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

APRIL 15, 1971
HEMPSTEAD, LONG ISLAND, N.Y., AND
MOUNT KISCO, N.Y.

PART 8

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CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

TUESDAY, APRIL 15, 1971

HEMPSTEAD, LONG ISLAND, N.Y.

MOUNT KISCO, N.Y.

STATEMENTS

ADDITIONAL INFORMATION

HEALTH CARE CRISIS IN AMERICA, 1971

THURSDAY, APRIL 15, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE
ON LABOR AND PUBLIC WELFARE,
Hempstead, Long Island, N.Y.

The subcommittee met at 9:30 a.m., at Hofstra University, Hempstead, Long Island, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy and Dominick.

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

Senator KENNEDY. The subcommittee will come to order.

America is in the midst of a health care crasis. This subcommittee has left Washington to hear how this crisis affects the people in every walk of life across this great land. Millions of Americans live in communities like Hempstead. Like Americans in our cities and rural areas, they depend for their very health and happiness on a system of care which charges enormous fees for inconvenient service whose quality is uncertain. The subcommittee has come to Hempstead to hear the people of suburban America.

We know you feel the crisis. You feel the crisis when you pay your bills. Doctor bills are 60 percent higher today than 10 years ago, and hospital bills are nearly three times what they were.

You feel the crisis when you are ill in the evening or on weekends, and end up driving long distances to a hospital emergency room.

You feel the crisis when you realize that being "laid off" from a job also means losing your health insurance and being left completely unprotected—just when you need it most.

You feel the crisis when you realize a friend or relative is sicker and a lot poorer because the doctor made a bad diagnosis. Several weeks ago I asked a well known pediatrician whether you could feel confident your children were getting good care if you could afford it. His answer was no. He insisted the quality varies tremendously from physician to physician and there is no way for the people to know what they are getting.

These problems need not exist. The providers of health care, together with the people, can change the system to serve us better. But the people must take the lead.

We cannot ask the same doctors and organizations who profit from health care to set the fees—or assure the quality—or plan for our convenience without any influence from the people who buy their

services. That is simply not the way we do business in this country.

We look forward today to hearing both consumers and providers testify on the nature and extent of the health care crisis in this suburban community and how we might correct these problems.

Before beginning, I would like to extend the subcommittee's special thanks to Hofstra University for their hospitality. We appreciate very much their courtesies and kindnesses which have been extended to us and to the members of the subcommittee, and we are appreciative of their hospitality.

Our first witness this morning is Mr. Sanford Lenz. He has some consumer witnesses with him. He is director of the Bi-County Consumer Alliance, regional director of IUI, chairman of Personal Health Services of Nassau, Comprehensive Health Planning Council.

Mr. Lenz.

STATEMENT OF SANFORD LENZ, DIRECTOR, BI-COUNTY CONSUMER ALLIANCE OF HEALTH CONSUMERS

Mr. LENZ. Good morning. My name is Sanford Lenz, and I am executive director of the Bi-County Consumer Alliance of Health Consumers, which is a not-for-profit corporation of neighborhood health committees, local unions, civil rights groups, and other organizations of health consumers.

I intend to summarize my remarks and request the right to expand my remarks in print later and not hold up this meeting.

We are primarily concerned—both with respect to the unions and consumers generally—that in the turmoil that is currently going on in health care services settles, we want to make sure that the consumer of health services is not the one who becomes victimized by the system for which he is footing the bill. We think if we do that we have failed in our responsibility as labor leaders to our members, failed in our responsibility to our commitment to work with the disadvantaged, and in our role as a progressive organization force.

We think we have been down that dangerous road before. We think we have been down the Defense establishment road which has been turned over to the professionals. There the cutting off of the citizenry from the decisionmaking process has resulted in essentially a failure in the mission of the department itself. If the mission of the Department of Defense was to bring peace, we are now in a war not in every generation, but in every half-generation. And the second result has been a major polarization of the citizenry fighting over what the experts are doing.

We have gone through it in education as well. We surrendered the system to the professionals, we watched the educational establishment fail in its mission and polarize the country as well. The educational establishment now measures its successes by the number of active Ph. D's. and has failed in its basic mission to bring education

to the community. The system is geared to serve those who are moving on to the next level of education and the devil takes the student who gets off in the process. The ex-student realizes that whatever he knows of the world he learned outside the classroom, and what he knows of his work he learned after he left school.

In fact, there was a quote in Newsday this week to the effect if the school undertakes to teach sex education as they have taught literature they will kill off the sex drive in 3 months.

We don't want to see that happen in health services, and we are afraid we are headed precisely there.

We view a national health security program with great hope and with great trepidation—with hope because we are thoroughly aware of the fact that we must have new financing methods for health care in the form of national health insurance immediately. But we view it with trepidation because we are afraid that once again we will see a massive infusion of money to health providers without any real change in the delivery system. That process can only cause inflation, can create an empire like defense and education with tremendous activity and little result; and most important, it will add another level of isolation between the consumer of health services and the provider, leaving the consumer helpless to do any more than to foot all the bills.

The present system of health care services is chaotic enough in the delivery of health care, but it is thoroughly organized in the distribution of the proceeds of the process. It has completely severed the consumer of health services from the decisionmaking process.

When a family physician existed, the patient was close to the decision about what he needed and could negotiate the cost. When hospital based medicine took over he became one step removed from that process.

Group insurance promised to give the consumer cost and quality control, and instead the consumer was given no voice in the insurance program. No quality control was ever exerted, and cost increases were handled on in the form of rate increases; so the consumer, the buyer found himself battling with the carriers, notably Blue Cross and Blue Shield, at public hearings through a commission instead of being on the insurance boards negotiating with the hospitals.

In addition, stress was placed on hospital based medicine to the exclusion of dental, optometric, psychiatric, psychological, and social services. In addition experience rating of employee groups became fashionable and the cost of insurance to anyone became prohibitive. As a result the system precluded those who needed it the most—the old, the unemployed, the retarded child, the emotionally disturbed, the addict, the alcoholic, the poor, the husbandless mother, the chronically ill. All the concentration was on the horizontal patient. More patient days, more and better tests. But those who needed care for unidentified pains and unusual symptoms or emotional problems, short of breakdown, had no access whatsoever to the system. The system gave lip service to the need for preventive and

diagnostic treatment and then refused to pay for it. And the real villains, the environment, poor housing, poor transportation, poverty, and factory safety, were all considered outside the scope of health services. And federal and state dollars did nothing to help.

It shifted the center of the health universe to the medical school, brought new and advanced research in hospital techniques, but the health of the man in the street has declined. A man who is walking in the street looking for a job and he feels chest pains or short breath, he will brush it off as indigestion because he must. He can't afford a doctor, he can't afford a hospital. And going into the hospital means he will miss his appointment for an unemployment check, for an unemployment interview, and therefore lose his check. What really does he care that high up in the medical center he is passing there is a heart transplant operation going on or a brand new machine has been delivered.

Or the child that is losing interest in school because all she can think about all day is her teeth hurt and she can't see the blackboard, or an emotional problem has gone unchecked because the school psychologist was the victim of the last budget slash.

Match the amazing medical advances against the things that matter to us, the citizenry and the consumer—increasing venereal disease, increasing alcoholism, increasing drug addiction rates. Doctors' offices that have signs that say that don't take medicaid, or worse, signs that say they charge $3 per page to medicaid patients to fill out the forms. Three-page forms cost the medicaid patient $9 to have the forms filled out.

The insurance policy steadily costs more, but they seem to exclude those items of care that one really needs.

The fault, we believe, has been the steady avoidance of real consumer authority that directs the course of health care. Most legislation provides for consumer advisory groups that have little or no power. RMP funds today are still designated by medical schools. Hospital facility funds are still divided up by hospital administrators. Consumer participation is far too limited to be effective, and in any case, the consumers are never involved in the planning process, but are only given the right to review proposals planned by providers.

Even in CHP where the consumers have effective voice, no money has been allocated, no real power is allocated, and it is ignored generally by the providers.

In the belief that this time around the Federal Government might be sincere in its promises, the founders of the Bi-County Alliance of Health Consumers set about pulling together the disparate elements of the community to a single cohesive consumer voice. We started at the county and bicounty levels of organizations. Labor organizations were asked to stop moving in separate directions. Minority and poverty advocate groups were asked to hold back on confrontation tactics. Social activity groups and even the League of Women Voters were requested to subordinate their separate pro-

grams, and religious based groups like the Council of Churches were invited to join forces.

That group incorporated as the Alliance and operated for a year on a purely voluntary effort, including the typing the the petty cash for the stamps. During that year the Alliance negotiated on CHP Council 18 seats, which is a third of the total consumer seats.

CHP staff then engaged in the next phase, the development of community health councils, and the Bi-County Alliance received a small grant for CHP for a part time director and all time secretary to coordinate and educate community groups in health care planning and to seek all the national forms of funding for them. There are currently 15 such local neighborhood community groups existing in Nassau and Suffolk.

The next phase of the program was to have Bi-County Alliance assume responsibility for the Economic Opportunity Commission over its 11 emergency food and medical service aides. The cooperation from the EOC has been excellent, and as recently as the last 2 weeks those EFMS aides were transferred over to become staff to health committees, which brings us to the point we are now and the great trepidation with which we are expressing our concern.

We have the aides in the field, we have organized consumer groups ready to cooperate and work in the planning conference. We have people involved currently in outreach in working day to day with people in the community who have had no contact with the health care services field, who are bringing them into that system, finding them the emergency medical services, ready to participate in the planning.

The question comes, when this legislation is passed will the Federal Government again walk away from its promises. Will it walk away from the EFMS aides that we have trained, that we have prepared for health career services, and leave them hanging and unemployed as EOC drops its EFMS program? And more important, for what purpose have we brought these groups together ready to participate in the health planning process if the Health Security Act at this point does not have safeguards in it to provide consumer participation and to insure consumer participation, and to provide the incentives for the providers to make absolutely certain that they know the consumers are going to participate. Then those neighborhood health groups, understanding the frustration and having been walked away from by the Federal Government again, are going to have to go some place else, do something else.

We are holding the groups together because we feel that in partnership with the Federal Government utilizing Federal legislation we can accomplish much in the way of solving community needs.

We have decided this morning to try to demonstrate what kinds of problems are going out there even in a suburban community like Nassau County. And so I have asked this morning for Mr. Ted Conlon, who is the supervisor of our emergency food medical service aides, to bring some of those aides to you and to indicate just within the past few months what kind of problems those aides are seeing

in the field. The kind of information you hear today, of course, is being logged, gathered by EFMS people, turned over to the Neighborhood Health Committee. But it is going to be no use if our Health Committee has whole dossiers on problems, whole dossiers on needed solutions, and the Federal Government ends up sending checks to providers and leaving us entirely out of the process.

At this point I would like to introduce Mr. Ted Conlon, supervisor of the EFMS program, and some of his people.

Senator DOMINICK. Before we continue. I was very interested in Mr. Lenz's testimony. I would like to ask to have a statement of my own put in the record at the beginning of the hearing.

Senator Javits, the ranking Republican member of the whole Committee on Labor and Public Welfare, regrets that he cannot be here with the Health Subcommittee, but he is out of the country on official business by order of the U.S. Senate to attend a meeting of the OAS in Costa Rica.

At his request, Mr. Chairman, I ask unanimous consent that the report, "Comprehensive Health Goals and Objectives for New York State," by the New York Health Planning Council be made part of the hearing record.

Senator KENNEDY. So ordered.

(The information referred to follows:)

COMPREHENSIVE HEALTH GOALS AND OBJECTIVES FOR NEW YORK STATE

New York State Health Planning Advisory Council

January 15, 1971

New York State
Health Planning Advisory Council

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New York State
Health Planning Advisory Council

COMPREHENSIVE HEALTH GOALS AND OBJECTIVES FOR NEW YORK STATE

Introduction

The overall comprehensive health goal in New York State is:

> *To attain optimum conditions conducive to social well-being; to attain optimum personal health; and to attain a favorable ecological balance between man and his physical and social environment.*

Few statements on human affairs can be considered absolute. Nevertheless, those which follow reflect the collective judgment, experience and belief of the broadly representative membership of the Advisory Council. They are presented as valid health goals and objectives during this decade for the citizens of the State of New York on the basis of present knowledge.

Optimum health for all New Yorkers will be achieved when the State attains a rational, humane system of personal health care in a healthful natural and social environment. The close interrelationships between health and social well-being are forcefully documented in many sources including the Health Planning Commission's study of Health Needs of the Disadvantaged.

In order to deal most logically with the immense and diverse problems of health, the totality has been broken into three spheres for consideration -- social well-being, personal health and environmental health.

Some of the goals chosen by the Advisory Council can primarily be met through the activity of agencies and individuals not ordinarily thought of as health-related. Some require the active commitment of all elements of our population. Others bear directly upon the providers of health services. While it is necessary to select priorities among objectives and goals, reaching the state of optimum health for all New Yorkers requires active attention to each goal.

The emphasis must shift away from the present tendency to define personal health care solely in terms of facilities, finances and personnel, and toward that of the individual in need.

Those aspects of the social environment which contribute positively towards health are: housing, employment, food, education, transportation, human dignity, social identity and aspiration, constructive attitudes toward health, positive personal health behavior, recognition of urban-rural-suburban differences, and attention to the needs of socially underprivileged groups.

The aspects of the natural and physical environment meriting major attention were defined by the Committee on Environment of the American Public Health Association as follows: "The Environment is considered the surroundings in which man lives, works and plays. It encompasses the air he breathes, the water he drinks, the food he consumes and the shelter he provides for his protection against the elements. It also includes the pollutants, waste materials, and other detrimental environmental factors which adversely affect his life and health."

The terms goal, objective and priority have different definitions to different users. For the sake of consistency the following definitions have been utilized: Goal is an expression of a desired state to be achieved, prescribing the direction and intent toward achieving the desired state. Objective is the tangible division of goals toward which specific activities can be aimed, including desired end results or specific accomplishments to be sought on the way to achieving the goal. Priority is a rating applied to goals and objectives representing the realistic ordering of choices with respect to time, the allocation of resources and other constraints. The priority rating which the Advisory Council has assigned to each objective is indicated in parenthesis in the text.

In the preparation of this statement there was full awareness of the resource constraints on the attainment of many of the goals and objectives. Yet, viewing this statement as an avowal of intent and direction, long-range goals and objectives, as well as those that are more immediately achievable, are both set forth for this decade.

THE PROBLEMS WE FACE

The attainment of a healthy society is dependent upon the physical, emotional and social well-being of its members. Poverty, unemployment, underemployment, inadequate housing and related social conditions create mental and physical health problems. The large magnitude of these problems among the poor, as compared to the more affluent, is particularly evident in the Health Planning Commission's study of the Health Needs of the Disadvantaged. Society has failed to recognize its responsibility for the health of its members. Pervasive apathy and collective insensitivity have served to inhibit the public's awareness of the relationship between the individual's well-being and the well-being of the community. Neither individuals nor the community have been made aware of their responsibility for the maintenance of optimum personal, family, and community health.

There is a cause and effect relationship between socio-economic pathology, and health dysfunction. However, this relationship has not been adequately recognized in the allocation of resources. Criteria for the allocation of resources (i.e. manpower, facilities, financing, technology, and knowledge) are concentrated on illness rather than health. This problem has been recognized by a number of authorities and studies, among them the Report of the National Advisory Commission on Health Manpower; Dr. George James in his article,"Life, Liberty and the Pursuit of Quality"; and the Fortune article by Dan Corditz entitled, "Better Care at Less Cost Without Miracles."

Individuals with special health needs have not been integrated into society as a whole. Minority and ethnic group membership, economic status, geographic location, age, crippling physical or mental handicap or disability are frequently the basis for isolation from the mainstream of health services and society.

Society's attempts to promote social well-being have been shortsighted and crisis-oriented and have tended to disregard the whole range of social, economic and environmental factors which impinge upon the health of the individual.

In the delivery of personal health care there is a lack of comprehensive preventive, diagnostic, treatment and rehabilitative services readily available for emergency, acute and chronic situations. The recent Carnegie Commission report on Higher Education and the Nation's Health discusses the uncoordinated proliferation and self-perpetuation of increasingly specialized and discrete professionals and institutions. This adds to the difficulties of caring for the total individual along with his family and the community.

59-661 O - 71 - pt. 8 - 2

Failure to adopt preventive medical procedures and to identify potential medical problems in poverty areas has led to a higher incidence and prevalence of many diseases. It is also precisely in these areas that health services are often unavailable, unaccessible, unacceptable to recipients; costly; frequently of poor quality; fragmented; and lacking in continuity. Health services are seldom integrated with health-related supportive services, and they are not offered in a family-centered context related to community needs. These negative factors increasingly apply to the population at large which has less and less primary care resources available for entering and moving through the present maze of health care. These problems are well developed in many studies.

There is a serious deficiency in fully utilizing available manpower, facilities, financing, and technology in providing better health services and restructuring their delivery. This has been shown by major studies such as works by Somers and Somers, the Report of the Task Force on Medicaid, and the Report of the National Advisory Commission on Health Manpower. Utilization based on conventional delivery methods and ability to pay, rather than on consumer need, makes health resources appear more limited than they are. In relating health and social problems there is an inadequate application of behavioral science knowledge to the delivery of services and to the education and training of all members of the health team. The increased demand for health services created by Medicaid and Medicare; the escalating costs of hospitalization; and the rapidly changing technology of modern care, have resulted in increasingly higher expenditures which are borne by the consumers of health care services. The mounting concern over these problems is reflected in the extensive coverage provided by every leading national magazine within the past few years.

Disregard for the consequences of the impact of man on the environment and the influences of the environment on man has resulted in serious deterioration in the quality of modern life. Paramount among his problems is incomplete understanding of what constitutes a healthful environment, and what attitudes and practices unfavorably alter the environment and thereby threaten his mental, physical and social well-being.

Now that the pervasiveness of environmental factors is becoming more and more evident, man is faced with the necessity of examining his fundamental attitudes and behavior. As the U.S. Department of Health, Education and Welfare's Task Force on Environmental Health and Related Problems has pointed out in its 1967 report, entitled "A Strategy for a Livable Environment," more needs to be known as to

what constitutes the optimal setting for human health. There needs to be an examination of present attitudes and practices, both individual and social, which, based on present knowledge, alter or affect negatively the health environment. Also required is an examination of present mechanisms for applying already acquired knowledge to determine whether they are adequate or in need of strengthening.

Specific attention must be given to the development of a far broader time perspective with regard to actions which may alter irreversibly the environmental balance or require great future remedial expenditures.

THE SOLUTIONS WE PROPOSE

THE GOAL FOR SOCIAL WELL-BEING

To provide opportunity for a standard of living adequate to ensure the dignity of every New Yorker; to provide opportunity for productive employment and education relevant to the needs of both the individual and society; and to develop both within the individual and the community a sense of responsibility for the maintenance of optimum personal, family and community health.

OBJECTIVES:

1. To advocate the design and construction of substantially more new housing, and the rehabilitation and maintenance of existing housing. (Priority No. 9)

   - Strive vigorously for greater private investment in housing for low and moderate income groups.

   - Provide innovative public programs to meet housing needs which are not satisfied by private investment.

   - Promulgate and consistently enforce housing standards which will ensure decent living conditions for all New Yorkers.

   - Seek new construction methods which provide housing at costs reasonably related to other sectors of the economy.

2. To provide an education which will enable all New Yorkers to realize their potential to the fullest, and provide training for productive and satisfying employment. (Priority No. 15)

3. To stimulate full employment in all areas of the State.(Priority No.21)

4. To ensure all New Yorkers continuous access to food sufficient in quantity and nutritional value to maintain physical well-being and promote the healthy growth and development of the young. (Priority No.13)

   - Establish and enforce quality standards and labeling requirements for all food products in relation to nutritional value as well as freedom from contamination and adulteration.

   - Disseminate information on nutrition which will enable the consumer to choose wisely in the selection, preparation, and consumption of food.

5. To relate population growth and distribution to the development of those resources needed to permit social well-being. (Priority No.17)

   - Make family planning information and services widely available.

   - Create conditions to promote a more rational distribution of the State's population.

6. To strengthen and make more effective social service programs so that they will enhance social well-being and health. (Priority No.19)

   - Provide adequate financing for social service programs to enable families to live in dignity.

   - Facilitate access to all social and health services.

   - Disseminate information on the availability of social and health services.

7. To ensure consumer involvement in health and social planning throughout New York State in order to make community agencies, institutions and services more responsive to the needs of those they are designed to serve. (Priority No.18)

8. To develop within the individual a commitment to personal, family and community health; the environment and its relationship to health; concern for persons with special health needs; and participation in the health planning effort and community programs. (Priority No.2)

   - Encourage the continuous self-examination and adjustment of attitudes and actions by every New Yorker so that the apathy and powerlessness of so many of our citizens is eliminated.

   - Develop during childhood and maintain throughout life attitudes and behavior which will enable individuals to play a more effective part in safeguarding their own health.

9. To increase our knowledge of the interrelationship between man and his social environment and its effect on health. (Priority No.26)

   - Promote research into the effects of the urban, rural and suburban environments on the physical, emotional and social well-being of the individual.

10. To develop interrelationships between health planning and social, economic and environmental planning. (Priority No.14)

    - Coordinate the programs and planning efforts of all health-related public and private agencies in the State.

THE GOAL FOR PERSONAL HEALTH CARE

To develop a responsive system, free of financial barriers, that provides continuous and comprehensive quality health care which is accessible and appropriate as well as acceptable to recipients and providers.

OBJECTIVES:

11. To ensure that the health care delivery system meets the special needs of urban and rural populations. (Priority No.6)

    - Explore the feasibility of various new delivery models to meet the special needs of urban and rural populations.

12. To encourage manpower recruitment, training, placement, utilization and retention, especially of minority groups. (Priority No.20)

    - Investigate various new means of licensing health personnel.

    - Train and better utilize paramedical personnel.

13. To make full use of existing technology and potential resources. (Priority No.22)

    - Develop objective, quantifiable measures of health status.

    - Develop health and management information systems for the delivery and utilization of health care.

14. To encourage the testing of innovative health care delivery systems. (Priority No.7)

    - Develop innovative primary care programs for populations with limited access to care.

15. To eliminate the financial barriers to health care. (Priority No.1)

    - Develop alternate methods of financing innovative primary care programs.

16. To maintain the health of those who are well. (Priority No.8)

    - Prevent the occurrence and progression of human ailments.

17. To provide care for people with emergency, acute or chronic health conditions as they utilize a full range of preventive, diagnostic, treatment and rehabilitative services.(Priority No.3)

    - Improve and extend the full range of comprehensive services.

    - Encourage the fluoridation of all water supplies.

18. To support continuing medical research aimed at reducing the incidence of mental, physical and emotional disorders.(Priority No.11)

    - Develop specific epidemiologic studies to reduce mental, physical, and emotional disorders.

    - Encourage applied clinical and basic research.

19. To encourage continuing education for professional groups, especially physicians without hospital affiliations.(Priority No.25)

    - Explore feasibility of re-licensing physicians based on examinations.

20. To promote the development of a physicians' service corps.(Priority No.31)

    - Utilize physicians to make health services more accessible through a service corps.

21. To promote the development of facilities centrally located within the community to provide the health care services and health-related social services needed. (Priority No.16)

    - Improve knowledge of availability of specific health services.

22. To encourage health services that are fully responsive to the needs and dignity of the patient. (Priority No.12)

    - Develop programs for the reduction of special health problems such as drug abuse and venereal disease.

    - Develop innovative approaches to special health problems related to age.

    - Change the attitudes of health personnel regarding patients and needed services.

    - Train health personnel in patient psychology.

23. To promote broad community involvement in decisions concerning local health services. (Priority No. 27)

24. To extend meaningful school and community health education programs aimed at developing an understanding and sense of responsibility for the individual's own health. (Priority No.10)

THE GOAL FOR ENVIRONMENTAL HEALTH

To attain a favorable ecological balance between man and his physical and social environment that will be conducive to optimum health, safety, and comfort and that will protect this generation, and coming generations as well, from the deterioration in the quality of life caused by uncontrolled environmental factors.

OBJECTIVES:

25. To develop a personal and societal responsibility for an environment conducive to health. (Priority No. 23)

    - Promote community and school health education programs designed to foster individual understanding of human ecology and environmental protection.

    - Increase public awareness of the frequent conflict between demands for a healthy environment and luxury or convenience products.

26. To reduce air, soil, water, food, drug, radiation and noise pollution. (Priority No. 5)

    - Promulgate and consistently enforce standards to reduce environmental pollutants.

    - Provide economic incentives that would encourage industry and local governments to reduce pollution.

    - Develop sewage treatment, air pollution control, and solid waste disposal systems.

    - Minimize human exposure to harmful radiation.

27. To reduce environmental hazards. (Priority No. 24)

    - Diminish vehicular, home, occupational and recreational accidents and resulting injuries.

28. To develop and maintain healthful conditions in residential environments. (Priority No. 28)

    - Eliminate rats, lead poisoning and other dangers from the dwellings of the poor.

    - Explore the relationship between residential density and health.

    - Support the establishment and enforcement of housing maintenance and occupancy codes.

29. To develop and maintain healthful conditions in occupational environments. (Priority No. 30)

30. To develop and maintain healthful conditions in recreational environments. (Priority No. 32)

31. To acquire knowledge upon which a workable technology can be based. (Priority No. 29)

    - Develop knowledge and technology to make greater use of reclamation and recycling of material from solid waste.

    - Develop an on-going ecological information system.

    - Secure basic information on pollution, to improve monitoring and to determine long-range effects on health.

    - Consider long-range implications, as well as immediate benefits, in the planning of programs and activities which affect the physical environment.

32. To assure the rational allocation of resources so that they will be of most benefit to the mental and physical health of both the individual and society. (Priority No. 4)

    - Reduce "crisis rhetoric" in discussion of the environment so that proper priorities can be assigned.

    - Encourage the provision of adequate manpower, facilities, financing and technology to implement the reduction of environmental hazards and unhealthful residential environments.

Senator DOMINICK. Mr. Chairman, before we continue I think it would be of interest to some of the people who are here today if I could just quote a few statistics from statements that I have obtained. I won't take long.

Having been at most of the hearings we have had in Washington—and I plan on being at most of the field hearings—one would get the impression that the United States is providing second rate medical care in many cases because it is said that other countries have lower infant mortality rates. In truth, infant mortality is for the most part a social rather than a medical problem. Factors such as poverty, malnutrition, poor housing, poor education and racial or ethnic differences are much more highly correlated with infant mortality than such factors as the number of physicians or hospitals.

It has been said, "In the analysis of the health care crisis, there is an acute and worsening shortage of all kinds of health personnel, especially doctors." The truth is that we have one of the highest ratios of doctors per capita in the world, and the number of physicians is growing at a rate faster than our population. In 1950, the population to physician ratio was 711 to 1. Now it is 630 to 1.

The number of medical schools and medical students is showing unparalleled growth. In the school year 1966–67 there were 89 medical schools and just over 33,000 medical students. It is anticipated that by next year—just 5 years later—there will be 114 schools and over 43,000 medical students—an increase of 25 schools and 10,000 students.

This is not to say that we don't need more medical schools and more doctors. We do. But the basic problems are maldistribution—too few doctors in crowded urban slums and in rural America—and a tendency to specialize. Steps are being taken by the medical profession, by the States and by the Federal Government to counter this trend toward specialization, to deal with the maldistribution problem, and to take some of the load off of doctors by training more allied health personnel.

I think this fits both with Mr. Lenz's statement and also the need which has been expressed by many of the witnesses before our committee. Listening to the hearings in Washington, one could almost conclude that we are about to come apart at the seams and that we are a nation that is ill-clad, ill-fed, ill-housed, and ill-cared for, whether it is in Maine, California, North Dakota, New York, or Florida. But infant mortality, for instance, has been reduced 66 percent in this country since 1900, and life expectancy is up 45 percent in the same period. In the United States we have virtually—some remains, unfortunately—but virtually no polio, no smallpox, diphtheria, nor typhoid fever, and we do have the means at hand to eliminate measles. And so despite the problems we have—and we have them, and might as well recognize them—America is, in general, healthier than ever.

I am hopeful that in these hearings we will start discussing some solutions. For instance, when we are speaking of infant mortality, I believe it would be useful to identify the reasons for the difference between the death rates of whites and blacks. Last year the national infant mortality rate declined as it has every year for some years. The black rate was not only higher than the white rate; the black

rate increased slightly. A perceptive comment on this fact was made by Dr. Rowland Scott, Professor of Pediatrics at Howard University in Washington. Speaking of that city's infant mortality figure—in a city which is about 73 percent black—Dr. Scott said, "This high mortality is not taking place in the hospitals—they are not too bad. It's what happens when these babies go home to the ghetto." So, better medicine is not the only answer. An effective solution is going to require broad—and I emphasize that—broad socioeconomic changes.

What I am trying to point out is that health problems are complex, and it would be unrealistic to place too much faith in simple solutions. Certainly we have made great progress. Certainly much more progress must be made. But there is no simplistic answer; no one scheme or program can do it all. In the words of H. L. Mencken, "For every human problem, there is a solution that is simple, neat, and wrong."

That is about as simplistic a statement as one can get on health care problems that we have around the country.

And I am hopeful that the press in reporting on these hearings and the ones in Washington will report on the health care programs that have been proposed by the administration and by many others, including the chairman, and that it can help in our effort to promote a national discussion based on facts rather than on myths. We need such a discussion if we are to continue to improve the quality and accessibility of health care for all Americans.

This problem is so monumental, and this is a quote from a Washington Post editorial of a few weeks ago—

> The health care problem is so monumental in scope and so intricate in detail that every idea is entitled to a full hearing on its own merits. Somewhere, out of such a free debate, a national consensus must develop, a consensus that rests on facts and solid theory, not on the whims of doing something to improve the situation or on notions of reaping political credit for the final product.

And I would like to have my full statement put in the record, as I said at the beginning, if I may.

Senator KENNEDY. The full statement will be included in the record.

(The prepared statement of Senator Dominick follows:)

STATEMENT OF HON. PETER H. DOMINICK, A U.S. SENATOR FROM THE STATE OF COLORADO

Mr. Chairman, as the Health Subcommittee begins its field hearings on the subject of "The Health Care Crisis," I believe it is important to point out to the witnesses that the jurisdiction of this subcommittee is quite broad. The rules of the Senate provide that legislation will be referred to the parent Labor and Public Welfare Committee if it involves the public health. In fact, this means that the Health Subcommittee has jurisdiction over the Public Health Service and also over a wide range of Federal health programs. In the last Congress under the chairmanship of Senator Yarborough, this subcommittee acted on a wide range of health legislation. Much fine legislation was enacted into law which will help immeasurably in providing better facilities and more man-

power to meet our problems. The subcommittee recommended and the Congress enacted legislation which provides grants to schools of public health, assistance for migrant agricultural workers health programs, Federal aid to community mental health centers, Federal assistance to medical libraries, Federal dollars for vaccination programs, an extension of the regional medical program which funds projects across the country in health education and delivery to control heart disease, cancer, stroke, and now kidney disease.

This subcommittee also acted on legislation during the last Congress to extend and strengthen comprehensive health planning, to provide additional aid to fight mental retardation and help children with developmental disabilities, to extend and improve the training programs for allied health professions, to establish a landmark program for prevention and treatment of alcoholism, and to authorize the use of Public Health Service personnel in areas where there are shortages of physicians.

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

In this Congress, some 30-odd bills and resolutions covering a broad range of health matters have already been referred to the Labor and Public Welfare Committee for initial consideration by this subcommittee. Some of the most important of these deal with urgent problems related to the shortage and maldistribution of health manpower. For example, the Health Professions Educational Assistance Act, which provides Federal assistance to schools and students of medicine, dentistry, osteopathy, podiatry, pharmacy, optometry, and veterinary medicine, will expire July 1 this year. Several bills which would extend and modify that authority are pending action before this subcommittee. Also pending is legislation to assist in the training of acutely needed nurses and other allied health personnel.

As everyone knows, several national health insurance proposals have been introduced this Congress. These raise significant issues because they represent the first comprehensive approach to improving the quality and accessibility of health care in the United States. Several weeks of this subcommittee's time this year have been spent listening to testimony directly related to these proposals. While such testimony is undoubtedly helpful to this subcommittee, I think it should be kept in mind that the various national health insurance proposals are not before us. Since they have revenue-raising features they have been referred to the Finance Committee. In summary, this subcommittee has pending before it considerable legislation dealing with urgent problems which fall within its broad jurisdiction. For that reason, I think the scope of these field hearings should be confined to those problems.

As we go into these field hearings, I think it is important to put a few facts into the record and to comment on some misconceptions

which have been apparent in previous hearings or in the discussion of the health care situation in the country.

Let's look at the use of statistics by some of the witnesses who have appeared before this subcommittee. Some would have us believe that the United States is providing second-rate medical care because other countries have lower infant mortality rates. In truth, infant mortality is for the most part a social rather than a medical problem. Factors such as poverty, malnutrition, poor housing, poor education, and racial or ethnic differences are much more highly correlated with infant mortality than such factors as the number of physicians or hospitals.

Moreover, comparisons of international statistics on infant mortality are not very meaningful. The Demographic Yearbook of the United Nations spends five pages pointing out why statistics from one country are not necessarily comparable to statistics from another country, especially in the field of infant mortality.

There also seems to be a popular misconception that the United States is the only major industrial nation in the world that does not have national health service or a program of nationalized health insurance. This claim was made last month on the floor of Congress, and the idea is widely shared, even among some health "experts." Those who hold this view seem to have in mind the British and Eastern European model in which health services are not the typical Western European model. In fact, continental health insurance schemes are predominantly financed by employer-employee contributions and operate within the framework of national standards.

It has been said, "In the analysis of the health care crisis, there is an acute and worsening shortage of all kinds of health personnel, especially doctors." The truth is that we have one of the highest ratios of doctors per capita in the world, and the number of physicians is growing at a rate faster than our population. In 1950, the population to physician ratio was 711 to 1. Now it is 630 to 1.

The number of medical schools and medical students is showing unparalleled growth. In the school year 1966–67 there were 89 medical schools and just over 33,000 medical students. It is anticipated that by next year—just 5 years later—there will be 114 schools and over 43,000 medical students—an increase of 25 schools and 10,000 students.

This is not to say that we don't need more medical schools and more doctors. We do. But the basic problems are maldistribution—too few doctors in crowded urban slums and in rural America—and a tendency to specialize. Steps are being taken by the medical profession, by the States, and by the Federal Government to counter this trend toward specialization, to deal with the maldistribution problem, and to take some of the load off of doctors by training more allied health personnel.

While it is clear that this country has critical health problems, I think we should keep the magnitude of those problems in some sort of perspective. Listening to the hearings in Washington as I have day after day, I could almost conclude that we are about to come apart at the seams and that we are a nation ill clad, ill fed,

ill housed and ill cared for from Maine to California and North Dakota to Florida. Therefore, I would like to point out that infant mortality, for instance, is down 66 percent in this country since 1900. That male life expectancy is up 45 percent in the same period. That in the United States we have virtually no polio, smallpox, diphtheria, typhoid fever, and have the means in hand to eliminate measles. Despite the problems we have, America is, in general, healthier than ever.

Having had the problem areas in health care identified repeatedly to this subcommittee, I am hopeful that in these hearings we will start discussing some solutions. For instance, when we are speaking of infant mortality, I believe it would be useful to identify the reasons for the gap between the death rates of whites and blacks. Last year the national infant mortality rate declined as it has every year for some years. The black rate was not only higher than the white rate, the black rate increased slightly. A perceptive comment on this fact was made by Dr. Rowland Scott, professor of pediatrics at Howard University in Washington. Speaking of that city's infant mortality figure—in a city which is about 73 percent black—Dr. Scott said, "This high mortality is not taking place in the hospitals—they are not too bad. It's what happens when these babies go home to the ghetto." So, better medicine is not the only answer. An effective solution will require broad socio-economic changes.

What I am trying to point out is that health problems are complex, and it would be unrealistic to place too much faith in simple solutions. Certainly we have made great progress. Certainly much more progress must be made. But there is no simplistic answer; no one scheme or program can do it all. In the words of H. L. Mencken, "For every human problem, there is a solution that is simple, neat, and wrong."

In conclusion, I think the press has a special and constructive role to play, reporting on these hearings and reporting on health care programs. It can help in our effort to promote a national discussion based on facts rather than myths. We need such a discussion if we are to continue to improve the quality and accessibility of health care for Americans. If I may quote from a Washington Post editorial a few weeks ago on health care programs:

> The health care problem is so monumental in scope and so intricate in detail that every idea is entitled to a full hearing on its own merits. Somewhere, out of such free debate, a national consensus must develop, a consensus that rests on facts and solid theory, not on the whims of doing something to improve the situation or on notions of reaping political credit for the final product.

Senator KENNEDY. Mr. Lenz.

Mr. LENZ. Mr. Conlin, one of the supervisors, will introduce some of the aides.

STATEMENT OF THEODORE P. CONLIN, PROJECT DIRECTOR, COUNTY-WIDE EMERGENCY FOOD AND MEDICAL SERVICES PROGRAM

Mr. CONLIN. Senator, I have a brief statement before I introduce my aides, if I might.

If nobody has taken the occasion at this point I, as a former undergraduate of Hofstra and an alumnus, welcome both Senator Kennedy and Senator Dominick to our campus.

I am going to address myself to concerns of the mentally disadvantaged this morning, and Senator Dominick asked for some solutions, and I am going to attempt to give both Senator Dominick and Senator Kennedy some solutions as the consumers down in the local communities see them.

State mental asylums were deemed archaic and obsolete better than 100 years ago by the founding fathers of the psychiatric community here in America.

State mental asylums were frowned upon as reminiscent of the 17th century pesthouse by these same men.

And yet today, when one nation such as ours, can bend its will, resources, and planning commitment to the end of achieving in a single decade, that which most men, at the time, considered to be possible only in fantasy or science fiction, the goal of moon exploration by earthlings, we still allow for the ugly spectre of the 17th century pesthouse to haunt our asylumized mental patients.

And I would like to remind the Senators that here on Long Island we have three of the nation's largest institutions, one of which is the world's largest, Pilgrims State Hospital.

It is indeed time that this same will, coupled with commitment of resources and planning, be applied towards the end of phasing out State mental asylums before the end of the decade.

We are on the Moon. We are already reaching for Mars.

If we can get our earthlings to such distant planets, why, then, can we not liberate the mentally incarcerated and have them treated in community oriented facilities where opportunity for expedited successful reentry into the mainstream of American life becomes more immediate, more promising, more hopeful.

The community is where these brothers and sisters can, and do, belong, and where they can, in the words of world famous psychiatrist Dr. Karl Menninger, become "weller than well."

Towards achieving this end, we would do well to advance the following concepts, concepts which could easily be translated into meaningful community action upon the part of health consumers geared towards implementation of same.

Ideally, the community should stress seven points:

(1) Treatment available in the community.

(2) Provision for early intensive treatment.

(3) Hospitalization near or in each person's community.

(4) A program during hospitalization directed towards the patient's family, friends, relatives, et cetera.

(5) Availability of outcare for acute epidodes.

(6) Provision for a wide range of services.

(7) Interagency cooperation in supporting therapeutic programs.

Ideally, the community should have:

(1) Psychiatric clinics for diagnosis, treatment, and rehabilitation of children and adults.

(2) Psychiatric services in schools, courts, and prison systems.

(3) Day care centers and residential services for disturbed children and the retarded.

(4) Intensive treatment facilities and services.
(5) Halfway houses.
(6) Suicide prevention services.
(7) 24-hour psychiatric emergency service.
(8) Psychiatric beds in general hospitals.
(9) Day care and night care in hospitals for adults.
(10) Rehabilitation and aftercare services.
(11) Community education.
(12) Advocacy for the mentally ill in cases involving civil and criminal conflict.
(13) Programing for preventive medicine, rehabilitative medicine, supportive medicine, and followthrough medicine; and let's get away from this crisis-oriented medicine.

Mr. Lenz has indicated what my position is. I am Nassau County field director for the countywide emergency food and medical services program. I have aides working in all of the poverty pockets in Nassau County who are encountering great difficulty in obtaining those immediate services for the people that are needed.

The three major constraints appear to be the lack of adequate staff to take care of our people; No. 2, the fiscal constraints are fantastic; and No. 3, we have absolutely no transportation facilities.

In regards to the first item I would just like to point out in my own community of Westbury we have 108 medical professional people in residence in my community. Of the 108 doctors who live in Westbury only one doctor is available for emergency calls. This man is an elderly man, he is a sickly man. The other 107 doctors are not available for emergency calls in their own community.

At this time I would like to call on one of my aides, Medio Anushu (phonetic), who is servicing the Hicksville center of Nassau County. Following Medio I have three other aides. I would appreciate it if you could give them a little bit of your time this morning.

Senator DOMINICK. Could I just ask one question? We found out in the process of the Drug and Alcoholism Subcommittee, on which I also serve, that courts in some areas of the country, particularly out west, have been experimenting with the idea of taking the alcoholic or drug abusers and turning them over to locally based community organizations rather than throwing them into the jails. This approach is certainly an improvement on the encouraged recidivism policies of the past.

Are the courts in Nassau County or the courts in New York as far as you know going along with that same type of idea? Are they turning alcoholics, for example, over to Alcoholics Anonymous or the drug abusers over to something like Sinon or Sinacore or anything of that kind?

Mr. CONLIN. We had a gentleman in this county, George McCarthy, who recently retired from an organization here in Nassau County that lends itself to the problem of the alcoholic, and he was the only man that I had ever known that would go into the courts and intercede on behalf of the alcoholic.

In all honesty, I really cannot answer that question. I wish I could.

Senator DOMINICK. As far as you know, the courts themselves have not initiated any?

VOICE FROM THE AUDIENCE. No! No!

Senator DOMINICK. That's all.

Mr. CONLIN. The next speaker will be one of my countywide emergency food and medical service program aides based at the Hicksville Center. Hicksville is a white community, predominantly middle class, very conservative. My aide is Medio Anushu.

STATEMENT OF MEDIO ANUSHU, AIDE, HICKSVILLE CENTER, COUNTYWIDE EMERGENCY FOOD AND MEDICAL SERVICES PROGRAM

Mr. ANUSHU. Thank you, Mr. Conlin.

Good morning, Senator Kennedy, Senator Dominick.

I just want to briefly describe a few cases which I have run into in the last week.

I had one client, a senior citizen, that was threatened with the loss of doctor care because the last medical bill of $10 was rejected by medicaid. This same individual is no longer able to receive pharmaceutical supplies from the local pharmacy only two blocks away because that pharmacy is no longer accepting medicare or medicaid payments. The client is 68 years old and unable to travel great distances for drugs and medical care. The closest pharmacy is on the west side of Hempstead.

In this particular case I would cite inefficient operation of medicaid and medicare and the providers' concern with money rather than health care are two main problems.

I have another client in his 70's, and the husband in question has become seriously ill on a number of occasions due to his age, and they have not been able to get a doctor to make a house call, and they are in an apartment facility. There are four doctors within four blocks of the apartment, and they tried another two in the local community, and nobody would make house calls.

I have a 9-year-old girl. I talked with her parents last Monday. She is an asthmatic child. The father is working for the post office. They have financial difficulty and they are unable to provide the child with an air filter for comforting her sickness. They applied through medicaid and they were told that many appliances do ease a patient's condition but they have no medical value, therefore, they cannot assist the family.

Senator KENNEDY. Who told them that?

Mr. ANUSHU. I called personally the doctor in charge of the medicaid office at the Department of Social Services, and after he hung up I called back and it was his secretary, and this has been recorded. It was his secretary that told me, and that is a quote, that many appliances do in fact ease a patient's condition but they are of no medical value. That was their statement.

There is a 22-year-old woman that is about to enter the hospital. After going through two miscarriages last year within the last 8

months the attending physician said that they did not use the usual treatment in cleaning which usually accompanies a miscarriage. The present service she will receive is a D and C, due to the miscarriage and not being taken care of at that time. And the operation will cost between $300 and $400. This couple is not medically insured and they will have to foot the cost.

I can continue on and on, but I am sure you have heard all kinds of problems like this.

The thing I would like to say is if the U.S. Congress is sincerely interested in effecting meaningful health legislation they must constantly keep in mind that the segment of our society, mainly the medical establishment, which has the greatest amount of power and finances available for the provision of meaningful and effective health care. It is the very same segment which has shown the least amount of interest and least amount of concern in attempting to resolve the health crisis which is at present plaguing our Nation. If they in fact keep this in mind, then the people of this country may finally see an improved health system.

Senator KENNEDY. Could you tell us a little about yourself? Are you trained in the——

Mr. ANUSHU. Yes, at present I am finishing a 2 months extensive community organizing course at the State University of Old Westbury. And basically my field is emergency food and medical service. The food problem is acute and emergency medical service is acute. Therefore, many of the aides are going into community organizing as well as the emergency food distribution service.

Senator KENNEDY. How long have you been working in this?

Mr. ANUSHU. Three months.

Senator KENNEDY. We are interested obviously in trying to get some kind of a better feel about the nature of the health crisis in the suburban area. Are there any general comments you would like to make about it? I think most people assume that in more middle-class suburban areas that we have got very few problems. I would be interested, from your limited kind of experience over 3 months but working rather intensively in this area, whether you would have any comments you would like to make.

Mr. ANUSHU. Well, I might say that the existing hospitals—for instance, we have a county hospital which provides health care for the county. My four areas are closest to this particular area, yet due to the dispersion of housing and the area that my four communities encompass, it is difficult for these people to get to this hospital.

Transportation is another problem, but I guess in this particular case it relates. But there is poor transportation in our area. Doctors are not making house calls. I have not been able to find a physician that will make a house call. Seventy percent of the people I deal with do not have anyone they can call a family doctor.

The clinic is providing the best care possible, but it is overcrowded. Many of my clients wait 2 or 3 hours to be treated in the clinic unless it is a dire emergency—and I mean you have to be dying to get treated immediately. Otherwise there is a long wait. We have a pediatric clinic located in Plainview which is completely distant from any type of services.

Senator KENNEDY. What sort of group are you talking about? Are you talking about the medically indigent, are you talking about the middle class?

Mr. ANUSHU. I am talking about marginal income and middle class as well as, of course, the poor.

Senator KENNEDY. Can't middle class people get a doctor to come to the house when they need one?

Mr. ANUSHU. Not usually. The family doctors of middle class families will sometimes come out to the house. I know of one doctor, for instance, on the edge of Hicksville who has a number of patients that have been with him for 10 or 15 years. Rather than make the house call he will say "okay, meet me at my office." But his office happens to be attached to his house. Now why he can't get in his car and go to the house I don't know. But I have known people to go there as late as 10, 11 o'clock to receive health care, and they have to go to his office.

Senator DOMINICK. Have you had any medical training?

Mr. ANUSHU. No, sir, I haven't.

Senator DOMINICK. In the group that you are working with do you have what we call allied medical helpers—in other words, corpsmen who come out of the service, or people who have been trained to be nurses' aides, assistants to pediatricians, and so forth?

Mr. ANUSHU. As I understand it, right now the State legislature is having a big to-do as to whether they are going to allow any type of paraprofessionals of this nature practice in the State of New York. I, myself, am interested in the physicians' assistant program which was supposed to start at Stonybrook this fall, and it is still doubtful of ever starting.

Senator DOMINICK. It has not started as far as you know in the medical schools that are around or here at the university?

Mr. ANUSHU. No.

Senator DOMINICK. We have to give the doctors a boost here because they have been cut up pretty badly. I don't know anything about the doctors in Hempstead, but I guess they are all overworked and pushed hard. We have had a lot of evidence that house calls, even though they are necessary with a bedridden patient, create a problem as to the number of people that may be treated. It is more difficult to make house calls than for people to come to them. In other words, they can take care of a lot more people at clinics. Have you any comment on that?

Mr. ANUSHU. I would say that in most cases—there are areas in this county, for instance Glencove, which have one doctor for every 125 people. Most of these people do not have any trouble getting house calls. In the town where I have lived for 15 years when we called our doctor he was there on the double. In an area like Levittown there is one doctor for every 500 people. That is an existing problem. In Uniondale there is one doctor with a very small caseload. There is another doctor with a very heavy caseload. Yet neither of the doctors make any attempt to exchange patients nor to coordinate with each other.

As I understand it, most of the doctors in our area when they hear the word group practice, which would serve more people in a given area, shun away from this idea. I think possibly the doctors

in the present state could in fact service more people and possibly make provision for house calls if there were some type of coordination made available.

For instance, at a hospital they always have, say, an orthopedic surgeon—they have one of the surgeons on call for a 24-hour period. The next day another surgeon will take that spot.

I think the doctors in a community should be responsible to each other as well as to the consumers in a given area, and I see no reason why a group of seven or eight doctors in any one small area, say, serving 20,000 people could not make some type of arrangement to have this type of service made available to the people in that area.

Senator DOMINICK. In other words, what you are saying is that in this area there is nothing comparable to what we have in Colorado. For example, a program now being developed in Denver entitles patients to complete health care coverage for a set, prepaid amount. I understand that doctors' foundations organized under this concept are being created throughout the State of Colorado.

Mr. ANUSHU. As far as I know, there is no such thing.

Senator DOMINICK. Do you know of any group program of doctors in this area or elsewhere which does make house calls?

Mr. ANUSHU. No, sir.

Senator DOMINICK. That's all I have.

Senator KENNEDY. Thank you very much.

Mr. ANUSHU. Thank you.

Mr. CONLIN. Senators, my next speaker will be Dorothy Ingram. Dorothy Ingram is from Freeport, N.Y. Freeport is a racially integrated incorporated village. It has a very high density of poor people, welfare people. I think Dorothy might have some very interesting things to say about her community in Freeport.

STATEMENT OF MRS. DOROTHY INGRAM, FREEPORT, N.Y.

Mrs. INGRAM. Welcome to Nassau County. It's good to see some Democrats on the scene again.

[Laughter.]

Senator KENNEDY. How do you think that makes Senator Dominick feel?

Mrs. INGRAM. Well, he's in good company. He looked like a Democrat.

Senator KENNEDY. We're working on him, but——

Mrs. INGRAM. Very good.

Senator KENNEDY (continuing). It's a pretty tough job.

Senator DOMINICK. I grew up in Connecticut and moved to Colorado.

Mrs. INGRAM. Oh, I see.

First I would like to address my attention to the fact that Nassau County is the richest county in the country, perhaps in the world. And unlike the cities or unlike the rural areas, our poverty is hard to find. So perhaps one of the first priorities, Senators, is to establish Nassau County in a category so that it can get some special attention, because everything is directed to the urban areas or the

rural areas, and suburbanites you like to think of as people who are living the life. Perhaps some of them are. But here in Nassau County we have 11 poverty areas which exist on the fringes of the more affluent areas.

We are exploding with problems. We are exploding with problems of poor housing, unemployment and underemployment, increasing welfare rolls. And all these things we know contribute to poor physical and mental health.

Senator DOMINICK. You sound like a Republican at that point.

Mrs. INGRAM. Do I really? They are working on me.

[Laughter.]

But I would like to address myself to the infant mortality rate. Perhaps the infant mortality rate is not as high here in Nassau County as in other areas, but if you will check the records you will see that in these 11 poverty areas and in some other areas infant mortality rate is much higher than the overall county rate, and this is attributed directly to social ills. Whether it is because of ethnic background or other problems of poverty—but it is there because of the social ills.

Consequently we have doctors who do make house calls, and I think the young man said in his community there is one doctor for every 125. But in the area where I come from does not have that many at all.

For instance, last week there was a family who had a youngster who was ill and the mother tried to get a doctor out, the doctor said, "Well, bring him in." It was said this was a doctor who makes house calls. The youngster wasn't feeling well at all, but the mother got him up and dragged him to the doctor, and the doctor diagnosed his case as having a fever and sore throat—as pharangitis, and prescribed some medication. The youngster went back home, and in about 6 hours he seemed to have gotten progressively worse, and after the mother looked and saw that this youngster was becoming delirious she took him to the county hospital, which is Meadowbrook. Luckily this family had a car.

The mother took this youngster to Meadowbrook, and his symptoms had become so intense that the doctors immediately diagnosed this as meningitis. A youngster with meningitis. And it was through prompt diagnosis and treatment that this youngster was saved.

But here again we have perhaps a mother who was somewhat sophisticated and could recognize these symptoms. The majority of the people in areas such as I live, and the other 10 areas, they are not sophisticated; they can't recognize it even if they were where they could get a doctor. So that kid in perhaps an unsophisticated family would have stayed home and died because here is a mother that thinks he has just got a sore throat and the fever will come down, has no transportation to get to the hospital, and he could have been "caput."

