a maintenance man in a hotel. His take-home pay is $103 a week. He is 60 years old. His wife, suffering with Parkinson's disease was hospitalized in October 1968. On December 17, 1968, she was hospitalized for surgery. She was discharged January 16, 1969. Since she had exhausted most of her Blue Cross in October, Blue Cross covered her for only $1,234.94 out of a total bill of $2,469.80, leaving a balance of $1,234.86, which was paid by her husband, the worker. This family did not qualify for any medicaid assistance, of course, because it is a childless couple between the ages of 21 and 65. In April 1970 she became 65 years old and now has medicare. She still has very large drug bills.

He is an elevator operator; single; 62 years old; had polio as a child and has been physically handicapped all his life. In the last few years he has had a great deal of difficulty with his feet, and has been hospitalized several times. As a matter of fact, he is in the hospital now. We tried to get him to come here today and he is sick again. He was hospitalized in January 1970 for surgery on four toes. Our disability records show him disabled from December 9, 1969, through March 1, 1970—11 weeks and 6 days. He worked for a few weeks and became disabled again May 13 through July 6–7 weeks and 6 days. When his Blue Cross was exhausted he applied for medicaid while in Joint Disease Hospital. We provided proof to the city investigator that his disability payments amounted to $46 a week. On the basis of his $46 a week income, he

was disallowed for medicaid. He is left with a balance to pay of $221.37, in spite of the fact that he is lame, and sick, and earns about $80 a week take-home pay.

We have with us today four people who have hospital bills, and we would like each of them to tell you their own story.

Now this is Betty Roche, who has worked for many years as a maid in a hotel. She is a union member. She had doctor coverage and Blue Cross, and we would like to tell you what happened to her—for her to tell you, when she became ill one day. Tell me, Betty.

Senator KENNEDY. Betty, I want to welcome you here.

Mrs. ROCHE. Well, you, too, Senator Kennedy.

I became sick at the hotel, so they sent me to the clinic.

Senator KENNEDY. Everybody let's be quiet. Can you bring that microphone up close, Betty?

Mrs. ROCHE. And I went to the medical center. They sent the doctor up and he looked at me and examined me and said I had to be operated on. So they put me in the hospital. I entered the hospital the 12th of October and I left the hospital on the 23d of November, 1970.

Senator KENNEDY. You had some medical bills.

Mrs. ROCHE. Yes, the Blue Cross paid some of it, but I got a bill for $1,800 and I don't know how much dollars from the hospital to pay.

Senator KENNEDY. You got a bill of $1,800, did you?

Mrs. ROCHE. Yes.

Senator KENNEDY. Did the Blue Cross pay that bill?

Mrs. KRONBERG. This is her bill, Senator. Her total bill was $5,824.99, of which Blue Cross paid $4,465.39. She is not eligible for medicaid assistance because she is between 21 and 65, childless, and was not permanently disabled at the time, and so she had a balance of $1,359. However, that was the estimate, the original estimate of the hospital, and when Blue Cross didn't send in what they had estimated for them, $472, the hospital revised its bill, and this is the revised bill—$1,832.02.

Senator KENNEDY. What is your take home pay, Betty?

Mrs. ROCHE. My take home pay was about $75 or so.

Senator KENNEDY. $75 a week?

Mrs. ROCHE. Yes.

Senator KENNEDY. You pay your expenses out of that $75 a week?

Mrs. ROCHE. Yes.

Mrs. KRONBERG. Are you a widow?

Mrs. ROCHE. Yes.

Senator KENNEDY. And you are going to have to try to start paying this bill off?

Mrs. ROCHE. Well, I don't know.

Mrs. KRONBERG. Since that time the doctors have said that Betty cannot return to work. There is no way of getting it from her. She hasn't got it.

Senator KENNEDY. But otherwise she would have to pay that?
Mrs. KRONBERG. That's right.
Senator KENNEDY. You would have been paying out $4 or $5 dollars a week for——
Mrs. KRONBERG. The rest of her life.
Thanks, Betty.
Senator KENNEDY. Thank you, Betty.
Mrs. KRONBERG. This is Mabel Dean—Edna Dean, excuse me. Edna was not yet covered by Blue Cross when she became ill, and she went to an emergency room of a hospital. Tell me what happened, Edna.
Mrs. DEAN. Well, I took sick on a Saturday night and my relatives took me to the St. Johns Hospital and they sent me home. They give me a prescription, but when I got home it was late, I couldn't fill it. And the vomiting started on Sunday, and I went back and they admitted me for 6 hours, and they sent me home in August last year, the second week of August. I don't remember the day. They sent me a bill for $319.
Senator KENNEDY. Wait. You were in the hospital how long?
Mrs. DEAN. Six hours.
Senator KENNEDY. And they sent you a bill for how much?
Mrs. DEAN. $319.
Mrs. KRONBERG. This is the bill, Senator. $319. I would like to read the bill. $75 for the bed she was in.
Senator KENNEDY. $12 an hour for the bed.
Mrs. KRONBERG. $127, laboratory services; $52, X-ray; $45, medical supplies; $20, cardiogram. She entered at 9 a.m., came out at 6 p.m. Her bill is $319.
We sent her to the Legal Aid Society because they refused us an itemization of this bill. And Legal Aid wrote—this is the reply from Legal Aid—wrote to the hospital asking for an itemization of this bill, the laboratory tests taken, the X-rays taken, et cetera, and we got back exactly the same thing. This is what Legal Aid sent us, exactly the same thing. No itemization.
Mrs. DEAN. All I got was the cardiogram, and they gave me saline and two X-rays. I didn't get any blood tests or anything like that.
Senator KENNEDY. Do you have any insurance?
Mrs. DEAN. No, Senator, I did not.
Senator KENNEDY. You are actually obligated then to pay this. What is your take-home pay?
Mrs. DEAN. $71. I am living alone. My husband is in Jamaica. He is not here.
Senator KENNEDY. Are you going to try and pay some of this?
Mrs. KRONBERG. We have asked Legal Aid if she gets a summons for this bill, a suit by the hospital, to prepare a defense for her based on the unconscienability of this bill.
Senator KENNEDY. You've got a pretty good case.
Mrs. KRONBERG. We think so.

This is Mr. Aberto Lagerre, who is an elevator operator in a hotel. We would like him to tell you what happened to him when he became ill.

Mr. LAGERRE. I went in the hospital, Knickerbocker Hospital. I stayed 45 days. And I was operated on—intestinal operation—two times. And when I went home they took quite a while to send a bill, but they loved me after all—they sent the bill for $1,130, I guess.

Mrs. KRONBERG. We have asked Mr. Lagerre to come here because we think that this is a very good example of the kind of bureaucracy that poor people are subject to that prevents them from taking advantage of the law even when the law is on their side. Mr. Lagerre was ill for over 6 months. Five of those months he was totally disabled. He would have been eligible for assistance from medicaid and he was interviewed for medicaid while he was in the hospital. However, the application was never processed, and he received a bill from the hospital 10 months after his discharge from the hospital. He came out in February 1970. He received the bill in December. By then he was ready to return to work, and he is no longer eligible for medicaid even though he was eligible for medicaid while he was ill and hospitalized.

We sent a letter to medicaid, and I am quoting from the letter: "On December 31, 1970, Mr. Lagerre receives a bill from the hospital for a balance owed them of $1,130.07. While he was hospitalized he applied for medicaid and assumed that he would not be receiving any bills. For whatever reason, it now appears that his medicaid application was never processed and the hospital is dunning him for payment. We respectfully urge that Mr. Lagerre's inclosed application be reviewed and medicaid coverage be granted for that period for which he was entitled for assistance."

He was rejected for assistance, and he went back to the hospital to make arrangements for payment. He is an elevator operator. His take home pay averages $80 a week, and he now owes a hospital bill of $1,130.07.

Senator KENNEDY. Do you have a family?

Mr. LAGERRE. I have a son.

Senator KENNEDY. How old is he?

Mr. LAGERRE. Sixteen years old.

Senator KENNEDY. Does he live with you?

Mr. LAGERRE. He lives with his mother.

Mrs. KRONBERG. This is Mr. Velez. We thought it only fair that the Spanish-speaking community of New York get a word in at these hearings, and so we invited Mr. Lucian Velez, who is going to tell his story in Spanish.

Mr. VELEZ (interpreted). I took my wife in the emergency hospital. She stayed in the hospital for 49 days. After she had been home a few days later I received a letter. The letter was a bill for $912.07. I went to the hospital, discussed the bill with the hospital. They told me that I had to bring $300 right away, and after that I had to bring $114 at a time or I would be sent to court.

And he had to make the one because he was afraid that maybe he would lose his job, and he got a loan of the money and he paid the hospital.

Senator KENNEDY. What interest rate did he pay on the loan?

Mr. VELEZ (interpreted). From a friend. So he didn't go to any loan company or bank. His friend loaned him the money.

Mrs. KRONBERG. You, of course, understand that Mr. Velez did receive some medicaid assistance. His bill for his wife's hospitalization was $5,895.95. This is for several weeks stay. She was diabetic and had a long hospital stay. Blue Cross paid $4,599. He was evaluated for medicaid, and because the family has no children at home under 19 and they are between the ages of 21 and 65 and he is not permanently disabled or receiving welfare they qualify only under the catastrophic illness clause, which means that he has to spend 25 percent of his annual income before qualifying for any medical assistance. Twenty-five percent of his annual income, because his take home pay is $84, is $986.12. That was his share of the bill, and medicaid paid $310.63. That was the balance over the $986.

He went to Mount Sinai to try to make arrangements for payment of this bill. They told him they wanted $300 down and $25 a week, which, of course, he couldn't possibly pay.

So he came to us there in the Union, and I called Mount Sinai and asked them to accept $25 a month so he wouldn't have to borrow or incur any loans.

Last month he received a letter from the hospital stating that if he wasn't in to make payment by April 16 the bill would be sent to an attorney for suit, for judgment and garnishee that follows. He became very alarmed about this. He didn't want his boss to think he was a deadbeat, didn't want a garnishee on the job, didn't want his credit hurt and everything else, so he found someone from whom to borrow $986.

Of course, if somebody gets ill again I don't know what he does then.

Senator KENNEDY. Sounds like in some of those instances the hospitals are better off in chasing the patients than they are providing services.

Mrs. KRONBERG. They have an excellent system now. There is a whole industry that has been created and built around collections. They just transferred over from the Slokes Stores—you know, the furniture stores where the furniture used to fall apart—now they are collecting hospital bills, Hate and Hate and several others. It employs hundreds of thousands of people, lawyers and all kinds of hounds that prey on people who owe hospital bills with the whole bit, the telephone calls to the employers and to the families and to friends, and all kinds of threats. And, of course, the people are frightened by this. Aside from the fact that this is where their medical records are, this is where they have to go back in the event they become ill again. These are the people upon whom they are dependent for medical care which can be life and death, and so it becomes very compelling to pay these bills—because if they would

take our advice they wouldn't pay them. We tell them just don't pay them.

If we clog the court calendars sufficiently with hospital bills it will take 6 years for them to collect, like it does somebody in an auto accident now. And I am for that. I am for clogging the courts with all hospital and doctor bills. We advise them not to pay, but they don't listen to me. They are honest.

Senator KENNEDY. I know you are, too.

Mrs. KRONBERG. But we are for national health insurance as proposed in the Kennedy-Griffin bill. We need insurance with cost controls, and the way to achieve such controls is by changing the system of delivering medical care. The medicare experience has proved that the administrators have been unable to prevent gouging of the elderly by the doctors. The doctors were the greatest beneficiaries of medicare. Medicare has become only a part payment of the total doctor bill.

Passage of the Kennedy-Griffin bill is essential to meet the health needs of working people today.

Senator KENNEDY. Thank you very much.

Mrs. KRONBERG. Thank you for this opportunity.

Senator KENNEDY. I want to thank all of the members of your panel for coming down here. I know it is not easy to talk about these questions in terms of these unfortunate experiences in the past, but you have really provided a great service to us. And if there should be any question in people's minds about the health crisis in the Nation, if they have an opportunity to read through this testimony it should be dramatic evidence about what is happening in our country at this time.

You have been very helpful to this committee.

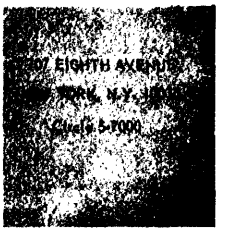
Mrs. KRONBERG. Thank you, Senator.

Senator KENNEDY. I want to thank you for coming.

Mrs. KRONBERG. We have copies of all those bills for you.

(The prepared statement of Mrs. Kronberg with enclosures follows:)

Neighborhood Service Councils of Hotel, Motel and Club Employees



Affiliated with the New York Hotel and Motel Trades Council AFL-CIO

PREPARED STATEMENT OF SHIRLEY KRONBERG, DIRECTOR OF THE NEIGHBORHOOD SERVICE COUNCILS OF THE NEW YORK HOTEL TRADES COUNCIL

The hotel workers of New York, by contract between their union, the Hotel and Motel Trades Council, and the Hotel Association, have complete doctor care and Blue Cross coverage for themselves and their dependents.

We have been providing medical care for our members since 1948. Since 1957 we have been providing medical care for our members and their families. Last year the cost of maintaining Blue Cross was a little over three million dollars. The cost of operating our Family Medical Centers was three million, six hundred thousand dollars. The total cost, almost seven million dollars is between 4½ and 5% of all payrolls in the hotel industry.

Our Family Medical Care program is administered through six Family Medical Care Centers. We had hoped that all of these Centers would be hospital based. Unfortunately, we have been unable to have them all in hospitals because of the oppesition of the Hospital Medical Boards.

Even though thousands benefit greatly from this program, we find each year that we are operating at a deficit and must re-negotiate for additional employer contributions to keep going. With other unions, we are torn between asking more money for the health fund or for urgently-needed improvements to meet the rising cost of living.

It is important for your committee to know that there are a variety of situations in which we are virtually helpless. The worker who loses his job is covered by Blue Cross for 28 days. To continue covered after that he must pay his own way. But how can he without a job?

Again: A worker going to a hospital emergency room is not covered by Blue Cross. We will show you that his bill can run into hundreds of dollars, even though there is no overnight stay in the hospital.

Blue Cross paid $80 for maternity confinement and now is increasing this to $100, but the average bill is over $600.

Medicaid eligibility levels for small families are totally unrealistic. A couple having its first child must show an income under $4000 a year or it will have to pay $500 for the hospital. Childless couples and single persons are virtually excluded from Medicaid. Even with a large hospital bill, one must either be totally disabled or have spent one quarter of his annual income for medical care.

I would like to show you typical hospital bills received by some workers. Bear in mind that they have received these bills even though they have free doctor care and Blue Cross coverage.

Telephone operator. In her late 50's. Married, no children. Husband is an elevator operator. She was hospitalized 7/8/69. Discharged 7/29/69. 21 days. Treatment for a nervous breakdown. Blue Cross covered only two full days. Balance of bill paid by husband - $2,342.90. Insurance does not cover hospitalization for mental illness.

He is a kitchen cleaner. He has a diabetic wife who was hospitalized December 21, 1969 through February 8, 1970. His total bill was $5,895.95. Blue Cross paid $4,599.20. Medicaid covered only $310.63 under the "Catastrophic Illness" provision. The balance of $986.12 has to be paid. His take-home pay is $84.33. We helped make arrangements with the hospital to accept $20 a month towards the bill. It will take our member only four years to pay this bill.

He is a maintenance man in a hotel. His take-home pay is $103 a week. He is 60 years old. His wife, suffering with Parkinsons disease was hospitalized in October of 1968. On December 17th of 1968 she was hospitalized for surgery. She was discharged January 16, 1969. Since she had exhausted most of her Blue Cross in October, Blue Cross covered her for only $1,234.94 out of a total bill of $2,469.80, leaving a balance of $1,234.86, which was paid by the member. This family did not qualify for any Medicaid assistance. In April of 1970 she became 65 years old and now has Medicare. She still has very large drug bills.