Okay, they were able to get there, the doctors were good and gave good care. And the family was somewhat concerned because this youngster was really in a bad way. And you know that hospitals are understaffed. The parents felt that since this youngster would be in a crisis situation for the first 24 hours that they would like

to get a private duty nurse. So the doctor said, "Well, I don't know whether we will be able to get one because it is so hard to get nurses to take meningitis cases." And I understand that efforts were made on the part of the hospital staff to get a private duty nurse. All the registries were called in Nassau County, and not one nurse, not one nurse. The same nursing association is fighting the training of paraprofessionals as physicians' assistants—the people who after being trained will come out and make house calls, will take on meningitis and other infectious disease cases, which nurses won't do.

Now I ask you are we going to continue these things, are we going to continue to let these things exist.

The same physician who says "oh, I don't think it is a good idea to have physicians' associates because malpractice suits may occur." Suppose this person would make a wrong diagnosis. And this mother says well, a simple thing like this, you are saying pharangitis, why couldn't a paraprofessional be able to diagnose and treat the same thing. And couldn't this parent say the same thing. Here is a physician who made a wrong diagnosis, who perhaps may not even have taken this youngster's temperature. But I think this is a parent who is concerned about the welfare of all and would not want to involve herself in such an entrapment as lengthy court cases and that sort of thing.

So we come down to some recommendations. It was said that you are looking for recommendations about what can be done. And I say could we first of all establish Nassau County as a priority crisis area because we know we have these problems of poor health, and so forth, where the help can be a special something. You need to do as you have done in the cities, the urban areas. You have set them up as crisis areas. So that would be the first thing.

Secondly, we would like to see funds from the Federal level that would generate positions for persons in high level health positions to develop and implement more and adequate health services. We have available only a few people in this county who are truly concerned about getting health care and improving health care and the delivery of services for all of the people of Nassau County, people who are not so provider oriented, or people who can work with both the provider and consumer.

We need more of these types of individuals because, believe me, the few of us who are here and who are working with consumer interest, we are fragmented. You start out from 7 in the morning and you go until past midnight. How can you last? You can't last that long. So help is greatly needed in providing manpower at that level, and this manpower will in turn be able to generate some of these other paraprofessional jobs that are needed, people to come in to assist the doctor, who will tell you we can't expand your services because we can't get a physician or we can't get a trained nurse.

We have people, many of these people who are sitting right here, our aides, our EFMS aides, our family planning aides—these are paraprofessional people who have gone out in the communities in less than 6 months, and they have covered numerous cases like

the young man from Hicksville told you about; the case that I told you about. We could go on and on.

But the thing is something must be done, and these are two—I think two of the main solutions for this problem.

Senator KENNEDY. Thank you very much.

Senator DOMINICK. Just one question. Mrs. Ingram, you stated that nurses were fighting the medical assistant program. Now the evidence we have from the Nursing Association is to the contrary. It shows they have been pushing for this. It is certainly true judging from the witnesses we have had in Washington. Now maybe there is something different here in Nassau County, I don't know. But as an association, as a profession, they are the first ones to admit that they need more help. So do you have any background on this?

Mrs. INGRAM. There was an ad in the New York Times about 8 weeks ago, I think, and it was the NLN—National League of Nursing—trying to discredit this. They were asking for support not to go along with this training of paraprofessionals in the physicians' assistant positions.

Senator DOMINICK. I don't happen to know that particular group, but the American Nursing Association is moving just the other way, and have been working hard to obtain more paraprofessionals who might be of assistance. I just wanted to make that point. Your information then is based on this ad from this particular group, right?

Mrs. INGRAM. Yes, and also the fact that it also was uncovered when this family was trying to get a private duty nurse. At the only county facility only RN's are permitted to do private duty nursing. So, of course, this places a damper It limits nursing services. Why can't a LPN be able to do private duty nursing? It is done elsewhere, and certainly it is done at Johns Hopkins Hospital, which is one of the greatest in the world. Why not Nassau County?

Senator DOMINICK. I agree. You ought to ask Nassau County.

Senator KENNEDY. Thank you very much.

Mr. CONLIN. Dorothy, thank you very much.

Senators, I understand that your time is running short. We will present one more speaker.

Senator KENNEDY. Well, we have got a 2-hour frame. We have about eight more witnesses. So we are going to try and make sure everyone gets a chance. This is very interesting. We would appreciate it if you could have the next witness and then maybe you could summarize your observations.

Mr. CONLIN. I think I would like to work it, Senator, if we could have one more witness, and then I think Mr. Lenz would like to do a wrap-up. I think we could do this within 5 minutes.

My next aide will be Cornelius Betly from Westbury.

STATEMENT OF CORNELIUS BETLY, HEALTH AND NUTRITION AID, EMERGENCY FOOD AND MEDICAL SERVICE PROGRAM

Mr. BETLY. Good morning, Senators. My job is health and nutrition aide under the emergency food and medical service program. It is to deal with the three communities of Westbury, Call Place,

and Newcastle. And the way I see it now, the problem is not so much we have poor health services or poor ecological conditions, the problem is the society. If the society was not the way it is today we would not have these problems.

So I think that is the main thing that has to be changed. People say, okay, transportation does not relate to health. I look at the problem on the Island and I see if I can't get to the hospital because of transportation that relates to health, or if someone talks about infant mortality and says it is a social problem—the problem is that, well, if you are in a certain economic level this is one of the reasons why once they get home the children die or something like that. But I see it as a problem of the society because if the society was right they wouldn't have to go home to this type of situation.

This is supposed to be the richest nation in the world, and why do we have these problems?

When I was in Vietnam I lived like a king. I looked over there, I saw everything they have. And I go home and I see people living in motels. And I want to know why do we have people living in motels with five and six people living in one room, now how is that a housing problem? When you have roaches and rats running all up and down how is that a housing problem? Or when you have 10 percent cut in your welfare checks or something, that is a social service problem. Okay. But how are you going to buy food, and as it stands now you don't have enough money now to buy food. And then they give you these food stamps where you can get X amount of dollars for this, but what can you really get with the food stamps? Depends on the limit, you know. But the maximum you could get free, I believe, with food stamps is $14 worth of free food, in comparison to the other system they have where they used to give food to people. Or even better, why not have food stamps and give them the food also, because I am quite sure you are burning a lot of food, you are throwing a lot of food away, you are wasting a lot of food.

I can remember when I was in basic training in the service I used to see them throw away a lot of food. And, you know, why?

Getting back on food, part of my job is emergency food. Why do we need emergency food? This country is supposed to be, you know, so hip as such—you know. But we have people starving, and this relates to health, directly on health, because if you are starving, you see, you can't make it. You can't go to school because how are you going to make it in school. You are starving.

And then one of the programs they got in school in my particular school district that I am involved in is the free food program, and I imagine that is for everybody. But the way it is set up it is so evasive that they say okay, you can obtain free food, but they practically put a sign on you saying "okay, here are all the people who are getting free food," so you can be harassed and everything. So people don't utilize it. And then the argument they give is "well, it's not our fault." But it is their fault, you know. The system, you know—change it.

Another thing is the hospitals, the clinics. In my particular community we don't have clinics. We need clinics. And you talk that the hospital might be good, but if you can't get to the hospital or if you can't pay once you are at the hospital what good is it, or once you get to the hospital you have to wait 3 hours or 4 hours to get some type of service.

One example, I picked up a lady and took her to the hospital. She didn't even have a dime to call me back. And then when I did pick her up she had a form to pick up some drugs at the drugstore for medicaid. She had the medicaid form, they gave her the medicaid form, but she doesn't have a medicaid card. What good is that?

Another problem we have is venereal disease. And the society, as it is now, pictures venereal disease, like a social problem. And this is what was presented to me in Westbury and in a sense by the Health Commission in Nassau County, was that it is like, you know, they don't want to start an uproar because it is a social-type disease. But a disease is a disease no matter how you look at it. They just keep putting names on it, they keep labeling different things.

And another problem that we have——

Senator KENNEDY. We are going to have to really sum up because we have seven more witnesses to go, and I want to give them a chance to talk, too. I want you to complete your thought, but we are getting into a time bind. We want to be fair to the other witnesses.

Mr. BETLEY. Well, really summing up, the only thing I can say is we need to start trying to meet the needs of poor people, just really see what is going on with poor people. And the only way you really get at the problem is to try to put yourself in their position, and then if you were in that position would you just sit around existing, or would you try to do something about it.

That's all.

Senator KENNEDY. Thank you very much.

Senator DOMINICK. Did you have medical corpsman training in the Army?

Mr. BETLY. No, I didn't. I had a brief training before I went overseas and a brief training that everybody had to go through.

Senator DOMINICK. But you weren't a medical corpsman or anything of that kind?

Mr. BETLY. But really I don't need to be a medical corpsman to see the problem. If you walk in——

Senator DOMINICK. I am not talking about that. I just wondered whether that was what led you into what you are doing. Obviously it was not. You got in this rather recently. That's fine.

Mr. BETLY. Well, yes. I guess.

Senator DOMINICK. That's fine.

Senator KENNEDY. Mr. Lenz, we are really in a time bind.

Mr. LENZ. I understand. I can sum this up in about 30 seconds.

The point we are trying to make is that obviously this tremendous frustration—behind me there are at least four other consumer

aides who thought they were going to be able to speak today, and we have told them they cannot. The frustration comes from the fact that there is a system in which the consumer has no voice. He thought he had an opportunity today, and he has. We appreciate it.

Much of this material will be given to you written.

We are summing our responsibility in the Bi-County Alliance for holding together the groups. We have asked the advisory group not to engage in confrontation. We have asked unions not to sign separate contracts with providers.

Consumers want into the system. CHP has given us that chance. HMO is about to take it away; health maintenance organizations be set up directly contracting between Federal Government and provider, and no consumer input.

Consumers even in this legislation are only on an advisory basis. The consumers are demanding a policy voice in the delivery of health care services, and they have got to have it; and if this legislation cuts it out then there are none of us who can speak for what might happen.

What we need is not reform in health care delivery, but revolution in health care delivery, and it has got to be returned to the hands of the people who are hurting.

Thank you very much, Senators. [Applause.]

Senator KENNEDY. Our next witness is Mrs. Norma Cohen. Mrs. Cohen is a professional caseworker for Family Service Association in Nassau County.

STATEMENT OF MRS. NORMA COHEN, SOCIAL WORKER, FAMILY HEALTH ASSOCIATION OF NASSAU COUNTY, N.Y.

Mrs. COHEN. I brought with me today two elderly ladies who are interested in talking about the difficulties that they have and the anxiety they have about their medical care. I was going to ask them to speak first, but I have reversed it because of something that happened on the way over.

The fear in our aged today is so tremendous, the anxiety I have seen in the last 2 weeks with the threats of the cuts in medicaid and with President Nixon's announcement that he may cut medicare to the 14 days. I have seen people really getting ill from the anxiety.

Now, one of the ladies who came with me today very bravely to tell her story is now frightened that the press may use her name, and as a result she may be cut off from medicaid entirely anyway. If so, I don't know how she would manage. But if the press has her name in the paper giving testimony today will this hurt her with medicaid? Are there doctors in the room?

This is the State many of our old people are in. I work primarily with the aged, and the fear is tremendous.

One of the ladies who came with me today was in the dental chair ready to get dental care from a dentist who used to take medicaid. He changed his mind. She didn't know this. This very dignified lady was told, "Up, out, I don't take it any more." Some

old people are so devastated by that they never go back. I had asked this woman if she would tell that experience today. She thought she might be able to, but then again she might be too frightened with the doctors here.

There are too few doctors who are accepting the New York State Medicaid, and the whole New York State Medicaid is in a big mess right now anyway.

Senator Kennedy, you had asked one of the young men about the middle class and how they are managing with health care. I do work with middle class elderly as well as the poor. They are also in a state of anxiety. I see people who have Medicare and who also have private insurance plans, and they feel then they are going to have adequate coverage. When the medicare allowance is nowhere near what the doctor's fee was, and very often between medicare and their private insurance they are really covered for 50 or 60 percent, and not that 80 percent for medicare and 20 percent for their private plan they thought they were going to have, many of them literally fall apart.

I was delighted to see number 4 up there in that health security act. I have seen people released from hospitals who really did not need the beds any more for medical reasons but who needed custodial care. Many of the people I work with are old enough that their children are senior citizens, and many of them have outlived their children.

Two years ago I was working with an elderly woman who had outlived her whole family. She was in the hospital in this county and was ready to be released because medically she didn't need treatment. But she lived alone. She could not stand on her own feet to prepare a meal. So some plan had to be made. We do have one marvelous home in the county to care for elderly people. I had an opening for her coming in 3 days. The hospitals say, "That bed costs $86 a day for this county, we can't wait 3 days. She has to go to the State hospital for the mentally ill."

I said, "Do you think she is psychotic?" "Oh, no, she is not psychotic. But we can't wait for 3 days. We need the bed."

Now I fought, she didn't get booted out before her 3 days were up and she did get into a decent nursing home, but what happens to the older person who doesn't have someone to fight for them?

Many times I see them come out of the hospital not needing the hospital care, but go home, not have anyone to help, get ill again and go back.

Several times today people have mentioned the shortage of doctors, which I think is very acute. I think if we didn't have such a shortage we might have many doctors more cooperative about the medicare and medicaid. But it is a seller's market right now.

There are many other services that the elderly need, too, and I am hoping that that is also in that "4" there. Oftentimes I see elderly people who have some minor problem that could be taken care of in an early stage, sometimes with homemaker service when they are having a temporary illness, sometimes with social workers, sometimes with nursing care. But this service exists for so few elderly people in this country that the problem often does have

to reach a crisis state where we are using the doctors who are in too short supply. We need that preventive kind of setup with the auxiliary services before someone has to end up in the hospital, and certainly afterwards.

I see many elderly people who wait months to get approval for dentures on medicaid. Now the ones who waited months turn out to be lucky because it looks like they won't even be on medicaid pretty soon.

As we all know, medicaid does not cover glasses, hearing aids, and it doesn't cover dentures. Now if there is one time an old person is apt to get depressed and break down emotionally and physically it is when they are isolated. How do you get a woman to go out and socialize if she doesn't have her teeth and can't hear? She has no choice but to be isolated.

There are so many gaps in that medicare bill that I strongly hope will be considered soon.

Now I do have the two women with me who were brave enough to come and say what their health problems are and how they are managing at this point. Could I ask for the lady who is frightened that she not have to give her name?

Senator KENNEDY. That's right.

Mrs. COHEN. All right, fine. My nameless friend, will you come up, please?

Senator KENNEDY. We will call her Mrs. Jones, I guess.

Mrs. COHEN. May I sit here with each one?

Senator KENNEDY. I wish you would.

Mrs. JONES. Good morning.

Senator KENNEDY. We want to welcome you, thank you very much for coming. You have been very kind to do so.

Mrs. JONES. Thank you.

Senator KENNEDY. And we appreciate your reluctance, but we are just interested in your story and we would very much value it if you felt you could share your story with the members of the subcommittee. We want you to feel completely at ease, as much as you can.

Mrs. JONES. Well, I have been a widow now since I was 51 years old. I had to go to work, and I worked for about 18 years—a widow without anything. I had no insurance to speak of. I had to depend totally on my little income from work. And paying my doctor bills and everything else took all of it during the years I worked, all of it. I did manage to get along until about 4 or 5 years ago, but since then I have earned absolutely nothing, and I am very concerned about medicaid because this is the only secure thing that I have to keep my health and well being, and I have had trouble with getting my dental work done. I have gone from one to another.

Senator KENNEDY. What sort of trouble have you had?

Mrs. JONES. Well, I have been going to the same dentist that I had been going to when I paid my bill years ago, and he told me that I couldn't have it any more because they had no medicaid when I got on medicaid. And I got the same story from another one. And the last one I went to got called and he told me to

come down—the young lady told me to come, and I did go, and I walked up the stairs. When I got up there he had me in the chair and was speaking about medicaid—he immediately said, "I can't touch you, I won't touch you, you will have to go." And, of course, I felt—well, you can imagine how I felt.

And I have been embarrassed many times with medication and things like that in spite of medicaid. But still medicaid has been a wonderful thing for me, and I imagine many more like me.

Mrs. COHEN. If it is taken away from you in the next few weeks how will you manage?

Mrs. JONES. Then I wouldn't know what to do. I don't want to go to welfare, but what else can a woman like me do if she don't get health care? I would be desperate. Just desperate.

Mrs. COHEN. Mrs. Jones is not on welfare at this point. She is managing on her social security and does very nicely. She is an excellent manager, except for the health care. But without medicaid now she would have to apply for welfare.

Senator KENNEDY. You take care of most of your other responsibilities, Mrs. Jones, your food? I know it is terribly difficult under social security in any event.

Mrs. JONES. It is, because my social security is quite low.

Senator KENNEDY. But at least you have been able to meet these responsibilities with the exception of your health needs, is that right?

Mrs. JONES. Yes, that is the important thing. That is very important.

Senator KENNEDY. Why do you think the dentists said that they wouldn't provide the services?

Mrs. JONES. Well, I was told there was some kind of association, or something or other, that got together and agreed not to take medicaid patients. Recently I had a very wonderful dentist.

Senator KENNEDY. Could I ask you, Mrs. Jones, have you lived out here your whole life?

Mrs. JONES. Almost 50 years.

Senator KENNEDY. In this county?

Mrs. JONES. In Freeport.

Senator KENNEDY. Did you work out here before, too?

Mrs. JONES. Well, I worked in Hempstead and I worked in Marick and I worked in Rusco Field.

Senator KENNEDY. You most probably have some friends. Do you find that they are concerned about health, too?

Mrs. JONES. Oh, very much so, sir. Very much so. It is the things that keeps you going, I think.

Senator KENNEDY. Thank you very much.

Senator DOMINICK. Mrs. Cohen——

Senator KENNEDY. I'm sorry. Just one minute.

Senator DOMINICK. Mrs. Cohen, just to substantiate the things you have been saying, on March 19 there was a report in the New York Times—it is not a paper that I quote all the time, as Senator Kennedy knows—which has an interesting article which says that 8.3 percent of the beds in 50 representative hospitals are occupied by patients who no longer needed hospital care, but who had no place to go for the convalescent care that they required.

Obviously, again, if one has a hospital problem and someone else who is desperately ill needs that bed, one has the same situation with the person needing treatment as one has in trying to find a convalescent home for the person who is already there.

Mrs. COHEN. I was not placing blame. I am just saying this is the situation we have to look at. We shouldn't use hospital beds for people who don't need hospital care. We must have more nursing homes and adult care facilities. I think it is a horrible thing to send an elderly citizen to a State hospital for the mentally ill who is not mentally ill.

Senator DOMINICK. I would agree. I gather that the medicaid problems to which you are referring is a cutback in the allowable amount put in by New York State, is that right?

Mrs. COHEN. Yes.

Senator DOMINICK. And it is a $500 cutback, from $5,000 to $4,500, or something of that kind.

Mrs. COHEN. Well, it is up in the air right now. I was on the phone with medicaid this morning. If someone here knows something more recent I would be delighted to know. We really have not known what to tell the people what the cuts will mean. The statement in the paper where people will be cut off unless they are on welfare concerns me. I had one elderly gentleman yesterday who askd his landlord to increase his rent which would then make him eligible for welfare. He could get along fine with his social security, but he needed that medicaid. He can't afford to lose it. He is partially paralyzed, his wife is blind and diabetic.

We are turning a lot of our older people into liars and cheats in order to be eligible. And the number who will be applying for welfare on May 15 if they really are taken off medicaid will be fantastic. As Mrs. Jones said, she has never wanted this, and she worked until quite a remarkable age. But she would have to do it now. Our other witness would be forced to do the same thing.

Senator DOMINICK. Thank you very much. You have been very helpful.

Mrs. COHEN. If Mrs. Delling could come up, too.

Mrs. DELLING. That't all right. I think you have said it rather well for me, too. I am very worried about the medicaid.

I am a widow. All my savings were taken up in my own illness and my husband's illness. And I just couldn't see being dropped from medicaid.

I was going to say I live in the senior citizen's project, and I know what Mrs. Jones is going through there. Others are going through the same thing—torment. They are so afraid of being dropped off medicaid, those who have it. And it isn't only the doctors, it is the medications that they get. I mean it is very hard for them.

Well, that's all I wanted to say, that we are all afraid of being taken off the medicaid. It may not be the best, but it's the best we have right now, and that's all I got to say.

Mrs. COHEN. May I add a little something to Mrs. Delling's. Mrs. Delling has been managing on social security and a son who contributes, and he is a blue collar worker with his own family

and it is not easy for him to make that monthly contribution, but he wants to. However, he can't cover the very extensive medical bills that his mother has. Now if she has to be dropped from medicaid her only choice is to ask her son to refuse to make the contribution. At that point she would be eligible for welfare. He doesn't want that and she doesn't want that. But they may be forced to do this.

Mrs. DELLING. You see, I worked as long as I could, and I am not able to work any longer. I have disability due to a stroke.

That's all I have to say, and I just hope that things will be a little better than they have been.

Senator KENNEDY. Thank you very much. We appreciate it.

Mrs. COHEN. May I just add one thing? Both of these ladies have testified about their anxiety with the medicaid. The majority of the people I see have just a little too much income to be eligible for medicaid and they are in a worse position. They are so-called middle class and cannot afford the medical care with the cost of it today, and I really feel I have to put in a plea for them. One of the worst things that happens to them—and I have learned to expect this for myself some day—is eventually if you live long enough you have to give up driving. In suburbia to get to that doctor or that hospital after you have had to give up driving is desperate. We had one 82-year-old woman last year who needed X-ray treatment for cancer and had to have this 6 days a week for 3 weeks. Her friends didn't drive any more, she had outlived her son and daughter. We arranged volunteer drivers. Every day she worried was the volunteer going to find the house, were they going to be late. She shouldn't have had to go through that in addition to her own cancer and two recent deaths. And I think transportation has to be considered in areas like this when you consider medical care.

And I thank you for the opportunity.

Senator KENNEDY. Just one point. You mentioned these individuals who were just above the middle class, so to speak. What are their real fears in this? I think we have heard a bit about it this morning, but could you just elaborate on that a bit?

Mrs. COHEN. Yes. It is the size of the cost of medical care today. I see many middle class people who could really afford to be living decent lives, could take some trips, and they are afraid if that big illness strikes. They all know someone who was in the hospital for months who ended up in a nursing home for recuparative treatment, and they know the cost and they are afraid to spend and enjoy what they do have, because God forbid the children have to pay and many times there are no children. We have to remember we have a lot of spinsters and bachelors, too.

I can think of one lady at this point who is 87 who manages on a pension and social security. She was once an editor for a magazine. She has a collapsed lung and asthma. Her medical bills this year were fantastic. Another year and the woman will have nothing.

Going on medicaid, of course, and welfare, also makes people think about insurance. We heard earlier people have to turn over insur-

ance, and they wonder then what kind of a funeral is going to be up for them. This is a pretty horrible state.

Senator KENNEDY. Thank you very much.

Mrs. COHEN. You are very welcome.

(The prepared statement of Mrs. Cohen follows:)

PREPARED STATEMENT OF MRS. NORMA COHEN, SOCIAL WORKER, FAMILY HEALTH ASSOCIATION OF NASSAU COUNTY

I am Norman Cohen of 125 Woodhill Lane, Manhasset, a professional social worker with Family Service Association of Nassau, a non-sectarian social work agency supported by voluntary contributions. My work is primarily with the aged. I have brought two ladies with me today to testify about their difficulties in securing adequate medical care.

In addition to the problems these ladies have mentioned, there are many others. I frequently see people who can manage to live on their social security or private pension or a combination of the two, but who cannot afford medical care. For many, the drugs prescribed cost more than the doctor's service and drugs are not included under Medicare. Many do not go to the doctor because they feel it pointless when they cannot buy the medicine. Often I see people deteriorate emotionally and physically when they experience that Medicare may pay only 40 or 50% of the medical bill instead of the 80% they expected. There is often a large discrepancy between the doctor's bill and what Medicare considers an allowable fee. Those who have private insurance in addition to Medicare still find themselves not properly covered for medical bills. Senior Care private policies usually offer to pay 20% of what Medicare has decided was allowable. This may leave a large margin for the individual to pay.

I see many elderly people who live alone and have no one to care for them. When such a person is hospitalized they frequently are held in scarce hospital beds longer than is medically necessary because they cannot afford custodial care that may be necessary for the recuperative period. When the hospital cannot or will not tolerate this the patient is often sent home unable to prepare meals, etc., and gets ill again. People who are not mentally ill are often sent to State Hospitals for the Mentally Ill for custodial care.

In suburbia, transportation is a big problem in securing medical care. Many elderly persons must use taxis to get to doctors or hospitals. I am reminded of one woman who needed x-ray therapy five days a week for three weeks and had to go three towns away to get a radiologist who would accept Medicaid. She could not pay the transportation costs and volunteer drivers were secured. If she had not been known to a social worker or some other person who would have arranged this? Her elderly friends had been forced to give up driving. As these ladies have testified, the anxiety for many about losing Medicaid is tremendous. Even for those who will continue to have it there are many problems. I have seen people wait months to get approval for dentures and literally shop for a doctor who will accept Medicaid. Some are emotionally tough enough to do this and many are not.

I know many who even under the old law had very small incomes but could not qualify for Medicaid and still could not afford the care needed. I have seen individuals do without hearing aids or glasses and thus have their social activities restricted. The isolated older person is most apt to be depressed and suffer emotional or physical breakdown, but if he cannot afford the aids to see or hear what option does he have except isolation.

The drastic shortage of doctors certainly underlies many of the problems stated above, but in addition to this we have no adequate plan to pay for auxiliary services. Frequently a homemaker, meals on wheels, a social worker, nursing care, etc., could prevent physical and emotional problems from reaching a crisis or could shorten the duration of the problem, but these services exist for very few of our elderly.

Many of the persons I see have outlived their children, have children who are themselves Senior Citizens or have children who are unwilling or most often, unable to help because of their own problems.

It doesn't take much for a relatively healthy older person to feel threatened in some way and start the emotional and physical breakdown. In the last two weeks I have seen the havoc caused in the increase in anxiety for my elderly

clients with the cuts in Medicaid and the President's proposed cut in Medicare. Even those who are healthy are afraid to spend the little they have because they live under the shadow of not being protected in the event of extensive medical costs.

Senator KENNEDY. Our next witness is Mr. Abe Hammer, resident of Freeport, Hempstead, does volunteer work for older Americans.

STATEMENT OF MR. ABE HAMMER, CONSUMER AND RESIDENT, FREEPORT, HEMPSTEAD, N.Y.

Mr. HAMMER. Senator Dominick, Senator Kennedy, members of the Subcommittee on Health. I have been asked to make a statement on medicare. But before I do I would like to pass on some information about the state of the nursing problem in the State of New York.

At present there is a bill being introduced in the State legislature which is being backed by the ANA which requires nurses who have been RN's who are staff graduates to go back to get a baccalaureate degree, and if they don't get that baccalaureate degree they will not be recognized as registered nurses, and that is causing a great deal of problems. In speaking to some of the administrators in hospitals they say they can't get nurses now, and if these girls or women who have been nurses for 25 or 30 years resign, as they threaten to, it is going to be catastrophic.

If you would like to get the name of the bill, it is the Parenian bill. In fact it is going to be debated in Garden City at Adelphi tonight by the assemblyman who introduced the bill.

Senator DOMINICK. Doesn't sound to me like he has a very good wicket to play with.

Mr. HAMMER. 20 million older Americans will seriously be affected if the medicare benefits are reduced. In addition, the children and relatives of these senior citizens will feel the pinch. It is estimated that each person on medicare has a family of approximately 2½ persons. Multiply the 20 million by 2½, and you have a total of 50 million persons who will be made to suffer.

Health, Education, and Welfare estimates that 60 to 70 percent of the 20 million medicare clients are wholly dependent on their social security payments. We will therefore have a large segment of the population, 12 million to 14 million, that will not be in a position to pay for their health care.

The older citizen is not in an enviable position today. He is living on a fixed income and is caught in a squeeze. Rents have gone sky high. Food prices have skyrocketed. Now they are threatened with reduced interest on their meager savings accounts.

We, the older Americans, vehemently oppose the proposed reduction in medicare. We suggest that waste be eliminated and those funds should be used for health care of the golden ages.

We would like to suggest an investigation of wasteful services which are not producing satisfactory care for the aged.

Number one, duplication of services in hospitals. When a general practitioner calls in a consultant there isn't any reason why two fees should be paid for each day the patient is hospitalized.

Number two, admittance to hospitals. Most hospitals have a set hour when they start counting the time of admittance. For example, let us say the hour of admittance is 10 a.m. If the patient checks in between 7 and 10 a.m. medicare is charged for 48 hours for the first day in the hospital. The patient should not be brought in before 10 a.m. unless an emergency exists.

The same applies on day of discharge. If the discharge hour is 11 a.m. and the patient is picked up by the family that hour medicare is charged for another day hospitalization.

Number three, blood tests and X-rays. Most hospital labs don't function on Saturday and Sunday. In many cases patients are admitted on Friday or Saturday and medicare is billed for 2 or 3 extra days.

Number four, doctors don't order all lab work at one time. It is therefore necessary to make additional tests which also extend the hospital stay.

Number five, utilization committees. After 12 days the committee makes its review and decides whether or not a patient requires additional time in the hospital. These committees are influenced by the patient's doctor when he is a member of the committee. An M.D. should disqualify himself if he happens to be on the review board and his patient's case comes up for examination.

Number six, outpatient basis. A goodly number of X-rays, blood tests, chemistry and work-ups can be done in an outpatient clinic, thereby saving the cost of a hospital room.

Number seven, in foreign countries they furnish free medical services to their people. You may check England, Israel, Denmark, and Sweden. Not only do they furnish this care to their own people, but also to anyone who visits their country.

Number eight, in New York State the United Medical Service makes the claims for medicare in this area. It is our understanding that they get a percentage of the funds disbursed. If this is so, it should be looked into. Why can't the Federal Government absorb the slack in unemployment and use these people to handle claims without paying on a percentage basis?

I have some late figures from the 1970 census. In Nassau County the figure is 1,422,905. It is estimated that 10 percent of these people, 142,290, are eligible for medicare.

The town of Hempstead, where we are right now, has a population of 800,684, and 80,068 are on medicare.

In this new proposed bill in the House Ways and Means Committee it has been suggested that medicare patients will no longer be entitled to extended-care facilities, nursing homes. It may also eliminate home health care for which they are now supposed to receive 100 days.

Thank you very much.

Senator KENNEDY. Thank you very much, Mr. Hammer. The suggested cutbacks I know are of concern to the senior citizens, as well they should. We have heard a great deal of comment about those.

Our next witness is Mr. Lewis Bernstein, who is the administrator of the welfare and pension funds for the Bartenders Union.

Mr. Bernstein.

STATEMENT OF LEWIS BERNSTEIN, ADMINISTRATOR, BARTENDERS UNION WELFARE AND PENSION FUNDS

Mr. BERNSTEIN. Good morning, Senator Kennedy, Senator Dominick.

I am the administrator for the Bartenders Union Welfare Trust Fund and have been the administrator for 23 years.

Since 1957 the fund has been self-insured and is a provider of benefits for over 4,000 members and their families.

We provide a long range of benefits for the members and families of the union, amongst them being surgical, medical, and hospital benefits. I should like to address myself particularly to the cost of hospital benefits.

For our covered members we provide a hospital plan which provides the full cost of hospitalization for 21 days and half the cost for 180 days thereafter. We have a great concern that these benefits shall not be reduced or terminated; for if this were to happen, our members and their families would be compelled to turn to the community for assistance in time of illness. Yet, at present, we are faced with this very real possibility.

In the allotted time it is not possible to present in great detail the tremendous increase in the cost of hospital care—care that is all too often of a mediocre quality, but I should like to particularize some of the growing abuses in the delivery of hospital care and present to the committee some of the more flagrant examples of grossly excessive charges which have come before me.

I have here a bill for 44 days of hospitalization—a length of stay during which the average cost should be considerably lower than the cost of a short-term acute illness. The bill in question totaled $18,728.50; an average of over $425 per day. Laboratory charges alone amounted to $7,663, an average of almost $175 per day.

I have another bill involving a 7½ day stay without surgery—the bill totaled $3,186.85—an average daily cost of $425.

There are many more, but I should like to cite one more particularly flagrant case. The hospitalization was for the removal of a cyst on the buttock—a procedure which can be done in the surgeon's office. The patient was kept in the hospital for 2 days at a cost of $634—$317 per day. The operating and recovery room charges were $243.

I can no longer accept the statement so commonly tossed at us by the hospital administrators and physicians, "If you want good medicine, you must pay the bill." Of what use is the very best of medical care if it is out of the reach of all except the very wealthy.

Now it is not alone the cost of hospital care but the daily increasing arrogance of the hospital heirarchy. We are now being told that we dare not question the accuracy of the bills submitted to us. To paraphrase the poet, "Theirs is the right to say—ours but to weep and pay."

I should like to read from three letters recently received from three different hospitals in New York City.

In the first case we had asked for an itemization of the bill so that we could determine acuracy and our liability for discount days. I quote:

It is not our policy to show a total recapitulation of charges by date order and it is not our intention to do same. If our breakdown is not acceptable to the Bartenders' Union Welfare Trust Fund and the payment of said claims is not expedited, we will have no other choice but to request that the patient being admitted to ——— Hospital with this coverage pay their account in full before discharge.

In the case of the cyst of the buttock at $317 per day, when we tried to negotiate with the hospital we were first offered a $50 reduction and then the hospital sent a letter to our member which said in part:

It took them over 1 year to make an "offer" which we were obliged to reject, because it represented less than 50 percent of our bill, and they insisted that it would have to be accepted as full payment. By law we cannot do this. The union official is fully aware of this and has, in effect, requested us to act in an underhanded manner.

It is now underhanded to ask for a reduction of an excessive bill.

We have informed the Bartenders' Union that we will no longer deal with them—and future patients will be asked for a deposit.

All of this in spite of the fact that over a period of years we had paid many bills to this hospital and this was the first time we had questioned a bill.

In still another case, a 39-day stay, billed at over $8,300, when we had the temerity to suggest that we negotiate the charges our member was informed that:

Upon submission of this hospital bill to the Bartenders' Union Mr. Lewis Bernstein, administrator of the trust fund, refused to pay the bill as submitted.

Again this is almost in the nature of criminal activity. We didn't refuse to pay the bill; we refused to pay it as submitted. And further on:

We no longer wish to deal in any way, form, or manner with the Bartenders' Union and request that you either pay the bill yourself or demand your rights as a union member and make the union pay in full.

So, it has now come to this—we are told by the hospitals either pay our bills without question or we will not accept your members—and this from hospitals that send us bills for $10 for a quart of water. Of course, they called it H_2O. They probably didn't think we knew what H_2O was. And when we called the hospital and said "how come the charge for a quart of water," instead of saying "we probably made a mistake," they said "well, we have to pay for it, too." I don't know how much they pay for water, but I don't pay for water.

We are all familiar with the newspaper and periodical articles which tell us that the cost of hospitalization is rapidly approaching the $150-per-day range. I can certify that the true picture in the metropolitan area is that hospital costs are about to reach an average of $200 per day.

I was interested when I heard—I believe it was Senator Kennedy who cited the statistics that hospital costs over the past 10 years have increased 60 percent. Our actual costs—and in spite of a drop of 20 percent in membership, our actual costs went from $128 in 1961 to $275 in 1970. Now that is an increase of about 120 percent, and I don't think that this applies just to our fund. I think that this is more universally true in this area.

Some hospitals are presently being reimbursed by medicaid at that amount, meaning in the $200 range, and I have recently received a bill from a Brooklyn hospital for a flat inclusive fee of just under $200 per day.

This condition cannot be permitted to continue. It is imperative that something be done to check the continued rapid spiral of hospital and medical costs.

Cost should be standardized so that every patient pays the same amount. Half a bill paid by a welfare fund should not be double the half paid by Blue Cross as is often presently the case, and a person who has no coverage at all should not be penalized by having to pay more than anyone with coverage.

Bad administration should not be rewarded by receiving a larger rate of reimbursement from Blue Cross, medicare, and medicaid than a similar hospital with good administration.

Hospital accounting procedures must be reviewed and changed to eliminate charges which are not justifiably chargeable to the patient.

Delivery of health care must not be given over to the private sector. This will only result in the further enrichment of those who are already greatly enriched by medicare and medicaid, and not in the improvement of hospital care for the individual.

Adequate hospital and medical care is no longer a luxury. It cannot be dealt with as a luxury. Adequate hospital and medical care is something that is the right of every citizen of this country. He should get it, and he should get it at a cost that he can afford.

Thank you very much.

Senator KENNEDY. Thank you very much.

I would be interested—in your program do you have deductibles?

Mr. BERNSTEIN. Not on hospitalization.

Senator KENNEDY. Not on hospitalization?

Mr. BERNSTEIN. No; we pay the full bill for the first 21 days and we pay half the bill for the next 180 days.

Senator KENNEDY. What do you have deductibles for?

Mr. BERNSTEIN. Well, not strictly a deductible, but, for instance, on our surgical program we offer it on a dual basis. If the member uses his own surgeon there is a schedule of payments which, of course, would not meet the entire fee, but we also have our own panel of surgeons which will provide the service, the surgery, at no cost to the member because they have agreed to accept our schedule.

Senator KENNEDY. Do you find that your members abuse the system at all in terms of overutilization of it?

Mr. BERNSTEIN. I don't think the members abuse the system. I find sometimes the doctors and surgeons abuse the system.

Senator KENNEDY. There has been a great deal made about this cost consciousness and deductibles in the various programs that have been suggested to the Congress, and I am always interested in the experience of a group like yours or other groups that don't have deductibles, and whether there is overutilization.

Mr. BERNSTEIN. I wouldn't say anybody tries to cheat on it. But I would say most people—and this doesn't go only for bartenders—most people don't cheat, whether it comes to medical care or anything else. I am a firm believer—even though I am an old man and

should be cynical, I am not. I think the average person is a decent, honest individual, and if he gets sick he is interested in getting well and not making a profit out of his illness.

Senator DOMINICK. Mr. Bernstein, you set up this trust fund by deduction from union members is this correct?

Mr. BERNSTEIN. No; that is not correct.

Senator DOMINICK. From their wages.

Mr. BERNSTEIN. It is financed entirely by employer contributions.

Senator DOMINICK. By employer contributions?

Mr. BERNSTEIN. That's right.

Senator DOMINICK. Now, as administrator of this particular trust fund, do you contract with specific hospitals for care for your members?

Mr. BERNSTEIN. We don't contract with specific hospitals. Our members are at liberty to go into any hospital, but we do have agreements with some hospitals for a special rate, you might say.

Senator DOMINICK. And in those hospitals you have not had this problem, is that correct?

Mr. BERNSTEIN. We haven't had it to the same degree. But I can tell you that only yesterday one hospital called me that a few years ago started off with us at a rate of about somewhat under $100 and told me that the new daily rate was going to be $176 per day.

Senator DOMINICK. I was interested in that because, again quoting the New York Times, it says that the average hospital cost in all the voluntary and proprietary hospitals in the area averages out at about $105.71 a day, of which, interestingly enough, 70 percent is payroll.

One of the things that has been of interest to me, having been in the hospital, as has Senator Kennedy, in the last few years, is the concern which many of the people have over the escalating costs which you have specified. Many of the doctors have been saying that the problem is caused in part by malpractice suits. In other words, they have to go through a much more elaborate set of tests than they ordinarily would in order to avoid this. I know that this was true in my particular case. This is one of the things.

Have you run into this problem? Have you had any conversation with doctors along that line?

Mr. BERNSTEIN. We have our own doctors, and we speak about it. But before I go to that I would say that with regard to that $105 a day figure, I would right now today be willing to sign with every hospital in the metropolitan area and agree to pay $105 a day for any of our patients that are admitted to that hospital. And, of course, any over amount, the Times would pick up whatever goes above $105 maybe, so everybody would be satisfied.

Senator DOMINICK. I want to make sure that is not my statement. That comes from the New York Times.

Mr. BERNSTEIN. That's why I said if they would pick it up. Not you, Senator.

With regard to malpractice——

Senator DOMINICK. We had testimony given to the staff yesterday which indicated the big city hospitals are close to $111.86 a day; the teaching hospitals are $102; community hospitals are down to $77.54;

and suburban hospitals, $73.98, this would indicate that there is a real discrepancy.

Mr. BERNSTEIN. There is a discrepancy.

Senator DOMINICK. The testimony we had yesterday concerned the particular hospitals you have been dealing with. You did challenge these bills, I gather.

Mr. BERNSTEIN. Oh, we continually do that. As a matter of fact, we have become known as mavericks. But with regard to those there is a schedule of medicaid reimbursements that are made to all the hospitals, and to date, this very day, some of those reimbursements, particularly for the voluntary teaching hospitals, run at $200 per day. This is what the city or the State combined are now reimbursing these hospitals for medicaid and indigent patients. Now they run on down from that. But the voluntaries are high. Some of the others are lower. But I haven't had a total bill in some time that ran less than about $140 or $150 a day.

Senator DOMINICK. Let me ask you just a couple more questions, and I will be very brief because I know we have other witnesses here, we want to get to their testimony. We want to hear it.

When you provide this service for your membership is this an all-inclusive type comprehensive care for them? In other words, it takes in hospitals, doctors, drugs, outpatient care, things of that kind?

Mr. BERNSTEIN. Very comprehensive. We don't include the cost of drugs. But aside from that it is very comprehensive.

Senator DOMINICK. Does that patient have the right to go to any doctor?

Mr. BERNSTEIN. In some situations, yes, in others, no.

Senator DOMINICK. So you have an option for your membership to go to any doctor that they choose or they can go to a closed panel system of doctors that you have also established, is that right?

Mr. BERNSTEIN. That is for surgery.

Senator DOMINICK. That is for surgery only?

Mr. BERNSTEIN. Right. For ordinary medical care, therapeutic care, they don't have that choice. We have a medical center to which they can go and secure treatment at no cost, and this includes everything, everything that is possible to render in a doctor's office. We also have a dental center where they can get treatment.

Senator DOMINICK. Concerning therapy, that is a closed panel?

Mr. BERNSTEIN. Closed panel.

Senator DOMINICK. Now I don't happen to know this—probably many of the ladies in here do. Do you have any lady members?

Mr. BERNSTEIN. Some; not so many, but we have some.

Senator DOMINICK. Do you have any objections from them due to the fact that therapeutically they must go to a closed panel?

Mr. BERNSTEIN. We haven't had any great degree. I won't say we have never had an objection. Some of our people who live in outlying areas have asked us about the possibility of getting medical care in their areas. But since most of our members work within an inclosed area most of them manage to reach our centers. Our medical, dental, optometrical.

Senator DOMINICK. On these particular hospitals that have been charging you up to $425 a day, were these specifically difficult cases or—I know you cited the one was a cyst on the buttock. But were the others particularly difficult case?

Mr. BERNSTEIN. The one with the $18,000 bill was—it was a circulatory case and it was a terminal case. But it didn't involve anything like the use of heart machines or cobalt therapy or anything of that nature. It did not. We find that in most cases today the laboratory bills are running exceedingly high, and we find that our highest bills today come from ward service cases as opposed to private or semiprivate. And I think that what is responsible for that is that a ward patient goes in and every resident or every intern that comes in orders some more tests. Everybody wants to get into the act and learn a little bit. But they send us the bill for that. I don't mind if they learn—they have got to, but please don't send us the bill for it.

Senator DOMINICK. I felt the same way when I was in the hospital.

Thank you, Mr. Bernstein.

Senator KENNEDY. Thank you.

Our next witness is Mr. Rocco Campanera, who is the executive director of the Long Island Federation of Labor.

STATEMENT OF ROCCO CAMPANERA, EXECUTIVE DIRECTOR, LONG ISLAND FEDERATION OF LABOR

Mr. CAMPANERA. Senator Kennedy, Senator Dominick, I am the executive vice president of the Long Island Federation of Labor.

The preservation of health, prevention of disease, the curing of illness is our country's responsibility. Every American is entitled to comprehensive quality health care.

Today's method by which medical care is delivered to the American people is inadequate. Symptoms of this crisis are the escalation in cost, unavailability of physicians when they are needed, the distorted distribution of health manpower and facilities.

Patchwork solutions will no longer do. Only a complete reconstructing of the delivery system will do the job. This can only come about with the enactment of a national health insurance program.

Let me state some vital facts. Under existing private health insurance programs 200 million Americans have no dental health insurance coverage at all; 186 million Americans have no nursing home coverage; 126 million Americans have no out of hospital prescribed drug coverage; 122 million have no private duty nursing care; another 122 million have no coverage for doctor and dentist's office and home visits; 115 million have no provisions for visiting nurse services at all; 107 million have no coverage for X-ray and laboratory examinations; 77 million have no coverage for in-house visits; 59 million have no surgeon's fees coverage; 53 million have no hospital care coverage at all.

Senator, today's high cost of medical care places good care beyond the reach of the recognized poor and the unrecognized or so-called middle income Americans.

I would like to cite an example of what happened to me when I was hospitalized in December 1969. My hospital bill for 6 days,

semiprivate accommodations, was $1,378.50. This is roughly $229 a day. Of course, this included use of the operating room and other sundry inhospital medical costs.

I want you to bear in mind this was in 1969. We are now in 1971.

In addition, I received an additional bill of $100 for anesthesia, and a $500 surgeon's fee, for a total of 6 days of $1,978.50. It is roughly $2,000 for that 1 week I was ill.

Now I was lucky. My organization covered over 90 percent of the expense involved through insurance. However, this type of insurance is very expensive. The present rate is $59.75 a month, or on a yearly basis $717 a year. Who can afford this?

In addition, Senator, we are having economic problems in Nassau and Suffolk Counties. The figures quoted are, I believe, 7-percent unemployment in Suffolk County, 6-percent unemployment in Nassau County. According to our members, the figure is closer to 10 percent.

What this means to us is that an employed member, after 30 days unemployment he is no longer covered by any insurance. So you are faced with a serious problem in that area.

Also under current major medical coverage today if you have a family of three or four and are unfortunate to have three members ill at the same time in the hospital your $10,000 coverage will go by the board very rapidly.

In closing, Senator, I appreciate very much the opportunity which you have given me to comment on a national health insurance program. We in the Long Island Federation of Labor are well aware of the strong fight you are making on behalf of a good health program. We will be glad to cooperate with you in every way, and we can assure you that we want a strong, effective law.

Thank you, Senator.

Senator KENNEDY. Could you tell us how aware the members of your union feel about the health issue generally?

Mr. CAMPANERA. They are very concerned, because the program I mentioned where I was covered personally is a good program. Most of the unions cannot afford that type of coverage. It is too expensive. And most of the members would like to see a national health program enacted. But a good program.

I have seen some of the programs that are being talked about. They are weak, ineffective. We are not talking about that. We want a real comprehensive program, and our members are all for it because they face a danger. When they lose their jobs after 30 days—even if it is limited coverage they don't even have that.

Senator KENNEDY. Why don't you talk about that point, because there are great numbers of people, skilled people, professional people, I know up in our State now, as well as other workers, and when they are separated or lose their jobs, what happens to their health insurance for the most part?

Mr. CAMPANERA. For the most part it does not go beyond 30 days. They are covered for 30 days after termination of employment with their employer, because most contracts have a clause that the employer contributes to a fund, and in turn that purchases the insurance that covers the member. When he stops contributing—he makes

his last contribution the week the employee is laid off. So the union will cover him for 30 days beyond that. After that if he doesn't have any savings, he will have to get the State to pick up the bill.

And this situation involves what we consider middle income people, and that is why I called them the unrecognized poor.

Senator KENNEDY. What is the average income of the members of the union or the federation?

Mr. CAMPANERA. I would say the average income is about $9,500.

Senator KENNEDY. And this is a group that is very much concerned about the escalation in cost. Are they concerned about availability of health care as well? Is it easy for you to get——

Mr. CAMPANERA. Well, it is not easy. But we must face one fact. When hospitals or doctors are aware that you are covered by an insurance fund they readily are agreeable to take you in and make room available. They know they will have on trouble getting their fees. So we don't face that unfair problem that I know people that are not protected by union contract face.

Senator KENNEDY. Do you find it more readily available to union individuals?

Mr. CAMPANERA. Right. Once the hospital and the doctor are aware you are covered by a labor agreement, they are very happy to take you on.

Senator KENNEDY. Do you hear about the quality of health care at all from your members? Do they know whether they are getting really good quality health care? Do they just assume that they are? Do you hear this talked about at all?

Mr. CAMPANERA. Well, we hear some dissatisfaction. But I am not an expert in that area. All I can say is we do have the coverage and the funds to pay for good medical care. So in most cases they are getting it. It is because the money is there they are getting good medical care.

Of course, you get involved in a situation where a hospital wants to gouge you, and the doctor also—his fee. But aside from that, if you have the money to pay you get it. It is when you don't have the money to pay you don't get medical care.

Senator DOMINICK. Mr. Campanera, just for the record I have got to say once again, as I have said many times before, and it would be of interest here, that this subcommittee on health, and in fact our full committee, does not have jurisdiction over the national health insurance program. S. 3. It is before the finance committee. So although we can take turns on what the problems are, we can't do anything about that particular piece of legislation.

I might say I am not throwing any kind of a jab at Senator Kennedy simply because I have a bill of my own which is designed to help the health problems of prepaid care programs for Federal employees which went to the Post Office and Civil Service Committee. I didn't get anywhere with that either.

The thing that was of interest to me was that I gather from what you are saying that most of the people that you represent have hospitalization and comprehensive care programs built into their union contracts which are in turn backed by insurance programs. Is that correct?

Mr. CAMPANERA. Correct.

Senator DOMINICK. And it is now established by agreement between the unions and the employers?

Mr. CAMPANERA. Right.

Senator DOMINICK. Thank you.

Senator KENNEDY. Thank you very much.

Dr. Harold Safian. Dr. Safian is a graduate of Columbia University, Long Island College of Medicine, and the vice president of United Medical Service. We appreciate your appearance.

STATEMENT OF DR. HAROLD SAFIAN, VICE PRESIDENT, UNITED MEDICAL SERVICE, INC., GREATER NEW YORK'S BLUE SHIELD PLAN, ACCOMPANIED BY ANTONIO FAVINO, 2d VICE PRESIDENT

Dr. SAFIAN. Senator Kennedy, Senator Dominick, I am Dr. Harold J. Safian, senior vice president of United Medical Service, Inc., Greater New York's Blue Shield Plan. Accompanying me today is Mr. Antonio Favino, second vice president.

As an individual and responsible citizen I am very concerned with the stories and statements we have heard today, and agree that these problems are critical and must be resolved.

My statement, however, relates to what we are doing in Blue Shield for Blue Shield subscribers in the area of costs involved and utilization.

We serve a 17-county area and currently provide medical-surgical protection for 6.1 million persons under our regular programs, and an additional one million under Medicare and CHAMPUS. Thus, Blue Shield in this area is serving 54 percent of the people in this heavily populated area.

Last year we paid out $266 million in benefits under our regular program and medicare. For each dollar we received from subscribers, we paid out 89 cents. Considering the large volume of small claims that we process, we think this is quite good.

United Medical Service is a community-oriented organization. We consider it a major obligation to make coverage available to the whole community without regard to health status, employability, or hazards of occupation. We consider it our responsibility to give the public the most for its health care dollar.

I think it is important to emphasize that in our inflationary economy United Medical Service has not had a rate increase since 1952. And I am talking about Blue Shield, which is coverage for physicians' services, not Blue Cross which is coverage for hospital services. And within this time frame, we have expanded benefits, decreased some rates, and continued our policy of open enrollment.

As to cost control, while most health insurance organizations now recognize the importance of meaningful utilization review, United Medical Service more than 10 years ago decided that our most important subscriber service was to maintain controls over the use of contracts and benefits. We knew that this was the only way to assure the subscriber that his funds were properly used.

During the late 1950's we formalized and implemented an effective utilization review and control program. Our early responsiveness in creating a program that would help assure our subscribers the high-

est quality of health care at the most reasonable cost—and our continuing refinements of activities in this vital area—had led to national recognition from both private and governmental sectors. Indeed, many of our utilization control techniques served as models for regulations and directives issued by the Social Security Administration for medicare.

Today, the need for sophisticated methods of controlling misutilization and outright abuse of health insurance coverage has become obvious. We responded to this need by further improving our own program, and expanding our Utilization Review Department.

Methods involved in effective utilization review include detection and investigation of possible abuse. This includes case finding techniques of possible error or misuse which could lead to, or have resulted in, unwarranted payments.

Detection involves investigations of many avenues of information relative to physicians' patterns of practice. This physician profile is obtained at UMS as part of an ongoing prepayment review of physicians claims as well as a post-payment analysis of practice patterns of reporting claims.

Our prepayment controls may be summarized as follows:

1. Unusual services or charges are referred for medical review during processing;

2. Randomly selected claims are verified by mailing questionnaires directly to the patient for verification of service, date rendered and charge;

3. A cross-check comparison is made of reported services rendered in a hospital with an audit of the hospital records;

4. A random review of a subscriber's entire claim history is made in relation to a new claim;

5. An explanation of benefits and the payment provided is sent directly to each subscriber for every service claimed by a provider;

6. Questionable services are queried directly with the physician;

7. Hospital charts are audited if it appears that services were not rendered;

8. Computer screens routinely regulate payment for certain procedures and services; limits are set and payment cannot be made without additional information from the doctor.