He is an elevator operator. Single. 62 years old. Had polio as a child and has been physically handicapped all his life. In the last few years he has had a great deal of difficulty with his feet, and has been hospitalized several times. He was hospitalized in January of 1970 for surgery on four toes. Our disability records show him disabled from December 9, 1969, through March 1, 1970 -- 11 weeks and 6 days. He worked for a few weeks and became disabled again May 13 through July 6 -- 7 weeks and 6 days. When his Blue Cross was exhausted he applied for Medicaid while in Joint Disease Hospital. We provided proof to the City Investigator that his disability payments amounted to $46.00 a week. On the basis of his $46.00 a week income, he was disallowed for Medicaid. He is left with a balance to pay of $221.37, in spite of

the fact that he is lame, and sick, and earns about $80.00 a week take-home pay.

We need national health insurance as proposed in the Kennedy-Griffin Bill. We need insurance with cost controls, and the way to achieve such controls is by changing the system of delivering medical care. The Medicare experience has proved that the administrators have been unable to prevent gouging of the elderly by the doctors. The doctors were the greatest beneficiaries of Medicare. Medicare has become only a part payment of the total doctor bill.

Passage of the Kennedy-Griffin Bill is essential to meet the health needs of working people today.

Enclosures.

opeiu:153 3/15/71

ROOSEVELT HOSPITAL
428 WEST 59TH ST.
NEW YORK, N.Y. 10019
TEL. 212 554 7061

PATIENT NAME	CODE NO.	DATE ADMITTED	DATE DISCHARGED	TIME	PATIENT NUMBER
	121-09	07/08/69	07/29/69	11.00 AM	35?61-1?980

T11-

WHEN CONTACTING US ABOUT THIS BILL, PLEASE REFER TO THIS NUMBER.

DATE	DESCRIPTION	CHARGES	ESTIMATED A.H.B. ALLOWANCES	ESTIMATED CITY ALLOWANCES	CASH AND OTHER CREDITS	ESTIMATED AMOUNT PAYABLE BY PATIENT
	BALANCE FORWARD					
7 25	0567 DRUGS	1 15				1 15
7 26	0567 DRUGS	1 15				1 15
7 27	0567 DRUGS	1 30				1 30
7 0	0767 TELEPHONE-LOCAL CALLS	10 50				10 50
7 28	0131 RESP-THERAPY IPPB TREATMENTS	45 00				45 00
	APPROVED BY BLUE CROSS FOR 2 FULL DAYS ONLY. .					
	ROOM AND BOARD AND OTHER CHARGES.....	$ 1,900 40				
	XXXX SPECIAL NURSES..	432 00				
	TELEPHONE $.50 PER DAY FOR LOCAL CALLS ...	10 50				
		$ 2,342 90				

PAYMENT IS DUE UPON PRESENTATION OF THIS BILL.

CHARGES	ESTIMATED A.H.B. ALLOWANCES	ESTIMATED CITY ALLOWANCES	CASH AND OTHER CREDITS	ESTIMATED AMOUNT PAYABLE BY PATIENT
				2,342.90

THIS BILL IS SUBJECT TO REVISION UPON RECEIPT OF ADDITIONAL POSTED CHARGES AND/OR CHANGES IN BENEFITS AS ESTIMATED. CREDIT FOR PAYMENTS MADE SINCE DATE OF THIS STATEMENT WILL APPEAR ON NEXT STATEMENT.

PLEASE RETAIN THIS PORTION OF STATEMENT FOR INSURANCE AND INCOME TAX PURPOSES.

ROOSEVELT HOSPITAL
REMITTANCE STUB

PATIENT NUMBER	PATIENT NAME	CHARGES	ESTIMATED A.H.B. ALLOWANCES	ESTIMATED CITY ALLOWANCES	CASH AND OTHER CREDITS	BALANCE DUE
35361-19980		2560??				2,342 XXXXX

PLEASE DETACH AND RETURN THIS STUB WITH YOUR REMITTANCE.

FORM A-1 A-2
100 G-P-D LAUNDRY

THE MOUNT SINAI HOSPITAL

Fifth Avenue and One Hundredth Street
New York, New York 10029

TR6-9600 MRS. WILDER 10/7/70

Bill to: 345

Statement of Charges for:

778231/173120

(Please return this stub with your remittance.)

THE MOUNT SINAI HOSPITAL
Fifth Avenue and One Hundredth Street
New York, New York 10029

Charges from: 12/21/69 to: 2/8/70	AMOUNT	BLUE-CROSS ALLOWANCE	OTHER CREDITS City Allowance	CHARGE TO PATIENT
Room and Board				
Room 40 days @ 82	4018.00	2870.00		1148.00
Room days @				
Blood				
Electrocardiograph	28.00	28.00		
Electroencephalograph				
Intravenous				
Laboratory Examinations	676.25	594.00		82.25
Operating Room	330.00	330.00		
Oxygen	440.00	392.50		47.50
Physiotherapy				
Radiotherapy	11.00	11.00		19.00
Pharmacy	315.20	286.20		
Special Nurses – R.N.				
Special Nurses – P.N.				
X-Ray Examinations	62.50	62.50		
Telephone				
RECOVERY ROOM	25.00	25.00		
				1296.75
			310.63	310.63
TOTAL CHARGES	5895.95	4599.20		986.12
			TOTAL PAYMENTS TO DATE	-0-
			BALANCE DUE	986.12

PENDARVIS

PARKOFF

WILLS

EXPLANATION OF CODE LETTERS

EARNINGS	DEDUCTIONS		BALANCES
A–REGULAR B–OVERTIME C–ROOM & MEALS D–OTHER	E–FED. W. S. INC. TAX F–FED WITH TAX AND F I C A G–MISC. H–UNION DUES-FEES J–TIPS	L–GROUP INSURANCE M–CITY TAX N–ROOM & MEALS P– R–ADVANCES V–	X–EARNINGS TO DATE Y–FED WITH TAX AND F I C A TO DATE Z–N Y STATE INC TAX TO DATE

HOURS		EARNINGS		DEDUCTIONS		BALANCES	
35.00	A	101.85	N	2.50	X	3,882.46	
	C	2.50	FU	15.52	Y	576.81	
		104.35	ET	1.60	Z	54.30	
Sep. 27, 1970			M	.10			
						84.33	

520 TAX DEDUCTION 'F' COMPUTED ON CASH EARNINGS PLUS ROOM & MEALS 'N'

THE BARCLAY

EMPLOYEE SHOULD DETACH AND RETAIN THIS STATEMENT

WHEN CORRESPONDING RE ABOUT THIS BILL, PLEASE REFER TO THIS NUMBER

SERIAL # 58555

UNIVERSITY HOSPITAL

NEW YORK UNIVERSITY MEDICAL CENTER
560 FIRST AVENUE - NEW YORK, N. Y. 10016

TELEPHONE: OR 9-3200 EXT. 3368

BILLING DATE: 1/30/69

PATIENT: 1

STATEMENT

UNIT NO.	ADMITTED	DISCHARGED
194014	12/17/68 6:00PM	1/16/69 4:00PM

BILL TO

05

*ESTIMATED AMOUNT TO BE PAID BY:
BX 8 656 562

PAGE NO. 1

POSTING DATE	DESCRIPTION			TOTAL CHARGE		← AMOUNT PAYABLE BY PATIENT
12/17	DAILY CARE	1154	SP	66.00	33.00	33.00
12/18	DAILY CARE	1154	SP	66.00	33.00	33.00
12/18	HEMATOCRIT		0002	2.40	1.20	1.20
12/18	WHITE BLOOD COUNT		0004	2.40	1.20	1.20
12/18	DIFFERENTIAL		0005	4.80	2.40	2.40
12/19	DAILY CARE	1154	SP	66.00	33.00	33.00
12/19	URINALYSIS		0115	2.40	1.20	1.20
12/19	PHARMACEUTICALS		1975	.50	.25	.25
12/20	DAILY CARE	1154	SP	66.00	33.00	33.00
12/20	SKULL XR		0408	45.00	22.50	22.50
12/20	BEDSIDE OR O.R. SURCHG		0556	7.00	3.50	3.50
12/20	INTRAVENOUS SOLUTIONS		1951	4.80	2.40	2.40
12/21	DAILY CARE	1154	SP	66.00	33.00	33.00
12/22	DAILY CARE	1154	SP	66.00	33.00	33.00
12/22	NON-ALLERGIC TAPE		0922	.60	.30	.30
12/22	SPECIAL BANDAGE		0944	.60	.30	.30
12/22	SPECIAL BANDAGE		0944	.60	.30	.30
12/22	OPERATING ROOM-TO 2 HR		1502	156.00	78.00	78.00
12/22	STERILE CATHETER		1536	1.40	.70	.70
12/22	SPECIAL SURG. SUPPLY		1584	1.10	.55	.55
12/22	SPECIAL SURG. SUPPLY		1584	1.10	.55	.55
12/22	SPECIAL SURG. SUPPLY		1584	1.10	.55	.55
12/22	SPECIAL SURG. SUPPLY		1584	1.10	.55	.55
12/22	PHARMACEUTICALS		1975	3.00	1.50	1.50
12/22	PHARMACEUTICALS		1975	.50	.25	.25
12/22	PHARMACEUTICALS		1975	.95	.48	.47
12/22	PHARMACEUTICALS		1975	.50	.25	.25
12/22	PHARMACEUTICALS		1976	3.95	1.98	1.97
12/22	PHARMACEUTICALS		1981	.50	.25	.25
12/23	DAILY CARE	1154	SP	66.00	33.00	33.00
12/23	INTRAVENOUS SOLUTIONS		1951	4.80	2.40	2.40
12/23	INTRAVENOUS SOLUTIONS		1951	4.80	2.40	2.40
12/23	INTRAVENOUS SOLUTIONS		1951	4.80	2.40	2.40
12/23	INTRAVENOUS SOLUTIONS		1951	4.80	2.40	2.40
12/23	PHARMACEUTICALS		1975	.50	.25	.25
12/24	DAILY CARE	1154	SP	66.00	33.00	33.00
12/24	PHARMACEUTICALS		1975	.50	.25	.25
12/25	DAILY CARE	1154	SP	66.00	33.00	33.00
12/25	PHARMACEUTICALS		1975	1.00	.50	.50
12/26	DAILY CARE	1154	SP	66.00	33.00	33.00
12/26	PHARMACEUTICALS		1975	.50	.25	.25
12/26	PHARMACEUTICALS		1977	1.45	.73	.72
12/26	PHARMACEUTICALS		1977	1.45	.73	.72
12/27	DAILY CARE	1154	SP	66.00	33.00	33.00

*ESTIMATED INSURANCE BENEFITS APPEAR ON YOUR BILL AFTER RECEIPT OF WRITTEN APPROVAL OR CONFIRMATION.

PLEASE PAY THIS AMOUNT

THIS BILL IS SUBJECT TO REVISION UPON RECEIPT OF [illegible] HOSPITAL CHARGES

WHEN CONTACTING US ABOUT THIS BILL, PLEASE REFER TO THIS NUMBER ▼

SERIAL # 58555

UNIVERSITY HOSPITAL

NEW YORK UNIVERSITY MEDICAL CENTER
560 FIRST AVENUE - NEW YORK, N. Y. 10016

TELEPHONE: OR 9-3200 EXT. 3368

PATIENT
1

STATEMENT

BILLING DATE: 1/30/69

UNIT NO.	ADMITTED	DISCHARGED
194014	12/17/68 6.00PM	1/16/69 4.00PM

BILL TO

05

*ESTIMATED AMOUNT TO BE PAID BY:
BX 8 656 562

PAGE NO. 2

POSTING DATE ▼	DESCRIPTION			TOTAL CHARGE		◄ AMOUNT PAYABLE BY PATIENT
12/28	DAILY CARE	1162	SP	66.00	33.00	33.00
12/29	DAILY CARE	1162	SP	66.00	33.00	33.00
12/29	PHARMACEUTICALS		1975	.50	.25	.25
12/30	DAILY CARE	1162	SP	66.00	33.00	33.00
12/30	PHARMACEUTICALS		1975	.50	.25	.25
12/30	PHARMACEUTICALS		1975	1.00	.50	.50
12/30	PHARMACEUTICALS		1977	1.20	.60	.60
12/31	DAILY CARE	1162	SP	66.00	33.00	33.00
12/31	LUMBAR SPINE XR		0412	50.00	25.00	25.00
1/01	DAILY CARE	1162	SP	66.00	33.00	33.00
1/02	DAILY CARE	1162	SP	66.00	33.00	33.00
1/02	PHARMACEUTICALS		1975	.50	.25	.25
1/02	PHARMACEUTICALS		1975	.50	.25	.25
1/02	PHARMACEUTICALS		1975	.50	.25	.25
1/02	PHARMACEUTICALS		1975	1.00	.50	.50
1/02	PHARMACEUTICALS		1975	.50	.25	.25
1/02	PHARMACEUTICALS		1975	.65	.33	.32
1/03	DAILY CARE	1162	SP	66.00	33.00	33.00
1/03	PHARMACEUTICALS		1975	.50	.25	.25
1/04	DAILY CARE	1162	SP	66.00	33.00	33.00
1/05	DAILY CARE	1162	SP	66.00	33.00	33.00
1/05	PHARMACEUTICALS		1975	.50	.25	.25
1/06	DAILY CARE	1162	SP	66.00	33.00	33.00
1/07	DAILY CARE	1162	SP	66.00	33.00	33.00
1/07	PHARMACEUTICALS		1975	.50	.25	.25
1/07	PHARMACEUTICALS		1975	.50	.25	.25
1/07	PHARMACEUTICALS		1977	1.45	.73	.72
1/08	DAILY CARE	1162	SP	66.00	33.00	33.00
1/08	SPECIAL BANDAGE		0944	.60	.30	.30
1/08	SPECIAL MED. SUPPLIES		0964	14.90	7.45	7.45
1/08	PHARMACEUTICALS		1975	.50	.25	.25
1/08	PHARMACEUTICALS		1975	1.00	.50	.50
1/09	DAILY CARE	1162	SP	66.00	33.00	33.00
1/09	GROUP PHYSICAL THERAPY		1307	5.00	2.50	2.50
1/09	PHARMACEUTICALS		1975	2.80	1.40	1.40
1/09	PHARMACEUTICALS		1977	1.45	.73	.72
1/10	DAILY CARE	1162	SP	66.00	33.00	33.00
1/10	PHYS THERAPY 30 MIN		1300	10.00	5.00	5.00
1/10	GROUP PHYSICAL THERAPY		1307	5.00	2.50	2.50
1/11	DAILY CARE	1162	SP	66.00	33.00	33.00
1/12	DAILY CARE	1162	SP	66.00	33.00	33.00
1/12	GROUP PHYSICAL THERAPY		1307	5.00	2.50	2.50
1/12	PHARMACEUTICALS		1975	.50	.25	.25
1/12	PHARMACEUTICALS		1975	1.00	.50	.50

*ESTIMATED INSURANCE BENEFITS APPEAR ON YOUR BILL AFTER RECEIPT OF WRITTEN APPROVAL OR CONFIRMATION.

PLEASE PAY THIS AMOUNT ▲

◆ THIS BILL IS SUBJECT TO REVISION UPON RECEIPT OF ADDITIONAL HOSPITAL CHARGES AND/OR CHANGES IN BENEFITS AS ESTIMATED [illegible] IS DUE UPON PRESENTATION OF

WHEN CONTACTING US RE: THIS BILL, PLEASE REFER TO THIS NUMBER

SERIAL # 58555

UNIVERSITY HOSPITAL

NEW YORK UNIVERSITY MEDICAL CENTER
560 FIRST AVENUE • NEW YORK, N. Y. 10016

TELEPHONE: OR 9-3300 EXT. 3868

STATEMENT

BILLING DATE: 1/30/69

UNIT NO.	ADMITTED	DISCHARGED
194014	12/17/68 6:00PM	1/16/69 4:00PM

BILL TO

*ESTIMATED AMOUNT TO BE PAID BY:

BX 8 656 562

05

33

PAGE NO. 3

POSTING DATE	DESCRIPTION		TOTAL CHARGE		AMOUNT PAYABLE BY PATIENT
1/12	PHARMACEUTICALS	1977	1.45	.73	.72
1/13	DAILY CARE 1162	SP	66.00	33.00	33.00
1/13	PHARMACEUTICALS	1975	.50	.25	.25
1/14	DAILY CARE 1162	SP	66.00	33.00	33.00
1/14	GROUP PHYSICAL THERAPY	1307	5.00	2.50	2.50
1/15	DAILY CARE 1162	SP	66.00	33.00	33.00
1/15	PHARMACEUTICALS	1975	1.00	.50	.50
1/15	PHARMACEUTICALS	1975	.50	.25	.25
1/15	GROUP PHYSICAL THERAPY	1307	5.00	2.50	2.50
1/16	DAILY CARE 1162	SP	66.00	33.00	33.00
1/16	GROUP PHYSICAL THERAPY	1307	5.00	2.50	2.50
1/17	PHYS THERAPY 30 MIN	1300	10.00	5.00	5.00
1/17	SELF HELP DEVICES	1341	20.40	10.20	10.20
1/30	INS. PAYMENT 327892			986.58CR	
			2.469.80	248.36	1.234.86

*ESTIMATED INSURANCE BENEFITS APPEAR ON YOUR BILL AFTER RECEIPT OF WRITTEN APPROVAL OR CONFIRMATION.

* THIS BILL IS SUBJECT TO REVISION

CHECK 193315

CHECK NUMBER	DATE MO	DAY	YEAR	EARNINGS REGULAR	OVERTIME	GRATUITIES	CASH	DECL TIPS	MEALS	TAXABLE	N Y C TAX
193315	02	13	1971	125 20			125 20			125 20	1 57

F I C A	W/H	STATE W/H	INS	LOAN	FEES	RCCS REC	ADVANCE	MISC	BONDS	DISA	
651	1274	236									

5.000

•10302 ◀ AMOUNT OF PAY

YEAR TO DATE 075-28-8820 1981

STATE W/H	MEALS	DECL TIPS	TAXABLE	N Y C TAX
4992 10098	1968		96013	4 52

THIS IS A STATEMENT OF EARNINGS AND DEDUCTIONS

PLEASE DETACH AND KEEP THIS STUB FOR YOUR TAX RECORDS

Adm. No. 258567 Date 9/27/20

LINE NO.	1	2	3	4	5	6	7	8	9	10	11	12

New York NY 10036

FINAL NOTICE

As of today, we have not had any response to our previous reminders regarding the balance still due on your account amounting to $ 221.37

Please be advised that unless payment is made within ten days, we will be obliged reluctantly to refer the account to our attorney for collection.

We sincerely hope this will not be necessary.

Credit Manager

Hospital for Joint Diseases

City told us again, you are able to pay

St. John's Episcopal Hospital
485 HERKIMER STREET
BROOKLYN, N. Y. 11213

$ ______ AMOUNT PAID

8-14-70

(PLEASE RETURN STUB WITH YOUR REMITTANCE)

		TOTAL CHARGES	EXCLUDED FROM BLUE CROSS BENEFITS (TO BE PAID BY PATIENT)
NAME	ADM. # 7u46421		
ADMITTED 7-23-70	DISCHARGED 7-28-70		
ROOM AND BOARD	DAYS AT $ 75.00	750	
" " "	DAYS AT $		
" " "	DAYS AT $		
NURSERY	DAYS AT $		
WARD-ALL INCLUSIVE FOR EXTRAS			
ANESTHESIA SUPPLIES			
OPERATING ROOM CHARGES			
DELIVERY ROOM CHARGES			
RECOVERY NURSING			
LABORATORY SERVICES		1270	
X-RAY (DIAGNOSTIC)		520	
DRUGS			
INTRAVENOUS SOLUTIONS			
MEDICAL SUPPLIES		450	
CARDIOGRAMS — HMR		200	
BLOOD-BLOOD PLASMA			
OXYGEN			
X-RAY THERAPEUTIC EQUIPMENT (USE OF EQUIPT. ONLY)			
TELEPHONE			
CIRCUMCISION			
FORMULA			
COMFORT KIT			
	TOTAL CHARGES	3190	
	A.H.S. ALLOWANCES		
	NET AMOUNT PAYABLE		
	CASH DEPOSITED		ALL BILLS ARE DUE UPON PRESENTATION
	BALANCE DUE		
	REFUND ENCLOSED		

† THIS BILL DOES NOT INCLUDE DOCTORS FEES OR PRIVATE PHYSICIANS FEE FOR ANESTHESIA SERVICES.

PLEASE REFER TO YOUR ADM. NUMBER IN EVERY COMMUNICATION WITH THE HOSPITAL

-661 ST. JOHNS EPISCOPAL HOSPITAL, BROOKLYN, N.Y.

LENOX HILL HOSPITAL

100 EAST 77TH STREET / NEW YORK, N. Y. 10021 / TRAFALGAR 9-6000

ITEMIZED STATEMENT

Court O-497-617

History No.	Journ. No.	Date
385179 1020	13463	12/5/70
Discharge Date	Coverage Full Days 21	Discount Days 24
11/23/70		

Service Rendered	Hospital Charges	Allowances	Allowances	Patient's Portion
Room 4 days at 89.00	356.00	356.00		
Ward 38 days at 90.00	3420.00	2475.00		945.00
Operating or Delivery Room	340.00	340.00		
Recovery Room	50.00	50.00		
Anesthesia	66.99	66.99		
Laboratory Tests	501.70	450.60		51.10
X Rays	96.00	96.00		
Drugs	366.80	360.20		6.60
Oxygen				
Blood Bank	320.00	—		320.00
Special Nurses				
Gift Shop, Telephone & TV	.90	—		.90
Circumcision & Formula				
Therapy & X Ray Treatment				
Central Supply	221.60	221.60		
EKG, EMG and BEG	25.00	25.00		
Red Cross processing fee	36.00	—		36.00
X Ray Telephone	24.00	24.00		
Totals	5824.99	4465.39	—	1359.60

Loss Previous Payments	—
Other Credits	—
Balance Due	1359.60

For additional information call the Patient Accounts Dept. at 879-8000 Ext. 414 or 454

Remittances should be made to Lenox Hill Hospital, Attention Patient Accounts 100 E. 77th St., New York, N.Y. 10021

Prepared By

LENOX HILL HOSPITAL

100 EAST 77TH STREET / NEW YORK, N.Y. 10021 / TRAFALGAR 9-6000 EXT. 414 EXT. 454

STATEMENT OF ACCOUNT

DATE 02/19/71

AMOUNT YOU ARE REMITTING $_____

BILLED TO: 000000000 M STATEMENT NUMBER

PAGE 1

PATIENT NAME
ACCOUNT NUMBER

ADMISSION DATE 10/12/70
DISCHARGE DATE 11/23/70

PLEASE RETURN THE UPPER PORTION WITH YOUR PAYMENT

DATE	DESCRIPTION		AMOUNT
11/30/70	BALANCE		5824.99
12/15/70	AHS NY PMT-1	BLUE CROSS	830.13CR
12/21/70	AHS NY PMT-2	BLUE CROSS	2632.56CR
12/28/70	AHS NY PMT-1	BLUE CROSS	313.58
01/15/71	AHS NY PMT-2	BLUE CROSS	1316.28CR
		ACCOUNT BALANCE	1359.60
	REMAINING COVERAGE	BLUE CROSS	472.42CR
		PATIENT BALANCE	1832.02

REMEMBER
PERHAPS YOU [illegible] OUR
LAST R[illegible] AND
PAYMENT [illegible] MAIL

PLEASE PAY THIS AMOUNT 1832.02

YOUR ACCOUNT IS OVERDUE. PLEASE PAY PROMPTLY.

Senator KENNEDY. The next witness is Mrs. Judith Schaffer, a social worker who has spent a great deal of time with Mrs. Franklin, who has two children suffering from lead poisoning.

STATEMENT OF MRS. JUDITH SCHAFFER, MEMBER OF THE CITIZEN'S COMMITTEE TO END LEAD POISONING, ACCOMPANIED BY MRS. WILLIAM FRANKLIN, MOTHER OF LEAD POISONED CHILD

Mrs. SCHAFFER. My name is Judith Schaffer, and I am speaking here today as a member of the Citizen's Committee to End Lead Poisoning. Our committee, which is entirely voluntary, was formed 3 years ago to alert parents and community groups to the "silent epidemic" of lead poisoning, which was threatening death or permanent injury to tens of thousands of children in our city, most of them residents of dilapidated housing in ghetto areas.

In 1968 the New York City Health Department admitted that it was discovering less than 3 percent of the children in the city with seriously elevated lead levels. The epidemic was "silent" not because it was unknown, but because a calculated decision was reached in the health bureaucracy not to screen and diagnose children. It was not cost effective to do so since little could be done to remove the basic cause of the disease, peeling lead-based paint chips in decaying tenements.

Mrs. William Franklin is here today to answer any questions you may have. She is the mother of one of these unscreened and undiagnosed children, Gregory, who will be 4 years old next month.

Mr. and Mrs. Franklin and their four children lived at 263 West 112th Street, a building managed, if that term is appropriate, by the Hahn Management Corp., of 152 West 72d Street. According to department of buildings records there were 98 outstanding serious violations against the building, most on record since 1966. There was no record of a single of these violations being corrected or of any legal action taken against the landlord to compel him to correct them. Some of the violations included peeling paint, holes in walls and ceilings, failure to paint, no heat, rats and vermin.

Mrs. Franklin brought her children to the Harlem District Health Office several times each year for medical checkups. Never, at any time, was she asked whether Gregory or the other children ate paint. Never, as the result of the calculated decision to ignore lead poisoning, was Gregory tested for lead poisoning. There was no information available to either Mr. and Mrs. Franklin or to medical personnel they came in contact with about lead poisoning—how widespread it was, its causes and symptoms, or as in Gregory's case, its lack of symptoms.

At 4 a.m. on September 10, 1969, Mrs. Franklin was awakened by Gregory who seemed to be choking. He was in a coma. The Franklins rushed him to Metropolitan Hospital where he remained in coma, hovering on the brink of death, for 5 days. After many attempts at diagnosis the verdict was severe lead encephalopathy. In lead encephalopathy the walls of the blood vessels are somehow affected so that the capillaries become too permeable. They leak, causing swelling of the brain tissue. Since the brain is enclosed in

a rigid container, the skull, severe swelling destroys brain tissue. Certain brain cells are also directly injured by the lead. Many of the tests made on Gregory in order to diagnose the cause of his coma in fact increased damage to his brain.

It is clear that had the interns at Metropolitan been more experienced—had they been aware of what lead poisoning was, what its symptoms were and, most important, how widespread a disease it was, they might have known enough to dispense with the more harmful diagnostic tests and to begin treatment immediately.

But a calculated decision was made not to screen children. A calculated decision to be cost effective. A calculated decision that Gregory Franklin would lay in a hospital bed screaming in agony, unable to see or hear or recognize even his own parents.

Gregory remained blind, deaf, and unable to walk for some time. Gradually be began to walk. Three months later he seemed at times to be able to see. Somewhat later than that his hearing and more of his sight came back.

Gregory is severely brain damaged. He must take three different medications several times each day, including phenobarbitol and dilantin, to prevent what appear to be epileptic seizures, the result of the damage to his brain and a common result of lead poisoning. Sometimes the drugs work and more often they don't. He can't talk very much and was only recently again toilet trained. He is difficult to control because he has trouble understanding things now and because if he becomes upset as when he is chastized he usually has a seizure.

Since the treatment for lead poisoning can only remove the lead in the blood at the time of the procedure and can't make a dent in the lead stored in the bones, aorta, and various other organs, each time Gregory gets a common childhood infection, such as a cold, a sore throat or the chickenpox, he again becomes "lead poisoned" as the stored lead reenters his blood. He has been rehospitalized three times since December 1969.

Gregory has a sister, Lisa, who is 3-years older than he is. The hospital never volunteered to test her for lead poisoning although she lived in the same lead-infested apartment. We finally forced them to test her and she was found to have a blood lead level of 60 micrograms for every milliliter of blood. New York City recognizes this level as critical while the U.S. Surgeon General recognizes a lower level of 40 micrograms per milliliter of blood as the level at which a child is considered to be poisoned.

Senator KENNEDY. This was after they had diagnosed——

Mrs. SCHAFFER. Gregory, and after he had been in the hospital for a while.

Senator KENNEDY. And did they test his sister?

Mrs. SCHAFFER. They wouldn't test her until we forced them to.

The hospital refused to admit Lisa. We obtained statements from various physicians to the effect that even if she wasn't deleaded Lisa must be removed from the lead trap in which she was living as a public health measure. After a great deal of pressure and the threat of press publicity and even legal action the hospital relented and admitted Lisa and treated her 3 weeks after her positive test result was known.

Two questions must be asked, why was it necessary to force the hospital to test Lisa, and why did they have to be forced to treat her. One must assume for these and other reasons that the lives of black children are considered to be expendible by our health establishment.

Gregory has been in the care of a private pediatrician and neurologist for the past year. This was possible because of medicaid, which allowed working people like the Franklins to receive medicaid if their incomes fell below a certain level and if they had large medical expenses.

Now Governor Rockefeller has, in his ultimate wisdom, taken medicaid from any but the welfare poor. What are the Franklin's to do now? A conservative estimate of Gregory's yearly medical bills is probably 10 times Mr. Franklin's annual salary. Gregory must remain with his private physicians if there is to be any hope for his leading a useful life for both himself and society. He must be under the supervision of one permanent physician who won't lose his records, who can be called on the phone and questioned about symptoms at any hour and who is concerned about him.

Gregory does not have an interesting disease, one professors can use as illustration for their students and write learned papers on. He is but one of many brain damaged children who are now allowed to vegetate in institutions with little or no effort made in their behalf. Gregory should not have to fall victim to this fate and he will if private medical care can't be provided him at this critical stage in his life. No matter what anybody tells you to the contrary, the services provided at city hospitals are inadequate, often dangerous and harmful, as in Gregory's case, and extremely depersonalized. Must the Franklins go on welfare in order to qualify for medicaid? Is this cost effective?

I am presenting this case as an illustration of what is wrong with health care today in New York and probably in the Nation. I expect that you will reach your own conclusions and make your own recommendation for change of our health care system. May I respectfully request that you consider and propose a system of health care radically different from our present system. A system whose primary function would be to provide not only excellent medical treatment, but compassionate and personal care for each of us based on our needs rather than on a bureaucrat's concept of cost effectiveness, a polite term in this case for genocide.

Thank you.

Senator KENNEDY. Mrs. Franklin, is there anything else you would like to say on this? How many times did you take Gregory to the hospital before they diagnosed lead poisoning, do you know?

Mrs. FRANKLIN. Before he was sick or when he took sick?

Senator KENNEDY. Well, how about just before, did he go to the hospital perhaps——

Mrs. FRANKLIN. To the health station.

Senator KENNEDY. Health station?

Mrs. FRANKLIN. Yes.

Senator KENNEDY. And he went to the health station several times?

Mrs. FRANKLIN. Yes.

Senator KENNEDY. And they never tested him?

Mrs. FRANKLIN. No, they never asked or tested him.

Senator KENNEDY. And even after they diagnosed lead poisoning in terms of Gregory, he went back to the hospital, and they didn't perform any tests on your daughter?

Mrs. FRANKLIN. No.

Senator KENNEDY. On Lisa.

Mrs. FRANKLIN. No.

Senator KENNEDY. Do you have any idea why not?

Mrs. FRANKLIN. No; I don't. I really don't.

Senator KENNEDY. You would certainly have thought or expected they would have, wouldn't you? Do you think that is a reasonable assumption that if a child from one family is affected by lead poisoning and another child is sick, wouldn't you think it would be just normal to assume that they would go ahead and provide this kind of testing?