During 1970, $341,000 was disallowed on prepayment review of claims for services not verified after UMS audits of hospital records. An additional $359,000 was disallowed as a result of prepayment limitations by computer screens.

Post-payment controls are also used with particular emphasis on computer-generated data. Under our system approach, a comparison is made of the physician's pattern of practice with the practices of physicians within his own peer group in the same geographical location. Norms have been established for each procedure and service within a specialty. Individual physician norms are then compared to the group norms.

In a comparison approach, data relating to the doctor's total medicare and Blue Shield earnings, the number of patients, number of services and dollars paid per service are analyzed. Statistics are then developed from this data for each physician and a comparison is made with the peer group.

Hospital audits of patients' records are conducted on a continuing basis. Forty-four hospitals were audited during the past year.

The Social Security Administration, the Senate Finance Committee and the House Ways and Means Committee called upon UMS in this area during the past year to furnish them with an analysis of the medicare billings of certain physicians thought to have unusual practice patterns. As part of this analysis, our Utilization Review Department compared the practice patterns of 5,200 individual physicians. When the doctors were compared in this manner, it was possible to detect those doctors who were overutilizing services. They constituted less than one percent of the doctors in our area.

Two hundred and nine physicians had patterns that demonstrated excessive utilization of physician services. UMS representatives held individual meetings with 34 physicians in this group with medicare incomes in excess of $75,000. As a result, $244,000 was refunded by these physicians during the past year. Our investigation of another 175 physicians, including a review of over 51,000 claims, hospital records and medicare beneficiary questionnaires, resulted in refunds of $82,000.

In short, our utilization review efforts last year produced some striking results—more than $2 million in savings from refunds, amounts in process of recovery, and disallowed charges. For the information of the committee and for the record of these hearings, I am attaching as an exhibit a document entitled "UMS Utilization Review in 1970."

I think it is important to emphasize that our utilization review program has had the support and cooperation of our local medical societies. Without the firm stand of the county medical societies on utilization review and the cooperation of their peer review committees, we could not have the degree of effective cost control that we have been able to document.

In closing, I would like to again emphasize our dedication to meeting community needs in the financing of health care. We are currently participating with prepaid, group practice on an experimental basis, we are continuing to upgrade our contracts and we are working to provide better subscriber service.

While we recognize that much needs to be done to improve the delivery and financing of health care, we believe that locally United Medical Service has made valuable contributions. We pledge our efforts to do an even more effective job in the future.

Thank you.

(The material supplied by Dr. Safian follows:)

UMS UTILIZATION REVIEW IN 1970

While the importance of meaningful utilization review and controls in health insurance plans is now recognized by the medical profession, Government, and community organizations, United Medical Service, more than a decade ago recognized its corporate responsibility to maintain controls over the use of contracts and benefits to assure that subscriber funds were properly expended. The responsibility of UMS in utilization review is directly related to its fiduciary role, commensurate with the public's trust in placing many millions of dollars annually with the Corporation to help prepay necessary health care costs.

During the late 1950's UMS formalized and implemented an effective Utilization Review and Control Program. Reports and papers prepared at that time presenting the specifics of the UMS program are still being used as source documents by other health insurance plans in implementing their own utilization programs. Our early responsiveness in creating a utilization review program and our continuing refinements of activities in this area, have led to national recognition from both private and governmental sectors. Many of the utilization control regulations and directives issued by the Social Security Administration for Medicare Part B have their origin in essential features of the UMS program.

The need for even more sophisticated methods of controlling mis-utilization and outright abuse of health insurance coverage, especially in government programs has become obvious. UMS responded to this need by improving its own program and expanding its Utilization Review Department to assume greater responsibilities.

The objectives of UMS's utilization review are:

1. To promote the effective use of health care services;

2. To conserve and encourage the efficient use of health care dollars;

3. To create equity among providers and the consuming public;

4. To serve its members, the medical profession, all levels of government and other community organizations actively concerned with problems associated with ineffective utilization.

Mechanisms involved in effective utilization review include detection and investigation of possible abuse. This includes case finding techniques of possible error or misuse which could lead to, or have resulted in, unwarranted payments for an unnecessary medical service or for services reported, but not in fact rendered.

Detection involves investigation of many avenues of information relative to physicians' patterns of practice. This information is obtained at UMS as part of an ongoing prepayment review of physicians' claims as well as a postpayment analysis of practice patterns.

Prepayment controls:

1. Unusual services or charges are referred for medical review during processing;

2. Randomly selected claims are verified by mailing questionnaires directly to the patient for verification of service, date rendered and charge;

3. A cross-check comparison is made of reported services rendered in a hospital with an audit of the hospital records;

4. A random review of a member's entire claim history is made in relation to a new claim;

5. An explanation of benefits and the payment provided is sent directly to each member for every service claimed by a provider;

6. Any allowed charge under Medicare in excess of $1,600 is reviewed by a staff physician prior to payment;

7. Questionable services are queried directly with the physician;

8. Hospital charts are audited if it appears that services were not rendered;

9. Computer screens routinely regulate payment for certain procedures and services; limits are set and payment cannot be made without additional information from the doctor.

During 1970, $341,000 was disallowed on prepayment review of claims for services not verified after UMS audits of hospital records. An additional $359,000 was disallowed as a result of prepayment limitations by computer screens.

Post Payment controls:

1. Computer—includes an analysis of statistically based computer generated reports which provide objective, impersonal, unbiased data concerning utilization patterns, trends and variations. The following are some types of reports produced from UMS's paid claim history;

    a. The System Approach—this involves a comparison of the physician's pattern of practice with the practices of physicians within his own peer group in the same geographical location. Norms have been established for each procedure and service within a specialty. Individual physician norms are then compared to the group norms;

    b. Comparison Approach—data relating to the doctor's total Medicare and Blue Shield earnings, the number of patients, number of services and dollars paid per service are analyzed. Statistics are then developed from this data for each physician and a comparison is made with the peer group.

2. Hospital Audits—hospital charts are audited on a continuing basis. Forty-four hospitals were audited during the past year;

3. Random Questionnaire Techniques—the Utilization Review Department routinely sends out various types of survey questionnaires to both patients and physicians to assure the verification and necessity of paid procedures and services.

The Social Security Administration, the Senate Finance Committee and the House Ways & Means Committee called upon UMS during the past year to furnish them with an analysis of the Medicare billings of certain physicians thought to have unusual practice patterns. As part of this analysis, our Utilization Review Department compared the practice patterns of 5,200 individual physicians. When the doctors were compared in this manner, it

was possible to detect those doctors that were overutilizing physician services. Two hundred and nine physicians had patterns that demonstrated excessive utilization of physician services. UMS representatives held individual meetings with thirty-four physicians in this group with Medicare incomes in excess of $75,000. As a result of these meetings, $243,772.83 was refunded by these physicians during the past year. Our investigation of another 175 physicians, including a review of over 51,000 claims, hospital records and Medicare beneficiary questionnaires, resulted in refunds of $82,000.

Late last year, our Utilization Review Department detected serious abuse relating to the billing by attending physicians for services in teaching institutions that were actually rendered by interns and residents without personal involvement by the supervisory physicians. As a result of these findings, the Social Security Administration in Intermediary Letter #372, set forth guidelines intended to clarify the criteria for reimbursement in the teaching setting. Similar criteria for reimbursement in the teaching setting had been established by directives issued by UMS to the teaching institutions early in the Medicare program and meetings were held with representatives of these institutions but it subsequently developed there was lack of compliance. Subsequent to the distribution of Intermediary Letter #372, UMS representatives again met with thirty-eight hospital groups and more than one hundred physicians to reaffirm the Government guidelines and to assure compliance with SSA regulations. In addition, hospital audits were completed by the UMS staff in 34 of the 66 accredited teaching hospitals in our area in 1970. These audits disclosed past improper Medicare billings in excess of $1,250,000 primarily in four institutions as follows:

Teaching hospital	A	$ 35,472	refunded
	B	58,215	refunded
	C	720,000	agreement reached with institution and in process of recovery
	D	474,000	as in "C"

It was apparent that both the doctors and the institutions involved did not follow the criteria and guidelines that had been carefully prescribed by UMS and discussed with them prior to the implementation of SSA policy in the teaching setting program. More than that, when SSA originally proposed guidelines that would provide reimbursement for these services, UMS identified the dangers inherent in this policy and the abuses that could occur. UMS indicated in writing to officials of the Bureau of Health Insurance our concern that if this policy were to be implemented, it could lead to abuse and increased costs to the Medicare program. These opinions were

59-661 O - 71 - pt. 8 - 5

unheeded and the difficulties that were anticipated have since materialized. This matter subsequently led to an extensive inquiry by the Senate Finance Committee and the House Ways & Means Committee. The Committee reports, which include UMS testimony and identification of prior concern, indicate that UMS' original reaction to the teaching setting policy enunciated by SSA has proven to be correct.

Disposition—depending on the results of the review and, as the facts warrant, every attempt is made to resolve a utilization problem where one exists with individual physicians.

1. If a determination has been made that a possible utilization problem exists, the doctor is asked to appear personally and discuss the matter with a UMS staff physician;

2. The problem is referred to the appropriate peer review committee of the physician's medical society. During the past 12 months, 500 cases have been referred to peer review committees for review and recommendation. During the year, liaison between these committees and UMS was established to provide support to these committees and resolve developing problems. Meetings were arranged between the Chairman of each committee and UMS Medical Affairs representatives. This past year we met with fourteen societies' peer review committees or their Chairmen to better acquaint them with our own program, to offer statistical and information assistance wherever possible, and to establish a close working relationship between the medical society and our organization. While all peer review committees have expressed an eagerness to participate in this type of case review, most committees are as yet not prepared to handle, within a reasonable period of time the volume of cases presented to them by our Utilization Review Department. Further, some of the recommendations that follow this review still reflect an unwillingness by peer review committees to comment on another physician's manner of practice. In particular, questions involving the medical necessity of services are often regarded as an intrusion into the doctor's right to practice as he desires. It is hoped that our continued assistance to these committees with data on patterns of practice and reporting will help them arrive at more prompt and appropriate recommendations;

3. The subscriber's employer is notified regarding member abuse of contract benefits;

4. The Social Security Administration is notified in matters pertaining to Medicare;

5. The State Education Department, Division of Professional Conduct could be notified in certain problems;

6. The District Attorney's Office could be notified (after review by UMS legal counsel) of any case involving fraud.

Summation

The UMS Utilization program during the past year has resulted in savings primarily to the Government in amounts exceeding $2.1 million. To a lesser extent, UMS has also benefited from the program. The $2.1 million savings includes approximately $325,000 in actual monies refunded. An additional $900,000 is in the process of recovery as an offset against future claims and $700,000 has been disallowed on cases prior to final disposition. Our experience indicates that there has been a significant reduction of unnecessary services performed by those doctors whose UMS and Medicare records have been under review because of previous misutilization practices. We are aware that the activities of our Utilization Review Department have not passed unnoticed by the medical profession and other providers of medical services and we have been identified as one of the few Plans with an effective on-going utilization review and control program.

Senator KENNEDY. Thank you very much. I am familiar with the efforts which you have been trying to initiate in terms of the peer review group in the hospital. We hear constantly that much of the medicine that is practiced in suburbia is practiced out in doctors' offices, and what can you say can be done to insure that an individual is going to receive quality care from a solo practitioner?

Dr. SAFIAN. Well, I believe that the doctors practicing in their community are qualified. They have to maintain certain standards within the hospital. They cannot practice only within their office. They need hospital backup, and I think they are judged as to their ability when they are taken on the staff of a hospital, and I think in general that doctors are well qualified and do a good job within the limits of their capability.

Senator KENNEDY. You are not just suggesting that once they get their license, so to speak, you are not going to have a review of the kinds of services and procedures that are going to be performed? I mean this is a very dynamic profession in terms of changes and techniques, various drugs, and all the rest, and I suppose the consumer ought to have some kind of assurances that the person——

Dr. SAFIAN. I am not a practicing physician, but I am aware that many of the societies, not only the specialty societies, but the Academy of General Practice, do require that doctors keep up with newer techniques and newer methods of medicine.

Senator KENNEDY. What is the situation if they don't?

Dr. SAFIAN. I believe really there is nothing done. In this State if you get a license to practice medicine you can practice medicine. There is in fact very little control over the individual.

Senator KENNEDY. If you have review of quality in terms of the hospitals why shouldn't you have it in terms of the doctors' offices as well?

Dr. SAFIAN. I think you should. I think one relates to the other.

Senator KENNEDY. Do you think that would be worthwhile?

Dr. SAFIAN. I think it is very worthwhile.

Senator KENNEDY. How can that be done?

Dr. SAFIAN. I really don't know. I haven't given much thought to it. I think it has to be done by peer groups of these physicians. I think it should be done by other doctors who are practicing in the same community with this physician.

Senator KENNEDY. Do you really want other doctors in the same community. Isn't there a lot of backscratching, so to speak? You know I am going to look at your work today and you are going to look at my work tomorrow. It has been suggested that in those instances you have almost a conflict of interest.

Dr. SAFIAN. You are suggesting that it should be done by a physician from another community or another area perhaps.

Senator KENNEDY. Perhaps.

Dr. SAFIAN. Perhaps. I think in a large community you can do it, or in a large metropolitan area. When you get off into some of the rural areas where you have a county with 10 or 15 physicians I think it is impossible to do it there. I think in a large metropolitan area or large community you can do it, and I think doctors are harder on some of the individuals in their profession than other people

might be. I found it in some of the problems we have had in utilization review.

Senator KENNEDY. But in these larger communities you would favor doctors reviewing other doctors' work that don't have anything to do with these doctors?

Dr. SAFIAN. Yes, I would.

Senator KENNEDY. You prefer that kind of setup rather than where one doctor reviews——

Dr. SAFIAN. I think it's important to know what is going on in the community, and I think there is an advantage to a doctor practicing in the community reviewing another doctor's qualifications within that community.

Senator KENNEDY. Well, as long as the other doctor isn't going to review the other person's in turn.

Dr. SAFIAN. As long as there is no self-interest or buddy-buddy systems.

Senator KENNEDY. Just finally, if you favor the kinds of review, even in solo practice type of medicine, can't Blue Cross and Blue Shield do something about trying to implement this kind of a suggestion?

Dr. SAFIAN. Well, in Blue Shield while we have no legal authority to do anything, we in some way control some of the money that goes to physicians, and it is possibly through the control of funds that we might be able to do something. But since we have no legal authority I think it becomes more a matter of legislation.

Senator KENNEDY. Well, the funds are a pretty good start.

Dr. SAFIAN. That's a good start. We found that to be true, too.

Senator KENNEDY. Sometimes that's even better than utilization.

Dr. SAFIAN. Well, most of our utilization problems—it is not the doctor collecting the money from the patient that causes the utilization; it is the doctor who is collecting the money from a third party and using the third party.

Senator KENNEDY. Why is it that you haven't had these increases since 1952? Practically every other group has had enormous increases.

Dr. SAFIAN. Well, Blue Cross has had large increases because the hospitals' costs have gone up so much. But our contracts are on schedules so that the payments have been fixed. When we have instituted a new contract and improved the benefits in that particular contract both in the scope of coverage and in the allowance we paid, then that particular new contract is rated, and the rate has held up. Some of our older contracts that go back to 1952 where the coverage is inadequate and payments are low, those contracts are now losing money.

But we have reserves which are able to cover all our contracts so that we don't need a rate increase. Where we are losing in some we are gaining in others.

Senator KENNEDY. Senator Dominick.

Senator DOMINICK. Doctor, I want to congratulate you on your statement. I think it is excellent, and I think it shows some of the things that can be done with peer review and cost control. I think you have really done a tremendous job.

I would presume that the $2 million-plus which you provided in the way of savings is simply absorbed by the physician who is involved, is that correct?

Dr. SAFIAN. That is correct.

Senator DOMINICK. In other words, he doesn't charge the patient for it or anything of that kind?

Dr. SAFIAN. Well, as I indicated, for example, under medicare you have the assignment and the doctor has to accept the payment from medicare. And we find that in the assignment cases where the money has gone directly to the physician, whether it be a Blue Shield contract or medicare, these are the doctors who are overutilizing and causing this problem. It is where the doctor is collecting the money from the third party. We can control this doctor by restricting the amounts of money we pay him and determining the medical necessity of the services, and he cannot go back to the patient for the additional funds.

Senator DOMINICK. Now we have had a lot of comments in previous testimony in Washington about the HMO's and foundations backed by insurance companies. What is your thought on this? Is this comprehensive care setup done by health maintenance organizations, under a foundation—is it pretty effective from your observation?

Dr. SAFIAN. Well, we don't have very many foundations, or any, in this area. We don't have any in this area, and most of them are out on the west coast and California.

Senator DOMINICK. Don't forget Colorado.

Dr. SAFIAN. That's right. We are just getting interested in them now and are holding various meetings to discuss foundations. They can be useful in the delivery and financing of medical care.

Senator DOMINICK. Now there isn't any particular reason why you have to worry about cost control, you are a nonprofit organization to begin with, isn't that correct?

Dr. SAFIAN. We are nonprofit, yes.

Senator DOMINICK. There have been implications that the increased cost, utilization of doctors, and so forth, has been brought about by mismanagement by the insurance industry or overgreediness by the insurance agency. Have you had any feeling that way at all? Have you figured that this has been a part of the problem?

Dr. SAFIAN. Well, I think this is an individual problem in a local plan or local commercial organization. I think we can demonstrate what we have done in our area and it must reflect good management; and I am sure that in anything, any industry, you will have good management in some companies and bad management in others.

Senator DOMINICK. What you are saying in effect is a lot of these costs are really effective if you really go out after them with the aid of the medical society?

Dr. SAFIAN. Yes, sir; I think so.

Senator DOMINICK. Now what happens when you get, as Mr. Bernstein did—I believe it was Mr. Bernstein—a $10 bill for H_2O? I think even for a bartender that's a little high.

Dr. SAFIAN. Especially with nothing in it.

Senator DOMINICK. Especially for a bartender. What do you do when you get complaints like this? Do you have a chance of looking into them at all? Do they come to your attention?

Dr. SAFIAN. Well, they happen to be under Blue Cross, and in the New York area the Blue Cross and the Blue Shield organizations are separate. They have two separate boards and two separate management staffs and are in different areas. So that this would be purely a Blue Cross problem which we wouldn't get involved in.

Senator DOMINICK. You would not get involved in it?

Dr. SAFIAN. No.

Senator DOMINICK. Wouldn't the Blue Cross get involved in that?

Dr. SAFIAN. I would hope so.

Senator DOMINICK. But you don't know?

Dr. SAFIAN. I don't know.

Senator DOMINICK. Well, I frankly was a little—not a little, but a great deal upset over the cost figures which he quoted, which I am sure are accurate because he has to pay the bill. It just seems to me that isn't necessary. I wonder what kind of a system one should have in order to be able to control this.

Now the medical society, for example, is cooperating with you on controlling a lot of these costs. Are they not cooperating with the Blue Cross? Is this the problem?

Dr. SAFIAN. Well, I think what they are doing is identifying their costs to Blue Cross, and as these costs go up, whether they are labor costs or equipment or X-ray or anything else, Blue Cross is just picking up the cost and in a reimbursement formula reimbursing them as their costs increase. I don't really know how much control or what efforts they try to make in controlling the hospital costs.

Senator DOMINICK. Well, maybe we better get some more testimony on what the Blue Cross is doing on some of this.

But again I just want to congratulate you on what I think is an excellent statement, which does show that costs are controllable as least as far as Blue Shield is concerned.

Do you get into teaching hospitals at all?

Dr. SAFIAN. We have been involved in teaching hospitals, reimbursement of teaching hospitals under Medicare.

Senator DOMINICK. Do you find any overutilization in teaching hospitals where residents are coming in and ordering lab tests all the time?

Dr. SAFIAN. Well, I was in a meeting last night over at Cornell Medical College where some of the attendees were objecting to the fact that in the residency teaching programs, the resident really wants to control the care of that patient when he comes into the hospital, and one of the internists expressed the feeling that—as one of the previous speakers here I believe made the statment—that in the teaching and in trying to learn they do a lot of excess laboratory services, some which may or may not be necessary. I think it is one of the problems of the teaching program and the control of the patient by the resident.

Senator DOMINICK. So you have found that some of the lab tests and costs that are involved are really for the purpose of medical

education as far as the internist or whomever it is that may be involved, as opposed to patient care?

Dr. SAFIAN. Yes, and I think research and education is one of the problems we have in trying to put this into insurance, whether it is Blue Cross or Blue Shield or a commercial carrier. I think that this shouldn't be funded by the people who have this insurance. I think it has to be funded outside that mechanism in other areas.

Senator DOMINICK. By increased support of the medical schools or something?

Dr. SAFIAN. That's right. I think research and education is a part of the hospital bill. As somebody mentioned to me a few days ago—I don't know the correctness of the statement—it could go as high as 26 percent, or something like that.

Senator DOMINICK. Have you found in your process of talking with the doctors about the controllable cost problem that this problem of malpractice suits comes into play?

Dr. SAFIAN. It does. The malpractice rates have risen very significantly, and doctors are paying what I feel are real high premiums in malpractice insurance, and what they try to do is justify because of malpractice they have to do this or they have to do that, and they just want to protect themselves, and they do have a point.

Senator DOMINICK. Do you have any thoughts on how this might be handled? I know in the President's message—and I am happy to say I put a lot of input in it through the Secretary of HEW—that they have established a Malpractice Commission in order to try and take a look at this problem. Do you have any ideas on that?

Dr. SAFIAN. No; but I think that in some way if there is malpractice the awards that are given should be in some way controlled. I think it is the excessive awards. I don't know how you can control anybody from bringing a malpractice suit. I think he has that right. But I think the problem has been in the very excessive awards that people have been getting in malpractice suits.

Senator DOMINICK. Would you give us your thoughts on the question of deductibles or coinsurance as factors in cost control or cost consciousness?

Dr. SAFIAN. Well, what the deductible and coinsurance does, it reduces the premium rate for all the people and it puts on the person who needs the medical care at that particular time some participation in the cost of that care. All it really does is reduce the premium rate for the general group that is buying the coverage. I would prefer to see programs without deductibles.

Senator DOMINICK. What do you have to do about utilization? Have you had any comparison or any ability to compare one program with coinsurance or deductibles and one program without it?

Dr. SAFIAN. I haven't had any real involvement in that. All I know is that it is cheaper to buy a program with deductibles and coinsurance.

Senator DOMINICK. Thank you. That's all I have.

Senator KENNEDY. Just finally, could you tell us who is on your board? Do you have a board?

Dr. SAFIAN. We have a board of 26 members. Thirteen are physicians and 13 are lay people. Some of the lay people are in the city or State programs that we have. We have a State representative. We have people from labor on our board.

Senator KENNEDY. So you have 13 physicians, half of them are physicians, half of your board are physicians?

Dr. SAFIAN. Half and half, 50–50.

Senator KENNEDY. What is the makeup of the other 13? Do you know?

Dr. SAFIAN. The lay people?

Senator KENNEDY. Yes, what are their occupations?

Dr. SAFIAN. Two or three of them represent labor unions. One represents the New York State Civil Service Employees Association. One is an executive director of a teachers' annuity fund, which is some type of an insurance fund. One is with one of the banks. That would be the general. We could make it available.

Senator KENNEDY. Could you make it available?

Dr. SAFIAN. Yes.

Senator KENNEDY. Are they elected or appointed?

Dr. SAFIAN. They are elected through a nominating committee of the board.

Senator KENNEDY. Of the board itself?

Dr. SAFIAN. Right.

Senator KENNEDY. Do you have any school teachers or engineers?

Dr. SAFIAN. No, but I am just reminded that we have a woman on the board also.

Senator KENNEDY. Is there only one woman on it?

Dr. SAFIAN. One woman, yes.

Senator KENNEDY. If you could give us a bit of a profile on the board I would appreciate it.

Dr. SAFIAN. We will do that.

Senator KENNEDY. Thank you very much.

Dr. SAFIAN. Thank you.

(The information referred to subsequently supplied follows:)

BOARD OF DIRECTORS OF UNITED MEDICAL SERVICE, INC.

(3)	Carl R. Ackerman, M.D.	United Medical Service, Inc., Two Park Ave., N.Y., N.Y. 10016 (340-5291)
(1)	John Beck, M.D.	24 Carlton Place, Staten Island, N.Y. 10304 (GI-2-8709)
(2)	Charles M. Brane, M.D.	169 Park Avenue, Yonkers, N.Y. (Area Code 914-YO-3-5475)
(3)	John T. Burnell	Area Manpower Director of the Human Resources Development Institute, AFL-CIO, 386 Park Ave. South, Room 601, New York, N.Y. 10016 (MU 5-9125)
(3)	C. Joseph Delaney, M.D.	118 East 60th Street, New York, N.Y. 10022 (PLaza 3-7798)
(1)	Robert M. Duncan	Executive Vice President and Actuary, Teachers Insurance and Annuity Association of America, 730 Third Avenue, New York, N.Y. 10017 (OX 7-7600)
(2)	Samuel Z. Freedman, M.D.	541 East 20th Street, New York, N.Y. 10010 (YU 6-5757)
(1)	Harold Glasser	Director, Employee Benefits Department, Glen Alden Corporation, 888 Seventh Ave., N.Y., N.Y. 10019 (957-8740)
(2)	Patrick Gleeson	President, Retail Food Clerks' Union, Local 1500, R.C.I.A., AFL-CIO, 221-10 Jamaica Avenue, Queens Village, N.Y. 11428 (479-8700)
(1)	Elvin E. Gottdiener, M.D.	100 A Fulton Avenue, Poughkeepsie, N.Y. 12603 (Area Code 914 - GL 4-0350)
(1)	Alfred P. Ingegno, M.D.	27 Eighth Avenue, Brooklyn, N.Y. 11217 (NEvins 8-5455)
(2)	Herbert E. Klarman, Ph.D.	Graduate School of Public Administration, New York University, 4 Washington Square North, N.Y., N.Y. 10003 (598-3726 or 3727)
(2)	Norton M. Luger, M.D.	61-34 188 Street, Flushing, N.Y. 11365 (GL 4-8700)
(2)	Robert A. Moore, M.D.	445 Lenox Road, Room 3-490, Brooklyn, N.Y. 11203 (270-2597)
(2)	Frederick H. Morris	Executive Vice President, Empire Savings Bank, 221 West 57th Street, N.Y., N.Y. 10019 (CI 7-6400)
(1)	U.V. Muscio	President, Muzak Incorporated, 100 Park Avenue, New York, N.Y. 10017 (889-1330)
(3)	William C. Porter, Jr., M.D.	157 East Main Street, Huntington, N.Y. 11743 (Area Code 516 - HA 7-8530)
(3)	Norman Racusin	Deputy Director, International Operations, Administration, The Reader's Digest Association, Inc., Pleasantville, N.Y. 10570 (Area Code 914 - 769-7000)
(1)	Lawrence Ravich, M.D.	4277 Hempstead Turnpike, Bethpage, N.Y. 11714 (Area Code 516 - WE 8-2130)
(2)	Louis Rolnick	Director, Welfare & Health Benefits Dept., ILGWU, 1700 Broadway, New York, N.Y. 10019 (CO 5-7000)
(1)	Juan Sanchez	Manager, Latin-American Dept., Tampax Inc., 5 Dakota Drive, Lake Success, N.Y. 11040 (N.Y.C. 895-2270 Lake Success (516) 437-8800)
(2)	Elizabeth T. Schack	845 West End Avenue, New York, N.Y. 10025 (254-8900 Ext. 313)
(3)	Leo J. Swirsky, M.D.	115 Remsen Street, Brooklyn, N.Y. 11201 (MA 4-2212)
(3)	John D. Van Zandt, M.D.	Route 17, Tuxedo Park, N.Y. 10987 (Area Code 914 - EL 1-4761)
(1)	Theodore C. Wenzl, Ed.D.	President, N.Y.S. Civil Service Employees Assn., Inc., 33 Elk Street, Albany, New York 12224 (Area Code 518 - 434-0191)
(3)	Benjamin Werne	122 East 42nd Street, New York, N.Y. 10017 (986-3040)

NOTE:
(1) Elected to serve until the Annual Meeting of Voting Members in the year 1973
(2) Elected to serve until the Annual Meeting of Voting Members in the year 1974
(3) Elected to serve until the Annual Meeting of Voting Members in the year 1972

As of March 18, 1971

Carl R. Ackerman, M.D.

Carl R. Ackerman, M.D., is chairman of the board of directors of United Medical Service, Inc.

Dr. Ackerman previously served as chairman of the board of UMS from 1959 to 1963. In 1959 he became a member of the board of directors of the National Association of Blue Shield Plans and was elected vice chairman in 1961. He became chairman of the board of NABSP in 1966 and held that office until April, 1970.

A graduate of Columbia College, Columbia University, Dr. Ackerman received his M.D. from The College of Physicians and Surgeons, Columbia University, in 1930. He has practiced general surgery in New York City since 1933. He also served as attending surgeon and director of surgery at St. Francis Hospital, Bronx, New York. He is presently consulting surgeon at Morrisania Hospital and St. Joseph's Hospital, also in the Bronx.

Dr. Ackerman is a member and past president of the Bronx County Medical Society, a member of the Bronx Surgical Society, and a Fellow of the American College of Surgeons. He is also co-chairman of the Carrier Advisory Group to the Social Security Administration.

He resides in Glen Cove, Long Island.

March 31, 1971

JOHN BECK

John Beck, M.D., is currently radiologist at Brooklyn Veterans Administration Hospital and Sea View Hospital and Home, Staten Island. He is consulting radiologist at the Public Health Service Hospital, Staten Island.

Dr. Beck was Chief Radiologist at Staten Island Hospital from 1941 to 1970. He also serves as vice president of UMS.

A native of Brooklyn, New York, he received his B.S. degree from New York University and his medical degree from the University of Geneva, in Switzerland. He was licensed in the State of New York in 1937.

In 1941 he received a Certification in Radiology from the American Board of Radiology.

From 1943 to 1946 he served with the U.S. military, including 28 months in the Mediterranean Theatre during World War II.

He is a member of the Richmond County Medical Society, American College of Radiology, the New York Roentgem Society, and the Radiological Societies of North American and the State of New York.

March 31, 1971

CHARLES M. BRANE, M.D.

Charles M. Brane, M.D. is attending surgeon at St. John's Riverside Hospital, and consultant in surgery at Yonkers General Hospital and Dobbs Ferry Hospital. He is past chairman of the board of directors of United Medical Service, Inc., and continues to serve as a director.

A past president of the Westchester County Medical Society and of the Yonkers Academy of Medicine, he is also honorary director and past president of the Yonkers Family Service Society, serves as a director of the Westchester County Council of Social Agencies, and is past president of the United Givers Fund of Yonkers.

He is a diplomate of the American Board of Surgery.

Dr. Brane serves as a delegate to the American Medical Association and is chairman of the Medical Review Committee of the Medical Society of the State of New York.

Born in 1908, he received his B.S. from Cornell University in 1928 and was graduated from Cornell Medical College in 1931.

Dr. Brane served in World War II, entering the Army Medical Corps as a captain in 1942 and was discharged as a major in 1945. He was awarded the Bronze Star for meritorious service.

Dr. Brane resides in Yonkers, New York.

John T. Burnell

John T. Burnell is Area Manpower Director of the Human Resources Development Institute,AFL-CIO. He is also chairman of the New York City Central Labor Council's youth corps committee and secretary of its Black Trade Unionists. A native of Brooklyn, New York, he attended C.C.N.Y., Columbia and Cornell Universities, and the New School of Social Research.

In addition, he serves as a board member, advisory committee, Queens College Parent and Teachers Association and the New York City Board of Education's cooperative education committee. He is a member of the Regional Planning Board for Queens District #26. Mr. Burnell is a former chairman of the human rights committee of The United Parents Association.

Among other activities, he is chairman of the Labor Advisory Committee of the Red Cross of Greater New York.

March 31, 1971

C. Joseph Delaney, M.D.

C. Joseph Delaney, M.D., is Attending Surgeon at Knickerbocker, Columbus, Flower-Fifth Avenue, Doctors, and Metropolitan Hospitals. He is Consultant in Surgery at Misericordia Fordham and Hackensack Hospitals.

Dr. Delaney is also Clinical Professor of Surgery at New York Medical College and Chief,Division of Pediatric Surgery, New York Medical College.

Born in Woburn, Massachusetts, he received his B.A. degree from Boston College and his M.D. from Georgetown University Medical School. He served with the U.S. Navy in World War II and presently holds the rank of Captain (Ret.) in the U.S.N.R. Medical Corps.

Dr. Delaney is Trustee and Past-President, the Medical Society of the County of New York. He is a member of the New York Academy of Science, the Board of Directors of The International Center in New York, and a Fellow of the American College of Surgeons and the New York Academy of Medicine. He is a member of the University Club.

Dr. Delaney is Senior Medical Officer, New York Maritime College, Fort Schuyler, New York.

He is an alternate delegate of the American Medical Association.

ROBERT M. DUNCAN

Robert M. Duncan is executive vice president and actuary, Teachers Insurance and Annuity Association of America. He has been associated with TIAA since 1948. He formerly spent 14 years with the Home Life Insurance Company of New York. He is also executive vice president and actuary of College Retirement Equities Fund, which is a companion organization of TIAA.

Born in New York City, he received his B.S. degree from New York University in 1932 and his M.A. from Columbia University in 1933.

Mr. Duncas is a Fellow of the Society of Actuaries. He is also currently serving on the Actuarial Advisory Committee to the Comptroller of the State of New York for the State Employees' Retirement System and the Policemen's and Firemen's Retirement Systems.

A resident of Port Washington, Mr. Duncan is married and has two sons

April 2, 1971

Samuel Z. Freedman, M.D.

Samuel Z. Freedman, M.D., is the Director of the Division of Standards of Medical Care of the Medical Society of the State of New York.

Doctor Freedman is a consulting genito-urinary surgeon at Beth Israel, Polyclinic, and Peninsula General Hospitals. He is a former director or urology at Gouverneur Hospital.

He was president of the Medical Alliance from 1938-1941. He is also past president and trustee of the Medical Society of the County of New York. He is a past treasurer of the Medical Society of the State of New York.

59-661 O - 71 - pt. 8 - 6

March 31, 1971

HAROLD GLASSER

Harold Glasser is Director of Employee Benefits, Rapid American Corporation, McCrory Corporation, and Glen Alden Corporation.

Born in Chicago, Illinois, he studied at University of Chicago and Harvard University.

He was formerly Director of Monetary Research for the United States Treasury, Director of the Institute of Overseas Studies of the Council of Jewish Federations and Welfare Funds, and a Fellow of Brookings Institution of Washington D.C.

Patrick Gleeson

Patrick Gleeson is president of the Retail Food Clerk's Union, Local 1500.

A native of Canada, he resides in Brooklyn, New York. He has studied at the Cornell School of Labor Relations and the Xavier Labor School, New York City.

Married, Mr. Gleeson has one son.

March 31, 1971

ELVIN E. GOTTDIENER, M.D.

Elvin E. Gottdiener M.D., is in the private practice of radiology. He is also consulting radiologist at the Veterans Administration Hospital, Castle Point, and Northern Dutchess Hospital, Rhinebeck, N.Y.

Born in Brooklyn, New York, he now resides in Poughkeepsie. He received a degree in medicine from the University of Maryland School of Medicine in 1937.

Dr. Gottdiener is a member of the American College of Radiology, the Radiological Society of North America, and the Radiological Society of New York State. He is a Past President of the Dutchess County Medical Society and delegate to the Medical Society of the State of New York.

Married to Dr. Florence Harris Gottdiener, he has three daughters.

April 14, 1971

Alfred P. Ingegno, M.D.

Alfred P. Ingegno, M.D., is attending physician and Chief of the Division of Gastroenterology at Long Island College Hospital, Brooklyn, New York. He is a Consultant Gastroenterologist at Brooklyn Veterans Administration Hospital, Wyckoff Heights Hospital, and the New York Board of Education. He is Clinical Professor of Medicine at State University of New York, Downstate Medical Center, and Visiting Physician at Kings County and University Hospitals.

Dr. Ingegno received his B.S. degree from Columbia University and his M.D. from the Long Island College of Medicine in 1933; he served his internship and residency in Internal Medicine and Radiology at Long Island College Hospital.

He is past president and trustee of the Kings County Medical Society, chairman of its publication committee and editor of its Bulletin. He is also a delegate to the Medical Society of New York State. He is also an active member of the American Gastroenterological Association, Fellow of the American College of Gastroenterology, Diplomate in Internal Medicine and Gastroenterology, and Life Fellow of the American College of Physicians.

Dr. Ingegno is a member of the Executive Committee of UMS.

He resides in Brooklyn with his wife and two sons.

3-24-71

HERBERT E. KLARMAN

Herbert E. Klarman is professor at the Graduate School of Public Administration, New York University.

His former professorial appointments, in fields related to Public Health, include John Hopkins University; Downstate Medical Center, State University of New York; Columbia University; and Brooklyn College.

Dr. Klarman has also served as a consultant to the World Health Organization; Social Security Administration; National Institute of Mental Health; U.S. Department of Defense; White House Task Force on Facilities for the Aged; and Department of Health, Education and Welfare Committee on Comprehensive Services for children.

Dr. Klarman is a graduate of Columbia University and holds a Ph.D. degree from the University of Wisconsin.

Norton M. Luger, M.D.

Norton M. Luger, M.D., is assistant clinical professor of medicine at Cornell Medical College. He is also assistant physician at New York Hospital and a consultant in medicine at Booth Memorial Hospital. Dr. Luger was director of the department of medicine at Booth Memorial from 1956 to 1964.

A graduate of Brooklyn College, he received his M.D. degree from St. Louis University.

Dr. Luger is a fellow of the American College of Physicians and the New York Academy of Medicine and a diplomate of the American Board of Internal Medicine. He is also a member of the Medical Section of the New York Board of Trade, the New York Academy of Science, and the Board of the Association of the Study of Abortion, Inc. He is past president of the Medical Society, County of Queens, and a delegate to the Medical Society, State of New York.

March 31, 1971

ROBERT A. MOORE, M.D.

Robert A. Moore, M.D., is an internationally known educator and medical lecturer. He is Medical Director of the National Fund for Medical Education and past honorary consultant in pathology to the Surgeon General of the United States Army and past Senior honorary consultant to the Surgeon General of the United States Navy.

A native of Chicago, Dr. Moore received his B.S., M.Sc., and M.D. degrees at Ohio State University. He holds a Ph.D from Western Reserve University. In addition, he has received honorary degrees from Union, Miami, Long Island, Washington and Ohio State Universities and Waynesburg College.

He is also currently professor of pathology at the College of Medicine of New York State. He is former president of the Downstate Medical Center and former dean of the College of Medicine in Brooklyn State University of New York.

Dr. Moore is a former member of the National Advisory Cancer Council, the United State Public Health Service, and the National Advisory Council in health research facilities. Now retired, he remains active in the medical field and maintains his memberships in state and county medical societies.

Married, Dr. Moore has two children. He resides in Brooklyn.

Frederick H. Morris

Frederick H. Morris is senior vice president of the Empire City Savings Bank, New York. He has been associated with Empire City since 1943.

Born in Albany, Mr. Morris studied at New York University, Hofstra College, Rutgers and Northwestern Universities, and Dartmouth College. He now resides in Katonah, New York.

Mor Morris participates in various community endeavors both in Katonah and in New York City. Active in the Investment Officers Forum of the State of New York, he is a former president of the New York State Savings Banks Life Insurance Council. He is a member of committees of the National Association of Mutual Savings Banks and the New York State Savings Banks Life Insurance Council.

In addition, Mr. Morris is on the faculty of the summer Graduate School of Savings Banking at Brown University in Providence, Rhode Island.

Married, he has three children.

3-24-71

U. V. MUSCIO

U. V. Muscio is president of Muzak Incorporated. He is also on the board of directors and executive committee of Fedders Corporation.

Mr. Muscio is a former treasurer and vice-chairman of the National Better Business Bureau, and former director of the National Electrical Mfgr. Association. In 1964, he was awarded the McGraw Edison Medal for "Contribution to Improvement of Business Ethics."

Long active in community affairs, Mr. Muscio serves on the Council of Fordham University. He is also a former trustee of the National Leukemia Society.

Mr. Muscio was educated at Fordham University and New York University Law School, where his degrees include an LL.M. in Labor Law.

April 1, 1971

WILLIAM C. PORTER, M.D.

William C. Porter, M.D., is a specialist in urology. He is on the staffs of Huntington, Meadowbrook, and King Park State Hospitals. He is a consultant in urology to the Veterans Administration Hospital.

Dr. Porter studied at Columbia and Princeton Universities. He received his M.D. degree from Cornell Medical School in 1950.

He is a fellow of the American College of Surgeons and a diplomate of the American Board of Urology. Dr. Porter is a member of the American Medical Association, the American Urological Association, American Fertility Society, Suffolk County Medical Society, the Suffolk County Multiple Sclerosis Society Medical Advisory Board, and the New York section of the American Urological Association, Inc. He is a delegate to the New York State Medical Society.

Born in St. Petersburg, Florida, he now resides in Huntington, Long Island. Dr. Porter is married and has two childern.

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3-24-71

NORMAN RACUSIN

Norman Racusin is deputy director of international operations for The Reader's Digest Association, Inc.

Prior to this position, Mr. Racusin was with the RCA Corporation for twenty years. At various times, he served as president of RCA Records; executive vice president of the National Broadcasting Company, Inc.; and staff vice president for operations planning of RCA Corporation.

Mr. Racusin is a member of Phi Beta Kappa Associates; past chairman of the Music Division, Greater New York Fund; former vice-chairman of the United Nations Annual Dinner; and recipient in 1969 of the Ed Wynn Humanitarian Award of the Parkinson's Disease Association.

Mr. Racusin was educated at Pennsylvania State College and Harvard Business School, where he received an MBA with distinction.

Lawrence Ravich, M.D.

Lawrence Ravich, M.D., a urologist, is on the staff of Six Nassau County hospitals. He maintains an office in Bethpage and Hicksville, New York.

A graduate of C.C.N.Y., Dr. Ravich received his M.D. degree from the Chicago Medical School. He served with the U.S. Army from 1945 to 1946 and the U.S. Air Force from 1954 to 1956. He was consulting urologist with the Third Air Force in England.

Dr. Ravich is a fellow of the American College of Surgeons and the International College of Surgeons. He is a diplomate of the American Board of Urology.

He is also a member of the New York State Medical Society, the Nassau County Medical Society, the New York and Nassau County Urological Societies, The American Urological Association, and the Association for the Advancement of Science.

Married, Dr. Ravich has three children.

He is a delegate of the American Medical Association.

March 31, 1971

LOUIS ROLNICK

Louis Rolnick has been the director of the welfare and health benefits department of the International Ladies' Garment Workers' Union since 1962.

He has studied at the College of the City of New York, John Marshall and New York Universities.

His work experience includes employment as a staff industrial engineer and engineering consultant. He served abroad as an employee of the Mutual Security Agency.

At the I.L.G.W.U., he has been a staff member and assistant director of the management engineering department and west coast director of the management engineering department. Prior to his present position, he was assistant director of the welfare and health benefits department of the I.L.G.W.U.

In addition, Mr. Rolnick supervises the activities of the various health centers located throughout the country. He also functions as administrator of the following management, labor jointly controlled national garment industry funds: Supplementary Unemployment Benefits Fund, ILGWU, ILGWU National Retirement Fund and ILGWU Health Services Plan.

Mr. Rolnick has recently been reappointed to serve as a member of the Medical Assistance Advisory Council to the Secretary of the Department of Health, Education and Welfare.

Juan Sanchez

Juan Sanchez is manager, Latin American Department, Tampaz, Inc.

Mr. Sanchez was born in Puerto Rico. He has lived in New York since 1931. A graduate of the Gomez Business College of Mayaguea, Puerto Rico, he also attended Columbia University. Mr. Sanchez served with the U.S. Navy during World War II.

Appointed to the New York City Commission on Human Rights, he also serves on the New York City Board of Correction and on Local No. 3, Panel A. Selective Service System. Mr. Sanchez is a member of the boards of directors of the Community Council of Greater New York and the Manhattan Council of the Boy Scouts of America. He has served on the Board of Education's Commission on Integration, the White House Conference on Education, New York State, and the Governor's Committee on the Minimum Wage.

Mr. Sanchez is co-founder and past president of the Federation of Hispanic Societies, Puerto Rican Social Services, Inc., and the Puerto Rican-Hispanic Parade.

March 31, 1971

ELIZABETH T. SCHACK

Elizabeth T. Schack is employed by the department of public affairs, Community Service Society, as a researcher.

She is past board president of the New York State League of Woman Voters and past president of the New York City League of Women Voters.

A native of Chattanooga, Tennessee, Mrs. Schack attended the University of Chattanooga, Hunter College, and the School of General Studies, Columbia University.

Mrs. Schack has been appointed by Mayor Lindsay to the Mayor's Committee on the Judiciary. She is a member of the Committee on Mental Health Services for the Family Court and the Association of the Bar of the City of New York's Centennial Committee on the decentralization of New York City's government.

Mrs. Schack has three children.

Leo Swirsky, M.D.

Leo Swirsky, M.D., has been a general practioner since 1941. He is past president of the Kings County Chapter of the New York State Academy of General Practice.

Dr. Swirsky is a graduate of the Royal Colleges of Scotland. He served in the armed forces from 1942 to 1946.

He is also a delegate to the New York State Medical Society House of Delegates and serves on several committees of the Kings County Medical Society and the New York State Academy of General Practice.

Dr. Swirsky is active in various civic projects, including the Brooklyn Museum, the Brooklyn Academy of Music, and the Brooklyn Philharmonic.

John Douglas Van Zandt, M.D.

John Douglas Van Zandt, M.D., is a general practioner. He is also chief of staff at Tuxedo Memorial Hospital, Tuxedo Park, New York.

Dr. Van Zandt completed his undergraduate training at New York University. He did post graduate work at Harvard, Cornell, Duke and New York Universities. During World War II he served as a lieutenant in the Pacific.

President of the Orange County Heart Association, he is past president of the Orange County Medical Society. Dr. Van Zandt is also a fellow of the International College of Surgeons, a member of the American Academy of General Practice, the New York Academy of Medicine, the American Medical Association and the World Medical Association. He is currently health official of the Village of Tuxedo Park and Tuxedo Hamlet.

Married, he has two children.

3-24-71

THEODORE C. WENZL

Theodore C. Wenzl is president of the Civil Service Employees Association in Albany, New York.

Previously, Dr. Wenzl was with the State Education Department for twenty-four years and served as director of the Division of School Financial Aid. For four years, he was assistant executive director of the New York State Teachers Retirement Board. Dr. Wenzl has been a public school teacher and has taught at the University of Maryland, University of Buffalo and Alfred University.

At the present time, Dr. Wenzl is president of the Bethlehem Public Library; trustee of the Upper Hudson Library Federation; and trustee of Capital District Chapter National Multiple Sclerosis Society, New York Arthritis Foundation, and United Fund Campaign Advisory Committee.

Dr. Wenzl was educated at Rensselaer Polytechnic Institute and received his doctorate in education at Columbia University.

Benjamin Werne

Benjamin Werne is a lawyer specializing in industrial relations and collective bargaining. He is a professor of industrial relations at New York University School of Business Administration and a lecturer at Columbia University School of Administrative Medicine. He is also editor of the Industrial Relations Law Digest.

Dr. Werne received his law degree from St. John's University and his J.S.D. degree from New York University.

Chairman of the American Bar Association Committee on Wage and Salary Stabilization, he is also a member of the New York State and New York City Bar Associations, the American Arbitration Association, and the Commerce and Industry Association.

Dr. Werne has also authored several books in his field of specialization.

Senator KENNEDY. The next witness is Dr. Sanford Kravitz. Dr. Kravitz is dean and professor of social welfare of the State University of New York, Stonybrook, since 1969. He received a Ph. D. in social welfare at the Heller School of Social Welfare of Brandeis, serves as consultant to numerous governmental agencies, has written extensively in many of these areas.

STATEMENT OF DR. SANFORD KRAVITZ, DEAN OF THE SCHOOL OF SOCIAL WELFARE, STATE UNIVERSITY OF NEW YORK, N.Y.

Dr. KRAVITZ. Senator Kennedy, Senator Dominick, as you have already stated, I am dean of the School of Social Welfare at the State University of New York at Stonybrook.

I come with a background of experience. I think as you know, Senator Kennedy, I was Associate Director of the community action program in the Office of Economic Opportunity, in whose office the neighborhood health center program was developed. And I am also a member of the Citizens Board of Inquiry into Health Services for Americans. And more directly related to your presence here, 2 years ago I was director of a study in Nassau County which looked at the relationship of transportation and housing location to poverty and the availability of health and social welfare services to the poor.

I would like to make several general points about health services which I believe are totally applicable to the suburban communities of Nassau and Suffolk Counties.

One, as you have already heard, there are thousands of people in this area who do not receive adequate health care; at best only sporadic care.

The system is in disarray. It doesn't need a minor shift or minor changes, it is in disarray. And it is draining resources of government at all levels, corporations, labor organizations, and individual citizens. We have innumerable organizations operating at large profits on the disarray of the system—the insurance companies, the drug companies, the for-profit institutions, the hospitals, and the fee-for-service practitioners, few of whom have any interest in the more effective operation of the system, but do in fact oppose programs which might contribute to more effective organization, and demonstrate incredible arrogance, as we have already heard.

Consumers have no effective role in health service delivery. And consumers, particularly the poor, have few meaningful options in health care today.

I have seen the worst of this system in places like Lee County, Ark., and Stone County, Ark., as you have already heard in your Washington testimony from the Citizens Board of Inquiry and as your committee will see when you travel to these places. But you can be assured that even in sophisticated areas like Nassau County and Suffolk County physical access to adequate health care is a serious problem for the poor and near poor.

Health services in these areas have been highly centralized, and with the incredibly medieval public transportation system that serves the counties of Nassau and Suffolk you can hardly get there from here. Health care is almost inaccessible for many of the poor and

near poor. Health services are organized for the convenience of providers, and there are literally no incentives to do anything else.

I shall submit for the record maps detailing travel times to major health centers and their relative inaccessibility, and maps showing the location of physicians' offices in this area and their relative inaccessibility to the poor, and maps showing the location of physicians who as of 1968, when the study was done, were participating in the medicare and medicaid program.

The bills, more which will flow into this system from some new Federal legislation, will only have meaning if it is inextricably linked to pluralism and to competition in improving the delivery system.

We need in suburbia conveniently located comprehensive care centers that are accessible to all who wish to use them. If you are healthy, mobile, and you have some money and some awareness, sophistication about the system, you can get with it and the system can deal with you, albeit inadequately. If you are poor, black, and you lack a car and you are relatively unsophisticated, you are caught in the middle of this chaos.

Let me cite a homely example which I think most of you who have children would be familiar with. If you are an upper middle class mother and you have a regular pediatrician and your child has an ache or a rash you phone the pediatrician and the answering service says the doctor will call you back at 9 o'clock. And I submit that about 90 percent of the medical care that middle class and upper middle class families get for their children is over the phone from physicians at no cost fairly regularly, the 9 o'clock consultation.

If you are poor and you have no regular pediatrician you get yourself on the bus to Meadowbrook Hospital with a baby in your arms and two by the hand, and you ride for an hour with two changes to get that information, and then you wait several hours before you get it.

We have not developed any systems within this industry for dealing with these issues. We are at the mercy of providers and professionals who design the service system in terms that maintain their professional or institutional needs. The private insurance operations have made no effective contributions to these broad system needs.

We have problems in the area of manpower. We have problems in the area of control in institutions. We have problems in the area of accessibility. We have problems in the area of quality of care, problems in the area of distribution of resources.

There is no reason to expect that a new windfall in terms of a Federal program will provide the extra incentive. A federally controlled program with incentives for innovation in delivery could conceivably do this. I think in large measure your bill, Senator, provides for this. But I think any Federal program we get must provide the incentives for innovation and for access and for quality in the program. What we have done so far has done none of this.

If I may, Senator Dominick, I would like to comment on your opening remarks. You did cite the maldistribution of physicians, and the maps that I will submit to the committee will show this maldistribution in Nassau County. But the statistics, these statistics

about the number of physicians and how well we are doing can be compared to the man who drowned in a lake with an average depth of 3 inches.

We have had an incredible expenditure of funds in the health industry in this country, far higher than other countries on a per capita basis, and we have not forced providers or professionals to act in a socially responsible manner. I would hope that this legislation will.

This is not a new problem. Anybody who has been concerned with this field knows that the discussion about health care and health insurance has been going on in this Nation for 50 years. Some of you may remember that President Truman in 1948 proposed a health care program. The reason we haven't had one is because of the, again I say, almost incredible arrogance and opposition of the health industry, the providers, who have absolutely no reason to try to improve the system unless the flow of funds forces them. The way in which the funds are expended by the Federal Government has to force them to respond to what people who are ill or people who may become ill may need.