Mrs. FRANKLIN. Yes; I do.

Senator KENNEDY. But they didn't. And you explain your story here to us in this subcommittee, but I am sure there are scores of people like yourself who have suffered in this incredible and intolerable way because there are no procedures. It would seem to me it wouldn't be very complicated to provide when any of these health stations test children who live in areas which have lead-base paint, that you would test for this. I mean if that is interferring in terms of the doctor's relationship then that's just too bad. I mean why can't we have that kind of a system that is going to insure at least some kind of detection?

You know, I wish we could be more encouraging to you, Mrs. Schaffer and Mrs. Franklin. As you may know, we passed a lead-base paint poisoning bill last year. It went through this subcommittee, as a matter of fact, and we authorized $15 million for this year, $20 million next year, and $25 the year after, in spite of the fact that the initial bill that passed the Senate was over double that. But in terms of the conference they told us that they would refuse to bring it up in the final days of the session, it could be objected to by a single objection in the final days. So they cut it down to 15, 20 and 25 over a 3-year authorization. And even in spite of the fact that that legislation passed the House and Senate, this administration didn't make a request for one cent in terms of lead-base paint poisoning. As a matter of fact, I can say it looked for a while that the President was going to veto it, and I think I am confident we could have overriden in that area.

But there are those that say within the department today we have programs that meet this need, in spite of the fact they never have in the past. And I don't blame you for being outraged about it.

I want to thank you very much.

Mrs. SCHAFFER. Thank you.

Senator KENNEDY. Mr. Daniel Ginsberg. Mr. Ginsberg, maybe we can bring these microphones over. Mr. Ginsberg is a paraplegic, working as a vocational counselor to the Bronx Community Corp., has to make a choice between working or getting free care under medicaid. Daniel wants to work, and yet may lose the health benefits he is getting if he does. Daniel, we want to welcome you here.

STATEMENT OF DANIEL GINSBERG, COUNSELLOR TO BRONX COMMUNITY CORPORATION

Mr. GINSBERG. Thank you, Senator. I appreciate the opportunity very much to have some input here as a consumer of health services in this city.

By way of background I would like to indicate that after being on public assistance for 17 years, since the age of 5, I was able to get employment, and this was four and a half years ago, and I got off welfare. This to me gave me a very good feeling—call it pride, self-esteem, whatever you will. I felt very good about it.

But progressively from that point I began losing medicaid benefits.

Before I started working I had 48 hours per week of attendant care. Then it was cut to 24 hours, and one day I received a phone call that the 24 hours would be cut to zero. When I questioned the caller as to the basis for this termination she hung up on me.

At this point I was forced to go back on welfare. I had struggled most of my life to get off welfare, and I was forced to go back on welfare. And I took the issue to court.

Now while I was on welfare I was quite well off financially, a lot more well off than if I was just on medicaid. However, it was a matter of principle with me, and I went to court and my case was in the courts for 2 years. At the end of the 2-year period the New York State Supreme Court determined that my medical attendant care was terminated without due process, and on July 1, 1970, I was reinstated.

By this time my mother's health—my mother is virtually my only attendant—had deteriorated drastically, and in January of 1971 I applied, reluctantly, for public assistance again. My application was ignored. I sent three applications. The third one was finally responded to in April, and the response was denial. This denial was based on the fact that I earned too much income to qualify for public assistance.

Now I have documented to the department of social services that although last year I earned $6,900 on my job, I had spent $8,500 just on care incidental to my personal well-being. Nevertheless, the position at the department of social services has been that the city would rather support me completely if I quit my job than partially if I continued to work. Medicaid holds firmly to their decision that my family can provide the attendant care that I need. A medical director in the Bureau of Health Care Services reached this conclusion from the sanctity of her office. She never examined me or the conditions in my home. Instead, she contradicted my personal physician who has intimate knowledge of my situation.

Now on December 6 of 1970, and on January 27 of 1971, my physician had written to medicaid requesting increased attendant care due to the deteriorating condition of my mother's health. Both certificates—the first certificate was ignored and the second one was denied verbally.

I am not certain how long I can continue to function with inadequate care, how long I can continue to function with 3 hours sleep

a night, and with inadequate personal attention. But one thing that I am certain of and one thing that is overpowering with me and continues to push me forward is the fact that I was not expected to live past age 20. Life is all the more sweeter for I stole the last 4 years—I stole them from those who said I was too disabled to work, so I got a job and have been working for four and a half years. I robbed the last nearly two and a half decades for those who said I was too handicapped to go school. So in addition to working I became a part-time student at Columbia, and I am in my junior year.

Despite these achievements the most important battle to be a viable human being remains to be won. In the East River lies Welfare Island and Goldwater Hospital, a repository for handicapped people who have no one to care for them. I am fighting for increased attendant care so I do not have to rely on my mother, who is consumed by illness, so I do not have to become a patient in Goldwater. I am fighting for my birthright to pursue my life in the mainstream and pursue my dreams here rather than in the back alleys and drab corridors of Goldwater Hospital.

I cannot zip my zippers nor button my buttons, but someone else can. And with government help I can hire attendants and continue to work, return to society at least as much as I have taken.

One thing is abundantly clear to me, and that is that the prospect of stopping work, of becoming truly a public charge seems inviting at times. Then I would be assured of all my creature comforts. But I have come too far to turn around now. As I search for justice I may have to strengthen my will some nights, but I will not cross the river to Goldwater Hospital. The city has forced me to the waterside, but I will not cross the river.

That concludes my statement.

Senator KENNEDY. What is your impression of a health system that treats you this way—attempts to keep you from realizing your own dreams?

Mr. GINSBERG. Well, I think the kind of personnel that the whole system attracts is perhaps at best very mediocre, and at best uniquely insensitive to human need.

Senator KENNEDY. I was thinking of the system itself which in effect attempts to discourage you from working and attempts to frustrate your very, I think, admirable desire to be a useful human being. What is your reaction to this?

Mr. GINSBERG. Well, when I am threatened with having to quit my job, to me this is a threat to my very existence because I contend that in order to justify the air that I breathe it is necessary for me to contribute. And it is very hard for me to speak of it in any other context.

I think that you could talk about the economics; you could talk about the value of the society that encourages people to be on the dole rather than contribute to their own well being; you could talk about all these factors, but to me there is only one dominating factor, and that is at this moment I am personally threatened and it is very hard for me to relate to it in any other way.

Senator KE NNEDY. Well, I want to thank you very much for coming here. I think it reminded us all about the indominatable quality

of the human spirit, and we appreciate your sharing it with us here this afternoon. I hope you can stay with us for a little while. Maybe we can get you a cooler place than underneath these lights here.

Mr. GINSBERG. Quite all right.

Senator KENNEDY. One witness who isn't on the list because we were not sure she would be here is Mrs. Ruth Atkins. She is now here, and I would like to ask her to testify. She is the chairlady of the East Harlem Health Council. We had initially scheduled her and then we were unable to get her confirmed. She would have appeared at this point on the witness list, and she has to leave very shortly, so we are going to ask here if she would comment briefly. We want to thank you very much.

STATEMENT OF MRS. RUTH ATKINS, CHAIRLADY OF EAST HARLEM HEALTH COUNCIL

Mrs. ATKINS. I want to thank you for the opportunity. Some of the things I was going to discuss have been put together very firmly by the previous speakers.

I was concerned with the mother with the problem with her child with lead poisoning because in the early season of 1969 the East Harlem Health Council with the Committee Against Lead Poisoning had a drive in East Harlem and we were trying to get the hospitals to examine every child that came into the clinic.

We have a committee in East Harlem which is called the East Harlem Health Council, which is made up of neighborhood people and providers, and our goal is to improve the quality of care in our community.

One of the things we have been able to do with the help of outside forces is to get reliable ambulance service. Everyone within this room knows the problem of getting ambulances within a community. Many times we are told there is an ambulance and an ambulance driver, but there is not an attendant. So what happened in our community, we were able to get a Volkswagen contributed by a Catholic charity through one of the hospitals, and a community organization is paying the salary of one of the workers, and this worker has been trained as an attendant, a driver attendant. So we are able to get the people back and forth to the hospitals.

Some of the problems we have found, for instance, is that there was a baby in our community that had gone over to Harlem Hospital, Harlem Hospital contacted the organization because they didn't have a bed for this child and the child had been there more than a day and a half. And we located a bed in Metropolitan Hospital. Nobody was able to get an ambulance to get that child from Harlem Hospital to Metropolitan. So our ambulance driver has done this.

Another thing, we find within our community after a certain hour you cannot get a prescription filled. The drugstores are closed. There is no place within the East Harlem community, and I am quite sure throughout other parts of the city like ours, where people can go even if they would sit in a doctor's office all day to get their prescription filled. And we are trying to see and hope that the hospitals will

be empowered that neighborhood people can take their prescription to the pharmacies within the hospitals and get them filled at a reasonable rate.

The other things we are concerned with is the buildings within our community. Many of them are rundown. And there is one thing to say—if a child is sick and has lead poisoning all the other children in that family should be tested. But if a child in one building has lead poisoning it stands true to fact that that entire building has lead poisoning because of the paint. And the housing people told us that if one person complained they would fix one apartment for the tenant that complained. But when you have 28 apartments in a building there should be some rule and regulation, and maybe it would have to come through health, that all this building be fixed.

Senator KENNEDY. What about even the hospital? We were at Lincoln Hospital last night and we found they were getting children with lead-base poisoning and found they were getting more infected when they stayed in the hospital. They found out that the paint that they had on the walls was lead based, so that the children were getting sicker staying in the hospital.

Mrs. ATKINS. What they fail to realize, they will say "well, we put paint on that is lead free," but they are not considering the paint that has been on there for years and years that wasn't lead free.

The other thing we are concerned about is the elderly. They sit all day in the clinics and then they have to stand in long lines to get their prescription filled. There has to be some way worked out where the Neighborhood Youth Crops young people could stand in a line to get the medication for the elderly.

In many of the hospitals, and particularly the city hospitals, the sections where they keep the elderly people aren't even cleaned properly, and they aren't getting the proper services they need.

Our council now is working in trying to develop a basic scheme to change the system in the delivery of health care so that each person, whether they have money or don't have money, can get the same amount of care.

Another question I have, many people pay Blue Cross-Blue Shield. A gentleman spoke about the various plans. But in communities like ours you never know what Blue Cross and Blue Shield is going to pay until you are sick. And Blue Cross will pay $99 a day for you to stay in the hospital; if you prefer to go home and come back for treatment they do not pay for postoperative care; they do not pay for clinic care. So you are forcing people, therefore, to stay in the hospital at times when they could be at home.

Another thing we are concerned about—and yesterday there was a meeting of Brotherhood in Action about the cuts in medicaid. You are getting whole groups of segments like ours who are not going to be able to pay for hospital bills at all, who will not be able to take care of their children's dental work. And one of the things we have been able to do is have some doctors to develop health care within the school. We have been asking for years throughout New York City for the board of education to develop proper health care within the schools. In one of the schools we found out there was a dentist's chair there for over 10 years never used. And we are trying to get dentists to come in and take care of the children.

The other thing that is necessary, somebody mentioned before that doctor's don't come into ghetto areas, because of the problems there. But since there has been medicare and medicaid every time you look there is another overnight gin mill, as we call them, opened, and they said we accept medicare and medicaid, and there is no one to evaluate the quality of care that is being given to our people.

The health council goes on record supporting your bill. The health council goes on record in that within every hospital every child who comes in ill should be tested for lead poisoning. And we also go on record that the hospital should begin to develop a system whereby the elderly don't have to wait in these long lines to get their prescriptions filled, so that they can get to the buses and on the subway before the prices go up.

We also would like them to work in reducing wait within the ambulatory services, and in those particular services where they have ambulatory care they can do health education in preventive medicine and in nutrition. It is one thing to criticize people and say you are big because you eat too much, but they don't know what you eat. There is another thing to say a person is ill and that they should take medication three times before meals or after meals, but somebody has to find out what the person is having for meals. Do they have a meal, and if they don't have a meal begin to work on helping the individuals to get the things they need.

There are other speakers and I am not going to take any more of your time, and I thank you for the opportunity.

And don't forget in all your health care, remember the drug addicts because they are human beings and they need health care. There are many medical problems that they have besides that addiction, and if we begin to move to give people the kind of dignity when they go for health care we will begin to reduce some of the problems that cause our citizens to turn to drugs.

Thank you very much.

Senator KENNEDY. Before you leave, I just read this morning in the newspaper about Dr. English announcing the possible closing of eight of these municipal hospitals. What effect would that have in terms of some of the people that you work with?

Mrs. ATKINS. This means that at least 75 percent of the people in the East Harlem community would be without medical care, because in our area that ambulatory service is equal to the private physicians in the middle-class and high-income area. And that's why the health council organized the community last year when there was rumors of cutting down outpatient departments to have those funds restored. And we are planning to try to get as many people as possible to give support to try to have the budget revised so that this would not have to happen. It would be more than a crisis. It would be a catastrophe within New York City.

Senator KENNEDY. I know you have been terribly interested in the whole drug area, too, and rehabilitation, and I understand provided great leadership in that area for your community.

What is your background? Could you tell me a little bit about yourself?

Mrs. ATKINS. Well, I was born in Harlem Hospital in 1923. In those days Harlem Hospital was still overcrowded, because my

mother gave birth to me in the bathroom. I grew up in East Harlem from 1925. I became interested in health when I saw my father in the hospital and visited other people, and the conditions that were in our hospitals way back in 1930, 1932, and so forth.

I even got further involved when my children began school. I had one son who died from pneumonia within a cold apartment, a child that had been going to the public health center where the visiting nurses had written also about the cold, and when you take your children to the emergency room they give them aspirins and send them home.

The other reason I got involved is because I went to a particular hospital with problems and because at that time I was a welfare mother they told me the problems were in my mind. When I went to another hospital 2 years later they said "why don't you people ever come for care on time," and I had to let them know I had been going for care but was being told it was in my mind.

And seeing what was happening to my family and other families within the community gave me all the more reason to become involved. And finally when they decided that I was not going to live that long I asked God if he spared my life that I would spend the rest of my life fighting for the people in my community. That is my purpose and that is my goal, and that is my background.

Senator KENNEDY. Well, you have expressed about as well as this subcommittee has heard the health crisis in the country. You have just run through example after example and expressed it very well. So I want to thank you very, very much for your appearing before the committee. It is extremely helpful to have your comments. We value them highly. Thank you.

Mrs. ATKINS. And thank you for the opportunity. And I am just recuperating from an operation and haven't paid all my medical bills either.

Senator KENNEDY. Mrs. Kronberg will take care of that. [Laughter.]

Mr. Charles Gildersleeve, who works in the Fulton Senior Center and is familiar with the health problems of the elderly, will talk about the failures of public and private health insurance programs.

STATEMENT OF CHARLES GILDERSLEEVE, COUNSELLOR, FULTON SENIOR CENTER

Mr. GILDERSLEEVE. Well, after following Mrs. Ruth Atkins—I have heard her speak many times—there is very little to say. I am sure it has been going on all day. But I can mention a few instances of the senior citizens.

Their problem is that they need a family physician to make house calls. In an emergency at night or even during the day it is very difficult to get a doctor to the home. They can't get them unless they can pay $15 or $25. All my people are on a tight budget from social security, maybe a little assistance from welfare, and they cannot afford this. So, therefore, they must get a neighbor or a friend to call the ambulance to take them to the emergency hospital or ward, and when they are in there they are kept for hours. Sometimes they are turned out at midnight to be sent home, and if they can't get an

escort to bring them back they sometimes send the police with them to their home.

Now many of them live in top-floor rooming houses in the rear, unlighted, no facilities for cooking or food. They are brought home and left alone. We really should have somebody to follow this up, either the nurses' aides or volunteers to follow this up and see how the people are doing, because often they die after they are sent home from the hospital for lack of care.

Now the experiences in the clinics are the same as I have heard other people say. They are overcrowded requiring hours of waiting. Sometimes the medical records are misplaced. And there is the problem of getting prescriptions filled at night at the drug counter at the hospital because there is a big line there all the time. And, of course, I found out that practically every hospital I visited they all have to wait, and these older people besides being old they are sick, and it is irritable for them to stand in line and wait and go from one clinic to the other expecting to be able to get out in a minute and they are there for 4 or 5 hours sometimes.

And before I came up here one of our clients came up to me and said "oh, you are going up there, another talk show, another talk show." He said "tell them up there that we won't talk any more, we want action. Get action." I said "why don't you come up here and give them a little action?" And he said "no, I never go out, don't speak, but no more talk."

Thank you very much.

Senator KENNEDY. Could you tell us a little bit about your reaction to those medicare, medicaid cutbacks?

Mr. GILDERSLEEVE. Yes, it is terrific, it is tragic.

Senator KENNEDY. How will this affect——

Mr. GILDERSLEEVE. It is tragic. I have people coming in all day long, especially with medicaid and with coinsurance now, even for the small amount of making up $50-$60 it is an ordeal to me. And to them—they are panicky. They say they are not going to the hospital. And the hospitals——

Senator KENNEDY. It is, of course, cost consciousness. Have you heard of cost consciousness? That is going to make them more cost conscious.

Mr. GILDERSLEEVE. It certainly is, and the hospitals have been cooperative. They have been billing the people, but they are not making any effort to collect it. But when a person gets a bill they are horrified anyway about that, see. So that is one problem.

The other thing is I have heard about this drastic cut in medicare down to 14 days during a period of sickness, and that is a big worry to them, too, because they are going to be kicked out and they won't have the money to pay.

Then the hospitals tell them about the funding they need and if they don't get this they won't be able to run the clinics. One of our tremendous clinics closed. But you hear these things—I haven't anything to back it up—due to the ghetto medicine bill they may not be funded this time. So it is a lack of money for all these places to operate, and that is the chief worry.

Senator KENNEDY. The Older Americans Act that came through this committee authorized, I think, $125 million this year. We appropriated last year about $32 million. It is less than the Defense

Department spends in public relations. And this year in spite of the doubling in terms of the authorization, the budget request was $29 million, which is a cut this year.

I agree with that person that said, you know, there's been a lot of talk and no action. I think that is a completely justified observation in terms of what this country is doing for the senior citizens.

Mr. GILDERSLEEVE. That is as we try to do down in the Fulton Center, we try to help others. We have volunteers. We can't always get them. But it is like the blind leading the blind, you might say, because they are older people, too, and they shouldn't be responsible for escorting a person to a hospital.

Senator KENNEDY. What has happened in the OEO programs for the young versus the old? I am glad we are doing as much as we are for the young, but in the poverty program our senior citizens are getting less than 10 percent of the funds that have been authorized by the Congress. Senior citizens have been shortchanged about as badly as any group in our society, and it is true in this whole health area. You have, I think, documented that quite completely.

Well, I want to express our appreciation. We are going to try and have something besides just "talk, talk" here, and we appreciate very much your coming down and testifying today.

Mr. GILDERSLEEVE. Well, thank you very much.

Senator KENNEDY. Carlos Cuevas is Director of Hunts Point Multiservice Neighborhood Health Center which serves 60,000 people. There are no alternative health facilities, as I understand, in that area, and the Center's budget will be terminated in 15 months. The only available facility will be the Lincoln emergency room, and that is already one of the——

Mr. CUEVAS. If you were up there, Senator——

Senator KENNEDY. I was up there.

STATEMENT OF CARLOS CUEVAS, PROJECT DIRECTOR, HUNTS POINT MULTISERVICE NEIGHBORHOOD HEALTH CENTER

Mr. CUEVAS. I think no matter what I say, the fact that you were up there you know what we are faced with.

Senator, if I may, my name is Carlos Cuevas, and I am Project Director of Hunts Point Multiservice Neighborhood Health Center. The gentleman sitting beside me is Mr. Paul Mejias, Chairman of the Board of Directors, Hunts Point Multiservice Center Corporation.

The Hunts Point Multiservice Neighborhood Health Center is funded by the U.S. Public Health Service and serves areas 40 and 41 in the South Bronx. There are approximately 60,000 people in these two health areas: 80 percent of which are Spanish speaking (of the 80 percent, 95 percent are Puerto Rican), 15 percent black and 5 percent others. To take care of the health needs of these 60,000 people (which, incidentally, is the size of a good average American city), there are two Child Health Stations, run by the New York City Health Department and our health center. Our center is the only source of comprehensive, family oriented health care in the area.

When we opened our doors officially, 18 months ago, we saw 200 patients a week. Today we average 1,500 patients a week. About

1,100 medical, 150 dental, 150 mental health, and 50 in our alcoholism program.

We are open every day from 9 to 8, Monday through Fridays, and Saturdays 9 to 2. We run a 24-hour ambulance shuttle service because, as you know, in our areas after dark you cannot get a taxi, you cannot get public transportation, and we are very much concerned that if a mother has a child with a bellyache at 2 o'clock in the morning we have to get her somewhere. So we run a 24-hour ambulance shuttle service.

Five years ago in the South Bronx we had St. Francis Hospital in our area. But that was taken away. The city put on a crash program to patch up Lincoln Hospital, but if today we go take a look at Lincoln Hospital we will find the holes in the wall that the workmen left when the money ran out.

Senator, I have often wondered who is going to take care of the health needs of our people when our HEW grant runs out. Lincoln Hospital can't even take care of its own patient load now. Imagine what would happen if you throw in 1,500 more patients a week. If this situation is intolerable now, what will it be if we did close our doors. There are nine OEO and PHS Centers in New York City now. If these centers have to close their doors, can the municipal hospitals pick up this additional load? I doubt it very much. They cannot even cope with what they now have. Is it not also true that ambulatory health services help keep medical costs down by keeping people out of hospitals? And let us not forget that ambulatory health care is less socially traumatic because it keeps the individual functioning and the family intact.

We have been trying for the last year to find viable means of financing our health center. Medicaid reimbursement is not enough, especially now that further reductions have been voted in by the New York State Legislature. Few, if any, of the people we serve have third party insurance. National health insurance, in our estimate, is at least 3 years away.

Senator, what are we to do? If we have to close our doors, must our people go back to Lincoln Hospital or to similarly unsatisfying institutions? In our center we pride ourselves on serving the community with courtesy, respect, and dignity. Must these elements of service go down the drain? Are we going to jeopardize the health of another generation?

Senator, allow me to make a recommendation of what we also need in our area. We need a 400-bed community hospital where patients will be treated with courtesy, respect, and dignity. We further must have several satellite centers, like ours, to give outpatient care. Legislation must be introduced to keep the neighborhood health centers open after the expiration of the 5-year grant and moneys for construction must also be available for the smaller community hospital. Let us, the consumers, decide what is it that we want; let us decide how we want it done; let us decide where and by whom it should be done.

Thank you.

Senator KENNEDY. Why are the funds to be cut off?

Mr. CUEVAS. Well, the legislation that set up the 314E's and the OEO centers has a 5-year limitation period on it. And most of the

centers are now well into their third or fourth year. We are well into our third year.

Senator KENNEDY. And you think that at the end unless there is other kind of legislation that the funding will terminate?

Mr. CUEVAS. Yes; no question about that.

Senator KENNEDY. Let me ask you why don't you close at 5 o'clock in the afternoons?

Mr. CUEVAS. Because our people work, and if we are talking about free care and if they have to take off half a day to come see us, Senator, how free is it? So if they don't pay for it one way they are going to pay for it another way.

Senator KENNEDY. Most of the neighborhood centers, though, actually close at 5, don't they?

Mr. CUEVAS. They have evening hours also.

Senator KENNEDY. More of them do, I guess, now.

Mr. CUEVAS. Yes; but we have always kept open until 8 o'clock.

Senator KENNEDY. Do you find there is greater utilization in terms of the evening?

Mr. CUEVAS. Yes.

Senator KENNEDY. Have any of the insurance carriers come forward to provide help for Hunts Point?

Mr. CUEVAS. No, sir.

Senator KENNEDY. Do you ever see any of the insurance companies ever come around and talk about how they are trying to provide or interest various groups in other programs?

Mr. CUEVAS. No, sir, they have not come to us.

Senator KENNEDY. I haven't found anybody they have gone to and I am trying to find somebody. Sort of like a volunteer army, I never find anyone that wants to volunteer.

Mr. CUEVAS. Senator, no matter what we say, what we write, the only way we find is to come up and see us, talk to the patients, talk to our staff. I think this is the best way.

Senator KENNEDY. To get back to this 5-year limit on the law, I don't know of a 5-year limitation on the law. Who told you about it? We can look into it. I just was unaware of it. I didn't know there was this kind of restriction.

Mr. CUEVAS. Well, our funding exhausts according to the U.S. Public Health Service.

Senator KENNEDY. Well, we will find out about that. We will follow that up in any event.

Mr. CUEVAS. We certainly would appreciate that.

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

These neighborhood health centers, as you probably know, initially were started under Joe English, and started up in Boston, Columbia Point, and Bayou County down in Mississippi, and what is really Gibson County. Dr. Geiger, up at Tufts Medical School, has provided extraordinary leadership in this area, and we were terribly impressed with this as a means and a system, and we were able to amend the OEO program to include these health centers. So we are terribly interested, I am, in the program in and of itself. I think it is an enormously valuable kind of experience, and I think that your comments, of course, are terribly helpful in this regard.

Mr. CUEVAS. Thank you again, sir.

(The prepared statement of Mr. Cuevas follows:)

HUNTS POINT MULTI-SERVICE CENTER CORP.

Ramón S. Vélez
Executive Director
Paul Mejias
Chairman

CARLOS CUEVAS, PROJECT DIRECTOR, HEALTH COMPONENT, HUNTS POINT MULTI-SERVICE CENTER CORPORATION, TESTIFYING BEFORE THE SENATE HEALTH SUBCOMMITTEE ON HEALTH CARE CRISIS IN AMERICA, APRIL 14, 1971, 2:00 P.M., IN THE WINSTON CONFERENCE ROOM OF THE ROOSEVELT HOTEL, 428 WEST 59th STREET, NEW YORK, NEW YORK.

Senator Kennedy, ladies and gentlemen. My name is Carlos Cuevas, and I am Project Director of Hunts Point Multi-Service Neighborhood Health Center. The gentleman sitting beside me is Mr. Paul Mejias, Chairman of the Board of Directors, Hunts Point-Multi-Service Center Corporation.

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Senator KENNEDY. Is Mrs. Lambrith here? We weren't sure. We will come back.

Mrs. Bertha Dixon—is she here?

This is really a tragic story of harassment and neglect by the public health system.

STATEMENT OF MRS. BERTHA DIXON, RESIDENT OF NEW YORK CITY

Mrs. DIXON. Good afternoon.

I am Bertha Dixon. I am the mother of two, sole provider for two children.

Back in February 1968 I was admitted to Beth Israel Hospital after being treated in the emergency room. At that time I was given several tests. I was discharged 5 days later.

At the time of my discharge I was told I would find out exactly what was wrong with me when I returned to the clinic. I kept my clinic appointment, returned, I waited several hours to see a doctor. After disrobing, waiting for the doctor, I was then told he could do nothing for me because my chart was not there. It seems as though the chart had gotten misplaced or temporarily lost.

At that time I was given another appointment. When I returned on the second visit my chart was there but the doctor wasn't there. I was told by the nurse she couldn't reveal anything to me. So I still did not know what was wrong with me.

Several days after I was discharged I received a bill for $599.95.

Senator KENNEDY. For what?

Mrs. DIXON. I still, 3 years later, do not know why—I am now paying off this bill, but I still do not know why I was hospitalized. Maybe it was neglect on my part. Maybe it was because I was just tired of going through the redtape.

And I have had several incidents of matters of this nature with Beth Israel. That was in 1968, February. In August of this same year I received a letter from a Beth Israel lawyer indicating unless payment was made by return mail and sent to his office he would have no alternative but to proceed further.

In August of that same year their lawyer contacted me by phone. He threatened that unless the bill was paid he would garnish my salary or repossess anything I had of value. He also suggested that I take out a loan.

In December of that same year, which was 1968, I received a notice of judgment against my salary. Since I was still unable to pay the bill and had no other recourse I contacted a lawyer at Mobilization for Youth. At his request all papers and bills that I had received were given to him. He informed me that he would submit the bill to the city for payment since it was his belief that the city would pay part, if not all, of the bill. I was assured that I would hear from him if this were not the case. I heard nothing from him, nor from the city, nor from the hospital lawyers, for over 2 years. Then on January 7, 1971, this year, I received a notice of judgment against my salary. I had assumed that the city had taken care of the bill since I had heard nothing for 2 years.

On January 12 of this year, after unsuccessfully trying to contact the lawyer I had initially contacted at Mobilization for Youth, I received a phone call from the lawyer representing the hospital. He had also made several phone calls to my office and had talked to my boss.

Senator KENNEDY. It seems they can't treat you but they can sure drag you into court.

Mrs. DIXON. Exactly. Well, after being threatened as to what he would do if I failed to pay the bill, an agreement was reached by the two of us that commencing February 10 I would pay $20 every other week until I had paid off the bill. He also sent me a letter of confirmation to this effect.

Despite receiving this letter of confirmation and despite making a payment on the 5th of February and also on the 19th of February in the amount of $20 each, on February 22 I received a notice from my employer stating a court order had been received to garnishee my salary effective immediately.

On February 23, the next day, after several calls between Beth Israel's lawyer's office and the marshal's office—by the way, he had referred me to the marshal's office indicating I should inform the lawyer that he should send my employer a letter of abeyance so they would not garnishee the salary. Naturally this was incorrect. I was again referred to the lawyer. At this time I guess he was annoyed with my telephone calls. He informed me that he had changed his mind and that, quote, "he was going to let the garnishee stand."

I still have a copy of his letter of confirmation concerning the arrangement we had made.

On that same day after making many, many telephone calls to various agencies I talked with the representative of the New York Office of Consumer Affairs. This office negotiated with Beth Israel's lawyer, and after several days the consumer affairs office notified me that he had agreed to my continuing payment as previously arranged.

I would like to point out certain things concerning this case. First of all, the hospital knew I had no hospitalization insurance and no medicaid before I was admitted. This was made very clear to them. Despite this fact, they placed me in a private room, since at that time it seemed the going thing was medicaid and they assumed that certain patients, especially blacks and Puerto Ricans, would automatically be approved for medicaid. This did not turn out to be true in my case, so I was faced with being billed for a private room which was unnecessary really.

It should also be noted that I had been using this same hospital, which is a voluntary hospital, long before the medicaid bill came into existence, and I received far better and far less expensive services before medicaid than after. I was not covered by any other form of hospitalization at the time simply because I could not afford Blue Cross, Blue Shield, et cetera.

The bill that I did receive which was for $599.95 is now $696.85.

And I would like to sum up my statement by saying poor people have a terrible hassle with voluntary hospitals, or any hospital for that matter, and if it had not been for Bess Meyerson's office a

garnishee would have been placed on my salary making it literally impossible for me to support my family. This would have occurred despite my not knowing to this day why I was hospitalized in the first place.

Senator KENNEDY. Well, I think fortunately your persistence—I am sure there are a lot of other people who feel overwhelmed obviously by the system and are paying out of their salaries. I am sure in many instances with the same kind of sense of frustration that you feel and the general despair about any kind of services that they received before.

I want to thank you very much for your being here.

Mrs. DIXON. Thank you for having me.

Senator KENNEDY. It has been helpful.

Mrs. Isabel Rodriguez.

STATEMENT OF MRS. ISABEL RODRIGUEZ, RESIDENT OF NEW YORK CITY

Mrs. RODRIGUEZ. My mother called me and told me to call you Mr. Senator. I think you are quite a good guy. I think I should call you Honorable. But I have heard so many such things—just to be a person that has the heart in the right place, the right place to come here and really take time to hear the terrible things that happen to the poor people.