Thank you. [Applause.]

Senator KENNEDY. Thank you very much, Dr. Kravitz. Could you direct your attention a little bit to the question of quality of health care in suburbia? There is a general kind of feeling in terms of middle America that if they have the resources, they can get to that hospital or call their doctor, that their sort of health needs are being met, and we have heard questions raised in terms of what that quality really is in suburbia, and should the middle income people really be concerned about the health crisis or is this really only a problem of the poor?

Dr. KRAVITZ. Well, again several witnesses have cited personal experiences. I consider myself a relatively sophisticated person in this area, and I know that I have no adequate way of judging for myself the quality of care which I get. I happen to be in a fortunate position of being in an institution which has a large number of well-qualified physicians, so I can, as a friend and colleague, call for responsible judgments. I am at a loss to know how someone who is not in that fortunate position knows whether or not they are getting quality care. And I am talking about the middle class, upper middle class, higher income person, who has the capacity to go out and purchase the care, has a car to drive, is physically able to do so.

If you are poor or if you are in a lower income category, if you have not had any kind of sophisticated background or education, you are at the mercy of the system.

It is only when we begin to educate consumers as to the kinds of things they should appropriately know about and ask about—the witness from Blue Shield testified on the kind of criteria which they internally use within that system. Well, people outside the system ought to know this. Consumers ought to know what represents an overexpenditure of funds, misuse of time, too many drugs being given, and so forth. I am sure that information is not generally shared with the public about those people who do misuse these programs. We ought to make public those institutions, those individuals

who misuse these programs in this way so that they can be held up for public condemnation and can be avoided by the consumer.

The professions protect themselves, and all professions—my own included—operate in the system maintaining waste, do not rock the boat. And until we begin to educate the public as to what are reasonable and responsible expectations that we can demand of professionals and institutions the public will not know what is good quality care.

Senator KENNEDY. Do you think that in terms of any kind of reform of the system that we ought to be able to institutionalize the question of quality care for middle income and upper income people?

Dr. KRAVITZ. I think, as you may know, the concept of the neighborhood health center presented a model for health care that some of us would believe is a model for middle class and upper middle class people because of the possibility of providing comprehensive quality care that is not fragmented. I think the same kinds of things that we had hoped might be provided for all the poor ought to be provided for all people. Unfortunately, we are not doing it anywhere near what we both, I think, hoped would happen.

Senator KENNEDY. Do you think middle income people and upper income ought to be concerned about the health crisis in this country today?

Dr. KRAVITZ. They ought to be. Of course they ought to be, and I think a lot of them are becoming——

Senator KENNEDY. Not only in terms of their interest and their concern for less fortunate people, but just in terms of their own self-interest.

Dr. KRAVITZ. The middle or upper income person has no reason to expect that they would get any better quality care in dealing with an individual practitioner or an institution than a poor person. The chances are they might. They just might because they have somewhat more choice available to them. But they have no guarantees that this system will provide them with quality care.

Senator KENNEDY. Do you think they really understand that?

Dr. KRAVITZ. No; I don't think they understand that, Senator.

Senator KENNEDY. I couldn't agree with you more.

Senator Dominick.

Senator DOMINICK. Doctor, for a long period of time every time we tried to do anything in our area of the world we were constantly told that you shouldn't do it in the outlying areas, you shouldn't get group practices going in the outlying areas, and you should centralize everything around a major teaching school, because if you didn't do that the doctors were going to have a lack of quality and you were not going to get good medical care, and so forth. This was backed for practically the entire decade of the sixties by HEW and by the respective administrations that were going on. And I gather from what you say that you want to decentralize medical schools and medical facilities rather than centralize them, is that correct?

Dr. KRAVITZ. Not entirely. What I am saying is a comprehensive system of care would provide for primary care located within easy access of every family who needed health service; decentralization to

provide primary care at the level of the community hospital which would take care of those nonserious, noncritical kinds of illnesses which can well be handled at the community hospital level.

We have tertiary care which is the medical school teaching kind of treatment. We don't need to replicate these resources wherever a group of people decide they want to establish a medical school or a hospital.

There has to be some system, and as I repeat, I think the system is in disarray, and it is in disarray because special interests have controlled where these services should be located, and rarely is the concern of the consumer or the user or the poor person ever figured into that system.

Senator DOMINICK. Well, let me get back to my question, and let's for a moment try to get away from the question of whether people are doing it for ulterior motives or something of that sort. I have been a strong supporter of decentralization of medical care at the primary level ever since I can remember, and I have been in more trouble trying to press this than anything I can think of.

Under the administration program they do have under the medical student loan provision a forgiveness deal which is much larger than under the NDEA to get them to work in the rural areas, in the urban ghetto areas, and so forth. Do you have any feeling that this will work?

Dr. KRAVITZ. I think it can work; yes. I think the medical students today are more and more interested in moving into those areas if they can be helped with the cost of their medical education. I see no reason why it can't be made to work.

We have had demonstration of interest on the part of people going into the Peace Corps, into VISTA. The best medical care that we encountered in the citizens board of inquiry study in the horrible setting of Lee County, Ark. was being administered by a VISTA physician. So I do think it can work, and I agree with you wholeheartedly about the need for decentralization.

Senator DOMINICK. And you also support the administration's proposal on health education centers which would be distributed around the country?

Dr. KRAVITZ. I am not familiar with the detail of the concerns about health education centers. But since you raised the issue whether I am supporting a particular administration program, the administration may be proposing that, on the other hand right now the administration in some of its cost-cutting efforts is grossly reducing the opportunity to train health professionals through the current cuts in a large number of scholarship and fellowship programs. And so at the same time we are proposing legislation which is to create this brave new world and these large groups of professionals, on the other hand currently in Washington we are reducing the number of fellowships and scholarships available to students in the allied health fields, in the nursing field, in the dental field, and in the medical field, to do that. Those two things are——

Senator DOMINICK. Doctor, let's get the record straight. They are putting per capita cost of five times over what it was before for the

medical students who are going to school, and if you can get him through medical school sooner he would still get the same amount of money; so you are going to get more people in the field presumably, which is the idea behind it anyhow. So on a per capita basis the support of medical school, the administration has pretty strong support behind it.

Dr. KRAVITZ. Is it what is, or is it what is coming?

Senator DOMINICK. In the 1972 budget.

Dr. KRAVITZ. In the 1972 budget?

Senator DOMINICK. Yes.

Dr. KRAVITZ. Delighted to hear it.

Senator DOMINICK. Do you believe that in the time span within which we are working, that is, before July 1972, a varied program of health services should be developed?

Dr. KRAVITZ. Oh, I certainly do think it is important. I think the legislation which emerges from these hearings should provide for a variety of options to be available, linking those options to their capacity to meet the kinds of needs that are uncovered by these hearings.

Senator DOMINICK. And not just one single system?

Dr. KRAVITZ. Not just one single delivery system at the local level. The method of financing at the Federal level could conceivably obviously be one system. It is the delivery system at the local level that ought to provide for choice.

Senator DOMINICK. But you ought to have a choice of whether you want to go to an HMO or private physician's office or closed panel or——

Dr. KRAVITZ. Yes; whichever could deliver the best care.

Senator DOMINICK. All right, thank you.

Senator KENNEDY. Thank you very much, Doctor. We appreciate it very much.

(The prepared statement of Dr. Kravitz follows:)

TESTIMONY BEFORE THE SENATE
SUBCOMMITTEE ON HEALTH ON
S-3 & H.R. 22

by Sanford Kravitz, Ph.D.
Dean
School of Social Welfare
State University of New York
Stony Brook, New York

Hofstra College
at Hempstead, Long Island, New York

Senator Kennedy, Senator Dominick, my name is Sanford Kravitz. I am Dean of the School of Social Welfare in the Health Sciences Center at the State University of New York at Stony Brook. I come with a background of experience as the Associate Director of the Community Action Program Office of Economic Opportunity in whose office the Neighborgood Health Center Program was developed, as a member of the Citizen's Board of Inquiry into Health Services for Americans and more directly related to your presence here as the Director of a study On Nassau County two years ago which looked at the relationship of transportation to poverty and the availability of health and social welfare services to the poor.

I would like to make several general points about health services which I believe are totally applicable to the suburban communities of Nassau and Suffolk Counties.

1. There are thousands of people in this area who do not receive adequate health care - at best only sporadic care - as you have already heard.
2. The system is in disarray and drains the resources of government at all levels, corporations, labor organizations and individual citizens.

3. We have innumerable organizations operating at huge profits on the disarray of the system. The insurance companies, the drug companies, the for-profit institutions, the hospitals and the fee for service practitioner. Few of whom have any interest in the more effective operation of the system, but do in fact oppose programs which might contribute to more effective organization and demonstrate incredible array in such opposition. Consumers have no effective role in health service delivery. Consumers, particularly the poor, have few meaningful options in health care today.

I have seen the worst of this system in places like Lee County, Arkansas and Stone County, Arkansas - as you will when your committee travels to these places.

But you can be assured that even in sophisticated and erudite Nassau & Suffolk County, physical access to adequate health care is a serious problem for the poor and near poor.

Health services have been highly centralized and with an incredibly medieval public transportation system in this

County and Suffolk County - you can't hardly get there from here. For many poor or near poor health care is almost inaccessable. Services and facilities are organized for the convenience of providers and there are literally no incentives to do anything else. I shall submit for the record, maps detailing travel times to major health centers and their relative inaccessability. Maps showing the location of physicians offices in this area, and their relative inaccessability to the poor.

The billions more which will flow into this system from some new federal legislation will only have meaning if it is inextrically linked to choice, pluralism and to competition in improving the delivery system . We need in suburbia, conveniently located comprehensive care centers that are accessible to all who wish to use them.

If you are healthy, mobile and you have some money and some awareness, the system can deal with you, albeit inadequately. If you are poor, black,lack a car and are relatively unsophisticated, you are caught in the chaos. Let me cite a homely example. You are middle class mother with a regular pediatrician. Your child has an ache or a rash so you get on the phone. At 9 AM you get a free pediatric consultation and you get 90% of your pediatric consultation over the phone. If you are poor, and have no regular pediatrician, you get yourself on the bus to Meadow-

brook with one baby in your arms and two by the hand and ride an hour with two changes to get the information.

We have not developed any systems within the industry for dealing with these issues. We are at the mercy of providers and professionals, who define the system in terms of maintaining their professions or institutional needs. The private insurance operations have made no effective contributions to solutions in the areas of manpower, control, accessibility, quality of care, or distribution of resources. There is no reason to expect that a new windfall will provide the extra incentive. A federally controlled program with incentives for innovation in delivery could conceivably do this.

Senator KENNEDY. Our next witnesses will be Mr. Leonard Kunken and his son, Kenneth. Until 5 months ago Kenneth was a junior in engineering in Cornell University, and last fall he suffered a tragic, devastating injury on the football field.

Mr. Kunken, would you be kind enough to come up? I believe your son is here?

Mr. KUNKEN. Yes, sir. He is in the process of being taken out of the car, Senator.

Senator KENNEDY. Maybe you could tell us a little bit about yourself and what your business is and also tell us what you could about this accident to your son.

STATEMENT OF LEONARD KUNKEN, AND HIS SON KENNETH KUNKEN, OF OCEANSIDE, N.Y.

Mr. KUNKEN. First of all, gentlemen, I want to thank you very much for the opportunity to allow me to talk before you today. I feel that I do have a message of great import, and since it happened in my family, to me personally, of course, I can speak with authority.

Ken was a junior in Cornell in the engineering school and was a member of the 150-pound football team. In a game against Columbia this past October 31 he made a tackle of the Columbia ball handler and instantaneously broke his neck and severed his spinal cord. Now most of the articles that have appeared in the various publications have been rather kind by just saying his neck was broken. But because of the fact that my son has retained all his faculties it wasn't until the other day that his doctor who initially performed the operation told him that he felt that the spinal cord had been severed.

As a result of Kenny having the spinal cord severed on the fourth and fifth vertebrae he is now a quadraplegic. He cannot move anything beyond his neck, his head, and a slight shoulder movement. But has absolutely no function of his arms, his limbs, nor can he perform the normal body functions that we all do every day.

The situation is such that the doctors haven't been too hopeful for any change in his medical prognosis. And as such we are looking—I shouldn't say we are looking forward to—but unfortunately the prognosis they gave is that there won't be any substantial change in his future situation as far as being able to do anything on his own.

I might say at the outset that it was rather touch and go for the first week, and, of course, the chances of his survival were quite remote. But he was able to pull through as a result of the excellent care that he received from the doctors up in Elmira where they transferred him after the accident, and subsequently after remaining there for a month he was brought down to South Nassau Community Hospital in Oceanside, which is the local community hospital where we reside.

While at South Nassau—he remained there for 3 months, and due to the fact that he was a local boy and the knowledge of the various physicians about his physical condition, I think that the medical staff both at South Nassau and also at Arnett Ogden Hospital in Elmira bent over backwards to minimize their bills. But even though they reduced their fees, I can tell you quite frankly, Senators, that

as of the moment, which is now five and a half months today since the accident, our medical costs have been somewhere in the neighborhood of $40-odd-thousand, and presently are running at the rate of about $6,500 a month or better. I say or better, because he is presently at the Institute for Rehabilitation Medicine in New York City, which I believe you are familiar with, and the costs there are more or less on an entirely different basis than they were heretofore at the local community hospitals.

Now how long he will remain at the Institute is problematical. The doctors are trying to perform certain rehabilitation procedures which they think may lend toward Kenny resuming a normal life. Since he has all his faculties and his mind is as sharp as ever, it is a question as to what they will be able to do that can make my son once again useful to society.

Now unlike most types of catastrophic situations, there is no end to the medical costs involved. And projecting the medical expenditures in Kenny's behalf I daresay it is going to be a minimum of anywheres from $75,000 to $100,000 a year.

But even on a basis such as this, if you knew once you had reached a certain amount of moneys that were to be expended that that would be it, you could say well, this is the problem, we will have to face it. But I don't see how anybody can cope with such a situation as this, because frankly it is endless. There is no end in sight with all the medical bills.

We have been told—and it is very obvious after you will see him—that he will need constant medical attention 24 hours a day for the rest of his life. He is presently—I think he will be brought in here in a wheelchair. But he cannot remain too long in a wheelchair because of the fact that he is still not that stable that he can take any length of time without being able to be in a reclining position.

I do have a major medical policy with my company, and ironically enough, I am in the insurance business. So it is something that I feel I know firsthand. I have been in the business going on 25 years, and I have sold a great deal of major medical and life insurance during that period. But to my knowledge there is no plan that is being underwritten by any insurance company that in any way would personally cover all of Kenny's medical expenses.

I have a $25,000 policy with my company, which is the maximum coverage that the company would provide, and it wasn't until just the beginning of this month that they added an additional $15,000, making a total of $40,000 coverage in toto which is the maximum amount that he will ever be able to have for the rest of his life. I have already used up about 40-odd-thousand and the chance of him ever being rehabilitated to the point where he would be self-sustaining or physically fit is out of the question. He is ineligible for ever obtaining more health coverage.

We are talking about a young boy of 20 years of age; one moment his whole life in front of him, and the next moment nothing.

Now my son does not want to become a social charge on the community. He had every indication of becoming an engineer, and if not pursuing an engineering career, possibly an actuarial career with

my own company. As a matter of fact, he was to have taken the actuarial exam the week after the accident happened.

Cornell has no coverage. They have never experienced any type of calamity in all their years of existence, and to my chagrin I find that most of the other schools are in the same position. Heretofore if a boy or a young female student were injured or ill they would utilize the facilities of the local medical center at the university and the college would assume all the costs. But suddenly out of nowhere they are faced with a devastating bill which is endless. I don't think they know how to cope with it any more than I do.

In addition to that, their first thought was that since they considered there was no liability on their part that they should make a token gesture of some moneys to cover his initial medical expenses, which they did. And they have contributed at the moment some $12,000, which has been exhausted.

Another fund instituted by the university from a special committee also brought forth an additional 10,000. But, Senators, we are talking about amounts that run into the hundreds of thousands. So these are—if you will pardon the expression—peanuts. They don't amount to anything after all is said and done because the situation still exists.

On the other hand, because of his age, 20, he wasn't covered by social security even though he did have a social security number—and this is an ironic twist of fate. The last two summers he had been working as a lifeguard for the county, and since that's more or less of a civil service position they are not covered by social security. In turn because they felt that these young boys who were working as guards at the beach clubs were just of a temporary nature they were ineligible for civil service status. So he had no social security, he had no civil service coverage. And in applying for disability benefits under social security I have a letter in my possession from the Government indicating that they are very sorry, but that he did not meet the necessary quarters; and yet while he was employed he was earning far in excess of the amount of moneys needed to be eligible for social security qualification.

True, he is eligible for medicaid when he reaches the age of 21. But in order to be eligible for medicaid, as I understand it, he must more or less make himself destitute, that he will not be able to have income of more than approximately 180-odd dollars a month and divest himself of any personal assets that he may own over and above $1,600, which in this day and age is absolutely ridiculous.

How do they expect a young man to be able to face society with this particular dilemma and be absolutely destitute and at the mercy of the world?

I think I better stop now. You might have some questions.

Senator KENNEDY. What is your reaction to the system of health in this country that burdens you not only with the enormous personal tragedy in terms of your son, but confronts you with financial ruin?

Mr. KUNKEN. The local community where I reside, Oceanside, felt they had a personal well-being in Kenny and they went all out to institute a drive, which is currently in effect, whereby from the schoolchildren on up are running raffles, they are going from door

to door and canvasing, they are doing everything humanly possible in order to raise funds to offset Kenny's medical expenses. Now I say this to you, sir, advisedly, because if they are fortunate they will raise about $15,000, which at the present rates won't last more than about two and a half months for us.

I can't expect these people to constantly shoulder my obligation. And let's face it, being realistic, time has a way of making people forget. At the moment you might say he is good copy. Tomorrow the situation remains, but other than his immediate family there is nobody going to be there.

Now my next step then is to divest myself of all my own personal assets and in turn become destitute in order to qualify for the system.

Since I sell major medical insurance individually and in groups, as good as some of the coverage may be that the companies offer it is meaningless, because as fast as the companies offer a certain limit the medical costs that are incurred far exceed the limits of the various policies that are being written, and I don't think that they will ever be able to cope with it because it is like the tail wagging the dog. And although I believe in free enterprise and I don't feel that I am talking out of both sides of my mouth, I don't really feel that the insurance companies—I am talking about the private carriers—can actually be able to take care of the health problem that the people are being confronted with in the United States.

And I might say parenthetically, sir, I am not destitute. But by the same token, when you are talking about sums in excess of a hundred-odd-thousand dollars it doesn't take very long to become destitute.

Senator KENNEDY. Do you know of any insurance policy by any private company in this country that could meet the kinds of obligations and responsibilities that you have?

Mr. KUNKEN. Well, since this accident came about, Senator, I have heard of one or two where they, let's say, have a deductible of the amount of insurance that I currently have in force and that there is what they commonly call the piggyback. That would be the deductible, and where that leaves off the other commences. But to my knowledge I never had heard of it until this thing became a reality.

Senator KENNEDY. You are in the business.

Mr. KUNKEN. I am in the business, and I never heard of it, because strangely enough—and I feel that I wrote one of the first major medical plans when it initially came out some years ago, and at that time they considered it a fairly large amount—I wrote a $5,000 major medical plan that was a cancellable plan by the company, with the understanding that the company would have the right to cancel if they felt they had too many claims. And in one of the first policies I wrote the man did have a thousand dollar claim. And I thought this was out of this world—a thousand dollar claim.

Now it is true everything is relative. But now, of course, most of the plans that are being written are being written on a noncancellable basis, but there is a lifetime maximum that the individual will be entitled to. And in my son's situation there wouldn't be any coverage.

And also it was a known fact that you could not have duplicate coverage. In other words, you could have a small medical plan or a

major medical policy with one company, and even if they only offered some $10,000 of coverage and you wanted to supplement it with a similar plan with another company you wouldn't be allowed to do it. There was an unwritten law they wouldn't allow you to have two plans in effect.

Senator KENNEDY. You live out here in this community?

Mr. KUNKEN. Yes, sir; I live in Oceanside.

Senator KENNEDY. How far is that?

Mr. KUNKEN. From Hofstra?

Senator KENNEDY. Yes.

Mr. KUNKEN. Oh, about 6 miles.

Senator KENNEDY. You have lived out here for some time?

Mr. KUNKEN. Well, I have lived out here most all of my life, Senator.

Senator KENNEDY. How far away do you work?

Mr. KUNKEN. My office is in Queens County. This is Nassau County. But my principal place of operation is in Nassau County, further out on the Island which is Suffolk County, and in New York City. I work all over except possibly where my office is.

Senator KENNEDY. This kind of tragedy which has affected your family and your son could really happen to anybody, couldn't it?

Mr. KUNKEN. After being at the institute for the past month and a half and seeing young boys, primarily, that are brought in from all parts of the country, and to see the devastating effects, I know now what people mean when they say "there but for the grace of God go I." Of course, it happens all over the country. And I am just wondering what the average person has been able to do who doesn't have the major medical coverage that I had or some of the so-called benefits that they gave me, which in this instance is still meaningless because I will have used them all up very shortly. So I don't think that the average person has even as much coverage or as little coverage as I have.

Senator KENNEDY. What is the life expectancy of your son?

Mr. KUNKEN. I have been told by the doctors that if Kenny gets through the first year his normal life expectancy is the same as you or I with maybe the exception of 1 or 2 years.

Senator KENNEDY. And your best judgment is that that will be in terms of cost—what do you think it will be?

Mr. KUNKEN. Well, I am projecting it on the basis that at the moment the costs are running over 200-odd dollars a day at the institute. That does not include special apparatus that may from time to time be needed which I automatically give authorization to the institute to obtain for my son's behalf. That's why I gave you a figure of anywheres from $6,500 to $8,000 a month.

Senator KENNEDY. Now, there's no private insurance program, there's no State program that you know of——

Mr. KUNKEN. Not for a boy Kenny's age, because he is not yet 21. Now if it had happened 4 years earlier, when he was 17, it would have been that much worse.

Senator KENNEDY. There is no Federal program?

Mr. KUNKEN. To my knowledge; no.

Senator KENNEDY. Even the suggested recommendation by the administration in the President's health message which puts the cutoff at $50,000, you would have run through that pretty quick, too, wouldn't you?

Mr. KUNKEN. I can answer you by telling you when people ask how is your son, I say, "well, quite frankly, he is a quadraplegic." They say "that's awful, but, of course, he can move his hands, can't he?" Most people don't even know what the term quadraplegic is. So when they are thinking in terms of $50,000, that in itself is astronomical. But what is 50,000 if you spend 51,000? It is nothing.

Senator KENNEDY. Well, I think once again perhaps it is a different feature, but it is still an essential part of our health crisis in this country where you can have this kind of devastation upon you and your family and your whole future.

Mr. KUNKEN. I can only look at my immediate family, and having always been what I thought was a good breadwinner in my own right, to suddenly be confronted with such a situation of this magnitude, how can a person who supposedly didn't have the wherewithal that I have have been able to cope with this. Impossible.

And he is my son. And it doesn't make any difference how bad his situation is, I must protect him. Now costs at a stage like this are meaningless. You will do everything because you only have one life.

But you see, I am still faced with the problem—so supposing I do divest myself of all my assets. So what? I am still going to be faced with the problem 1 month after it is all over, and I will still need the same medical attention, and then what am I supposed to do?

Senator DOMINICK. Mr. Kunken, I just want to say I think you have great courage, and secondly, this is the type of situation which these hearings specifically hope to develop so we can see if we can't get some program which will be of assistance to you. You are not alone in these kind of problems, as you know from having been to the institute yourself. Hopefully we will be able to work out something. Now when this will come about or what the magnitude is, no one knows at the present time. But certainly this is one of the things that we must as a committee consider.

If a person with your ability and your knowledge of the whole industry finds himself faced with this, there are many others around the country that must be in similar positions.

Mr. KUNKEN. It was rather coincidental, Senator, that this article appeared in an editorial of Newsday the other day, which I assume prompted my being called to talk with you today, and I find that as a result of being here—I was just in the process, believe it or not, of contacting Senator Javits and Congressman Lent, who is my local Congressman, to see if some special law could be passed in Congress that could be of some help to my son. Now as a result of my having this opportunity to appear before you, if anything that my son has ever been able to accomplish in his short life would be to show people the catastrophic consequences as to what is happening to Kenny, I think he has done a tremendous service for the whole United States. And I don't feel this could have been obtained in any other fashion than appearing before you representatives of our Government.

Senator KENNEDY. Kenneth is here. He came out from New York. We didn't want to burden him, but I understand he feels quite comfortable in talking about this. You are his father. You have told the story marvelously well. We are glad to have Kenneth comment, but I will follow whatever guidance——

Mr. KUNKEN. I don't tell my son what to say. He is almost 21.

Senator KENNEDY. Okay. We will hear from him.

Mr. KUNKEN. Do you want me to stay here?

Senator KENNEDY. Why don't you? If you would be good enough to stay there.

Mr. KUNKEN. Pardon me, Senator. My son may feel a lot freer if maybe I wasn't here in the immediate vicinity. So I would rather go in the back. Is that all right with you?

Senator KENNEDY. Yes, it is.

Ken, we appreciate very much your coming out from the Rusk Institute. As you know, this is the Senate Health Subcommittee. We are interested in health legislation, and we have been holding hearings in Washington and now around the country. And, of course, we are terribly interested in the kinds of catastrophic health needs of the people of this Nation. There have been different suggestions which have been made in terms of recommendations to the Congress and the Senate, but we really haven't responded to this kind of a problem in a really meaningful way.

And you are good enough to come here today. Your father told us a bit about your experience earlier, and I think has dramatized perhaps as sadly, but as effectively as possible the unmet needs of this Nation in terms of meeting the kinds of problems which are suggested by your case. So you are really providing a great service, I think, to this committee and to the Senate, and I think to the American people, in coming and talking with us today, and I want to express my very deep sense of appreciation on behalf of the committee for doing it.

Mr. KENNETH KUNKEN. Thank you.

Senator KENNEDY. I thought if you might just tell us a little bit about yourself now and how you are getting along, and perhaps tell us a little bit about the accident itself, it would be very helpful.

STATEMENT OF KENNETH KUNKEN, SON OF LEONARD KUNKEN, OCEANSIDE, N.Y.

Mr. KUNKEN. I got hurt playing in a football game up at Cornell University, and that was October 31. And since I was hurt I have been paralyzed from the neck down. And that was instantaneous with the injury. It was after a tackle.

Then I had a bone fusion done in my neck about 9 days later, and after about a couple of weeks I did get a little return back in my left arm. And I have the use of my shoulders, but very little else. So there is really nothing that I can do for myself now, or for the last 23 or so weeks that it has been since I have been hurt.

So, what has been happening is I have had aides and attendants and nurses pretty much around the clock that have had to feed and dress me and turn me, say, every 2 hours to prevent my getting bed

sores or to aid circulation. And I have been undergoing a lot of different sorts of therapy hopefully trying to get some movement back if it is possible. And I have been taking different sorts of breathing treatments because I don't have the full use of my chest cavity, and it is really only my diaphragm I understand that is working to keep me breathing.

So there have been a lot of different things that have been happening since I have been hurt, and depending on each hospital I have been, where I have been moved to, I have had to go to a different schedule.

Senator KENNEDY. How many different hospitals have you been to?

Mr. KUNKEN. Well, I guess you could say it was four. I was originally brought to a hospital in Ithica, Sage Hospital, where they took x-rays of my neck and cut off my uniform. But from there I was transferred almost immediately to a hospital in Elmira, N.Y., which was the Arnett Ogden Hospital. I was there for 4 weeks. That's where the operation was performed.

When they felt I was well enough I was transferred to South Nassau Hospital in Oceanside. And I spent just a little over 13 weeks there, and then I was moved to the Institute of Rehabilitation Medicine in New York, where I am now.

Senator KENNEDY. You were studying, as I understand, engineering at Cornell.

Mr. KUNKEN. That's right. I was majoring in industrial engineering. I was in my junior year.

Senator KENNEDY. You wanted to be an engineer?

Mr. KUNKEN. I did at the time. But I understand it may not be feasible for me to go back into engineering with the movement that I have or my ability to move around. I also hear engineers in the field have a little trouble at the moment, too.

Senator KENNEDY. What kind of activity can you undertake now? Can you read?

Mr. KUNKEN. Well, they are working on a page turner for me so that I may be able to read. They would have to prop a book on to the page turner and I would be able to work, say, a button with my chin. But as of yet we haven't come up with a device that works well enough to read without getting really frustrated, because the page turner doesn't work all the time and sometimes it turns more than one page, other times doesn't even turn one page. So since I have been injured I have read very little.

Senator KENNEDY. Did you use to read a good deal before?

Mr. KUNKEN. Well, I did a good deal as far as my studies went. Outside of my studies, a few magazines—you know, one or two books. But not really a great deal.

Senator KENNEDY. As I understand, you never lost consciousness.

Mr. KUNKEN. That is correct.

Senator KENNEDY. So in terms of your mind or your ability, it has never really been affected at all by this accident, has it?

Mr. KUNKEN. Well, not as far as any type of injury done to it. But I think it has affected me a lot mentally as far as realizing the present condition that I am in now and the possibilities that I have for recovery, you know. There was no damage done.

Senator KENNEDY. Are you looking forward to trying to go back to school some time in the future?

Mr. KUNKEN. Yes; I am. But I am really not sure how that is going to work out, though, once I do go back. I understand I will always need an attendant with me for getting dressed, getting around, feeding, one thing or another. I am not even sure what I would like to study now, too. But I would like to go back to school.

Senator DOMINICK. Ken, how many people are there in the Institute with the same type of situation in which they need attendants all the time. Do you have any idea, or are you alone pretty much?

Mr. KUNKEN. Well, I don't really have any figures, any real numbers. I have yet to see someone there that has as little movement as I do. I understand there have been quite a number of people that were there that had very little movement. Right now, though, I haven't seen anyone with this little movement. I know there are people, though, that do have some movement more than I do, but they still need attendants and they still need to be fed because the movement they have isn't great enough to allow them to do it themselves.

Senator DOMINICK. Are they younger people down there with you or are they older people?

Mr. KUNKEN. Well, they are mostly people right around my age group, I would say. I know they do have a pediatrics part to the hospital that I haven't seen, so I know that there are a lot of young kids there.

Senator DOMINICK. Are these mostly from accident cases, do you know?

Mr. KUNKEN. The people that I have seen have been mostly from accidents.

Senator DOMINICK. Automobile or motorcycle?

Mr. KUNKEN. A lot of them have been from automobile accidents. A lot of them have been swimming and diving accidents. Those are the two accidents I think I have seen most commonly since I have been there.

Senator DOMINICK. Well, I think both Senator Kennedy and I are extremely impressed with your willingness to come up and testify. I think it is going to be extremely helpful in our trying to work out something that will be of value to you, but also to the rest of the country.

Mr. KUNKEN. Well, I hope so.

Senator DOMINICK. And we really appreciate it.

Mr. KUNKEN. Thank you. It is my pleasure.

Senator KENNEDY. We want to thank you. I think all of us have been enormously impressed by the tremendous advances in terms of research on injuries, particularly from the war in Vietnam.

Mr. KUNKEN. Right.

Senator KENNEDY. And I think great progress is being made. So we want to wish the best for you in the future, and we admire your determination.

Mr. KUNKEN. Thank you.

Senator KENNEDY. Keep up the good work. Thank you very much.

Our next witness is Dr. Peter Rogatz. Dr. Rogatz is Associate Director for Patient Care Services at the Health Institute, State University of New York at Stony Brook.

Is he here?

Doctor, you have been extremely kind and patient in waiting, and our hearings are starting in northern Westchester at 2 o'clock so we are really under a time limit, but we want to hear from you. So you could file your testimony that you do have and we will make it a part of the record. Perhaps you can summarize briefly. We would certainly appreciate it.

STATEMENT OF PETER ROGATZ, M.D., ASSOCIATE DIRECTOR FOR PATIENT CARE SERVICES, HEALTH SCIENCES CENTER, STONY BROOK, LONG ISLAND, STATE UNIVERSITY OF NEW YORK; DIRECTOR, UNIVERSITY HOSPITAL AND PROFESSOR OF COMMUNITY MEDICINE AT THE HEALTH SCIENCES CENTER; VICE CHAIRMAN, NASSAU-SUFFOLK COMPREHENSIVE HEALTH PLANNING COUNCIL; AND VICE PRESIDENT, HEALTH AND WELFARE COUNCIL OF NASSAU COUNTY, N.Y.

Dr. ROGATZ. Thank you, Senator Kennedy, Senator Dominick, my name is Peter Rogatz. I am associate director for Patient Care Services at the Health Sciences Center being developed on the Stony Brook, Long Island, campus of the State University of New York. I am director of the university hospital and professor of community medicine at the Health Sciences Center, vice chairman of the Nassau-Suffolk Comprehensive Health Planning Council and vice president of the Health and Welfare Council of Nassau County.

It is a privilege to be invited to offer this testimony to your committee. These views are my own. I am not speaking as a representative either of the State university or of any other organization with which I am associated.

Long Island, comprising the two counties of Nassau and Suffolk, represents a total area of approximately 1,400 square miles and a population exceeding 2.5 million. Because Long Island contains a variety of urban, suburban, exurban, and rural communities, it is in some respects a microcosm of the United States. The problems of health and medical care in Long Island exemplify those of our country as a whole. At the risk of oversimplification, I would say that, in general, Suffolk County is primarily exurban and rural in character, while Nassau County is more typically suburban, with some significant urban concentrations. It is my understanding that this hearing is concerned chiefly with "suburbia," and I will therefore concentrate my comments on Nassau County.

Economic levels in the county range from extreme affluence in some of the suburban "bedroom communities," to bitter poverty in urban slums and in small, depressed "poverty pockets" that are scattered throughout Nassau.

Hospitals, some of very good quality, are dispersed throughout the county. There is only one public hospital in Nassau County—the

Nassau County Medical Center—and none in Suffolk. Distances from many parts of Nassau to the county medical center are considerable and the problem is compounded by serious deficiencies in public transportation.

Two years ago, the one-way bus fare from Port Washington (on the north shore of the County) to the county medical center was $1.20 and travel time was approximately 1 hour and 15 minutes. Thus, for a mother to make that trip with two children would have cost $7.20 round trip and she would spend 2½ hours just in travel time. Furthermore, for a person in pain or a mother with a sick child, a bus may be impractical or impossible; many people do not live within reasonable walking distance of bus routes; in some areas of the county, bus service is discontinued after 10 p.m. I was told recently of one person who found it so difficult to get to the Medical Center by public transportation that, despite a very limited family budget, she traveled by taxi, at a round trip cost of $10.50.

Physicians' offices are, of course, distributed more widely than hospital facilities. Although the ratio of physicians to general population is highly favorable (one physician to 527 people) by comparison to the U.S. average, physicians' offices are heavily concentrated in affluent areas of the county; in poor areas the number of physicians is extremely small and, by almost any criterion, grossly inadequate. The County Medical Center operates a neighborhood health center in southwestern Nassau, and North Shore Hospital operates one in the northwest. In many situations, however, poor people lack reasonable access to primary health care services. Those who cannot utilize the Nassau County Medical Center, because of distance, tend to utilize the clinic facilities of the seven voluntary hospitals or the four centers operated by the County Health Department, but the range of services at many of these facilities is limited. Since the hours at which service is available are also limited, persons tend to present themselves at hospital emergency rooms, which were never designed to handle the heavy demand for primary health services now being placed upon them.

Disease and death rates—for example, infant mortality and prevalence of tuberculosis—are high in those areas where the supply of physicians is low. This phenomenon is not due primarily to a shortage of physicians, but rather to the underlying factor of poverty which, itself, is the key reason for these areas being undersupplied with doctors.

I believe that Long Island—perhaps because of its proximity to New York City—has attracted physicians who are above average in terms of professional qualifications. Where the number of physicians is adequate, middle- and upper-income patients are able to secure relatively good medical care. I have already commented on some of the difficulties that beset the poor. The low-middle- and low-income families who have cars and are thus not dependent upon public transportation often find their access to medical care limited by financial barriers. Many have little or no health insurance; those who do commonly find that their "coverage" is riddled with gaps and leaves them more "exposed" than "covered."

Even under the best of conditions, for the relatively affluent patient, delivery of medical care in Nassau County suffers from the

same kinds of problems observed elsewhere in the country. Utilization of hospital facilities, as elsewhere, is distorted by the benefit structures of available Blue Cross and commercial insurance plans. Coordination of services among different sources of care is poor; there is duplication of some services and absence of others. Mental health services, including prevention and treatment of drug abuse, are woefully lacking. Solo practice of medicine is the prevailing pattern and the potential advantages that group practice has to offer—both to patients and to physicians—are yet to be tapped on a large scale.

The problems I have mentioned cannot properly be laid at the doorstep of the physicians or the hospitals in the area. One can cite any number of instances in which a particular doctor has extended himself in the most extraordinary ways to help patients—poor as well as rich; and instances in which hospitals have undertaken programs to aid communities despite the lack of available financing. I believe the difficulty resides more in the fact that all providers of health care—physicians, dentists, nurses, hospitals, departments of health—are functioning within an archaic system, recognizing the defects of the system but almost powerless to modify it significantly because its nature is determined by factors that are essentially nationwide in character. Until there is a rational system established in which the individual elements can be properly coordinated and can function effectively, I think we shall continue to have serious discrepancies and inequities in the level of care available to different elements of our population, and serious inefficiencies in many of our health care programs.

I consider the following to be fundamental premises upon which any effort to rationalize our health care system must be based:

(1) There must be full entitlement to comprehensive health care for all persons. We must not continue to tolerate different standards of health care for different people, based on economic status. Welfare medicine cannot be good medicine. Medicaid, despite initial hopes, has proven to be nothing but welfare medicine in a poorly disguised form, and is being cut back step-by-step, until it has become no more than a grotesque caricature of its originally stated intentions. I think it is clear that universal health insurance is an essential first step.

(2) Universal entitlement to health care will not, by itself, solve the problem. Reference is often made to our health care "delivery system." Unfortunately, health services cannot be delivered in the same sense that milk, groceries, or newspapers are delivered. The patient who needs a gastrectomy cannot decide for himself when it is needed or if it is needed, and cannot have it delivered to his home. He must have access to a system that will stress maintenance of good health, prevention of disease, early detection and prompt treatment—whenever practical, on an ambulatory basis—and prompt referral to any needed source of specialized care.

(3) A rational system can best be described by classifying health care into several levels: "Primary care" represents care rendered at the first point of contact. For minor conditions, definitive diagnosis can often be established and definitive treatment can sometimes be rendered at this point, but primary health care should not be de-

signed chiefly to accomplish this. Its major purpose should be to enable every person to receive prompt and easy access to the health-care system, with assurance either that definitive care will be rendered at the primary source or that he will be referred elsewhere for such care. Primary care may be provided by physicians in solo practice or in group practice, by hospital clinics or emergency rooms, by health department clinics, neighborhood health centers, and a variety of other sources.

"Secondary care" encompasses diagnostic or treatment services requiring knowledge, skills, equipment or other resources not available at the primary level. In addition to referrals for hospitalization, this would include referrals to consultant physicians—in solo practice, group practice, or on salary at a hospital—as well as referrals to hospital clinics or free-standing clinics and referrals for radiologic or laboratory procedures under either private or institutional auspices.

"Tertiary care" includes highly complex diagnostic and treatment services not available in most community hospitals, for which patients must be referred to major centers—for example, nuclear medicine, super-voltage radiotherapy, kidney dialysis, and cardiovascular surgery.

(4) If the system can be visualized as having these three major elements, we can clearly see the importance of developing close functional interrelationships among these elements. Such relationships should include procedures for the prompt referral of patients from one source of care to another; prompt transmittal of clinical data on each patient; efforts to establish reasonable uniformity of recordkeeping among all health-care agencies in a given area; and procedures designed to facilitate discussion of patient care problems and administrative problems among various sources of care. The recording and transmittal of clinical data in an organized and carefully structured format can be a key tool in maintaining a rational system of health care. The "problem-oriented medical record" pioneered by Dr. Lawrence Weed at the University of Vermont offers the promise of a major breakthrough in this area.

(5) Primary health care is the area where the need is greatest and where existing arrangements leave most to be desired. In the effort to improve primary health services, stress should be placed upon the following:

(*a*) Special programs should be developed for those areas that are otherwise inadequately supplied with health services. A reasonable pattern might be neighborhood health centers staffed along group practice lines by teams of physicians, social workers, nurses, physician assistants, and other allied health personnel.

(*b*) Hospital clinics, health department clinics, neighborhood health centers and other such sources of primary health care should provide service during evening and weekend hours. In situations where hospital emergency rooms are not readily accessible, limited staffing should be provided in clinics and health center facilities, 24 hours a day, 7 days a week.

(*c*) A significant problem is the tendency for some physicians to become relatively isolated from the mainstream of current scientific and medical practice. Lack of a hospital staff appointment can repre-

sent an almost insuperable obstacle to a doctor's keeping abreast of new developments. Every physician should have a hospital staff appointment. Those who cannot meet the standards for staff appointments should have access to continuing education programs and incentives should be developed—for example, periodic relicensure—to strongly encourage participation in such programs.

(*d*) Physicians should be encouraged to develop group practice arrangements, through such means as support for construction of facilities, special grant support for effective experimental or demonstration projects, and provision of reimbursement incentives to reward demonstrated efficiency.

(*e*) More imaginative and more extensive use should be made of nonphysician health-care personnel. New roles for existing categories and the development of completely new categories of personnel—for example, physician assistants—must be explored. Let me stress that I believe it would be an error for educators and administrators to create training programs for new types of personnel or to establish experimental staffing patterns in isolation from the professional groups concerned and from the community-at-large. For example, I believe that physician assistants will be able to play a useful role only if plans for their training and their future roles are developed in concert with practicing physicians, who will be their supervisors; with practicing nurses, who will be their coworkers; and with representatives of the community-at-large, who will be consumers of the services they will provide.

(*f*) The emphasis, in primary care, must be upon maintenance of health, prevention of disease, and early detection of disease. Such emphasis can be expected only if health insurance benefits are designd so as to encourage ambulatory services in general and preventive services in particular.

(*g*) Medical care should be given at that level within the system which can handle the problem least expensively, consistent with the needs of the patient.

(*h*) The rights and feelings of every patient must be protected. A doctor cannot treat effectively any patient whose personal dignity he disregards, whether that patient be elderly, black, non-English-speaking, or a long-haired youth.

(*i*) Multiphasic screening can be a valuable element of the primary health-care network, provided that all patient information required by such a screening unit is transmitted to an appropriate source of medical care for follow-up and for incorporation into each individual's permanent clinical record.

(6) In giving attention to the health services that I have classified as primary, secondary, and tertiary, we should not overlook such institutions as skilled nursing homes, convalescent homes, rehabilitation facilities, and domicilliary facilities, which do not fall logically into the categories outlined above. These institutions represent vital elements in the health-care system and must be tied effectively into any network of health services. Physicians, nurses, and other personnel working in these institutions should have some type of affiliation with community hospitals and medical centers. The traditional isolation that has made intermediate and long-stay institutions unattractive to professional personnel must be ended.

I want to close with three general observations which I believe are of fundamental importance in any efforts toward improving health services in this country. First, medical care is not an end in itself, but is only one of the methods by which society seeks to secure the maximum degree of health for its citizens. There are other vital determinants of health. Broad social reforms, such as protection and control of our environment, adequate housing for all, adequate employment for all, and adequate education for all will do more to secure the health of our citizenry than the doubling of our medical care manpower and capital plant. This does not mean that I regard the issues I have addressed in this statement as trivial, but rather that I believe they should be seen in the broadest possible perspective.

Second, I believe that consumers of health care must be seriously involved in developing overall policy directions for health. I am not referring to scientific and technical decisions, but to broad policy issues. I believe those of us who hold professional positions make a serious mistake when we seek to establish policy in line with our own concepts of what is needed, without sufficient regard for consumers' perceptions of their own needs. Thus, although the proposals I have outlined in this statement represent my personal views, I would want to see them tested in the fire of consumer participation. The comprehensive health planning agencies that have been established in States and regions throughout the country under Public Law 89–749 are a significant step in the direction of consumer participation and should, in my opinion, be encouraged and supported.

Third and last, when one endeavors to outline a program involving significant organizational change, there is always the danger that it will appear oversimplified and will be interpreted as a plea for a rigid, monolithic system. This is certainly not my intention. For example, although I believe that group practice and development of new ways to utilize supporting personnel will permit significant improvements in the delivery of health care, I do not believe that physicians now in solo practice can be expected to abandon overnight the professional patterns to which they have been accustomed throughout their careers and to conform to new patterns with which they are unfamiliar. However, incentives can and should be developed that will encourage physicians newly embarking on their careers—as well as those already in practice—to examine the advantages that group practice can offer to themselves and to their patients.

Whatever the defects in our medical care system—and they are many—there is also much that is good, and this can be lost to us if we attempt to impose Utopia through bureaucratic or legislative mandate. Utopia will always be out of reach—as it should be—but we will approach it best through a process in which providers and consumers share the responsibility for major policy directions and in which thoughtful legislation, making reasonable use of incentives, represents the vehicle for change.

Thank you.

(The following information was subsequently supplied for the record:)

The consumer—the patient or his advocate—must begin to have a voice in planning and policy-making if we are to obtain comprehensive health services.

ROLE FOR THE CONSUMER

PETER ROGATZ AND MARGE ROGATZ

PETER ROGATZ, M.D., is Professor of Community Medicine and Director of the University Hospital at the State University of New York at Stony Brook. MARGE ROGATZ worked for CORE, Head Start In-Service Training, and, most recently, the Organization for Social and Technical Innovation (OSTI).

Until recent years, the hospital with the most prestige and the greatest ability to confer prestige upon those associated with it (administrators, physicians, trustees) was the hospital offering the largest number of beds, the most elaborate radiologic facilities, and the most spectacular surgical procedures. With this prestige comes power—power within professional organizations and within the political environment of the community—and, more often than not, monetary rewards.

In the past few years we have seen some modest changes in the system of rewards and approvals, so that the most elaborate hospital is not always viewed as "the best"; and often the administrators, physicians, and trustees of the very elaborate hospitals bear the onus of explaining whether the hospital has been overnourished at the expense of sound community planning, whether it has become a source of ego gratification for its leaders at the expense of self-restraint and interinstitutional cooperation that might better serve the interests of its community.

Although the new trend has not been dramatic, we can perceive today that some of the rewards of professional prestige, community approval, and federal funding are beginning to go to those administrators, physicians, and trustees who have committed their institutions to a more balanced program, one more cognizant of, and responsive to, community needs. There is a slowly dawning awareness, for example, that a comprehensive mental health center may be more valuable than a unit for open-heart surgery, a neighborhood outreach program more worthwhile than a supervoltage radiotherapy unit or a hyperbaric chamber. But these new values need to be incorporated into an incentives system. Accrediting bodies and third-party payers, along with public information media, have the power to reward those institutions and programs that enable middle- and low-income consumers to participate actively in policy-making.

Clearly, this will not happen merely because consumers say it should. It can, and should, happen as a consequence of a dialogue among consumers, professionals, and trustees. If such a dialogue does not develop, or if it fails to produce a working consensus on involvement of consumers in an effective way, then consumers must take their case to third-party payers, accrediting bodies, and public information media, which represent the most effective points of leverage.

PLANNING AND POLICY-MAKING

Until recently, opportunities for consumers to play a meaningful role in the development of national policy for health care have been distinctly limited. Except for occasional "blue

ribbon" advisory panels and occasional testimony before Congressional committees and at other public hearings, there are no channels for consumer input at the national level. Some believe that the recent establishment of statewide and regional comprehensive health planning agencies, with no less than 51 percent consumer membership mandated, will represent a new channel for affecting national policy. This view may be prematurely optimistic. We do not know yet whether such regional and state groups will be genuinely representative or how much power they will acquire; nor do we have any indication thus far that the chaotic and fragmented process by which national health policies are developed in the executive branch and in Congress will be responsive to inputs from these groups.

Simply mandating a technical majority of consumers offers no assurance that the decision-making processes will not continue to be dominated, directly or indirectly, by professionals. First, many individual consumers are unconsciously under the spell of the professional. Second, professionals have both an economic and an emotional stake in the decisions of these agencies and usually are able to attend meetings with greater regularity than the lay person. Third, there is always the possibility that even a majority of consumers at a given meeting may be outmaneuvered by the professionals who, after all, are operating on their own turf. In recent years, consumers have dealt with this by using the tactics of confrontation, boycott, and packing of meetings. Such tactics may spread, but must sooner or later be replaced by ongoing, effective interaction if adequate care is to be regularly provided and received.

This interaction is most necessary at the local level, and it is locally that the greatest opportunities exist for consumers to assume a directive role in planning. Organization to obtain representation, accountability, and responsiveness is more feasible at the local level than at higher echelons. The financial and time commitment required to attend even local meetings regularly is difficult for many consumers, but it is less of an obstacle when the meetings are near home. Once the local planning agencies and boards of trustees have been altered to reflect the economic, ethnic, and age composition of the communities they serve, comparable action at regional and national levels may be facilitated.

What of the frequent argument that the poor are "not ready" for major roles on boards of trustees because they lack experience in such matters as financial management? In fact, lack of such experience is less of a handicap than that faced by an affluent white banker who is knowledgeable in the preparation of budgets but has no experience with deficiencies in the delivery of health care to the poor. Members of the upper middle class, of course, have been serving on the boards of health agencies and boards of education for generations. Not surprisingly, the question of "readiness" was raised only when low-income blacks and Puerto Ricans began to assert their determination to direct the institutions in their own communities. The question is prejudiced and self-serving.

Since consumers, directly or indirectly, must foot the bill for abuse of hospital facilities, are they not entitled to information about the deliberations of the utilization committees charged with preventing unnecessary use of hospital beds and/or ambulatory facilities? Should this not extend beyond mere information to actual participation in the deliberations of such committees? Although this raises questions of confidentiality and technical competence, the former issue can be resolved, and the latter is probably not a valid concern. There is no reason why a lay person cannot understand the matters dealt with by a hospital utilization committee and contribute constructively to its deliberations. There is no reason, for that matter, why consumer-established standards should not be included as criteria in every aspect of health program evaluation.

"Criteria for the selection and evaluation of students, staff, and faculties of professional schools must be reexamined in the light of consumer needs and experiences."

MEDICAL EDUCATION

One further area that might, at first glance, seem totally outside the purview of the consumer is professional education. Yet herein lies one of the most critical keys to a reorientation of the health-care system in this country if it is to attain greater responsiveness to the needs of users. Consumers must be included in decisions affecting this crucial element of the macrosystem. Criteria for the selection and evaluation of students, staff, and faculties of professional schools must be reexamined in the light of consumer needs and experiences. The same is true for the design and content of curricula and materials. Traditional models—such as the goal of "scientist-practitioner"—need fresh scrutiny, with active participation by consumer spokesmen. New models being developed at a few schools, such as Case Western Reserve (Cleveland, Ohio), stress early relationships with patients. These models need encouragement and support.

Until recently, the idea that a patient might have some useful ideas

about the education of a doctor, nurse, or social worker would have been inconceivable. The patient has always been utilized essentially as an inanimate object in the teaching process. He is a subject for examination; and if he is invited to speak at all, it is only for the purpose of reciting his symptoms so that the student can evaluate his illness.

However, students can also learn much from patients about provider-user relationships. It is time for the consumer—the patient—to become a teacher as well. Some police departments, recognizing the need for policemen to better understand those with whom they are so often in confrontation, have asked students and representatives of the poor to participate in training seminars. Why shouldn't professionals in the health field show at least as much enlightened self-interest in exposing themselves, in their own education, to those who are, or will be, their clients?

Implicit in the preceding discussion is the unsettling thought that there may actually be something inherent in the training of the professional that helps to build a barrier between him and his patients, blurring communication, making him resistant (perhaps subconsciously) to certain of his patients' demands, and making the patient suspicious of the professional's ability or willingness to provide the care that is needed. Often when a member of the indigenous poor secures access to a provider role—even as an aide or a paraprofessional—he is subject to many of the same symptoms of professionalism that afflict physicians, nurses, and social workers. Can we learn how best to encourage the nurse's aide, as well as the physician, to resist adopting the mystique of the professional? This would involve both behavioral scientists and community groups in designing and implementing new patterns of training. Neighborhood health centers, from Mississippi to New York, have used such training and have established promising models.

References here to the consumer's need to speak for himself and confront the professional establishment should not obscure the fact that the consumer does have allies in the professional world who are addressing themselves seriously to his needs and concerns. Far more active than established professionals are the students. Increasing numbers of medical students, for example, are telling their deans and professors that, although they are confident of being well educated scientifically and technologically, they want their schools to be concerned with the application of science and technology in the day-to-day delivery of personal health care.