I am a Puerto Rican. I came here 32 years ago. I am a widow. I had 2 years as a teacher when I came here. I could never teach here because I have an accent.

I have two children. One of them is a handicapped child. A few weeks ago my handicapped child, which is an epileptic, fell down. He had a big blow in his eye. The pain was terrible. I had to call somebody to lend me money to bring him to the hospital.

After he stayed there for an hour and a half and crying, because my child was in such terrible pains, the hospital told me that there was no doctor to see me, only assistants, attendants. Nobody worth while. I said "well, I cannot take my child back home because his pain is terrible." They said "well, we will talk to a doctor upstairs." You know what the doctor did? He sent me eight pills over there, tell him to take one every 4 hours. I said "well, this is ridiculous."

So I really was crying on the way—I had to walk eight more blocks to bring him to another hospital. And in that other hospital they said we don't have a specialist in the eyes at this hour, because poor people cannot get sick after 5:30 or Saturdays and Sundays in this city.

Senator KENNEDY. Why not?

Mrs. RODRIGUEZ. Because we do not get an ambulance on time. I live on Acey Row. I can tell you what it is to live where we see rats and roaches day and night, and that is very depressing for everybody, and to walk through those long halls at night, to see the faces of the senior citizens—and I tell them why don't you go to the hospital, I want to call you an ambulance. Know what they tell me, they say it is no use, it is not long now, we are waiting for death.

That is what is happening in this big city, which I thought was the most promised place where we could get health care.

I am disabled now because I fell down. I was a community organizer, and I met your lovely brother, Bobby. I fell down because for me a community organizer was like a priest, we should help people wherever the problem is, and I went out of my community to help some people in a building—in that building there were 53 children living in a dump, like mine, but at least they were very small children. I felt so sorry that I went three or four times every week. So I started to call on people and to go to that place. And it was 8 o'clock I fell down through the stairs, and when the ambulance came it was around an hour and 15 minutes later. I was in terrible pain.

They took me to one of the municipal hospitals, and from 10 o'clock in the night to 3:30 two young attendants were practicing with my leg, twisting it from one place to the other. I spent there 3 months and I stayed with the same bedclothes for 1 month, the same sheets, the same pillowcases, same pillow, no towels, no nothing.

Senator KENNEDY. Which hospital is that?

Mrs. RODRIGUEZ. I don't want to tell you right now, Senator. I will tell you later why.

Senator KENNEDY. Why not?

Mrs. RODRIGUEZ. Well, it was Metropolitan Hospital really. My chart is there. And I can tell you that I decided 1 day to talk for everybody that was there because I saw people—they had cuts, they were crying for bedpans. I said, "Listen, I want to get to a wheelchair because I am going to stop this." So you know what I did. Somebody told me the administrator comes here once in a while. I said you let me see who is the administrator, stop him in the middle of the hall, and I said I have been here so long, they have practiced with me, this is ridiculous. I am a poor woman and my children need me. I know we are doomed to be poor, but how come you are telling them they didn't have nobody. I was a translator for everybody there, and I am glad I could do it, and I still am fighting for my people because to be poor is to be doomed.

We have no faith. Everybody plans because of us. Every time they have a grant it is for gratification. They plan, we are going to have this beautiful for the poor people. You know how many questionnaires we have to answer a year, because we believe that this establishment and this Government is going to do something for us. The question is—they stopped even asking me—what did your father die of. My brother died in 1927. I don't have to tell nobody. And the questions they ask you, it is ridiculous.

You go to emergency and you have to wait such hours. And, you know, one doctor attendant asked me—I go there because of a terrible pain, because I have everything except my spirit, and you know—instead of examining me, the man asked me, Do you use the pot? And I said to myself what does this mean. And I said, "Of course I do for the children." He said, "What are you talking about?" Because I never thought a woman who has lived here 32 years and worked—even as crippled as I am, I got a job in an office created by HEW.

Well, you know, I said to myself it will be closed after a year—it was a grant—and I have to spend $1.25 to come, but even like

that I wanted to help my people and put them up in such a way, because we have a lot of poorness. I am sick and tired of being called ghetto, ghetto people, ghetto this and that. We don't want it any more.

Mr. Senator, this is ridiculous. We have to tell our people, our children, remember that you are poor. If they are intelligent they have to have terrible stamina inside them to continue with it because we cannot provide really what they need, the service—we are consumers of services, where are the services? They are not given to us. They are nothing.

I have already decided to never go back to a hospital to provide services to myself. I have to do it for my children because I can't do it another way. I am a Catholic, a Christian. I have faith in everybody, I had faith in this country. This was America, the promising land. It has promised me nothing. I don't owe America a thing. They haven't given me a thing that I didn't fight for. Everything has been wrong.

I don't know whether the establishment and the society is that they don't come down to see the poor people, the way they are dying because we cannot be provided services on time. We need them on time, not tomorrow. We are sick and tired of being planned for. We, the poor people, want to stand up and fight, is the only solution.

I only hope that God gives me a little strength more to help my own people because at least I can translate for them. I can bring them to the hospital. Last night I had to bring a woman—her husband was killed by a car and she didn't have nobody. She came home and at 3 o'clock in the morning people are knocking on my door, do you know where I can get this and that. At least I can give the people things like that, and I just give them a little hope, a little faith.

We need people like you, Mr. Senator. We need people like you, more of them, thousands of them, because if not, this is a real crisis. We are already frustrated and hopeless. We have no hope any more. We have no faith. The only faith is God. And that is what I want, is faith to the people. Let's continue fighting, because we cannot give up. We must find people that really realize what is going on.

Thank you very much, Mr. Senator.

Senator KENNEDY. Thank you very much. We appreciate it very much.

Mr. Walter Newberger. We again had him scheduled. Is he here? Mr. Walter Newberger. He will be our final scheduled witness, and we will have a brief period, if there are some people from the floor who want to make comments we will welcome those.

STATEMENT OF WALTER NEWBERGER, PRESIDENT, CONGRESS OF SENIOR CITIZENS AND EAST COAST VICE PRESIDENT OF THE NATIONAL COUNCIL OF SENIOR CITIZENS IN WASHINGTON

Mr. NEWBERGER. Thank you, Senator. My name is Walter Newberger.

Senator KENNEDY. President of the Congress of Senior Citizens.

Mr. NEWBERGER. That's right, and the east coast vice president of the National Council of Senior Citizens in Washington.

I don't think I have to go into any details, but that I am here as amicus curiae in a way, and we are supporting your bill 100 percent.

My organization has 200,000 retired members in this city, and we are deeply concerned. And I was listening carefully to what some of the other people said about senior citizens. I think it is true. They are in trouble.

We are going to have a rally here in New York on May 10, and the main topic of that rally is going to be your bill. In fact, we want to accomplish two purposes by it. We will help ourselves and do away with the shortcomings of the bills that are being operated now such as medicare, and we do want to do our best to break that so-called generation gap which in my mind doesn't really exist. It is another one of these things where one segment of the population is riled up against the other, and we are going to show the young generation that we are going to fight for them for universal health care as we fought for medicare.

Now the main reason I came here today is to express my distress at what the Ways and Means Committee did in reducing the hospital coverage from 60 days to a mere 15 days. We are terribly distressed about that because we think that it will mean something very, very disastrous and catastrophic. There is no question about it that this is a form of euthanasia. These people cannot afford it, and I think if they go to a hospital, they cannot get medical treatment, the ultimate consequence is they are going to die.

Now I would like to know from you, Senator, what your feelings are on the matter. Is there a possibility that the House Ways and Means Committee will change their mind on this thing, and if it then comes to your part of this Congress and the Senate writes a different bill the Senate bill will lose in Conference? I am given to understand that Wilbur Mills is not very much impressed by this thing, that he has opposed it, and I think was overruled on this thing. And just what is going to happen to it?

We feel that the universal health care that you are proposing will do away with medicare and medicaid. It will mean a tremendous saving to the State and the city, and that is the thing that they should push, the Government should push. The city administration should push it because this is really getting help from the Federal Government, and better than they had proposed.

So I would very much like to hear from you just what you think about what is going to happen to this particular provision.

Senator KENNEDY. It is difficult for me to judge what the Ways and Means Committee will do on this. I can just give you assurances, though, that when it comes out of the Ways and Means Committee and out of the Finance Committee we will make every effort on the floor of the Senate to restore both the present position, which isn't terribly satisfactory. I would be interested in what observations you might make of ways we could strengthen that provision and make it more satisfactory in terms of our senior citizens. We are wide open in terms of recommendations on this,

and if you would have a chance to review with your board and your executive committee and want to make some suggestions we would be terribly interested.

Mr. NEWBERGER. Well, we are always down there. Matson is down there, and so is Bill Hutton.

Senator KENNEDY. So we will make every effort to do what we can.

Mr. NEWBERGER. And I will be down there, too.

Senator KENNEDY. You stop in and see us.

Mr. NEWBERGER. I am still concerned about what form it will take when it comes out of the Finance Committee.

Senator KENNEDY. It is awfully difficult for us to tell at this time. But we will give you assurances that regardless of what form it comes out, we will try and see on the floor of the Senate if we can't provide additional kinds of protection for senior citizens.

Mr. NEWBERGER. And this time it will have a chance in the conference.

Senator KENNEDY. Well, this is always more difficult to tell. I mean I would be misleading you if I would say that it would, but I think we can make some progress. I think the country is much more aware of the problems of health.

The President said there was a health crisis 20 months ago and it took 18 months to get the message up. Well, things are moving much more rapidly now, and I think the administration is much more aware of it, I am sure the Congress is, and I think we can do a better job in terms of the interests of senior citizens.

Mr. NEWBERGER. The President's solution to this health crisis, the administration bill on health care isn't exactly what the doctor ordered.

Senator KENNEDY. What is wrong with it in terms of senior citizens?

Mr. NEWBERGER. Well, first of all, it is handing it over to the insurance companies. It contains a means test, and we certainly have thought this is—this is why we wanted medicare in the first place to supplant the Kerr-Mills bill, and it is not comprehensive.

Senator KENNEDY. That's right.

Mr. NEWBERGER. We want a comprehensive bill, Senator. We want your bill.

Senator KENNEDY. Very good. Thank you very much.

Now we have a list of people who have asked to testify that aren't on the list who have given their names to the subcommittee. Mr. Doug Edelson, and then Mr. Stephen Moore, Mrs. Bella Altshuler, Esther Armstrong, Paul Leith, and Julie Reed.

Is Mr. Edelson here? He was here earlier. As a matter of fact, when we were hearing earlier this morning about some of the kinds of catastrophic illnesses, he was working with the WINX radio group, and handed me this:

"My wife passed away in this hospital 3 months ago following a cardiac arrest that left her in a coma for 11 weeks. The hospital bill exclusive of doctors' services was almost $30,000. I still don't know how much is covered by insurance. This ran out somewhere along the line."

Mr. Edelson isn't here, but he passed this out, which goes to show that this problem obviously affects everyone.

We had a similar kind of circumstance a year ago when we were having hearings before this subcommittee in the fall. We had a photographer who was working, I think, for the AP, and was making $250 a week, with nine children. His 16-year-old son dove into an empty swimming pool. His wife as a result had a nervous breakdown. He had, I think, $28,000 in medical bills over a period of 22 months, I believe, and he was having to pay off $10 or $15 a week and still provide for all the other children.

Stephen Moore.

Mrs. MOORE. Mrs. Stephen Moore.

Senator KENNEDY. Mrs. Stephen Moore. Please just stand up, right at that microphone?

STATEMENT OF MRS. STEPHEN MOORE, WITNESS FROM THE FLOOR OF THE HEARING

Mrs. MOORE. I am kind of part of the depressed middle class. I recently took leave from the New York City Board of Education and went on maternity leave. At the time that I left I was told that I had health insurance as all New York City employees do. And on February 10 I received a letter from Blue Cross, Blue Shield that said I was not covered. However, for 5 years while I was teaching, a premium was paid.

During this period I had a cesarean delivery and 8 days in the hospital, a bill which comes to about $2,000. Also our infant son had to undergo surgery. He was in the hospital for 1 day for the surgery, and we have a bill of $800 for the surgery and the stay of 1 day.

We have not heard from Blue Cross, Blue Shield as far as our case goes except that they refused to pay any of our bills.

Senator KENNEDY. Do I understand you correctly that you said it was $800 for 1 day?

Mrs. MOORE. Yes, $319 for the stay. You know, there is a $200 operating room charge alone.

Senator KENNEDY. Which hospital is this?

Mrs. MOORE. This is the State hospital, the downstate hospital, University Hospital in Brooklyn. And the charges for the stay of the infant for 24 hours is $78.

Senator KENNEDY. How many hours were you there?

Mrs. MOORE. I would say 24 hours.

Senator KENNEDY. You got an $800 maximum.

Mrs. MOORE. Well, there is a $350 surgeon's fee. There is an anesthesiologist to pay. So for 24 hours would have about $800 in bills to pay, for minor surgery really.

Senator KENNEDY. What kind of insurance—you don't have any?

Mrs. MOORE. Well, I assumed that I had Blue Shield, Blue Cross major medical. However, their records show that we do not. And the city's records show that we do. There is a discrepancy. But at this point I am being billed for $800 for the surgery and for $2,000 for the birth and stay in the hospital for the child.

I find it kind of incredible. I am in the middle. I was a professional and I worked and I paid my insurance, and now I am liable for let's say $2,800 in medical bills.

I was in London on a holiday 2 years ago and we had the misfortune that my husband had to have an appendectomy. He was hospitalized for 3 weeks in London and we did not pay a penny. It was a tragic thing to happen, but we were not doubly liable for this misfortune.

Senator KENNEDY. What do you mean you didn't pay a penny? Did he go to a hospital over there?

Mrs. MOORE. He went to a hospital.

Senator KENNEDY. Get operated on?

Mrs. MOORE. Wonderful care. They did emergency surgery operation. They have the National Health Security Act very similar to what you are proposing. Everyone pays for the National Health.

Senator KENNEDY. Did he have laboratory fees?

Mrs. MOORE. No fees at all. Absolutely none at all.

Senator KENNEDY. No deductibles?

Mrs. MOORE. Nothing.

Senator KENNEDY. Coinsurance?

Mrs. MOORE. Completely covered.

Senator KENNEDY. Paperwork?

Mrs. MOORE. Nothing. Absolutely nothing. I kind of wonder why it is in a country this wealthy one has to be liable for one's health. It is a double indemnity. I mean it just doesn't work at all. There is no logic to this.

My case may be straightened out, but why is it that the middle-class person, the one who works, also has to worry about Blue Cross and Blue Shield and very high insurance rates and really shudders at the idea of getting sick. The worst thing that could happen to you in America is to get sick because then you have to pay your doctors, you lose your salary, and you really pay off for the rest of your life.

I had 1 day's stay and an $800 bill. What happens with someone who is chronically ill?

Senator KENNEDY. Thank you very much.

Is Mrs. Bella Altshuler here?

STATEMENT OF MRS. BELLA ALTSHULER, CHAIRMAN OF THE COMMITTEE ON INCOME MAINTENANCE

Mrs. ALTSHULER. It is a very hard name, so they call me Bella.

I am really the chairman of the Committee on Income Maintenance, and I have a lot of letters from you, Senator. You probably know me by name by this time, and so did your brothers.

I am not going to speak what I wanted to speak for the simple reason you have heard so many of these cases I think you are well aware of what is doing here. I wanted to cite two examples in my own life because you heard so many others it wouldn't make any difference.

One is that one of my family, and I can't name her by name—a very close child got sick at one time only 2 years ago and she was taken to the hospital. She had Blue Cross, Red Cross, whatever

it is called, and in 3 weeks she was out, before the operation took place. My private doctors had to recommend other doctors that are good on operations. We didn't know how good he was. He happened to be bad. I think it cost her, the doctor alone without anybody else, $800. We had to pay the $800 downstairs in the hospital before he went up. He wouldn't go up to operate on the woman before we paid him the $800.

I think nobody mentioned that. That's why I am mentioning it.

We went into so much debt during the few weeks she was there that it is already 2 years where we can get out of it. It will take another couple of years to pay off what we had borrowed from people, private people, that must be paid back.

Now I am going to tell you something else. I was sick 10 years ago. I was almost bedridden. Senator, I like to do a lot of things for everybody else and I couldn't do nothing for myself, so I had family in Russia then and they said I should come there. I had two sisters there. I was there four times, and I am going to tell you they didn't take a half penny from me. They didn't ask me anything. They cured me with the best they had. And the doctors said "how come you come to us when you have the best medicine, much better than ours, and you come to us?" Is because we have nobody to treat us here; besides that would be a very lot of money. Otherwise I am going to the hospital. All they give me is aspirin and some other medicine like that. In there they took the atomic energy and they made certain baths with this atomic energy, they had three people standing near you while they bathe you. And I tell you, you see me walking now and you see me walking for a lot of things, and this for the reason they have medical care for old people, no matter if you come from a different country.

I have friends that went to England special that they needed an operation. They went to Scandinavian countries. In our country where we have everything and all the medicine they need, all the knowledge they need, they couldn't get it.

And I hope, Senator Kennedy, that your bill—in various communities, that the health council in my community that sits in the place where you are sitting right now in Chelsea, in Clinton, would have a community model. I am certainly going to make my help to do that.

I could cite more cases, but I won't take the time. It is late. It will make you work harder if you know this is done in other poor countries and not in this rich one.

Senator KENNEDY. Thank you very much.

(The prepared statement of Mrs. Altschuler follows:)

COMMITTEE ON INCOME MAINTENANCE
344 WEST TWENTY-THIRD STREET, SUITE 2W
NEW YORK, NEW YORK 10011

212 989-8662
212 WA 9-9188

September 10, 1969

The New York Committee on Income Maintenance has worked tirelessly for the past two years to abolish our degrading system of welfare, established as a temporary measure during the national depression thirty-five years ago -- a system which nevertheless exists and spreads today in the midst of national prosperity.

Three generations of Americans, never integrated into American society and its way of life, have been brought up under this system -- and there is no end in sight. In fact, the remedies employed, such as, the "War on Poverty" in the program of the "Great Society" have not done much to abolish the ills of the poor.

After having examined the Kerner Report, we have come to the conclusion that its proposal for a guaranteed annual income would do much to heal the sickness of poverty in our society. For that reason we proposed that bills be introduced into the House and Senate to provide for a guaranteed annual income.

We are pleased to say that both Congressmen and Senators responded and introduced bills now resting in the House Ways and Means Committee and the Education and Labor Committee as well as in committees of the Senate. Unfortunately, no action has been taken to bring them out of committee.

We believe that the President's proposal over the air on Friday, August 8, 1969, that the Federal government begin to take responsibility for the thirty million Americans, who live in poverty under the present system with no hope of climbing out of it, is a great step forward on the road to achievement of our goal.

(Organizations for Idenification Only)

At a conference held in New York City on May 6, 1969, where 400 people, five Congressmen, representatives of State and City government participated as well as economists, trade unionists and community organizations, the following recommendations were made:

That a $4,000 minimum income be given a family of four;

That there be $300 given for every additional dependent;

That a single person, regardless of age, who is not a dependent, senior citizens included, be guaranteed an annual income of $2,500;

That day care centers be more widely established so that mothers may leave their children to go to work or to be trained for work and the professions;

That training be an integral part of this program so that all able bodied persons may learn to support themselves;

That an incentive pay system be established on a 50-50 percent basis until income reaches $8,000 for a family of four.

The responsibility for this program should rest on the Federal government as it does with the social security system which works so well. A uniformly funded and administered program by the Federal government, without regard to locality or region, would put a halt to the migration of the poor to overcrowded and overtaxed cities where the problems of housing, unemployment, crime and its threat to law and order, are aggravated.

The program for an annual income would give Americans dignity and security. It would go a long way towards abolishing the causes of poverty in a rich and abundant society that all Americans should enjoy.

May we count on your support for this program. We hope so.

Sincerely yours,

Bella Altschuler

Bella Altschuler (Mrs.)
Chairman

Senator KENNEDY. Now we have a few others that have asked to talk. We are going to have to conclude at 6, so we have about 12 minutes, so we will try to limit everyone to a couple of minutes.

Esther Armstrong—is she here? (No response.)

Paul Leith.

STATEMENT OF PAUL LEITH, WITNESS FROM THE FLOOR OF THE HEARING

Mr. LEITH. I come here not because I need your health care program, the Health Security Act, because I am taken care of through my wife's being a pensioner in district 65 that you heard about so much this morning. And in connection with that I would recommend that your committee make a study of the various plans, trade union medical plans. Whatever they do is good, but a comparison of these various plans would be helpful.

Now I am wondering why a small meeting is called of 100 people, mostly professionals, on this question, when the public educational value could be brought out at a big meeting where not only professionals are present, but half of them public people, including senior citizens. And I hope you will take that into consideration when you go into other cities.

I am somewhat dismayed because not enough speakers have linked the deficiencies of health care with the Health Security Act, and they haven't spoken, those that did, with the urgency of getting it passed, because I am afraid there is too much "business as usual" in this thing. We are getting statements by public officials, but does it get down to the bottom? I doubt that.

I know in this connection with senior citizens clubs that I have gone into recently, you will go down and ask—you go into emergency hospitals, go to a center and ask them whether they know the differences between your bill and the other bills, and I will guarantee that very few are going to know the differences between the bills. I found that out by personal experience. And I am afraid that if there isn't more pressure we may get the same thing we got from the Kerr-Mills Act a few years ago that blocked off, for many years, the hospitalization through social security.

And I urge, therefore, more urgency and much more done with it, a campaign to acquaint the public with these bills and to get more action.

Now we know young people don't look at things the way old people do. I am not too far away from 80, and we want action more quickly than you do and younger people. For you people 5, 10 years doesn't mean much. To some of us that is about the average of our years that are left to us if we reach that average.

So I am calling for greater urgency, for a bigger campaign for the Health Security Act and getting information down below to the senior citizens centers and clubs into the hands of every one of them so that they will take action, and unless you get more popular action by the public, by senior citizens—not only letters, but really bringing them to Washington so that the people there will understand that the public really wants this Health Security Act and wants it now, and not manana. [Applause.]

Senator KENNEDY. Thank you very much. I think you put your finger on a very important part of it, and that is the question of its educational aspects. We have a major educational job, and I hope you will help us. I am sure with that voice of yours and that commitment of yours you can help us in providing some understanding among senior citizens groups. We will try and provide even a greater educational program than we are doing. But this is certainly a part of the purpose of our meeting here today.

Julie Reed.

STATEMENT OF MRS. JULIE REED, WITNESS FROM THE FLOOR OF THE HEARING

Mrs. REED. I am an ad hoc committee of one which I call Fight Medical Delinquency—Write Your Congressman Now Committee. This committee is going no place. I have been at it for 6 years. I, an intelligent person, a respectable person, a person of capacity and of education, am treated just like the rot that you have heard today of other people.

We are in an arena of vast social warfare in medical care. It hasn't got a damn thing to do with health. We are being tricked by the U.S. Congress by rhetoric; rhetoric of the medical establishment, if you please, sir. Health—every word is health. It is medical care we are talking about. Health doesn't need that kind of care.

People in this country know what is wrong—greed. The U.S. Senate and U.S. House of Representatives are going to give this country the shaft and sell us out like they have been selling us out all of these years to big business.

Yesterday afternoon I stood on the street at 86th Street East and asked people what they wanted and those who wished socialized medicine to sign here (indicating). Socialized medicine—socialized medicine is what people want. Socialized medicine. Socialized medicine. Socialized medicine. This is 2 hours work. Socialized medicine. Socialized medicine. They have no trust in any Health Act, sir.

Of course, I was almost arrested. The police came.

In 1964 I stood on that same street and shouted out my lungs for the election of Robert F. Kennedy. That's where I learned to speak. I was never bothered in that instance as a member of the speakers bureau of his campaign headquarters, but all through these past 6 years I have been bothered by the police and arrested many times.

I have only been talking about the want of medical care. Every fifth person in the State of New York dies for want of medical care.

When I was a young woman—and the reason I have done this and have been persisting and have taken up the occupation of merely articulating the fact of our getting rotten and no medical care, rotten medical care being worse than no medical care. This lady here is not going to go back to the hospitals—good, that's what they want.

Gordon Chase was here. He is going to close eight hospitals. A couple of years ago they were going to close four hospitals. We are being brutalized over and over again. So you will not go back to the hospitals. You will not seek medical care.

At Coney Island they take out the beds at Coney Island Hospital and they put them on the walk because they have no place to put them. There they rust.

People were given a ticket with a number on it like a baker ticket, and they are given a high number because they are bleeding at the emergency room. They will not stay. They are charged $11, and they say that it is a requirement of Congress in the Medicaid Act that the New York City hospitals charge. I have not been able to track down any place where this is law.

And these reporters, these publicists for the big medical industrial complex who are in this room and every single room like it, and have been in every single hearing I have attended in New York State throughout the State and in Washington, D.C., they are here giving us garbage. They say that we are required to pay this fee, and the hospitals, the New York City hospitals must charge.

I beg you, sir, we want socialized medicine—just as the lady who had been to Russia stated and the lady who had been to England stated, socialized medicine outright. We want doctors on hospital staffs. We no longer need this unjust enrichment. We don't need this profiteering. Profit is a reward for the risk of capital, and they haven't risked any capital.

That is my statement.

One thing more. If I may just say one thing, what has motivated me in all of this was when I was a young woman I was where the rest of our men were. And my job every day for 2 solid years was to count up the dead in the Mediterranean theater of war. That was very, very hard to do, and I could hardly wait for it to be over. I went to the end and that took all my endurance. But there isn't a man who was injured there—and I, myself, did not endure crossing the Atlantic Ocean on a ship chased by German submarines and being bombed in North Africa for anything less than equal medical care for every single person in the United States. And instead, we have here a tyranny that brutalizes us. There isn't a death that I counted, there isn't a man, I would say, who died in any way of the United States who did it for anything less than equal medical care.

Senator KENNEDY. Thank you very much.

Ira Klemons.

STATEMENT OF IRA KLEMONS, WITNESS FROM THE FLOOR

Mr. KLEMONS. Thank you, Senator. I would like to speak to you about this health manpower crisis shortage in 1970. You have up there a number 15,000——

Senator KENNEDY. Will you please be as brief as you can? We have really run out of time.

Mr. KLEMONS. 15,000 dentists as necessary to help to eliminate the shortage which we currently have. I would like to point out to you something, and that is that even if 15,000 dentists were graduated today from dental schools it would mean very little to most of this country. The reason for that is the State licensure boards which were established more than 100 years ago in order to protect the public from practitioners who learned by apprentice-

ship rather than by the stricter medical schooling—the medical type of schooling which we receive today. They protected the public from people who did not know what they were doing, or knew very little.

Today dentistry is not the same as it was 100 years ago. It is a branch of medicine, and it is taught as such. But yet the State board is precisely the same as it was at that time. ADA studies have shown that as many people from the top 25 percent as the bottom 25 percent of graduating classes in dental schools in the United States pass or fail in the individual State licensure boards—board of examinations that is.

The ADA evaluates all schools. Without the ADA's recommendation no school can receive certifications. Schools evaluate all students for 4 years. In 2 days the State boards attempt to evaluate graduates by testing procedures, some of which are very rarely, if ever, used by even general practitioners. Surgeons are tested with exactly the same kind of tests where they are told to place gold foil restorations which are simply not used, and surgeons never use anything of that sort—that is not within their realm.

The fact is that the State boards are arbitrary and they are very unfair to all of the people of the United States. This is intolerable, particularly in the light of the current public concern over the inadequacies of health care delivery coupled with the current commitment by dental students to serve the poor in this country.

The fact is that in many States two, three, four, or five times as many out-of-State applicants are failed on their State board examinations as in-State. This has to be arbitrary. This must indicate that they are completely arbitrary in the way that they are testing. And what is more——

Senator KENNEDY. About another minute or so.

Mr. KLEMONS. I can give you several States where they have absolutely no dentists in a number of counties—13,000 people, 14,000 people in one county in Nevada, and there are six counties of that type, six counties with 13,000 people and no dentists at all. And yet 65 percent of all out-of-State applicants were failed versus 18 percent of in-State applicants. Nevada has no dental school of their own.

Mr. Parker has a position paper which was given to him I believe this morning which will explain the position of our committee, which is a committee to re-orient the purpose of the State boards. We think they have a tremendous value, but not in what they do. And I hope that Mr. Parker will be sure to give you that paper.

Thank you very much.

Senator KENNEDY. Thank you very much. We appreciate your comments.

Miss Spring.

STATEMENT OF MISS LILA SPRING, WITNESS FROM THE FLOOR

Miss SPRING. In 1969 I was a patient in several different hospitals for psychiatric care for head surgery. I just wanted to mention Blue Cross coverage in regard to the psychiatric.

I had 23 days on the psychiatric ward of a general hospital here in New York City for which Blue Cross covered me completely.

Now I had had the 120-day full-coverage policy. Then I had—this is not in sequence, but I also had several months of hospitalization in a private psychiatric hospital. Blue Cross covered $10 per day; out of that total of 30 days, 23 were used up at—well, University Hospital here in New York. So for the time at the private hospital, even though it was several months, they paid me $10 per day for up to a total of 30 days for both hospitalizations.

Then I also had some time spent in two separate State psychiatric hospitals. One was—well, Psychiatric Institute which, although it is a State psychiatric hospital it is also the psychiatric department of the Columbia Presbyterian Medical Center. Blue Cross—and this means, when I say Blue Cross it really means Blue Cross and Blue Shield—does not pay a penny towards time—at least in 1969—for people who had the 120-day full-coverage policy. They did not pay a penny towards time spent at two State psychiatric—New York State psychiatric hospitals.

For the time spent, frankly, right here at Roosevelt Hospital for head surgery of a lifesaving nature and then for more repair work up in this area, of course that was covered fully.

But also one other thing. It is really very puzzling as to why Blue Cross would not cover at all for time spent—you know, it is not just—I just happen to be one patient, but it makes no difference who the patient is in a New York State psychiatric hospital, of which there are, of course, several in the State—why Blue Cross does not cover that at all.

One other item is I would assume that either on the State level, meaning either on the New York State level or on the Federal level, there either is or should be a law that says that a private hospital, be it a nursing home, or in my case it happened to be a private psych hospital, that charged me as if for 17 days that I was actually at Roosevelt Hospital in June of 1969. You know, it just doesn't make sense to be charged—you know, you can only be at one hospital at one time.

And also I deeply appreciate the work done here for me at Roosevelt Hospital. I owe many, many people many thanks.

And thank you, Senator Kennedy.

Senator KENNEDY. Thank you very much.

We are going to conclude the hearing.

I want to thank our stenographer. You have had a busy day. You have been marvelously patient and wonderfully helpful.

I want to thank again the staff here at the hospital and administration for providing these kinds of facilities and cooperation they have today.

As I mentioned at the outset of our hearing, we have had 8 weeks of very comprehensive hearings in Washington. We have listened to the experts, but I don't think we have had a day of more eloquent testimony about the nature of the health crisis in this country from the people who are really living with it, have lived with it, have lived with it as it affects their families, their children, their husbands, their loved ones. And I think this is perhaps some of the most eloquent testimony that we have received in terms of all of our hearings.

So I want to thank all of the witnesses for their patience and bearing with us here today, and for their comments. The others who spoke—I regret we were unable to hear the gentlemen this morning who were here, but we try over the course of this hearing to listen as much as we possibly can. We can't visit every community in this great Nation of ours or visit every area of critical need, but I think we are establishing what I firmly am convinced will be a solid record about the dimension of the crisis which exists in this country, and hopefully will be able to make the kind of constructive suggestions to best address ourselves to that crisis.