Students learn at least as much by example as by precept, and role models are of great importance in forming future attitudes. It does little good to tell students about a hospital's responsibilities to its community if they observe in the emergency room of their university hospital that patients with conditions that do not satisfy the intellectual interest of their staff or faculty are shunted away to other hospitals. Nor is there much value in lecturing about the dignity of the individual when students observe the predisposition of doctors and nurses to patronize patients from minority groups and those of low income by addressing them by first name (while the patient, of course, is expected to use formal terms of address when speaking to a doctor or nurse). These examples have a fundamental impact upon the attitudes of students in medicine and nursing.

Many medical schools reserve their highest rewards (in terms of promotion, tenure, and salary) for those faculty members who are concerned primarily with research, rather than for those concerned with patient care. Students can hardly fail to be influenced by such practices. This is not to say that medical schools should stop doing research or that they should admit to the hospital any patient who presents himself to the emergency room and demands admission regardless of valid clinical indications. It is to say, however, that many of the practices and procedures followed in our professional schools and university hospitals offer an example of indifference to patient care that belies the stated purposes of these institutions. Consumers and their allies among students and professionals must be listened to and heeded in these respects.

"The more local the focus of a particular program, the more critical it is that consumers participate actively in it."

PROGRAMS AND SERVICES

This nation is just beginning to give lip service to the point of view that the delivery of health care is sufficiently important and complex to require the development of a carefully designed network of coordinated programs. Such programs must range from health promotion and maintenance, through prevention, screening, and early detection, to an integrated network of primary, secondary, and tertiary centers for diagnostic and treatment services.

Well-informed professionals, with good intentions, have persistently and self-righteously resisted the obvious fact that consumers must have a significant role in the design, implementation, and evaluation of health-care services. Indeed, some programs (for example, those for the prevention of venereal disease or lead poisoning) can be successful only insofar as residents of the community participate in their development, in disseminating information about them, and in their staffing.

The more local the focus of a particular program, the more critical it is that consumers participate actively in it. A graphic example is the recent "hijacking" by the Young Lords of a mobile tuberculosis screening unit operated by the New York City Department of Health. The Young Lords believed that a change in the location of the unit would produce a substantial increase in utilization and, through the dramatic "hijacking," they effectively demonstrated this point.

The problem is not that professionals are trying to put something over on their patients, but that the perceptions of providers differ substantially from those of consumers. More importantly, underlying assumptions of providers and consumers differ significantly.

59-661 O - 71 - pt. 8 - 9

The professional sees himself as the central or pivotal figure in the provider-user equation: it is he who possesses the vital knowledge and who must perform numerous tasks within a limited period of time in order to care for a large number of patients. They, after all, are the ones in need; and if they wish to have their needs met, they must make themselves available to him at the times and places and under circumstances that make it possible for him to function with the greatest economy of effort.

The consumer, on the other hand, sees it differently: he needs relief from pain, disability, or anxiety; and he sees it as the provider's responsibility to help him obtain that relief. Poor consumers are beginning to come to the point of view that affluent consumers have long held—that optimum health care can be provided only under conditions that protect the dignity and convenience of the patient as well as of the physician and the nurse.

This latter view is gradually coming into vogue among professionals; but, here again, it is one thing to give lip service to this point of view and quite another to function under conditions that are determined by this premise. Professionals will find it difficult and irksome to function under consumer surveillance and will be quick to charge that this will result in unwarranted and dangerous interference with medical practice. Consumers and professionals will have to confront a host of questions, ranging from minor procedures to fundamental policy.

Shall the outpatient department be organized primarily along departmental lines, or shall each clinic be oriented toward comprehensive health services, with consultants on call at every clinic? Many physicians believe that conversion to comprehensive clinics will make it more difficult and time-consuming to treat patients with common specialty problems. Consumers seem to feel that a patient's total needs are more likely to be met by a comprehensive clinic than by a series of isolated specialty clinics. Professionals argue that if specialists do not have ongoing involvement with concentrated pools of patients, their specialized skills will atrophy and will

no longer be adequate to serve the needs of consumers. Consumers counter that the main advantage of specialty clinics is to serve the academic curiosity and ego needs of the specialist.

Consumers assert that nursing procedures, such as waking patients at early hours for temperature-taking and baths, are designed for the convenience of the nursing personnel. Nurses and hospital administrators respond that the realities of staffing patterns and the multiplicity of the essential procedures to be carried out throughout the day make it impractical to allow each patient to wake at his own convenience. Consumers complain that mealtimes are set for the convenience of the staff; the professionals counter with arguments relating to the demands of personnel schedules and the complexity of overall hospital operations.

Consumer participation in the planning process is likely to result in services' being brought to neighborhoods where consumers work and live, rather than the construction of facilities that require people to travel unreasonable distances to obtain primary health care. When communities have been permitted to join in planning for their own services, many have proposed such measures as greater use of mobile health units and the placing of facilities in stores, housing developments, and other outreach sites. In addition to improved physical access for users (leading to improved utilization and, one hopes, improved health), such outreach arrangements increase the likelihood that professionals will become better acquainted with the living and working conditions of those they serve.

Hospitals and other agencies that establish outreach facilities may find that staffing advantages result. The chronic shortage of personnel that afflicts large, centralized facilities may be substantially ameliorated when facilities are decentralized and thus are accessible to potential pools of employees. This assumption, of course, rests on the premise that hospitals and health-care agencies are prepared to draw upon indigenous groups as sources of manpower for jobs beyond the menial ones to which they have been traditionally confined.

The combination of readiness to train and employ indigenous persons for semiprofessional and professional jobs and decentralization of formerly centralized facilities offers the promise of very significant improvement in the nation's ability to meet its health manpower needs. This solution can be effective only if there is cooperative planning among provider agencies, professional schools, and communities. There must be arrangements that assure that a steady supply of indigenous applicants will be accepted by the professional schools and that, when they subsequently return to their own local communities, they will be reasonably sure of employment by the provider agencies.

PATIENT-ADVOCATES

In the final analysis, there are few unassailably "right" answers; and differences of opinion will be resolved in favor of whichever side holds an edge in terms of power. What must be sought is a reasonable balance of power between providers and consumers—a balance that will persuade each to listen to the other with some degree of restraint, respect, and attention and that will, in the long run, enable both points of view to be worked into a series of compromises that will best serve the needs of the community of which the professional, too, is a part.

Special arrangements will have to be made if consumers are to participate to the extent proposed here. Day-care programs, which should be provided for employees who need them, should be available also for those consumers who, as patients, as visitors, or as members of boards and committees, require such services. Additional assistance may also be necessary for travel subsidies, for example, to enable consumers to attend meetings.

Until programs and services receive enough consumer input to be reasonably responsive to consumer demand, there will be a continuing need in almost every program for a patient-advocate, or ombudsman. Such a person, selected by the community, should be particularly sensitive to, and have the ability to intervene on behalf of, consumers whose needs are not being met.

Introduction of a patient-advocate raises complex and sensitive issues. If the advocate is to function effectively, he must be able to report his findings to the community—that is, to a body representing the community. Neither the administrator nor any group made up exclusively of professionals—no matter how well motivated—can serve as his sole channel of reporting. Although it is vital that the professional (including administrative) staff be aware of what the ombudsman learns, his authority must derive from the community, or he will be essentially impotent to effect change. If the board of trustees is broadened to include low-income consumers, it may be able to serve as the ombudsman's line of reporting. A community advisory board can serve this function, but its effectiveness will depend on the extent to which it (the advisory board) has access to, and influence upon, the board of trustees.

The matters that will concern a patient-advocate range from mundane to fundamental. Is there a faulty air conditioner in a patient's room that has not been repaired? Are outpatient clinic hours set without regard for patient needs? Are patients who seek abortions subject to unreasonable delays? Because of the wide range of problems with which he must deal, the ombudsman must have access to lines of communication that will assure prompt repair of the air conditioner as well as lines of communication that will affect long-range policy issues.

Consumers in policy roles and nonprofessionals in service roles represent a long-overdue invasion of the health field on two fronts. This invasion may ultimately produce important changes in the attitudes of providers and users, rich and poor. In the process, there will undoubtedly be innumerable confrontations and severe upheaval. But health services will not become consumer-responsive until consumers in all economic groups are accepted as full partners in directing basic reform of the total health system. ■

Senator KENNEDY. Thank you very much.

Senator Dominick I think has some questions.

Senator DOMINICK. I have just one question, Doctor. We have an effort going in our city of Denver to provide linkage between the primary, secondary, and tertiary care system by electrograph computer bank which is community based supported by three of the principal proprietary hospitals, not voluntary hospitals, and linked in with outlying areas, so that a doctor can call up and say, "look, I have got the electrodes on this guy, this is what it shows," it goes into the bank, and out this comes on the panel. Now the cardiologist goes over to make sure the computer hasn't made a mistake, which I think is necessary in a community center.

I think this is the type of thing which seems to me to be on its way. Do you know many places where this is going on? We had Dr. Schwartz, I believe it was, testify. Dr. Weed has testified. Are there other places that are doing this?

Dr. ROGATZ. There are experimental demonstration efforts along this line. It happens that electrocardiography lends itself well to this type of computer analysis. And I do believe in fact that except in very, very rare kinds of electrocardiography the computer is as good as the physician in interpretation. There are other kinds of medical services that do lend themselves to the use of modern technology. Multiphasic screening, which is a way of testing large numbers of apparently well people for evidence of latent disease, is another important example. Laboratory procedures can be now handled extremely well by computer.

And I think while every once in so often we get a little bit concerned that the computer is going to mechanize and dehumanize the patient's care, in fact if we recognize it as a tool, and as a tool which we control rather than allowing that tool to control us, we can really greatly facilitate patient care and at the same time leave professionals more time and leave them more free to deal with the direction personal doctor-patient contact, and I think that this kind of tool is one that we should use and exploit.

Senator DOMINICK. Thank you, Doctor. I look forward to reading your full statement, and I think you have been very helpful. I really appreciate it.

Senator KENNEDY. Thank you very much.

(The prepared statement of Peter Rogatz, M.D., follows:)

TESTIMONY BEFORE SENATE SUB-COMMITTEE ON HEALTH
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE

April 15, 1971

Hofstra University, Hempstead, New York

by

Peter Rogatz, M.D.

Mr. Chairman, my name is Peter Rogatz. I am Associate Director for Patient Care Services at the Health Sciences Center being developed on the Stony Brook, Long Island campus of the State University of New York. I am Director of the University Hospital and Professor of Community Medicine at the Health Sciences Center, Vice-Chairman of the Nassau-Suffolk Comprehensive Health Planning Council and Vice-President of the Health and Welfare Council of Nassau County.

It is a privilege to be invited to offer this testimony to your Committee. These views are my own. I am not speaking as a representative either of the State University or of any other organization with which I am associated.

Long Island, comprising the two counties of Nassau and Suffolk, represents a total area of approximately 1,400 square miles and a population exceeding 2.5 million. Because Long Island contains a variety of urban, suburban, exurban and rural communities, it is in some respects a microcosm of the United

States. The problems of health and medical care in Long Island exemplify those of our country as a whole. At the risk of over-simplification, I would say that, in general, Suffolk County is primarily exurban and rural in character, while Nassau County is more typically suburban, with some significant urban concentrations. It is my understanding that this hearing is concerned chiefly with "suburbia," and I will therefore concentrate my comments on Nassau County.

Economic levels in the County range from extreme affluence in some of the suburban "bedroom communities," to bitter poverty in urban slums and in small, depressed "poverty pockets" that are scattered throughout Nassau.

Hospitals, some of very good quality, are dispersed throughout the County. There is only one public hospital in Nassau County -- the Nassau County Medical Center -- and none in Suffolk. Distances from many parts of Nassau to the County Medical Center are considerable and the problem is compounded by serious deficiencies in public transportation.

Two years ago, the one-way bus fare from Port Washington (on the North Shore of the County) to the County Medical Center was $1.20 and travel time was approximately one hour and fifteen minutes. Thus, for a mother to make that trip with two children would have cost $7.20 round trip and she would spend two and a

half hours just in travel time. Furthermore, for a person in pain or a mother with a sick child, a bus may be impractical or impossible; many people do not live within reasonable walking distance of bus routes; in some areas of the County, bus service is discontinued after 10:00 pm. I was told recently of one person who found it so difficult to get to the Medical Center by public transportation that, despite a very limited family budget, she travelled by taxi, at a round trip cost of $10.50.

Physicians' offices are, of course, distributed more widely than hospital facilities. Although the ratio of physicians to general population is highly favorable (one physician to 527 people) by comparison to the U.S. average, physicians' offices are heavily concentrated in affluent areas of the County; in poor areas the number of physicians is extremely small and, by almost any criterion, grossly inadequate. The County Medical Center operates a neighborhood health center in southwestern Nassau, and North Shore Hospital operates one in the northwest. In many situations, however, poor people lack reasonable access to primary health care services. Those who cannot utilize the Nassau County Medical Center, because of distance, tend to utilize the clinic facilities of the seven voluntary hospitals or the four centers operated by the County Health Department, but the range of services at many of these facilities is limited.

Since the hours at which service is available are also limited, persons tend to present themselves at hospital emergency rooms, which were never designed to handle the heavy demand for primary health services now being placed upon them.

Disease and death rates -- for example, infant mortality and prevalence of tuberculosis -- are high in those areas where the supply of physicians is low. This phenomenon is not due primarily to a shortage of physicians, but rather to the underlying factor of poverty which, itself, is the key reason for these areas being under-supplied with doctors.

I believe that Long Island -- perhaps because of its proximity to New York City -- has attracted physicians who are above average in terms of professional qualifications. Where the number of physicians is adequate, middle-and upper-income patients are able to secure relatively good medical care. I have already commented on some of the difficulties that beset the poor. The low-middle and low-income families who have cars and are thus not dependent upon public transportation often find their access to medical care limited by financial barriers. Many have little or no health insurance; those who do commonly find that their "coverage" is riddled with gaps and leaves them more "exposed" than "covered."

Even under the best of conditions, for the relatively affluent patient, delivery of medical care in Nassau County suffers from the same kinds of problems observed elsewhere in the country. Utilization of hospital facilities, as elsewhere, is distorted by the benefit structures of available Blue Cross and commercial insurance plans. Coordination of services among different sources of care is poor; there is duplication of some services and absence of others. Mental health services, including prevention and treatment of drug abuse, are woefully lacking. Solo practice of medicine is the prevailing pattern and the potential advantages that group practice has to offer -- both to patients and to physicians -- are yet to be tapped on a large scale.

The problems I have mentioned cannot properly be laid at the doorstep of the physicians or the hospitals in the area. One can cite any number of instances in which a particular doctor has extended himself in the most extraordinary ways to help patients -- poor as well as rich; and instances in which hospitals have undertaken programs to aid communities despite the lack of available financing. I believe the difficulty resides more in the fact that all providers of health care -- physicians, dentists, nurses, hospitals, departments of health -- are functioning within an archaic system, recognizing the defects of the system but almost powerless to modify it significantly because

its nature is determined by factors that are essentially nationwide in character. Until there is a rational system established in which the individual elements can be properly coordinated and can function effectively, I think we shall continue to have serious discrepancies and inequities in the level of care available to different elements of our population, and serious inefficiencies in many of our health care programs.

I consider the following to be fundamental premises upon which any effort to rationalize our health care system must be based:

1. There must be full entitlement to comprehensive health care for all persons. We must not continue to tolerate different standards of health care for different people, based on economic status. Welfare medicine cannot be good medicine. Medicaid, despite initial hopes, has proven to be nothing but welfare medicine in a poorly disguised form, and is being cut back step-by-step, until it has become no more than a grotesque caricature of its originally-stated intentions. I think it is clear that universal health insurance is an essential first step.

2. Universal entitlement to health care will not, by itself, solve the problem. Reference is often made to our health care "delivery system." Unfortunately, health

services cannot be delivered in the same sense that milk, groceries or newspapers are delivered. The patient who needs a gastrectomy cannot decide for himself when it is needed or if it is needed, and cannot have it delivered to his home. He must have access to a system that will stress maintenance of good health, prevention of disease, early detection and prompt treatment (whenever practical, on an ambulatory basis), and prompt referral to any needed source of specialized care.

3. A rational system can best be described by classifying health care into several levels: Primary care represents care rendered at the first point of contact. For minor conditions, definitive diagnosis can often be established and definitive treatment can sometimes be rendered at this point, but primary health care should not be designed chiefly to accomplish this. Its major purpose should be to enable every person to receive prompt and easy access to the health care system, with assurance either that definitive care will be rendered at the primary source or that he will be referred elsewhere for such care. Primary care may be provided by physicians in solo practice or in group practice, by hospital clinics or emergency rooms, by health department clinics, neighborhood health centers, and a variety of other sources.

Secondary care encompasses diagnostic or treatment services requiring knowledge, skills, equipment or other resources not available at the primary level. In addition to referrals for hospitalization, this would include referrals to consultant physicians (in solo practice, group practice, or on salary at a hospital), as well as referrals to hospital clinics or free-standing clinics and referrals for radiologic or laboratory procedures under either private or institutional auspices.

Tertiary care includes highly complex diagnostic and treatment services not available in most community hospitals, for which patients must be referred to major centers (e.g., nuclear medicine, super-voltage radiotherapy, kidney dialysis and cardiovascular surgery).

4. If the system can be visualized as having these three major elements, we can clearly see the importance of developing close functional inter-relationships among these elements. Such relationships should include procedures for the prompt referral of patients from one source of care to another; prompt transmittal of clinical data on each patient; efforts to establish reasonable uniformity of record-keeping among all health care agencies in a given area; and procedures designed to facilitate discussion of patient care

problems and administrative problems among various sources of care. The recording and transmittal of clinical data in an organized and carefully structured format can be a key tool in maintaining a rational system of health care. The "problem-oriented medical record" pioneered by Dr. Lawrence Weed at the University of Vermont offers the promise of a major breakthrough in this area.

5. Primary health care is the area where the need is greatest and where existing arrangements leave most to be desired. In the effort to improve primary health services, stress should be placed upon the following:

(a) Special programs should be developed for those areas that are otherwise inadequately supplied with health services. A reasonable pattern might be neighborhood health centers staffed along group practice lines by teams of physicians, social workers, nurses, physician assistants and other allied health personnel.

(b) Hospital clinics, health department clinics, neighborhood health centers and other such sources of primary health care should provide service during evening

and weekend hours. In situations where hospital emergency rooms are not readily accessible, limited staffing should be provided in clinics and health center facilities, 24 hours a day, seven days a week.

(c) A significant problem is the tendency for some physicians to become relatively isolated from the mainstream of current scientific and medical practice. Lack of a hospital staff appointment can represent an almost insuperable obstacle to a doctor's keeping abreast of new developments. Every physician should have a hospital staff appointment. Those who cannot meet the standards for staff appointments should have access to continuing education programs and incentives should be developed (e.g., periodic relicensure) to strongly encourage participation in such programs.

(d) Physicians should be encouraged to develop group practice arrangements, through such means as support for construction of facilities, special grant support for effective experimental or demonstration projects, and provision of reimbursement incentives to reward demonstrated efficiency.

(e) More imaginative and more extensive use should be made of non-physician health care personnel. New roles

for existing categories and the development of completely new categories of personnel (e.g., physician assistants) must be explored. Let me stress that I believe it would be an error for educators and administrators to create training programs for new types of personnel or to establish experimental staffing patterns in isolation from the professional groups concerned and from the community-at-large. For example, I believe that physician assistants will be able to play a useful role only if plans for their training and their future roles are developed in concert with practicing physicians (who will be their supervisors), with practicing nurses (who will be their co-workers) and with representatives of the community-at-large (who will be consumers of the services they will provide).

(f) The emphasis, in primary care, must be upon maintenance of health, prevention of disease and early detection of disease. Such emphasis can be expected only if health insurance benefits are designed so as to encourage ambulatory services in general and preventive services in particular.

(g) Medical care should be given at that level within the system which can handle the problem least expensively, consistent with the needs of the patient.

(h) The rights and feelings of every patient must be protected. A doctor cannot treat effectively any patient whose personal dignity he disregards, whether that patient be elderly, black, non-English-speaking, or a long-haired youth.

(i) Multiphasic screening can be a valuable element of the primary health care network, provided that all patient information required by such a screening unit is transmitted to an appropriate source of medical care for follow-up and for incorporation into each individual's permanent clinical record.

6. In giving attention to the health services that I have classified as primary, secondary and tertiary, we should not overlook such institutions as skilled nursing homes, convalescent homes, rehabilitation facilities and domiciliary facilities, which do not fall logically into the categories outlined above. These institutions represent vital elements in the health care system and must be tied effectively into any network of health services. Physicians, nurses and other personnel working in these institutions should have some type of affiliation with community hospitals and medical centers. The traditional isolation that has made intermediate and long-stay institutions unattractive to professional personnel must be ended.

I want to close with three general observations which I believe are of fundamental importance in any efforts toward improving health services in this country. First, medical care is not an end in itself, but is only one of the methods by which society seeks to secure the maximum degree of health for its citizens. There are other vital determinants of health. Broad social reforms, such as protection and control of our environment, adequate housing for all, adequate employment for all and adequate education for all will do more to secure the health of our citizenry than the doubling of our medical care manpower and capital plant. This does not mean that I regard the issues I have addressed in this statement as trivial, but rather that I believe they should be seen in the broadest possible perspective.

Second, I believe that consumers of health care must be seriously involved in developing overall policy directions for health. I am not referring to scientific and technical decisions, but to broad policy issues. I believe those of us who hold professional positions make a serious mistake when we seek to establish policy in line with our own concepts of what is needed, without sufficient regard for consumers' perceptions of their own needs. Thus, although the proposals I have outlined in this statement represent my personal views, I would want to

see them tested in the fire of consumer participation. The comprehensive health planning agencies that have been established in states and regions throughout the country under Public Law 89-749 are a significant step in the direction of consumer participation and should, in my opinion, be encouraged and supported.

Third and last, when one endeavors to outline a program involving significant organizational change, there is always the danger that it will appear over-simplified and will be interpreted as a plea for a rigid, monolithic system. This is certainly not my intention. For example, although I believe that group practice and development of new ways to utilize supporting personnel will permit significant improvements in the delivery of health care, I do not believe that physicians now in solo practice can be expected to abandon overnight the professional patterns to which they have been accustomed throughout their careers and to conform to new patterns with which they are unfamiliar. However, incentives can and should be developed that will encourage physicians newly embarking on their careers -- as well as those already in practice -- to examine the advantages that group practice can offer to themselves and to their patients.

Whatever the defects in our medical care system -- and they are many -- there is also much that is good, and this can

be lost to us if we attempt to impose Utopia through bureaucratic or legislative mandate. Utopia will always be out of reach -- as it should be -- but we will approach it best through a process in which providers and consumers share the responsibility for major policy directions and in which thoughtful legislation, making reasonable use of incentives, represents the vehicle for change.

Senator KENNEDY. Our final witness was to have been Dr. Leo Fishel, president of the Nassau County Medical Society. I understand that Dr. Fishel is ill, and I believe that Dr. Glaubitz is here with his statement.

STATEMENT OF DR. JOHN GLAUBITZ, ACTING PRESIDENT, NASSAU COUNTY MEDICAL SOCIETY

Dr. GLAUBITZ. I am Dr. John Glaubitz, speaking for the Nassau County Medical Society.

Senator KENNEDY. I again apologize to you for the lateness of the hour and the difficulties we are having. But I would appreciate it if you would submit your statement, it will be printed in its entirety, and perhaps you could make any comments you care to.

Dr. GLAUBITZ. Fine; I would like under that circumstance to make two comments.

We have been very interested in peer review. We have had an active committee for the past 12 to 18 months.

We are involved in setting up a medical services foundation. It is the nature of our problem in medicine that our story doesn't get around very well, and certainly that was made evident to me today.

I think those are the two areas in which we in Nassau County have been working to try to answer some of the problems of access to the medical care system, the quality and the cost.

Senator KENNEDY. What about the peer review in terms of solo practice? Is this something that you——

Dr. GLAUBITZ. Yes, sir; we are involved with peer reviewed in the solo practice. In the past 12 months we have submitted two cases to the district attorney, one to the State department of education, and three cases to the Board of Censors of the Nassau County Medical Society.

Senator KENNEDY. And are there other societies that you know in the State that have this kind of a——

Dr. GLAUBITZ. Yes; but even in our own situation this is only a beginning. We get cases from insurance companies, from people who have a complaint. We are interested in a larger input. But for that we need electronic data processing. We would like to expand our endeavors.

Senator KENNEDY. What about the peer review of one doctor, this sort of backscratching kind of effect? Does this concern you? Would you rather have peer review of doctors reviewing other doctors' work that are outside the community, or at least maybe within the community but have very little kind of association?

Dr. GLAUBITZ. Well, we thought about that, and with the answer that I gave of some of the cases that we have actually turned over to various authorities, actually the doctor is hardest on himself. We have at least six to 12 cases a month in which recommendations are made on reduction of fees. We have actively gotten into this and feel that the local scoiety man is best able to do it especially in a society with at least several hundred members.

Senator KENNEDY. Senator Dominick.

Senator DOMINICK. Doctor, I am glad you brought these points up because previous testimony would indicate that none of this stuff was going on, and I was wondering what had happened in the Nassau County Medical Association. I am glad to hear it is alive and on its feet. This is very encouraging. And I have no real questions. I look forward to reading the testimony when you can get it in to us.

I just have perhaps one point. The experience we have indicates that the doctors as a whole in our city, where we are trying a foundation supported by an insurance company with peer review, are coming in without any problems at all. Is this true in your situation, or are you having some problems?

Dr. GLAUBITZ. Not completely; there is a segment of physicians resisting this particular effort, and we are not sure whether it should be translated to a resistance to the peer review aspect or the fee aspect. We are not sure.

We believe that we will have a viable foundation and it will be participated in by a majority of the physicians, but by no means will it be the entire society, from where we can see at this point.

Senator DOMINICK. One other question which I think has not been covered in previous hearings. It is my understanding that if you find a doctor who has been misbehaving, as we find lawyers, nurses, or engineers or any other profession——

Senator KENNEDY. Politicians.

Senator DOMINICK. Politicians—do you have any authority to prevent them from practicing medicine? You don't, do you?

Dr. GLAUBITZ. No, sir.

Senator DOMINICK. It has to be done by the State, does it not?

Dr. GLAUBITZ. Yes; and this is why I say we referred two cases to the district attorney, one to the State department of education, and so forth, because we really have no authority as a medical society to prevent the man from practicing. This has to be done by the State.

Senator DOMINICK. And that is taken before a court if the district attorney accepts the case?

Dr. GLAUBITZ. I presume that that is the proper mechanism.

Senator DOMINICK. And then would his license to practice be taken away at that point?

Dr. GLAUBITZ. Then the recommendation would probably go to the State department of education, and I believe that decision is made up at that level.

Senator DOMINICK. I see; all right, fine. Now that is true, generally speaking, of medical associations around the country?

Dr. GLAUBITZ. Yes, sir.

Senator DOMINICK. Fine. Thank you, Doctor.

(Prepared statement of Dr. Fishel follows:)

PREPARED STATEMENT OF DR. LEO FISHEL, PRESIDENT, NASSAU COUNTY (N.Y.) MEDICAL SOCIETY, PRESENTED BY DR. JOHN GLAUBITZ, PAST PRESIDENT, NCMS

I am Dr. John Glaubitz speaking for Dr. Leo Fishel, President of the Nassau County Medical Society. I am a past president of the NCMS and a member of its executive committee. First, let me thank you for the opportunity you have extended to me as a practicing physician, to speak to you about some of the

unique problems of medical care in this large suburban county. The fact that you are here today would indicate your awareness that the problems of this county are not the same as those of the core cities, or even the same as other counties. The fact that you have invited me as a practicing physician indicates that you are willing to listen to those most intimately involved, on a day to day basis, with the provision of medical care.

What is the nature of this County? Nassau County is unique in New York State, and, indeed, in much of the nation. We have more practicing physicians here than in any other suburban county in the United States. We have 7 voluntary hospitals, 10 proprietary hospitals, 1 large County medical center, and several Health Department clinics.

We have, therefore, an elaborate health care delivery system—one which is constantly changing, constantly being expanded to meet the changing needs of our citizens.

Is everything perfect then? No. We have problems . . . but they are related to the nature of this suburban area. We have poverty, but it is not throughout the county. There are poverty pockets—often close to affluent areas. There are problems of the large middle class in this county, many of whom have been hit by unemployment. There is the problem of the cost of catastrophic illness. There is the problem of transportation to free medical facilities for those in need. In this county, we have the facilities, the manpower and the incentive to make fuller use of the health care systems which we now have, and to build upon them.

How have we worked to solve these problems? We are most fortunate in this county in that for many years, the County Medical Society—its committees and its members—have had an excellent relationship with government. We have worked closely with the County government in developing programs and facilities to provide for this growing area. In the 30s, even before the county began its tremendous growth, the Medical Society saw the need for a County hospital to care for the indigent. The Medical Society was a driving force behind the creation of that hospital, and has continued to work closely with the hospital. Our members give of their time and effort to provide free care for the indigent, with one of every four doctors giving their services free of charge to the Nassau County Medical Center. Our doctors, through their Medical Society, were instrumental in bringing about a unified County Health Department to serve the needs of the entire county. The Medical Society was one of three co-sponsors instrumental in establishing a Cancer Detection Center. The Society was responsible for a county-wide polio immunization program several years ago. In recent years, we have actively supported and participated in Regional Medical Planning and Comprehensive Medical Planning. We are not boasting of this. We believe it is our responsibility as doctors and as citizens to look to the constant improvement of health care delivery systems.

Most recently we have spent a great amount of time on the development and establishment of a Medical Services Foundation, with the purpose of obtaining better use of our health care delivery systems, of improving quality, and of making full use not only of our larger facilities, but also of the thousands of physicians' offices which are on the firing line of medical care.

After extensive planning, we will shortly be initiating two pilot projects under the Nassau Medical Services Foundation. One will be designed as a special program to provide adequate care for the needy, the other involving a program of comprehensive insurance.

A key element in the Foundation plan is the use of Peer Review, in which doctors assure the maintenance of quality care and the improvement of health care delivery systems.

Through all this, one thing clearly emerges. A good health care deliverv system must be constantly changing, responsive to the needs of the area. Above all, it must be flexible. If there is one thing I can get across today, it is the importance of this flexibility. I would ask you gentlemen to give serious consideration to avoiding rigid formulas which put every area into a unified mold. Medicine is constantly changing. The ways of medical care are constantly changing.

If the hearing was held thirty years ago, one of our main concerns would be how to improve our sanitorium facilities for tuberculosis. Today we look to the solution of other problems, and any legislation which you develop should

take into account the need for flexibility and experimentation with multiple systems of health care.

Our experience in Nassau County shows us something else. The importance of consultation between the practicing physician and government. We have had it here, and we hope that this type of communication will be fostered on all levels of government.

In our direct dealings with our patients and in our broader activities, we have seen something else. Money alone for medical care will not eliminate disease.

Many of the most serious health problems are related to nutrition, housing, and environment, and these can only be corrected through education, experimentation and other *non-medical* programs. Yes, we must improve our health care delivery system. But this is only part of the story, and, as you gentlemen are well aware, the health of our nation is related to many other factors and subjects of concern.

As physicians, as members of a olcal medical society, we will continue to work and respond to the ever-changing challenges related to health care in our communities and our county. We appreciate the opportunity you have given us to speak with you today. We hope that there will be more opportunities like this, more meetings designed to constructively work out solutions; more opportunities for the local areas to be heard.

We share a common concern . . . the health of our citizens. Towards the improvement of the health of our citizens, we offer the energies, the expertise and the cooperation of the practicing physicians of Nassau County.

Senator KENNEDY. Doctor, I want to thank you very much.

And just before we conclude we want to welcome Mrs. Dominick, who has been with us all morning long. We want to welcome you, and we appreciate your coming.

We again want to thank Hofstra University for their kindness.

We will stand in recess.

(Whereupon, at 1:30 p.m., the subcommittee recessed, to meet in afternoon session at Mount Kisco, N.Y.)

HEALTH CARE CRISIS IN AMERICA, 1971

THURSDAY, APRIL 15, 1971

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

The subcommittee met at 2:45 p.m., at Northern Westchester Hospital, Mount Kisco, N.Y., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Also present: Congressman Ogden Reid, Representative in Congress for the 26th District of New York.

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

Senator KENNEDY. We are delighted to have Congressman Reid join with us here at the start. Would you like to make a comment?

Mr. REID. No; I am just very happy, Senator Kennedy, that you can be here with the Senate subcommittee. I think this is a vital subject, and I think the country is very grateful to you for your leadership in this field.

Senator KENNEDY. You usually don't get Members of the Congress and Senate making such brief statements. [Laughter.]

We are getting started late, and we want to apologize to our witnesses and to the others who have been kind enough and patient enough to wait. We are going to have to conclude the hearing a little before 5 o'clock, so we have about an hour and 45 minutes. We have four scheduled witnesses and a panel. Then we would like to open the hearing for any comments that any of you would like to make. We try to do this at each of the hearings. Therefore, we will try to conclude the more formal statements at 4:30.

Our first witness is Mr. Jerome F. Peck, Jr., administrator of Northern Westchester Hospital for the past 25 years, a member of the American College of Hospital Administrators, and director of the Northern Metropolitan Hospital Council.

STATEMENT OF JEROME F. PECK, ADMINISTRATOR, NORTHERN WESTCHESTER HOSPITAL

Mr. PECK. Mr. Chairman and members of the subcommittee, I am the administrator of the Northern Westchester Hospital. I am accompanied by Mr. Thomas McCance, chairman of our board of trustees, Dr. Harold T. Brew, the chairman of our medical board and chief of surgery, Mrs. Lyndall E. Boal, our director of social

service, and Dr. Morgan F. Pruyn, a member of our staff and a partner in the Mount Kisco Medical Group.

First of all, Mr. Chairman, I would like very much to welcome you and the subcommittee to Mount Kisco and to the Northern Westchester Hospital. We are extremely pleased that you have chosen to visit this area as part of your hearings on health care in America, and we appreciate the opportunity to testify this afternoon.

The Northern Westchester Hospital is a nonprofit, community hospital serving approximately 130,000 people of northern Westchester County. Our community is both growing and changing. Population pressures are bringing more and more people into the northern part of the county and what was once generally an area of scattered, single-family houses is becoming a mixture of apartment houses, garden apartments, and housing developments. Moreover, new highways and new industries have assured the area's continued growth in the future. By 1985, the population is expected to increase by 65 percent.

In light of this projected growth, we at Northern Westchester consider ourselves very fortunate to have a progressive, forward-looking board of trustees which has always been careful to plan for the future health care needs of the area.

As has been seen on your brief tour—briefer than we hoped, and perhaps you can do it again, Senator—we are now in the process of replacing, rehabilitating, and adding to our physical plant.

The overall goal of the Northern Westchester Hospital is to provide quality medical care at an economically feasible cost. Unfortunately, this noble goal is very easy to state, but extremely difficult to achieve. In fact, this goal cannot be achieved using conventional methods of hospital construction and hospital operation.

Consequently, our new facility, to be known when completed as the Northern Westchester Hospital Center, will incorporate several new and innovative design concepts. It is our expectation that the incorporation and utilization of the new concepts will enable us to achieve our goal of providing quality care at a reasonable rate for all the people in our community.

Perhaps the most interesting and illustrative of these new concepts is our plan to construct single occupancy rooms only. While at first glance this may seem to be an unnecessary and expensive luxury, in reality it will result in significant cost-reduction as well as a significant increase in the quality of patient care.

Studies have shown that the occupancy rate of two-bed, semi-private rooms cannot exceed 85 percent, because the mix of male and female patients seldom matches the available room. Other difficulties occur in placing patients of different ages, in handling the extremely ill, and in isolating potentially infectious patients. Two-bed rooms are thus often only half occupied. In Northern Westchester, patient preferences require moves from doubles to singles, when available. Each move costs the hospital $35 to $45.

In sharp contrast, a nursing unit of only single-bed rooms is faced with none of these difficulties. And it can function effectively at a 95-percent occupancy rate. The savings resulting from this 10-percent differential in occupancy rates far exceeds the higher construction costs of single-bed rooms.

Moreover, patients prefer single-bed room and get better care in such rooms. The human animal, like other animals, likes to be alone when he is ill. They appreciate not being disturbed by the presence of a roommate with different waking and sleeping, TV watching, and talking patterns. They appreciate being able to discuss their problems in privacy with visitors, nurses, doctors, and religious counsellors. They appreciate the convenience of having shower, washing, and toilet facilities unshared with anyone else. They appreciate being able to have heating, ventilating, and lighting adjusted to their own desires and needs and being able to have their room door closed or left open as they prefer. Nurses and physicians, on the other hand, can perform all required services for their patients without disturbing room sharers. Even an orthopedic patient need not be moved for a change of cast. This long procedure can be carried out at his bedside if he occupies a single-bed room.

Mr. Chairman, I have described this single-bed concept in some detail to make two points. The first is that the best care need not be the most expensive care, as I think my description has shown. The second point is that careful planning can uncover such economies as the single-bed concept. At the outset of our planning phase, a private financial contribution enabled a team from Northern Westchester Hospital to visit more than a score of outstanding new hospitals in this country and in Europe to become familiar with recent innovations which might be adaptable to our situation. We feel that no other hospital ever built has had the benefit of such extensive studies of the success and failures of other hospitals' designs.

Another innovative feature of our hospital center will be a "service base" of four floors with a capacity for vertical and horizontal expansion which will be economical and which will not interrupt the normal functioning of the rest of the hospital, and meet the needs of the future.

A new management engineering system for the nursing service has been built into our plans. This system has two principal advantages: (1) The nurse staffing patterns will be set in accordance with the needs of the individual patients; and (2) the handling of material will be accomplished in such a way as to free the nurses from having to leave the patient areas.

In other words, we keep the nurses by the patients. We get the supplies and other things to them so they don't have to leave the patient.

Other services new to our hospital will include ambulatory care for minor surgery, extended care, minimal care, expanded outpatient services and home care services, and a psychiatric unit.

With some additional beds, the increased utilization of beds, shared services with other hospitals on a regional basis, and the new emphasis on ambulatory care, we are confident that we will be able to handle our community's projected 65 percent population increase with only a 35 percent immediate increase in beds.

I would like to say just a few words about a subject of immediate concern to your subcommittee: health manpower.

We at Northern Westchester share your concern about the shortage and maldistribution of health professionals of all types. The estimated current shortage of 50,000 physicians, 150,000 nurses, and over

a quarter of a million allied health professionals (including 105,000 environmental specialists) is staggering enough. But the projected shortage figures for 1980—26,000 physicians, 210,000 nurses, and almst a half million allied health professionals—is truly frightening to a hospital center such as ours. The excessive competition for scarce specialists has two major adverse effects on a hospital: staff shortages and increased costs resulting from the large salaries which have to be paid to meet the competition. Unfortunately, both of these adverse effects have to be passed on to the patient in the form of less complete care and higher per diem charges.

Fortunately, our enlarged facilities will make possible a greatly expanded teaching and training program. Within the next few years the present New York Medical College will move out of that city and relocate at the county's Grasslands Hospital, near White Plains, to become the Westchester Medical College.

Arrangements have already been made for an extremely close affiliation between the Northern Westchester Hospital and this new institution. Many of its undergraduate and postgraduate students will come to our hospital for clinical, bedside training coupled with instruction in our classrooms. A number of our senior physicians will receive appointments as professors or adjuncts in their respective specialties.

Senator KENNEDY. Does it concern you, Mr. Peck, that more and more doctors are moving out of the urban areas into suburbia, and it appears now that the medical schools are doing likewise? Perhaps it is good for the people that are served by this hospital, but what is your feeling about the general problem that is suggested by this movement?

Mr. PECK. Certainly, as you say, we are in a favored position. With us it is more a matter of distribution. Dr. Brew, our director of surgery, is sitting on my left and, of course, we have talked about it. Are there enough surgeons or are there too many, and do we need more primary physicians? Not very far from here, over in Sullivan County, there is a woeful lack of all physicians. So I hope that through the centering of hospitals we will attract doctors who can provide better distributed services. Hopefully by working with institutions like the new college coming up we will be able to have some more effective answers to that.

Senator KENNEDY. Well, I was more interested in the general movement that is beginning, of teaching medical schools away from urban areas where they have been established traditionally. They seem to be following the flight of the more skilled health manpower, into the suburban areas. This really complicates and adds to the maldistribution problem rather than remedying it.

Mr. PECK. Well, I think it will help. Dr. Brew, our chief of staff, and I were talking about how to adapt the curriculum of medical schools which——

Senator KENNEDY. I don't doubt that it is good for Northern Westchester or Mount Kisco. I wonder, however, if New York City can afford to lose the NYU Medical School. I know you are interested in this particular problem. Perhaps there is very little that you can really do about it. But I am just interested in how you view this.

Mr. PECK. Well, we certainly view with great relief the coming of a medical school. Somebody asked me if it was true that in all of Westchester County there is no American-born, American-trained intern or resident. I think that is true. If you grant that you must have medical education to have high quality of medical care then we need it in Westchester.

I know there are dreadful problems in New York, and while we are concerned about that, we have the feeling that people in the suburbs have problems just as real and need solutions to them just as much.

Let's go back a little to this hospital. The most recent expansion of our facilities took place approximately 10 years ago, when a $3 million addition was constructed. This project added 89 new beds, two cafeterias, a diet kitchen, one of the country's first intensive care units, plus some other much needed space. A substantial amount of this project was financed by a Federal Hill-Burton grant.

Unfortunately, in 1971, when we face the need for still more space, the Hill-Burton program is no longer a likely source of assistance. As you know, the grant program has been cut back to the point where, for fiscal year 1972, the administration is requesting an appropriation of just $58.3 million for such grants to be allocated among the 50 States. The cost of our construction project alone is $30 million—more than half the amount the Federal Government proposes to make available for the entire Nation.

A construction grant program of reasonable proportions is clearly needed if the health care needs of the country are to be met.

I heard you say on the elevator and I agree completely—that if there is a new system of financing health care with the demand that is already there, then the resources that are part of that delivery system have to be improved, too.

Continued reliance on loan programs alone, either direct loans or guaranteed loans, will result in prohibitive construction costs in many instances and excessive per diem costs in others, since mortgage payments must come out of operating revenue.

In this particular hospital a 50-percent mortgage, or in this case 15 million, would mean that the interest and principal payments would be $14 per patient per day the first year. That's pretty close to prohibitive. I think a grant program is the only answer.

We at Northern Westchester have developed our plans in close cooperation with the New York State Department of Health and, until very recently, we were confident of receiving a mortgage loan under section 28B of the New York Public Health Law which would cover half the cost of our project. We were prepared to raise the other $15 million from private contributions. In fact, we had accumulated gifts and pledges totaling nearly $10 million. However, on March 24 of this year, we were informed by the New York Department of Health that the maximum mortgage loan permitted for our construction program had been administratively reduced from $15 to $10 million. This decision was based on a statewide "review" of all projects requesting mortgage loans.

We were subsequently informed by the department that we should be able to construct our new facility for $16 million instead of the

$30 million which had previously been agreed to. Later on we were told that perhaps our project could be constructed for $24 million if we conduct an "indepth architectural review" of our current plans. We are now in the process of appealing this rather arbitrary and, we feel, unjustified decision.

I raise this point only to illustrate the extent to which hospitals often find themselves at the mercy of various government agencies. In a peculiar sense we were perhaps fortunate that the Hill-Burton program had already been sharply cut back by the time we were ready to arrange financing, since we were at no time counting on support from that source. Hence, our plans were not disrupted by any Federal funding decisions. The New York State problem, of course, is another matter. It is our hope, however, that we will be able to clear the matter up with no loss of either construction time, money already spent on the project—you can see the hole out there, steel is on order and being fabricated—or, and this is the point—the innovations which will make possible our goal of quality care at a feasible cost.

This concludes my testimony, Mr. Chairman, but I would like Dr. Brew to briefly discuss the patterns of medical care as seen from the physician's eye in this community, especially as it relates to our own. Then Mrs. Boal will give you a brief rundown on the problems in the area of social services faced by our community and Dr. Pruyn will say a few words about the Mount Kisco Medical Group.

Thank you once again for this opportunity to testify, and we, of course, will be pleased to answer any questions.

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

(The prepared statement of Dr. Peck follows:)

Testimony Statement

of

Jerome F. Peck, Jr., F ACHA

Administrator,

Northern Westchester Hospital

before the

Subcommittee on Health

of the

U. S. Senate Committee on Labor and Public Welfare

April 15, 1971

Mr. Chairman and members of the subcommittee, my name is Jerome F. Peck. I am the Administrator of the Northern Westchester Hospital. I am accompanied by Mr. Thomas McCance, Chairman of our Board of Trustees, Dr. Harold T. Brew, the chairman of our Medical Board and Chief of Surgery, Mrs. Lyndall E. Boal, our Director of Social Service, and Dr. Morgan F. Pruyn, a member of our staff and a partner in the Mt. Kisco Medical Group.

First of all, Mr. Chairman, I would like very much to welcome you and the subcommittee to Mt. Kisco and to the Northern Westchester Hospital. We are extremely pleased that you have chosen to visit this area as part of your hearings on Health Care in America, and we appreciate the opportunity to testify this afternoon.

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The Northern Westchester Hospital is a non-profit, community hospital serving approximately 130,000 people of northern Westchester County. Our "community" is both growing and changing. Population pressures are bringing more and more people into the northern part of the county and what was once generally an area of scattered, single-family houses is becoming a mixture of apartment houses, garden apartments, and housing developments. Moreover, new highways and new industries have assured the area's continued growth in the future. By 1985, the population is expected to increase by 65%

In light of this projected growth, we at Northern Westchester consider ourselves very fortunate to have a progressive, forward-looking Board of Trustees which has always been careful to plan for the future health care needs of the area. As you have seen on your brief tour of our facilities, we are now in the process of replacing, rehabilitating, and adding to our physical plant.

The overall goal of the Northern Westchester Hospital is to provide quality medical care at an economically feasible cost. Unfortunately, this noble goal is very easy to state, but extremely difficult to achieve

In fact, this goal cannot be achieved using conventional methods of hospital construction and hospital operation.

Consequently, our new facility, to be known when completed as the Northern Westchester Hospital Center, will incorporate several new and innovative design concepts. It is our expectation that the incorporation and utilization of the new concepts will enable us to achieve our goal of providing quality care at a reasonable rate for all the people in our community.

Perhaps the most interesting and illustrative of these new concepts is our plan to construct single occupancy rooms only. While at first glance this may seem to be an unnecessary and expensive luxury, in reality it will result in significant cost-reduction as well as a significant increase in the quality of patient care.

Studies have shown that the occupancy rate of two-bed (semi-private) rooms cannot exceed 85%, because the mix of male and female patients seldom matches the available rooms. Other difficulties occur in placing patients of different ages, in handling the extremely ill, and in isolating potentially infectious patients. Two-bed rooms are thus often only half occupied. In Northern Westchester, patient preferences require moves from doubles to singles, when available. Each move costs the hospital $35 to $45.

In sharp contrast, a nursing unit of only single-bed rooms is faced with none of these difficulties. And it can function effectively at a 95% occupancy rate. The savings resulting from this 10% differential in occupancy rates far exceeds the higher construction costs of single-bed rooms.

Moreover, patients prefer single-bed rooms and get better care in such rooms. They appreciate not being disturbed by the presence of a roommate with different waking and sleeping, TV watching, and talking patterns. They appreciate being able to discuss their problems in privacy with visitors, nurses, doctors, and religious counsellors. They appreciate the convenience of having shower, washing and toilet

facilities unshared with anyone else. They appreciate being able to have heating, ventilating, and lighting adjusted to their own desires and needs and being able to have their room door closed or left open as they prefer. Nurses and physicians, on the other hand, can perform all required services for their patients without disturbing room sharers. Even an orthopedic patient need not be moved for a change of cast. This long procedure can be carried out at his bedside if he occupies a single-bed room.

Mr. Chairman, I have described this single-bed concept in some detail to make two points. The first is that the best care need not be the most expensive care, as I think my description has shown. The second point is that careful planning can uncover such economies as the single-bed concept. At the outset of our planning phase, a private financial contribution enabled a team from Northern Westchester Hospital to visit more than a score of outstanding new hospitals in this country and in Europe to become familiar with recent innovations which might be adaptable to our situation. We feel that no other hospital ever built has had the benefit of such extensive studies of the success and failures of other hospitals' designs.

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Health Manpower

I would like to say just a few words about a subject of immediate concern to your subcommittee: health manpower.

We at Northern Westchester share your concern about the shortage and mal-distribution of health professionals of all types. The estimated current shortage of 50,000 physicians, 150,000 nurses, and over a quarter of a million allied health professionals (including 105,000 environmental specialists) is staggering enough. But the projected shortage figures for 1980 -- 26,000 physicians, 210,000 nurses, and almost a half million allied health professionals -- is truly frightening to a hospital center such as ours. The excessive competition for scarce specialists has two major adverse effects on a hospital : staff shortages and increased costs resulting

from the large salaries which have to be paid to meet the competition. Unfortunately, both of these adverse effects have to be passed on to the patient in the form of less complete care and higher per diem charges.

Fortunately, our enlarged facilities will make possible a greatly expanded teaching and training program. Within the next few years the present New York Medical College will move out of that city and relocate at the county's Grasslands Hospital, near White Plains, to become the Westchester Medical College.

Arrangements have already been made for an extremely close affiliation between the Northern Westchester Hospital and this new institution. Many of its undergraduate and post-graduate students will come to our hospital for clinical, bedside training coupled with instruction in our classrooms. A number of our senior physicians will receive appointments as Professors or Adjuncts in their respective specialties.

While these young physicians and physicians-to-be will be coming to us primarily to receive clinical training, their presence on duty here will permit us to provide more skilled services to our patients and, at the same time, their questing minds will serve as a constant stimulus to all our staff. Many will remain with us, after they win their medical degrees, to serve their internships or residencies. And the very best among them will undoubtedly join our permanent medical staff and settle in our community to share in serving its medical needs.

Similar affiliations with the Nursing and Technicians-Training Schools of the Medical College will also be made possible by our new teaching facilities.

Financing Health Care Facilities

The most recent expansion of our facilities took place approximately ten years ago, when a three-million dollar addition was constructed. This project added eighty-nine new beds, two cafeterias, a diet kitchen, one of the country's first intensive care units, plus some other much-needed space. A substantial amount of this project was financed by a Federal Hill-Burton grant.

Unfortunately, in 1971, when we face the need for still more space, the Hill-Burton program is no longer a likely source of assistance. As you know, the grant program has been cut back to the point where for Fiscal Year 1972, the Administration is requesting an appropriation of just $58.3 million for such grants to be allocated among the fifty states. The cost of our construction project alone is $30 million -- more than half the amount the Federal Government proposes to make available for the entire Nation !

A construction grant program of reasonable proportions is clearly needed if the health care needs of the country are to be met. Continued reliance on loan programs alone, either direct loans or guaranteed loans, will result in prohibitive construction costs in many instances and excessive per diem costs in others, since mortgage payments must come out of operating revenue.

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money already spent on the project, or the innovations which will make possible our goal of quality care at a feasible cost.

This concludes my testimony, Mr. Chairman, but I would like Dr. Brew to briefly discuss the patterns of medical care in this community, especially as they relate to our hospital. Following that, Mrs. Boal will give you a brief rundown on the problems in the area of social services faced by our community, and then Dr. Pruyn will say a few words about the Mount Kisco Medical Group (a private group practice in our community).

I thank you once again for this opportunity to testify. We will be happy to answer any questions you may have.

Senator KENNEDY. We hear a great deal about the health crisis that we are facing generally in the country. President Nixon has identified the crisis and Secretary Richardson has talked about it, as well as others in the Congress and Senate. Do you have a health crisis in Northern Westchester?

Mr. PECK. I think there is a crisis, but I don't believe it is generally recognized. Certainly the first side of it we see is economic—it is not possible to provide quality care, as we now do it, at a cost that can be afforded. So we must come up with innovative methods of some kind. The status quo won't do, and I think that's the dimension of the crisis.

There is a crisis, not everybody recognizes it, but they know it when Blue Cross premiums come due. There are other aspects to the crisis that Mrs. Boal will tell you about. But I see it first as a financial crisis.

Senator KENNEDY. Do you think perhaps the crisis is not quite as apparent in a community such as this as it is in the urban areas? But I would agree with you that the crisis is just as present in suburban communities as it is in urban areas where it is more pressing and obvious.

Could you tell us how the hospital room cost has increased, say, in the period of the last 5 years and what you can see down the road in terms of the next 2 or 3 years?

Mr. PECK. Yes, sir; I can. Presently our cost of daily patient care is $80 on the audited reimbursable cost. However, in intensive care or coronary care it is about $140 per day there, although we still receive the same $80. Compared with 5 years ago, this percentage increase fits in with all the figures you are familiar with. It has gone up more than average, higher than I guess anything except the construction industry.

Senator KENNEDY. It has gone up even higher than that.

Mr. PECK. As for our projections for the future, if we talk about traditional care as delivered—put everybody in the same kind of bed—I think we will be at crisis proportions very quickly, and $150 a day in 1974. That is the financial measure of the crisis.

Senator KENNEDY. Now what does that mean generally to the people that live within this community?

Mr. PECK. The great majority, 80 percent, have their bill paid by somebody else—medicare, medicaid, Blue Cross, and so forth. So it is a deferred kind of economic problem. As I said, Mrs. Boal will tell you what it means to some individuals.

Senator KENNEDY. Before we hear from Mrs. Boal, what can you tell me about the quality of health care in a community such as this?

Mr. PECK. I think it is superb. I think it is first rate. One of our problems is being able to provide that top level of care to the total population consistently, not just to the intensive care, coronary care, but to the areas of preventive medicine, home care and psychiatry. I think the more serious and obvious the problem the more clear it is that the level of care is superb.

As you know, the flight of doctors to the suburbs—I think our medical staff is outstanding, and you couldn't have this superb care without superb doctors.

Senator KENNEDY. Do you have peer review here?

Mr. PECK. Yes; I think we do.

Senator KENNEDY. Could you tell us a little bit about it?

Mr. PECK. I think we were one of the very first to start it.

Morgan, this is where you ought to come in, because it began 15 years ago when the medical board had Dr. Pruyn and Dr. Dan Brown on it. They were one of the very first to start peer review, which didn't make them the most popular individuals around, but it did improve the quality of care.

Senator KENNEDY. Could you tell us a little bit about the peer review?

Mr. PECK. Harold, you have the microphone right here. You have been up to your neck in it the last 5 years.

Dr. BREW. Senator Kennedy, within the hospital itself we have review by departments—specialty departments. We do have review, sir, within the hospital by departments, as to the caliber of work performed, the nature of the disease, requirements of treatment, and a critique of the quality of medical care. We also have an ongoing utilization review to insure this.

Senator KENNEDY. What kind of peer review do you have of the solo practitioner in a community like this? Do you have any review?

Dr. BREW. In the doctors' offices? No, sir; we do not.

Senator KENNEDY. Say outside the doctor's office. Do you have any kind of review of this kind of practice? Do you think it would be useful or helpful?

Dr. BREW. In terms of the community at large outside of the hospital, which has the review mechanism I mentioned, to my knowledge, no. I think ongoing review is inevitable in evaluating what we are doing in the quality of medical care. I might touch on that in my prepared remarks.

Senator KENNEDY. OK, fine.

STATEMENT OF DR. HAROLD T. BREW, CHAIRMAN OF THE MEDICAL BOARD, AND CHIEF OF SURGERY, NORTHERN WESTCHESTER HOSPITAL

Dr. BREW. If I might before testifying, in response to your comment about the transposition of a medical school from one area to the other, it would seem to me that this only highlights our need to increase our educational facilities for training medical personnel of all categories. I think the point of the transfer of schools creating a void is well taken, and we just need more training facilities.

In brief, the Northern Westchester Hospital provides a broad spectrum of inpatient, outpatient care to the people of Northern Westchester County. It is staffed by 140 physicians practicing in the communities in the hospital district. The majority of these are specialists. They practice privately in solo, association, partnership or multispecialty groups. Within the hospital they are grouped by specialty with responsibilities to patient care, continuing education, review of caliber of medical care and teaching responsibilities at all levels, be it interns and residents, various nurses and technicians programs, or community forums for the dissemination of medical information to the community at large.

Parenthetically, I might add that in spite of what might seem to be an abundance of physicians, there are communities within this district that lack primary physicians.

Additionally, the hospital is presently well staffed with competent nurses and technicians; also with ongoing educational program. Intern and residency training program under the full time director of medical education is well established and has added to the caliber of patient care over all, and to the ongoing medical education program.

We have an active social service department and home care program which help with patient problems prior to, during hospitalization, and are invaluable in discharge planning and disposition of patients when their hospitalization needs are over. In an acute care institution discharge planning and disposition is a very vital function.

A county health center adjacent to the hospital provides multiple outpatient services, clinics and nursing services.

Our commitment for the future is in our plans for an inpatient psychiatric unit and an extended care unit underscore a current lack in providing these services to this community.

The problems of our existing physical plant you have heard about, and in spite of a very thorough review and utilization study of inhospital patients, our occupancy rate continues to climb.

As providers of medical care, we are well aware of the increasing costs of hospital beds and the need for efficient utilization of the same. The increase in demands on providers of medical care by a growing population will require changes in the delivery system to include specially trained paramedical personnel to relieve the strain at both the physician and hospital level. The long successful experience of the military with this concept, as well as more recent interests and implementation in a limited way in several areas of the country, should encourage us to avail ourselves of this now, and to implement the training programs necessary to meet the needs.

Any discussion of medical care problems, be it distribution or financial, must take into account the needs and desires of the consumer of these services, namely the patient. As a surgical specialist in practice for 12 years in this community, I am more firmly convinced than ever before that what most patients want is the availability of competent professional care in a competent medical facility, whether it be physician's office, outpatient area or an inhospital setting. To most people this implies an ongoing relationship with their physician, and this is the keystone. This cannot be rendered by assembly line techniques or by itinerant personnel. It's true that as more paramedical personnel are involved in patient care of all types physician time with an individual patient may be shortened. However, if this results in more medical care for more people, we will have moved in the right direction.

Senator KENNEDY. Thank you very much.

You hear that surgery is really sort of the prestige specialty of the medical profession. Because it is viewed this way, more medical students are getting into surgery. Do you think perhaps we have too many surgeons?

Dr. BREW. I would say this—I can't answer that question intelligently. I think probably by specialty designation there are more general surgeons certainly in this country than there are other categories in which there are substantial shortages. How much is too

many? If we are still not delivering a good product I am not sure I can say we have too many of anything at this time.

Senator KENNEDY. But if you have too many, then they have to make a living and I suppose they have to perform more surgery. This raises the question of whether you can maintain continuing quality with an oversupply of physicians in a specialty. I would be interested in what your general reaction to this is. We hear many charges made about this problem, and I am interested in how you view it in terms of this community and generally in terms of suburbia.

Dr. BREW. Yes. Specifically locally I think the surgical staff here undertakes a volume of surgery that they can handle very adequately, and I think as one has more and more well-trained people at any level of hospital, be it suburban or large center, who are continuing their education, who continue to review their own work in conferences, I think anyone not doing things by the book would stand up. I think the review mechanism we have is a protection for this kind of thing. So that I would view that locally at least as not a problem.

Senator KENNEDY. Well, how many surgeons do you have on the staff?

Dr. BREW. We have approximately 20 surgeons of various specialty interest on our staff.

Senator KENNEDY. What is the most that any one of them might operate a week and what is the least?

Dr. BREW. Conceivably one might do 10 cases a week, not specifying by days or hours, and one might do two or three cases a week.

Senator KENNEDY. Can a surgeon maintain competency by doing two or three a week?

Dr. BREW. I think so. I think we also——

Senator KENNEDY. Obviously there is a great distinction between different types of surgery and there are different levels of skill needed. But what number of surgical operations would be necessary to maintain competency?

Dr. BREW. Well, that gets into the business of numbers, and I am not sure that the numbers are total answers. There used to be a great emphasis years ago on going to a place where you could do everything. I think doing everything is fine, but if you are doing it without proper instruction or supervision in your formative time I am not sure that this is any benefit in the longrun.

I think we do have the mechanism whereby all major surgery at least, two surgeons of equal training partake. So there is a great deal of give and take. These men are more active than their own individual practices might indicate. They also have appointments at other hospitals where they may be supervising residents. So that their hands are in, as it were. They are actively engaged in the practice of surgery in some way. Primary physician, assisting physician, teaching physician.

Senator KENNEDY. You have an interesting group practice situation here. We hear group practice talked about a great deal. Most of the programs that we have heard about or looked into are prepaid group practice. You have a different kind of situation here. I wonder if you could describe it briefly to us.

(The prepared statement of Dr. Brew follows:)

Testimony Statement

of

Harold T. Brew, M. D.

Chairman of the Medical Board and Chief of Surgery,

Northern Westchester Hospital

before the

Subcommittee on Health

of the

U. S. Senate Committee on Labor and Public Welfare

April 15, 1971

The Northern Westchester Hospital provides a broad spectrum of In Patient-Out Patient care to the people of Northern Westchester County. It is staffed by 140 physicians practicing in the communities in the hospital district. The majority of these are specialists. They practice privately in solo, association, partnership or multi-specialty groups. Within the hospital they are grouped by specialty with responsibilities to patient care, continuing education, review of caliber of medical care and teaching responsibilities at all levels, be it interns and residents, various nurses and technicians programs, or community forums for the dissemination of medical information to the community at large. Parenthetically, I might add, that in spite of what might seem to be an abundance of physicians, there are communities within this district that lack primary physicians. Additionally, the hospital is presently well staffed with competent nurses and technicians; also with on-going educational programs. Intern and residency training program under the full time director of medical education is well established and has added to the caliber of patient care over all, and to the on-going medical education program. We have an active social service department and home care program which help with patient problems prior to, during hospitalization and are invaluable in discharge planning and disposition of patients when their hospitalization needs are over. In an acute care institu-

tion, discharge planning and disposition is a very vital function. A county health center adjacent to the hospital provides multiple outpatient services, clinics and nursing services. Our commitment for the future in our plans for an inpatient psychiatric unit and an extended care unit, underscore a current lack in providing these services to this community. The problems of our existing physical plant you have heard about and in spite of a very thorough review and utilization study of in-hospital patients, our occupancy rate continues to climb. As providers of medical care, we are well aware of the increasing costs of hospital beds and the need for efficient utilization of the same. The increase in demands on providers of medical care by a growing population will require changes in the delivery system to include specially trained para-medical personnel to relieve the strain at both the physician and hospital level. The long successful experience of the military with this concept, as well as more recent interests and implementation in a limited way in several areas of the country, should encourage us to avail ourselves of this now, and to implement the training programs necessary to meet the needs. Any discussion of medical care problems, be it distribution or financial, must take into account the needs and desires of the consumer of these services, namely the patient. As a surgical specialist in practice for 12 years in this community, I am more firmly convinced than ever before, that what most patients want is the availability of competent professional care in

a competent medical facility whether it be physicians office, out patient area or an in-hospital setting. To most people, this implies an on-going relationship with their physician, and this is the key stone. This cannot be rendered by assembly line techniques or by itinerant personnel. It's true, that as more para-medical personnel are involved in patient care of all types, physician time with an individual patient may be shortened. However, if this results in more medical care for more people, we will have moved in the right direction.

Dr. BREW. Dr. Pruyn, who is one of our partners, is there with that specific purpose.

STATEMENT OF DR. MORGAN F. PRUYN, MOUNT KISCO MEDICAL GROUP

Dr. PRUYN. Senator, I was asked by you to present the reasons for the formation of the medical group and what the advantages were to professional members, and also to say what are the advantages of the patient, to everybody, of a service medical group.

The Mount Kisco Medical Group was formed in 1947 when it became legal in New York State to have a partnership for the practice of medicine. From a start of five physicians, it has grown with the demand for its services to full-time board certified specialists, a business manager, clinical laboratory, and limited diagnostic x-ray. It relies on outside specialists for services not represented in the group. There is very little referral of patients to the group by local physicians. The group physicians comprise a sixth of the hospital medical staff.

Professional advantages of a service group practice of medicine are:

1. The assurance of having talented and reliabile associates.
2. The assurance that the quality of medical care will be enhanced by the day-to-day example and influence of physicians working under the same roof, the democratic principle of policymaking, and the exchange of information.
3. The assurance that his patients will be well taken care of by other group physicians when he is unavailable.
4. The security a new member has in being needed in the community, in rapidly having his own practice, and in not having to make an immediate capital investment and yet being assured of an immediate income.
5. To be relieved of day-to-day managerial, personnel and financial matters.

The advantages that patients derive from group practice are:

1. The availability of a physician at all times.
2. The unit medical record which affords a continuity of medical care by all involved physicians in a sequential manner, and is available to all group physicians at all times avoiding duplication of tests and pitfalls.
3. The obtaining of informal or formal consultations under the same roof, and often simultaneously with their initial visit for that illness.
4. The fact that fees are not determined by the whim of any one physician or physician assistant, but by the group as a whole.
5. No means test is required of a new patient.

It is important to point out to your committee that because of our availability on short notice, and because this is a wealthy community and there is widespread third-party payment of sickness benefits, we care for a good deal of inconsequential illness as well as perform a large volume of so-called periodic health examinations. This is luxury medicine and is not what primary physicians have been

trained for, nor is it what they expect after intensive postgraduate medical training. It is certainly the antithesis of what a comparable group would be performing or could afford to perform in a low-income area under existing methods of medical economics. Nonetheless, it is what sophisticated Americans have been led to believe is a necessity and are willing to pay for.

I should add also that in this community is a younger medical group consisting of 12 physicians, of which this hospital is duly proud.

Senator KENNEDY. Do they have a group practice association?

Dr. PRUYN. Similar, but younger.

Senator KENNEDY. How do you differ from them, other than experience?

Dr. PRUYN. I suppose basically there's very little difference.

Senator KENNEDY. What can you do to assure quality control?

Dr. PRUYN. I think it is the built-in peer review. The record of a patient is the property, you might say, of the medical group, and if I were not to be in the office today and one of my patients came in, that patient's records would be reviewed by the physician who was going to look after the patient. If it wasn't considered a good record I would be called on the carpet about it. The very fact that I know my work is going to be reviewed is an incentive to the lazy doctor who might ordinarily cut the corner.

And I think these are all the advantages of working in unison with people. It has a profound influence on the quality of care, and also on the urge to try and keep up with the young fellows that are coming along after you.

Senator KENNEDY. Of course, that wouldn't exist in solo practice, would it?

Dr. PRUYN. No.

Senator KENNEDY. And there really is very little peer review done for solo practice across the country, as I understand.

Dr. PRUYN. Well, it is hard to see how it could be done. Private records are not reviewable by any person who wants to do such a thing. You could subpoena them, I suppose, but you certainly couldn't just walk in the doctor's office and review records because they are privileged communication. Patients would raise the roof.

Senator KENNEDY. Well, how do you address the problems of quality? How can people know when they go to a doctor and he prescribes X, that X is really the best in terms of their problem? They can't shop around and look for someone else. They have confidence in this doctor, but do they have to just take it on faith?

Dr. PRUYN. I think the only place you——

Senator KENNEDY. You have given us two of the advantages of some kind of peer review. You have made that case, and quite effectively, in terms of your own kind of group. We can perhaps be assured of a higher quality in terms of this kind of a group, but some consumers have asked how they are going to be sure that their child is getting the best from a doctor when there has been no one really taking a look at his record over the last 15 or 20 years.

Dr. PRUYN. I suppose the hospital is the only place where there is any review of what a man is performing.

Mr. REID. Well, Dr. Pruyn, is there any problem in the patient waiving the right to privileged communication, and in fact asking the solo practitioner to have the records reviewed from time to time?

Dr. PRUYN. Well, this would mean showing records which you don't usually do. You see, if you keep records only for yourself you can be pretty sketchy and you can say you will do it tomorrow. If you have partners who may need the record tomorrow you can't put it off, and I think this is what I said. Certainly, in a hospital they make tremendous efforts to keep good records. I don't think you can do that in solo practice.

Senator KENNEDY. Well, let me ask this. If you pay high cost in terms of health care—does that necessarily mean that you are getting good care?

Dr. PRUYN. That's a loaded question. [Laughter.]

I don't think they bear any relationship, Senator.

Mr. REID. Let me ask the other side of that question. What are the incentives in group practice to lower the fees so that the average patient can more nearly afford the best care?

Dr. PRUYN. I think the incentive other than local competition would be a moral, shall we say, philosophical one.

Mr. REID. Do you find that is a strong sanction?

Senator KENNEDY. I feel that the doctors for the most part are caught up in the system. I don't know how much we can expect from the kind of health system that we have in this country, and from doctors that obviously are enormously committed, dedicated, and compassionate individuals on the whole. How can we expect that the burden would fall to physicians to devise a program that is going to drive the cost down. I think that is obviously demanding too much.

What we are trying to find out is what is happening in terms of cost, in terms of quality, and in terms of shortage of manpower. It is my own feeling that the cost of health care and quality don't necessarily run together. I think there are an awful lot of people that assume that because they are paying high premiums on their insurance or expensive medical bills, they are necessarily getting quality care. We are trying to decide what role we should be playing at the level of the U.S. Senate to find ways that can insure quality and control costs. Obviously we need the input from doctors on these questions.

Could I ask you, Mr. Peck, do you have any shortage of manpower here at the hospital?

Mr. PECK. We work very hard and very industriously, and I think are able to say that we have the manpower shortage in better control than most. But in order to say that we would be able to make that statement 2 years hence we do have to go to any number of lengths.

I think the major one in what I was talking about before in management engineering; that is, nurse staffing so that we don't have nurses, who are going to be in even shorter supply in the future, doing nonnursing duties. By doing that and recruiting well-trained nurses overseas we are in pretty good condition. We also try to use the best management techniques to minimize shortages, so I think we are in very fortunate shape.

Senator KENNEDY. Would you say that you have a shortage but it is manageable?

Mr. PECK. I think we are better off than that. For example, we were able with the help of a joint program with the board of cooperative educational services, local school district, to educate practical nurses, so that there are enough practical nurses to fill our jobs. I think there would have been a shortage had those programs not been in existence.

Likewise Pace College has a registered nurse school here, so they produce some.

I think the area is so fortunate in having industries like Readers Digest and IBM and others coming in, where the young wives might be nurses or that kind of personnel, that has helped. Plus trying to minimize the use of unskilled people. So that I would say it is a little better than manageable. I think we have met it quite well. But it is just again the status quo wouldn't take care of the future.

Senator KENNEDY. Do you have difficulties in getting doctors at nighttime to provide services in the hospital?

Mr. PECK. Staffing our emergency room has been one of our perplexing problems, but I think we do it very well. And this was another example of how quality of care demands medical education because it needs our intern program, our residency program. We have a full-time director of medicine who has among his duties the handling of the emergency room, and the fact, as Dr. Brew said, 140 doctors on our staff do give wonderful backup coverage. So that that exists.

I am sure we could hear from people who say no, I can't get a doctor at night.

Senator KENNEDY. What about nighttime? Can a person in this community call a doctor at night and get him to come out to their home? Say a mother has a sick child.

Mr. PECK. Senator, we do have here the president and president-elect of the Westchester County Medical Society. They have a countywide program designed to meet that, so I am sure they would be able to speak to that, and then we have some consumers. I don't know what they are going to say, but I am sure they can testify about it.

Senator KENNEDY. We visited a number of the emergency rooms in New York City the other night, Elmhurst, Kings County, Lincoln, Roosevelt, Mount Sinai, and a number of the other great hospitals. I saw as we went through a little placard about the minimum cost of $12.50 that is charged for use of the emergency room. Could you tell me a little about that? Is that needed in terms of balancing your books? Do you find that it discourages people that might otherwise come because they are concerned about it? What is really the effect of such a charge?

Mr. PECK. I am sure that it does not discourage, no, sir .We don't enforce that—for example, the collection rate from that kind of service is about 50 percent, whereas the collection rate for the hospital in general is something like 98 percent.

Certainly there is an economic one. We do, as I know you can appreciate, having looked at other emergency services, lose a lot of money in emergency room services. Our unit cost is approximately

$20 per visit, so that the $12 charge is a little bit more than half. On the total per year that costs us probably $300,000 to run the emergency room. We receive an income of about $150,000. So yes, it is a factor, we do lose money.

It is also one of the most rapidly growing departments of the hospital. You are well advised to consider it a significant part of any hospital.

Senator KENNEDY. Dr. Franklin Hall, the first deputy commissioner of health, secretary of Westchester County Board of Health, long experience in public health in State and county departments.

STATEMENT OF DR. E. FRANKLIN HALL, FIRST DEPUTY COMMISSIONER OF HEALTH, WESTCHESTER COUNTY

Dr. HALL. Honorable Members of this Senate Health Subcommittee, I am pleased to be invited to participate in this hearing. Due to the extremely short notice to our department of this meeting (confirming telegram received Apr. 14), it is impossible for the Commissioner of Health, Dr. Jack Goldman, to be present due to prior commitments. For the same reason, it was not possible to prepare a broader in-depth statement to present to the subcommittee at this time.

The Westchester County Health District, with a population of 816,024 people, presently includes all municipalities and towns of the county, with the exception of the city of New Rochelle.

Our county executive, Edwin G. Michælian, having early recognized the importance of health in the lives of the citizens of this county, has provided the leadership which our health department wants to recognize here and now as the impetus for the generally excellent level of health care in this county. In fact, in his last annual message delivered on January 18, 1971, he pointed the path to the future in the health disciplines in this county by stating, and I quote:

> I venture to forecast that delivery of quality health care will become the most talked of subject in our country. Just as the welfare system and its reform, the environment and environmental controls, and drug abuse were topics of the day throughout all of 1970, quality health care and its availability to every American, irrespective of socio-economic status will be the order of the day in the 70's and 80's. That is the reason why, as the head of this government, I place such great emphasis upon development of a medical center in Westchester County and the necessity to affiliate all of our voluntary and nonproprietary hospitals therewith. We must also stress the necessity of protecting the economic viability of these hospitals to insure their serving the medical needs of the people of their area. In the not too distant future, I believe our county will witness the establishment of what has heretofore been called a 'storefront' operation to bring health care to the people rather than vice versa. Strong clinical departments, hospital organizations and practitioners in the various disciplines of medicine, public health and mental health are vital for the delivery of medical treatment of substance and quality to our population to assure their good health. Besides, the topics to which I referred earlier, are tied to health care—the environment, drug abuse, the welfare syndrome and the economic health of our country. Hence, the great emphasis upon the Medical Center, which, when it comes to fruition, in my opinion, will be the most important forward step for Westchester County in the last half of this century.

Many of our citizens have an increasing concern relating to the availability of high quality health services for all in the community.

Accordingly, our department has attuned itself to the many implications and possibilities inherent in this concern. Faced with this mandate, it has been necessary for our department to shift its emphasis to the extensive community involvement in the planning, establishment, and execution of public health programs designed to improve upon previously inadequate systems of delivering health care to the grassroots of our communities.

Although not unique to Westchester County, the problems of poverty with its associated substandard health findings, are present in well-established pockets of poverty areas throughout the county. Many people who are not familiar with Westcheser County are quite surprised that we have 58,000 individuals being served by the department of social services. I am not referring only to the areas of poverty of the southern tier, but also to the rural suburban poverty of northern and eastern Westchester County.

The problem of poverty and its health evils are only a part of the total health crisis in Westchester. We have long been aware of the growing middle income health deficiencies with delivery of health services becoming more difficult due to one of or a combination of factors: (1) high cost of services; (2) poor accessibility of services; and (3) unavailability of services—or a combination of these—there are many combinations. Perhaps the family is not even motivated to seek health services and then again perhaps they may be ignorant of what health services are available and where.

One of the greatest bugaboos to public health people has been and still is the splintering of health services and the fragmentation of health services and, of course, there is always the duplication of health services, which seems such a waste in any society. Sometimes we defeat our own purpose by dividing the patient into so many parts, into so many specialty clinics, that as he functions he feels like a machine.

One could continue almost indefinitely listing the problems attendant to the delivery of health services. The important factor we believe is that we concentrate on the more effective delivery of health services for most of the people—all of the people, if possible.

Although this county is blessed with a significant number of assets in terms of its health manpower and facilities, inclusive of approximately 2,200 highly trained, skilled and dedicated physicians resulting in a ratio of approximately one doctor per 400 people, or twice the national average, along with an equally proportionate share of dentists, nurses, therapists, technicians, 16 accredited and quality-oriented general hospitals, coupled with above-average nursing home and rehabilitative facilities, it is of interest to note that the steering committee on comprehensive health planning has clearly discerned the existence of significant gaps in the availability of general medical care to target groups in various communities of our county. As a result of these and related studies, the county health department has intensified its efforts to make high quality care available to everyone who is disadvantaged in not receiving high quality health care for himself or members of the family unit.

The cause for this apparent anachronism in a county like Westchester can be stated in simplistic terms, and it is believed that the Federal level can most directly lead to its solution.

In such an action, it is modestly submitted that the cause of this top priority problem results in the basic inability of our present old-fashioned health care system to respond effectively to the health needs of today's society.

Briefly, a few of the things we have done during the recent past and a few of the things we are in the process of doing and propose doing are as follows:

The merging of the Mount Vernon City Health Department into the county health department was finalized on January 1, 1970. The coordination between the county and city officials was most effective and resultant action has already attested to the success of such agreement.

A similar merger was completed for the city of Yonkers in January of this year, 1971, and it is anticipated that this merger will broaden the base for health services into Yonkers.

Health Guide Program—Initial programs were established in Mount Vernon and Port Chester and additional programs for White Plains, Greenburgh, and Peekskill are now being formulated.

Other programs, such as unwed mother services, family planning services, and rubella immunication programs have been initiated. A lead screening program for children 1 to 6 years of age is pending approval of the New York State Department of Health.

Facilities have been improved with the latest being our new health and social services center to open next month in White Plains. Previous such facilities have been built in Mount Kisco and Peekskill.

Another major item is the support and encouragement given by the county to promote the New York Medical College's move to Westchester, with the ultimate coordination and improvement of services in the county, due to the development of a large medical complex in Valhalla.

We in this county are working hard to achieve the desired solution, and this is coming about through the partnership that is developing among the health professionals of the official voluntary and private sectors in the coordination of the leaders of the various consumer groups who are increasingly addressing themselves to the health problems of the people at the grass roots of our community.

The solution that we are talking about concerns itself with the need for the establishment of community comprehensive health care centers that will be available to provide a total health care package for everyone's service by such system, inclusive of screening, diagnosis, preventive, therapeutic and rehabilitative care, inclusive of general and specialized outpatient and inpatient hospital care. The county health department, working cooperatively with the appropriate citizen groups, hospitals, physicians, dentists, mental health interests, et cetera, is striving desperately to achieve such goals in such areas as Fairview-Elmsford section of Greenburgh Town, and the city of Mount Vernon. Similar interest is now germinating in the city of Yonkers.

It is believed that these proposed programs will not only do the indicated job, but it is maintained that existing resources will provide more services at lower unit cost than at present. This will be accomplished through a program improved in the utilization of exist-

ing services. For example, a private practitioner cannot benefit from all the paraprofessionals that could be available to him in a group practice. In comprehensive care program, he need perform only the tasks for which he was trained at medical college.

Based on the belief that the Congress will move forward on the high priority health delivery programs that the President is presenting, we on this local level will continue exploring and implementing new and innovative programs to accomplish the goals we need. We need early and significant funding approval on the part of the Congress to accomplish our purpose.

Thank you.

Senator KENNEDY. Thank you very much, Dr. Hall.

Mrs. Boal.

STATEMENT OF MRS. LYNDALL E. BOAL, DIRECTOR OF SOCIAL SERVICE, NORTHERN WESTCHESTER HOSPITAL

Mrs. BOAL. I will try to be brief because I think the main bulk of the people we want to hear from are the consumers that are here.

I appreciate being asked to testify before this Committee because I care very deeply about the provision of good comprehensive health care to the people of our community. The provision of basic medical services to the entire population of our community is in a precarious position. Good medical care is a commodity available in our suburbs, semirural and relatively affluent community, but there are serious breakdowns in the delivery of this care to all people. Severe individual tragedies result. Patients frequently fall between various programs and plans, regardless of their economic level. There is a grave need for a basic foundation of guaranteed health care to be provided by a Federal system, regardless of State and local variations.

Preventive services in particular are lacking for many residents. Medicare will not pay for the routine physical examinations so essential for the proper health care of the old and medicaid recipients frequently have difficulties obtaining this kind of care. Clinic facilities, where good medicine can be provided at lower cost for those who cannot afford private care, are woefully lacking. Northern Westchester Hospital provides the only treating clinics in the whole of Northern Westechester and southern Putnam counties. These consist of a prenatal-gyn clinic and a medical clinic, each held only once a week during the working day. The population in these two clinics has been increasing markedly. It is clear that both expansion and the addition of new clinics is necessary.

There is no pediatric outpatient treatment facility, other than private care, in the area. The nearest pediatric clinic is situated in the county hospital, 16 miles to the south and accessible by public transportation—only with great difficulty. It takes approximately 1 hour and 45 minutes one way, including a wait to change buses, which is impossible for a mother with a sick child. Transportation is a problem peculiar to this area, and one which makes medical care virtually inaccessible to many. There is no public transportation in this community except for one north-south bus line through Mount Kisco.

Patients without their own automobiles are dependent on costly taxis or friends and neighbors.

The emergency room of the hospital is frequently used as a source of primary medical care for those patients unable to afford private care. This results in a lack of continuity of care and the provision of emergency treatment only. This hospital is currently attempting to rectify this gap by incorporating a viable ambulatory care unit into its new structure.

Preventive dental care covered by third party payment is also impossible to obtain. Virtually no dentists accept patients covered by New York State's medicaid program, a service which has been drastically cut in recent weeks. Medicare does not provide coverage and, again, there are no dental clinics. There is only crisis care which could and should have been avoided.

Patients living on close to a welfare-eligible level have severe problems in obtaining medical care. They represent one of the most vulnerable groups needing medical care. A married couple, under 65, receiving welfare benefits, who become eligible for social security disability benefits go off welfare, thereby losing that health care coverage. They are not yet old enough to receive social security coverage under medicare and are therefore without any medical coverage whatsoever. Even to qualify for coverage under the catastrophic illness clause of the New York State medicaid program, their medical expenses must equal 25 percent of their income. Medicaid will only cover medical expenses incurred 3 months prior to the date of application—it frequently takes a longer period of time to reach a total equal to one-fourth of income.

A disabled father living in our hospital area supports his wife and two young children on combined social security and Veterans' Administration benefits of $449.10 per month. He has a surplus income of $24.60 per month over the eligibility level for full medicaid assistance. He must therefore pay the full $24.60 toward medical expenses each month plus 20 percent of all medical costs. Under the medicaid cutbacks, he will be required to pay $66.60 per month, plus 20 percent of all medical costs. The family is totally drained financially and emotionally by this constant financial struggle. This man with metastatic cancer knows that in order to pay his medical bills, he must leave his wife and young children with nothing for their future.

It is my feeling that any individual receiving disability benefits under social security should be eligible for medical coverage. He should not have to wait until he reached the age of 65—he may not live that long. I also feel that payment for drugs should be included under social security benefits. Not to do so is rather like building a house without a roof—in many instances, if the patient does not have access to prescribed medications the total treatment plan is futile.

In this State, patients between the ages of 21 and 65 with marginal incomes are ineligible for medicaid but their medical expenses frequently cause them to enter the welfare program. When they do apply for welfare, debts have accumulated and they have frequently delayed seeking care due to the cost or failed to follow medical

recommendations for the same reason. This has then affected their employment situation, family relations and general level of functioning. A husband and wife, in their late 50's, are slowly approaching this. The husband has had a lengthy illness, suffering from metastatic carcinoma with many hospitalizations and extensive home care. The wife has recently been hospitalized. They must sell their house, their only child may not be able to go to college, and they may eventually slide onto welfare solely because of their medical expenses.

I would like to mention that we do have someone in the audience who is a representative of the welfare rights group from this area who can speak even better to these points than I can.

Two other quick points, and I will eliminate the rest—equipment, which may seem like a small item, is no longer provided under the auspices of a home health agency unless the patient meets the criteria of skilled nursing care. The patient usually cannot pay for the equipment prescribed by his physician and therefore is not able to have it. Frequently the patient is unable to manage at home and must be transferred to a nursing home or rehospitalized with consequent disruption to the family and greatly increased cost to the community.

We struggle constantly with the question of nursing home care for patients. Payment for nursing home care has also been a victim of cutbacks in allowed benefits, as you all know. Many families have been experiencing retroactive denials of medicare benefits, some several months after the patient has entered the nursing home by which time the bills have reached unmanageable proportions. It was interesting the national influential American Nursing Home Association has recently requested that all member nursing homes withdraw from participation in the extended care program, medicare program, which would be a disaster for the individuals needing this kind of care.

Human tragedies such as these should not occur. I feel very strongly that it is within our power to prevent them. Medical care is a basic right that should be guaranteed to every citizen whether rich or poor, black or white, well or ill. We must have the basic foundation of a national health insurance program available to all.

Thank you very much.

(The prepared statement of Mrs. Boal follows:)

Testimony Statement

of

Lyndall E. Boal, M.S.S.W.,

Director of Social Service

Northern Westchester Hospital

before the

Subcommittee on Health

of the

U.S. Senate Committee on Labor and Public Welfare

April 15, 1971

STATEMENT OF MRS. LYNDALL E. BOAL
TO U.S. SENATE SUB-COMMITTEE ON HEALTH

My name is Mrs. Lyndall Boal. I hold a Master's Degree in Social Work, and am licensed to practice as a social worker in the state of New York. I am currently Director of the Social Service Department of Northern Westchester Hospital, Mt. Kisco, New York.

I appreciate being asked to testify before this committee because I care very deeply about the provision of good comprehensive health care to the people of our community. The provision of basic medical services to the entire population of our community is in a precarious position. Good medical care is a commodity available in our suburban, semi-rural and relatively affluent community, but there are serious breakdowns in the delivery of this care to all people. Severe individual tragedies result. Patients frequently fall between various programs and plans, regardless of their economic level. There is a grave need for a basic foundation of guaranteed health care to be provided by a federal system, regardless of state and local variations.

Preventive services in particular are lacking for many residents. Medicare will not pay for the routine physical examinations so essential for the proper health care of the old and Medicaid recipients frequently have difficulities obtaining this kind of care. Clinic facilities, where good medicine can be provided at lower cost for those who cannot afford private care, are woefully lacking. Northern Westchester Hospital provides the only treating clinics in the whole of Northern Westchester and Southern Putnam Counties. These consist of a Pre-Natal-Gyn Clinic and a Medical Clinic, each held only once a week during the working day. The population in these two clinics has been increasing markedly. It is clear that both expansion and the addition of new clinics is necessary.

There is no pediatric out-patient treatment facility, other than private care, in the area. The nearest pediatric clinic is situated in the county hospital, 16 miles to the south and accessible by public transportation - only with great difficulty. It

takes approximately one hour and forty-five minutes one way, including a wait to change buses, which is impossible for a mother with a sick child. Transportation is a problem peculiar to this area, and one which makes medical care virtually inaccessible to many. There is no public transportation in this community except for one north-south bus line through Mt. Kisco. Patients without their own automobiles are dependent on costly taxis or friends and neighbors.

The emergency room of the hospital is frequently used as a source of primary medical care for those patients unable to afford private care. This results in a lack of continuity of care and the provision of emergency treatment only. This hospital is currently attempting to rectify this gap by incorporating a viable ambulatory care unit into its new structure.

Preventive dental care covered by third party payment is also impossible to obtain. Virtually no dentists accept patients covered by New York State's Medicaid program, a service which has been drastically cut in recent weeks. Medicare does not provide coverage and, again, there are no dental clinics. There is only crisis care which could and should have been avoided.

Patients, living on close to a Welfare-eligible level have severe problems in obtaining medical care. They represent one of the most vulnerable groups needing medical care. A married couple, under 65, receiving Welfare benefits, who become eligible for Social Security disability benefits go off Welfare, thereby losing that health care coverage. They are not yet old enough to receive Social Security coverage under Medicare and are therefore without any medical coverage whatsoever. Even to qualify for coverage under the catastrophic illness clause of the New York State Medicaid program, their medical expenses must equal 25% of their income. Medicaid will only cover medical expenses incurred three months prior to the date of application - it frequently takes a longer period of time to reach a total equal to one-quarter of income.

A disabled father living in our hospital area supports his wife and two young children on combined Social Security and Veteran's Administration benefits of $449.10 per month. He has a surplus income of $24.60 per month over the eligibility level for

full Medicaid Assistance. He must therefore pay the full $24.60 towards medical expenses each month plus 20% of all medical costs. Under the Medicaid cutbacks, he will be required to pay $66.60 per month, plus 20% of all medical costs. The family is totally drained financially and emotionally by this constant financial struggle. This man with metastatic cancer knows that in order to pay his medical bills, he must leave his wife and young children with nothing for their future.

It is my feeling that any individual receiving disability benefits under Social Security should be eligible for medical coverage. He should not have to wait until he reaches the age of 65 - he may not live that long. I also feel that payment for drugs should be included under Social Security benefits. Not to do so is rather like building a house without a roof - in many instances, if the patient does not have access to prescribed medications the total treatment plan is futile.

In this state, patients between the ages of 21 and 65 with marginal incomes are ineligible for Medicaid but their medical expenses frequently cause them to enter the Welfare program. When they do apply for Welfare, debts have accumulated and they have frequently delayed seeking care due to the cost or failed to follow medical recommendations for the same reason. This has then affected their employment situation, family relations and general level of functioning. A husband and wife, in their late 50's, are slowly approaching this. The husband has had a lengthy illness, suffering from metastatic carcinoma with many hospitalizations and extensive home care. The wife has recently been hospitalized. They must sell their house, their only child may not be able to go to college, and they may eventually slide onto Welfare after all these sacrifices.

Families just able to move off Welfare frequently return to the rolls if they are unfortunate enough to incur medical expenses within the first few months. Families in which the wage earner is self employed and those who are not covered by Social Security are also vulnerable to similar economic pressures. We have been finding that employers are hiring on a contract basis to avoid paying benefits such as health insurance.

This community also has a high proportion of families in which the wage earner would be classified as a junior executive or in a middle-management echelon. Many of these families spend to the limit of income, with little savings or insurance. Medical expenses, even of a relatively minor nature, cause a disproportionality high dislocation of family functioning.

The recent cutbacks in coverage by both Medicare and Medicaid have resulted in severe problems for many residents in need of health care. Benefits are no longer extended under Medicare unless the program's criteria of "skilled nursing care" is met. Our local District Nursing Association is currently seeing a patient who has had progressively crippling multiple sclerosis for over thirty years. Her husband recently had surgery for cancer, and has a colostomy which needs care. When Medicare coverage was denied, the nurses continued to provide highly skilled nursing care free. Their sound nursing evaluation indicated a need for this, and the family was unable to pay. However a small nursing agency is obviously unable to continue to do this indefinitely.

Equipment is no longer provided under the auspices of a home health agency unless the patient meets the criteria of "skilled nursing care". The patient usually cannot pay for the equipment prescribed by his physician and therefore is not able to have it. Frequently the patient is unable to manage at home and must be transferred to a nursing home or rehospitalized with consequent disruption to the family and greatly increased cost.

Payment for nursing home care has also been a victim of cutbacks in allowed benefits. Many families have been experiencing retroactive denials of Medicare benefits, some several months after the patient has entered the nursing home by which time the bills have reached unmaneagable proportions. A spouse of an institutionalized patient is frequently reduced to a subsistence level even with state and county aid for the nursing home bills. The influential American Nursing Home Association has recently requested that all member nursing homes withdraw from participation in the extended

care program, with the consequent human suffering involved.

Human tragedies such as these should not occur. It is within our power to prevent them. Medical care is a basic right that should be guaranteed to every citizen whether rich or poor, black or white, well or ill. We must have the basic foundation of a national health insurance program available to all.

4/15/71

Senator KENNEDY. Thank you very much. A splendid statement.

Mr. Eugene Curry, who is chairman of the Citizens Committee on Aging and Chronically Ill of Westchester County.

STATEMENT OF R. EUGENE CURRY, CHAIRMAN, CITIZENS COMMITTEE ON AGING AND CHRONICALLY ILL OF WESTCHESTER COUNTY

Mr. CURRY. Senator, I was certainly heartened by your picture of the person who had saved during his lifetime and was in full expectation of being able to remain independent and able to care for himself and what has happened. I think the words yesterday at the White House conference where we are getting ready for the large meeting on the 27th spoken by those leaders of the seven counties, agreed that inflation unless stopped will dissipate anything that may be done for the older citizen.

So if I may, I will carry your point about the lifetime of saving to the next step, and I think something should be done. There are many people who could be retained in their own home—who want to be retained in their own home. Their great fear is that they will not be able to stay there because of their health or because they can't afford it. And these supportive services would cost so much less than to put them into any form of institution care.

We have already in our committee and under the Northern Metropolitan Council granted permits for the health related facilities and nursing homes that we believe are adequate. Now we need the extension of the hospital so that these people staying in their own homes, in the nursing home and in the health related facility can have a place to go immediately in, and then back to their proper place. So we need balance and we need, of course, the new hospital enlargement.

The tragic fact is that costs of supporting services and per diem rate for care, as you have pointed out, have risen rapidly, out of all proportion to past savings and present income of older citizens. They have lived frugally and carefully, with every expectation of being self-supporting, independent members of society to the end. Their savings can be wiped out in a very short period of a few weeks with any prolonged illness. Of course, it is hard for us to believe, but the savings of these older people of the 1930's, when many of them were in their prime, are two-thirds wiped out by inflation. The savings of 25 years ago are half wiped out, and even since 1967 the value of savings and pensions have been decreased by one-sixth. That is 3½ to 4 years.

Now as we come into this nice new health insurance of the United States, I hope you and Mr. Reid will listen to the words of good old Lord Beveridge, about 82 years old. He was here a few years ago as our guest in this community, and he said two things that happened in financing in Great Britain—First, the actuaries in the Government underestimated the cost, and second, inflation underestimated the building up of the benefits. We have already had the underestimation, as you well know, in medicaid and medicare, and we have

the inflation. So I hope we are not repeating those great mistakes which Great Britain went through.

We must get this balance back between savings and the cost of care.

Now let's go further. As a Nation we are not facing up to our problems of inflation but have turned to subsidies in construction and belated increases in social security, never going to the causes of our problems.

We have got to begin with the Federal Government, where inflation has had its greatest impetus.

We must have cooperation from and control over those with monopoly power to force increases in wages and profits far exceeding increases in the cost of living, and all too often without increased productivity or changes to permit it. That could be enlarged upon, but this is not the time or place to do so.

It is not in the national interest to have the powerful and the well organized exploit the worker and it is reprehensible to see the helpless older citizen robbed of his life savings.

Unless and until we as citizens in our various capacities, and our representatives at every level of Government, understand and attack the causes of inflation there cannot be any security for the older citizen in the health or any other field.

Senator KENNEDY. Good statement.

Do you live out here, Mr. Curry?

Mr. CURRY. Yes, sir.

Senator KENNEDY. You have lived out here how many years?

Mr. CURRY. Forty years.

Senator KENNEDY. And you have been a part of this community for that period of time?

Mr. CURRY. Yes, sir, I have.

Senator KENNEDY. We have been hearing this afternoon, as we have over the period of the last 7 weeks in Washington and yesterday in New York City that we have a real health crisis in the country in many areas. You point out what is happening in terms of the suburban communities, and how individuals who live out in a community such as this are disadvantaged.

Thank you, Mr. Curry.

(The prepared statement of Mr. Curry follows:)

R. Eugene Curry
21 Mead Road
Armonk, N. Y. 10504
Tel. (914) AR 3-3004

Statement for U.S.Senate Sub Committee on Health Care in America
Northern Westchester Hospital, Mount Kisco, New York, April 15,1971

By R. Eugene Curry, Chairman, Westchester Citizens Committee on the Aging and Chronically Ill, and Chairman of the Advisory Committee on Nursing Homes, Northern Metropolitan Health and Hospital Planning Council; time did not permit submission of this statement to these bodies for approval or change.

The greatest threat to the older person is the loss of the home or the ability to live in it by reason of failing health or insufficient income under soaring costs of living.

Supporting services could keep many older citizens in their own or similar residential quarters at a fraction of the cost of health related, nursing home or other institution.

Health related and nursing home facilities are important in the total program, and permits for the estimated needs have been granted in this area. It is essential that we build adequate, accessible and complete hospital services for those in their own homes and for those under group care.

The tragic fact is that costs of supporting services and per diem rates for care have risen rapidly, out of all proportion to past savings and present income of older citizens. They have lived frugally and carefully, with every expectation of being self supporting independent members of society to the end. Their savings are wiped out rapidly in the event of prolonged illness; this great imbalance between past savings and present costs is the terrible toll of inflation. The savings of the 1930's have lost two thirds of their value, those of 25 years ago half, and even savings and pensions of 1967 have lost one sixth of their value.

As we approach our own national version of Health Insurance, it is evident that we are repeating needlessly the mistakes of others. Lord Beveridge, sponsor of the National Health Service of Great Britain, was our guest in this community a few years ago; he stated that their great effort had suffered two great blows : Underestimate of costs by the actuaries in government, and the inflation. We see that here, in the underestimates for Medicare and Medicaid and the excessive inflation of recent years.

We must reestablish a balance between savings and ~~expenses~~ to cover health costs; this is vitally important to those over fifty, as well as to those already in retirement.

R. Eugene Curry
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As a nation we are not facing up to our problems of inflation but have turned to subsidies in construction and belated increases in Social Security, never going to the causes of our problems.

We must begin with the federal government, where inflation has had its greatest impetus.

We must have cooperation from and control over those with monopoly power to force increases in wages and profits far exceeding increases in the cost of living, and all too often without increased productivity or changes to permit it.

It is not in the national interest to have the powerful and the well organized exploit the worker and it is reprehensible to see the helpless older citizen robbed of his life savings.

Unless and until we as citizens in our various capacities, and our representatives at every level of government, understand and attack the causes of inflation there cannot be any security for the older citizen in the health or any other field.

R. Eugene Curry

Senator KENNEDY. We have now completed the formal witness list. Some individuals have given us their names, and we will hear from them now.

Mrs. Hausner has to leave at 4:30, and then we will hear from Mrs. Sanchos. For any of you who want to file a statement, we will be glad to include in the record that so that your views are represented. We ask those that speak if they can keep to 3 minutes or so. If we are able to get through everyone we will come back and give you another chance after that.

STATEMENT OF MRS. STOWE W. HAUSNER, MOUNT KISCO, N.Y.

Mrs. HAUSNER. I will try to speed through this.

I am here as a citizen, as a consumer, someone who has lived in this community for over 20 years. You have described this as an affluent community. I really feel the description of affluence is a deceptive one. Our pockets of poverty remain fairly invisible to most of us. Our neighbors living in poverty include those who are post-revolutionary war settlers as well as newly arrived families. The group that is least visible to us are the seemingly middle class families, who even before this inflationary time, were barely coping on their incomes. Most of them have fed our inner cities, and now find themselves house-poor. When income is limited, health care without insurance becomes one of their postponable budget items. Medical care for many of these families, who are in every respect responsible citizens and community members, is something they allow themselves and their families only in situations of severe or extreme illness. The use of such services frequently results in increased debt.

I feel great concern about this situation because I, too, regard comprehensive health care as a basic right.

Children within our community are the most frequent victims of their parents' poor financial planning or lack of income. So that some are really poor and others are not visible to us as poor people. They cannot electively choose medical care. I'm sure the kids themselves would be reluctant for their parents to use it.

Medical care is possible for any family in northern Westchester despite lack of income. But let me briefly describe to you how fragmented it can become, for children in particular.

We have a well child conference available to all children from birth to 5 years of age whose families cannot afford private care. I think Mrs. Boal described to you the trek, but not the cost of $3 in just fare in order to obtain medical care. Where a family has no physician our emergency rooms have become the physician's substitute.

Without some type of universal health insurance within this democracy I feel we offer no free choice of medical care. This is primarily what physicians tell us—that everybody must have a choice. We are not allowing that choice. Choices exist only for those who can pay their own way.

Medical care must become available to all of us. We should be able to make the judgment as to the best care we wish. This may be a private practitioner, a medical group, or a clinic.

I would like to see the day when the hospital clinics and emergency rooms would be filled only with those people waiting there because this is where they believe they receive top level medical care, rather than as now exists, emergency rooms and clinics are seen by patients as the only place they can afford and frequently the only medical facility which will tolerate them.

(The prepared statement of Mrs. Hausner follows:)

PREPARED STATEMENT OF MRS. STOWE W. HAUSNER, MOUNT KISCO, N.Y.

I submit this statement as a private citizen; a resident of an area the subcommittee has described as "affluent". The description of "affluence" is a deceptive one. Our pockets of poverty remain fairly invisible to most of us. Our neighbors living in poverty include those who are post-revolutionary war settlers as well as newly arrived families. The group that is least visible to us are the seemingly middle class families, who even before this inflationary time, were barely coping on their incomes. Most of them have fled our inner cities, and now find themselves "house-poor". When income is limited, health care without insurance becomes one of their "postponeable budget items". Medical care for many of these families, who are in every respect responsible citizens and community members, is something they allow themselves and their families only in situations of severe or extreme illness. The use of such services frequently results in increase debt.

I feel great concern about this situation because I too regard comprehensive health care as a basic RIGHT. It is already axiomatic that the wealth of the nation can and should be measured by the health of its people. We readily accept that people living in poverty have a disproportionate number of health problems—due to malnutrition, lack of availability of pre and post-natal care, etc. What is less evident is that otherwise self sufficient families can become poverty stricken due to illness. This poverty is not only due to the direct cost of medical care to a family; but also to loss of income for either the husband or wife bread winner. Health care, which families cou'd afford to use freely could prevent much of this poverty. I have no question but that we have superior medical care available in our community. It is important that all our citizens have equal access to it.

Children are the most frequent victims of their parents poor financial planning or lack of income. They cannot electively choose medical care—I'm sure they wou'd most frequently be reluctant to. Medical care really is possible for any family in Northern Westchester despite lack of income. Let me briefly describe how fragmented it can become for children. We have a Well Child Conference available to all children from birth to five years of age whose families cannot afford private care. Beginning at the age of five a child needing pediatric services wou'd have to use our county hospital some fifteen miles away. If the family has no physician in the community the hospital emergency room will become the substitute. Another category of victimize children are those whose family may have marginally sufficient funds but whom mismanage their income. Without some system of insurance coverage, we allow these children to suffer from their parents distorted sense of values. We do them and our nation a disservice.

Without Universal Health Insurance we offer NO free choice of medical care for those with marginal incomes. Choices exist only for those who can pay their own way. Medical care must become available to all of us. We should be able to make the judgment as to the best care we wish. This may be with a private practitioner, a medical group or, in a clinic. I would like to see the day when hospital clinics and the emergency rooms would be filled with those people waiting there because they believed that this was where they would find top level medical care—rather than the only places they can afford, who will "tolerate" them.

Senator KENNEDY. Thank you very much, Mrs. Hausner.

Mrs. Sanchos—just for the record, could you give us your complete name and address?

STATEMENT OF MRS. BLANCHE SANCHOS, COMMUNITY WORKER, COMMUNITY ACTION PROGRAM, YONKERS, N.Y.

Mrs. SANCHOS. My name is Mrs. Blanche Sanchos, community worker, community action program in Yonkers; address, 138 South Broadway. I am also an active member of the Poor People's Consumers Committee on Real Health Care.

I don't have a statement prepared. I do have a few points I would like to respond to.

I heard mentioned before, peer review, and who does the peer review. It is impossible to think that in the medical profession this can ever be a reality, simply because standards of health care are set up by doctors, codes for standards are set up by the medical profession. There is no independent body or accountability to anyone in the community at large for either service or expenditure of public funds. I say public funds because there is no such thing as private medical care. Today we have what you call a voluntary system that is quasi-public. All health care depends upon public funds in one way or another.

We find that there are ways in which this can be found and the big barons of the medical empire know how to get them. There are tax exempt funds they know where to tap. Before any of the poorer communities are able to know where the Federal funds are coming from and how to obtain them for the local communities they already have their grants in.

I am particularly kind of keen to one of the points brought out in terms of the New York medical complex coming up here. I am disturbed because besides losing that medical school we might lose a second one, the Einstein complex. Today there are games being played by the Montefiore medical complex to see how they can improve their affiliation and hook up with NYU, and this way not only will they control the medicine in the Bronx, they will control Westchester and Rockland.

But let me relate now to what I really wanted to speak about, and that is that here in northern Westchester we are talking about health care. The county of Westchester has very well people. We don't have that in Yonkers or any of the poorer cities in southern Westchester. Yonkers, whose health care is one of the saddest things in this Nation—we talk about Lincoln Hospital—Senator, before you leave please visit Yonkers. Come to St. Joseph and Yonkers General. Come and see an emergency room that has no staff. Come and see one-third of the population who is poor, has no power—and simpler, there are no services.

I heard about the department of health. We have no department of health in Yonkers. We have some well baby clinics. I heard of your comprehensive health centers. When I came here I knew about the ghetto hospital.

We were told there are no plans to expand. We have something going in Greenbury, but not in Yonkers right away.

In the county of Westchester with all its poverty—and there is a lot of poverty—I am talking about Yonkers, Mount Vernon, New Rochelle, Peekskill—all over the county there are little pockets. In the county of Westchester, with all respect sir, we don't have a lead poison program. Incredible. Twelve thousands units of substandard

housing in Yonkers, and the county of Westchester does not have that program. The city of New York has had it for 2 years.