So the subcommittee will recess now. We are meeting tomorrow out on Long Island, and from there on to other parts of the country. We are going out there to hear about the health care crisis in some of the suburban areas.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

(The material referred to follows:)

PREPARED STATEMENT OF THE NATIONAL COUNCIL FOR IMPROVEMENT OF DENTAL LICENSURE, NEW YORK, N.Y.

Our Council represents a rapidly growing organization of dentists and students who feel that the present system of dental licensure is in need of change. In response to widespread sentiment on this matter, the Council was formed in order to crystallize the issues and to present a unified voice. The basic premises are as follows:

that the system of dental licensure is in need of change

that state board clinical examinations are not a necessary pre-requisite for licensure

that graduates of accredited dental schools, upon the achievement of universally accepted scores on the National Board Examination, shall be able to practice dentistry anywhere in the country.

The rationale upon which these premises are based is developed in some detail in the text below, which represents the official position paper of the Council.

POSITION PAPER: ELIMINATION OF STATE AND REGIONAL BOARD EXAMINATIONS

It is our contention that State and Regional Board examinations, as a prerequisite for licensure, are no longer relevant to the nature and posture of the dental profession. They are the embodiment of licensing practices from an era when dentists were being trained via unqualified and unsupervised educational programs. In those times board examinations were necessary to protect the public from graduates of non-recognized proprietary schools and apprenticeships.

The current concept of dental education and practice is so radically different from the state of affairs that led to the creation of state board examinations (over three-quarters of a century ago), that it has become completely untenable to retain this anachronistic licensing system for modern day health professionals. We are not overlooking or minimizing the vital role that State Boards have played in the evolution of the dental profession to the high level that it has achieved today. However, we are asserting our firm belief that these governing bodies, in retaining their initial function in a time which no longer requires it, are performing more of a disservice than a service.

Today, every dental school that is graduating dentists in this country is accredited at the national level. This means that these educational programs have received the independent critical review of those groups charged with the responsibility of assuring the highest standards of dental teaching and dental practice. Certainly, these accredited institutions can, over four years, judge the competence of their students far better than board examiners who are given only one abbreviated and artificial setting—the state board examination—within which to evaluate candidates.

A critical scrutiny of present-day licensing practices reveals many inconsistencies which make it clear that not only are the rights of dentists being violated, but that the public interest is being usurped rather than protected. It is impossible to determine whether these inequities represent the dehumanized end-product of an archaic system, or the attempt of a few individuals and/or states to protect their vested interests.

The major rationale for the perpetuation of state and regional board examinations is that they protect the public from being exposed to incompetent practitioners. As such, State Boards claim to assess the knowledge and clinical competence of dentists. Ostensibly, the only criterion of interest is the level of performance of the State Board examinee, yet it is easy to demonstrate that a host of factors other than knowledge and competence are determining who is passing and who is failing these examinations. The facts speak for themselves:

> according to the last five years of available data *prior* graduates of dental school are failing state board exams at twice the rate as *current* graduates.[1] This result leads one to the paradoxical conclusion that the public has to be protected from experienced dentists since they are incompetent by State Board criteria.
>
> the validity of the testing procedures has even been questioned by the American Dental Association. Their most recent study comparing class ranking and state board examination performance indicates that in practically *every* state there is an aberrant relationship between academic standing in the senior class and passing or failing the exam. Specifically, most of the states are certifying as competent the same number of applicants from the bottom 25% of their class as from the top 25%.[2]
>
> more than half of the states pass virtually the same percentage or a greater percentage of applicants from the bottom half of their class as from the top.[3] In these cases the exam is so invalid as to give the poorer student an equal or better chance of becoming a dentist licensed in that state!

It is difficult to accept the supposed rationale behind the licensing exam when, in fact, a patient is equally likely to choose a dentist who was highly accomplished in school, as one who did relatively poorer over the four years of training.

There are additional facts which point out the rather dubious validity of the state board examinations:

> an average of ten states a year pass all 100% of their applicants while fourteen states fail one out of every five applicants. Some states are notoriuos in this regard—Arizona, California, Nevada, and Florida often fail 1 out of every 2½-3 applicants.[4]
>
> there is not even one state that makes provisions for modifying its clinical examination for specialists. An oral surgeon is still required to excavate a cavity and insert a restoration even though these procedures are totally irrelevant to his specialized skills as a practitioner. Over 85% of the State Boards require examinees to perform an inlay or a gold foil restoration,[5] which are the most infrequently performed restorative procedures by practicing dentists.[6]

It is clear from the available data that factors other than an individual's ability contaminate the allegedly "objective criteria" of test performance. For instance, if one examines the performance of examinees, it becomes apparent that whether one passes or not is closely related to residency status:

> almost every state that regularly fails anyone at all (35 of 41 states in 1967) fails a greater percentage of their out-of-state applicants than their own residents. In some states the disparity is more than obvious

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[1] Council on Dental Education, A.D.A. Summary of Dental Licensure Examinations: prior and recent graduates 1958-68.
[2] Council on Dental Education, A.D.A. Nationwide study comparing dental school class standing and state board examination results for the 1964 graduating class.
[3] Ibid.
[4] Council on Dental Education, A.D.A. Dental Licensure Statistics: comparison of in-state versus out-of-state residents 1961-67.
[5] Bureau of Economic Research and Statistics, A.D.A. Facts about states for the dentist seeking a location, 1970.
[6] Bureau of Economic Research and Statistics, A.D.A. Survey of dental services rendered, 1969. JADA 81:35 July 1970.

i.e., New Jersey often fails out-of-state applicants at almost twice the rate, and in California the odds are 3:2 against this group.[7]

It seems reasonable to conclude that many states are most interested in limiting the numbers of dentists by restricting the influx of out-of-state applicants. To the extent that this is so, these states are failing in their obligation to the public.

These facts, which are merely a sample from a wealth of similar data, lead one to conclude that dental state licensing examinations do not validly discriminate, and are often arbitrary and inequitable. Furthermore, they act to prevent the public from receiving adequate health care by restricting the right of dentists to live and practice where they wish. This situation is particularly intolerable in the light of mounting legislative and public concern over the inadequacies of health care delivery, coupled with the increasing awareness and commitment of dental students toward serving the disadvantaged of our country. Leading educators are urging a doubling of health professionals by 1980 in order to meet the impending manpower needs. At the same time the social commitment of many dentists, both young and old, is being stiffled by state licensing requirements which restrain them from practicing where they are most needed.

We recognize some conscientious attempts to alleviate some of these inequities. The creation of the North East Regional Board has embraced some of our ideals by establishing a precedent for reciprocity amongst ten states. While we greatly admire the forward looking approach of the N.E.R.B., we must decry the fact that even it still perpetuates the practice of subjecting current and prior dental graduates to a clinical examination which is totally unnecessary.

Our concern for the public and the dental profession dictates that we can no longer remain apathetic, or merely passively concerned. We must seek immediate resolution of existing conditions which permit the self-perpetuation of a system that shows too few signs of healthy growth. Therefore, our Council is taking a leadership role in consolidating existing efforts to abolish practices which are unjust and deprive both the profession and the public of their personal rights.

State and Regional Board requirements should be immediately modified so that dental students and graduates will no longer be subjected to board examinations. This will enable all dentists, upon the successful completion of dental school and the achievement of universally accepted scores on the National Board Examination, to apply their skills anywhere in the country. Furthermore, we recommend a revision of State Board activities in order to update the functioning of this body; namely:

insuring the high level of dental education via a more active involvement of the Council on Dental Education, of which the American Association of Dental Examiners is part

acting as the state agency responsible for implementing nationally standardized continuing education requirements

serving as a repository of information on vital statistics for dentists wishing to locate in the state, and acting as an advisory body on this matter

acting in accord with recent legislation charging the Boards with the responsibility for the licensure of foreign-trained dentists

We strongly urge you to consider our proposals and to respond as quickly as possible, preferably within the month.

Prepared Statement of the Sydenham Hospital Child Development and Mental Retardation Program—Dr. Thomas H. Hyatt, Jr., Director

Introduction

Developmental defects and mental deficiency constitute what is probably the number one handicapping condition suffered by children today. In the United States approximately 3% of the general population has had the diagnosis of mental deficiency made on them. Of this number some 5 out of 6 are absorbed

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[7] Council on Dental Education, A.D.A. Dental Licensure Statistics: comparison of in-state versus out-of-state residents 1961-67.

into the population or are at least lost to statistical follow up. Up until some 30 years ago, the plight of the mentally deficient was pitiful indeed. Such children were considered a blight upon the family and were generally hidden away, ignored and denied. They were outcasts from human society. Over the past 25 to 30 years the condition of these children has been coming to the attention of society; slowly and of limited scope at first, but with increasing acceleration and broadening of scope.

A great deal of time, effort and money has been and is still being expended in researching the causes and treatment of developmental defects and mental deficiency.

Out of the acquired mass of information some conditions which were thought to be mental deficiency were found not to be, i.e., specific learning disabilities and dyslexia—the Minimal Brain Dysfunction Syndrome which is often amenable to medication. This syndrome may or may not be associated with mental deficiency. A number of congenital and acquired conditions have been found and/or explored which are associated with either primary or secondary mental deficiency. Eighty per cent of children with mental deficiency have no identifiable cause and only a tiny percentage with diagnoses can be given specific therapy.

In dealing with any pathological human condition not only must we, if possible find the cause and cure, but we must also elucidate how this person will fit into society when and if this question arises. For instance, cardiac victims after their attack may range from complete activity to almost complete inactivity. Yet their functioning at whatever level must be considered in the context of the whole person.

Persons with mental deficiency are no different—these unfortunates are human beings. Research has shown that the vast majority can be helped to find a place in life. Unlike former times, no longer are they to be hidden away in out-of-the-way places and forgotten.

Rather, they (the children) need the same things as the normally endowed child. That is, to be loved and accepted for what they can do. They must be educated and challenged to the best of their abilities. Their families and the public must be educated as to the nature of mental deficiency and what can be done about it. The problem is a community problem and not one of an individual illness.

Most programs and agencies dealing with mental deficiency are research oriented with a relatively small service component or offer one or more specific services limited to the specific physical facilities of the agency i.e. special schools. Other agencies have become aware of the need and are offering services, i.e. day care centers. In most cases the services are limited because the facility is not set up to give a comprehensive approach to the problem. I have started a *service* program whereby diagnostic, evaluative and treatment recommendations will be made. Then by cooperating with the community the child will receive his "treatment" on an at home basis via assistance to his family. We will back up the community facilities. We propose to do this with a relatively small trained professional staff and a large community para professional staff who will be responsible for the bulk of the personal contacts and who will be supervised by the professional staff. We feel that such an approach can offer effective service to many more persons than can be handled in an institutional setting and will allow the community as a whole to work with this problem rather than a few specialists.

We recognize that there will be many problems that cannot be handled in this manner. But like other difficult medical problems, these will be referred to the centers which are set up for this purpose.

ADDENDUM I

COMMUNITY PARA PROFESSIONALS

Our Community Para Professionals which we call Community Specialists in Mental Retardation and Child Development have had extensive training at the Flower Fifth Avenue Mental Retardation Department.

These Community Specialists were trained by persons with specific expertise in this area.

Field trips were made to other agencies delivering various types of services to the Mentally Retarded and to the below-normal scale children.

To date these are the only group of Community Para Professionals who have received this type of training in the New York Area.

ADDENDUM II, SOME INITIAL CASE FINDINGS

FAMILY A

Family (A) was referred by Neighborhood Board No. 4.

The household consists of Father, Mother and 7 siblings who are all retarded.

The children (7), of which the oldest 11 years, cannot speak. They are going through intensive evaluation and treatment.

Mother.—Somewhat below normal scale.

Father.—Seems to be good provider, does not cooperate with agencies offering help for the siblings.

Since our services have taken on this situation, there has been some improvement shown. They are presently being given Speech Therapy at C.C.N.Y. Speech and Hearing Department. Our Community Specialists arrange and transport the family to all of their various treatment appointments.

FAMILY B

Family B. was referred to us by both the district Health Officer, Dr. Robert Adair and Sydenham Hospital.

The child is a male of 4½ years, who lives with his grandmother. Mother, Father and 1 other sibling reside at another address. This boy was thought to be over-active, with definite speech problems, cannot understand simple direction, wets and cannot feed himself.

We have started intensive evaluation on this child, who was on waiting lists of 6 other agencies prior to coming to our program.

FAMILY C

Family (C) was referred to our program by the Northside Center for Child Development.

Household consists of Father, Mother and 2 siblings—one boy and one girl.

The daughter is 14 years of age and has had many difficulties in school and has been put into a special class. She has been tested by other agencies but has not been fully evaluated.

Mother.—Supports the family.

Father.—Ill, unable to work.

Other agencies found the mother defensive regarding her child's retardation. Our contact found the mother concerned and also found that the daughter had been attacked and severely beaten in school at an earlier age, this information was not reported in work-up forwarded to us from the other agencies. In addition to this, prior to being attacked by two students, this girl was functioning at a level well above normal.

This girl will be going through intensive evaluation by our program.

PREPARED STATEMENT OF JEANNE MILES—CONSUMER, NEW YORK, N.Y.

THE HEALTH CARE CRISIS IN NEW YORK

I am concerned that all the talk in government these days about the health care crisis means only that the White House is now aware about how much it costs when people get sick. We hear so many numbers—billions of dollars spent in this country on health care every year, millions on health insurance with the rates spiralling up, up all the time (I received an increase just this morning), health care in New York was over 20% higher than all other items on the consumer price index, hospital service charges have risen more than 80% over the last 5 years. But only in a few programs do we hear anything about improving the quality or accessibility of health care.

It is heartening to hear that Health Care is high on the President's list of priorities, but it is distressing to realize that the Nixon health strategy does not mean the United States now has a health policy. I believe that such a

policy must be developed and it must be based on the principle that Health care is a right. Everyone should have equal access to care. It should be available to all, on the same basis, with the same amenities. Do the people quoting all these numbers and offering these many plans and programs take the responsibility to assess the delivery of services and then become accountable for doing the job that is revealed to be needed?

Those of us who have been working at the neighborhood level on community oriented health programs know that even if every person in our area had the money—had the purchasing power—this would not guarantee them good health care. We learned this with the Medicaid program. In that program we learned what over utilization of hospitals meant: higher costs, not better care. Most of the new programs perpetuate the fee for service concept, and continue to support the built in incentives for excess hospitalization. The result will continue to be inflation. The price tag for health care will go up but the product will remain the same and the availability of supply will not expand substantially.

Senator Kennedy's plan for health insurance seems to be the best one offered because it acknowledges the need and attempts reforms in the health system. It does not just pump money into an already overburdened and nonfunctioning system. The following points are suggested as improvements for the plan:

(1) Eliminate the fee-for-service payment provisions, (2) strengthen the public accountability sections, (3) strengthen the role of the consumer in planning, budgeting and in setting up quality control and economic incentive award systems. For example, unless very stringent controls were set up a hospital could cut down on life support service in order to save money and pick up an incentive award.

It has been suggested and the idea becomes increasingly more attractive to consumers and to community oriented programming, that rather than trying to eliminate the crisis-care type of medicine dispensed in hospitals today, we should perhaps consider that the future role for consumers is to assume the major responsibility for preventive medicine, for the maintenance of neighborhood health and for a modernized concept of family medicine. Let the doctors and hospitals continue to practice disease-oriented, acute care medicine.

In the neighborhoods, other kinds of medicine do not require seven years of graduate education, staff privileges, board certification and medicaid vendor numbers, nor do they offer high salaries either. This kind of medicine can best be practiced in neighborhood family care health centers. Those that exist need your support to continue. More should be built We would be interested in supporting legislation that incorporates these ideas, that would involve and educate consumers in preventive medicine and health maintenance programs. What we as consumers DON't need is to get caught in the middle between the doctors and the hospitals in their tug-of-war over who gets control of the Nixon sponsored health maintenance organizations.

(Whereupon, at 6:10 p.m., the subcommittee recessed, to reconvene at 9:30 a.m. the following day in Hempstead, Long Island.)

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