Senator KENNEDY. We don't have a program at a national level. We authorized $15 million for this year, $20 million for next year, 25 the next year. But not one cent was requested by the administration for lead poisoning programs.

Mrs. SANCHOS. Should I rephrase it then?

Senator KENNEDY. OK.

Mrs. SANCHOS. I just took some notes, and I'm sorry.

Senator KENNEDY. That's all right. You are doing very well.

Mrs. SANCHOS. I would like to refer you to the problem of the aged, one of the things that concerns me particularly with the voluntary hospitals. At one point—that must have been about 3 or 4 years ago—there was money in the Federal Government for the extension of this service among the ambulatory. Then some funds dried up. I notice now the voluntary hospitals have been decreasing the service. I became familiar with it when I was working for the affiliation and spent a lot of time in the emergency room. I became impressed with the home care service simply because most of the population—80 percent of it was aged. This program released hospital beds to take care of the poor. It also gave other services; in other words, it coordinated services that were in existence that were not being tapped, and I feel that there should be an extension of this.

Senator Kennedy, the county of Westchester has got to wake up. On their doorstep is one of the greatest problems that they have turned their backs on, and that is the drug addiction.

Formerly I worked in the South Bronx area and I thought nothing can be worse than this, but, I found the worst part in Yonkers—found 14-year-olds dealing in the streets. They weren't only taking the needle, they were pushing the drug in order to maintain the habit.

I'm sure you go nationwide and hear this, but I am talking about the county of Westchester. I am talking about the fourth largest city in the county of Westchester who suddenly the county has turned its back on. When I heard of such a fantastic program going on here, I thought perhaps somehow we can come up and visit with you and see how that program could be initiated down there.

We need help and we need desperate help, but I think that the only way that we can get it is at hearings like this so public attention can be brought to bear on the problems.

But we have a few other people here from Yonkers, and I think they have other points to bring up.

Thank you very much.

Senator KENNEDY. Thank you very much.

Mr. Maisel.

STATEMENT OF ALBERT MAISEL, WRITER, READERS DIGEST

Mr. MAISEL. Yes, sir.

Senator KENNEDY. We will try and follow the 3-minute rule.

Mr. MAISEL. I will follow the 3-minute rule.

I am a writer for the Readers Digest specializing in medical matters, and particularly in social aspects of medicine.

My purpose in coming here is twofold. First, I think it may be of value to you to know that there is a crisis among the middle class. That may come as an anticlimax after hearing the very acute, very desperate, very heart-rending aspects of the crisis as it affects the poor. But there is also a crisis among the middle class.

The Readers Digest, for example, has for very many years maintained an insurance program, the usual Blue Cross and Blue Shield and the major benefit program, the Digest paying two-thirds of the cost and the employees, some 2,800 of them in this area, paying one-third of the cost. When this started this was a minor fringe benefit in the total wage package, salary package of the Digest. Today, after repeated increases in cost, this has become part of the package, much more than a fringe benefit. And yet the Digest employees, who are middle class people, well paid, well salaried, are unable to get as good health services as they were able to get some years ago in spite of the fact that the cost has gone up.

This is not the fault, let us say, of Northern Westchester Hospital. Here there has been great devotion, volunteer devotion by all sorts of people in the community, including many Digest people, to build this hospital and maintain it and maintain the services. But the fact is here is a plant that is in part obsolescent and that is not able as it stands, until it gets its new building, to give the same sort of service it could give 10 years ago simply because the population of the area has grown while the plant has aged.

And this is happening not only here in Westchester, not only to the Digest middle class employees, but it is happening to similar groups throughout the country.

I think in part because my editors see this from day to day among themselves, they feel the fact that their coverage, in spite of trying to buy the most complete coverage and the ability to buy the most complete coverage, this coverage is with deductibles——

Senator KENNEDY. What do you think is the answer?

Mr. MAISEL. The answer, I think—and I know our readers think, from the letters we get from them when we publish articles on this—is that we do need some form of national health insurance. As we said in an article that we published in February, the debate has largely shifted from whether to adopt national health insurance to what kind of a program we need and how big.

And I think that increasingly this disgruntled middle class group is finding that it needs in its own interest, as well as a desire to help the disadvantaged—that what we need is a health program, a form of national health insurance, but beyond that it must not be a program that merely adds insurance. If you give us just insurance you will be compounding the mistake that was made in 1965 with medicare and medicaid, the mistake of adding buying power without adding supply. A program such as this has to have imbedded in it a segment of the funds collected, however you collect, whether by wage tax or by income tax, that will go for the building of new hospitals, that will go for the building of medical schools, that will increase the supply of physicians, that will permit the peer review, and every other goal that has been mentioned here today. And I say that this is what we get in our mail, this is what I get when I interview members of the Digest staff or when I go out and interview middle class people who are the Digest readers.

Senator KENNEDY. This is what we get in our hearings, too.

Mr. MAISEL. I am sure.

Senator KENNEDY. Would you not agree with me that the hospitals alone can't meet this problem?

Mr. MAISEL. No. Here is a hospital who has not been able to meet this problem, and let us say although it is struggling manfully to do so, it can't raise the money.

Senator KENNEDY. Any more than you could expect the doctors in and of themselves to try and remedy the situation.

Mr. MAISEL. They can locally by extra efforts, or something, in the way they used to give charity and remedy the situation.

Senator KENNEDY. But I think your point is that it is the system itself. When you talk about the development of some kind of health insurance you also talk about increasing the supply of services, as well as the whole question of quality and establishment of innovative and creative programs that develop competition between health delivery systems.

Mr. MAISEL. Without feeding them the answer, I find they volunteer the answer—they don't want just national health insurance. They want a national health insurance program that will increase the supply of health facilities.

Senator KENNEDY. Well, I appreciate your comment. I think it reinforces at least my view on it, and I think Congressman Reid has expressed it as well. It is very reassuring—Readers Digest has maintained contact with the people, and has a real feel for what people are thinking about; I think this is an extremely important and useful comment.

Mr. MAISEL. I don't take any position in favor of one program or other, and I am speaking here on my own on that, but the fact is the Digest experience is part of the total experience of the middle class here and they are disgruntled over what they have today.

Senator KENNEDY. Thank you very much.

Joan Munley, director of health services, public schools.

I am going to have to leave. Congressman Reid has indicated that he would be able to remain for a while. Our two staff will remain, and I hope that we will continue along. I will read the transcript of the testimony very carefully. We will not recess, but continue right along.

We have Joan Munley and Mrs. Claire Marcus, who is a private citizen, and Mr. John Harris, who want to make a statement.

Mr. REID. And I hope also that anyone in the room that wants to speak for the record will do so even though we may not have the name.

Senator KENNEDY. I want to thank you very much for your coming here, and thank Congressman Reid, and thank the hospital administration of the Northern Westchester Hospital.

We are asked often what you can learn from these hearings. We are only here for a couple of hours. But we spent a couple of hours out in Nassau County earlier today. We were down in the city of New York yesterday, and in the emergency rooms of some of the hospitals the night before. We have been holding hearings on this general health care crisis area for 8 weeks in Washington, and now we are going into the field. We have seen yesterday and today that

none of the national experts' testimony is more eloquent than that coming from people that have a very direct contact with health care services. It is enormously helpful to the Senate and to our understanding of this issue. We are very appreciative for the courtesy that you have shown and the attentiveness which has been reflected at this meeting here this afternoon.

We will go ahead and continue the record as long as Congressman Reid can stay. And I want to once again thank you all for your interest and your attention here.

(Senator Kennedy withdrew.)

Mr. REID (presiding pro tempore). I think we will proceed, and I would like Joan Munley, as director of the health services, public schools of——

Mrs. MUNLEY. Bedford public schools. That is a central school district that serves this area.

Mr. REID. If she will proceed, and we have three or four that have asked to speak, and then we will open it up.

STATEMENT OF MRS. JOAN MUNLEY, DIRECTOR OF HEALTH SERVICES, BEDFORD CENTRAL SCHOOLS

Mrs. MUNLEY. I just want to say that we in the health services in the schools work with the so-called well child, and Mrs. Boal and Mrs. Hausner have very ably related to you how our marginal families do and do not use health services.

However, I would like to point out most especially the mental health needs of growing youngsters. We see on a daily basis scores of children in our health services that have semantic complaints that really are related to stress, stress in their private lives and/or in their school lives. And we feel that the mechanism for promoting the mental health and protecting the mental health of growing children is very, very vital.

Mr. REID. What therapy are you able to give in that regard?

Mrs. MUNLEY. By law the schools are forbidden to give therapy. This is not permitted. We do screening only. And we are totally dependent on the communities for whatever services are needed.

Mr. REID. Well, when you refer a child to whatever means that you choose what are the chances that he will get any kind of adequate therapy?

Mrs. MUNLEY. The chances that he will get therapy when we from the school refer a youngster depend on his parents. They have the final responsibility for the care of the child. From there on Mrs. Boal has——

Mr. REID. Are there a significant number who need therapy that are not getting it?

Mrs. MUNLEY. What I am speaking here to at this moment is the growing child and help for him in coping with the stress that he finds in his daily life.

Mr. REID. Fine. Well, thank you very much. We appreciate that comment, and we will look into it.

Mrs. Claire Marcus. Thank you very much for staying.

(Supplemental information subsequently supplied by Mrs. Munley follows:)

BEDFORD PUBLIC SCHOOLS
THE FOX LANE CAMPUS, P. O. BOX 180, MOUNT KISCO, NEW YORK 10549
Area Code 914: 666-6731

ANTHONY C. SABELLA
Superintendent of Schools

ERNEST L. HUNTER
Assistant Superintendent

April 21, 1971

Senator Edward Kennedy, Chairman
Senate Labor & Public Welfare Committee,
Sub Committee on Health
Washington, D.C.

Dear Senator Kennedy,

Your personal assurance, during your visit to Northern Westchester, that a spokesman for the school children of Westchester County would be heard and that a statement made would become a part of the record of the Senate Labor and Public Welfare Committee, Sub Committee on Health has motivated follow through.

Repetition, in this instance, has its value. To be sure, what is written on the attached statement you have heard before. However, what is said does not come from a health agency but from public education. This view of how health care affects the lives of children and youth as they face their daily responsibilities in the school can complete the total health care picture.

Rarely is one sought out by his federal government and asked to speak of the concerns in the daily lives of growing children. This is in itself an event. At the same time it was conveyed to me that what was said at The Hearing does and will have meaning toward a better life for all in the future.

Thank you for making this possible.

Sincerely yours,
N. Joan Munley
N. Joan Munley, Director
Health Services

BEDFORD PUBLIC SCHOOLS

SCHOOL HEALTH SERVICE

P.O. Box 180, Mount Kisco, New York 10549

We work in the public schools with what is known as a "well child" population.

Our purpose is to promote and maintain health in order that children can make the best use of their educational opportunities.

Our responsibility is to guide families to health services for their children and, at times, to guide parents as well. Sometimes, children are at home to care for parents who are ill.

By law, public schools are not free to render diagnostic and therapeutic services and therefore are entirely dependent on services in the community.

What are those things that block children from getting the services they need?

1. Availability of diagnostic services when exceptional problems occur.

   A. Timing for working parents is not appropriate. Public service schedules require time off from work to obtain care for children and their parents.

   B. Geographic location - special services are at some distance and require private transportation. It is unusual that parents refer themselves to these services and more than usual that they are there on referral of a physician.

      Such families are apt to live with their daily health problems and use the Emergency Room at the Hospital at times of crisis

      or

      drift from private physician to private physician and there is therefore no continuity of care or a total view

point of the family and its problems and how they might affect an individual's health.

This is aggravated by a great deal of mobility. 10% of our children are new to the school each year. They are from all parts of the country and of the world.

Children and parents of these middle income families depend a great deal on school medical and nursing services for health supervision. Concretely this means discovery of either acute or chronic health problems at the school. Part of this reflects the families priorities and values and part the rising cost of medical care. These families do not go to doctors unless "something is wrong".

Mandated annual health inspections in the past lead to a false sense of security in that numbers precluded examination of the children in depth.

Now that the mandate has been changed to 4 or 5 times during the school life of a child, we are in a better position to perform broader and more complete and more meaningful screening examinations.

What are the major health problems of school children as viewed from the daily life of a child?

1. Debilitating, recurring marginal infections resulting in frequent school absence or lethargic presence in classes. ie. One stays sick until he gets well unless a crisis occurs.
2. Somatic complaints that are seemingly related to stress in the child's life at home and/or at school.
3. Dental caries: It's not unusual for a child to be at home in bed with a toothache!

What would make things better for school children and their families?

1. One place where families can consistently, freely, and conveniently go with all of their problems, both health and social.
2. Total coordinated care whether under the supervision of a family physician or a public service rendered to families.
3. Services geared to needs of working parents so that they will not need to lose a days work to get them.

STATEMENT OF MRS. CLAIR MARCUS, FLOOR WITNESS

Mrs. MARCUS. My statement is very brief. But I am rather surprised the point has not been made up until this moment—the breakdown in amount of money that supports hospital care, medical care, research, and what have you. I feel—and many will agree with me when I say this—if the war in Vietnam were to end this money could then be channeled very usefully into all of these fields. And since we seem to be at such a crisis pitch as far as the kind of medical care that is available in this county and many other counties across the country I certainly think that this war has to stop at the very earliest opportunity.

Mr. REID. Well, I agree with you, and we also need a peace dividend and a change in priorities so that we can really make major amounts of money available for health care and environment, schools, and other needs.

Thank you.

Mr. John Harris had two questions.

STATEMENT OF JOHN HARRIS, FLOOR WITNESS

Mr. HARRIS. Thank you, Congressman.

I don't know whether they are questions or a comment. I raise them anyway.

I am doing some preliminary doctoral research concentrating principally on the problem areas within the hospital and focusing on the training areas, and in some preliminary work I have been doing I find a tremendous woeful lack of training, particularly with the nonprofessional staff. I am not speaking about universities, and so forth, which seem to have a tremendous program. But in the area of the nonprofessional staff the hospitals seem plainly aware of the need of it, but felt their greatest problem was not just funds, but in getting people released, getting supervisors to understand.

Mr. REID. Let me ask Dr. Brew if he would like to comment on training for nonprofessional staff here.

Dr. BREW. Yes, sir, we have a full-time, in-service director of ongoing educational programs that relate to nurses and others, and these are not restricted only to nurses. But I think this is frequently a void. I concur with that.

Mr. HARRIS. One of the key areas, it would seem to me, is in the area of supervisory training, and this is among the professional people. The nurses are trained very well, and other professional people, but they have had very little training in supervisory management skills which take on a whole different aspect when they are thrust into positions and frictions in human relations and employee relations areas.

The other question, maybe you would comment, Congressman, on Mr. Curry's point of inflation and the cry of many hospital administrators versus the unionization of hospital workers. By this I mean I believe as of July 1st many hospitals in the city will have a base pay for the lowest worker of $130 a week, and we know that the poverty level for a family of four in New York City is about $6,000. So the problem is how can a worker support a family and survive, and yet hospitals have the crying problem of inflation.

Mr. REID. Well, I think that inflation is very serious, and it is one of the reasons why I have supported hooking social security benefits to cost of living so that social security benefits go up automatically with the cost of living.

But it is very true that many citizens have very little in the way of savings and they are wiped out almost overnight by catastrophic illness, and that's why the legislation that we are holding hearings on today is trying to deal across the board with a whole series of needs to develop a coherent national health delivery service that we just don't have. And it has got to reflect, in my judgment, not only inflation, but in addition provision for a shortage of—well, 150,000 nurses, 50,000 doctors, perhaps a quarter of a million health professions personnel, plus increases in facilities. All of that has got to be part of this, as well as the capacity to provide the service for the individuals. But if it is just an insurance plan the individual can't afford, with the services not available, it is not meeting the needs.

So I think your point is very well taken.

Mr. HARRIS. Thank you.

Mr. REID. Thank you.

Yes? Would you give your name?

STATEMENT OF JOSEPH GARRISON, NURSING HOME ADMINISTRATOR, PEEKSKILL, N.Y.

Mr. GARRISON. Joseph Garrison, Nursing Home Administrator, Peekskill, N.Y.

I want to bring to your attention a problem which I have run across recently which seriously affects the aged when they become nursing home patients. The State hospital code requires a nursing home patient be visited at least once a month by the physician of his choice, and, of course, more if necessary. I have run across the situation where a number of doctors refuse to treat and care for nursing home patients at all. Maybe physicians who have spent many years caring for an individual, but when that individual goes to a nursing home the doctor washes his hands of the individual and says, "It is just not my policy to treat nursing home patients. It is not that I can't care for them, I just don't want to." And here you have an individual late in life who has been associated with a physician for a good number of years, suddenly finds he has been tossed out.

Now couple this with the traumatic experience of moving from a home or hospital into a nursing home, it is a serious problem for this person. And I don't know how to solve it, but I think the medical associations and societies must police themselves and correct the situation.

Mr. REID. Well, that is a very important problem. I am glad that you raised it. And let me ask either Mr. Peck or Dr. Brew if they would care to comment on that problem. Did you hear this, Mr. Peck?

Mr. PECK. I didn't hear it.

Mr. REID. Well, it is a case that there are many individuals in nursing homes who are unable to have their physicians or any physician visit them, and there is a requirement under the law that this be done from time to time.

Mr. GARRISON. It is really a problem that they cannot have a physician of their choice. Their physician may say, "I'm sorry, I don't treat nursing home patients." Then the individual has to hunt around and try to find another doctor who will treat them.

Mr. PECK. Well, I share with Mr. Garrison the feeling that this is a problem, and I hope we will be able to cooperatively work it out. Mr. Garrison runs a nursing home with which we have transfer agreements. We do try to keep in close touch, and that is what Mrs. Lyndall Boal meant when she was talking about a continuity of care. I think it is important, but it is a hard thing to achieve. Dr. Brew can comment on the problem from the doctor's viewpoint.

One reason why Northern Westchester Hospital's center program includes an extended care unit—and I am sure you don't view that as competition, understanding that those patients are ones that need a little more doctor visiting and will get it through the new plan.

I agree wih you, and we would like to try to work with you to improve it. Harold, what do you say?

Dr. BREW. No, I think the basic premise of ongoing efficient patient relationship doesn't stop at the door of entry to the hospital or door of entrance to the nursing home, so this has got to be solved.

Is geography a problem?

Mr. GARRISON. It is not a problem of geography. I really don't think it is a problem that the hospitals face.

Dr. BREW. I think it is something the medical profession will have to come to grips with and increase their own practitioners.

Mr. REID. Is there anything further?

Dr. DELAUGHEN. May I answer that? I think a part of this is——

Mr. REID. Will you give your name?

Dr. DELAUGHEN. Dr. DeLaughen from Pleasantville. Part of the problem is we do not have that many nursing homes in our particular local area. Geography is an important point I think, and on the other hand, if there is one particular reason—so far as I know, every effort is made that this patient is being transferred to a physician who may be much closer to a nursing home, and with proper transfer of charts and information, medicines, and so forth, and then the care will be continued there, and so there is no discontinuance of care, it may be transferred.

Mr. REID. Well, of course, I think doctor-patient relationship is terribly important, but be that as it may, I am glad you raised that point.

I think Mrs. Gurgenheim is scheduled to testify and hasn't had the opportunity to.

STATEMENT OF MRS. GURGENHEIM, FLOOR WITNESS

Mrs. GURGENHEIM. I am very happy sitting here today, Congressman Reid. I was going to take this up with you myself, but Mr. Curry insisted I come here this afternoon to the hearing because he is very familiar with this case. He has known my parents for as many years as he lived in town, which is over 45 years.

My mother had a stroke some time ago. She is now in a nursing home which costs over $1,000 a month without any extras. The financial sacrifice many of us are facing is tremendous when we try to provide decent care for our aged and sick loved ones.

My parents came here from Europe 70 years ago with nothing. They worked hard and sacrificed. After a long time they were able to build—and much of it was with their own hands—a house where they hoped to live out their days on their hard-earned savings. For most of their lives they earned as little as $3 a day, and often less, doing manual labor—farm work, cooking, cleaning, and whatever else they could find to do. Due to the inflation the earnings and savings of a lifetime can now be used up in just a few months when a major illness occurs such as in the case of my mother's recent stroke.

If my parents had not saved their money and done without many things and did not have any assets such as their home my mother would today be automatically taken care of by the Government. If they had been very wealthy my mother could afford a staff of nurses and would be able to live out her days comfortably in her own home. But my parents are neither of these extremes. They were good hard-working, taxpaying middle income Americans.

Now the Government tells us that if we, the children, cannot afford to pay this more than $1,000 a month—and we cannot much longer—to keep my mother in a decent nursing home the Government will place a lien on her home. This to me is criminal.

If my mother recovers—and we hope and pray she will—where will she go and what will she live on? All her possessions and memories of a lifetime are in that house. She looks forward to returning to it.

There must be a better system of financing convalescent care for the elderly, especially for the elderly who have contributed so much to this great country during their younger years. They have lived in this immediate vicinity for over 60 years. [Applause.]

Mr. REID. I appreciate your comments, Mrs. Gurgenheim, and it is our hope that the Congress will provide some better answers.

Mrs. GURGENHEIM. Well, I know it may not help my mother, but it may help other people that are facing the same problem.

Mr. REID. Thank you for being so patient.

STATEMENT OF STEPHEN KIDD, YONKERS, N.Y.

Mr. KIDD. My name is Stephen Kidd. I live in Yonkers.

My concern has to do not so much with the bad conditions of health care in Yonkers for poor people, black, white, and Spanish, because I think that those were very well covered by Mrs. Sanchos. I think, however, that the question that has to be asked is what can be done. I think also that everybody is shying away from the central issue in the real solution. The real solution to me starts with beginning to say that no one has a right to make a profit off another human being's misery. This is the problem—because you have a medical establishment that is out for its own good and can afford to put a lobby in Washington to get laws bent to their benefit while poor people suffer.

When I go to the emergency room and pull out my medicaid card it is not because I want to go to the emergency room—it is because I know that if I go to any of the private physicians in my community that they are not going to accept it, or that I am going to have to wait 6 hours while 200 other people in the same economic position as myself wait for 5 minutes of half-ass treatment. And we are tired of it.

People have talked about all sorts of revolutions, but there's going to have to be a health revolution. And if the President doesn't do something about health then it is going to be the people who do something about health, because we are tired of dying and nobody gives a damn. And that's really all that I have to say. [Applause.]

Mr. REID. Well, thank you for your eloquent statement. It speaks very clearly.

Mr. Fred D. Zwick.

STATEMENT OF FRED D. ZWICK, PRESIDENT OF THE COUNCIL OF SOCIAL AGENCIES, WESTCHESTER COUNTY

Mr. ZWICK. Congressman, I have a long report which I just filed with Senator Kennedy's staff aides for the use of the committee afterward. I am sending in a letter of transmittal as president of the Council of Social Agencies. These reports are of conferences and task force committees over a period of 6 or 8 years of private and public planning work in the county of Westchester on the subject of health and health service lacks.

I thank you for having this hearing today, and I am delighted to be able to help.

Mr. REID. Well, thank you. Is there anything in particular you would like to highlight?

Mr. ZWICK. I think it was all done much more dramatically than I could and these words really back up much of what has been said, particularly in the field that Mrs. Boal had to speak to, Mr. Curry, Dr. Hall, from a public standpoint, and some of the people from South County. Much of the work of the Westchester Council in planning, of course, does emphasize the lack of health care in the south county, so I am delighted to just put it into the record to back up what they said.

Mr. REID. How would you characterize the delivery of health care of the northern part of the county at this point?

Mr. ZWICK. I think the entire situation is governed by the crisis type of health care that we have through our health system. Our insurance programs, both medicaid and private, emphasize going to the hospital before you really are cared for too well, whereas what our surveys have shown for many years is that we would be far better off if we could shorten or short circuit this care in the homes or in treatment centers within the neighborhoods where the care would be more attuned to the problem of the individual and their family, more personalized, with less of a traumatic dislocation, and far cheaper.

The use of the hospital as a provider of primary care is probably one of the greatest difficulties we have today, and I can understand why, because the delivery system for health care has broken down.

Mr. REID. Well, I thank you very specifically and warmly for appearing today personally. The Westchester social agency over the years has focused on the need and the importance of getting some major help in this area. Thank you very much.

(Further information subsequently supplied by Mr. Zwick follows:)

WESTCHESTER COUNCIL of SOCIAL AGENCIES, Inc.
COUNTY OFFICE BUILDING • WHITE PLAINS, NEW YORK 10601 • 914 WH 9-0370

TESTIMONY BEFORE HEARING OF
UNITED STATES SENATE SUB-COMMITTEE ON HEALTH
at Northern Westchester Hospital
Mount Kisco, New York
April 15, 1971

My name is Fred D. Zwick and I live in Pound Ridge not far from this hospital. I am President of the Board of Directors of the Westchester Council of Social Agencies, the only countywide, voluntary, health and welfare planning center in Westchester.

Since 1954, planning and coordinating health services has been an integral, full-time function of the Council. Through its Health Consultant Service, the Council organized meetings, conferences and studies on specific health areas and unmet needs in Westchester. Copies of reports are being submitted with this statement. To save time, I will not discuss them in detail.

As one of the most affluent counties in the United States, Westchester can claim that its health and welfare resources exceed in number those of most other counties. The 1968-69 Directory of Community Services in Westchester County, published by the Council, lists 536 different programs and services --- 227 supported by tax funds and 309 supported primarily by voluntary contributions. Not listed in the Directory are proprietary services such as two general hospitals, more than 50 nursing homes and two home care agencies.

It must be noted that this impressive number of health services does not mean that all essential services are available. For example, Westchester's chronically ill psychiatric patients must be sent outside the County for long-term care.

The profusion of services combined with the increasing complexity and specialization of health services create frustrating predicaments to those who need health care, regardless of financial circumstances.

Federal programs for the most part, have been unable to fulfill their promise. Medicare and Medicaid, for example, are mechanisms to pay for medical services within the current system of fragmented health care. Without relating the newly-developed payment ability to increasing the manpower supply to meet the increasing demand, the subsequent escalation of health care costs is threatening the ability to deliver services

to all segments of society. Co-insurance and deductible features of insurance plans compound the incomprehensibility of the federal programs for the consumers and add unanticipated expenses when they can least afford them. This is particularly true for the elderly.

Present medical care is crisis- and institutionally-oriented, i.e., patients who are hospitalized may have their bills paid in full. Furthermore, eligibility for admission to a nursing home, which costs less, or for receiving nursing care at home, must follow a brief hospital admission before payments for these services can be approved. The result is emphasis and overuse of the most expensive medical service -the acute hospital- and no financial encouragement for preventive or ambulatory and home care.

Based on our years of working closely with lay and professional people (now called consumers and providers of services), we believe that order must be brought to the present chaotic system. Just as incentives are offered now for the use of hospitals, there is need for the development of incentives for alternate medical services. The purpose would be to provide a greater variety of services accessible to those who need them at less cost to patients and society as a whole.

Incentives should be offered for use of preventive services, such as local neighborhood health centers, which would provide primary health care within an identifiable geographic area. Such centers would provide preventive medical care and treat minor difficulties which can be handled appropriately out of hospitals.

Care in the home is the second important alternative for which incentives should be provided. Sending nurses, homemakers, social workers and other therapists into homes is much cheaper and more sound psychologically than hospitalization.

Finally, insurance programs which focus on payment mechanisms alone can only feed the fire of escalating costs. Manpower training programs must be set up concurrently and should include programs for ancillary personnel such as physician aides, home health aides and community aides.

Thank you for this opportunity to meet with you.

COMMITTEE ON COMPREHENSIVE HEALTH PLANNING FOR WESTCHESTER COUNTY
713 County Office Building, White Plains, New York 10601

FACT SHEET ON HEALTH SERVICE RESOURCES
Prepared for Information of
Workshop Leaders and Co-Leaders
CONFERENCE ON HEALTH
October 30, 1969

NOTE: Following is a compilation of health and health related services available within Westchester County. The intent is to show the number and variety of such services. Many agencies provide more than one type of service and are counted under each category. This should not be considered as being a complete listing.

SERVICES IN THE HOME

Bedside Nursing:

10 agencies (including county and 3 city health departments, voluntary visiting nurse services, 6 combinations of the two, plus one other cover the county).

Home Care:

10 voluntary hospitals, plus two other agencies, extend coordinated hospital services according to the individual patient's needs, shortening hospital stay for those discharged to the program.

Home Health Aides:

7 agencies (including the 4 Health Departments and 3 family agencies) provide limited patient care under supervision of a public health nurse.

Homemaker Service:

8 agencies (7 voluntary and the Department of Social Services) provide homemakers, under supervision of a social worker, to undertake household and child care duties in the temporary absence of the mother; some but not all serve the aging.

HOSPITALS -- GENERAL

Inpatient Care:

14 general hospitals (13 voluntary and Grasslands, the County Hospital) serve the acutely ill, with a combined capacity of 3,261 beds and 427 bassinets.

Ambulance Service:

Available to all hospitals largely either by number of volunteer ambulance corps or commercial carriers; very few maintain their own service.

Outpatient Clinics:

11 general hospitals provide clinic service ranging in type from 5 to 40.

DENTAL CARE

11 dental clinics are conducted, 3 by city health departments and by 8 general hospitals.

MENTAL HEALTH SERVICES

Emotionally Disturbed Children:

1 voluntary day school, plus mandatory classes in public schools.
7 voluntary institutions; not limited to Westchester children.

Inpatient Services for Adults:

5 hospitals (3 psychiatric, 2 general).
7 private institutions, licensed by New York State Department of Mental Hygiene, with combined capacity of 235 beds.

Outpatient Clinics Serving Families and/or Children, Individuals:

17 (9 voluntary, including 3 general hospitals; 8 public).

Convalescent Care Clinics:

2 State Hospitals conduct monthly clinics for patients on convalescent care or discharged from hospital.

Outpatient Day Care:

1 psychiatric hospital (voluntary).

Half-Way Houses:

2 serve a limited number of women who need a protective setting following or to prevent hospitalization.

Reorientation and Retraining:

2 agencies (1 public and 1 voluntary).

Retarded and Brain Injured:

2 voluntary agencies provide such services as training, education, recreation.
6 private residential institutions licensed by the New York State Department of Mental Hygiene, with combined capacity of 328, in addition to State Schools located elsewhere.

NURSING HOME BED CAPACITY AND OTHER HEALTH RELATED FACILITIES
-- Westchester & Putnam Counties, Public Voluntary & Proprietary --

4,664 long-term beds to meet need by 1972.
650 beds currently under construction.
1,668 beds have been approved, pending construction.
2,188 existing beds conform to standards of which 1,420 are certified as extended care facilities and eligible to receive Medicare payments.

PUBLIC HEALTH AND HEALTH EDUCATION

Public:

health departments (3 cities and the County).

Voluntary:

11 Voluntary agencies have health education programs and provide some patient service.

REHABILITATION SERVICES

Alcoholism:

3 agencies, 1 public walk-in clinic, 1 half-way house (for males, recovering and employable) and 1 information and referral.

Blind:

2 agencies, 2 voluntary, 1 public.

Mental Health:

3 agencies, 2 voluntary, 1 public.

Narcotics:

4 agencies, 2 voluntary, 2 public -- 1 inpatient.

Speech and Hearing:

3 clinics, 2 voluntary, 1 public.
1 residential and day school for the deaf.

Physical Medicine and Rehabilitation:

6 hospitals provide inpatient and outpatient care (2 serve children only).

Workshops:

3 agencies provide workshop programs -- rehabilitation and sheltered.

TRAINING OF HEALTH PERSONNEL

Schools of Nursing:

6 general hospitals have schools with Registered Nurse programs. (1 is college affiliated).
3 general hospitals have schools with Licensed Practical Nurse programs. (1 of above has both programs).

Home Health Aide Training:

1 health department (county) has on-going program to train home health aides for its own program, other health departments, visiting nurse services and family agencies.

Technician Training:

2 colleges offer a variety of health related technical training programs.

WHAT'S GOING ON WCSA

at the Westchester Council of Social Agencies

Bulletin No. 19 1969 CONFERENCE HIGHLIGHTS January 1970

CONFERENCE ON HEALTH

October 30, 1969

Conducted under the auspices of

THE COMMITTEE ON COMPREHENSIVE HEALTH PLANNING
FOR WESTCHESTER COUNTY

Sponsored by

Westchester Council of Social Agencies
Westchester County Medical Society
Westchester County Department of Health
Westchester Community Mental Health Board
Westchester County Hospital Association
New York Medical College

COMPREHENSIVE HEALTH CARE -- WHO CARES?

This conference substituted for the WCSA's Sixteenth Annual Westchester Conference of Community Services. The purpose was to pinpoint problems consumers have in obtaining quality health care and problems providers have in delivering quality health care and to serve as a springboard for deliberations by the Committee on Comprehensive Health Planning. The Conference Program Committee aimed to give equal time to both sides of the health care coin -- consumers and providers.

As keynote speaker, Mrs. Atkins graphically portrayed her first-hand experience as a consumer. And so did Dr. James, an eminent medical educator and provider of health services, the dinner speaker. Condensations of their addresses follow. Fourteen workshops, each led by a consumer and a provider, addressed themselves to the same topic. Workshop summaries also follow.

I wish to thank Mr. Robert L. Popper, Conference Chairman, and the members of the Conference Program Committee who served with him in developing this program.

-- Mrs. Carl H. Pforzheimer, Jr., Chairman
Committee on Comprehensive Health Planning
for Westchester County

COMPREHENSIVE HEALTH CARE: *WHO* CARES?
Condensation of Keynote Address by
Mrs. Ruth Atkins, Community Worker, Union Settlement
and Chairman, East Harlem Health Council

We're all concerned about health. I think the greatest emphasis is on health now because those who have the money to pay for good health care are finding that they, too, cannot always get it. I think that good health care is the right of all people in our country -- those who have and those who don't have. Many professional health providers seem to feel that Medicaid is a welfare program, not an insurance program for people who have limited or no income.

COMMUNITY OUTREACH

You know of Mount Sinai Hospital. Mrs. Ruth Ravich is the community representative. We can go to her if we have a complaint. She tries to find out if what you said is so, why it happened and sees that it does not happen again.

But many people say, "Well, the poor are not concerned with health. The poor are not interested in health. The poor do not keep their hospital appointments." But they don't take time to find out why.

Way back, when it wasn't fashionable to identify with the poor, Union Settlement was concerned with low income people, regardless of color. When they wanted to discuss something that was going on in the area, they always called in some residents to see what their complaints were, what recommendations they might have and then work together on the problems.

STUMBLING BLOCKS

My definition of quality health care is having the best service at the time you need it, in a facility close by whether you can pay for it or not. People have waited a long time for something close by them where they can walk in with their heads high. Many times, when you go to the emergency, the first thing they want to know is, who is going to pay the bill? In the meantime, you're aching and aching. When you say you are on Medicaid or welfare, they say your pain is your imagination.

You never know at what hour you're going to get sick. Many low or no income people do not get health care because of the hours. If you're a welfare client, after 2:30 P.M., you just don't get sick because if you do and you call up Social Service, no doctor comes. At a meeting, I had to let a doctor know we really didn't want to go to the emergency ward. It's only after you did your best to get your child feeling better and failed, did you go there. We know the long wait. We know the overcrowding. Time after time we have had wrong diagnoses.

A mother has to take one child to a certain clinic because the child has asthma, and another child to still another hospital because the hospital that would take a child for asthma will not take the other children. So you'll find people going to four or five different hospitals trying to get treatment at five or six different clinics all in one day, and sometimes three clinics at the same time -- Wednesday at 1:00 o'clock.

I always have to be thankful to Mount Sinai Hospital. But for them, I would not be alive today. Someone told me to go there although it was out of my district. I went. Right away some big shot came and examined me and then wanted to know why I hadn't been to the hospital before. "What's wrong with you people? Don't

you believe in taking care of yourself?" I said,"I've been going to three different hospitals for five years and they kept on telling me it was my imagination." When people need health care and get it, it may be expensive the first year, but the problems that had gone unattended for years will not repeat themselves.

I keep on hearing and hearing the poor are not concerned; the poor do not believe in taking care of themselves. But let me ask you, what have you or your agencies done to see that preventive health education is passed out through your day care programs, through your senior citizens' programs? What have you done when parents come in for day care and the child has a cold and tell you the house is cold? What do you do to help her out?

HUNGER

One of your groups can find out the extent of malnutrition. How many children in your class or your day care program are hungry? Why are they hungry? Beans and cheese are not the most appetizing but they keep you alive. And when you see poor people, it's just amazing how many big, poor women we have. But beans and biscuits kept us from being hungry, hungry.

If my child can get proper food and be in a warm place, this is better for you. When my child grows up, your tax money will not have to be paid to keep him on welfare. My child then will be able to compete equally for jobs.

ODDS AGAINST GOOD MENTAL HEALTH

When a child is growing up seeing the mother embarrassed every three months by a different investigator who comes and says, "Good afternoon, Mrs. Atkins, how are you?" I'll say, "Fine." "Mrs. Atkins, are your married?" In 1965 they knew I was married. "Mrs. Atkins, how many children have you?" "The same four I had in 1965." "Mrs. Atkins, are they all of the same father?" "No." Why is this necessary when they have the report? How can I have good mental health when I have to answer such unnecessary questions? How can my children function properly and feel like they're somebody? When they go to school and have a "W" on their card in order to get lunch? When they're not entitled to dessert because their mother is on welfare?

COMMITMENT NEEDED

We don't need more surveys and studies. But we do need some commitment, some follow-through, some sharing of ideas. I hope and I pray that there are enough people in America willing to stand up and be counted as committed, so this land of opportunity will be opportunity for all, people,"with liberty and justice for all." Those of you in this room, who are emotionally secure enough and don't feel threatened by the poor, can bring about many changes.

Are you mature enough to work with the poor and not see them as a threat? Can they work with you? Can they show you how best you can spend your dollars to help them? Are you secure enough so when an extreme militant comes and yells at you, you don't jump and buy him off?

On your maturity will depend the future of America. The time has come when we can no longer continue to put bandaids on problems and give people aspirin. We consumers and providers must join forces to bring about change.

THE RESPONSIBILITY OF THE HEALTH CONSUMER
Condensation of a Dinner Address by
George James, M.D., President
Mount Sinai Medical Center

I am going to try to relate the role of the health consumer and that of the health professional. My favorite philosopher these days is Colonel Edwin Aldrin. After coming back from the moon, he said,"What this means is that other problems can be solved in the same way: by making a commitment to solve them in a long-time fashion . . . ." It is sobering to realize that one rocket launch costs more than the tuition of every medical student in the United States.

CONSUMER POWER AND BETTER MEDICINE

We have a crisis in medical care. Education and television have made medical care a household word and increased the demand for it. We in public health have known for a long time that medical care is a right. Democracy is more solidly in control than ever before. What do the people want? What priority do they give to their wants? What does the consumer want of the profession -- to be blind servants at your beck and call, or to contribute leadership?

The rapid advancement of medical science is startling. Thirty years ago, the greatest doctor was powerless to control lobar pneumonia. Compare this with the power our youngest practical nurse has today with a penicillin syringe in her hand.

An outbreak of poliomyelitis in the Buffalo area in 1944 struck 2,000, leaving hundreds of crippled children in its wake. A group of citizens was considering various projects. One might have been construction of a large chain of rehabilitation hospitals. At the same time a man working at Harvard Medical School, John Enders, sought only a few tens of thousands of dollars to work on tissue cultures. Without professional leadership, it would have been difficult to make a case. Yet, he received the Nobel Prize because his tissue cultures were needed to develop a vaccine which was eventually to eradicate poliomyelitis, measles, German measles, and, some day, hepatitis and all other virus diseases.

But such dramatic successes have left us a residue of uncontrollable disease and a residue of science inadequate at the moment for the major tasks before us. If you look at recorded history, practically every disease that has been controlled, has been controlled because we have learned how to attack it before clinical symptoms have occurred. Work is going on now that someday will give us the keys to preventing heart disease, cancer and stroke. This is why we need professional leadership; why we need specialists and researchers.

In a democracy, if people demand the care they feel they need and want, they have a right to it if they are willing to pay for it and to take the steps to get it. But the demand can only exist in terms of what is known and what is available and, at the moment, the biological needs of people are insatiable. We lack the scientific knowledge to launch effective medical care programs to solve the major killers and disablers. Not only is medical science not all it might be, but the existing system, or lack of it, has marked shortcomings, John Gardner pointed out when he was Secretary of Health, Education and Welfare. This is why we need comprehensive health planning to develop programs to suit local needs and performances.

There has never been any question that the consumers control the medical system. The question is, how? It takes the best of our scientists working together with

our consumers to see what can be done to develop new techniques and streamline old ones, and how the partnerships should develop.

COST OF MEDICAL CARE

A recent study at Mount Sinai, based on careful cost accounting, showed our per diem cost per patient at over $100. Room and board with three meals a day came to $19.88 per day and more for the more than half of our patients on special diets. This compared with well over $40 a day at the Hotel New Yorker, with room service. Why are costs so high? What accounts for the difference? We have 100 patients on the kidney machine three days a week. The cost for each is between $10 and $15,000 a year. Without it they would die. Open heart surgery costs $3,200. More than half of these patients are poor and pay nothing. Our clinics lose about a million dollars a year. No hospital like ours has to run clinics. We have a three month waiting list for private surgery and medicine. We could fill our hospital with patients who can pay and run at a profit. Would you have us deny a portion of these people the gift of life? If so, which ones?

Our Department of Community Medicine has walked around the area and talked with people to find out what is troubling them. This is people-oriented research. We found a large number of hepatitis cases and opened a special clinic; we found that people from the Caribbean area seem to have a higher incidence of asthma and set up asthma programs. The other day, a group from East Harlem came to see if they could involve us in a major service program to push methadone treatment throughout the city. We said yes, and have enlisted the help of about twenty of the top scientists in the city. All these programs cost money.

COST OF MEDICAL EDUCATION

The cost of a medical education is fantastic -- approximately $24,000 per year in New York City. This means if a medical student pays $2,000 tuition, society is certainly picking up the rest. The pressure for more general practitioners is real. People tell us we are training too many specialists and researchers. We need more doctors and more allied health professionals to extend their services. But I ask, would you really have wanted Jonas Salk to have been a general practitioner? He has done more for health in the ghetto than 100 G.P.'s distributing tens of thousands of pills.

We have started two programs with foundation grants to take young black high school students in the summers to get them into health careers and provide tutorial help during the school year. We will make many of them physicians. All of us in the medical field train not only doctors but a host of others. My medical faculty is giving $100,000 a year of free education to train allied health professionals at Hunter College.

COSTS CAN BE CUT, BUT . . .

Instead of the necessary 16 tests for hypertension, would you have us do five and train M.D.'s to do just those? Kingston has never had flouridation. The dental bills are two-and-a-half times those of Newburgh, which has it. One way to cut costs: Immunization programs are success stories of professional leadership working with the consumer. Official agencies must be given the resources to be more than giant accounting and eligibility determining centers. Take Medicaid. Despite what some of us told them, government went into this program without doing anything about the manpower. We have only a limited amount of talent. We have to work together with consumers who will take the trouble to learn, ask questions and work with us.

SUMMARY OF WORKSHOPS

ARE YOU GETTING GOOD HEALTH CARE ???
Who controls it? *Who* delivers it? *Who* pays for it?

All 14 workshops discussed these questions against the proposition that comprehensive planning is essential to the delivery of quality health services for all consumers -- the wealthy, the comfortably off, the poor and the not so poor -- when needed and where needed by all members of the Westchester community. Each workshop had a health service provider as leader and a co-leader from the ranks of consumers.

A. *RECOMMENDATIONS TO THE COMMITTEE ON COMPREHENSIVE HEALTH PLANNING*

Master Plan:

. . . Develop a master plan for the delivery of comprehensive health care that would incorporate objectives and priorities with respect to availability, equality, quality and financing of health services, including merging similar health agencies to strengthen services and decrease costs.

. . . Undertake health planning on a sub-county as well as on a countywide basis, in view of the differing characteristics between northern and southern Eastchester. With health and mental health services clustered in the more populous localities, provision must be made to meet needs in outlying areas.

. . . Take immediate steps to comply with criteria to establish an agency qualified for organizational and operating funds under the Hill-Staggers Act.

Health Care -- A Right:

. . . Establish a patient "Bill of Rights." Equal and quality medical care is the right of everyone, regardless of who pays the provider. The right to good health is equal to rights to public education and to police and fire protection. The ombudsman principle to secure these rights was proposed.

Delivery of Health Services

. . . Establish local community health centers to provide health services around the clock, fully staffed by medical and paramedical personnel, including a system of emergency transportation, and backed up by hospitals and other facilities for specialized care. District offices of the County Health Department might be the nucleus of such centers; planning should be conducted in cooperation with the Medical Society, boards of health and hospital boards and implemented as soon as possible.

. . . Modernize methods for the delivery of health services; eliminate waiting lists that seriously impair ability to return to good physical and mental health; improve the physical facilities of emergency rooms and clinics and eliminate overcrowding.

. . . Involve greater numbers of consumers, including the poor, in all planning and decision making, e.g., as board members of hospitals and all other physical and mental health agencies. Organize parent and consumer groups to urge establishment of services they require.

. . . Pursue with the Departments of Health ways to reduce the infant mortality rate in Westchester County. (Statistics available on request to WCSA.)

Health Manpower:

. . . Encourage government-sponsored training and subsidy for medical students and nurses to help alleviate personnel shortages.

. . . Develop part-time work-training programs for paramedical personnel so they can earn as they learn . . . Increase training of paraprofessional personnel . . . Recruit and train more indigenuous as health aides.

. . . Help professionals recognize that paraprofessionals can perform essential services and accept them as helping people and colleagues.

Payment for Health Care:

. . . Promote legislation to correct problems of individuals and families caught "in the middle" and unable to pay costs of medical care, drugs, etc.

. . . Make quality medical care universal through a national insurance plan.

Handicapped and Aging:

. . . Start planning immediately to meet the needs of chronically ill, multi-handicapped young people, including those with emotional problems.

. . . Make total health care available for the aging, both physical and mental.

Public Education and Communications:

. . . Establish programs to instruct in basic health care and hygiene, nutrition, sanitation, symptoms of illness and available medical and social service; educate the public to want and expect good medical care.

. . . Obtain listing of health services in Yellow Pages of telephone directory.

. . . Develop more meaningful communication between service and funding agencies and break down resistance to joint planning.

. . . Keep problems, needs of people and effects of legislation before legislators by letters and telegrams.

Transportation:

. . . Explore possibility of obtaining half-fares for elderly people in southern Westchester for public transportation system in New York City.

. . . Investigate use of school buses in off hours for transportation to medical facilities.

. . . Establish a coordinated countywide bus transportation system, plus special transportation where needed, to make health services more accessible.

B. *PROBLEMS CITED IN WORKSHOP DISCUSSIONS*

Clinics and Emergency Rooms:

. . . Indifferent attitudes of clinic and emergency room staff and mental harassment by clerks who want to know who is going to pay the bill greet the poor before care is provided. Long waits, overcrowded conditions and too few physicians in attendance are common complaints.

. . . Taking the clinic to the people via a "Module Unit," set up as a pilot project to go into populous areas, was proposed.

Hospitals:

. . . "Come off the business attitude," hospitals were urged. But all hospitals have difficulty in meeting rapidly rising costs. They have to operate as business does, they point out, and charges must be related to cost.

. . . The Joint Commission for Accreditation of Hospitals was criticized for confining its attention to the physical plant, procedures and records, and not to the social needs of patients as well.

. . . Voluntary hospitals serve doctors' patients primarily and do not meet community needs. They need to be more closely related to the community.

. . . Broader inter-hospital planning would eliminate needless duplication of some types of expensive equipment making for better utilization, and more efficient operation through the use of common computers, etc.

. . . Broaden the scope of home health services to free expensive hospital beds.

. . . All hospitals should review their policies against admitting patients with a diagnosis of alcoholism alone.

. . . Practices among hospitals differ widely in dispensing drugs after hours. Most people do not realize local police know which drug store is on call.

Delivery of Health Care:

From one workshop leader's opening remarks: "We know there are serious problems in the delivery of health services and in the economics of the delivery of health services. The survival rate now increases the demand for services. The origins of health services were not designed to meet the medical needs of growing patient loads and chronic illness. Some early problems in the delivery of service included lack of funds. Where more funds became available, personnel problems became more serious . . . "

. . . Some available health services are not used fully due to lack of community outreach. Fragmentation makes it difficult to obtain complete health care. Insufficient planning and coordination hamper delivery of comprehensive health care. "Consumers must be in on the planning, otherwise it takes years to undo the mistakes."

. . . More efficient use and further development of existing health care facilities are needed, rather than more facilities.

. . . Dental care is of major importance but too many children do not get it. In some areas, large segments of the middle class population may be just as lacking in medical and dental services as are the poor.

. . . More general practitioners are needed. The family physician is disappearing--an outgrowth of medical specialization -- and physicians are not oriented to the total family. Home visits are becoming rare: "Bring your child to the office; wrap him warmly." But doctors contend, "Most home calls are unnecessary."

. . . Physicians in private practice and hospitals alike face problems of growing patient pressure, increasing workloads and paperwork, keeping up with the rapid expansion of knowledge and slowness in reimbursement.

. . . New technology and use of paraprofessionals and technical personnel should improve the quality of health services.

. . . Many providers showed strong identification with consumers; some suggestions:

"Go after the guys who make the laws"
"Social agencies should have legislative committees and develop leadership to solve these problems"
"Let's stop talking and meet needs"

Health Care Deficiencies:

. . . Lack of adequate services for the care of the sick in the home.

. . . Lack of adequate family planning education.

. . . Lack of rehabilitation for drug addicts and alcoholics.

. . . Lack of facilities for disturbed elementary school children.

. . . Lack of services for preschool handicapped children.

. . . Lack of dental care, eye and hearing tests for children in day care centers. Health problems of children in elementary school could be prevented if they were to receive adequate preschool medical care.

. . . Lack of comprehensive health screening facilities such as are conducted for trainees in programs at Rochambeau School, e.g., eye and hearing tests, counseling for the overweight and health education.

. . . Lack of training in low income areas in such basics of daily living as budgeting, nutrition and where to turn for advice and assistance.

Insufficient Manpower:

. . . Severe shortages of personnel in all phases of the medical field, sometimes causing people to be placed in jobs they are not properly prepared for.

. . . Career ladders for paraprofessional personnel should be developed, with community colleges providing the necessary training. Some college credit should be given for on-the-job training of such personnel.

. . . More young people should be trained and employed in hospitals; and elderly people could be trained and used in home care programs.

59-861 O - 71 - pt. 8 - 15

Workshop discussions - continued

. . . With more doctors needed, additional federal aid for costly medical education is necessary.

. . . With health personnel historically underpaid, the best personnel is not being attracted to the field and many leave for better paying jobs in industry.

. . . Nursing homes with staffing problems might look to CAP groups as recruiting sources for non-medically related personnel.

Paying for Health Care:

. . . Only 35% of the population is covered by major medical insurance.

. . . Medicaid cutbacks are detrimental to the provision of health services and affect people least able to provide for themselves or make their plight known.

. . . Many physicians do not accept Medicaid patients because of delayed reimbursement and fee schedules allowed are unrealistic in relation to cost of care. Many pharmacists refuse to fill Medicaid prescriptions, while others are known to dispense less than the amount prescribed. "Remove blinders from all vendors of care so they can see the problems around them."

. . . Even if the 20% cuts in Medicaid were restored, with payments to hospitals based on 1967, not 1969 costs, there still would be a gap between cost of care and payment per patient day.

Nursing Homes:

. . . Legislation is needed requiring all nursing homes to accept a given percentage of Medicaid patients.

. . . More nursing home beds are needed. Church groups should be encouraged to sponsor new nursing homes.

. . . If mental health specialists offered help to nursing home staff in understanding problems of the aging and in managing difficult cases, patients would benefit.

Transportation:

. . . Lack of adequate, convenient and reasonable public transportation is a real obstacle to getting medical care. Many patients must travel for hours to reach clinics. Many others simply don't go when it means losing a day's pay

. . . Many hospitals are moving toward preventive medicine, but if people can't get to them, it is of no avail.

. . . Red Cross Motor Corps and members of hospital auxiliaries should be available to transport patients to hospitals and clinics.

WESTCHESTER CITIZENS COMMITTEE FOR THE AGING AND CHRONICALLY ILL
713 County Office Building
White Plains, New York 10601

REPORT OF

SUB-COMMITTEE ON COMMUNITY CARE FOR THE DISTURBED AGED

April 17, 1969

PROBLEM: This is a report, with recommendations, of the Sub-Committee on Community Care for the Disturbed Aged. Many of the disturbed aged in Westchester have heretofore been cared for in state mental hospitals.

The care of these elderly became critical when, on June 19, 1968, the Deputy Commissioner of Mental Health, New York State Department of Mental Hygiene, Division of Mental Health, issued Memorandum No. 68-27 to all state hospital Directors concerning the Department's policy in the screening of admission of elderly patients referred to state mental hospitals.

> "Sections 71, 72 of the Mental Hygiene Law . . . state that the Director of a State Hospital may receive and retain patients suitable for care and treatment. Sections 75 and 76 governing admissions . . . are even more explicit providing that the need for hospitalization shall be confirmed by the receiving hospital . . . There is a clear-cut responsibility for the Director of the State Hospital or his medical representative to ascertain and certify that patients who enter the hospital are in need of hospitalization in order to obtain psychiatric care and treatment . . .
>
> " . . . it is the duty of the Directors of our State Hospitals to ascertain in the case of every patient presented to them, and especially in the case of elderly patients where we believe most abuse of this principle occurs, that a patient is most appropriately cared for or treated in a State Hospital.
>
> " . . . admission of patients whose problems are primarily physical infirmity, or social and economic difficulty into State Hospitals, places a burden on the hospital to which they are not equipped to respond. It also removes from the community the necessity for developing adequate services to solve the problems . . .

" . . . we therefore request the Directors of State Hospitals . . . to scrutinize more closely the condition of persons who are candidates for admission . . . and to determine prior to their admission whether or not such persons are suitable for care and treatment . . .

" . . . persons should not be accepted if care and treatment would more appropriately be given by another facility . . . Patients should not be admitted when their problems are primarily social, medical or financial or for the convenience of some other care facility . . ."

". . . this may mean a considerable change in policy and will have an impact on other social and treatment agencies . . ."

On June 28, 1968, the Deputy Commissioner of the Division of Local Services, State Department of Mental Hygiene, issued Memorandum No. 68-14 to Chairmen of Community Mental Health Boards and Directors of Community Mental Health Services.

" . . . this policy will affect people over 65 years of age more than any other group, and it is anticipated by the Mental Hospital Division of the Department that during fiscal year April 1, 1969 to March 31, 1970 this program will have achieved a reduction in the admission of people over 65 by 50%. Since the number admitted in this age category each year is approximately 8,000, a sizable group is involved . . .

" . . . the immediate effect will be that the communities will find it necessary to expand the kinds of services which such patients who are not accepted will need. Such services include general medical and nursing care, financial and welfare aid, and psychiatric services such as consultation to patients in general hospitals and other health caring facilities in the community, as direct alternatives to in-patient care in a State Hospital . . .

" . . . it is rare that hospital admission of geriatric patients is a psychiatric emergency and a system of screening of all patients by the county mental health services is recommended and has already been initiated in some counties."

SIZE OF PROBLEM: During the year April 1, 1966 to March 31, 1967, 325 patients in the 65 and over age group were admitted to State mental hospitals from Westchester County. This number represented 25.9% of all State mental hospital admissions from Westchester County for the same period (325 of 1,255 admissions). Since it is estimated that admissions of these individuals will be reduced by 50%, it would appear that approximately 163 of Westchester's disturbed aged who have been admitted to State mental hospitals will remain in the community and will require a variety of local services as an alternative to admission to State mental hospitals. This estimate would appear to be minimal. It does not include elderly patients who occupy beds in general hospital and nursing homes.

LOCAL RESOURCES: Existing resources in Westchester County include medical and psychiatric services in hospitals, Community Mental Health Board clinics, visiting nurse services, social and recreational facilities, financial assistance, social services, homemaker services, home health aide services, nursing homes, homes for the aged, information and referral services, friendly visitors, and legal services. However, because of the fragmentation and skewed distributions of many of these services and facilities, elderly persons often find these services inadequate or unavailable.

SERVICES NEEDED: The lack of transportation and scattered locations of many facilities often prevent full utilization. An expansion of or addition to these services would help alleviate the situation. These include housing facilities, friendly visitors, visiting nurse services, homemaker services, home health aide services, long-term facilities for the chronically ill, meals-on-wheels, outpatient clinic services, psychiatric clinic services, social and recreational programs, rehabilitation programs (physical and occupational therapies), sheltered workshops, information and referral services, and nursing home facilities. There is a need for a public information program, a geriatric screening program, a mobile crisis unit for evenings and week-ends, a geriatric-orientation program for existing services, and a foster home care program. All these services need to be coordinated. Possibly this could be done through the establishment in the County Executive's Office of a Division on the Aging.

THE STATE'S ROLE: Historically, the State has carried the responsibility for and the financing of the care and treatment of the mentally ill in hospitals, including the elderly. The present emphasis of the State Department of Mental Hygiene upon the development of community care for the disturbed aged may be appropriate. However, the abruptness of the decision together with the lack of opportunity for local communities to plan to meet the changes occasioned by the Department's new directives, is regrettable and unfortunate.

It is expected that Westchester County as well as other counties in the State would be willing to devote efforts to planning appropriate programs for this age group. However, the responsibility for providing the numerous services is too expensive to be borne by the local communities alone. Payments per-capita in a skilled nursing home presently range from $17 to $24, and they are expected to increase. Payments for care in health-related facilities currently range from $12 to $15 per person and are also expected to increase. Foster home care costs are estimated at a minimum of $175 per month. In general hospitals, payments are currently running as high as $100 per patient per day.

Currently Westchester County is reimbursed 50% by the State of New York for community mental health services, and the proposed cut-backs would call for a reduction to 45%.

In contrast, beginning July 1, 1969, the State of California will provide 90% reimbursement to local communities for mental health services for all people requiring them, including those in the 65 years and over age group.

RECOMMENDATIONS

1. The State Department of Mental Hygiene should place a moratorium of at least one year, beginning April 1, 1969, upon implementing its directives of June 19 and 28, 1968, so local communities can have time to develop local resources and facilities for elderly patients who will not necessarily benefit from psychiatric treatment but who require special programs to enable them to remain in their own homes or special facilities in which they can receive care.

   During the moratorium and the program of the Geriatric Screening Unit (see number 2 below), various types of at-home and outside-home care for the disturbed aged should be considered and developed, among them the following:

   a. Special services to senior citizen housing programs to assist the elderly to remain at home as long as possible.

   b. Special hostels, possibly to be operated by the Community Mental Health Board.

   c. Possible utilization of a relatively new building at Harlem Valley State Hospital which is presently vacant.

   d. Placement and supervision in foster homes.(1)

   e. Strengthening and expansion of existing community services to the elderly in their own homes to help prevent mental and emotional deterioration, e.g., Homemaker Services, Home Health Aides, Friendly Visitors.

2. For at least one year, from April 1, 1969, it is recommended that the New York State Department of Mental Hygiene provide a financial grant for a Geriatric Screening Unit in Westchester County, to be operated by the Community Mental Health Board. This Unit would evaluate the needs of those elderly patients formerly admitted to State hospitals and mobilize appropriate local resources to care for them.

   The Geriatric Screening Unit would be similar to one in San Francisco, California which was financed by the California State Legislature in 1963 as a pilot screening program for the mentally impaired aged. The Bureau of Social Work of the California Department of Mental Hygiene was delegated the responsibility for developing the program. The primary objectives were to reduce the number of inappropriate commitments of elderly persons to State hospitals, to provide alternatives to State

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(1) Over the past ten years, the Veterans Administration Hospital, Montrose, New York has developed a foster home program that now serves 500 veterans in 80 selected and supervised homes.

hospitalization by developing and utilizing community resources, and to provide consultation and information to persons or organizations serving this age group. The Screening Unit staff consisted of a half-time internist, a part-time psychiatrist, a psychiatric social worker, a supervising psychiatric social worker who functioned as coordinator, and a senior stenographer. From 1965 through 1967, 1,290 persons were screened through the project. Of this total, 4% were committed to to State hospitals, 33% were placed in nursing homes, 8% in boarding homes, 10% were admitted to county or private medical hospitals, and 45% remained in their own home with supportive services.

3. Additional nursing home beds appear to be required, and the formula now used to allocate nursing home beds to meet the needs in Westchester County should be changed to allow for the construction of additional nursing homes for the care of the chronically ill, including the disturbed aged who do not necessarily require or can benefit from psychiatric treatment.

4. In order to foster the development of adequate services locally, New York State should reimburse localities 90%, as will California on July 1, 1969, for the development and maintenance of programs for the disturbed aged. At the same time consideration should be given to utilizing this reimbursement formula for the entire service program of the State Department of Mental Hygiene.(2) The reimbursement formula for community mental health services in New York State is only 50%, and the proposed cut-backs in the State budget would reduce this to 45%.

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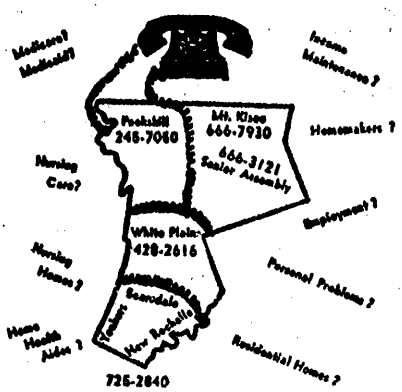
(2) Effective July 1, 1969, in California, the Lanterman-Petris-Short Act will provide for 90% reimbursement by the State for all mental health services. The share of Counties with over 100,000 population would be 10% including care of the mentally ill in State hospitals.

1952

INFORMATION, PLEASE!



ANNUAL REPORT • 1969

Senior Information and Referral Services

Conducted by

WESTCHESTER COUNCIL OF SOCIAL AGENCIES
County Office Building, White Plains, New York

1953

WESTCHESTER COUNCIL OF SOCIAL AGENCIES, INC.
(WCSA)

SENIOR INFORMATION AND REFERRAL SERVICES
(SIRS)

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SENIOR INFORMATION AND REFERRAL SERVICES

Conducted By

WESTCHESTER COUNCIL OF SOCIAL AGENCIES, INC.
Supported by Contract #MS 3963
with the New York State Office for the Aging
under the Older Americans Act of 1965

Annual Report - 1969

INTRODUCTION:

The following is the final Annual Report of the Senior Information and Referral Services (SIRS) which has been conducted by the Westchester Council of Social Agencies (WCSA) in cooperation with the New York State Office for the Aging under Title III of the federal Older Americans Act of 1965.

SIRS completed its three-year demonstration on December 31, 1969. Its functions have been absorbed by the White Plains Regional Office of the New York State Department of Health, and all of its resource data and case records have been transferred.

SIRS was supported by federal, state and local funds with governmental contributions diminishing and local support increasing each successive year.

GOALS AND FUNCTIONS:

Westchester County has a great number and diversity of services and facilities scattered throughout its six cities, eighteen towns and 22 villages. Locating an essential service at time of need is often complex for professionals and frequently overwhelming to less sophisticated lay people.

To help locate essential resources quickly, especially for the aging, SIRS concentrated all known health and welfare services available to the aging in one central repository. Thus, through a single telephone call, those looking for services could find them rapidly or learn that no such service was available. In addition, recognizing that some people -- possibly through ignorance, fear, prejudice or pride -- would probably not reach out for the services they needed, SIRS' two skilled workers tried to evaluate the needs and, if necessary, actively assisted the callers in securing the necessary service.

As a secondary goal, while providing information to the callers, the staff accumulated statistical data attempting to specify the services requested, the gaps in community resources and the characteristics of those requesting information.

METHOD OF OPERATION:

Accessibility to SIRS was considered essential to its effectiveness. Westchester County, with 453 square miles of densely populated communities in the south and sprawling rural areas in the north, created a special problem. Public transportation is inadequate. As a result, it was assumed that the elderly or those interested in their behalf would make most of their inquiries by telephone.

To facilitate telephone inquiries, especially for the aged who live on fixed, limited incomes, a telephone network with four trunk lines throughout the county was set up so that a call could be made at no more than a local charge.

NUMBERS OF CONTACTS:

During 1969, SIRS served 2,347 different individuals, an average of 195.5 per month. This compares with 2,157 individuals served during 1968 (an average of 179+ per month) and 1,009 people in 1967 (an average of 84 per month).

Responding to the 2,347 calls required a total of 6,704 "contacts," e.g., telephone calls, letters, office interviews, field visits. This meant an average of 2.8 contacts per inquiry. This compares with an average rate of 3.4 contacts per inquiry in 1968 and 5.5 in 1967. Efficiency was enhanced with increasing experience by the professional staff and greater familiarity with community resources.

PERSONS SERVED:

During 1969, 75% of inquiries were received from the elderly themselves or their families as compared with 66% in 1968 and 77% in 1967. On the other hand, there was a decrease in the number of inquiries received from agency personnel: 18% in 1969 compared to 22% in 1968 and 12% in 1967.

In 1969, as in 1968, 74% of those who sought information used the telephone. Even so, the numbers of written inquiries increased to 417 in 1969 compared with 373 in 1968 and 60 in 1967. This was due largely, as in the past, to the Westchester-Rockland newspapers for the increasing number of letters received. These newspapers published SIRS' address in their frequent reports but generally omitted the telephone numbers.

For the third successive year, residents in every Westchester community were served. In addition, residents in the metropolitan New York area and from other states were helped.

COMPARISON OF SERVICES REQUESTED:

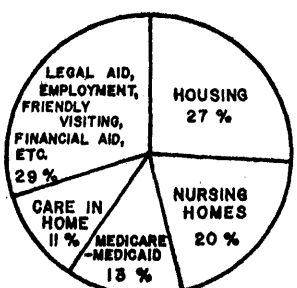
Significantly, housing retained its position as the most called-for resource in 1969 and increased its proportion of the number of calls: 34% in 1969, as compared with 32% in 1968 and 27% in 1967.

Similarly, information about nursing homes was the second most frequently requested service for the third consecutive year. Twenty per cent of all inquiries in 1969 requested information about nursing homes compared with 25% in 1968 and 20% in 1967. Equally consistent as the third most frequently requested service was the proportion of inquiries for care in the home (homemakers, home health aides, housekeepers, companions, etc.). Ten and one-half percent of all calls requested some form of home care as compared with 11% in 1968 and 1967. Inquiries about Medicare and Medicaid comprised 5% of all calls in 1969, compared with 5½% in 1968 and 13% in 1967. People seem to be increasingly familiar with these programs and know where to obtain them without SIRS' assistance.

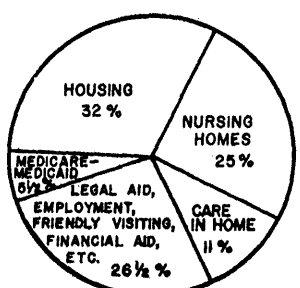
COMPARISON OF MAJOR SERVICES REQUESTED

1956

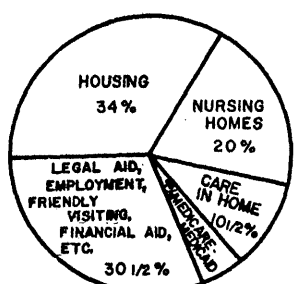
1967
(1009 INQUIRIES)



1968
(2157 INQUIRIES)



1969
(2347 INQUIRES)



The four major categories noted above comprised 69½% of all telephone calls received in 1969. The balance pertained to other important services, such as financial assistance, employment, friendly visiting, legal aid. Since each of the other categories comprised less than 5% of the total questions, they have been combined for convenience. Nevertheless, it must be stressed that each service was important to the individual who was calling for information.

For statistical convenience, only one service was listed for each caller even though an elderly person might inquire about two or more. In such instances, for statistical simplicity, the professional staff determined the primary service according to the individual situation.

COMPARISON OF NEW INQUIRIES:

The chart on the following page reveals an inconsistent pattern of the numbers of inquiries received each month. Inquiries ranged from a high of 298 in April to a low of 127 in November. No seasonal pattern could be traced during 1969 or the previous two years. However, publication of news items in the newspapers invariably stimulated a noticeable increase in inquiries at that time.

In the fall of 1969, the number of inquiries began to decline. When it became apparent that SIRS would no longer be able to continue under its existing auspice, publicity was deliberately avoided to allow the staff to complete its work and transfer the program to the Regional Office of the New York State Department of Health.

THE FOLLOW UP STUDY:

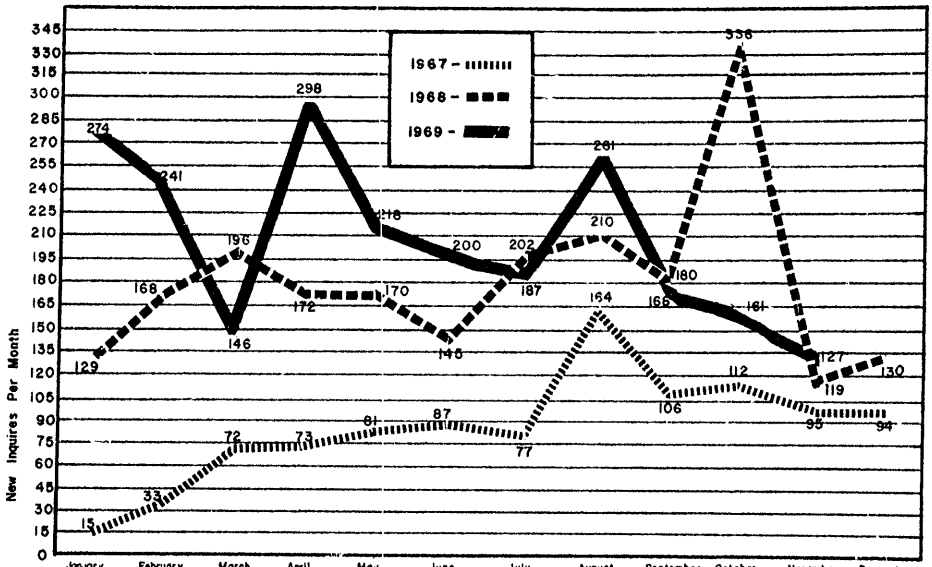
On the basis of their involvement with the people they served, the staff felt that the service was helpful. Nevertheless, it was agreed that a formal follow-up study could better document the effectiveness of the program.

With the support of the New York State Office for the Aging, a retired professional social worker was employed part-time during the early part of 1969. In three months, she extracted a sample of all even-numbered cases served during the seven-month period beginning January 2, 1968. Excluding inquiries from agencies, she called or, when necessary, wrote 442 individuals who had requested information. The guidelines employed in the follow-up included the following five questions:

1. Did the resource requested exist?
2. Was the information used by the inquirer?
3. If inquirer was other than client, did client find the information helpful?
4. Was this method of getting the information satisfactory?
5. If SIRS made a referral, was the person or agency to whom they referred helpful?

SUMMARY OF FINDINGS:

The resources requested by 90% of the people contacted existed. This is not to suggest that an existing service was available since some who were eligible were often confronted with formidable waiting lists, and others were ineligible because of restrictive residence requirements.



SIRS - Comparison of New Inquires Per Month - 1967-1969

Out of 413 inquiries where the resources existed, the information was used in 61% of the cases, not used in 30% and not known in 9% of the cases.

In the 225 situations where the inquirer was other than the elderly person himself, 44% found the information helpful and 55% found the information was not helpful.

Ninety-five percent of the 349 who telephoned SIRS found this method satisfactory. Of the 74 who chose to write, 70% were pleased with this method, and 99% of the 29 who came to the office for personal interviews were satisfied with this approach.

Out of 101 situations where SIRS referred the inquirer to another agency, 80% stated that SIRS' guidance was helpful.

CONCLUSIONS OF FOLLOW-UP STUDY:

It is apparent that SIRS was useful and helpful to most of those who inquired by assisting them through a maze of resources which they might or might not have found without professional assistance. Where services were available, 61% of the inquirers used the information provided.

In those instances where the staff made referrals, i.e., actively arranged appointments for the clients, 80% of the callers stated that SIRS' participation was helpful. What is not possible to measure is the number of situations where anxious elderly people and/or their families, upon being provided with factual information, were able to develop their own plans.

In selected situations, where elderly individuals were unable to follow through, for whatever reason, the staff assumed the role of advocate in order to open doors to insure that the dependent elderly secured the help they needed. In these instances, the staff remained active until it was determined that a decision had been made by the client and the agency to which he had been referred.

There is no way of evaluating the amelioration of aggravation, anxiety and expense spared the clients and their families when they were able to get by means of a single telephone call factual information about the services they wanted and needed and directions on how to secure them.

Routine follow-ups as performed in the study revealed that in some cases, new problems had arisen since the initial inquiry, and in others, that secondary problems which had not been presented became more significant following resolution of the primary need and, finally, that some problems had not been resolved, because, for a variety of reasons, the callers did not follow through.

RECOMMENDATIONS:

After three years' experience in providing information and referral services for the aging, the Council of Social Agencies offers the following suggestions to those who contemplate providing similar services:

1. Publicity

Repeated newspaper accounts, meetings with lay and professional groups, and other public relations activities are essential to publicize the service. While some elderly people save news clippings for possible future use, many pay little heed until they need help. Repeated news releases serve to remind the community of the service at times of need.

2. Professional Staff

From the outset, the program was designed to make available the skills of professional people to all who called even though it was believed that many inquiries could be classified as "routine." Experience has reinforced the conviction that skilled professional assistance is needed. Trained, experienced and full-time personnel are the hallmarks of an effective information service. The trained sensitivity of professionals and the continuity of full-time staff will afford, on the one hand, more precise evaluations of the problems presented and the proper delineations of the services needed and, on the other hand, more efficient use of staff time.

3. Maintaining the Mandate

As is the case all too frequently, many people procrastinate when some kind of action should be taken. By the time some people call for information, the problem has become critical and the pressures on the staff to "do something" immediately is difficult to contend with. This is particularly true when family problems require prompt amelioration but attempts at seeking relief are frustrated by waiting lists.

Despite pressures and the desire to fill the vacuum, the staff must provide only those services for which the program was established. If possible, they should document the gaps in services and resources and stimulate the community to provide the needed programs. This is not to imply that the staff is to do nothing but provide information. While avoiding duplicating existing services, there are two functions which are appropriate to the Information and Referral Services and which experience has shown may be performed productively. The staff could be advocates in behalf of the callers and could follow up calls which had been made to ascertain what had transpired.

ADVOCACY:

Unless an individual is sufficiently aggressive and persistent, he can frequently fall through the cracks of the maze of services available in the community. For the timid, the unsophisticated, the insecure, the uneducated and the non-English-speaking, breaking through the barriers of rigid intake procedures can be so formidable that those in need are unable to apply for, let alone secure, the services that have been established to help them. In such instances, staff can serve as the "advocate" -- the sophisticated expert who knows which telephone to ring, which doors to open, which pressures to apply -- to insure that eligible applicants receive what they need at the time of need.

FOLLOW-UP:

A planned follow-up on a systematic basis is a second activity which an information and referral program could pursue, time permitting. A planned follow-up call one month from the initial inquiry could help to ascertain whether or not the caller had followed through on the recommendations, clarify what difficulties had been encountered, and how they might be corrected, determine if other services might be needed and show some of the elderly that they are not isolated and forgotten.

SIRS AS A PROTOTYPE:

Under the title, "A Project Report on Countywide Information and Referral," SIRS was written up by the Administration on Aging, U.S. Department of Health, Education and Welfare, in its publication series entitled, "Designs for Action for Older Americans" as a prototype for an information and referral service. Ten thousand copies were printed and distributed nationally.

ACKNOWLEDGEMENTS:

During the three years in which it operated, the Senior Information and Referral Services served 5,513 different individuals from every community in Westchester, the surrounding metropolitan region and other states.

The success for this endeavor is due to the happy combination of the support of the New York State Office for the Aging, the assistance of its staff, the initiative and sponsorship of the Westchester Council of Social Agencies, the help and counsel of the Community Advisory Committee, and the patient and persistent efforts of the devoted staff.

1962

WESTCHESTER COUNCIL OF SOCIAL AGENCIES, INC.
County Office Building, White Plains, New York

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SENIOR INFORMATION AND REFERRAL SERVICES
129 COURT STREET WHITE PLAINS, N. Y. 10601

WESTCHESTER AREA TELEPHONES
Southern 728-2840 Central 428-2616 North West 245-7050 North East 666-7920

THE CASE OF MRS. A.

(75 year old chronically ill woman)

AND THE EFFORTS REQUIRED TO OBTAIN
HOSPITAL AND MEDICAL CARE FOR HER
January 6th, 7th, 8th
(Monday, Tuesday, Wednesday)

January 1969

Mr. A walked into the SIRS office to request help in placing his 75 year old mother in a nursing home. He learned of SIRS (Senior Information and Referral Services) from a poster at the extended care facility where he is employed as an attendant on weekends. He works as an attendant at a private mental hospital during weekdays. Mr. A is a foreign born young man with some language difficulty.

BACKGROUND

Mr. A brought his mother to the United States from her native country last July (1968) expecting to provide her with a healthier diet and proper medical care. Some years ago, Mrs. A had a stroke which caused partial paralysis. Subsequently, she broke her hip. However, she remained ambulatory.

Since she has been in the United States, she has received bilateral cataract surgery and dental surgery (all her teeth extracted) at Phelps Memorial Hospital. She was in Grasslands Psychiatric Unit for two days (12/6 to 12/8) for possible referral to a state hospital, but she was discharged. The doctor told Mr. A she isn't "crazy".

59-661 3136

conducted by
WESTCHESTER COUNCIL OF SOCIAL AGENCIES, INC.
713 County Office Building, White Plains, New York 10601, Under Contract #1465963
with the New York State Office for the Aging under the Older Americans Act of 1965.

Dr. Z had been Mrs. A's general physician in the community but he has withdrawn from the case. Mr. A showed a letter dated 12/18/68 from Dr. Z stating, "Mrs. A requires more care than I care to undertake." The letter continued that Dr. Z is sorry Mrs. A is not in a nursing home where she belongs, but this is through no fault of his. It concludes, "do not call this office for any further medical advice or prescriptions."

Mr. A made it clear that Dr. Z's care of his mother was generous while he was on the case. He made house calls even during the night and also made efforts to get Mrs. A into a nursing home, both while she was at Phelps Memorial Hospital and after she was returned home. We understand that Dr. Z was in contact with the Department of Social Services in the course of his efforts. Since Dr. Z withdrew from the case, Mr. A had tried to get another doctor for his mother. One doctor he contacted refused the case after talking with Dr. Z. As we understand it, the Department of Social Services tried to help Mr. A secure another physician.

SITUATION AT THE TIME OF INTERVIEW

Mrs. A's prescription medication to control high blood pressure was exhausted three or four days ago as was her prescription for "nervousness". Mr. A is also concerned about bed sores which are developing. His mother is no longer ambulatory, but Mr. A thinks that with proper therapy she would walk again.

As Mrs. A received Old Age Assistance, the matter of placement in a nursing home has been referred to the Institutional Placement Unit at Grasslands.

ACTIVITY

Summary of Contacts: In a period of three days (1/6/69 through 1/8/69) approximately 20 contacts were made involving SIRS, WCSA, Department of Social Services (Medical Assistance and District Office), Westchester County Department of Public Health; Grasslands Hospital (Medical, Social Service and Clinical Departments.)

Details and Chronology of Contacts

Called Worker, Institutional Placement Unit: (Mr. A still at SIRS desk). The worker said she tried to arrange placement for Mrs. A but when the nursing homes learn she is "confused," does not speak English and does a great deal of yelling and screaming, they

refuse to admit her. Apparently the patient is so noisy the A's have been threatened with eviction. The worker said there was nothing more she could do. When we explained that Mrs. A is now without medical supervision and without medication, the worker responded she has told Mr. A he could get his mother into Grasslands if he would call the police during the night while she is screaming and have her taken to the hospital. In such a situation, Grasslands must admit her.

Further discussion with Mr. A. Mr. A verified that his mother "cries" and calls for her children, but he said that at the nursing home where he works, old people often do the same. He went on that his mother is now incontinent. His young wife (they have been married 8 months) cannot or will not clean her up and it must wait until he comes home from work. (He is aware this contributes to developing bed sores.) It is evident Mr. A cannot bring himself to use the police as the worker suggests.

Telephone supervisor at Institutional Unit: Reviewed the situation as it now stands. After clarifying some points, she called back to say that her worker has done all that can be done about nursing home placement. Mrs. A was calm and quiet during the two days she was at Grasslands Psychiatric. With "the directive"* from the State Mental Hygiene Department, placement in a state hospital cannot be expected.

We inquired about getting a doctor from Grasslands to go to the home at least to prescribe necessary medication. We were told this is not possible. The supervisor said the best she could suggest regarding renewal of the prescription was to have Mr. A bring his mother to the admission desk at the Psychiatric Unit. There the doctor on call would examine Mrs. A and prescribe medication. She gave us the telephone extension to use in making such arrangements.

Discussion with Mr. A: He felt his mother could not stand the trip to Grasslands and back just to be examined. He explained his mother weighs about 175 pounds and he cannot move her alone in any case. In the past an ambulance has been called to transport her.

Supervisor: referred us to the District Office regarding calling an ambulance. (Mr. A had to go home to care for his mother and then to report to work. We promised to continue to work on the situation.)

Called Supervisor, District Office: After we reviewed the situation, she expressed concern and said she would see what could be done.

*Issued in June, 1968, stating that State Mental Hospitals will accept only those patients who can benefit from psychiatric treatment.

Call from Mr. A: at 2:00 p.m. to inquire what had happened. He was due to work at 3:00 p.m.

Called Supervisor of District Office: She had been in touch with the Director of Social Services at Grasslands Hospital. They were working on getting Mrs. A admitted to the hospital on an emergency basis.

Called Mr. A and reported the above. Suggested he tell his employer he will be delayed.

Call from Supervisor, District Office: to say, although there was no guarantee, she believed an ambulance would be sent during the afternoon and she suggested Mr. A remain at home.

Called Mr. A and gave above information.

Called Supervisor, District Office: (as we had heard nothing further and it was close to 5:00 p.m.). She explained the only basis on which Mrs. A could be admitted to Grasslands was the bed sores. However, someone would have to verify the bed sores. Therefore the visiting nurse agency had been contacted. A nurse was to have visited that afternoon if possible. If not, she would visit the following morning.

When we pointed out that the patient was still without medication and suggested if Dr. Z knew that the community was moving towards hospitalizing Mrs. A and understood that her medication was exhausted, he might be willing to write the prescription. The supervisor replied she had discussed it with the worker who said she thought he would not. When I pressed what might be done now, the supervisor could make no further suggestion.

Called Mr. A: Let him know the visiting nurse was to come to his home the following day. We made sure he knew how to reach the Medical Association for a doctor in an emergency. We found he already had this information.

1/7/69

Mr. A called as arranged at 9:30 a.m. He said he had heard from no one. His mother had spent a quiet night.

Called Supervisor, District Office: She said she had been in contact with Supervisor of the local visiting nurse agency and a nurse was being sent to the home that morning. If Mr. A contacted me again, I should refer him to her.

Called Mr. A Let him know the visiting nurse would be coming to his home during the morning. Also let him know that he could speak with the District Office Supervisor if he wished to do so.

Called Mr. A in early afternoon: He said two nurses had come and looked at his mother. They told him they would contact him again either before he left for work or at his job, and had taken his phone number there. He was a little vague as to what they had said regarding plans, but he thought they hoped to get his mother into the hospital.

Called Visiting Nurse of the Department of Health: She told us the family was taking rather good care of Mrs. A under the circumstances. However, Mrs. A did have bed sores, and her skin was in poor condition. The bed in which Mrs. A had to sleep was very poor. The nurse's supervisor was already aware of the nurse's findings.

Called Grasslands Social Service: The worker there explained that the supervisor of the visiting nurse agency has been in contact with the Coordinator of Health Services between Grasslands and the Community. The Deputy Commissioner of Health has also been consulted. The next move would be up to him, as we understood it.

When we focused on the matter of medication for Mrs. A, the worker said she would bring it to the attention of the Deputy Commissioner of Health right away.

Call from Grasslands Social Service Worker: The Deputy Commissioner of Health was not in his office, a note was left for him regarding Mrs. A's lack of medication.

Situation at 5:00 p.m. 1/7/69: In spite of the concern and activities of various agencies, Mrs. A was still without medication, medical supervision or placement in an appropriate medical facility. Representatives of the various medical and welfare agencies concerned were keenly aware of the lack of facilities in Westchester County for chronically ill patients. We were told that Grasslands gets at least one case each day similar to Mrs. A.

Called Grasslands Director of Social Services and explained we felt something must be done for Mrs. A. She advised we call the doctor in charge of the Emergency Room.

Called Chief Doctor in charge of Emergency Room: After we reviewed the situation, the doctor said Mrs. A could be admitted through the emergency room under the circumstances. However, there might be a problem of deciding which service would admit Mrs. A; medical for high blood pressure or surgical for bed sores. It was, therefore, suggested the admission should be postponed until the morning of January 8th when the chief doctor would be on duty.

Called Mr. A at his job to let him know that his mother would be admitted to Grasslands on January 8th if he would bring her to the Emergency Room. We gave him the name of the doctor to ask for, also let him know he could have her admitted during the night, if he felt it was necessary. Again he was told the police would help him if he called them.

1/8/69

Mr. A called at 9:30 a.m. and wished to verify what he should do. We reviewed just what he was to do, and made sure he had the doctor's name. We stressed that Mr. A was under no circumstances to bring his mother away from the hospital once there. We told him to call if he had any question or if admission was refused.

Mr. A called at 12:30 p.m. from a public telephone booth. Said he was in the Emergency Room, that he had arrived at 11:00 a.m., that his mother had been examined by the doctor, and he had been told he was to wait and speak with the doctor. Mr. A was beginning to be apprehensive about whether his mother would be admitted and also whether he would be at his job on time.

Called Emergency Room: learned they still intended to admit Mrs. A but it was a question as to which section.

Tried to call Mr. A Unable to reach him. At about 1:30 p.m. Mr. A telephoned. He was then in the Psychiatric Building with his mother. He said he had been told by the doctor to wait. It was his impression they would not be admitting her. Also, he was concerned about getting to his job.

Called the Emergency Room doctor who said they knew Mrs. A was in the Psychiatric Building and had left instructions that when they were finished with her there, she was to return to the Emergency Room. When I explained Mr. A's need to get to his job, the doctor said he could leave. I explained that the doctor in the Psychiatric Building had told him to wait. The doctor said she would herself speak with Mr. A and tell him he could go home, that his mother would be admitted to Grasslands.

At about 3:00 p.m. Mr. A called again. Said he had been told it was impossible that his mother be admitted to the hospital. His mother had been sitting in a wheelchair all this time. She was terribly tired and needing to go to the bathroom. He was told there was nothing they could do about her personal needs. Mr. A's voice had become increasingly anxious from call to call.

Telephone call was made to the Medical Director of Grasslands Hospital and let him know of refusal to admit Mrs. A after all. He said he would check and call back.

Telephoned the Chief Doctor of the Emergency Room who stated that while the Hospital Director of Medicine had agreed to admit Mrs. A, the doctor in charge of patient utilization had countermanded the order.

Called Social Service to ask whether there was anything which could be done to make Mrs. A more comfortable. Not able to reach worker.

Called Mr. A told him to be patient a little longer.

Medical Director called back to say that Mrs. A is to be admitted. Director of Social Services is to follow the case and see that no discharge occurs without an appropriate plan for another facility.

Mr. A called us at 4:30 P.M. Said he was at home and that his mother had been admitted to Grasslands and was in bed when he left. He was still somewhat upset that his mother had been so tired at the end of the day, and when I inquired if she had been given any lunch, Mr. A said she had not. He thanked us for our efforts and concluded in his broken English, "I'm hauppy".

Agencies involved:

1. Department of Social Services, District Office
2. Department of Social Services, Institutional Unit
3. Local Visiting Nurse Agency, Department of Health
4. Psychiatric Institute Grasslands Hospital
5. County Hospital doctors
6. " " Social Service Department
7. Department of Health, Deputy Commissioner

8/9 WCSA and SIRS (three staff members, including executive director.)

Telephone calls:

8 from Mr. A.
7 to Mr. A
17 to and from agencies and hospital
32 different telephone contacts plus Mr. A's visit to SIRS office.

Post Script: On January 28, 1969 Mrs. A was discharged from Grasslands Hospital and placed in a nursing home.

1970

WESTCHESTER COUNCIL OF SOCIAL AGENCIES, INC.
County Office Building, White Plains, New York

AD HOC COMMITTEE ON WESTCHESTER'S HEALTH RESOURCES AND UNMET NEEDS

co-sponsored by

Westchester Council of Social Agencies
Westchester County Medical Society
Westchester County Department of Health

RECOMMENDATIONS

of

TASK FORCES

April 28, 1966

1. Since many young people display an interest in a health career at an early age, all efforts to foster and develop their interest and desire should be intensified long before they reach high school age.

2. To help guidance counselors in Westchester's forty-seven public school districts advise and counsel young people for careers in the health fields (medicine, nursing, dentistry, technicians, practical nursing, home health aides, etc.), the official and voluntary health agencies should prepare and distribute a packet of materials describing various health occupations.

3. Nurse educators and school guidance counselors should engage jointly in an intensive program to recruit candidates for the nursing profession.

4. Hospitals should provide more in-service orientation and education for all general staff nurses, particularly the newly graduated who are frequently required, because of personnel shortages, to assume responsibilities for which they had not been prepared.

5. In view of the trend toward collegiate schools of nursing, the diploma schools of nursing in Westchester should immediately develop, in concert, an appropriate plan for future nurse education programs.

6. The Westchester Nursing Council should take the initiative in establishing a program for training and utilizing home health aides. Such a program should draw heavily upon the experience of the District Nursing Association of Northen Westchester which has demonstrated the effectiveness of a home health aide program during the past three years.

7. The Westchester Heart Association, together with other health agencies and appropriate organizations such as the Westchester Council of Social Agencies (WCSA), the Westchester Medical Society, Westchester Academy of Medicine, and the Hospital Review and Planning Council of Southern New York, should continue its leadership in developing a regional medical complex, emphasizing medical education and seeking such aid as may be available under the federal Regional Medical Programs: The Heart Disease, Cancer, and Stroke Amendments of 1965, Public Law 89-239.

8. In order to recruit and retain more American-trained interns and residents, Westchester's community hospitals should institute a system of rotation for their continued medical education and training; such a program should not wait for the establishment of a medical school as part of the Westchester Branch of the State University.

9. A centralized information and referral service, possibly an extension of the Information Bureau of the Westchester Council of Social Agencies, should be established on a three-year demonstration basis to meet the needs and interests of the fields of medicine and education as well as health and welfare.

10. Because of the fragmentation of health screening programs (chest x-rays by the Westchester Tuberculosis and Public Health Association; urine tests by the Diabetes Association; glaucoma tests provided in some hospitals by some of the Lions Clubs, etc.), official and voluntary health agencies should get together to coordinate and expand such health screening programs, with follow-up incorporated in them.

11. Particular emphasis should be placed upon developing programs providing annual physical examinations for persons over forty years of age since they are more susceptible to disease and disability.

12. To promote the establishment of a unified Health Department in Westchester County at the earliest date possible, the Westchester Tuberculosis and Public Health Association, with the support of the Westchester Council of Social Agencies, the Medical Society, health and welfare organizations as well as civic groups, should continue its leadership towards this objective.

13. Every free-standing nursing home in Westchester County at present is operated under profit-making auspices. Non-profit, philanthropic health (including hospitals), welfare, religious and civic groups should be urged to sponsor such programs with whatever financial assistance in the form of grants or loans as may be available from governmental sources.

14. To assure the sound development of the County hospital at Grasslands, the Westchester Medical Society is urged to work more closely with the Board of the County Department of Hospitals and the Medical Board of the Hospital.

15. Grasslands Hospital is urged to continue the development of specialized services (e.g., cardiopulmonary center, renal clinic, chronic illness institute) with the full participation and support of the Medical Society.

16. Members of the medical profession, hospital trustees and administrators should join the official and voluntary health departments and agencies in planning the health services necessary in the community.

17. To make the services of the hospital better known to the community, to help the community better understand the needs of the hospital and to help the hospitals better understand what community needs are, workshops should be instituted by and for hospital trustees, hospital administrators, and members of medical Boards.

18. Since social service is an essential part of the total treatment of the patient hospitals should develop social service departments, staffed by qualified graduate personnel who should also participate in hospital program planning, both within the hospital and within the community.

19. There is urgent need for hospitals to make provision for the in-patient care and treatment of psychiatric patients.

20. Hospitals should give special attention immediately to the need for improved, round-the-clock emergency services; for patient-care, from the most intensive to the least intensive, and for more adequate out-patient clinic care and treatment.

21. Hospitals should expand their services to include skilled nursing home programs for patients who require nursing care primarily, either by the direct operation of such nursing homes by the hospital itself or by the hospital's affiliation with a skilled nursing care facility.

22. Rehabilitation services should be expanded to assist physically, mentally and socially disabled persons to achieve a socially satisfying way of life in addition to the present exclusive requirement of potential employability.

23. Since public transportation in Westchester County at present is inadequate, a program should be developed to transport disabled patients to appropriate rehabilitation facilities.

24. Since most of Westchester's sixteen voluntary nursing associations constitute units that are too small to attract and retain the qualified staff required, the visiting nursing association should accelerate their efforts to consolidate on a regional basis or to establish one countywide nursing organization.

25. All hospitals in Westchester County should set up comprehensive home care programs which have become an important segment of modern medical care.

26. Despite indications that there is an urgent need for rehabilitation and sheltered workshops in Westchester County, the nature and extent of this need should be studied and documented more precisely, with blueprints for such workshop(s) as may be recommended being drawn up and implemented.

STATEMENT OF DR. PARCELL, PLEASANTVILLE, N.Y.

Dr. PARCELL. My name is Dr. Parcell, of Pleasantville, N.Y.

Much has been said today about hospitals and everything else, but very little has been said about how this service can be delivered, and unless we have the personnel to do it it will never be available to anyone. Beautiful hospitals do not treat patients. We need the primary physician, call them a general practitioner or whatever you want.

I have been a general practitioner for 40 years. I am working harder today than I ever worked in my life covering my community. I am getting tired. I have no coverage. Unless you train more primary doctors all this beautiful talk can go to naught. We need 70 percent of the doctors coming out of medical schools for the next 10 years, or primary doctors. We have an excess of specialists. They can serve the community for the next 20 years with only 20-percent replacement. These are the men we need.

We wil not need the paramedicals if we have general practitioners taking care of the patients—we do not need to train midwives or we do not need the corpsmen. They can fill a gap in between until the 70,000 general practitioners are produced, or the primary doctors. This is important, and without them, forget it. Billions of dollars will never do it.

Mr. REID. Well, I am delighted that you have highlighted this, and I was one of those in the Congress who supported legislation that would have strengthened, I think, funds, scholarships, and others, to insure that we have more general practitioners. I was sad and upset that the White House saw fit to veto the bill.

But I think the point you raise is very valid, and I hope that we will get more young men and women that will become general practitioners and meet the needs, and I think the Federal Government has a responsibility to help make this possible.

Dr. PARCELL. Now one other thing I would like to bring out, hospital costs should be divided in total, those for the maintenance of the physical structure such as salaries, for that which are mandated by the State or Federal Government, and those for medical services. I have possibly figured out a formula, that taking the average of 3 years running, what hospital costs are running, take 50 percent of that and give it as a direct contribution to each hospital. We have less than 10,000 hospitals in the United States, and by making out 10,000 checks or less, we can help keep those hospitals in the black instead of the red.

Mr. REID. And keep the cost of the patient down.

Dr. PARCELL. So that our insurance premiums will be less. We won't have to pay for the maintenance of the hospital.

Mr. REID. Mr. Peck, would you care to comment on this?

Mr. PECK. Well, I think three-quarters of the cost of a day in the hospital is the cost of the people. So I am not sure how you divide it, Joe. But if you divide it between the professional, say, that still has a lot of the people cost. For example, the radiologist, the——

Dr. PARCELL. Radiologist would be part of the medical cost, and laboratory would be. But when we have to pay for the superin-

tendent who takes care of the maintenance man and the man who cleans the halls and cuts the grass outside, that should not be part of the medical cost. Those are the costs I wish to have reimbursed by the Federal Government as part of the first line of defense in health, because our physical structures are our forts, and if we don't have those we don't have anything.

Mr. REID. Well, I thank you for a very creative suggestion.

Lyndall, would you like to say a final word?

Mrs. BOAL. No, I think it has been covered amply. Thank you very much.

Mr. REID. Are there any others in the room that would like to comment?

STATEMENT OF HAL BOGEN, PLANNING CONSULTANT

Mr. BOGEN. My name is Hal Bogen, planning consultant. I spent a couple years planning health facilities for a New York metropolitan public agency, and there were two observations I thought might possibly be useful. You may have had testimony on the overall needs for the metropolitan area in terms of facilities. The calculation, as I recall, as of a year or so ago, was about 4.4 billion. I am not sure that is in your records, but some work has been done on that.

The two points that may be of more significance and may or may not be in the record are, first, regarding the balance of attention that has been given by public funds and public programs to urban versus suburban facilities, it should be clear surely by now that the program under the Hill-Burton Act and its followup program——

Mr. REID. Unfortunately that act, the funding for it has been cut back very drastically, and New York is only going to be receiving, I think, 10 million.

Mr. BOGEN. But over the entire length of that time, a couple of decades now, the formulas that were used for the calculation to me have not been determined by need, but by growth alone. And so this, of course, has shortchanged some areas.

The second point has to do with the location of hospital expansion facilities, the most glaring example surely being the grasslands medical facility expansion to a medical school, in locations not accessible to either the great bulk of patients being served or certainly those who work there at low wages. And this is not a problem unique to Westchester, of course. It has occurred in other counties in the metropolitan area. And certainly those two points I think should be investigated further as your work proceeds.

Mr. REID. Thank you for those two points, and we will pursue them.

Yes, sir?

STATEMENT OF SAMUEL SMITH, COORDINATOR OF THE NEW ROCHELLE COMMUNITY ACTION AGENCY AND CHAIRMAN OF THE NEW ROCHELLE WELFARE RIGHTS

Mr. SMITH. Well, I am glad to see you, Congressman. My name is Samuel Smith, coordinator of the New Rochelle Community Action Agency and chairman of the New Rochelle Welfare Rights. What I

have to say can go hand in glove with both the welfare rights and the community action agency.

First I would like to say, however, that we were very distressed in New Rochelle because this meeting that we are holding today was never publicized to the point where it even reached the ears of the New Rochellees, because I am sure there would be more people here to this meeting from different organizations, and what not, that would like to see——

Mr. REID. Well, I am glad you had a good set of ears and were able to hear us.

Mr. SMITH. I am here to ask for help, Congressman. As you know, speaking as the chairman of the welfare rights, the aim of welfare is to get the people off welfare so they can support themselves and their families. And contrary to the belief of many people, we do have a multitude of welfare recipients that would like nothing better than this.

Now in the community action agency in New Rochelle we have started two programs. One is a licensed practical nurse and the other is a registered nursing program. Knowing that the hospitals need help and the shortage of this type of professionalism, the programs caught fire. We have a waiting list of approximately 300 more girls waiting to go into this program.

Our stumbling block is this and it is where we need the help. We have a 10-week nighttime program where students attend school for 3 hours, two nights a week. After this there is a 20-week session, and this part of the program has to do with the hospital. But our trouble lies with reception of our program by the State of New York itself. We are having difficulty getting the State to recognize our program as a legal program.

Now these girls are trained by the Yonkers College, that is, the Cooperative College Center of Yonkers. They have licensed teachers, and what not. However, the State itself does not want to recognize our program as being a legal program.

Mr. REID. Well, I am glad you mentioned it, Mr. Smith, and I will be happy to intervene with the State and see what can be done.

Mr. SMITH. Because time is growing short. The 10 weeks are almost up now, Congressman, and a lot of these girls have to know what is going to happen because the next 20 weeks are daytime sessions, all day sessions, and some of them do have menial jobs and they have to give up these jobs in order to continue in the program. This is our stumbling block, and we would appreciate your help.

Mr. REID. We will look into it promptly. Thank you.

I think the lady——

STATEMENT OF MRS. ELIZABETH LORENTZ, WITNESS FROM FLOOR

Mrs. LORENTZ. My name is Elizabeth Lorentz, and I would like to place in the record the need felt by my friends in the new careers movement for a part in the legislation that encourages people to develop guidelines for training paraprofessional personnel of all kinds. The medical centers vary greatly in the way they use paramedical personnel and have no agreement about what partnership should be developed in the medical field.

As we know from the experience of Permanente—and Dr. Garfield has written that—once you insure people you get all the people who want to talk about their health even if they are not sick—the worried well, they are called. They have a right to a hearing, too, but they do not have a right to take up the time of the busy physician who is needed by a very sick person. So that three-quarters, I guess, or more, of the patients at the Permanente Foundation are handled by paramedical personnel. Now the training seems to me important.

Mr. REID. And some form of uniform guidelines.

Mrs. LORENTZ. Right. Dr. Brew is very interested in the paramedical field but guidelines are very hard to find for the people embarked on careers in medicine, whether they are poor people or young people, looking for a career. We are trying to introduce high school kids in this area to the world of work to help fill their needs for a career and also to use them for health personnel.

Mr. REID. Might I ask whether you have looked at the Health Training Improvement Act which was signed into law last year and ascertained whether that is of any assistance to you in this regard?

Mrs. LORENTZ. I haven't studied the bill. But I think I would have been told whether it solved the needs I am referring to because my friends at Johns Hopkins have recently had a meeting where this was discussed.

But I am sorry, if this does cover the situation I brought up—I certainly will look it up. Do you feel that it does?

Mr. REID. It doesn't cover it. It does call for a study, I am advised by counsel. But I think the point you are making is valid, because if you look at the shortage of paraprofessional personnel, which perhaps is a quarter of a million, I think there is going to have to be some understanding both as to training and as to guidelines. And if this is a gap in the pending legislation we will certainly take a look at it to see what we can do to be specific.

Mrs. LORENTZ. Thank you.

Mr. REID. Thank you. It is a very good point.

Yes, sir?

STATEMENT OF MR. CONTIERE, ASSISTANT ADMINISTRATOR, ST. AGNES HOSPITAL, WHITE PLAINS, N.Y.

Mr. CONTIERE (phonetic). I am assistant administrator of St. Agnes Hospital, White Plains.

Mr. REID. A very fine hospital.

Mr. CONTIERE. Thank you. Just for the record and for the Senator's information I wanted to mention that along with catastrophic illness there is also the catastrophe of having multiple handicapped children, and I don't know if you have heard about the plight at St. Agnes which has been recognized to some degree now. We are giving day care and outpatient services to these children, but there are many programs and many conditions, like muscular dystrophy, and so forth, where there isn't sufficient funds to care for it.

Mr. REID. Would you care to estimate just from your own experience the number of handicapped children that need care and are not receiving it?

Mr. CONTIERE. Oh, well, presently we care for approximately 250, and I can say there's about five times that many children in the Greater Westchester area. Now I am talking about we are the only agency that does this in Westchester County. So I would estimate about five times that number.

Mr. REID. Well, I am glad you mentioned it, and I am glad that St. Agne's appearance has been made possible by your appearance here today.

If there are no others here I will close the hearing and merely say on behalf of Senator Kennedy and myself how grateful we are for all of you having stayed, and to express our commitment to work for creative and effective legislation to maintain the quality of our medicine, for the first time in our history make it available to all who need it, and hopefully get the cost under control, not alone for the poor, but for the middle income family that has been so badly affected as well.

At this point we will insert all statements of those who could not attend and other pertinent material submitted for the record.

(The material referred to follows:)

Gordon R. Meyerhoff, M.D.

19 Hillside Avenue
Roslyn Heights,
New York 11577
Mayfair 1-4881

April 16, 1971

Senator Edward Kennedy
Subcommittee on Health
U.S. Senate
Washington, D.C.

Dear Senator Kennedy:

Thank you for your kind invitation to present testimony to the Committee regarding medical care. It is a pleasure to see someone so concerned with such an important matter. Especially combined with wanting to see how the people feel about it.

In this regard, one can easily predict that you will hear from everybody that medical care should be available to those who need it, and where it is not, this problem should be solved. The only question will be how it should be solved: within the ways of our cherished free society or shall we give up that way and institute some form of government control, some form of socialism.

Your proposed bill seems to say we must foresake the free way of life, not allow people to have full free choice of physician, and we must, in essence, conscript physicians, telling them where, when, how, and for how much to perform their service. The Medicredit approach purports to solve these same problems within our cherished free way of life.

It is hoped as you tour the country you will not only be tuned in on the problems, but that your own heart will be open as well to the more fundamental heartbeat of the American way of life, for which men, from its very inception, were willing to sacrifice honor, fortunes, health, become maimed, and even gave up their very lives so that cherished freedom could be preserved.

It would be a tragedy for the world that if, for the sake of better health, you attempted to turn people from further cultivating this garden of freedom, to sacrificing freedom for health. The freedom appraach shows how we can have freedom and health.

It is hoped that whatever it is that is turning you, personally, away from the free way of life, that it hasn't reached the point whereby you would keep this testimony from all the other members of the committee.

Sincerely yours,

Gordon R. Meyerhoff, M.D.

Senator KENNEDY. Thank you very much.
(Whereupon, at 5:45 p.m., the subcommittee adjourned.)

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